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A DISTINCTION WITHOUT A *MORAL* DIFFERENCE? AN ESSAY ON THE DIFFERENCE BETWEEN PALLIATIVE SEDATION AND PHYSICIAN-ASSISTED DEATH

by

PATRICK T. SMITH

DISSERTATION

Submitted to the Graduate School

of Wayne State University,

Detroit, Michigan

in partial fulfillment of the requirements

for the degree of

DOCTOR OF PHILOSOPHY

2013

MAJOR: PHILOSOPHY

Approved by:

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Advisor Date

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DEDICATION

This work is dedicated to my immediate family. First, to my lovely wife, Dr. Johnelle Ryan Smith and two beautiful children, Gabrielle Carsyn and Caleb Alexander, thank you for your patience and encouragement along the way. I hope in the days ahead the times we missed as a family while I was working on this project will be rewarded with many years of exciting opportunities together. I could not have done this without each of you. And to my parents, Willie Frank Smith, Sr. and Carolyn Smith, thank you for your unwavering support of all my endeavors throughout the years. I am so grateful to have you as parents and hope to have made you proud to have me as your son. Special thanks, of course, goes to Frank Jr. and the Gadson clan, Jerome, Monique, Imani, and Nia. Our times together as a family during the breaks made all the difference in reenergizing me to complete this work.

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CHAPTER 1

PALLIATIVE SEDATION, PHYSICIAN-ASSISTED DEATH, AND AN INCONSISTENCY ARGUMENT

Contemporary Scene

Currently in the United States, Oregon, Washington, and Montana stand alone in legalizing some form of physician-assisted suicide (PAS). While these represent a relatively small number of states, according to one prominent proponent and advocate of PAS it "will probably soon become legal on a state-by-state basis, culturally tolerated, and openly practiced."[1] It appears there will be ongoing and increased pressure for other states to follow suit so that those who are terminally ill can exercise the full scope of their autonomy and "die with dignity" through PAS. Further, some would say that if suicide, or less pejoratively self-killing, can be justified in some settings then voluntary active euthanasia ought to be justifiable in some cases as well.[2] That is, if these patients deem it a fit end to their lives given their unique circumstances and specific personal life journeys.

A growing number of medical and health care professionals, many moral philosophers, several theologians and clergy from various traditions, and

[1] Margaret Pabst Battin, "Is a Physician Ever Obligated to Help a Patient Die?" *Ending Life: Ethics and the Way We Die* (New York: Oxford University Press, 2005), 88.

[2] Michael Tooley, "In Defense of Voluntary Active Euthanasia and Assisted Suicide," *Contemporary Debates in Applied Ethics*, edited by Andrew I. Cohen and Christopher Heath Wellman (Malden, MA: Wiley-Blackwell, 2005) 161-178.

ordinary citizens support the view that PAS and voluntary active euthanasia (VAE) should be a legitimate, and in some cases a morally obligatory, palliative care option that should be provided for patients at the end of their lives under carefully prescribed circumstances.[3] For examples, Margaret Battin, a philosopher and ethicist, and Timothy Quill, a medical doctor, in their affirmation of this point write, "Relief of suffering—and with it the *freedom* to face dying as one wishes—*must* be available to suffering patients now" [emphasis added].[4]

One can provide further examples from religious thinkers in reference to the aforementioned point. The Episcopal Bishop, John Shelby Spong comes "at the issues of assisted suicide, active euthanasia, and the freedom to die with dignity from a specifically religious position."[5] Not only does he think these should be legal practices but also that they "should be acclaimed as both moral and ethical—a human right, if you will." He has committed to "work through ecclesiastical processes of [his] church and all the forces of organized

[3] This point is substantiated in a recent volume compiled on the topic. See Timothy E. Quill and Margaret P. Battin, eds. *Physician-Assisted Dying: The Case for Palliative Care & Patient Choice* (Baltimore: The John Hopkins University Press, 2004).

[4] Ibid., 2. Further interaction with philosophers and medical professionals are in subsequent chapters.

[5] John Shelby Spong, "A Death to Be Welcomed, Not an Enemy to be Defeated," *Physician-Assisted Dying: The Case for Palliative Care & Patient Choice*, edited by Timothy E. Quill and Margaret P. Battin (Baltimore: The John Hopkins University Press, 2004) 150.

religion to change [the] consciousness" of various communities concerning the issue.[6]

Or consider the stance of Gerrit G. de Kruijf, a theologian from the University of Leiden, who takes the ethical issue of euthanasia as a test case for applying his preferred approach to public theology. While he is a bit more tempered in his conclusion than Spong concerning patient autonomy, de Kruijf thinks that autonomy has to be relativized and cannot be absolute in a health care context. He, nevertheless, would advocate for a law that provides judicial tests that can account for a doctor's decision to be involved in euthanasia or PAS. He thinks "because killing can never be a normal act of medical care, but only a paradoxical one, it should always be accounted for in order to protect patients from unauthorized decisions by doctors."[7] The primary concern for de Kruijf is to provide safeguards for patients in physician decision-making regarding euthanasia. Clearly, these thinkers and many others see this issue as one of patients' rights or of physicians' moral obligation or some combination of both.

There are many other professionals who are also members of the various groups mentioned above, alternatively, who see trends towards legalizing PAS and VAE as not upholding the inherent dignity of human beings, nor the inherent

[6] Ibid., 160.

[7] Gerrit G. de Kruijf, "The Challenge of a Public Theology," *Theology Between Church, University, and Society*, *Studies in Theology and Religion, Volume 6,* edited by Martien E. Brinkman, Nico F. M. Schreurs, Henrik M. Vroom, and Conrad J. Wethmar (The Netherlands: Royal Van Gorcum, 2003) 148.

honor of the medical profession. This stance is in contradistinction to that which is often claimed by proponents of PAS and VAE. Instead, opponents of PAS and VAE see this as actually undermining patient "dignity" by violating the "sanctity of human life" and perhaps even dissolving the integrity of the healing art of medicine.

For example, Leon Kass, a medical doctor and bioethicist, sees "the sanctity of life" and "human dignity" as compatible notions that when rightly understood are mutually reinforcing. He writes:

> In the current debates about euthanasia, we are often told that these notions pull in opposite directions. Upholding death with dignity might mean taking actions that would seem to deny the sanctity of life. Conversely, unswervingly upholding the sanctity of life might mean denying to some a dignified death. This implied opposition is, for many of us, very disquieting. The dilemmas themselves are bad enough. Much worse is it to contemplate that human dignity and sanctity might be opposed, and that we may be forced to choose between them.[8]

Kass is highlighting the tension that many feel who simultaneously are opposed to PAS and VAE, but also who are not proponents of any form of vitalism, which seeks to preserve bodily functioning and "life" at all costs regardless of circumstances. Where the lines are to be drawn is not very clear in many situations.

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[8] Leon R. Kass, "Death with Dignity and the Sanctity of Life," *Last Rights? Assisted Suicide and Euthanasia Debated*, edited by Michael M. Uhlmann (Grand Rapids: Eerdmans, 1998) 202.

Many proponents of PAS and VAE think allowing these practices as legitimate end-of-life options for medical professionals and patients to utilize can ease the tension by not having to make distinctions where it may be the case that none can be made. Further, many of those who oppose PAS and VAE would affirm that patients ought to be enabled to exercise their autonomy in a health care context, but would point out that autonomy in medical decisions, as is the case in a liberal political democracy, has its limits. And PAS and VAE, its opponents suggest, are such expressions of autonomy that extend beyond morally legitimate medical and legal boundaries. The position of Arthur Dyck, an ethicist of Harvard University's School of Public Health, is illustrative of this point.

> An individual's life is to be protected as having incalculable worth. Being hopelessly ill or fatally wounded or being one for whom life has in various ways become a burden does not qualify, that is, does not reduce the law's interest in preserving life. This interest is not diminished in any way by the medical condition and the wishes of the one whose life is at stake.[9]

The primary issue at stake for others is the intrinsic honor of the medical profession. As Sissela Bok has noted, "Anyone raising the question of physician-assisted suicide among a group of doctors comes to recognize their conflicted response….When it comes to singling out their own profession to carry out a *practice* of assisted suicide, both proponents and opponents share a sense of

[9]Arthur Dyck, *Rethinking Rights and Responsibilities: The Moral Bonds of Community* (Washington D.C.: Georgetown University Press, 2005) 265.

worried unease."[10] It is this notion that will become more central in the work presented here.

Continued Debate

As indicated in the section above, informed thinkers disagree concerning the appropriateness or lack thereof of PAS and VAE. Interestingly, divergence of judgment is had by those within the medical profession, within the same academic disciplines, say, philosophy, and within singular religious traditions such as Christianity. So it does not appear that difference surrounding this issue is simply a question of *Weltanschauung* or worldview. Much ethical and political debate will continue to go forth in various contexts concerning the appropriateness of PAS and VAE as being legitimate practices in the medical profession.

To be sure, many of those persons working in the fields of palliative medicine, pain management, and hospice care who may oppose PAS and VAE do struggle with determining when some currently accepted medical practices such as withholding and withdrawing life sustaining treatments and deep sedation of patients to unconsciousness at the end of life cross into these areas that they have traditionally considered beyond the scope, morally speaking, of

[10] Gerald Dworkin, R. G. Frey, and Sissela Bok, *Euthanasia and Physician-Assisted Suicide: For and Against* (New York: Cambridge University Press, 1998) 133-134.

proper professional healthcare. They recognize that while death may be an event, dying is a process with many uncertainties. And so discerning fine distinctions in some of these matters often prove difficult though not impossible.

Many working in end-of-life care and who also engage in ethical reflections in this area maintain that things may not be as straightforward as some who participate in the contemporary philosophical debates suggest. This is true for those on all sides of the issue. Kenneth Vaux astutely observes that "in the ethics of dying, absolutist principles must always be chastened by mercy."[11] Of course, this should not be thought to endorse a claim that a plea for merciful motive is an excuse to direct intentional homicide.[12] The issues surrounding euthanasia still need to be vigorously sorted as to the range of what counts as morally permissible palliative care options for patients at the end of life. Regardless, health care professionals engaged in palliative care have responsibilities to do everything possible within ethical, professional, and legal boundaries to medically treat and care for their patients. Therefore, reflecting

[11] Kenneth L. Vaux, "Debbie's Dying: Mercy Killing and the Good Death," *Euthanasia: The Moral Issues*, edited by Robert M. Baird and Stuart E. Rosenbaum (New York: Prometheus Books, 1989) 31.

[12] Willard Gaylin, Leon R. Kass, Edmund Pellegrino, and Mark Siegler, "Doctors Must Not Kill," *Euthanasia: The Moral Issues*, edited by Robert M. Baird and Stuart E. Rosenbaum (New York: Prometheus Books, 1989) 25.

on these issues not only empirically, but also conceptually is essential for end-of-life medical ethics.[13]

A Widely Embraced Alternative?

One complex ethical issue in end-of-life palliative care is the use of palliative/terminal sedation to manage otherwise uncontrollable pain and symptoms. Palliative/terminal sedation is thought to be an advance in palliative care that has alleviated the need for PAS and VAE to be implemented in those circumstances where many proponents may deem these latter procedures as being ethically and medically preferred. A very broad understanding of palliative/terminal sedation is: aggressive symptom control through the use of sedation even to the point of deep unconsciousness if needed in terminally or otherwise gravely ill patients who are in the dying process. This process is widely embraced in law and accepted by numerous professional health care organizations such as *The Hospice and Palliative Nurses Association*, the *National Hospice and Palliative Care Organization*, the *American Academy of Hospice and Palliative Medicine*, and the *American Medical Association* among others. It is important to mention here that what each of these organizations have in common is that they approve of palliative/terminal sedation as being a

[13] The reference here to empirical reflection has to do with the clinical realities of what actually is taking place with respect to the implementation of certain palliative care options that are invoked at the end of life in a health care context.

legitimate practice and form of palliative care while rejecting euthanasia and PAS.

An "Inconsistency Argument"

However, many philosophers and medical ethicists have challenged the claim that palliative/terminal sedation is the kind of advance that has excluded the need for PAS and VAE to be options for patients at the end of life. There is some question as to whether this procedure is sufficiently distinct in a morally relevant way from PAS or VAE. Some claim that there is no real moral distinction between the two practices of palliative/terminal sedation and euthanasia. In other words, palliative/terminal sedation simply reduces to "slow euthanasia" or as also described "euthanasia in disguise." If so, the implications are clear. PAS and VAE should be legal and legitimate end-of-life treatment options for patients along with palliative/terminal sedation. If not, then palliative sedation should be prohibited as well.

The general thrust here can be summarized in the following argument that claims to show the inconsistency when one assumes that palliative/terminal sedation is morally permissible whereas VAE and PAS remain morally problematic in a health care setting. This is, of course, despite the fact that PAS has been legalized in a few states. Let's call this the "Inconsistency Argument." It begins with the following assumptions:

1) For any two practices, X and Y, if there are no morally relevant differences between X and Y, then if Y is morally impermissible, X is morally impermissible.

2) There are no morally relevant differences between palliative/terminal sedation and PAS/VAE.

From 1) and 2), it follows that:

3) If PAS/VAE are morally impermissible, palliative/terminal sedation is morally impermissible.

Next, we assume that:

4) PAS/VAE are morally impermissible.

5) Therefore, palliative/terminal sedation is morally impermissible.

In other words, it is impossible, given the truth of 1) and 2), to believe that PAS/VAE is morally impermissible, while at the same time believing that palliative/terminal sedation is morally permissible. So one who opposes PAS and VAE on ethical, philosophical, professional, and/or religious grounds should also oppose palliative/terminal sedation. The problem is, of course, that many medical professional organizations, as noted above, and legal scholars acknowledge the legitimacy of palliative/terminal sedation while rejecting PAS and VAE. This, to say the least, would be awkward for those who hold this view if the "Inconsistency Argument" is cogent. This issue is not only important for health care professionals, but also for ethicists, counselors, social workers, chaplains of various stripes, and others, who may be asked to assist and support patients and their families concerning end-of-life treatment options.

Broad Responses to the "Inconsistency Argument"

As should be clear, there are four primary stances to the conclusion of the "Inconsistency Argument" given that it is valid (its conclusion is true if its premises are). First, one could accept the conclusion and advocate that both sets of practices should be prohibited as options for medical care at the end-of-life. This seems to be the position of Howard M. Durcharme, a philosopher at the University of Akron. He challenges the application of what he calls permanent terminal sedation as advocated in an earlier policy draft on this issue from the National Hospice and Palliative Care Organization. He writes:

> The prima facie ethic on PTS [permanent total sedation] is this: If and when it is ethically wrong to kill an individual by PAS or euthanasia, so too it is wrong to end an individual's conscious, personal life by PTS. Given that PAS and euthanasia are ethically wrong, it follows that PTS is ethically wrong. For the same reasons that one ought not to choose suicide or euthanasia, one ought not to choose PTS. For the same reason that a physician ought not to do PAS or euthanasia, a physician ought not to do PTS.[14]

There are many details that Durcharme raises in his objections to palliative/terminal sedation that are specific to the particular conception which he is considering.

Perhaps there are other ways of approaching the issue of palliative/terminal sedation that are not subject to some of the exact criticisms

[14] Robert J. Kingsbury and Howard M. Durcharme, "The Debate Over Total/Terminal/Palliative Sedation"; http://www.cbhd.org/resources/endoflife/kingsbury-durcharme_2002-01-24_print.htm. Accessed 11/04/2008.

he raises in the essay referenced. Moreover, it may be the case that Durcharme would not have the same ethical stance toward these alternative conceptions of palliative/terminal sedation. Nevertheless, at this stage of our discussion, he stands as an example of one who would embrace the "Inconsistency Argument," generally speaking, and that both practices should be prohibited as options for palliative care at the end-of-life.

Second, some may decide to accept premises 1) and 2) yet reject premise 4), thus allowing them to also reject the conclusion of the argument. So instead of rejecting both practices, they would argue, alternatively, that current understandings of the moral impermissibility of PAS and VAE by its opponents are wrongheaded. So given the moral permissibility of palliative/terminal sedation, one should also embrace PAS and VAE as legitimate treatment options for patients at the end of life. To quote Margaret P. Battin again,

> It's not that palliative sedation/sedation to unconsciousness is wrong. It can be practiced hypocritically…. Because there is so much anxiety that it might be confused with euthanasia, the features that it shares with euthanasia are obscured or sanitized. …The implausible effort to draw a completely bright line between continuous terminal sedation and euthanasia makes the practice of terminal sedation both more dangerous and more dishonest than it should be—and makes what can be a decent and humane practice morally problematic.[15]

Another able proponent of this second stance is Dan W. Brock. He writes:

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[15] Margaret P. Battin, "Terminal Sedation: Pulling the Sheet over Our Eyes" *Hastings Center Report* 38, no. 5 (2008): 30.

> [T]erminal sedation…and physician-assisted suicide each have complex sets of advantages and disadvantages. For each practice, particular advantages and disadvantages may be more or less important with a specific patient seeking a hastened death. No one of these practices has a clearly superior balance of advantages over disadvantages in all cases. This implies that physician-assisted suicide should not be prohibited while…terminal sedation [is] permitted.[16]

The third stance one can take with the "Inconsistency Argument" is again to deny that this is a sound argument for the conclusion because it rests on a false premise, as is the case with the second stance. Here, though, one would reject the argument for the conclusion not by rejecting premise 4) as in the previous approach. Instead, she would reject premise 2) by arguing that there are morally relevant distinguishing factors between palliative/terminal sedation and PAS/VAE. Or she could argue that palliative/terminal sedation and PAS/VAE are morally incommensurable, that is to say, not comparable in moral terms, so that it is improper to categorize the practices together.

If the line of reasoning reflected in the third stance can be shown correct in some way, then it thereby indicates that one does not *necessarily* need to accept that both of these practices morally stand or fall together in a health care context in order to be consistent in advocating for palliative/terminal sedation while opposing PAS and VAE. Of course, this claim for consistency is on the assumption that an individual may have some legitimate reasons for thinking

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[16] Dan W. Brock, "Physician Assisted Suicide as a Last-Resort Option at the End of Life," *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice*, eds. Timothy E. Quill and Margaret P. Battin (Baltimore: The John Hopkins University Press, 2004) 135.

PAS and VAE are morally impermissible to begin with. But further, that palliative sedation is not subject to the same ethical criticisms that are used in the condemnation of PAS and VAE. As spelled out below, I argue for a nuanced version of this third stance to the "Inconsistency Argument."

A fourth stance to the "Inconsistency Argument" could be to maintain that PAS and VAE actually are to be preferred over palliative/terminal sedation in a medical context given the goals of palliative care. One who takes this approach would deny the conclusion in 5) by rejecting both 2) and 4) of the "Inconsistency Argument." The fourth stance differs from the third in that its proponents think that 4) is false. In other words, there are good reasons to think that PAS/VAE are morally permissible, according to this view. This fourth position is similar to the third stance in that it also rejects 2). The two sets of practices under discussion are not morally equivalent. An advocate of this view could proceed by making a case that PAS and VAE have some ethical and medical advantages over palliative/terminal sedation given the goals of end of life palliative care. Some may even maintain that PAS and VAE should be embraced while palliative/terminal sedation should be rejected.

A counter-argument of this sort can be formulated in the following manner. Let X= PAS/VAE, Y=palliative/terminal sedation, and Z=effective palliative care.

6) For any two groups of morally permissible actions X and Y, if X is more beneficial than Y in accomplishing goal, Z, at which X and Y are aimed, then X is to be morally preferred over Y.

7) If PAS and VAE are more beneficial than palliative/terminal sedation in accomplishing effective palliative care, then PAS and VAE are to be preferred over palliative/terminal sedation.

Let us assume:

8) PAS and VAE are morally permissible.

9) PAS and VAE are more beneficial than palliative/terminal sedation in accomplishing effective palliative care.

Then it follows that:

10) Therefore, PAS and VAE are to be morally preferred over palliative/terminal sedation.

Premises 8) and 9) are key here. To be sure, the standard arguments for the moral permissibility of PAS and VAE would be marshaled to substantiate premise 8). There appear to be, at the very least, a couple ways to support the claim made in premise 9). First, if there is data to suggest that palliative/terminal sedation may unnecessarily prolong the dying process, then a proponent of this fourth stance may well argue that palliative/terminal sedation is no improvement from the morally problematic vitalism, which advocates maintaining the biological functioning of patients despite their medical condition. To be sure, this is a situation that many medical professionals and ordinary citizens seek to avoid.

Another way a proponent could argue for the moral superiority of PAS and VAE over against palliative/terminal sedation is to make a distinction between a human being's biological life and biographical life. The argument would suggest that when someone is sedated to unconsciousness at the end of life that her biographical life has ended while her biological life nevertheless remains. But, as the advocate of this view might contend, it is the biographical life of the human beings that is of ethical importance when it comes to care for them at the end of life. If one's biographical life is gone, then this is tantamount to the person's being gone regardless of whether the physical body still functions to some degree. In that case, employing palliative/terminal sedation unnecessarily prolongs the dying process, uses more human and economic resources that are already scarce, and exacerbates many of the problems that plague the health care system for human beings who have lost personhood.

Research Aim of the Project

To reiterate, the point being made by the "Inconsistency Argument" as formulated above is that given palliative/terminal sedation is not clearly superior to PAS and VAE—on the assumption that there are no morally relevant differences between the two sets of practices—both sets of practices, then, should either be included in the scope of palliative care options or they should be excluded as such for patients at the end of life. This is because they are

either both morally permissible or both morally impermissible. For health care professionals, medical ethicists, moral philosophers, and theologians to think otherwise is inconsistent.

This dissertation will seek to address the "Inconsistency Argument" from the perspectives of the second and third stances as described above. The project is a philosophical one that seeks to deal with issues of consistency and conceptualization, while incorporating relevant empirical data. This latter aspect is important not only because of the interdisciplinary nature of contemporary bioethics, but also given that many moral judgments often hinge on non-moral facts. Concerning the former issues of consistency and conceptualization, the primary question of this dissertation is to determine whether or not medical professionals and others invested in this area are ethically consistent if they reject PAS and VAE while embracing the practice of palliative/terminal sedation. So this project is to be considered a work in applied analytic bioethics.

I do not seek here to settle the ethical issue of whether or not PAS and VAE are morally permissible under any or every circumstances whatsoever. In the years to come, there is not much doubt this issue will continue to be hotly debated in liberal political democracies around the world and in health care systems that have been influenced by a predominantly Hippocratic and Western approach to medicine. Nor am I necessarily seeking any prescriptions

for public policy on this matter even though some of the issues regarding how the law views PAS, VAE, and palliative/terminal sedation do emerge in my discussion. Instead, my attempt is a more modest one. It is simply to explore the consistency of practice and thinking for those who are opposed to PAS and VAE yet embrace palliative/terminal sedation when both are carefully circumscribed.

Chapter Overview of the Thesis

The first four chapters (including this one) provide the milieu for the problem as understood by many medical ethicists and health care professionals who focus on end-of-life care. After highlighting the rigors of crafting definitions for some of the central terms used in this work (chapter two) and outlining what I consider the more interesting arguments against PAS and VAE and some responses and counter-responses to these (chapter three), I provide specific reasons that some thinkers have given to substantiate the general "Inconsistency Argument" (chapter four). In the fifth chapter, I introduce and examine a response to the generic "Inconsistency Argument" that I think fails as an attempted "Wedge Argument." From there, in the final chapter, I aim to offer another form of a "Wedge Argument," what I consider a more defensible one, that suggests there are both empirical and conceptual reasons for maintaining that there are morally relevant differences between PAS/VAE and

palliative/terminal sedation for those who have some reasons to think the former is ethically problematic as articulated in chapter three. Therefore, those who are morally and professionally opposed to PAS and VAE for *certain* reasons are not *necessarily* being inconsistent in their support of palliative/terminal sedation as a legitimate treatment at the end-of-life when it is carefully defined, understood, and practiced.

In what follows, I sketch the content and contribution that each of these chapters makes to accomplishing the task of this work as described thus far. Chapter two, "The Nature of Physician-Assisted Death in a Health Care Context" crafts important definitions, justification of particular language use, and key concepts that must be established at the outset of any discussion concerning the ethical issues surrounding certain end-of-life medical decisions. Chapter three, "A Survey of Some Arguments Against Physician-Assisted Death" provides some reasons given in favor of premise 4) of the "Inconsistency Argument." In that chapter I identify those arguments that seem best to cohere with the definitions developed in chapter two. These two chapters (two and three) set the backdrop to better examine the claims of the "Inconsistency Argument." Specifically, to provide a framework for determining if the arguments and reasons for resisting PAS and VAE count equally against those who wish to advocate for palliative/terminal sedation over against PAS and VAE. Many of

the central distinctions that historically permeate the euthanasia debate are essential in evaluating the justification proffered for palliative/terminal sedation.

In chapter four, "The Challenge of Inconsistency Arguments for Palliative/Terminal Sedation," I provide specific examples of philosophers who seem to make arguments that support the basic thrust of the "Inconsistency Argument" in their written scholarship. The philosophical bioethicists Margaret P. Battin from the University of Utah and Dan W. Brock at Harvard University Medical School were chosen based on their academic output in the field of bioethics and their influential contributions to moving this discussion forward. Both have been exposed to and have worked as bioethicists in clinical settings as well as academic institutions. Therefore their philosophical analysis is shaped by the application of these practices in the medical professional context. I set forth their arguments for the claim that PAS and VAE should be palliative care options available to patients at the end of life just as palliative/terminal sedation is. All of this lends support to premise 2) of the "Inconsistency Argument."

In chapter five, "An Indefensible Wedge Argument," I begin by pursuing the line of reasoning provided by Torbjörn Tännsjö of Stockholm University, who suggests that terminal sedation provides an alternative to euthanasia and PAS/PAD. He suggests:

> My argument rests on the observation that while the sedation of the patient may mean that the patient is actively killed (by complications related to, and caused by, the sedation), the death of the patient is not,

> in that case, intended by the doctor but merely foreseen. So this is different from euthanasia. As for the withdrawal of artificial nourishment and hydration of the patient, the intention may certainly be to hasten death, I submit. However, since the means of doing so are passive rather than active this is once again different from euthanasia.[17]

I argue that Professor Tännsjö has not sufficiently delineated the practice of terminal sedation in a morally relevant way that does not fall prey to the charge that it is a type of euthanasia, as euthanasia is understood by a large group of medical ethicists and practitioners. Further, I claim that aspects of his conceptual analysis are problematic and that he fails to take into consideration important empirical data in attempting to defend his position. It seems to be that Professor Tännsjö does not provide a suitable alternative to euthanasia for those who find the practice problematic nor does he provide an adequate response to the general thrust of the "Inconsistency Argument."

In the sixth and final chapter, "Toward a More Defensible Wedge Argument," I attempt to distinguish the practices of PAS and VAE on the one hand and palliative sedation, my preferred nomenclature for reasons stated in that chapter, on the other. Moreover, I suggest that the manner in which some philosophers have described terminal/palliative sedation should be of concern to those who are opposed to PAS and VAE. It would seem that their descriptions and characteristics are "too close for comfort" for opponents of PAS and VAE.

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[17] Torbjörn Tännsjö, "Introduction," *Terminal Sedation: Euthanasia in Disguise?* edited by Torbjörn Tännsjö (Dordrecht, Netherlands: Kluwer Academic Publishers, 2004) xvi.

So if medical ethicists and practitioners were to embrace palliative sedation without also embracing euthanasia on these philosophers' accounts of palliative sedation and euthanasia, they would seem to be inconsistent.

I argue that one problem with the "Inconsistency Argument" is that there is some ambiguity on the various understandings of when palliative sedation is warranted at the end of life during the dying process. Many discussants are often talking past one another by using the same terms but employing very different meanings and connotations. There I tackle the controversial issue of definition and competing conceptions of the practice in the literature. I set out to provide and commend a more nuanced description of palliative sedation that is more or less accepted by a number of professional organizations. It is important that this re-conceptualization be consistent with many organizations' opposition to PAS and VAE. Based on this understanding and application of palliative sedation, I am not inclined to accept premise 2. That is, as it is often understood by proponents of inconsistency styled arguments. The conceptualization I offer seeks to take into account the relevant clinical indications that aptly describe when the procedure is appropriate. It is also one that does not reduce to "slow euthanasia."

Furthermore, I introduce and attempt to defend what I understand to be the morally relevant distinguishing features of the two practices. A host of questions need to be addressed such as: How, if at all, is evidence that suggests

the appropriate use of sedation at the end of life does not directly hasten death matter for this discussion? What about withholding artificial feeding and hydration while using sedation for long periods of time? Do clinical intentions matter in moral assessment of these issues? What role, if any, does the relevant empirical data help with the difficult discussion of clinical intentions? What place does the controversial notion of double-effect have in the conversation?

One More Distinction and an Overall Conclusion

In the literature on this subject many often craft the conversation around the claim that palliative sedation is an alternative to PAS/VAE by showing how the former is morally distinct from the latter. In my understanding, however, there seem to be two concerns at work that generate two different questions, such that each question may yield different answers. They are: 1) Does palliative sedation suffer from the same perceived wrong-making properties of PAS/VAE for those who are opposed to these latter practices? And 2) is the kind of palliative sedation developed in Chapter 6, namely proportionate palliative sedation, a suitable alternative to PAS/VAE?

As mentioned above, I answer the first question negatively based on the nuanced understanding of palliative sedation developed in Chapter 6. The answer to the second question, it seems, is not merely about whether palliative sedation should be seen as a compromise or an alternative between the

extremes of intolerable suffering *resulting from a physiological base*, on the one hand, and PAS/VAE, on the other. It seems that it is difficult to attempt an answer to this question in isolation from the agents (including both medical professionals and patients) involved and the context in which it is being considered. An answer to this second question cannot adequately be given without identifying *for whom* and *for what reasons* it is seen to be a compromise or an alternative.

It seems that on the account developed in the last chapter of this work that what I call proportionate palliative sedation is a suitable alternative to PAS and VAE in addressing the suffering that originates *from intractable pain* (i.e. pain that is resistant to relief) *and refractory symptoms* (i.e. symptoms that are not responsive to standard treatments). For this group, the compromise is that patients do not need to be left in a state of excruciating pain and refractory symptoms that result in suffering with no medical recourse. However, for those patients who fear overall loss of control at the end of life even though pain is sufficiently managed, or want to primarily die on their own terms, proportionate palliative sedation, it would appear, may not be an apt compromise or legitimate alternative.

Nevertheless, I conclude that on a more nuanced understanding of palliative sedation, namely that of proportionate palliative sedation, there is no inconsistency on the part of medical ethicists or practitioners who affirm

palliative sedation while being opposed to PAS and VAE for particular reasons. And this is the case even if some find it an unsuitable alternative for their particular circumstances.

CHAPTER 2

THE NATURE OF PHYSICIAN-ASSISTED DEATH IN A HEALTH CARE CONTEXT

Introduction

The contents of this chapter identify some of the theoretical issues that go into the difficult task of defining terms in this debate. I seek to put forward definitions of physician-assisted suicide and various forms of euthanasia that while admittedly not universal, should not be thought idiosyncratic either. Along the way, I provide some justification for the nuanced understandings of these terms that are developed. These definitions can be said to enjoy broad acceptance from those with varying perspectives on the morality of the issue.

From these conceptual resources, I then provide some reasons for why 'physician-assisted death' (PAD) is to be understood as an umbrella term that includes both *voluntary* active euthanasia and physician-assisted suicide for this project. In sum, it is these two practices that much of the contemporary debate centers on when being compared to other kinds of medical procedures at the end of life (e.g. palliative sedation). I conclude the chapter by highlighting some perceived benefits and burdens for the understanding of PAD on offer. All of this is in service of identifying the key issues that seem to capture the essence of the debate so that one has a clearer basis from which to evaluate the practices that would fall under the scope of the term.

The Kind of Definition Needed for this Debate

Anyone acquainted with the debate realizes that the question of defining "euthanasia" in many ways has proven difficult. John Finnis has rightly observed, "The term 'euthanasia' has no generally accepted and philosophically warranted core of meaning."[1] I want to suggest that much of the disagreement that surrounds the conversations regarding the moral permissibility or impermissibility of PAD often centers on the use of terms where there is either no clear agreement or lack of clarity concerning terminology use. I think this is the case even with informed parties on this issue.

John Keown makes these points more forcefully when he writes, "The euthanasia debate is riddled with confusion and misunderstanding. Much of the confusion derives from a failure of participants in the debate to define their terms."[2] He goes on to provide examples of how the resultant confusion surrounding euthanasia is expressed in the broader contemporary context when he writes:

> [I]f an opinion pollster asks people whether they support 'euthanasia', and the pollster understands the word to mean one thing (such as giving patients a lethal injection) while the people polled think it means another (such as withdrawing a life-prolonging treatment which the patient has

[1] John Finnis, "A Philosophical Case Against Euthanasia," *Euthanasia Examined: Ethical, Clinical, and Legal Perspectives*, edited by John Keown (Cambridge: Cambridge University Press, 1995), 23.

[2] John Keown, *Euthanasia, Ethics, and Public Policy: An Argument Against Legalisation* (New York: Cambridge University Press, 2002), 7.

> asked be withdrawn because it is too burdensome), the results of the poll will be worthless. Similarly, if two people are discussing whether 'euthanasia' should be decriminalised and they understand the word to mean quite different things, their discussion is likely to be fruitless and frustrating.[3]

Of course, Keown is describing and expressing frustration over classic cases of equivocation. Therefore, in order to minimize these unwelcome states of affairs, attention is needed in crafting a definition to be used in a specific context for the purpose of appreciating the relevant points of contention in the discussion.

To be sure, the claim here is not that our being clear on definitions will necessarily solve the issue. Instead it is that having a better grasp of the meanings of words in a given discourse affects not only the understanding of the claims being made but also the evaluation of the arguments in which the terms are used. So even if there remains no clear agreement regarding the conclusion of the arguments, there can at least be clarity on the use of certain terms, which in turn should minimize the potential of disputants simply arguing passed one another. A further benefit for the purposes of this work is that a clearer sense of what is meant by the terms can aid in evaluating whether or not one is consistent with respect to ethical judgments regarding other practices associated with end-of-life medical care.

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[3] Ibid., 9-10.

Many discussions of this topic begin with an etymological analysis of the word 'euthanasia' which simply means "good death" or "gentle death." If this were all the discussion turned on, there would not be the kind of fervent debate on the issue. One would be hard pressed to deny someone a good or gentle death. Of course, this general description based on etymology is not what is under such scrutiny. The issues involved with crafting a definition of PAD are more complex than this. What is needed is a definition that is robust enough to serve as a basis from which rigorous moral reflection on the practices of PAD can take place without begging the question.

The approach taken here can be described as an attempt to provide an intensional definition of PAD that is both precising and theoretical. Brief elaboration is in order. An intensional definition seeks to identify the "set of all and only those properties that a thing [or in this case, a medical practice] must possess for that term to apply to it."[4] I think that this should be the preferred method when it comes to defining the central terms of this discussion. The approach undertaken here is to include both precising and theoretical aspects to the intensional definition offered below since intensional definitions have varying purposes.

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[4] Merrilee Salmon, *Introduction to Logic and Critical Thinking, Fourth Edition* (United States of America: Thomson Learning, 2002) 58.

Concerning the precising aspect, the euthanasia debate often suffers from a degree of vagueness regarding the very term itself. There are questions as to what practices should be included as instances of PAD. And this is the case regardless of the moral assessment of these actions. Consider a scenario of removing a ventilator from a patient with the patient's or surrogate's consent when there is no longer any chance of recovery and the dying process is being forestalled by these means. Should this be considered an instance of PAD? There is some disagreement on how this should be classified, though there is fairly strong agreement as to its moral permissibility in a health care context under certain conditions. So what is needed is a more précising definition, which seeks to eliminate borderline cases of vague terms insofar as possible.

Furthermore, an intensional definition of PAD needs to be theoretical. This aspect of an intensional definition also is aimed at reducing vagueness, but in addition carries with it some underlying theory whose truth is presupposed alongside other interrelated claims about the nature of the world, an act, or some event in order for it to have any sense. For example, consider one among other definitions of death. Let's say the "'death of a person' means "cessation of that person's brain functions." If so, then this definition involves a theory, which includes being "committed to the view that a human body that has totally and

irreversibly lost the use of its brain is no longer a person, even if machines can maintain the body's circulatory, respiratory, and other systems."[5]

The underlying action theory implicit in the definitions below maintains that there are five elements in a moral event, namely, the agent, an act, "the circumstances under which it is taken, the consequences of the act, and its intention." [6] I think that Edmund Pellegrino's commentary on this claim is important to the development of the point being made in this section concerning the theoretical aspect of an intensional definition so I will quote him at length.

> Contemporary moral philosophy has tended to emphasize one or the other of these elements. Thus, consequentialists focus on the outcome of the act, that is, it balances of harms and goods. Situation ethicists focus on the circumstances surrounding the act, and deontologists focus primarily on the intention of the act itself, and on its intrinsic or intuitive rightness or wrongness. For virtue theorists, the moral agent takes center stage.
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> Any complete description or judgment of a moral event requires consideration of each component and the relationships of the components to each other. Most ethical theories make these connections

[5] Ibid., 63-64.

[6] Edmund D. Pellegrino, "The Place of Intention in the Moral Assessment of Assisted Suicide and Active Euthanasia," *Intending Death*, edited by Tom L. Beauchamp (New Jersey: Prentice Hall, 1996), 163. The terms "act" and "intention" will be defined and more thoroughly developed in the last chapter along with other important concepts. Here I hope that it will suffice to describe an "act" as "those events that take place in the world and that are explained by the intentions of the agents." (Daniel P. Sulmasy, "'Reinventing' the Rule of Double Effect," *The Oxford Handbook of Bioethics*, edited by Bonnie Steinbock (New York: Oxford University Press, 2007) 122), and "intention" roughly speaking, as "the reason, purpose, or end for which and to which, moral acts are directed." (Pellegrino, "The Place of Intention in the Moral Assessment of Assisted Suicide and Active Euthanasia," 164)

> informally and indirectly. Consequentialists, for example, are concerned that moral agents choose acts with the best balance of harms and benefits; deontologists want agents to choose the right act; and virtue theorists want people to be habitually disposed to act well in all moral circumstances. Situationists want agents to have good intentions so far as circumstances dictate. Implicitly, whatever theory one may espouse, there will be some appeal to right intention. No moral theory would urge wrong intentions.[7]

It should be noted that there is a difference between saying that theoretical definitions carry along with them some underlying theory, which is *considered to be true*, and that theoretical definitions *themselves are true*. They are "neither true nor false, strictly speaking. The reason is that theoretical definitions function as proposals to see or interpret some phenomenon in a certain way. Since proposals have no truth value, neither do theoretical definitions."[8]

As shown below, the intensional definition proposed is one that affirms the important *theoretical* and *practical* roles that *intention* plays, among other qualities, in the moral assessment of actions. Furthermore, the definition suggests that in identifying instances of PAD there is a move from merely *observed* objective or external qualities of an act to consider subjective qualities of the agents that may also need to be *discerned* in determining what kind of moral event has taken place. It should go without saying that not all agree,

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[7] Ibid., 163.

[8] Patrick J. Hurley, *A Concise Introduction to Logic, Eighth Edition* (Belmont, CA: Wadsworth Thomson Learning, 2003) 91. This is distinct from merely stipulating a definition.

ontologically speaking, that intention matters in the way I want to suggest in distinguishing the moral meaning of two actions even though they may have the same consequences or outcome. This much is uncontroversial. What would be controversial is failing to acknowledge the point. This is discussed in more detail in Chapter 6.

An intensional definition that is both precising and theoretical should be able to capture the essence of what medical professionals seem to be debating concerning PAD. It, then, also would be an aid in making judgments regarding the compatibility of certain medical procedures with what would be regarded as "proper" medical care. Of course for these judgments to be made, there still need to be reasons given as to why practices that are considered instances of PAD should be thought of as falling outside or inside the scope of proper medical care. For example, those who are opposed to PAD would need to provide an account of the wrong-making properties of the actions that are considered instances of PAD (which is the goal of Chapter 3). So, at least initially, any proposed intensional definition of PAD should leave open the question of the morality of PAD in a health care context.

Some Common Characteristics

There are dizzying arrays of nuanced distinctions that permeate every level of discussion in this conversation. These distinctions that some find relevant

for meaningful dialogue to take place are often reflected in the various definitions proffered for what is meant by the practices of voluntary active euthanasia and physician-assisted suicide. All of this makes it very difficult to settle on an agreed understanding of the key terms.

A helpful way of proceeding at this juncture is to highlight what the more helpful definitions share in common. In order to do this, I set forth some conditions that select thinkers in the debate claim must be in place in order to have an instance of euthanasia generally speaking. I begin with the account by Grisez and Boyle where, among other issues, they specifically address voluntary active euthanasia. After indicating that the term 'Agent' refers to anyone who brings about the death and the term 'Patient' refers to anyone being killed, they then provide the following criteria:

> (1) Patient either is suffering and dying, or is suffering irremediably, or at least irremediably subject to some disease or defect which would generally be considered by reasonable persons to be grave and pitiable. (2) Agent sincerely believes that Patient would be better off dead—that is, that no further continuance of Patient's life is likely to be beneficial for Patient. (3) Agent deliberately brings about Patient's death in order that Patient shall have the benefit of being better off dead—that is, not continue to suffer the condition (1) under supposition (2).[9]

[9] Germain Grisez and Joseph M. Boyle, Jr., *Life and Death with Liberty and Justice: A Contribution to the Euthanasia Debate* (Notre Dame, Indiana: University of Notre Dame Press, 1979) 139.

Another important and more recent voice in providing the conditions from which one can recognize when death by euthanasia has taken place is Tom Beauchamp of Georgetown University. He writes:

> [A] death will be considered euthanasia of any type if and only if the following conditions are satisfied: (1) The death is intended by at least one other person whose action is a contributing cause of death; (2) the person who dies is either acutely suffering or irreversibly comatose (or soon will be), and this condition alone is the primary reason for intending the person's death; and (3) the means chosen to produce the death must be as painless as possible, or a sufficient moral justification must exist for a more painful method.[10]

Both of these representative sets of conditions, the former set from opponents of euthanasia and the latter from a proponent of particular forms of euthanasia, share some basic features that are important for any attempt to capture better the essence of euthanasia. Several characteristics can be readily identified here.

First, the decision made by either the patient or the medical professional has the effect of shortening life in some way.[11] Second, the discussion is limited to innocent people in a medical context. One observes here that the patient is deemed to be innocent. The death of the patient is here distinguished from, say, a case of a convicted felon dying of capital punishment. As Dan Brock has

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[10] Tom L. Beauchamp, "Introduction", *Intending Death: The Ethics of Assisted Suicide and Euthanasia*, edited by Tom L. Beauchamp (New Jersey: Prentice Hall, 1996) 4.

[11] This is not to say that any action in a medical context, which has the effect of shortening a patient's life is considered euthanasia. Shortening the life of a patient than it otherwise would have been is a necessary condition of euthanasia though not sufficient.

pointed out, "the claim that any individual instance of euthanasia is a case of deliberate killing of an innocent person is, with only minor qualifications, correct."[12]

Furthermore, the professional circumstances of euthanasia in a medical context should be emphasized. So if there are such events taking place where someone is not a certified trained medical professional operating outside the safeguards of a skilled and licensed medical facility, then this is not considered euthanasia. Most advocates of some form or other of euthanasia would be against such practices. Fourth, it is thought the patient would be better off dead or that death is considered beneficial for the patient. And last, the agent intentionally engages in a course of conduct that has as its aim to bring about the death of the patient.

Three Broad Categories of Definitional Strategies

These common conditions or characteristics lie in the background of approaches to crafting a definition of euthanasia. "Beyond these points of agreement, there are…several major differences" in how 'euthanasia' is

[12] Dan W. Brock, *Life and Death: Philosophical Essays in Biomedical Ethics* (New York: Cambridge University Press, 1993), 208. Brock goes on in the essay quoted to defend the fact that in a medical context it is not always wrong to deliberately kill an innocent person. Given certain conditions and qualifications killing an innocent could be morally justifiable.

defined.[13] There are three approaches to which an intensional definition has been developed ranging from more narrow attempts (i.e., limiting the practices that would be considered instances of euthanasia) to more broad (i.e., to include practices that many medical professionals don't think to be euthanasia) that highlight the different connotations of the term.[14]

To begin, the narrowest category is where 'euthanasia' "connotes the *active*, *intentional* termination of a patient's life by a doctor who thinks that death is a benefit to that patient."[15] In view here primarily are *acts* (not omissions) that directly cause the death of a patient. Daniel Callahan, former Director of the Hastings Center, expresses this narrow definition. He describes 'euthanasia' as "the direct killing of a patient by a doctor, ordinarily by means of a lethal injection." He considers 'physician-assisted suicide' as "the act of killing oneself by means of lethal drugs provided by a physician."[16] Callahan, while not explicitly stating this in the quote above, includes that these are intentional acts on the part of the medical agent for what are considered

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[13] Keown, *Euthanasia, Ethics and Public Policy,* 10.

[14] See the discussion given by John Keown on pages 10-16 where he identifies these three broad areas in his *Euthanasia, Ethics and Public Policy.*

[15] Ibid., 10.

[16] Daniel Callahan, "A Case Against Euthanasia," *Contemporary Debates in Applied Ethics*, edited by Andrew I. Cohen and Christopher Heath Wellman (Malden, MA: Blackwell Publishing, 2005) 189, n.1.

beneficent reasons. These are the necessary background conditions for the context in which his thoughts on this issue are developed.

Likewise, the *American Medical Association* (AMA) follows suit in describing euthanasia as "the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering."[17] The *AMA* sees physician-assisted suicide as occurring when "a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act."[18] Another example of this narrow approach to defining euthanasia is found in the 1994 report of the New York Task Force on Life and the Law, which described it as "direct measures, such as lethal injection, by one person to end another person's life for benevolent motives." And they viewed 'physician-assisted suicide' as referring to those "actions by one person to contribute to the death of another, by providing medication or a prescription or taking other steps."[19]

The main point with each of these examples in the narrow sense of euthanasia is that there is an introduction of a known lethal cause into existing

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[17] American Medical Association, *Code of Medical Ethics: Council on Ethical and Judicial Affairs: Current Opinions with Annotations*, 2012-2013 Edition, Opinion 2.21.

[18] Ibid., Opinion 2.211.

[19] *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (New York: The New York State Task Force on Life and the Law, 1994) x.

patient care. Notably, what is *excluded* in this narrow sense of euthanasia are actions (or some would say omissions) such as withholding and withdrawing life sustaining treatment *even in those instances when the aim of the agent in doing so just is the death of the patient* because it is deemed that they would be better off dead than alive.

But there is also a wider sense in which actions or even omissions between a medical professional and a patient are thought to constitute instances of euthanasia. This leads to the second category. Here 'euthanasia' is understood as any act or omission in a health care context that has as its aim or intention the death of the patient. In expounding this view John Keown writes:

> On this wider definition, 'euthanasia' includes not only the intentional termination of a patient's life by an act such as lethal injection but also the intentional termination of life by an omission. Consequently, a doctor who switches off a ventilator, or who withdraws a patient's tube feeding, performs euthanasia *if the doctor's intention is to kill the patient*. Euthanasia by deliberate omission is often called 'passive euthanasia'…to distinguish it from active euthanasia.[20]

Here again, as is the case with Callahan above, the context in which Keown is making his points presupposes that these practices are being engaged in for reasons that are thought to be beneficent. The key for him is that intending the death of the patient by some act (or inaction/omission) is considered an instance of euthanasia. So the narrow category would exclude the withholding

[20] Keown, *Euthanasia, Ethics and Public Policy,* 12.

and withdrawing of life sustaining treatment as an instance of euthanasia even if *the intent in doing so just is the death of the patient*, whereas the second category would not.

Keown thinks this second categorization has more to commend it in assessing the ethical issues involved in the debate concerning medical euthanasia in a health care context.[21] And hence, he advocates this view. On Keown's account described above, there are two observations that deserve mention. To begin, as is the case with the first narrower category, a direct (intentional) action undertaken that is intended to kill the patient for what are thought to be beneficent reasons is an instance of euthanasia. This is in some ways a reiteration of Keown's aforementioned thought but needs to be stated to highlight the next point.

Second, it is important to note that while the withholding of life-prolonging measures could be an instance of euthanasia, albeit "passive" euthanasia, it is by no means necessary to always categorize the forgoing of life sustaining treatments as such. Supporters of this second category claim that in order to understand the difference they want to make between "passive" euthanasia and medically indicated forgoing life sustaining treatment one must recognize that the intention of the agent and the reasons for acting are different. And this distinguishes them as different events. They would not consider as an

[21] Ibid., 16.

occurrence of passive euthanasia the withholding or withdrawing of life sustaining treatment when medically indicated or "*because the treatment is either futile or too burdensome, or in order to respect the patient's refusal of treatment*."[22]

The reason is that death in such cases are unintended or not part of the agent's aim in acting. Therefore, those who hold this second view argue that passive euthanasia, in which the death of the patient is the aim, and the withholding/withdrawing life sustaining treatment under said circumstances are discrete events. At this point, the description of euthanasia as described in the second category is not to make a judgment on the actions' moral permissibility/impermissibility, but to highlight the salient features that they think make these distinctive.

The third and broadest category is to see 'euthanasia' as including "not only the intentional termination of life by act or omission, but also acts and omissions which have the *foreseen* consequence of shortening life."[23] One should presume here that the foreseen consequence is *unintended*. This third approach to defining 'euthanasia' differs from the first category, the narrow view, in that it includes under the scope of euthanasia "omissions," passive, or

[22] Ibid., 217. I say more about each of these criteria in the section titled "Problems with the Third Definitional Category" below.

[23] Ibid., 15.

so-called indirect "acts," whether intended or unintended, where death is an expected consequence of the chosen course of behavior. However, this last approach to defining 'euthanasia' shares in common with the other two that the practice includes the deliberate termination of the patient's life by some direct action, say, lethal injection, for what are thought to be beneficent reasons. Another feature it shares in common with the second category, though not the first, is that both acts and omissions can be instances of euthanasia when the patient's death is *intended* thereby.

The third category also goes further than the second. It includes circumstances in which death may be merely a foreseen though an *unintended* consequence such as when life-prolonging treatment is withheld or withdrawn when it is deemed that the treatment is either futile, too burdensome, or done in order to respect the patient's refusal of treatment, as falling under the category of euthanasia, albeit passive euthanasia. This is contrasted with the second category, which as indicated does not judge such cases as being euthanasia when the death of the patient is not intended and when done for what is considered medically indicated reasons.

Many advocates of voluntary active euthanasia tend to adopt definitions of this third sort. One such example is John Harris. He thinks of euthanasia as "the implementation of a decision that a particular individual's life will come to an end before it need to do so—a decision that a life will end when it could be

prolonged. The decision may involve direct interventions (active euthanasia) or withholding of life-prolonging measures (passive euthanasia)."[24] While he does not explicitly state that foreseen consequences which have the effect of shortening life is included under euthanasia, it is nevertheless implicit in his understanding of passive euthanasia.

Another such example of this third approach is Michael Tooley, who is a very skillful proponent of euthanasia. He refers to it as "any action where a person is intentionally killed or allowed to die because it is believed that the individual would be better off dead than alive—or else, as when one is in an irreversible coma, at least no worse off."[25] Similar to Harris, Tooley seems to include in the scope of his definition of euthanasia those actions (or inaction depending on how these are described) that have the *unintended* but *foreseen* consequence of the death of the patient.

Problems with the First Definitional Category

Tooley wants to maintain a broad definition of euthanasia and rejects more narrow attempts at defining the term such as the one by ethicist Daniel

[24] John Harris, "Euthanasia and the Value of Life," *Euthanasia Examined: Ethical, Clinical and Legal Perspectives*, edited by John Keown (New York: Cambridge University Press, 1995), 6.

[25] Michael Tooley, "In Defense of Voluntary Active Euthanasia and Assisted Suicide" *Contemporary Debates in Applied Ethics*, edited by Andrew I. Cohen and Christopher Heath Wellman (Malden, MA: Blackwell Publishing, 2005) 161.

Callahan referred to above who defines it as "the direct killing of a patient by a doctor, ordinarily by means of a lethal injection."[26] Tooley thinks this narrow definition is problematic for the following reasons. He writes:

> In the first place, one is deprived of crisp and very useful expressions – such as "passive euthanasia" – for referring to cases where a terminally ill person is allowed to die. Secondly, and more seriously, the person who identifies euthanasia with the direct killing of a terminally ill person typically does so because he or she views the indirect killing of a terminally ill person as morally unproblematic, and similarly for an action of merely allowing a terminally ill person to die. If one holds, however, that such actions are morally permissible, but that the direct killing of a terminally ill person is morally wrong, then among the most crucial issues that one needs to address are, first, why the direct versus indirect distinction has such moral significance, and secondly, why the same is true in the case of the distinction between killing and letting die.[27]

I do think along with Tooley, that Callahan's definition is too narrow, but not for all of the same reasons. First, I do not think, *contra* Tooley, that "passive euthanasia" is a "crisp and useful expression." In fact, I hope to show below that it probably confuses the issue to some degree, which is in part why I think that medical professionals should adopt some variation of the second category of 'euthanasia' for the purposes of moral assessment. And so, given that we may lose this active/passive distinction in Callahan's definition, it is not all that troubling to me since I do not think it to be relevant, again with respect to

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[26] Ibid., 162.

[27] Ibid., 162-163.

ethical evaluation. I say more in defense of this claim in a section below and again in Chapter 5.

What is of more concern about Callahan's definition, at this juncture of the discussion, is that it doesn't seem to capture what I think to be an important element in this conversation. Callahan thinks that euthanasia and physician-assisted suicide, as he describes them, ought not be allowed in a medical context even if it is for motives of compassion or an expression of mercy.[28] If this is so, then Callahan's definition does not seem to include the fact those "passive" acts or "acts of omission," *where death is intended and done for reasons of compassion*, should also be considered a form of euthanasia.

For example, suppose a health care professional decides to forego life-sustaining treatment with the *intent* of bringing about the patient's death as an act of beneficence because the physician judges that the patient's quality of life has deteriorated to an intolerable point. Further, the reason for this was not based on any medical indications that would deem the treatment to be unacceptably burdensome. It would appear, then, that on Callahan's narrow account, it is possible that this would not be judged as being an instance of euthanasia. This seems to miss the essence of the euthanasia debate is about.

[28] Callahan, "A Case Against Euthanasia," 183-189.

To be fair to Callahan, he does affirm that not all cases of deliberately terminating treatment are *morally* permissible. He thinks that "physicians can misuse their power and terminate treatment wrongly: they can stop treatment when it could still do some good, or when a competent patient wants it continued. In that case, however, the physician is blameworthy."[29] So there can be culpability. It is just that there are states of affairs in a medical context that many others think should be substantially thought of as instances of euthanasia that are unaccounted for on Callahan's definition. So I do think that Tooley is partially correct in his analysis of the problematic nature of the narrow definition of 'euthanasia.'

Problems with the Third Definitional Category

On the other side of the definitional spectrum, I think Tooley's definition is too broad. It appears that he includes forgoing life sustaining treatment or what he calls merely "allowing to die" to be categorized as euthanasia even when the intention or aim of these actions *is* not the same as it would be in an instance of the indirect *intentional* killing of a patient by identical means in a medical context. This appears to be the thrust of the second part of his concern of the more narrow definitions of 'euthanasia' from the quotation above. One may recall where Tooley states, "the person who identifies euthanasia with the

[29] Ibid., 184-185.

direct killing of a terminally ill person typically does so because he or she views the indirect killing of a terminally ill person as morally unproblematic, and similarly for an action of merely allowing a terminally ill person to die." Again these statements were made in response to losing potentially the distinction between passive and active euthanasia on a narrower definition.

Tooley would view the *indirect* killing of a terminally ill patient and seemingly all actions of merely allowing a terminally ill patient to die as both being classified as passive euthanasia regardless of the reason for doing so or of the intention behind the action. It seems that Keown is correct when he writes that "If what characterises euthanasia is an *intention* to kill, it surely makes no *moral* difference if the doctor carries out that intention by an omission rather than by an act."[30] And so if the doctor carries out the *intention* to bring about the death of the patient for beneficent reasons by some omission or in an indirect way, then this is passive euthanasia. So far, so good, it would appear. Tooley would no doubt agree with Keown on this score.

Where Tooley and Keown would disagree—which reflects the difference between the second and third definitional strategies—is that Keown would not classify *all* instances of withholding or withdrawal of life sustaining treatment as passive euthanasia. Wherein lies the difference? Those who advocate the

[30] Keown, *Euthanasia, Ethics and Public Policy*, p. 14.

second definitional approach would say at the level of intent and medical warrant. Again, to quote Keown, "An intention to remove a burdensome treatment is not an intention to end life" even though death may be foreseen.[31] Or so proponents of this second view claim. Yet there is an insistence, and rightly so in my view, that while one can maintain the category of passive euthanasia it should nonetheless be kept as a distinct category from that of forgoing life-sustaining treatment just in those cases when the intent is not to bring about the death of the patient and the cessation of life-sustaining treatment is clinically indicated.

Those who have reflected on the moral issues surrounding end-of-life ethics in a medical context are aware that there are situations in the process of dying where it is morally appropriate to either refuse treatment or discontinue current treatment and there is and should be a legal right to do so. Though mathematical precision cannot be had with respect to determining exactly when this is the case there are a few helpful and widely accepted observations that can provide some assistance. First, "physicians have no obligation to provide pointless and futile or contraindicated treatment."[32] As ethicist Gilbert Meilaender has described:

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[31] Ibid., 16.

[32] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics,* Sixth Edition (New York: Oxford University Press, 2009) 167. One needs to tread carefully when

> This criterion is especially important when a person is in the last stages of dying. (We should note, however, that to be irretrievably dying is not the same as to be terminally ill. One can be terminally ill but still be expected to live for months or even years.) For the patient who is irretrievably dying, few if any treatments can really be useful. Continued attempts to cure such a patient may well get in the way of the effort to care for this person as best we can. In any case, no one is obligated to pursue treatments that are not expected to be helpful, and to refuse such treatment is exactly that: a refusal of treatment, not the rejection of the gift of life. It is not killing but "allowing to die."[33]

Second, life sustaining medical treatment can be withheld or discontinued and should not be considered obligatory if treatment becomes excessively burdensome or if the burdens outweigh the benefits.[34] This includes that one can "rightly refuse even useful treatment that would prolong … life for a significant period of time if that treatment really does carry with it significant

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speaking of treatments that are deemed futile because the literature on this notion and its application in health care is complex and varied. Nevertheless, "typically the term *futile* refers to a situation in which irreversibly dying patients have reached a point at which further treatment provides no physiological benefit or is hopeless and becomes optional….All of the following have been referred to as 'futile': (1) whatever physicians cannot perform, (2) whatever will not produce a physiological effect, (3) whatever is highly unlikely to be efficacious (i.e., statistically, the odds of success are exceedingly small), (4) whatever will probably produce only a low-grade, insignificant outcome (i.e., qualitatively, the results are expected to be exceedingly poor), (5) whatever is highly likely to be more burdensome than beneficial, (6) whatever is completely speculative because it is an untried 'treatment,' and (7) whatever—in balancing effectiveness, potential benefit, and potential burden—warrants withholding and withdrawing treatment. Thus, the term *futility* is used to cover many situations of predicted improbable outcomes, improbable success, and unacceptable benefit-burden ratios. This situation of competing conceptions and ambiguity suggests that we should generally avoid the term *futility* in favor of more precise language." Ibid.

[33] Gilbert Meilaender, *Bioethics: A Primer for Christians, Second Edition* (Grand Rapids: Eerdmans, 2005), 69.

[34] Beauchamp and Childress, *Principles of Biomedical Ethics,* 168.

burdens." Again, for those who do not see instances of forgoing life-sustaining treatments (under these conditions) as occurrences of passive euthanasia since death is not intended, would suggest that this should be considered "a refusal of treatment, not of life."[35]

The active/passive distinction does not clarify the *ethical* issues, or so I would claim. It is primarily descriptive and "concerned only with identifying the medical cause of death."[36] So the insight from John Kilner should be taken seriously when he writes:

> We must look for categories other than…passive/active to guide ethical decisions to forgo treatment. In fact, we need a different heading altogether under which to examine such questions, for the term euthanasia itself is problematic. On its surface it might seem to be an excellent term, formed from two Greek words meaning 'good death.' However, even without the modifier 'active,' it suggests in the minds of many the intentional causing of a patient's death. As such, it does not serve well as an umbrella term for end-of-life decisions.[37]

This, in my estimation, is the problem with definitions that are developed along the lines of the third category. It includes too much. There are many end-of-life decisions that are made in a medical context. And to be sure, some of them have the effect of shortening life or as some would say "hastening death."

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[35] Meileander, *Bioethics*, 70.

[36] John F. Kilner, "Forgoing Treatment," *Dignity and Dying: A Christian Appraisal* (Grand Rapids: Eerdmans, 1996) 72. Of course, this descriptive account can be helpful in moral assessment given that many ethical judgments oftentimes hinge on non-moral facts. The point being made here is that the active/passive distinction in itself cannot bear the weight of giving us the insight needed for ethical evaluation of euthanasia and physician-assisted suicide/death.

[37] Kilner, "Forgoing Treatment," 72.

Take for example a person who decides not to undergo rigorous chemotherapy treatments for an aggressive cancer that was detected late in its development and instead opts for good palliative care so that in the remaining days he can be alert and attentive to his relationships with loved ones. It would seem that it could rightly be said that he does potentially shorten his life with this "end-of-life" medical decision relative to some alternative, but he does not shorten it relative to the "natural" course of events. This, though, does not seem to be what the euthanasia debate is all about. Yet the third definitional category allows for these kinds of situations to be included under the umbrella term "euthanasia." This appears wrongheaded.[38]

Third, in *most* cases a patient has a right to refuse treatment and medical professionals have a moral obligation to honor that right, all things being equal. In respecting the patients' refusal of treatment, the medical professional is not necessarily in a position where he or she is performing euthanasia. That is, if they are not intending the death of the patient thereby (more on the role of intention in moral assessment in Chapter 6). While death may be a foreseen

[38] The suggestion being made here that excludes instances of the forgoing of life sustaining treatment when medically indicated or in otherwise "appropriate" circumstances where death is not intended thereby from the category of euthanasia and physician-assisted suicide (to be discussed below), of course, is vigorously challenged. Two formidable essays to this end are Judith Jarvis Thomson, "Physician-Assisted Suicide: Two Moral Arguments," *Ethics*, 109/3, (April 1999): 497-518, and Dan W. Brock, "A Critique of Three Objections to Physician-Assisted Suicide," *Ethics*, 109/3, (April 1999): 519-547.

consequence in honoring patient refusal of treatment, the key question in this second category is what does the medical professional intend in acting or not?

This line of reasoning does place quite a bit of weight on the notion of intention in determining whether or not there is an instance of euthanasia in a health care context. Further, to better see the moral obligation of respecting the right of a patient to refuse treatment, all things being equal, even if it goes against sound medical advice, we must consider the alternatives. Medical professionals should not violate bodily integrity of patients without their consent even if taking the treatment would prolong life. There is a negative right that patients have to be left alone though it is much more controversial and unclear as to whether there is a positive right to be euthanized if they desire it. In the cases of honoring patient refusal of treatment, the intention of the medical professional should not be to aim for the death of the patients, but to respect the patients' right to bodily integrity. So it would seem that if the intention of the agent matters at all in moral assessment that this would not be an instance of euthanasia since death is not the intention for the course of conduct. So again it appears that the third category is too broad in that it includes too much. The third definitional strategy makes it difficult to discriminate between the myriad of EOL choices and options in a health care context.

Why the Second Definitional Category

It seems that for the sake of consistency that medical professionals, who want to support the current legal and professional prohibitions against certain forms of euthanasia while also affirming the appropriateness, in prescribed circumstances, of forgoing life-sustaining treatment (and for the purposes of this dissertation, the use of palliative sedation), should adopt some version of an intensional definition of 'euthanasia' that falls within the second category. So between Callahan and Tooley, I propose that the understanding of 'euthanasia' for the purposes of this dissertation be along the lines developed by Grisez and Boyle:[39]

> Euthanasia $_{(def.)}$ = An event in a medical context where (1) Patient either is suffering and dying, or is suffering irremediably, or at least irremediably subject to some disease or defect which would generally be considered by reasonable persons to be grave and pitiable. (2) Agent sincerely believes that Patient would be better off dead—that is, that no further continuance of Patient's life is likely to be beneficial for Patient. (3) Agent deliberately brings about Patient's death in order that Patient shall have the benefit of being better off dead—that is, not continue to suffer the condition (1) under supposition (2).[40]

This intensional definition does include those basic features identified above that many assert are essential to the discussion. With this definition in

[39] One recalls that Grisez and Boyle stipulate that 'Agent' refers to anyone who brings about the death and 'Patient' refers to anyone to whom death is brought in the prescribed medical context.

[40] Grisez and Boyle, *Life and Death with Liberty and Justice: A Contribution to the Euthanasia Debate*, 139.

place, a few other distinctions need to be made. They are between voluntary, non-voluntary, and involuntary forms of euthanasia.

> *Voluntary* Euthanasia (def.) = cases of euthanasia where Agent knows Patient has given free and informed consent to have his or her life ended thereby.
>
> *Non-Voluntary* Euthanasia (def.) = cases of euthanasia where Agent knows that Patient has *not* given consent and *does not know* whether Patient has dissented or would dissent had he or she the capacity or competency to do so.[41]
>
> *Involuntary* Euthanasia (def.) = cases of euthanasia where Agent knows that Patient has dissented to have his or her life ended thereby.[42]

For the purposes of clarity going forward, euthanasia can be understood as not simply an act but a moral event. As mentioned in Chapter 1, I propose

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[41] There is some debate concerning the notions of *capacity* and *competency*. Some suggest that there is a distinction based on legal and clinical usages of the terms. As Jonsen, et. al. have noted, "In the law, the terms *competence* and *incompetence* indicate whether persons have the legal authority to affect certain personal choices, such as managing their finances or making health care decisions. Judges alone have the right to rule that a person is legally incompetent and to issue a court order or appoint a guardian. In medical care, however, persons who are legally competent may have their mental capacities compromised by illness, anxiety, and/or pain. We refer to this clinical situation as decisional *capacity* or *incapacity* to distinguish it from the legal determination of competency" (Albert R. Jonsen, Mark Siegler, and William J. Winslade, *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*, Seventh Edition (New York: McGraw Hill Medical, 2010), 65-66). Alternatively, other notable figures working in medical ethics suggest the "distinction breaks down in practice. As Thomas Grisso and Paul Applebaum note, 'When clinicians determine that a patient lacks decision-making capacity, the practical consequences may be the same as those attending a legal determination of incompetence'" (Beauchamp and Childress, *Principles of Biomedical Ethics,* Sixth Edition (New York: Oxford University Press, 2009) 111). It seems that for my purposes here not much of substance turns on affirming one approach or the other. I include both terms to account for the broadest understanding of decisional capacity in determining what counts as acts of non-voluntary and involuntary euthanasia.

[42] I am indebted to Bruce Russell for the significance of including the epistemic criterion in definitions of voluntary, non-voluntary, and involuntary euthanasia.

this definition as the one from which medical professionals and other interested parties can adjudicate whether or not they are being consistent if they: (i) think there is reason to deem that euthanasia is morally impermissible in a health care context while also (ii) embracing the practice of palliative sedation as morally permissible in a medical setting.

Physician-Assisted Death as an Umbrella Term for PAS and VAE

In this section I want to argue that based on the account of euthanasia being offered, physician-assisted suicide should be considered a *form* of voluntary active euthanasia. And further, that both PAS and VAE can be seen as practices under the umbrella term, "Physician Assisted Death."

PAS as a Form of VAE

I begin this part of the discussion with a point made by the *Hospice and Palliative Nurses Association* (HPNA) in one of their position statements. It reads, "Euthanasia is a term that is often confused with assisted suicide. Active [voluntary] euthanasia is the act of bringing about the death of a person at his or her request. In euthanasia, someone other than the patient performs the act with the intent to end the patient's life."[43] The statement is correct with respect

[43] *HPNA Position Statement on Legalization of Assisted Suicide* (Pittsburgh, PA: Hospice and Palliative Nurses Association, 2011) 1.

to the fact that euthanasia and physician-assisted suicide should not be thought synonymous. Certainly they remain practically distinct from one another. If this is what they are highlighting, then they are certainly correct, and these should not be confused.

However, it should not be thought that since they do remain practically distinct and are not synonymous, that they could not be related in a way where one is a subset of the other such that they perhaps can be morally assessed together. The reason why physician-assisted suicide should be considered a form of voluntary active euthanasia in this work is due to the fact that in cases of PAS the patient presumably gives consent, desires to be dead due to their illness, considers death to be beneficial, and the physician directly assists in the facilitation of this state of affairs.

Furthermore, the proposed necessary conditions for an instance of euthanasia expressed above are also true of physician-assisted suicide. This is clearly the case with Beauchamp's conditions already noted. He therefore acknowledges, "Physician-assisted suicide is often considered a form of voluntary active euthanasia, because in the latter the death often seems to be both suicide [i.e., VAE includes suicidal intent on the part of the patient, which is

to be understood descriptively and not pejoratively, nor as an evaluative statement at this juncture] and physician assisted."[44]

While the claim being developed here—that PAS is a form of VAE—is compatible with the original formulation of the conditions given by Grisez and Boyle on pages 35-36, its compatibility is not as explicit on this point as it is expressed in the conditions provided by Beauchamp. Their third condition would need to be slightly expanded to see that PAS can be subsumed under the general description of VAE they develop to read something along the lines: "(3) Agent deliberately brings about Patient's death [or Agent provides the means for Patient to become the primary Agent in his/her own death] in order that Patient shall have the benefit of being better off dead—that is, not continue to suffer the condition (1) under supposition (2)." Hence, the following definition:

> Physician-Assisted Suicide $_{(def.)}$ = a form of voluntary active euthanasia whereby Patient is the Agent who acts directly on the known lethal means supplied by a certified health care professional which serve as the final link that brings about the patient's death.

Some maintain that there are morally relevant differences between PAS and VAE, such that the former should be allowed in a medical context whereas the latter ought not. This appears to be the thrust driving some of the "Death with Dignity" initiatives that many states have had, are having, or will have to

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[44] Tom L. Beauchamp, "Introduction," *Intending Death: The Ethics of Assisted Suicide and Euthanasia*, edited by Tom L. Beauchamp (New Jersey, Prentice Hall, 1996) 4.

address. These initiatives argue for the legalization (and hence moral permissibility) of PAS, while keeping VAE illegal in a health care context. Such a concession, that is, to argue for the legality, and hence permissibility, of PAS while excluding VAE, seems to be more for the purposes of political expediency than on the basis of sound moral reasoning.

Michael Tooley has made this point with, I think, substantial clarity. Consider the following argument.

(1) If a person is suffering considerable pain due to an incurable illness, then in some cases that person's death is in his or her own interests.

(2) If a person's death is in that person's own interest, then committing suicide is also in that person's own interest.

(3) Therefore, if a person is suffering considerable pain due to an incurable illness, then in some cases committing suicide is in that person's own interest. (From (1) and (2).)

(4) A person's committing suicide in such circumstances may very well also satisfy the following two conditions:

a) it neither violates anyone else's rights, nor wrongs anyone;

b) it does not make the world a worse place.

(5) An action that satisfies conditions a) and b), and that is not contrary to one's own interest, cannot be morally wrong.

(6) Therefore, a person's committing suicide when all of above conditions obtain would not be morally wrong. (From (3), (4), and (5).)

(7) It could be morally wrong to assist a person in committing suicide only if (i) it was morally wrong for that person to commit suicide, or (ii) committing suicide was contrary to the person's own interest, or (iii) assisting the person to commit suicide violated an obligation one had to someone else.

(8) Circumstances may very well be such that neither assisting a person to commit suicide nor performing voluntary active euthanasia violates any obligations that one has to others.

(9) Therefore, it would not be wrong to assist a person in committing suicide in the circumstances described above. (From (3), (6), (7), and (8).)

(10) Whenever assisting a person in committing suicide is justified, voluntary active euthanasia is also justified, provided the latter action does not violate any obligation that one has to anyone else.

(11) Therefore, voluntary active euthanasia would not be morally wrong in the circumstances in question. (From (8), (9), and (10).)[45]

This argument was developed for the purpose of showing that "voluntary active euthanasia and assisted suicide are not morally wrong in themselves" according to Tooley.[46] In standard philosophical fashion, given that this argument is valid, those who think that *both* VAE and PAS are morally problematic would need to respond to one or more of the premises. And this is certainly a difficult task in its own right.

[45] Tooley, "In Defense of Voluntary Active Euthanasia and Assisted Suicide," 163.

[46] Ibid.

Be this as it may. However, Tooley's argument seems to pose a particularly more challenging obstacle for those who hold that PAS is morally permissible and hence ought to be legalized while maintaining that VAE may be morally problematic and thus should not be legalized (or at least at this time). It would seem that the moral and legal justification one would have for PAS is the same moral and legal justification one could marshal for VAE. I use Tooley's argument here to show that PAS and VAE are practices that do not appear to be morally distinct from one another in any fundamental way. Moreover, they share many morally relevant common features. In light of the kind of justification usually provided for PAS, it would seem odd, ethically speaking, that one would not be in favor of VAE for the same reasons.

The worry seems to be that trying to either legalize VAE or argue for its moral permissibility is too radical of a position given current public sentiment or some perceived reticence toward the idea. If this is so, then the strategy employed is not so odd. As a first step, one could argue for the legalization of PAS. Then eventually one could argue for not only the moral permissibility of VAE but also the legalization of the practice once PAS does not seem to be as deleterious as some may have suspected. However, if Tooley is correct in his argument concerning the link between PAS and VAE, then there is no morally principled reason as to why one should not simultaneously argue for the same legal and moral status for VAE and PAS. So this is why I say that it may be

politically expedient to make a two-part argument and why I suggest that it does not seem to be on the basis of moral principle. All of this is to lend credence to the claim that on the definition of 'euthanasia' advocated here that PAS should be seen as a sub-set of euthanasia, more specifically, as a form of *voluntary* active euthanasia.

PAS and VAE as Physician Assisted Death

Some may still object to the broad use of 'euthanasia' as a term where PAS and VAE are included in the way specified. Further, they may also insist on keeping these in separate categories. Even so, both VAE and PAS could be considered as moral events that can be classified under the umbrella term of 'physician-assisted death.' Broadly speaking, both of these practices (PAS and VAE) "involve some form of assistance in bringing about another's death" for beneficent reasons in a medical context.[47] At least, this much appears to be true.

Many proponents of the "Inconsistency Argument" claim that PAS and VAE share many of the morally relevant features with most cases of palliative/terminal sedation. And so, classifying these two practices under a common term could streamline the discussion concerning the "Inconsistency

[47] Beauchamp, "Introduction," *Intending Death*, 4.

Argument" due to this perceived affinity.[48] So for the purposes of the dissertation, unless otherwise stated, I will use the term 'physician-assisted death' to include both what is described here as VAE and PAS.

This nomenclature is to be preferred over "physician-assisted dying." In my opinion, this phrase is too wide, as it would seem to include some aspects of hospice care, various forms of palliation for the irretrievably dying patient, and cessation of life-sustaining treatment when it becomes too burdensome or futile. Are these instances of physician-assisted dying? They could plausibly be conceived as such depending on how the details are fleshed out. Yet I want to say these are distinct issues from the discussion at hand. There would be no need to unnecessarily blur the lines by using this phrase especially since many are using the term already. 'Physician-assisted death' does seem to adequately capture the essence of both voluntary active euthanasia and physician-assisted suicide as I have defined them in this chapter.[49]

Some Benefits and Burdens of this Approach

[48] The claim of the "Inconsistency Argument" is that there are no real qualitative differences between palliative sedation and PAD that are morally relevant. As types of medical practices, these should all be morally assessed in the same way.

[49] An added advantage of employing this convention is that it should make the wording in some of the premises of the "Equivalency Argument" given in Chapter 1 slightly less cumbersome.

There are some perceived benefits for defining 'physician-assisted death' as I have for this context. I mention a few of these alongside some corresponding burdens. First, I think that it avoids the fallacy of *petitio principi* or "question-begging." One concern in making any attempt to define terms in ethical debate is that those definitions can become circular or that the moral assessment is embedded into the definiens. I have attempted here to define our key terms in a way that accurately describes what actions are taking place without incorporating the moral judgment in the account itself. Of course, some may think that the words "kill" and "suicide" that show up in my discussion are necessarily pejorative and prejudices the discussion in favor of opposing physician–assisted death. This is certainly a burden that needs to be overcome insofar as possible without losing the clarity that comes with words like "kill" and "suicide" for this conversation. I do acknowledge that some may think the words "kill" and "suicide" *necessarily* describe actions that are inherently wrong. But I do not think these judgments would be correct.[50]

Concerning killing, we must ask, "are all acts of killing human beings morally wrong?" Though I talk more about this in the next chapter, at this juncture, we can say without argument that many people (other than principled

[50] This particular terminology use should not be thought to skew the debate before it begins by using language that may seem pejorative to some who have a stake in the discussion. To be sure, this often proves difficult given that much of our language use in these areas is value laden and perhaps may be perceived as somewhat emotive.

pacifists) think that while there remains a strong *prima facie* prohibition against killing humans, not all instances of killing are morally unjustifiable (e.g. using lethal force in self-defense when no other alternatives seem plausible). So there is nothing about the word itself that would suggest any type of impropriety in using it to describe accurately what would be a condition of physician-assisted death.

Furthermore, with respect to suicide, something similar can be said. In fact, many of the arguments that are offered in favor of physician-assisted death hinge on the case for the claim that there can be rational suicides and that they are morally permissible.[51] There will still need to be an account of the wrongness of killing when it is wrong. So I do not think that the definitions proffered here have in some way defined "killing as morally unjustified, then [defined] euthanasia as killing, and then concludes that euthanasia is morally unjustified."[52] And hence, the definitions do not commit the fallacy of *petitio principi*.

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[51] For philosophical arguments in favor of rational suicide and criteria for moral permissibility of such actions that are aimed at medical ethicists and healthcare professionals see the works from C. G. Prado, *Choosing to Die: Elective Death and Multiculturalism* (New York: Cambridge University Press, 2008) and *The Last Choice: Preemptive Suicide in an Advanced Age*, Second Edition (New York and Westport, CT: Greenwood and Praeger Presses, 1998).

[52] Daniel P. Sulmasy, "Reading the Medical Ethics Literature," *Methods in Medical Ethics, Second* Edition, edited by Jeremy Sugarman and Daniel P. Sulmasy (Washington D.C., Georgetown University Press, 2010), 318.

A second benefit is that it provides conceptual tools to distinguish the unique features that characterize instances of PAD from other end-of-life medical decisions such as allowing an irretrievably ill person to die without appeal to a dubious claim that the morally relevant distinction between these two is *solely* based on a basic distinction between killing and letting die or between acts and omissions. Some have thought that what makes forgoing life sustaining treatment morally permissible and voluntary active euthanasia impermissible is that the former is considered "allowing to die" and the latter is actually "killing" the patient. Critics have rightly constructed "Bare Difference" arguments on these assumptions. The Bare Difference arguments show that appeal to these distinctions in the abstract simply will not do. Too many counter-examples can be marshaled to highlight this is wrong-headed.

On the definition of 'euthanasia' advocated here these distinctions *in themselves* are irrelevant to aid in morally assessing particular actions (or inactions) in a health care context. As one ethicist has rightly put this:

> Allowing a patient to die, or letting a patient die, are often considered to be morally different from killing. Correctly labeling an act as "allowing to die" does not tell us whether the act is morally justified. If, for example, an individual whose life could have been saved in an emergency room is knowingly and deliberately allowed to die, such inaction would be morally akin to an unjustified killing, given the moral and legal obligations to treat in such circumstances.[53]

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[53] Arthur Dyck, *Rethinking Rights and Responsibilities: The Moral Bonds of Community* (Washington D.C.: Georgetown University Press, 2005), 245.

The point here is to highlight that it is not simply the bare difference between killing/letting die that *alone* provides the morally relevant qualities. Yet it should not be thought the killing/letting die distinction is morally irrelevant. To be sure, I agree with one noted philosopher on this point when he states, "the concepts of killing and letting die are not evaluatively neutral. Yet their use, while reflecting certain moral beliefs, is nevertheless governed primarily by empirical criteria. This is in part because they both exemplify broader categories that are clearly defined largely if not exclusively in nonmoral terms."[54]

The definitions given in this chapter focuses on the notion of intention as being one essential feature, among others, in morally assessing a particular moral event. So if one who adopts the definition on offer wants to argue for the moral impermissibility of PAD, then she should not do so on the basis of the direct/indirect, active/passive, killing/letting die, or act/omission distinctions *alone* as abstract moral principles where the former of each pair is deemed morally impermissible and the latter as morally permissible.

Moreover, the focus on the notion of intention instead of merely the direct/indirect kinds of distinctions just noted, addresses a worry that Tooley raised concerning narrower attempts at defining euthanasia stated above. One

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[54] Jeff McMahan, "Killing, Letting Die, and Withdrawing Aid," *Killing and Letting Die,* Second Edition, edited by Bonnie Steinbock and Alastair Norcross (New York: Fordham University Press, 1994), 383.

recalls that he thinks there is a heavy burden of proof of one who wants to adopt narrower definitions of 'euthanasia' than the one he offers. To quote Tooley again:

> If one holds, however, that such actions [such as when there are medically indicated and otherwise appropriate[55] forgoingof life-sustaining treatment] are morally permissible, but that the direct killing of a terminally ill person is morally wrong, then among the most crucial issues that one needs to address are, first, why the direct versus indirect distinction has such moral significance, and secondly, why the same is true in the case of the distinction between killing and letting die.[56]

While the definition of 'euthanasia' given in this chapter is narrower than Tooley's, it is broad enough to account for the fact that the moral evaluation of practices that fall under PAD do not merely rest on the "Bare Difference" between direct/indirect kinds of distinctions alone. It should be clear that the chosen definitional strategy taken in this chapter does not turn, with respect to ethical evaluation going forward, on merely the distinctions with which Tooley is concerned as being morally irrelevant.

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[55] The word "appropriate" that modifies the kind of forgoing of life-sustaining treatment in question means in this context the cessation of treatment is considered morally permissible when it is in keeping with the patient's expressed wishes to refuse invasive medical procedures or when there are other medical indications that the patient is irretrievably dying, treatment is either futile, or too burdensome and ought to be discontinued. The intention in these scenarios would not be to forego life-sustaining treatment in order to make the patient dead. If so, as already noted, this would be an instance of passive euthanasia. At this point this would still be descriptive of what has taken place given that no moral assessment of these kinds of actions have been provided.

[56] Michael Tooley, "In Defense of Voluntary Active Euthanasia and Assisted Suicide," 162-163.

Still related to this second point of this section, the understanding of PAD on offer in this chapter carries with it the burden to specify plausible responses to some of the difficult challenges that are raised by emphasizing the notion of intention in evaluating human actions and moral events. Judith J. Thomson raises such concerns. She argues that the intentions of the agent have more to do with the character of the actor and not so much the moral permissibility or impermissibility of the act itself. She writes,

> I think it is plainly a fact—that the question whether it is morally permissible for a person to do a thing just is not the same as the question whether the person who does it is thereby shown to be a bad person. The doctor who injects a lethal drug to get revenge or out of hatred is a bad person. We can add that she acts badly if she acts for that reason. That is compatible with its being morally permissible for her to inject the drug. [57]

Another issue that emerges is the relationship of intention with the controversial principle of double-effect reasoning. It is not feasible for the claim undertaken in this work to deal with all of the issues that are raised concerning action theory, including intention and the myriad of questions that surround the principle of double-effect. Though this is a burden of this approach, to be sure, and more will need to be said regarding it and J. J. Thomson's concern. This is undertaken partly in Chapter 5 and more constructively in Chapter 6.

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[57] Judith Jarvis Thomson, "Physician-Assisted Suicide: Two Moral Arguments," *Ethics*, 109/3, (April 1999): 517.

Third, the intensional definition offered seems to capture the current understanding of the stance of some professional statements concerning issues of physician-assisted suicide and aggressive end-of-life care. Take for instance, the *American Medical Association* (AMA), which affirms:

> When the usual armamentarium of medical interventions has been exhausted, choices still remain; these range from letting the terminal illness take its course without further intervention to unacceptable choices, such as euthanasia. Actions that are *solely intended to hasten the death* of patients, such as physician-assisted suicide or euthanasia, are ethically and medically unacceptable.... In contrast, the withholding and withdrawing life-sustaining treatment, when done *based on the patient's autonomous refusal of unwanted care, and allowing the natural course of disease to take place*, are ethically and medically appropriate.[58] [My emphasis]

This commentary expresses the understanding of the AMA concerning some of the issues surrounding the ethics of end-of-life (EOL) medical care. It certainly includes those relevant features that are found in the definitions of 'physician-assisted suicide' and 'euthanasia' as developed in the second definitional category above. Of course, the AMA statement makes value judgments on PAD. The point here though at this stage, is to cite them not in reference to the value judgments that are being made, but with respect to the categorizations of the practices one can detect.

In the quote given above, one can readily discern the groupings of practices that the second definitional category wants to keep distinct

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[58] "Sedation to Unconsciousness in End-of-Life Care," *Council on Ethical and Judicial Affairs Report, 5-A-08* (American Medical Association, 2008) 4:27-34.

concerning EOL medical care. Namely, the appropriate forgoing of life-sustaining treatment is to be kept distinct from being identified with or included under those practices that are considered euthanasia, whether passive or active, as developed in this chapter. While the AMA in the quoted statement does not use the language of omission or passive euthanasia, it would seem that actions that would fall under these descriptions are also in view given they use the phrase, "Actions that are *solely intended to hasten the death* of patients." Presumably, the examples they give of physician-assisted suicide and euthanasia as practices that are solely intended to bring forth death, one would think, do not exhaust the kinds of events that can be characterized as such.

The *AMA's* statement is wholly compatible with what some may consider omissions or indirect acts that would withhold or withdraw certain kinds of life-sustaining treatment if the *sole intention* was to make the patient dead. In this case, this would be considered inappropriate withdrawal/withholding of life-sustaining treatment and as passive euthanasia. Given its context, the *AMA's* use of the phrase "hastening death" in their commentary seems to highlight the importance of the role that intentions play in morally assessing various EOL medical decisions regardless if it is done by act or omission, directly or indirectly.

If the above line of reasoning is correct regarding an exegesis of the their commentary, then this would seem to call for the *AMA* to revise its definition of euthanasia by expanding it slightly from the narrower first category to the slightly

broader second category recommended here which includes those events that are sometimes considered passive euthanasia.[59] The reasoning of the commentary already provides the conceptual categories for this move. It is the second definitional category that seems to be most in line with the ethical reflection of the current stance of the AMA.

Conclusion

The account of PAD on offer seems to provide the clearest backdrop to readily identify those features of the practices in question that medical professionals and many others who have a stake in this debate perceive as most vexing. Certainly, these properties that are perceived by some opponents of PAD as being the most troubling may not be on the basis of sound moral reasoning. Therefore, arguments are still needed to substantiate why PAD as described/defined above is morally troublesome in a health care context. The moral arguments that are built on those features or properties that seem to be of most concern for opponents of PAD would need to give good reasons why most variations of these practices should remain morally impermissible in a health care context. Of course, proponents of PAD would need to be able to

[59] As cited previously the AMA's definition of 'euthanasia' is "the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering."

provide arguments that are strong enough to override the *prima facie* prohibition against killing in a health care context and provide reasons why PAD should be included in the scope of EOL medical care.

All of this (i.e., the definitional work and the arguments against PAD), then, sets the stage for determining whether or not the currently widely accepted practice of palliative sedation is an instance of PAD and hence is subject to the same ethical evaluation. Or is it the case that there are any morally relevant differences between them that can be distinguished? One recalls that this brings us back to the "Inconsistency Argument" given in Chapter 1 that is slightly modified to take into account the use of PAD as advocated in this chapter:

1) For any two practices, X and Y, if there are no morally relevant differences between X and Y, then if Y is morally impermissible, X is morally impermissible.

2) There are no morally relevant differences between palliative/terminal sedation and PAD.

From 1) and 2), it follows that:

3) If PAD is morally impermissible, palliative/terminal sedation is morally impermissible.

Next, we assume that:

4) PAD is morally impermissible.

5) Therefore, palliative/terminal sedation is morally impermissible.

It is to the moral arguments marshaled in defense of premise 4 of the "Inconsistency Argument" that I turn.

CHAPTER 3

A SURVEY OF SOME ARGUMENTS AGAINST PHYSICIAN-ASSISTED DEATH

Introduction

This chapter develops some of the arguments and criticisms of them that have been marshaled in favor of premise 4 of the "Inconsistency Argument" which states in its augmented version, "Physician-Assisted Death is morally impermissible." I highlight two general areas of argumentation often developed against PAD. The first centers on the "Prohibition of Killing Innocents." The second is what is known primarily as the "Argument from the Integrity of the Medical Profession."

To be clear, the point of surveying these arguments is to highlight why some think that instances of PAD are morally impermissible in a health care context. Again, as emphasized in chapter one, this is to serve as the basis for evaluating whether or not the same arguments can be readily applied to the practice of palliative sedation that is currently widely accepted in the medical profession. Therefore even if a proponent of PAD thinks the arguments against these practices ultimately fail is, in some ways, beside the point for the purposes underscored in this project. The issue is this: If opponents of PAD think the arguments presented here are adequate to support their view, do these same arguments along with their various perceived wrong-making properties equally

count against palliative sedation as well? Still the arguments against PAD ought to be as robust as possible. So, I sketch below what seem to be the most common *types* of arguments that have been used in the discussion. The issue going forward is whether or not those medical professionals and organizations are being inconsistent if they embrace palliative sedation on the one hand, while opposing PAD on the other.

Argument from the *Prohibition of Killing Innocents (PKI)*

All things being equal, there is a strong moral prohibition against killing human beings. The operative moral principle would seem to be something like:

> MP_1: It is morally wrong intentionally to kill human beings without sufficient moral justification.

MP_1 takes the form of a *prima facie* moral principle. In many Western societies, MP_1 is usually appealed to when considering the appropriateness of killings of various sorts. Some of these instances where it is thought that killing humans may be morally justifiable have included those of self-defense, the killing of combatants in the context of a just military conflict, and in cases of capital punishment. Of course, not all would agree that these examples are justifiable.

Given the context of this debate, MP_1 is not as central to the discussion developed here given that PAD focuses on the moral justification of killing those who are apparently innocent. It is in this sense that it is often thought, however

ironically it may seem to principled pacifists, that capital punishment and killing in self-defense are compatible with homicide law and the strong *prima facie* prohibition against killing human beings reflected in MP_1. As one ethicist notes:

> Killing an individual who is not threatening anyone's life, however, is unjust, and homicide law neither permits such an act nor leaves it unpunished. Given that there are those who threaten to kill or do kill others, homicide law recognizes a moral basis for using as much force as necessary, even to the point of killing, in order to defend and protect innocent human life, whether one's own life or the life of others.[1]

Clearly with respect to instances where claims of self-defense, engaging in a just military conflict, or capital punishment are in view, presumably we are not discussing the moral justification of taking the life of those who are innocent. This is true regardless of whatever judgments one makes about these matters. It is claimed that the aforementioned situations are said to include individuals who do pose a significant threat to the common good. Whether or not lethal force is justified in such situations remains controversial and rigorously debated. Nevertheless, the point can still be taken.

The argument advanced for the claim that PAD is morally impermissible is on the basis of what is claimed to be a longstanding and widely accepted moral principle. The discussion of this section develops in three phases. The first phase identifies this principle, and then develops and evaluates the moral argument built upon it. I call this argument the "*Argument from the Prohibition of*

[1] Arthur J. Dyck, *Rethinking Rights and Responsibilities: The Moral Bonds of Community* (Washington D.C.: Georgetown University Press, 2005) 242.

Killing Innocents" (PKI). Moreover, in the following sub-section, I highlight some of the ways in which the argument has been challenged while sketching out in the final sub-section what would be needed in any potential counter-responses for those who want to maintain moral opposition to PAD based upon *PKI*.

An Exposition of the Prohibition of Killing Innocents Argument, *PKI*$_{(AA)}$:

If MP_1 is an appropriate moral principle with respect to the ethics of killing, then, *a fortiori*, there is a moral prohibition against killing *innocent* human beings. Some would perhaps be willing to argue that the moral prohibition against killing innocents should be considered absolute. The operative moral principle in this case would be:

MP_2: It is morally wrong intentionally to kill *innocent* human beings.

MP_2 takes the form of an *absolutist* moral principle. It appears to be the principle to which many, though by no means all, opponents of PAD make appeal. That is, when the opposition is made on the basis of the wrongness of killing innocents in a *medical* context.

If MP_2 is a legitimate moral principle and PAD is rightly described as events that violate MP_2, then the moral impermissibility of these events would be established, that is, according to opponents of PAD. An argument to this end could be constructed as follows. Let's call this absolutist version of the argument, the *Prohibition of Killing Innocents*, PKI$_{(AA)}$.

1. It is morally wrong intentionally to kill innocent human beings. (MP_2)
2. The practices that fall under PAD are instances of intentionally killing innocent human beings.
3. Therefore, PAD is morally wrong.

So what can be said in favor of premise 1 of $PKI_{(AA)}$? Some have appealed to the idea that the sanctity or inviolability of human life is what undergirds MP_2. Simply stated this view holds that "all human life has an inherent dignity, worth and sacredness" such that "its very essence is distinct within the biological world and of incalculable worth, thus warranting protection throughout the course of its entire existence."[2] One proponent of this view identifies "the ethical core of the doctrine of the sanctity of human life [as] an absolute (i.e., exceptionless) prohibition on intentionally killing another human being for reasons incompatible with justice."[3] The impetus behind this idea for traditional morality is that "respect for justice rests on the belief in the equality in fundamental worth and dignity of every human being."[4] Human beings are the kinds of entities whose lives ought not be taken in "virtue of their *nature* as human beings rather than in virtue of

[2] Dennis Hollinger, "Sanctity of Life," *Encyclopedia of Bioethics*, *Volume 3, Third Edition*, edited by Stephen G. Post (New York: MacMillan Reference, 2004), 1402.

[3] Luke Gormally, "Terminal Sedation and the Sanctity of Life," *Terminal Sedation: Euthanasia in Disguise?* (Norwell, MA: Kluwer Academic Publishers, 2004), 83.

[4] Ibid., 84.

the value we attach to activities in which we are able to engage because of the development of distinctive human abilities."[5]

Many often associate this notion with religiously based philosophical systems, and in some cases rightfully so, given that many such traditions often appeal to the idea.[6] On the one hand, Helga Kuhse describes this idea as flowing from a religious context. She writes, "The Doctrine has its source in the Judaeo-Christian tradition, which holds that all innocent human life, irrespective of its quality or kind, is equally valuable and inviolable and must never deliberately be taken."[7] Kuhse ultimately goes on to reject the idea of the sanctity of life being helpful for discussions in end-of-life medical ethics.

On the other hand, some claim that the sanctity or inviolability of life need not be construed as a purely religious idea or necessarily flowing from religious

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[5] Ibid., 84-85.

[6] Some examples include the works of Jewish theologian and moral philosopher, David Novak, *The Sanctity of Human Life* (Washington D.C.: Georgetown University Press, 2007); the Neo-Orthodox Protestant theologian, Karl Barth, *Church Dogmatics: The Doctrine of Creation, Volume III, Part 4* (Peabody, MA: Hendrickson Publishers, 2010) especially pages 397-470; the Jesuit philosopher, John F. Kavanaugh's development of his view of "Radical Personalism" in *Who Counts as Persons? Human Identity and the Ethics of Killing* (Washington D.C., Georgetown University Press, 2001); and the protestant theological ethicist, David P. Gushee, *The Sacredness of Human Life: Why an Ancient Biblical Vision is Key to the World's Future* (Grand Rapids: Eerdmans, 2012) amongst many others that could be listed.

[7] Helga Kuhse, "Why Terminal Sedation is no Solution to the Voluntary Euthanasia Debate," *Terminal Sedation: Euthanasia in Disguise?* (Norwell, MA: Kluwer Academic Publishers, 2004), 58.

contexts even if oftentimes it is associated closely with these. As one ethicist writes with respect to the notion of sanctity/inviolability of life:

> As this account of human dignity may suggest, the principle can also be articulated in non-religious terms, in which 'inviolability' would be a more fitting word than 'sanctity' with its religious overtones. Indeed, a prohibition on killing is central to the *pre*-Christian fount of Western medical ethics—the Hippocratic Oath—and the modern reaffirmation of that Oath by the arguably *post*-Christian Declaration of Geneva. Indeed, many non-believers recognize the right of innocent human beings not to be intentionally killed. …[t]he sanctity principle has long been recognized in most, if not all, civilized societies throughout the modern world, as is evidenced by its recognitions by international conventions on human rights.[8]

In other words, the notion of the sanctity or inviolability of life indicates that human beings are the kinds of things that have intrinsic value or worth in some way or other.

Perhaps Kant is an example on this latter score. For him, it must be kept in mind that the only things that are intrinsically good and of ultimate value are a good will and a person. Kant's first and second formulations of the categorical imperative are linked to these two areas of absolute value. It is his application of the second formulation of the categorical imperative, which seems *most* relevant for this context. That formulation holds that one is to "Act in such a way that you treat humanity, whether in your own person or the person of another,

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[8] John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legalisation* (New York: Cambridge University Press, 2002) 40-41.

always at the same time as an end and never simply as a means."[9] He develops his moral prohibition against suicide, and presumably of assisting another in the same, on the basis of the first two formulations of his categorical imperative. Though it is his application of the second version of the categorical imperative to the issue of suicide that is important for the point being made. Kant writes:

> [A]s regards the concept of necessary duty to oneself, the man who contemplates suicide will ask himself whether his action can be consistent with the idea of humanity as an end in itself. If he destroys himself in order to escape from a difficult situation, then he is making use of his person merely as a means so as to maintain a tolerable condition till the end of his life. Man, however, is not a thing and hence is not something to be used merely as a means; he must in all his actions always be regarded as an end in himself. Therefore, I cannot dispose of man in my own person by mutilating, damaging, or killing him.[10]

The point here is not to suggest that Kant's categorical imperative establishes for us the moral impermissibility of suicide even though he thought that it did. It is, instead, to acknowledge that for Kant the human person is of ultimate worth or inviolable and his moral philosophy was in many ways predicated upon this idea.

Whatever the judgment concerning the ultimate grounds of the inviolability or sanctity of human life, or whether it is best thought of in religious or non-religious terms, the claim is that human beings nevertheless possess intrinsic

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[9] Immanuel Kant, *Grounding for the Metaphysics of Morals*, (429), translated by James W. Ellington (Indianapolis: Hackett Publishing Company, 1981), 36.

[10] Ibid.

value and therefore should be preserved from unjust assault. If so, then there are corresponding obligations on the part of communities to recognize the moral bonds with others to nurture and protect innocent human life, even from one's own self. On this account, then, the wrong-making properties of killing innocents (i.e., why killing innocents is wrong when it is wrong) is that it disregards the inviolability of life and stifles genuine flourishing of human communities which nurture the inalienable right to life.

Furthermore, from this line of reasoning it is observed that MP_2, as it is rooted in the notion of the inviolability of life, is what undergirds current homicide law. While to be sure, it is not always the case that what the law reflects is ethical, it does raise the issue, according to opponents of PAD, as to "whether killing oneself and assisting someone to kill himself or herself [violates] the moral basis for homicide law, even when this is done and allowed under very limited circumstances."[11] Some claim that by allowing PAD to be an exception to current homicide law that it "does indeed attack the existing moral structure of homicide law and leaves it without a principled basis for protecting life."[12] And this for opponents of PAD, to say the least, would be problematic since the goal

[11] Arthur Dyck, *Rethinking Rights and Responsibilities*, 243.

[12] Ibid., 243.

of homicide law is the protection of innocent human beings and maintenance of the common good.[13]

Some perhaps would say that PAD should not constitute murder given that there may not be malicious intent involved. Others, however, argue that at the very least, it should be viewed as manslaughter. Even though PAS (which on the account on offer is a form of PAD) is legally permitted in three states at the time of this writing, "Many states [nevertheless] have specific statutes that criminalize [physician-assisted suicide]. Even in the states where this is not clearly defined as a crime, it may nonetheless be considered a form of homicide."[14] If so, this lends some credence to the charge from opponents that PAD is a violation of homicide law, which again, is rooted in MP_2, so it is claimed.

All of this is said to be in defense of premise1 of $PKI_{(AA)}$, which is the affirmation of MP_2: "It is morally wrong intentionally to kill *innocent* human beings." To reiterate, the wrong-making properties of intentionally killing innocents for whatever reason is that in doing so: (i) we fail to recognize the intrinsic value of human life that is the basis of morality, and (ii) it erodes the moral bonds of human community that promote human flourishing on which our long-standing current homicide law is based.

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[13] Ibid., 241-275.

[14] Jerry Menikoff, *Law and Bioethics: An Introduction* (Washington D.C.: Georgetown University Press, 2001) 327.

With respect to premise 2 of $PKI_{(AA)}$, the question at this point is, "Are the practices that fall under PAD instances of intentionally killing innocent human beings?" One recalls from chapter 2 that the description of PAD on offer in this project would be seen as describing events in the medical context, which include the intentional killing of innocent human life. This point would be difficult even for proponents of PAD to deny. PAD simply does include the intentional killing of innocent human beings, albeit in a medical context for reasons thought to be morally sufficient to warrant the actions, which, of course, is what opponents of PAD reject. Again, as discussed in chapter 2, this descriptive point must be coupled with some moral principle in order to engage in moral evaluation. In this case, it would be MP_2. Therefore, in keeping with the conclusion of $PKI_{(AA)}$, PAD is considered to be morally wrong.

Three Categories of Criticisms to *PKI*:

These claims certainly are not without their ablest detractors. Several types of formidable objections have been leveled against these, admittedly general, reasons given in favor of $PKI_{(AA)}$. Given what was stated above concerning premise 2, this section will provide a general analysis of premise 1, which affirms MP_2. In what follows, I highlight three coalescing categories of criticism of premise 1, namely, (i) that it fails to account for the moral significance of the distinction between a human being and a human person, (ii) it highlights the

wrong wrong-making properties, and (iii) the moral principle on which it is based is too strong.

To begin, it may be argued that premise 1 is false because it situates the locus of value in the wrong place. The issue of moral importance centers not on the value of mere human beings but the value of human persons. It is human persons who matter with respect to ethics and our human rights talk. So human value is in personhood, and not merely in the fact that the entity in question is human. This notion reflects the common and widely appealed to distinction between biological and biographical life that is brought out with particular precision by James Rachels. He writes:

> [T]here is a deep difference between *having a life* and *being alive*. Being alive, in the biological sense, is relatively unimportant. One's *life*, by contrast, is immensely important; it is the sum of one's aspirations, decisions, activities, projects and human relationships. The point of the rule against killing is the protection of *lives* and the interests that some beings, including ourselves, have in virtue of the fact that we are subjects of lives… In deciding questions of life and death, the crucial question is: Is a life, in the biographical sense, being destroyed or otherwise affected? If not the rule against killing offers no objection.[15]

We can see that this view affirms that it is human persons who have rights. Human beings, if they lack the property of personhood, do not. This is not to say that there won't remain strong sentiments with respect to the "human being formerly known as grandma" or that any kind of treatment towards the human

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[15] James Rachels, *The End of Life: Euthanasia and Morality* (New York: Oxford University Press, 1986) 5.

being would necessarily be morally permissible if the entity in question lost the property of personhood, any more than a coroner can do anything she pleases with a corpse. It is to say that any language that employs concepts of "inalienable rights to life," "the sanctity of life," or "the inviolability of human life" more aptly applies to persons than it does to human beings. Rachels, and those who follow him on this score, suggest that if one wants to make some kind of appeal to the sanctity of life idea, then "[it] ought to be interpreted as protecting life in the biographical sense and not merely life in the biological sense."[16] So on some accounts that develop this line of thought, it *may* always be wrong to kill innocent human persons, while it is not always wrong to kill innocent human beings, contra MP_2. Hence, premise 1 of $PKI_{(AA)}$ is false.

Of course, the question emerges as to what is the difference between a human being and a human person? Or what are those properties that would need to be possessed by human beings that make them persons such that when humans lose these they cease to be persons? Many contemporary thinkers have followed or further developed the discussion provided by Mary Anne Warren in her widely read and often referenced essay from 1973.[17] She argues that human beings, in the genetic sense, should not be thought to be

[16] Ibid., 26.

[17] Mary Anne Warren, "On the Moral and Legal Status of Abortion," *Monist 57* (1973).

included in the moral community, which is the set of beings with full and equal moral rights.[18] She suggests that the moral community "consists of all and only people, rather than all and only human beings."[19] This self-evident truth is demonstrated, according to Warren, by considering the concept of personhood, which is characterized in people.

She identifies five traits "which are most central to the concept of personhood, or humanity in the moral sense." They are:

i. Consciousness (of objects and events external and/or internal to the being), and in particular the capacity to feel pain;

ii. Reasoning (the developed capacity to solve new and relatively complex problems);

iii. Self-motivated activity (activity which is relatively independent of either genetic or direct external control);

iv. The capacity to communicate, by whatever means, messages of an indefinite variety of types, that is, not just with an indefinite number of possible contents, but on indefinitely many possible topics;

v. The presence of self-concepts, and self-awareness, either individual or racial, or both.[20]

The result of these is that "[b]iological life alone does not endow a being with interests. Without interests, they cannot have moral status."[21] And hence

[18] Ibid., 54

[19] Ibid.

[20] Ibid., 55.

human non-persons (or mere human beings) are not necessarily included into the moral community. Many others have also developed various criteria for personhood.[22] But for the purposes of this chapter Warren's criteria should suffice both to illustrate how the distinction is to be understood and to prefigure how they are subsequently applied.

This leads to the second area of critique of premise 1. By maintaining the human being/human person distinction, one is in a better position to identify the wrong-making properties of "Why killing innocents is wrong when it is wrong." The proposed wrong-making properties of MP_2 noted above, critics claim, are simply not wrong-making properties. Killing innocents is not wrong due to the fact that it disregards the inviolability of life, nor because humans possess intrinsic value. Instead, they would maintain that killing innocents is wrong when it is wrong is due to the fact that it harms them. As Rachels straightforwardly highlights, "If we should not kill, it is because in killing we are harming someone. That is the reason killing is wrong. The rule against killing has as its point the

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[21] Bonnie Steinbock, *Life Before Birth: The Moral and Legal Status of Embryos and Fetuses* (New York: Oxford University Press, 1992) 5. It should be noted that Steinbock is not in support of legalizing physician-assisted suicide for consequentialist reasons. See her essay "The Case for Physician Assisted Suicide: Not (Yet) Proven," *J Med Ethics* 2005; 31:235-241. doi: 10.1136/jme.2003.005801, at least at the time of the referenced essay.

[22] See for example the following: Daniel Dennett, "Conditions of Personhood," *What is a Person*, edited by Michael F. Goodman (New Jersey: Humana Press, 1988) 145-167; Joseph Fletcher, *Humanhood: Essays in Biomedical Ethics* (New York: Prometheus Books, 1979) Chapter 1; H. Tristram Englehardt, Jr., *The Foundations of Bioethics* (New York University Press, 1986) 107-108; Michael Tooley, *Abortion and Infanticide* (New York: Oxford University Press, 1983).

protection of victims."[23] Don Marquis, writing in another though related bioethical context, identifies the nature of the harm inflicted in circumstances of wrongful killings when he writes:

> The loss of one's life is one of the greatest losses one can suffer. The loss of one's life deprives one of all the experiences, activities, projects, and enjoyments that would otherwise have constituted one's future. Therefore, killing someone is wrong, primarily because the killing inflicts (one of) the greatest possible losses on the victim.[24]

Interestingly, both Rachels and Marquis seem to develop a type of Harm Based account of the wrongness of killing, though, in application Marquis thinks that abortion would be morally wrong for the same reason that killing adult human beings is wrong. Yet Rachels would disagree. To be sure, there are a myriad of philosophical reasons underlying their disagreement on the application of the operative harm principle that have not been mentioned due to the general thrust of this section. Nevertheless, there does seem to be something missing from the Harm Based account of the wrongness of killing as articulated to this point. Otherwise, according to Jeff McMahan, "it implies that, if other things are equal, the killing of a fetus or infant is more seriously wrong than the killing of an older child or adult, because the death of the fetus or

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[23] James Rachels, *The End of Life: Euthanasia and Morality* (New York: Oxford University Press, 1986) 6.

[24] Don Marquis, "Why Abortion is Immoral," *Journal of Philosophy* 86 (1989): 189.

infant involves a greater harm—that is, the effect of the death on the value of the life as a whole is worse."[25]

The point here is not to enter into the even more controversial debate over abortion. Instead it is to home in on why it is thought that killing is wrong when it is wrong and what makes death bad when it is bad. The description given by Marquis above, which identifies the nature of the harm in killing humans, is thought to be deficient for those who would push back against MP_2. It is thought to be deficient because the reason why the loss of life is so tragic is not simply due to the loss of life itself but it is that certain desires by the human person remain unfulfilled or frustrated. There needs to be a "conceptual link between harm and desire" to capture the essence of the wrongness of killing in developing a Harm-Based account.[26] In other words, a person is harmed "if she is prevented from accomplishing her aims [or desires] by being killed."[27] So this can be described as a Desire Based Harm account of the wrongness of killing. This is thought to be more fitting for identifying the wrong-making properties of killing when it is wrong.

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[25] Jeff McMahan, *The Ethics of Killing: Problems at the Margins of Life* (New York: Oxford University Press, 2002), 192.

[26] Ibid.

[27] Alberto Giubilini and Francesca Minerva, "After birth abortion: why should the baby live?" *JMed Ethics* Published Online First: 23 February 2012. doi: 10.1136/medethics-2011-100411

When these aforementioned distinctions are applied to the issue at hand, it follows, then, that there can be some instances such that not only innocent *human beings,* but also innocent human *persons* may be killed. In such cases it may not always be morally wrong to kill human beings or human persons since these individuals would not be harmed thereby. The reason could either be due to the fact that they lack the capacity to have desires *or* they desire another agent to assist them in their death for various rational considerations.

Let's first consider the moral permissibility of killing *human beings* on this Desires Based Harm account. If a distinction between human being and human person is upheld, then we are in a position to identify cases where a human being ceases to be a person. Hence, the entity would not be harmed if killed via PAD. There would just need to be criteria in place to determine when personhood is deemed to be lost and if the implementation of PAD is consistent with previously stated values of the patient in question.[28] As noted above, this is what Mary Anne Warren and others have attempted to do. With respect to situations like this, it is difficult to see how one can meaningfully speak of the entity actually being harmed in some way if the decision is made *intentionally* to cease the biological life of the patient. Or so it is argued.

[28] One could suggest that this latter point is irrelevant if one holds to the human being/human person distinction. See more on this below.

If it is only wrong to kill innocent *persons,* there could be instances of killing innocent human *beings* that are not morally problematic because the wrong-making properties that make killing wrong when it is wrong are absent. Furthermore, those who reject MP_2 can claim that now there also may be some instances where the killing of an innocent human *person* could be morally justified under specific conditions. The point is made clear if we recall to mind very common and widespread scenarios where a patient's life has deteriorated to a point where it no longer has any value for that person, she has nothing else to accomplish, and she makes a rational request to give up her right to life by having it intentionally ended due to the patient's perception that her life lacks an acceptable level of quality. This approach usually takes the form of "Quality of Life" (QOL) type arguments also coupled with notions of autonomy (to be discussed below). Again, one would be hard pressed in these situations to see how PAD would indeed harm a patient in some way or other. So it may not always be wrong to kill an innocent human person though, of course, there remains a strong *prima facie* prohibition against it. And so there is another reason to reject premise 1 of $PKI_{(AA)}$ according to the critics of the argument.

The third category of criticism is that proponents of PAD could argue is that MP_2 is too strong of a moral principle especially in light of the highly casuistic nature of medical ethics. There just seems to be some extreme circumstances where it would be morally permissible to kill innocents intentionally. Of course,

we could develop thought experiments of various sorts that would describe a scenario where the continued existence of the world population is hanging in the balance unless some innocent person is killed. Some would then ask, "Is it not morally permissible to kill an innocent in these situations?" If so, then the prohibition against killing innocents cannot be absolute.

Thought experiments, certainly, have been part of the conceptual tools philosophers have employed to do their work to test intuitions and develop counter-examples to specific claims, and rightfully so. Though in this situation one would not need to appeal to thought experiments that employ highly improbable states of affairs, even if philosophically it would not be inappropriate to do so. One could think of significant natural meteorological occurrences (combined with human moral irresponsibility) that have disastrous effects on communities such as Hurricane Katrina in 2005. Many cases emerged where medical professionals felt forced to decide between non-voluntary euthanasia on the one hand and what some describe as patient abandonment on the other in those situations where patients were unable to be moved out of rooms in some clinical facilities where there were rising flood waters. There has been much debate surrounding what the right course of action should have been in these cases. Even if these are not common occurrences in the context of health care, they are, nevertheless, real scenarios. Perhaps, then, the argument should be framed around *prima facie* responsibilities.

The aim would be to modify MP_2 away from an absolutist formulation given that it is not clear that it is always morally wrong to kill innocent human beings while maintaining there is a strong *prima facie* prohibition against it. Proponents of PAD would perhaps be more likely to accept something akin to:

> MP_3: It is morally wrong intentionally to kill *innocent* human beings without sufficient moral justification.

MP_3 is a modification of MP_1 in that the qualification of the person's innocence is included. Proponents of PAD would then appeal to some of the reasons given in favor of PAD and suggest that these do provide sufficient moral justification for the killing of innocents under certain proscribed circumstances, those in which the patients are benefitted and not harmed.

And so proponents of PAD can develop an alternative argument to the absolutist version of the Prohibition of Killing Innocents (*PKI*) that would argue for the moral permissibility of PAD under certain conditions in a medical context. Let's call this *prima facie* counter-argument, $PKI_{(PFCA)}$. It can be stated as follows:

4. It is morally wrong intentionally to kill innocent human beings without sufficient moral justification. (MP_3)

5. The practices that fall under PAD are instances of intentionally killing innocent human beings in a health care context.

6. Patient autonomy and the alleviation of pain and suffering are essential values in the professional practice of medicine.

7. Honoring the values of patient autonomy and the alleviation of pain and suffering in some cases may require, professionally and morally, PAD.

8. If 6 and 7, then in some cases the values of patient autonomy and the alleviation of pain and suffering provide sufficient moral justification to override the *prima facie* prohibition of killing innocent human beings in a health care context.

9. Therefore, in some cases the values of patient autonomy and the alleviation of pain and suffering provide sufficient moral justification to override the *prima facie* prohibition of killing innocent human beings in a health care context.

10. If 9, then PAD is sometimes morally permissible in a health care context.

11. Therefore, PAD is sometimes morally permissible in a health care context.

What can be said in favor of the premises? Premise 4, which affirms MP_3, is thought to be a more reasonable operative moral principle. Much of what was stated concerning MP_2 coupled with the extreme scenarios identified above would lend support for premise 4 of $PKI_{(PFCA)}$ argument or the adoption of MP_3. Even if the extreme scenarios described infrequently are actual and the philosophical challenges to MP_2 have some initial responses to them, it would seem that one must consider that there may be some cases in which it is not so clear that it is *always* wrong to kill innocents, even in a medical context. Moreover, that it may sometimes be right.

Premise 5 (as in the case with premise 2 in $PKI_{(AA)}$) has been established with respect to the descriptive analysis of PAD provided in chapter 2. Patient autonomy and the alleviation of pain and suffering as stated in premise 6 are essential values in the practice of medicine. The importance of these concepts

in medical care cannot and ought not be minimized or trivialized. Both of these values should be accepted by all who are involved in professional health care though there is some debate as to what counts as genuine expressions of autonomy and compassion in alleviating suffering. But the values themselves generally speaking are almost universally accepted in Western approaches to medicine.

The next premise is stated as follows:

7. Honoring the values of patient autonomy and the alleviation of pain and suffering in some cases may require, professionally and morally, PAD.

The majority of the literature on this topic identifies variations of two primary arguments, which contend that there does exist sufficient moral justification in health care to allow for the intentional killing of human beings under carefully proscribed conditions of PAD. These are the arguments from patient autonomy and the argument from the alleviation of pain and suffering.

With respect to the former, patients have the right of self-determination. If they so choose and are not under duress or any other form of coercion and if they think that death is better than their current debilitated medical condition, then they have every right to PAD even if they are not required to choose that option. A notable text in the area of medical ethics has defined the concept of autonomy relevant for the field as:

> [E]ncompassing, at a minimum, self-rule that is free from both controlling interference by others and from certain limitations such as an inadequate understanding that prevents meaningful choice. The autonomous individual acts freely in accordance with a self-chosen plan, analogous to the way an independent government manages its territories and establishes it policies."[29]

If patients indeed are autonomous, then there are corresponding obligations on behalf of others to treat patients as autonomous persons and assist them in PAD, provided patients are so inclined. As Margaret Battin summarizes the argument when she writes:

> In the context of end-of-life medical care, respecting autonomy for the dying patient not only means honouring as far as possible that person's choices concerning therapeutic and palliative care, including life-prolonging care if it is desired, but could also mean refraining from intervening to prevent the person's informed, voluntary, self-willed choice of suicide in preference to a slow, painful death, or even providing assistance in realizing that choice.[30]

The alleviation of pain and suffering is the second major argument given for the moral permissibility of PAD. It is often known as the argument from compassion and mercy as well. There are instances of intractable pain that cannot be managed otherwise. No patient "should have to endure pointless terminal suffering. If the physician is unable to relieve the patient's suffering in other ways acceptable to the patient and the only way to avoid such suffering

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[29] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, Sixth Edition (New York: Oxford University Press, 2009) 99.

[30] Margaret P. Battin, "Euthanasia and Physician Assisted Suicide," *Ending Life: Ethics and the Way we Die*, edited by Margaret P. Battin (New York: Oxford University Press, 2005) 20-21.

is by death, then as a matter of mercy death may be brought about."[31] The remaining combination of premises and conclusions found in lines 8 through 11of the $PKI_{(PFCA)}$ argument follow the basic rules of inference which collectively take the form of *modus ponens*. So maybe it is preferable to think about these issues in ways that are along the lines of $PKI_{(PFCA)}$ in order to rule out potential counter-examples that stretch our intuitions on the absolutist version of the *PKI* argument.

Some Responses to Criticisms of *PKI*:

In this section, I can only offer a sketch of what *might* comprise an adequate response to what is stated above. For those who want to maintain that $PKI_{(AA)}$ is sound, what could an opponent of PAD say by way of rejoinder to these criticisms? Primary focus here again is on premise1.

To begin, defenders of premise 1 of $PKI_{(AA)}$ may respond to the first objection by denying the legitimacy of the human being and human person distinction since it has a number of counter-intuitive implications. The first counter-intuitive implication is that it goes too far as it ends up excluding a number of vulnerable groups of human beings whom we would otherwise, absent the distinction, consider a part of our *moral* community and hence have moral obligations to them.

[31] Ibid., 29.

Recall the traits that are most central to the concept of personhood provided by Mary Anne Warren, namely (i) consciousness, (ii) reasoning, (iii) self-motivated activity, (iv) the capacity to communicate, and (v) self-awareness. While acknowledging "there are apt to be a great many problems involved in formulating precise definitions of these criteria, let alone in developing universally valid behavioral criteria for deciding when they apply," she nevertheless thinks that these should be clear enough - so much so that any entity "which satisfies none of [(i)-(v)] is certainly not a person."[32] An individual must *possess* these characteristics in order to be deemed as having personhood. Yet, one may ask, what are we to do with human persons who are asleep, temporarily unconscious, or in a reversible coma? Human beings in these states do not satisfy the criteria of personhood that Warren et. al. identify. But it is counter-intuitive to think that human beings in such conditions are no longer part of our moral community.

Now of course, the most obvious counter-response to this is to *emphasize the temporary states* of the examples given above. Yet it seems that according to the criteria, it is *not enough* for it to be the case that *the human being will have these in the future* or perhaps, and more importantly for this discussion, *has had these traits in the past*. Personhood rests in the exhibition of the traits described in the criteria above. If the counter-response takes the form of

[32] Warren, "On the Moral and Legal Status of Abortion," 56.

emphasizing the temporary nature of these conditions, then this would suggest that what gives human persons value is not the actual exercise or lack thereof of particular traits identified in these criteria at time t_1 or t_2, and so on.

Consider a scenario where some human being, *S*, is temporarily unconscious at t_1 and then regains consciousness at t_2. Then, say, a defender of the human being/human person distinction emphasizing the temporary nature of this condition claims that *S* remains part of the moral community. But this would imply that during the interval between t_1 and t_2 none of Warren's criteria are met. So then a critic of the distinction would suggest that perhaps it is that which grounds the expression of the capacities that is fundamentally important. And this ground is intrinsic to the nature of the *kind* of complex entities human beings are.

Further, how does the being/person distinction fare for those who have impairments that limit the expressions of the capacities in question? Some examples here would involve infants, the mentally handicapped, and human beings suffering from dementia. Arguably, those human beings in these categories fall below the base threshold given in the criteria. Health care has been on the forefront of reaching out to vulnerable populations such as these to provide care and assistance for the very fact that it is thought these individuals are part of the moral community. Hence, we have special obligations to care for those human beings who are not in the best position to care for themselves.

Perhaps an additional way of "framing the view is that the members of the moral community include not only duty-bearers (moral agents who have the capacity to perform their duties) but also right-holders (who may not be duty-bearers because they lack the relevant moral capacities but have claims or rights against others)."[33]

The second counter-intuitive implication of the distinction is that it allows us to judge certain actions towards human *beings* as being morally permissible that we otherwise think and actually take to be ethically inappropriate. Consider the following scenario. A cognitively fully functioning man goes into the hospital for a 12-hour surgery. The doctors render the patient completely unconscious using strong narcotics in preparation for the procedure. During the time of the surgery the estranged ex-wife of the patient finds his debit card along with his pin number and then proceeds to wipe out his bank account. The patient recovers fully from the surgery only later to discover that he has no money. On the criteria set forth concerning personhood, would an advocate of the distinction be in a position to say that the estranged ex-wife's actions violated the patient's rights at the time of the taking of the money? Critics of the

[33] I am indebted to Dr. Katherine Kim for this point in personal correspondence.

distinction do not think so. But they would then add that this does not seem to be right-headed, which in turn *may* indicate a problem with the distinction.[34]

Maybe the case above has assumed an uncharitable understanding of consciousness in Warren's criteria. What should be emphasized is that only conscious *or* temporarily unconscious beings are in the moral community. If so, perhaps the case could be modified further to consider two scenarios. The first is one in which the man in the 12 hour surgery regains consciousness only to learn his account has been wiped out by his estranged ex-wife. The second scenario is one in which he never regains consciousness and is officially pronounced dead 18 hours after the surgery. So a critic of the view may suggest that a defender of the human person/human being distinction is to conclude that the estranged ex-wife's action was wrong while the man was in surgery in the first scenario when he was completely and deeply unconscious. Since the state was temporary, he is still part of the moral community. However, in the second scenario, one would be forced to conclude that there was no moral wrong committed during the time of the surgery because of what turned out to be the

[34] Now, to be sure, this kind of response to the human being/human person distinction is based on certain interpretations of it. There no doubt are moves that can be made to counter these concerns. Nevertheless, the point here is not to provide a complete refutation of the distinction given the complexity of the topic. Instead is to highlight that not all agree that these kinds of moves can be made with the kind efficiency that it sometimes suggested. The goal is to simply point in the direction that a more robust response to the being/person distinction must take. The arguments developed in this chapter are to provide an exposition of select reasons as to why some have thought PAD is morally problematic, which when all is said and done could be misguided.

permanent nature of his unconscious state. So it would seem that we must suspend moral judgment as to the actions of the estranged wife until we know whether the man would regain consciousness or not.

A further question would be: At what point, then, would the man no longer be part of the moral community? While not a refutation of the distinction, the claim that moral evaluation of the estranged ex-wife's action can only be made retrospectively may strike some as odd. Intuitions, no doubt, will run in opposite directions on these kinds of scenarios and further modifications to the distinction might be made (say, that membership in the moral community can be possessed by those who are only temporarily unconscious *and* by those who in the past have been conscious). These sorts of additions and modifications have been proposed in discussions of the abortion problem, but to pursue them would take us too far afield here.

Another case in point would be a severely senile person or someone with advanced dementia who is living in a skilled nursing facility. These individuals' property and bodily integrity are protected by codes of professional conduct and the law such that actions such as theft of their property or sexual abuse against them would be penalized in some form or other. The perpetrators of these acts would be judged to have done something not only illegal, but also on most accounts, something morally impermissible. Again, on the criteria set forth concerning personhood, would an advocate of the distinction be in a

position to say those perpetrators against the severely senile or human beings with advanced dementia act wrongly? It seems not, unless the distinction were expanded to include those who have once been conscious, along with those actually conscious and only temporarily unconscious, in the moral community.

Lastly, most proponents of PAD insist that it only be performed with patient consent such that any proposals in favor of these practices should not slide into non-voluntary euthanasia. At times many have expressed moral outrage either when non-voluntary euthanasia is performed *or* if it is suggested that support of PAD naturally leads to it. Fair enough—though if one wants to maintain the human being/human person distinction along with this stance against non-voluntary euthanasia, then there is a conceptual tension present. Critics of the human being/human person distinction point out that, "if biographical life is the determinant of personhood such that when it is lost, we are not killing a person, then there is no reason to be outraged when euthanasia is performed without someone's consent or even without their knowledge."[35] Of course, this is completely consistent for those who think that non-voluntary euthanasia is morally permissible. However, for those who do not, it would seem that this judgment would be inconsistent with the human being/human person distinction.

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[35] J. P. Moreland and Scott B. Rae, *Body and Soul: Human Nature and the Crisis in Ethics* (Downers Grove: InterVarsity Press, 2000) 326.

Given the serious ethical implications involved in these discussions many critics argue that the distinction is imprudent. This is the thrust of Robert Spaemann's book length critique of the notion. He writes:

> What properties must someone possess to have the right to recognition as a person? But that is the wrong way to pose the question, because it uses the word 'someone'. Anything that is 'someone' is a person. We would do better to ask, When is some-*thing* some-*one*? But that is still wrong. Some-thing is never some-one. To be 'some-one' is not a property of a thing, whether animate or inanimate; it is not a predicate of some previously identified subject. Whatever we identify, is identified either as someone or as something from the word go.[36]

To be sure, Spaemann overstates his case since we can identify some x in the class of humans as "some being," which does not presuppose that it is some-one nor some-thing. Nevertheless, rightly or wrongly, for Spaemann and other critics, it is more appropriate to think of all *living* human beings as human persons. "Human beings have certain definite properties that license us to call them 'persons'; but it is not the properties we call persons, but the human beings who possess the properties."[37]

To be sure, there has been much debate on this point. The literature on the subject is immense. And there remain a number of other criticisms that can be leveled against the distinction and just as many counter-responses or

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[36] Robert Spaemann, *Persons: The Difference between 'Someone' and 'Something'*, translated by Oliver O'Donovan (New York: Oxford University Press, 2006) 237.

[37] Ibid., 236.

modifications to the views can be made to circumvent these particular charges. Moreover, a host of metaphysical issues concerning philosophical anthropology are not raised here. Nevertheless, enough has been hinted at to underscore that regardless of however meaningful the human being/human person distinction appears to be, on some accounts it is not wholly unproblematic.

The second criticism of $PKI_{(AA)}$ is that it advocates for the wrong wrong-making properties concerning the ethics of killing humans. What could defenders of MP_2 say in response to this charge? Perhaps they would proceed by noting that any account of right and wrong action or the nature of the good is embedded in some overarching moral philosophy. It could be the case that a rejection of Desire-Based Harm accounts of killing humans (DBHA) would be on the grounds that the moral philosophy from which it is derived is flawed or simply just different. In such instances, we have conflicting and some cases incompatible moral philosophies at work in the same field of ethical discourse. Certainly, it is not always the case that different moral theories generate conflicting conclusions. In many instances they may converge in the realm of applied ethics albeit for different reasons perhaps.

It is important to emphasize that many actions in various contexts are morally complex. In other words, they often have more than one right and wrong-making property. Perhaps the insight from W. D. Ross's moral philosophy and the development of his notion of *prima facie* duties shed some light on the

claim being offered. He notes, "any act is the origination of a great variety of things many of which make no difference to its rightness or wrongness. But there are always many elements in its nature … that make a difference to its rightness or wrongness, and no element in its nature can be dismissed without consideration as indifferent."[38]

So one could concede that the DBHA of the wrongfulness of killing humans, *per se*, may not be completely wrongheaded when considering the "nature" of killing humans. If so, then it is possible that DBHA could be a legitimate expression of the wrongfulness of killing when it is wrong in some circumstances. However, this is not to say that if the killing in question does not violate DBHA, then it is therefore morally permissible. It could be, but may not necessarily be so. The reason is, it may be claimed, that the killing in question while not exhibiting one wrong-making property, could exhibit another. If so, then it would seem that for some particular action that instantiates any wrong-making property with respect to the ethics of killing humans would constitute a sufficient condition for it to be judged as morally wrong. It may not be as wrong as it would be if, say, multiple wrong-making properties supervened on the action, but wrong nonetheless, though feasibly to a lesser degree. As Jeff MacMahan writes:

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[38] W. D. Ross, *The Right and the Good*, edited by Philip Stratton-Lake (New York: Oxford University Press, 2002) 33, n. 2. (originally published in 1930)

> An act may have various morally objectionable or, as some have said, "wrong-making" features. These features may, in certain contexts, be outweighed by other considerations, so that the act, though morally objectionable in some respects, may be permissible, or not wrong (in the sense that it ought not to be done), all things considered. But if the reasons why it is morally objectionable are not outweighed (or nullified or otherwise overcome), it will be wrong, in the sense that it ought not to be done. Still, the degree to which it is morally objectionable is variable. If the moral objections to it, or the reasons why it ought not be done, are very strong and are not substantially opposed by countervailing considerations, we say that the act would be seriously wrong. If, by contrast, the objections to it are weak, or are almost counterbalanced by countervailing moral considerations, it may be only slightly wrong.[39]

It could be argued by opponents of PAD that what we have with regard to the killing of innocent human persons are actions that, depending on circumstances, may have more than one *right* or *wrong*-making properties. This is a similar situation to the role that Ross's *prima facie* duties play. So perhaps it is not the case after all that opponents of PAD have highlighted the *wrong* wrong-making properties. Opponents of PAD could argue that DBHA has just possibly identified another wrong-making property in addition to those already recognized by those who are proponents of the inviolability of life view as discussed above.

Now these same opponents of PAD, say, may reject the underlying moral theory of which DBHA is a part, if it required "right action" to be reduced *only* to that which allows for the greatest expression of human desires or something akin

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[39] Jeff MacMahan, *The Ethics of Killing: Problems at the Margins of Life* (New York: Oxford University Press, 2002), 190.

to this. It does seem that if they make this sort of move, one that acknowledges that there might be multiple right and/or wrong-making properties, then perhaps they would need to move from an absolute prohibition of killing innocents to understanding it in a 'Rossian' *prima facie* manner.[40]

MacMahan's comments above lead nicely to the third and final area of criticism of $PKI_{(AA)}$ noted in this section, which is that MP_2 is too strong of a principle. What about the claim to adopt something along the lines MP_3 which states, "It is morally wrong intentionally to kill *innocent* human beings without sufficient moral justification" and the subsequent $PKI_{(PFCA)}$ argument? And then, moreover, are there "countervailing moral considerations that counterbalance" MP_3?

Obviously, one response could be to hold to a principle of tenacity and maintain an absolute prohibition against killing innocents in any and every conceivable situation. But to many moral philosophers, including those who may be opposed to PAD, this would seem a bit difficult to embrace given certain, admittedly extreme, thought experiments. This is the case even if they hold to some form of the "inviolability of life" or "sanctity of life" principle. For those in this latter category the sanctity of life principle and MP_3 are not incompatible.[41]

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[40] See particularly chapters 1 and 2 of Ross's *The Right and the Good.*

[41] As discussed in the next section, some opponents of PAD could maintain that the prohibition against killing innocents may not be an absolute moral principle in the sense of

And so some opponents could concede the point to those who suggest that MP_2 is too strong.

It would seem that some opponents of PAD might be willing, at least for the sake of argument, to embrace MP_3 as endorsed in premise 4 of $PKI_{(PFCA)}$. If MP_3 would be accepted by many of the disputants in the conversation, both *pro* and *con*, then we would be in a position to evaluate the claims of $PKI_{(PFCA)}$. The moral permissibility or impermissibility of PAD would turn on whether or not there is *sufficient* moral justification that would override the killing of innocents in a medical context under certain conditions. $PKI_{(PFCA)}$ is crafted as a *modus ponens* styled argument. Given this, we have the classic case of one person's *modus ponens* is another's *modus tollens*. So opponents of PAD conceivably can embrace MP_3 and reject a crucial premise in $PKI_{(PFCA)}$. It does not take much to see that premise 7, which appeals to patient autonomy and alleviating pain and suffering, is the crucial premise of $PKI_{(PFCA)}$ rejected by opponents of PAD.

How might a response look for proponents of MP_3 to this objection? Certainly, they would need to affirm that autonomy is of utmost importance in medical ethics. When properly understood it is a principle that is wholeheartedly

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universally applied, but could be seen as an absolute moral rule within the context of health care. To avoid being a completely question-begging justification the reasons why it is considered an absolute moral rule in the context would need to be different from the reasons developed here in this section.

endorsed in professional health care. Though, autonomy should not be thought to be an absolute value. To be fair, this is acknowledged by many who are proponents of some forms of PAD. For example, Beauchamp and Childress carefully acknowledge, "we do not hold, as some critics suggest, that the principle of respect for autonomy overrides all other moral considerations."[42] We already have limits on our autonomy because we are necessarily social beings. This is true for the medical context as well. Beauchamp and Childress also make this point clear, "Furthermore, we attempt to show that, in a properly structured theory, respect for autonomy is not excessively individualistic (thereby neglecting the social nature of individuals and the impact of individual choices and actions on others)…."[43]

And so it is widely accepted that patients cannot demand a health care facility provide any treatment whatsoever simply because it is requested. If (1) a health care team says "no" to some request for a treatment that the facility is able to provide and (2) the treatment is *morally permissible* to perform *in principle*, then there should be good reason given to the patient as to why it is being withheld. It could be for reasons that the treatment is not medically indicated, or futile (providing no benefit on balance) for the particular patient

[42] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, Sixth Edition (New York: Oxford University Press, 2009), 99.

[43] Ibid.

making a request, say. Furthermore, autonomy does not require physicians to perform acts they deem to be morally impermissible for health care professionals to engage in, even if they have the professional expertise and skills to accomplish it.

Moreover, many question whether or not it is even possible for patients to be truly autonomous in the relevant sense given the medical circumstances surrounding their requests. For if the moral claim "to autonomy is to be actualized in clinical decisions, the patient must, in fact, be able to exercise her autonomy."[44] Many opponents of PAD think that the "complex and highly uncertain phenomenology of fatal illness, dying, and suffering make the exercise of genuine autonomy highly problematic."[45] Consider the description by Edmund P. Pellegrino:

> The person desperate enough to seek exit by suicide or euthanasia is beset with anxiety, despair, guilt, depression, and a sense of unworthiness. These, as much as pain, are at the root of the desperate pleas for surcease through death. Often these feelings are exacerbated by the way family, friends, physicians, nurses, and others behave and respond to the patient's predicament. Any signs or semblances of insensitivity, indifference, revulsion, loathing, distancing, pity, or impatience to be about one's business are quickly transmitted to those in the grasp of a fatal illness. They can see either reassurance or confirmation of their worst fears in the way others approach them. Their feelings of alienation from the world of the well and their sense of a loss of dignity are easily

[44] Edmund P. Pellegrino, "The False Promise of Beneficent Killing," *Regulating How We Die: The Ethical, Medical, and Legal Issues Surrounding Physician-Assisted Suicide*, edited by Linda L. Emmanuel (Cambridge, MA: Harvard University Press, 1998), 80.

[45] Ibid., 81.

> reinforced. Unknowingly, physicians and family may add to a patient's depression or influence his choice of suicide.[46]

The observations that Pellegrino makes may be contested in a place or two and may not always obtain. For instance, not all people seeking suicide feel guilty or unworthy, and it might be rational for them to feel anxious and depressed. Furthermore, proponents of PAD may declare that at most Pellegrino's comments would only go to support stringent safeguards, not universal moral impermissibility.[47] His statements, nevertheless, do highlight the psychological, professional, and social complexity that raises moral concern in sorting through what an autonomous request *really* looks like in the situations in which a request is made. The effect of more stringent safeguards to stem potential abuse would result in people who otherwise would seem to be good candidates for PAD being excluded from taking advantage of the option. This is already the case in those states that have legalized PAS. The current safeguards in order to rule out unwanted consequences end up excluding certain kinds of patients that seem to be likely candidates for PAD.

Along slightly different lines, opponents of PAD wonder, if the argument in favor of it is really about autonomy at all. To make this point more salient, consider the fact that most proposals for implementing PAD by its proponents

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[46] Ibid.

[47] I am thankful to Dr. Bruce Russell for raising this sort of observation.

are not advocating for 'PAD on Demand' that is, "simply at the patient's request and without the considered assessment, judgment and approval of a responsible doctor."[48] Responsibility in the medical profession would require its practitioners to be discerning. An autonomous request for particular drugs on behalf of the patient does not obligate a physician to prescribe them if they are not medically warranted or deemed medically inappropriate. So opponents of PAD argue that the "the real…justification for [PAD] is not the patient's autonomous request *but the doctor's judgment that the request is justified because death would benefit the patient.*"[49]

If this is correct, then some further worry that this issue becomes exponentially more complex in a health care setting. Consider the descriptive claims by physician and medical ethicist Edmund Pellegrino about the position that health care professionals find themselves in:

> Physicians, like all other human beings, cannot entirely escape their own prejudices and biases about what constitute quality of life, a good death, and whether suffering has meaning. In the end, physicians will be the key interpreters of any criteria established by law or society when applied to a particular patient. Their interpretations will vary tremendously and may well reflect their preferences rather than the patient's. This is not to ascribe to physicians a collective defect of character, but only to recognize the power of a physician's own values, beliefs, and fears when deciding about the lives of others.[50]

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[48] Keown, *Euthanasia, Ethics and Public Policy*, 77.

[49] Ibid.

[50] Pellegrino, "The False Promise of Beneficent Killing," 80.

Certainly, proponents of PAD would push back against Pellegrino on this score and suggest that the universal criteria are established to help minimize instances of poor judgments on behalf of the medical profession. The reality is, proponents of PAD maintain, that medicine is an art and a science. There is inevitability and unavoidability of making clinical judgments that do include the background, context, training, biases, etc. of the physician making the judgment. And at any given time for the same patient, physicians may disagree on their judgments. Opponents of PAD point out that this is no doubt true. But given the well-documented ethnic and economic health care disparities that currently plague the U.S. health care system, do we really want to make the kinds of judgments where, for the most part, there are no "do-overs"?[51]

So while on the one hand the argument from autonomy seems to be a powerful one that provides counter-balancing evidence to the strong prohibition against killing innocents as applied in a health care context, opponents argue to the contrary. It may be a necessary condition for a legitimate instance of PAD only if PAD can be first shown to be morally permissible. But in itself, patient autonomy is not a sufficient condition to

[51] For details and documentation for the widespread problem of health care disparity in the U.S. health care system see for examples Donald A. Barr, *Health Disparities in the United States: Social Class, Race, Ethnicity, and Health* (Baltimore, MD: Johns Hopkins University Press, 2008) and Harriet A. Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (New York: Harlem Moon, Broadway Books, 2006).

substantiate the moral permissibility of PAD in a health care context. If so, then the argument in favor of PAD cannot be made purely on the basis of patient autonomy. It would need to be coupled with justification that there are medical or health care needs that cannot be met unless PAD is implemented. This is what seems to be behind the claim of the second argument in favor of the moral permissibility of PAD.

The second primary reason often given for allowing PAD is that it is an act of compassion in the face of pain and suffering. The problem here for opponents of PAD is in addressing the powerful emotion of compassion "that can take on a life of its own and, in distorted forms, can produce harm."[52] It is difficult for most human beings, but especially for medical professionals, to be around suffering patients and not be moved by compassion to want to act. Certainly, the experience of the powerful emotion of compassion does, in most cases, come with a strong desire or motivation to do something. This emotion is important, most definitely, for human flourishing and human relationships. Without it, many of the vulnerable in our moral community could suffer the most inhumane treatment. "The emotion of compassion has engendered some of the most admirable and heroic acts of which humans are capable. But the fact that we experience the emotion of compassion does not *per se* give moral

[52] Pellegrino, "The False Promise of Beneficent Killing," 83.

legitimacy to any action that compassion might motivate."[53] In other words, how is it that being motivated to act by a particular emotion, legitimizes the acts themselves that fall under PAD? It would seem that in order to keep the argument from compassion from becoming merely question-begging there would need to be independent reasons given in favor of PAD.

So perhaps the real issue is need. PAD should be morally permissible as a last resort since it may be the only way to alleviate pain and suffering of patients. So the argument is not based on compassion, an emotion, per se, but on the moral responsibility that medical professionals have to alleviate pain and suffering. However, through advances in effective pain management medical professionals can manage patients' pain extremely well. So pain doesn't appear to be the primary issue here. Suffering often stems from the meaning that one gives to their circumstances and at times can be more difficult to address. The response here is usually an appeal to the fact that there are options in dealing with suffering that do not cross the line of killing innocents in a health care context such that there is no need for PAD. Some of these options are the rise of hospice, more highly developed and improved palliative care services, and most notably for this project, palliative sedation.

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[53] Edmund Pellegrino, "Compassion is Not Enough," *The Case Against Assisted Suicide: For the Right to End-of-Life Care,* edited by Kathleen Foley and Herbert Hendin, (Baltimore, MD: John Hopkins University Press, 2002), 45.

Defenders of premise 7 may suggest that the response being developed is based on an incorrect conception. They will argue, as alluded to above, that the responses up to this point have assumed that these are independent reasons offered for the morality of PAD. Autonomy and the merciful alleviation of pain and suffering should not be thought of as being individually sufficient conditions for PAD. Instead, it should be "most naturally and plausibly understood as providing necessary conditions that, in suitable circumstances, may be together sufficient for making it permissible."[54] So the individual problems with autonomy and with the alleviation of pain and suffering are overcome by both of these being necessary conditions for the morality of PAD. Gerald Dworkin admits, "if either of these views is considered by themselves they do have unwanted implications. But the most plausible view that it is both choice *and* condition [of the patient] that make a doctor's killing permissible."[55]

Opponents of PAD push back against Dworkin's move here by asking an important question. Why is this so? How is it that these two reasons are jointly sufficient to render PAD morally justifiable? As stated, Dworkin thinks that these joint conditions "may be together sufficient for making it permissible" in suitable circumstances. But there is no discussion of exactly how.

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[54] Gerald Dworkin, "The Nature of Medicine," *Euthanasia and Physician-Assisted Suicide: For and Against*, edited by Gerald Dworkin, R. G. Frey, and Sissela Bok (New York: Cambridge University Press, 1998), 10.

[55] Ibid.

Perhaps a defender of Dworkin's move may say something along the lines that "these principles are intuitively plausible, explain what lies behind lots of our intuitions about what is permissible and what not, and there aren't any good counterexamples to them." A potential counter-response to this entirely credible claim is that the intuitions of opponents of PAD may go in the other direction. For those who *think*, rightly or wrongly, that they have good reasons against PAD, the declared intuitive force of Dworkin's claim that "both choice *and* condition [of the patient is what] make a doctor's killing permissible" will not be felt as strongly as it does for those who may be more inclined to PAD. To be sure, our intuitions do a lot of philosophical work for us but cannot do all of it. There would still need to be some account of how this conjunction bears the property of moral permissibility given conflicting intuitions.

Certainly, the claim cannot be from opponents of PAD that because the two reasons may be individually flawed, therefore, jointly they must be flawed as well. This would be a standard example of the informal fallacy of reasoning from the parts to the whole, though claiming that these are jointly sufficient conditions does not seem to *make* the case as to *why* PAD is morally permissible. There would need to be independent reasons given as to why this combination of properties overrides the *prima facie* prohibition of killing innocents. It appears that the move to see these as jointly sufficient conditions give us a *test* as to *when* an instance of PAD would be considered morally justified only if it can be

shown *first* that there are some instances where it would be morally permissible. But a proponent of PAD cannot simply make this appeal to justify the act itself without begging the question. Or so it would seem to some critics of premise 7.

It is thought by opponents of PAD that advocates of the position have not met the burden of proof needed to justify this crucial premise.[56] Debate on this issue, of course, continues, though many opponents of PAD think that the *current* arguments given in favor of these practices, regardless of however moving, do not constitute sufficient moral justification that would warrant the killing of innocents even in carefully proscribed medical circumstances contra premise 7 of $PKI_{(PFCA)}$.

Argument from the Integrity of the Medical Profession (*IMP*)

We now turn to the second argument highlighted in support of premise 4 of the "Inconsistency Argument" concerning the moral impermissibility of PAD. The primary claim is simply that PAD violates the integrity of the medical profession. So opponents of PAD may claim that even if there remain no fully adequate philosophical responses to the principled argument developed in $PKI_{(AA)}$, they would nevertheless be compelled to reject the practices on the basis of the integrity of the medical profession.

[56] Bonnie Steinbock, "The Case for Physician Assisted Suicide: Not (Yet) Proven," *J Med Ethics* 2005; 31:235-241. doi: 10.1136/jme.2003.005801

The professional moral principle (PMP) in operation here would be along the lines of:

> PMP: It is always wrong in a health care context for a health care provider to intentionally cause, or bring about, the death of another person.

Here it would be maintained that PMP at once provides both the operative moral principle to guide appropriate medical decisions at the EOL as well as to identify one of the key wrong-making properties of PAD from the perspective of the medical profession. An argument can be constructed in the following way. We'll call it the Argument from the Integrity of the Medical Profession (*IMP*):

12. It is always wrong in a health care context for a health care provider to intentionally cause, or bring about, the death of another person.

13. The practices that fall under PAD are instances of intentionally causing, or bringing about, the death of another person.

14. Therefore, PAD is morally wrong in a health care context.

With respect to premise 12, it is not in the purview of medicine, as a profession, to engage in killing innocents. Or so it is argued. Even if there is no perceived harm with respect to the patient, there is harm with respect to the profession. There are actions in certain professional occupations that are morally and professionally impermissible to engage in even if there may be no perceived harm involved on an individual basis.

For example, consider a scenario in which there is a professional counselor who develops romantic feelings for a client. Let's assume that the client was not

in bad shape to begin. It actually turns out the client didn't really need the counseling after all, but decided to go because a friend suggested that he do so after a close familial death. And furthermore, the friend paid for a set number of sessions in advance. During the process of the counseling an intimate relationship develops between the client and the counselor. Both are consenting adults. There was no manipulation on the part of the counselor. As stated, the client really didn't need the counseling but continued the remaining sessions because his friend had already paid for it and because he had developed romantic feelings for the counselor. The client and counselor go on to have a very fruitful committed relationship for several years after the initial sessions were completed.

Yet this would be deemed entirely inappropriate, morally and professionally, on most accounts of professional ethics. There are certain rules that govern particular kinds of jobs to guard the integrity of that profession. So too is the case with medicine, opponents of PAD claim. Medicine has "*its own* immanent principles and standards of conduct that set limits on what physicians may properly do."[57]

Implementing the practice of PAD would be a decisive shift in the philosophy of medicine as currently practiced within the confines of the

[57] Leon R. Kass, " 'I Will Give No Deadly Drug': Why Doctors Must Not Kill," *The Case Against Assisted Suicide: For the Right to End-of-Life Care*, edited by Kathleen Foley and Herbert Hendin (Baltimore, MD: Johns Hopkins University Press, 2002), 19.

Hippocratic tradition, broadly understood. Physicians would be called upon to participate in the dying process of patients in ways that have been customarily considered as being at odds with what falls under the scope of proper medical care. To be sure, medicine has been "successful" in preserving physical or biological life even in the face of debilitating disease and illness. The problem is that this ability has too often generated "conditions of great pain and suffering, irreversible incompetence, and terminal loss of control."[58] Medical professionals suggest that there are other ways to deal with the problems created by the "successes" of medical technology that simply prolong the dying process. One way is by providing better education concerning the purposes of technological developments in medicine as bridge treatments and not necessarily life sustaining ones. Another way is by implementing quality palliative care earlier in the process of treating those illnesses where death seems inevitable in the short-term. Regardless of technological changes that have taken place in contemporary medicine that seem to create a need for PAD or changes in public opinion towards tolerating these practices, these do not, according to opponents of PAD, constitute a need nor provide justification for a blurring of the lines between medical care and medical killing (even if the latter is said to be for beneficent reasons).

[58] Ibid., 17.

As some health care professionals have claimed "Neither legal tolerance nor the best bedside manner can ever make medical killing medically ethical."[59] For these health care professionals "the first and most hallowed canons of the medical ethic [is that] doctors must not kill."[60] "The heart of the argument rests on understanding the special moral character of the medical profession and the ethical obligations it entails."[61] This issue for some medical professionals runs deep. It is that killing, even for beneficent reasons, is fundamentally at odds with the practice of medicine.

Premise 13 claims that PAD just does represent instances in a health care context that violate PMP. Again, if one accepts the account of PAD provided in chapter 2 of this work, then it would seem that this claim would be descriptively true. One also recalls, there was some care taken there to make an attempt to describe PAD in a way that does not necessarily embed the wrongness of killing in a medical context in the very concept itself. Leon Kass, a bit more

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[59] Willard Gaylin, Leon R. Kass, Edmund Pellegrino, and Mark Siegler, "Doctors Must not Kill," *Journal of the American Medical Association* 259, no. 14 (April 8, 1988): 2139.

[60] Ibid. Now of course, it is not the case the medical profession to a person would wholeheartedly agree with the Gaylin, et. al. here. For they were responding to an essay titled, "It's Over, Debbie" in the *Journal of the American Medical Association* (JAMA) written by an anonymous resident earlier that year where he describes his role in mercy killing of a particular patient named Debbie. Given that the resident felt compelled to act in this situation, write about it, and that it was published in *JAMA* would suggest that there are differences of opinions on the matter. Nevertheless, the medical professional *qua* profession at the time of this writing remains fairly resistant to the idea despite a growing affinity for PAD in the general public.

[61] Kass, "'I Will Give No Deadly Drug': Why Doctors Must Not Kill," 17.

aggressively, summarizes the specific thrust of the claim in premise 13 when he writes:

> [i]n assisted suicide and all other forms of direct killing, the physician must necessarily and indubitably intend primarily that the patient be made dead. And he must knowingly and indubitably cast himself in the role of the agent of death. This remains true even if the physician is merely an assistant in suicide. Morally, a physician who provides the pills or lets the patient plunge the syringe after he leaves the room is no different from one who does the deed himself. 'I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect.'[62]

By way of conclusion (premise 14), it is maintained that it is morally and professionally inappropriate for doctors or any other health care professional to use their professional skills in the intentional taking of human life. Some have offered a clarion call "for the medical profession to rally in defense of its fundamental moral principles, to repudiate any and all acts of direct and intentional killing by physicians and their agents." They go on to state rather forcefully, "we must say to the broader community that if it insists on tolerating or legalizing active euthanasia, it will have to find nonphysicians to do its killing."[63]

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[62] Ibid., 37.

[63] Willard Gaylin, Leon R. Kass, Edmund Pellegrino, and Mark Siegler, "Doctors Must not Kill," *Journal of the American Medical Association* 259, no.14 (April 8, 1988): 2140. Many have taken up this gauntlet laid down by these physicians. For example, in a recent article the authors suggested that the lethal prescription would not need to come from a physician. They "envision the development of a central state or federal mechanism to confirm the authenticity and eligibility of patients' requests, dispense medication, and monitor demand and use." They go on to say, "Such a mechanism would not only obviate physician involvement beyond usual care but would also reduce gaps in care coordination." (Julian J. Z. Prokopetz and Lisa Soleymani Lehmann, "Redefining Physicians' Role in Assisted Dying," *The New England Journal of Medicine*, 367:2, 97.) Interestingly, Gerald Dworkin, a proponent of PAD, rejects such proposals

Objections & Responses to the *PMI* Argument

This section is significantly shorter than its counterpart under $PKI_{(AA)}$. Here the primary objective is to set the stage for the subsequent chapter that moves us into the heart of this project. While there are a number of potential criticisms that can be leveled against the Integrity of the Medical Profession argument, the primary one raised here is that the intentional killing of patients is already being done in other medical practices that are currently deemed morally permissible.

Actions that are considered morally permissible, such as the voluntary cessation of eating and drinking, aggressive pain management at the end of life, the forgoing of life-sustaining treatment, and terminal/palliative sedation are not significantly different in a morally relevant way from the kinds of actions said to fall under PAD. All of these options, along with PAS and VAE, are options for patients who decide against continuing curative therapy because they have chosen to no longer prolong the dying process. Yet these latter two options, at the time of this writing, are considered widely to be outside the pale of

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in general since he thinks "it is preferable that the same person who has been the ally of the patient in the patient's fight against illness remain an ally to the end." And furthermore he thinks, "it is important that the physician experience the full consequences of his convictions. If it is emotionally difficult to aid a patient to die, the physician should not be able to evade that difficulty." (Gerald Dworkin, "The Nature of Medicine," *Euthanasia and Physician-Assisted Suicide: For and Against*, edited by Gerald Dworkin, R. G. Frey, and Sissela Bok (New York: Cambridge University Press, 1998), 16.)

professional medical practice. This inconsistency to many thinkers is unacceptable. Dan Brock is one such example. He writes:

> Voluntary stopping eating and drinking, terminal sedation, and physician-assisted suicide are all potential interventions of last resort for competent, terminally ill patients who are suffering intolerably, in spite of intensive efforts to palliate, and desire a hastened death. Many opponents of physician-assisted suicide defend the current legal status of these options, arguing that, along with forgoing life-sustaining treatment, voluntary stopping eating and drinking and terminal sedation constitute adequate and appropriate options for hastening death, obviating the need for legalization of physician-assisted suicide. However, in my view, the differences between these practices and physician-assisted suicide do not justify the continued prohibition of assisted suicide.[64]

Many such proponents of PAD follow Brock in this sentiment.

Contra Brock, there is thought to be an asymmetry between the morally permissible practices and those that fall under PAD. It is often purported that the ethical asymmetry is justified on the basis of the "moral significance of distinctions such as killing versus letting die, intention versus foresight (and the associated principle of double effect), act versus omission."[65] However, most proponents of PAD claim that these distinctions simply do not hold up under careful philosophical scrutiny.

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[64] Dan W. Brock, "Physician-Assisted Suicide as a Last-Resort Option at the End of Life," *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice*, edited by Timothy E. Quill and Margaret P. Battin (Baltimore, MD: Johns Hopkins University Press, 2004) 131.

[65] Gerald Dworkin, "Introduction," *Euthanasia and Physician-Assisted Suicide: For and Against*, edited by Gerald Dworkin, R. G. Frey, and Sissela Bok (New York: Cambridge University Press, 1998), 4.

Opponents of PAD insist that we must keep each of these nontherapeutic end of life care options separate and evaluate them independently in order to best examine their moral permissibility or impermissibility in a health care context. With respect to pain management and refusal of life-sustaining treatments, one thinker attempts to clarify the primary differences:

> Refusals of treatment, including of life-support treatment and artificial hydration and nutrition, and the provision of necessary pain-relief treatment or treatments for other symptoms of serious physical distress are not euthanasia, even if these actions shorten life. In respecting refusals of treatment, the primary intention is to respect the person's right to inviolability-the right not to be touched, including by treatment, without one's consent. In giving pain-relief treatment, the primary intention is to relieve pain, not to inflict death. In euthanasia, the primary intention is to inflict death in order to relieve pain and suffering. It is this primary intention that makes euthanasia unacceptable to those who oppose it.[66]

Notably absent from the statement above is mention of terminal/palliative sedation. Nonetheless, this response, with its emphasis on the role of intention in moral assessment, illustrates a key aspect of the ongoing debate concerning PAD. Each of these end of life medical decisions mentioned above merits its own isolated discussion to sort through the ethical concerns and philosophical issues germane to making appropriate moral judgments. It is beyond the scope of this project to address all of these. Going forward I isolate one of these practices, namely, terminal/palliative sedation, in order to examine whether or

[66] Margaret Somerville, *The Ethical Canary: Science, Society, and the Human Spirit* (Montreal, Canada: McGill-Queen's University Press, 2004) 119.

not medical professionals who deem PAD as morally impermissible can consistently practice the former.

Conclusion

Of course, not all in the debate will embrace the aforementioned justification for rejecting PAD. Furthermore, many would also think that the counter-responses to the objections that were raised against the initial arguments for rejecting PAD are inadequate. As mentioned above, the point here was to highlight those arguments that many think to provide good reasons for rejecting the practice of PAD in a medical context, rightly or wrongly, in order to offer a back drop for evaluating if these same arguments count against the acceptance of palliative sedation. In other words, is there any inconsistency on the part of those who reject the former while embracing the latter? The subject matter taken up next explores some of the arguments provided for thinking that palliative sedation and PAD are morally equivalent (i.e. in defense premise 2 of the "Inconsistency Argument" raised in Chapter 1).

CHAPTER 4

THE CHALLENGE OF THE INCONSISTENCY ARGUMENT FOR PALLIATIVE/TERMINAL SEDATION

Introduction

In the first chapter of this work, the "Inconsistency Argument" makes manifest the conceptual ethical tension that obtains when attempts are made to limit the scope of palliative care options to dying patients by excluding PAD. The argument goes as follows:

1) For any two practices, X and Y, if there are no morally relevant differences between X and Y, then if Y is morally impermissible, X is morally impermissible.

2) There are no morally relevant differences between palliative/terminal sedation and PAD.

From 1) and 2), it follows that:

3) If PAD is morally impermissible, palliative/terminal sedation is morally impermissible.

Next, we assume that:

4) PAD is morally impermissible.

5) Therefore, palliative/terminal sedation is morally impermissible.

This chapter focuses on what can be said in support of premise 2 of the argument.

PAD as Morally Equivalent to Terminal Sedation

Many philosophers and medical ethicists have set out to argue that terminal sedation is morally equivalent to (or at the very least, no less worse) than PAD.[1] In other words, one procedure is not intrinsically more advantageous or better than the other, ethically or practically speaking. In chapter 1, two very capable and accomplished proponents of this view were identified, namely Dan W. Brock and Margaret P. Battin. This chapter begins with the argument developed by Dan Brock and others in a seminal essay and subsequent versions of this earlier piece. Then, I present a similar argument by Margaret P. Battin. Both of these can be seen as in essence contending for what is claimed in premise 2 of the "Inconsistency Argument."

Brock's Formulation of the Argument

In making his case, Brock offers definitions of the terms 'terminal sedation', 'physician-assisted suicide', and 'voluntary active euthanasia'. He then lists the ethical and practical advantages and disadvantages of each of these

[1] Margaret P. Battin, "Terminal Sedation: Pulling the Sheet over Our Eyes" *Hastings Center Report* 38, no. 5 (2008) 27-30; Dan W. Brock, "Physician Assisted Suicide as a Last-Resort Option at the End of Life," *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice*, edited by Timothy E. Quill and Margaret P. Battin (Baltimore: The John Hopkins University Press, 2004) 130-149; and Timothy E. Quill, Bernard Lo, and Dan Brock, "Palliative Options of Last Resort: A Comparison of Voluntary Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia," *Terminal Sedation: Euthanasia in Disguise?* edited by Torbjörn Tännsjö (The Netherlands: Kluwer Academic Publishers, 2004) 1-14.

practices. While I have combined both physician-assisted suicide (PAS) and voluntary active euthanasia (VAE) in this work to include what is to fall under the scope of physician-assisted death (PAD), they will be separated in this section since Brock and others think that VAE and PAS as medical procedures do not share all of the same ethical and practical advantages and disadvantages with one another.

On the Advantages and Risks of Terminal Sedation

According to Brock, 'terminal sedation' refers to "the administration of sedative drugs at the end of life; it is not, strictly speaking, a form of assisted death."[2] Yet he does think that there remains no *morally relevant* difference between terminal sedation, on the one hand, and PAS or VAE, on the other. He gives a more vivid description of the practice by writing:

> With terminal sedation, the suffering patient is sedated to unconsciousness, if need be, usually through ongoing administration of barbiturates or benzodiazepines, and all life-sustaining interventions, including nutrition and hydration, are withheld. Generally, the patient then dies of dehydration, starvation, or some other intervening complication. Although death is inevitable, it usually does not take place for days or even weeks, depending on clinical circumstances.[3]

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[2] Dan W. Brock, "Physician-Assisted Suicide as a Last-Resort Option at the End of Life," *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice*, edited by Timothy E. Quill and Margaret P. Battin (Baltimore: The John Hopkins University Press, 2004) 132.

[3] Ibid. Interestingly, Brock in a later co-authored piece seems to be a bit more nuanced in identifying the range of various forms of what is known as palliative sedation or what is often called terminal sedation. See Timothy E. Quill, Bernard Lo, Dan W. Brock, and Alan Meisel,

It is thought that this procedure as *described by Brock and others* is widely accepted and practiced in contemporary medicine, particularly in hospice.

Further, Brock identifies a number of ethical and practical advantages. To begin, it can be performed in patients who have severe physical limitations.[4] Next, the delay between the time when terminal sedation begins and the patient's death occurs allows for reconsideration of the procedure along the continuum. He includes in this possible reassessment period both the reconsideration of members of the professional health care team as well as the family. Last, the patient's decision is informed and voluntary, keeping with patient autonomy, since a professional health care team would need to administer and monitor the kinds of drugs that are used in sedations of this sort.[5] Of course, this last point can be said to be an advantage of the other options as well. Nevertheless, given the centrality of autonomy in medical ethics, Brock includes it in order to establish its moral permissibility along with other EOL palliative care options.

Brock also raises a number of corresponding risks that may be and often are associated with terminal sedation *as he describes it above*. First, with

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"Last-Resort Options for Palliative Sedation," *Annals of Internal Medicine 2009*, Volume 151, Number 6: 421-424.

[4] As noted below, the relevance of this is seen when one considers the fact that in states where PAS is legally practiced the laws require that patients must be physically able to take the lethal prescription of medication that has been provided to them by a physician.

[5] Ibid., 133.

terminal sedation, "unlike physician-assisted suicide, the final actors are the health care providers, not the patient. Terminal sedation could therefore be carried out without explicit discussions with alert patients who appear to be suffering intolerably, or even against their wishes."[6] This, of course, would not be in keeping with the value of patient autonomy and hence potentially morally problematic. Second, some patients believe that their dignity is violated and their families will suffer during a prolonged or drawn out terminal sedation. Third, those patients who desire to die at home may not be able to do so since admission to a health care facility is required in order to administer and monitor the sedation properly.[7] Fourth, terminal sedation is not a panacea. There are some symptoms that cannot be relieved by this particular procedure.[8] Fifth,

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[6] Ibid.

[7] Brock does not seem to consider that those individuals who receive palliative sedation while in hospice programs can and often do have the procedure performed at home by and with trained hospice palliative care staff. Given the context and patient population in which Brock describes terminal sedation taking place, it would seem that a good number of those would be hospice eligible and hence able to have the procedure performed in the home if they were appropriate candidates. So while Brock's comment on this score may very well be true, it seems far less likely to be the case that if one wanted to have a terminal sedation performed in the home that they would be prohibited from doing so unless they are admitted into a facility.

[8] Ibid. Brock and others do provide some examples to consider for the point he is making. Some instances where terminal sedation would not address symptoms are occurrences "when a patient is bleeding uncontrollably from an eroding lesion or a refractory coagulation disorder, cannot swallow secretions because widespread oropharyngeal cancer, or has refractory diarrhea from…AIDS." Timothy E. Quill, Bernard Lo, and Dan W. Brock, "Palliative Options of Last Resort: A Comparison of Voluntary Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia," *The Journal of American Medical Association* December 17, 1997, Volume 278, No. 23: 2100. It would seem that these

there is controversy surrounding whether or not deeply sedated patients "are actually free of suffering or are simply unable to report or remember it."[9] Sixth, it is dubious that families will perceive the sedated patient's death as being dignified or peaceful.[10] Seventh, terminal sedation would be deemed inappropriate to use if the patients found their condition personally unacceptable even if they were not experiencing considerable pain as would be the case with PAS. And last, clinicians are sometimes confused about their role and professional "ethical responsibility for contributing to the patient's death."[11]

On the Advantages and Risks of Physician-Assisted Suicide

Brock defines PAS as those instances when "the physician provides the means, usually a prescription of a large dose of barbiturates, by which a patient

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symptoms would be palliated by other means than terminal sedation. If terminal sedation could otherwise eliminate particular symptoms for a patient experiencing the aforementioned problems, there is no reason that other palliative measures cannot be employed simultaneously to address the kinds of refractory symptoms that Brock identifies.

[9] Brock, "Physician-Assisted Suicide as a Last-Resort Option at the End of Life," 133. On page 146 of this essay, he references the work of N. Moerman, B. Bonke, and J. Oosting, "Awareness and Recall During General Anesthesia: Facts and Feelings," *Anesthesiology 79* (1993): 454-64; and J. E. Utting, "Awareness: Clinical Aspects, Consciousness, Awareness, and Pain," *General Anesthesia*, edited by M. Rosen and J. N. Linn (London: Butterworths, 1987) 171-79, 184-92 in support of this claim.

[10] Brock does not cite a specific source for this particular point.

[11] Ibid., 133.

can end his or her life. Although the physician is morally responsible for this assistance, the patient has to carry out the final act of using the means provided."[12] The ethical and practical advantages for PAS are numerous. First, having a prescribed lethal dose of medication may provide the needed reassurance to persevere in the dying process if patients know that they could escape if their situation becomes intolerable for them. Second, PAS is likely to be voluntary since patients must take the lethal prescription themselves. Third, the death may be considered more dignified and humane since it doesn't entail a prolonged period of days or weeks after the medication has been ingested. Fourth, some physicians are "more comfortable with assisted suicide than with voluntary active euthanasia, presumably because their participation is indirect."[13]

The first, and perhaps most obvious disadvantage of PAS, is that many professionals think, rightly or wrongly, that it violates their duty and ethical responsibility not to be involved (albeit, on some descriptions of action, indirectly) in an intentional way in the death of a patient. Another associated risk of PAS is that "since there is often a substantial period of time between the provision and use of the means for assisted suicide, and since physicians are often not present when the means are used, there is often no evaluation and

[12] Ibid., 134.

[13] Ibid.

assurance of competence or voluntariness at the time of use." Moreover, there are instances when medical complications arise such as vomiting or aspirating as a result of the medication. If the physician is not present this can be seen as an instance of patient abandonment. And furthermore, there is a related, though nevertheless, distinct point: if the medications are not bringing about the death of the patient in the way they are intended, then the absence of a physician in such circumstances leaves "families to respond to medical complications alone." If they are brought to an emergency room in this situation, patients are likely to "receive unwanted life-prolonging treatment" by these hospital facilities' medical staff. Last, there is concern that PAS is discriminatory in unacceptable ways.[14] I want to expand further on this fourth point.

In the states where PAS is legal, only those patients who are physically capable of taking the medications and are mentally competent to give consent are allowed to take advantage of PAS. The problem here may not be as obvious on the surface. PAS could be guilty of "Compassion Rationing."[15] PAS doesn't provide comfort *to* or the freedom *for* people with, say, ALS or advanced dementia. ALS stands for Amyotrophic Lateral Sclerosis and is

[14] Ibid.

[15] I am indebted to my colleague, Paul MacLean, who serves with me on the Community Ethics Committee sponsored by the Harvard Ethics Leadership Group in Boston, MA for this particular expression. In the lines that follow, I provide insight and expand the concept that the phrase designates.

commonly known as Lou Gherig's disease (named after the professional baseball player whose career was ended by it). ALS is a neurodegenerative disease of unknown cause that breaks down tissues in the nervous system and affects the nerves responsible for movement. So at a certain point in the illness, ALS patients may have the mental capacity to make a free and informed decision for PAS, but lack the physical ability to actually ingest the lethal dose of medication on their own. Advanced dementia patients have the physical capacity to ingest the lethal prescription but lack the mental competence to make a free and informed decision to do so. But given the beneficial reasons often cited by proponents of PAS as to the need for this option, it would seem that advanced dementia and ALS patients should be included under the scope of any such practice. But, as things stand at the time of this writing, in states where the practice is legal these patient populations are prohibited from participating in the practice of PAS.

On the Advantages and Risks of Voluntary Active Euthanasia

In cases of VAE, Brock and others state, "the physician not only provides the means, but is the final actor by administering a lethal injection at the

patient's request." [16] Of course, this more infrequent proposed option of palliative care has the practical advantage of being "quick and effective." Morally speaking, this eliminates the possibility of prolonging the suffering of the family who is anticipating the inevitable death of the patient, the same inevitability of death as with the case of terminal sedation. Further, patients do not need to be physically able to ingest a lethal prescription, though presumably they must be mentally competent to give consent for VAE to be performed. Last, it "requires active and direct participation" on the part of physicians so that they can "ensure the patient's competence and voluntariness at the time of the act, support the family, and respond to complications."[17] The ethical implication is that one is better able to avoid the potential moral problems of patient abandonment that may obtain in some instances of PAS.

Concerning the moral disadvantages, it is first to be acknowledged that even more apparent than is the case with PAS, VAE is *thought* to transgress an ethical prohibition of medical professionals being directly and actively involved in the death of a patient in a medical context. For opponents of PAD, this is true, regardless if it is done for beneficent reasons and from motives of compassion. For some who are proponents of PAS, VAE would be seen as crossing an ethical

[16] Timothy E. Quill, Bernard Lo, and Dan W. Brock, "Palliative Options of Last Resort: A Comparison of Voluntary Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia," 2101.

[17] Ibid.

line, though, to be sure, this is not the case for all who are proponents of PAS.[18] Second, Brock and others point out that VAE is seen as relieving suffering by causing death.[19]

Drawing to a Conclusion in the Direction of Premise 2

One of the key ingredients that each of these proposed and controversial options of palliative care at the end of life share in common is that each seems to have the outcome of hastening death, according to Brock. If all options have the outcome of "hastening death" and each has its own set of distinct moral advantages and ethical risks, then it becomes arbitrary to limit one option over the others as being morally superior in every situation. Therefore, Brock summarizes the thrust of his observations when he writes:

> [T]erminal sedation…physician-assisted suicide [and voluntary active euthanasia] each have complex sets of advantages and disadvantages. For each practice, particular advantages and disadvantages may be more or less important with a specific patient seeking a hastened death. No one of these practices has a clearly superior balance of advantages over disadvantages in all cases. This implies that physician-assisted suicide

[18] See for example the essay by Michael Tooley, "In Defense of Voluntary Active Euthanasia and Assisted Suicide," *Contemporary Debates in Applied Ethics*, edited by Andrew I. Cohen and Christopher Heath Wellman (Malden, MA: Blackwell Publishing, 2005) referenced in Chapter 2.

[19] Ibid.

> [and presumably VAE] should not be prohibited while…terminal sedation [is] permitted.[20]

His analysis certainly appears to support the *general* contention made in premise 2 of the "Inconsistency Argument" which reads, "There are no morally relevant differences between palliative/terminal sedation and PAD."

While I think this is correct for the purposes set up in this chapter, it could be that Brock, if pushed, would draw a more nuanced conclusion relevant for premise 2 of the "Inconsistency Argument." An interlocutor might suggest something along the lines of changing premise 2 from, "There are no morally relevant differences between palliative/terminal sedation and PAD" to including a qualification, which would then read: "There are no *universally morally relevant differences* between palliative/ terminal sedation and PAD." The implication would be then for Brock that in some situations one form of ending life is morally superior than other options and at another time one of the other options along the spectrum of palliative care is to be preferred morally.

Further, perhaps it would be the case, that with this qualification our interlocutor might propose that "in some situations" now be included in the antecedent and consequent of 3, before 4, and before "palliative" in the

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[20] Dan W. Brock, "Physician Assisted Suicide as a Last-Resort Option at the End of Life," *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice*, eds. Timothy E. Quill and Margaret P. Battin (Baltimore: The John Hopkins University Press, 2004) 135.

conclusion of the Inconsistency Argument. The modified argument would then read:

1*) For any two practices, X and Y, if there are no "universally" morally relevant differences between X and Y, then if Y is in some situations morally impermissible, X is in some situations morally impermissible.

2*) There are no "universally" morally relevant differences between palliative/terminal sedation and PAD.

3*) Therefore, if PAD is in some situations morally impermissible, then in some situations palliative/terminal sedation is morally impermissible.

4*) PAD is in some situations morally impermissible.

5*) Therefore, in some situations palliative/terminal sedation is morally impermissible.

The question on this reading, then, is 1*) true? It would seem not. For example, say, "If PAD is morally impermissible when dealing with incompetent patients, nothing seems to follow about whether palliative/terminal sedation is impermissible for them, or for anyone else. Whether it is or isn't would have to be established independently, for other things will not be held equal when" the move is made "from one class (incompetents) to another (competents) or even within the same class (say, incompetents) because the balance of moral advantages/disadvantages of PAD might make it impermissible to apply to

incompetents while the balance of moral advantages/disadvantages makes it permissible to apply palliative/terminal sedation to incompetents."[21]

Those who think that PAD may be morally permissible in some situations might want to develop the argument in the way described above in order to show that the "Inconsistency Argument" is unsound. However, as stated in Chapter 1 and delineated throughout this work, I am exploring the consistency of those who embrace palliative/terminal sedation while *categorically* rejecting PAD. So in the modified version of the Inconsistency Argument above PAD is not *categorically* rejected as is the case with the "Inconsistency Argument" stated at the beginning of the chapter. So this modified line of reasoning is not open to those who think PAD is categorically impermissible, which is the scenario constructed for the purposes of this dissertation.

My appeal to Brock in support of premise 2) is not to imply that he would argue for the "Inconsistency Argument" in the same manner in which I have set it up in this work. Instead, one is to keep in mind that Brock, in his essay, provides common observations concerning various practices at the EOL such that a general conclusion may be drawn. And it is that: there are no morally relevant differences between palliative/terminal sedation and PAD since each category of practice is said to hasten the death of the patient and have varying degrees

[21] Thanks to Dr. Bruce Russell for personal correspondence on this particular line of reasoning and some of the implications that could be drawn from it developed in the latter part of this section.

of advantages and disadvantages. And thus, based upon his comments above, we can find support for premise 2 of the "Inconsistency Argument," which is the primary aim of this chapter. Of course, Brock doesn't think that premise 4 of the "Inconsistency Argument" is true. But if it were, then it would seem that he would not have any problem affirming that terminal sedation also would be morally impermissible. And hence, to quote Brock again, PAD "should not be prohibited while…terminal sedation [is] permitted," thus providing some support for premise 2).[22]

Battin's Formulation of the Argument

Margaret P. Battin develops her version of what I am calling generically the "Inconsistency Argument" in a slightly different manner than Brock. She argues that terminal sedation is no compromise with respect to the debates surrounding PAD and this claim is developed along two discernible lines. The first is by identifying the key concerns of proponents of PAD and then showing how the terminal sedation alternative fails to meet these. The second is by highlighting the reasons often given by opponents of PAD to reject the view and then showing how terminal sedation is just as vulnerable to the same criticisms.

[22] See footnote 20 on page 140.

Terminal Sedation Fails to Meet the Concerns of Proponents of PAD

Battin begins by noting that those who are in favor of PAD often make their case by appeal to autonomy and mercy/compassion as being the primary grounds for the moral justification of the view. She thinks that both of these are undermined by terminal sedation such that it is not plausible to think this would be a reasonable "alternative" for those who advocate PAD. Let's take each of these in turn.

According to Battin, the practice of terminal sedation undermines patient autonomy. She thinks that consent is necessary for genuine instances of autonomy to be expressed. And consent cannot be "honored in decisions to use terminal sedation."[23] She gives two primary reasons why this is the case. The first is that unimpaired consent is really not possible due to unrelieved pain experienced by the patient. Therefore, decision-making about treatment "must be deflected to a second party."[24] Of course, one could argue that the patient could make a decision for terminal sedation in advance of the onset of excruciating pain that is unable to be managed otherwise.

While acknowledging this point, Battin says the problem is more severe than this. Herein is the second primary reason why autonomy is undermined. She

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[23] Margaret P. Battin, "Terminal Sedation: Pulling the Sheet over Our Eyes" *Hastings Center Report* 38, no. 5 (2008): 27.

[24] Ibid.

thinks that even if there is a decision made in advance, the focus of what a patient gives consent to is actually suppressed. In other words, the aim of terminal sedation is obscured. If so, this makes advance consent difficult since it is not fully understood what a patient is giving consent to. The issue for Battin is that while it is true that "terminal sedation may end pain, it also ends life."[25] It is this point that is not so clear in the minds of patients. There are two ways in which life is ended. The first is that *sentient* life is ended immediately along with the possibility of any ongoing social interaction. Second, *biological* life is ended because artificial nutrition and hydration are usually withheld.

Moreover, Battin thinks the linguistic shift to "palliative sedation"[26] from "terminal sedation" is a new euphemism that only goes to further bolster the problem of concealing the true aim of terminal sedation making consent difficult, if not impossible. She takes the word "terminal" to signify the intent of the sedation and says then that the practice is confused with palliative care.[27] So she concludes that terminal sedation undermines consent and thereby autonomy "because the assumption is that sedation is used just to end pain, without the *intention* of ending life, the patient cannot be asked for consent to

[25] Ibid.

[26] This phrase and variations of it is my preferred use for thinking about this particular medical procedure. This is done in order to distinguish and bring clarity to the multiple forms and contexts in which palliative sedation is practiced. This is described in more detail in chapter 6 of this work.

[27] Ibid., 28.

end his or her life, but only to relieve his or her pain."[28] So the focus of consent should be firmly on the more crucial claim of the fact that life, whether sentient or biological, will be ended. If this, then, is part and parcel of terminal sedation, the question emerges: What really is intended in providing terminal sedation? The answer that Battin would give to this question is clear when she writes, "the focus of consent is on avoiding pain, but it should be on causing death." If her charges are correct, then they render genuine consent, which is necessary for patient autonomy, nullified "whether the patient's capacity for reflection is impaired by severe pain or not."[29]

Not only is autonomy undermined, but also terminal sedation is not an adequate proactive merciful or compassionate response to suffering patients in the way that PAD is thought to be. She writes, "The use of terminal sedation 'to relieve pain' presupposes that the patient is *already* experiencing pain. It provides no rationale for sedating a patient who is not currently in pain. Thus, the rationale for the use of terminal sedation in effect *requires* that the patient suffer."[30] This claim is evident for Battin since terminal sedation is often billed as a last resort on the continuum of palliative care in dying patients. And so when

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[28] Ibid.

[29] Ibid.

[30] Ibid.

terminal sedation is evaluated in light of *both* autonomy *and* mercy, it falls short as a reasonable "alternative" for those who would prefer the option of PAD.[31]

Terminal Sedation Violates the Reasons Given for Rejecting PAD

Battin identifies two widely held and broad reasons as to why many have rejected PAD. They are that it violates the sanctity of life and that there is the possibility of abuse. Those who consider terminal sedation an adequate alternative to PAD are being inconsistent, if their reasons for doing so fall under the two mentioned above. Upon analysis, Battin thinks that terminal sedation fails to uphold the sanctity of life principle and it does not fare any better with respect to the possible forms of abuse that many are troubled about with respect to PAD.

The sanctity of life principle, according to Battin, "has focused mainly on ending a person's life before it would 'naturally' end." Terminal sedation violates this principle because "it unarguably causes death, and it does so in a way that is not 'natural.'" She then goes on to describe the process as to how her conception of terminal sedation works and is practiced by medical professionals. It involves two components. First, sedation is induced in the

[31] Battin would affirm that terminal sedation might appeal to some patients and their families. For example, "those who see the gradual induction of death over the several days or more that terminal sedation takes…especially if this slow process is perceived as gentler and easier for the patient, and as permitting the family more time to absorb the reality of their loss." ("Terminal Sedation," 28)

patient, which of course, is not lethal itself. Second, the administration of fluids and nutrition are usually withheld from the patient. This second component, however, if pursued long enough, is fatal. She makes the strong claim that in a terminal sedation where the two components are employed, the patient will "necessarily die virtually always before they would have died otherwise."[32]

She further claims that not only do the two components taken together form a lethal mix, but also that this is often billed as letting nature take its course. But she thinks otherwise. The way patients die with respect to terminal sedation is unnatural in that it is not the underlying disease that is the cause of death. Instead, "death typically results from or is accelerated by [an unnatural physician induced] dehydration." In sum concerning this point, Battin concludes: "If respect for the sanctity of life means that a patient's life should not be caused to end, but rather that death must occur only as the result of the underlying disease process, then terminal sedation does not honor this principle."[33]

Beyond the practice of terminal sedation failing to uphold the sanctity of life principle, it also does not fare any better with respect to two primary forms of the possibility of abuse that are often associated with PAD. The two general

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[32] Ibid.

[33] Ibid.

forms in view are: "1) concern that the integrity of the medical profession will be undercut, and 2) concern that various familial, institutional, or social pressures will maneuver the patient into death when that would have been neither her choice nor in accord with her interests."[34] She thinks that terminal sedation is just as susceptible to abuse as is PAD. The same issues of overworked physicians, biased health care providers, exasperation with difficult patients, and so on that may lead to premature and involuntary use of PAD that alarms many of its opponents are no less real with regard to terminal sedation.

In contrast, she thinks that on this score PAD may actually fare better than terminal sedation. She observes that in those states where PAS is legal, such as Oregon, there are a series of safeguards in place that mitigate the possibility of abuse which are missing with respect to terminal sedation. Terminal sedation is more easily influenced negatively because what the patient is agreeing to, to reiterate a point made above, is obscured. This goes back to the problem of terminal sedation and autonomy. Since the question is not framed as "a choice of death versus life, but only as pain versus the relief of pain – a seemingly far easier choice to make, and hence one presumably far more easily shaped by external pressures from greedy family members, overworked or intolerant

[34] Ibid.

physicians, or the agents of cost-conscious institutions."[35] So the inevitable conclusion here would be that terminal sedation may be even more prone to abuse than PAD, or perhaps at least as likely, according to Battin. Therefore, terminal sedation provides no greater protection against abuse than PAD does.

Drawing to a Conclusion in the Direction of Premise 2

Based on Battin's views expressed above, terminal sedation is no compromise with respect to the debates surrounding PAD. Terminal sedation fares no better than the problems often associated with PAD. And further terminal sedation seems to be condemned by the reasons often given for rejecting PAD. Again, to be clear, Battin does not think that terminal sedation is morally wrong *per se*. For she thinks "a case may be made for [it]" in that "it offers a definite response to uncontrollable suffering,"[36] though she interestingly takes the argument in favor of terminal sedation to be one primarily of perceptions. It seems that one may be able to detect a modest cynicism in Battin's view on this point when she writes:

> The argument in favor of terminal sedation is one of perceptions: it may *feel* natural (even if it is not), it may *feel* safer (even if it offers less protection from abuse), it may *feel* like something the patient can openly choose (even if the choice is constructed in a way that obscures its real

[35] Ibid.

[36] Ibid., 29.

> nature), and it may *feel* to the physician as if it is more in keeping with medical codes that prohibit killing (even if it still brings about death). We live in a society that tolerates many obfuscations and hypocrisies, and this may be another one we ought to embrace.[37]

It is by no means an interpretive reach to see that Battin understands terminal sedation as really a form of slow euthanasia. Recall her quote from Chapter 1 of this work, where she states:

> It's not that palliative sedation/sedation to unconsciousness is wrong. It can be practiced hypocritically…. Because there is so much anxiety that it might be confused with euthanasia, the features that it shares with euthanasia are obscured or sanitized. …The implausible effort to draw a completely bright line between continuous terminal sedation and euthanasia makes the practice of terminal sedation both more dangerous and more dishonest than it should be—and makes what can be a decent and humane practice morally problematic.[38]

Conclusion

If Brock and Battin are correct, then their arguments lead us in the direction of affirming the claim made in premise 2 of the "Inconsistency Argument." If so, then we have a couple of arguments developed that attempt to establish the soundness of the "Inconsistency Argument" such that if one thinks that PAD is morally impermissible, then one should hold the same judgment with respect to terminal sedation.

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[37] Ibid.

[38] Ibid., 30.

CHAPTER 5

AN INDEFENSIBLE WEDGE ARGUMENT

Introduction

This chapter presents the argument given by Torbjörn Tännsjö in which he attempts to make a morally relevant distinction between the two practices of terminal sedation and euthanasia contra the kinds of claims discussed in chapter 4. I ultimately think that his attempt is not fully adequate as a "Wedge Argument" to sufficiently distinguish the practices in a morally relevant way on the supposition that PAD is morally problematic. After presenting his arguments, I then offer a series of objections to his view. In sum, it appears that sometimes he uses the wrong conceptual tools in an attempt to make his case. And the *potentially* legitimate conceptual tools he does use, he employs them the wrong way.

Tännsjö's Wedge-Argument

Torbjörn Tännsjö has sought to develop a "Wedge Argument" that defends the moral status of terminal sedation against the kinds of equivalency arguments made by Brock, Battin, and others. He understands terminal sedation as:

> [A] procedure where through heavy sedation a terminally ill patient is put into a state of coma, where the intention of the doctor is that the patient

> should stay comatose until he or she is dead. No extraordinary monitoring of the medical state of the patient is undertaken. Normal hydration is ignored. All this means that in some cases where patients are being terminally sedated, death is hastened; if the disease does not kill the patient, some complication in relation to the sedation, or the withdrawal of treatment and hydration, or the combination of these, does.[1]

He positions his view between the extremes of those involved in the euthanasia debate and suggests that terminal sedation, as described above, provides the best compromise for such a contentious issue. He writes:

> Adherents of euthanasia may well argue that terminal sedation is not good enough. Some patients may want to be intentionally and actively killed by their doctors, they may claim. However, while they continue to argue their case, they should be prepared to admit that terminal sedation renders dying easier for the very patients on behalf of whom they put forward their argument for euthanasia.
>
> And adherents of the Sanctity-of-Life Doctrine, who oppose euthanasia, should be able to appreciate that there exists a way for them to answer the stricture that they are insensitive to human suffering. They can accept a practice of terminal sedation and yet, for all that, stick to the Sanctity-of-Life Doctrine and their opposition to euthanasia.[2]

Tännsjö thinks one can hold to his understanding of terminal sedation and still identify morally relevant differences between it and PAD. So in essence he seeks to argue against premise 2 of the "Inconsistency Argument" that there are no morally relevant differences between palliative/terminal sedation and PAD.

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[1] Torbjörn Tännsjö, "Terminal Sedation: A Substitute for Euthanasia?" *Terminal Sedation: Euthanasia in Disguise?* edited by Torbjörn Tännsjö (Dordrecht, Netherlands: Kluwer Academic Publishers, 2004) 15.

[2] Ibid., 29.

Morally Distinguishing Features

He takes euthanasia to be incompatible with "two basic principles of medical ethics" which are the principles of "acts and omissions and double effect."[3] Further he thinks that terminal sedation, as he has defined it, does not suffer the same fate as euthanasia with respect to these principles, and moreover it is in fact compatible with them. He wants to say that it is on this basis that he is able to make an ethical distinction between terminal sedation, on the one hand, and euthanasia, on the other.

How does Tännsjö see the relevance of these two principles at work? With respect to the acts/omission distinction, he thinks that this has traditionally affirmed something like the following: "it is always wrong actively to kill a person, it may sometimes be right to allow death to come about. Active killing is always wrong, passive killing may sometimes be right."[4] To be clear, he thinks the phrases "passive killing" and "letting nature take its course" as being both apt descriptions that can refer to the same state of affairs. Actions that would fall under "passive killing" for him are those such as deciding not to feed a patient who thereby starves to death or removing a ventilator and then the patient subsequently suffocates as a result.

[3] Ibid., 17-18. In my opinion, what he is calling medical ethical principles seem better to be understood as key conceptual distinctions. Nevertheless, this is the nomenclature chosen by Tännsjö. He does, though, refer to these on occasion as distinctions throughout his essay.

[4] Ibid., 18.

He acknowledges, "all concrete actions are active under some description of them. However, some *kinds* of actions allow that we sort instances of them into the active or passive category, relative to the kind in question." This is a key move for Tännsjö's appeal to these principles and the ethical work that they are supposed to do for him. So just as removing a ventilator could constitute an instance of passive killing, actions like "injecting an opioid, which kills the patient, is to kill actively."[5]

He goes on to state that the acts/omission distinction in itself is not of moral importance within the euthanasia discussion. The reason is due to the fact that "in most Western countries, even active killing of severely ill patients is legally tolerated." What he has in mind on this point are "cases where patients are given a sedative medication or opioids in a manner that hastens death. *This* is clearly a case of *active* killing."[6] So in order for the acts/omission distinction to have moral import it needs to be coupled with something else, which is identified below.

He articulates the second medical ethical principle, the principle of double effect, in the following way: "it is always wrong intentionally to kill a patient, but it may be right to provide aggressive palliative care, with the

[5] Ibid.

[6] Ibid.

intention of relieving pain, even if it can be foreseen that the patient will die from the care in question."[7] He believes that the principle of double effect is clear enough for most and perhaps seems reasonable to a good many people. Here again, as is the case with the first distinction/principle, he suggests that this distinction in itself is not of moral importance with respect to the euthanasia discussion. He also thinks that in most "Western countries…we do not abide by it" since "intentional killing of patients is legally tolerated."[8] What Tännsjö has in view are situations like those many others have classified as instances of passive euthanasia in the sense that it is understood as "the withholding/withdrawal of medical treatment (or tube-feeding) *with the intention (aim) of hastening death.*"[9] Understood in this way, he sees the refusal of treatment with the aim or intention of causing death as an instance of "passive killing" and this is legally tolerated and morally permissible.

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[7] Ibid.

[8] Ibid., 19.

[9] John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legislation* (New York: Cambridge University Press, 2002) 217. Tännsjö does not make a distinction between passive euthanasia and withholding and withdrawing treatment. However, in this work, following Keown and many others, I suggest that what counts as instances of PAD relies heavily on the notion of intent being a necessary ingredient of what constitutes the moral event in question. So that when treatment is withheld or discontinued with the intention of causing death it is deemed an instance of passive euthanasia. However, if treatment is withheld or withdrawn "*because the treatment is either futile or too burdensome, or in order to respect the patient's refusal of treatment*," then on the account developed in Chapter 2 of this work, this is not seen as an instance of passive euthanasia. (Ibid.) Tännsjö does not make appeal to this sort of distinction in his essay. He only seems to identify and conceptually embrace the former notion.

The question emerges, then, if neither of these two principles that Tännsjö takes to be part of medical ethics, in and of themselves, are of moral importance with respect to the discussion surrounding euthanasia, then how does euthanasia violate these two principles as he claims in his essay? He wants to say that it is "only a *combination* of the two principles (of acts and omissions and the double effect) [which] can substantiate" the moral impermissibility of euthanasia while morally permitting terminal sedation.[10]

So then according to Tännsjö, we can sort various end-of-life medical practices or medical decisions into four discrete categories based on the combination of these two principles or distinctions. The first category is that of *active killing where death is intended*. An example here would be the practice of active euthanasia, and though he does not state explicitly, one would presume that he would include here as well instances of PAS. The second category is that of *active killing where death is merely foreseen*. He would place his form of terminal sedation into this category. For "the point in sedating the patient is not to cause death, but to relieve suffering. So even if the sedation (actively) kills the patient, the death of the patient is merely foreseen, not intended."[11] Third, there is the category of *passive killing where death is*

[10] Torbjörn Tännsjö, "Terminal Sedation: A Substitute for Euthanasia?" 19.

[11] Ibid., 20.

intended such as the *withdrawing* of life sustaining treatment with the aim of causing the death of the patient. He states, "the withdrawal of treatment is undertaken with the intention to hasten the death of the patient. However, this is a case of passive, not of active, killing."[12] And the last category is *passive killing where death is merely foreseen*. What he has in view here seems to be the *withholding* of life sustaining treatment (in contrast to the *withdrawing* indicated in the third category above) or refusing to feed someone (without sedation) in a health care setting, if that is what is chosen by the patient or the patient's proxy. So in other words, this category would include not even initiating certain LST to begin with.[13]

[12] Ibid.

[13] I do have some questions as to whether or not Tännsjö has accounted adequately for the idea of "passive killing." The notion, as he develops it, seems a bit problematic. He has as an account of "passive killing" that is two-fold. First, "passive killing" can be an instance of intended death by withdrawing LST. He gives the famous Tony Bland case as an example. He writes, "In this case it was decided that a patient in a persistent vegetative state should not be artificially fed or hydrated *any more*. It is obvious that the intention behind the action (of not feeding or hydrating the patient) was to hasten death." (emphasis mine, Ibid., 19) So this is represented by box (3) in the Brussellian Matrix below on page 160. Second, "passive killing" as represented in (4) is "not to feed a patient, who, as a consequence, starves to death, is to kill passively (to allow nature to takes its course)." (Ibid., 18) From this we see that he marks the distinction between types of "passive killing" on the basis of withdrawing (intending death) and withholding (not intending death). Further, he thinks that both of these are "tolerated." On the account developed concerning the role of intention for moral permissibility in this work, his approach is problematic. We can intend death by withholding and fail to intend death by withdrawing LST. We may just intend to discontinue futile treatment, or even intend to use the one ventilator we have to save someone else with better life prospects in a genuine triage situation foreseeing that removing it from this patient will mean his death.

Concerning moral evaluation of these four categories, he wants to say that only the first category, that of active killing where death is intended, would be morally forbidden in a health care context. Actions in the other three categories are legally tolerated, and hence on Tännsjö's view, morally permitted. With regard to the moral permissibility of passive killing or allowing nature to take its course, he does qualify somewhat his view.

> Of course, this does not mean that *all* instances of passive killing are morally acceptable. Sometimes it is morally wrong to kill passively. As a matter of fact, this is wrong, and very wrong in most cases. But when it is wrong to kill passively, this is not due to the *inherent* wrongness in the act, but to particular *consequences* of it. It may for example be wrong to allow a patient to die because of lack of treatment, if one has promised, or undertaken, to provide the treatment in question, most obviously so if the treatment would had saved the patient.[14]

Tännsjö's view can be represented in the following "Brussellian Matrix":[15]

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[14] Ibid.

[15] Tännsjö does provide a matrix in his chapter that is essentially the same as this one though the wording is slightly different in the one represented here to highlight some of the points made in the preceding footnote. Professor Bruce Russell, who is known for clarifying and evaluating certain philosophical distinctions using various matrices, which I call "Brusselian," inspires the inclusion of it in this chapter. By way of brief commentary, many think that the difference between withdrawing and withholding will not give the essential difference between the two types of "passive killing." Given that for Tännsjö both of these are "tolerated," he would respond that appeal to these distinctions are just meant as examples to illustrate the essence of the distinction as indicated in the matrix above about "intending" as a means and "merely foreseen" or "unintended" as a consequence. A charitable reading of Tännsjö can let this be as it may. However, my purpose in this part of the chapter is to highlight his views and then later interact with the category where he would place his understanding of terminal sedation, which is box (2). Boxes (3) and (4) represent the distinction he makes with respect to "passive killing." These areas are not the primary aim of my criticisms of Tännsjö.

KILLING	Death Intended	Death is not Intended
Active – what is done causes death	FORBIDDEN (1)	TOLERATED (2)
Passive – what is done does not cause death	TOLERATED (3)	TOLERATED (4)

It is somewhat unclear as to exactly how his emphasis on the consequences is supposed to be as significant as he intimates. He admits his view "may seem strange" to some. If instances of *active killing* are tolerated and also if *intentional killing* is tolerated, then how can these all of a sudden be morally problematic when taken together? He responds to this question by noting "it is the argument from the observation that a certain distinction lacks moral relevance in one situation to the conclusion that it lacks relevance in all situations that is fallacious."[16] And so, this is his exposition of how the two principles independently are not morally important for the euthanasia discussion, yet jointly they do have moral significance for it. Tännsjö thinks that his view has adequately developed a wedge argument that distinguishes the moral permissibility of terminal sedation for those who also want to oppose PAD. In the next section I evaluate Tännsjö's view.

[16] Ibid., 20.

A Critique of Tännsjö' Wedge Argument

The reasons Tännsjö provides as to why his view is able to justify the use of terminal sedation while euthanasia still may be opposed legally, and perhaps morally, are two-fold. It is, first, that terminal sedation does not violate two basic "principles" of medical ethics, namely, acts and omissions and double effect; and second it is consistent with the sanctity of human life view. But many have thought his development of these issues is exceptionally problematic, myself included. He seems to be using the wrong conceptual tools and the conceptual tools he does use, he uses wrongly. Thus his view does not constitute an appropriate response to the "Inconsistency Argument" developed in this work.

First, with respect to the claim that he is using the wrong conceptual tools, I think this is seen in his combined appeal to acts and omissions and double effect.[17] The way Tännsjö discusses the "acts/omission" distinction closely parallels the conversations surrounding the "active/passive" distinction, which also corresponds in many ways to the more specific "killing/letting die" distinction. This fact seems unavoidable based on what he writes and the general direction of the literature on the subject for those who are acquainted with it. Dan Brock's description is correct when he states: "The active-passive

[17] This is not to say that some form of double effect reasoning is a wrong conceptual tool for this discussion. This is made evident below. It is to say, instead, that the appeal that he makes to the acts/omission distinction seems not to be morally relevant in the manner in which Tännsjö needs it to be to substantiate his claim.

distinction is typically understood to mirror the distinction between killing and allowing to die. … However, how the distinctions between active and passive and between killing and allowing to die should be drawn, as well as how they apply to these…practices, remains controversial."[18] And ultimately, he thinks, unhelpful.

To be charitable to Tännsjö, he admits this much as noted above when he says, "all concrete actions are active under some description of them."[19] Furthermore, he also admits that the distinction taken alone is not of moral importance to the discussion at hand. Fair enough. However, when this is combined with double effect, he still seems to make appeal to the wrong tools to distinguish ethically between euthanasia, on the one hand, and terminal sedation, on the other. How so?

It seems that despite his denial, he needs the act and omissions distinction to be morally important as such in order to make his case as to why *intentional active killing* is morally prohibited but *intentional passive killing* may not be. For Tännsjö, an instance of medical killing that is morally impermissible or forbidden (to use his term) must both be active and intentional. These serve as individually necessary and jointly sufficient conditions of an immoral case of medical killing. The question for him then is, "Why is intentional active killing wrong, but

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[18] Brock, "Physician-Assisted Suicide as a Last-Resort Option at the End of Life," 137.

[19]Tännsjö, "Terminal Sedation: A Substitute for Euthanasia?" 18.

intentional passive killing not?" The answer is not explicitly given in his essay. On the surface, he affirms that the first category of intentional active killing is not *legally* tolerated whereas the other categories are. But he would need to say more than this if we are to understand why instances of intentional active killing are *morally* wrong but ones of intentional passive killing are not. In other words, asserting that the practices in this first category are *not legally* tolerated does not get at the proper wrong-making properties to answer our question.

If he is pressed on this point, we can suppose his response would be based on other more explicit comments made in his piece. Perhaps he would say that it is intentional active killing that violates the sanctity of life that he wants to maintain in some form, at least for his project. But what is it about intentional active killing that gives it a wrong-making property that intentional passive killing in a health care context, *ceteris paribus,* does not? It seems that the only recourse he has is appeal to the *mode* of the intentional killing, which under a particular concrete description is said to be *active*.

So while he wants to say that it is the combination of acts and omission and double effect reasoning that is of moral importance, it seems difficult to avoid introducing the moral significance of the former, in itself, in order to explain why intentional *active* killing is wrong whereas intentional *passive* killing need not be. The notion of intention is not synonymous with double effect reasoning. These are not by any means coextensive. Here is where there seems

to be the conceptual rub. Many have pointed out that the use of the acts/omission distinction is unable to carry the moral freight often placed upon it. Tännsjö agrees to this in principle but seems in practice to make appeal to it anyway. But it seems wrong-headed to put this kind of moral freight on the active/passive distinction, even if he claims it is not independently sufficient to determine moral impermissibility. The reason why the actions in the first category, that of of *intentional active killing*, is morally forbidden for Tännsjö is that the state of affairs described therein, presumably, violates *the sanctity of life*. But as discussed below, the sanctity view focuses on the role of intention with respect to a course of conduct when determining the wrongness of killing when it is wrong, not the passive or active mode of agency. If so, then this leads us to the next primary concern.

Second, Tännsjö seems to use the conceptual tools he does employ inappropriately. His conception of terminal sedation seems to be deeply flawed. The tools Tännsjö utilizes and the manner in which he makes his case ends up making terminal sedation on his view a form of euthanasia, albeit slow euthanasia, which is incompatible with *traditionally* formulated accounts of the sanctity of human life view. Furthermore, he misunderstands the sanctity principle and misapplies double effect reasoning. I look at these latter two in more detail below. Chapter 6 of this work seeks to provide a more nuanced understanding of palliative/terminal sedation that clarifies certain factors

involved in the process that Tännsjö and others appear to miss. His inadequate understanding of terminal sedation should be apparent in the contrasting picture developed in the next chapter.

Most traditional formulations of the sanctity view exclude all *modes* of intentionally killing innocents, whether passive or active.[20] In order to see the problem, it is helpful to follow the line of thinking developed by Luke Gormally. The prohibition of intentionally killing innocents that is entailed by the principle of the sanctity of human life bears not only on "physical causation as such but on chosen courses of conduct, i.e., courses of conduct specified by the reasons for which they were chosen."[21] Gormally describes a "course of conduct" as being "identifiable as intentional precisely by reference to the practical reasoning of the agent."[22] This notion is an important component for the sanctity of human life view for those proponents of it. Gormally further expounds on this idea in a

[20] A defender of Tännsjö on this point could say something like "perhaps he is providing a revisionist stipulative definition of the sanctity of life view." It is possible that he may very well be doing so self-consciously, though there is nothing in his essay to indicate that this is what he is aiming for. Further, it is seems to be what he does not want to do given that he sees his model as being a compromise of views put forth in the contemporary discussion, which would presumably be utilizing the categories and components that are held essential for traditional formulations of the sanctity view. I fail to see how this move would be of any help to Tännsjö's claims here.

[21] Luke Gormally, "Terminal Sedation and the Doctrine of the Sanctity of Life," *Terminal Sedation: Euthanasia in Disguise?* edited by Torbjörn Tännsjö (Dordrecht, Netherlands: Kluwer Academic Publishers, 2004) 83.

[22] Ibid.

way that the relevance is made clear concerning the discussion surrounding PAD. He writes:

> Thus a course of conduct is a case of intentional killing if what results in the killing was brought about, or allowed to happen (when it might have been prevented), because an agent chose that course of conduct in order to bring about the death of another. The purpose of securing the other person's death was the *reason* for the agent's action.[23]

So proponents of traditional formulations of the sanctity of human life do not have conceptual space for a "distinction between acts and omissions," even if it is coupled with double effect, in the way that Tännsjö thinks morally relevant.[24] It is difficult to avoid the conclusion that his conception of terminal sedation and intentional passive killing entail employing a course of conduct in order to bring about the death of another. Terminal sedation then, *as understood by Tännsjö,* does involve intending death though *when properly understood*, I want to argue that it ought not. He appeals to, uses, and applies the sanctity of human life view in the wrong way.

Does the appeal to the rule of double effect get Tännsjö "off the hook" so to speak? I do not think so. This is another area where he employs a potentially appropriate conceptual tool in the wrong way. The rule of double effect is

[23] Ibid. To be clear, many of those who do embrace a sanctity view think it is morally permissible in certain circumstances to withdraw and withhold life-sustaining treatment. They may posit different reasons for doing so other than simply bringing about the death of the patient. They usually appeal to some form of proportionality of benefits and burdens. For proponents of the sanctity view the death of the patient cannot be the aim of the action.

[24] Ibid., 85.

invoked typically as a *last resort when most other plausible options have been exhausted*. Simply stated, the rule is that under certain conditions "an action is morally permissible, even if it results in something one would deem wrong if done intentionally."[25] It is said to entail the following conditions as given by Sulmasy:

1. That one's action has two effects, [one good, one bad], that follow from it immediately ("immediate" not in a temporal sense but in the sense that there are no other intended intervening states or other agents).

2. That one's action not be intrinsically wrong.

3. That one foresees but does not intend the bad effect; one only intends the good effect.

4. That the bad effect not be the cause of the good effect that one does claim to intend.

5. That one's act is proportionate: that is, that the means are proportionate to the end, and that the good to be expected outweighs the bad in the particular situation.[26]

Tännsjö seems to be advocating a form of palliative/terminal sedation known as "palliative sedation to unconsciousness" where the intended goal of the sedation is unconsciousness in contrast to the sedated state being a

[25] Daniel P. Sulmasy and Nessa Coyle, "Palliative Sedation and the Rule of Double Effect," *End-of-Life Ethics: A Case Study Approach*, edited by Kenneth J. Doka, Amy S. Tucci, Charles A. Corr, and Bruce Jennings (Washington D.C.: Hospice Foundation of America, 2012) 111.

[26] Daniel P. Sulmasy, et. al., "Ethics of Palliative Sedation and Medical Disasters: Four Traditions Advance Public Consensus on Three Issues," *Ethics & Medicine: An International Journal of Bioethics*, Volume 28:1, Spring 2012: 41.

foreseen consequence.[27] One recalls the first line of his description of terminal sedation at the beginning of this chapter, when he states that terminal sedation is "a procedure where through heavy sedation a terminally ill patient is put into a state of coma, where the intention of the doctor is that the patient should stay comatose until he or she is dead."[28] In palliative sedation to unconsciousness the aim of the sedated state is used "as a means of dissociating patients from their symptoms." [29] The claim by many advocates of "palliative sedation to unconsciousness" is that it is distinguished from euthanasia in that with respect to the former death is foreseen, but not intended, as would be the case with the latter. However, upon analysis, "palliative sedation to unconsciousness cannot be justified under the rule of double effect."[30]

The problem is that this form of terminal sedation, palliative sedation to unconsciousness, does not satisfy some aspect or other of the double effect criteria. To begin, with respect to "palliative sedation to unconsciousness" it does

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[27] See the distinctions and descriptions of this and other forms of palliative sedation in Timothy E. Quill, Bernard Lo, Dan W. Brock, and Alan Meisel, "Last-Resort Options for Palliative Sedation," *Annals of Internal Medicine 2009*, Volume 151, Number 6: 421. These are discussed in Chapter 6.

[28] The quote is found on pages 152-153 of this chapter.

[29] Daniel P. Sulmasy and Nessa Coyle, "Palliative Sedation and the Rule of Double Effect," 114.

[30] Ibid. This is not to say the palliative sedation to unconsciousness may not be morally justified in some other manner. Instead the claim here is that double effect reasoning is not the appropriate tool to be appealed to for justification of this particular form of palliative sedation.

not meet the first criterion since the action in question only produces one effect, not two. The first criterion, "that one's action have two effects that follow from it immediately," has often been rightly and reasonably presupposed but often not explicitly stated. Yet it is obvious that "if one is to employ double-effect reasoning there need to be two distinct effects."[31]

In order to illustrate the criticism, consider the following. It is often claimed that aggressive use of morphine can be justified under the rule of double effect because it meets all the criteria, including the first one. Morphine, as an opiate, causes both pain relief and respiratory depression.[32] In other words, with respect to the relation between the brain's receptors and various subsequent physiological functions that result, morphine serves to produce these two effects in the form of a *causal fork*, that is, in the form of "a causes both b and c." Morphine does not fit into a *causal chain of the form* "a causes b which causes

[31] Ibid., 114-115.

[32] It is not the case that respiratory depression always leads to a hastened death when it is used in patients at the end of life care. This would be the wrong implication to draw. Yet it is true that it can lead to death either if it is not monitored carefully or if the dose has to be significantly high enough to get the symptoms under control that it could lead to an unintended hastening of death. It should be pointed out that this would be the case with any drug. Hence, this is why there is often appeal to the rule of double effect. The physiological effects of morphine use need to be carefully understood to minimize the anxiety often associated with it in managing pain. This anxiety is perpetuated and increased by a number of unfounded and unwarranted statements about its use in dying patients.

c."[33] In order to appeal to the rule of double effect, one action is to produce two effects in the form of a *causal fork* and this is the case with the use of morphine. In another essay Sulmasy develops this point in greater detail. He writes:

> Although in such a case it might not seem immediately obvious, there *are*, in fact, two separable events, distinct in time and space: pain relief (intended) and respiratory depression (unintended). To see why these really are two distinct events, making the application of the RDE [rule of double effect] plausible, it is perhaps best to think about this case on a molecular level. The analgesic and respiratory depressant effects of morphine occur by the binding of morphine molecules at different subtypes of morphine receptors, populating different locations in the nervous system. The chemistry for each effect has a different time course (kinetics). Morphine achieves pain relief via μ_1 receptors and respiratory depression via μ_2 receptors. These molecular differences are manifested in the response of the patient to the drug. Pain relief occurs at lower doses and more rapidly than respiratory depression. Thus, while the effects are scattered throughout the body, conceptually this is still a Causal Forks Scenario…. So the claim that one intended pain relief and not respiratory depression is plausible and coherent. [34] [Sulmasy's parenthetical remarks]

On the other hand, "If one is using benzodiazepines to induce sedation, one cannot claim that there are two distinct effects that both follow from the administration of the drug, sedation and hastened death. The benzodiazepines would be used to cause unconsciousness, and unconsciousness, in turn hastens

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[33] Daniel P. Sulmasy and Nessa Coyle, "Palliative Sedation and the Rule of Double Effect," 115.

[34] Daniel P. Sulmasy, "'Reinventing the Rule of Double Effect," *The Oxford Handbook of Bioethics*, edited by Bonnie Steinbock (New York: Oxford University Press, 2007) 142.

death."[35] One can see that this is a *causal chain* with the form of "a causes b which causes c." Consequently, in a causal chain there is "really only *one* effect and so 'double' effect does not apply." [36] So if "palliative sedation to unconsciousness" is morally justifiable at all, it cannot be on the basis of the rule of double effect. It would need to be done on some other basis.

Perhaps, Tännsjö could reply that his understanding of terminal sedation is justified by appeal to double effect reasoning claiming that unconsciousness is not the aim, but instead it is the relief of suffering. He does, in fact, make a move in this direction in the middle of his essay, which is a decisive shift from what he previously had stated. When he moves to identifying what sort of practices fall within the four categories developed by the combination of acts/omission and double effect, he writes of the second category: "the point in sedating the patient is not to cause death, but to relieve suffering.[37] So even if the sedation

[35] Daniel P. Sulmasy and Nessa Coyle, "Palliative Sedation and the Rule of Double Effect," 115.

[36] Ibid.

[37] There may be an inconsistency here for Tännsjö given that he initially stated that terminal sedation is a procedure "where the intention of the doctor is that the patient should stay comatose until he or she is dead. No extraordinary monitoring of the medical state of the patient is undertaken. Normal hydration is ignored. All this means that in some cases where patients are being terminally sedated, death is hastened; if the disease does not kill the patient, some complication in relation to the sedation, or the withdrawal of treatment and hydration, or the combination of these, does." See quote on page 153, footnote 1.

(actively) kills the patient, the death of the patient is merely foreseen, not intended."[38]

However this may be, the question remains, "Does this shift from aiming to unconsciousness to aiming at the relief of suffering now entitle Tännsjö to make use of the rule of double effect in order to justify terminal sedation?" I do not think this shift fares any better with respect to the rule of double effect when it is applied to his formulation of terminal sedation. His overall purpose, once again, is to distinguish terminal sedation from euthanasia. It would seem that he has a singular intention, which is to relieve suffering and two effects, namely, (1) the intended effect, relief of suffering and (2) the foreseen effect, unconsciousness leading to death. On the *assumption* that the rule of double effect is defensible, what, then, is the problem with Tännsjö's view?

Several points can be made. First, as is the case with his initial description of terminal sedation as discussed above, one wonders if this modified way of depicting the event involves a causal chain (rendering one effect) rather than a causal fork (which renders two effects). Again, the latter is what would be needed for a legitimate appeal to the rule of double effect (see pages 168-171).

[38] Tännsjö, "Terminal Sedation: A Substitute for Euthanasia?" 20.

Second, the shift by Tännsjö to say that the intended aim is "the relief of suffering" lacks specification. It is simply too vague to be useful for double effect reasoning. The rule of double effect does not have conceptual space for affirming simply that the ends justify the means. So the *means* by which the goal of suffering relief is accomplished must be evaluated. This is a central concern for appealing to the rule of double effect in the first place. Of course, one would not think it morally justifiable to kill all the children in a city to alleviate child abuse therein. While the goal of alleviating child abuse is certainly worthwhile and to be sure morally praiseworthy, there are ways, such as the one suggested above, that are offered to accomplish the goal of alleviating child abuse that would be morally unacceptable. So then the question must be asked in reference to the topic at hand, "How is the goal of relieving suffering to be attained for Tännsjö?" This has to be specified in a concrete way in order to judge if it meets the other stated criteria of the rule of double effect. It appears that he does offer a more concrete description of terminal sedation as a medical procedure. This brings us back to the initial description of Tännsjö's understanding of terminal sedation that was provided at the beginning of this chapter (pages 152-153). If so, then the criticisms from the previous section come back to the fore.

Third, Tännsjö does not provide any philosophical reflection on the relevance of the timing of when terminal sedation is to begin in the patients'

trajectory toward death. Nor does he provide any philosophical reflection on identifying under what circumstances would the withholding or withdrawal of life-sustaining treatment affect one's moral assessment of the practice of terminal sedation. I argue in Chapter 6 that both of these tasks, not seen as relevant by Tännsjö, need to be accomplished and incorporated into the practice of palliative sedation in order for it to be adequately distinguished from PAD. Otherwise, some procedures performed under the name of "terminal sedation" in essence may be the same as PAD. Sulmasy and Coyle rightly identify the problem with claiming that it is morally justified via double effect reasoning to *aim* for or *intend* unconsciousness in order to relieve suffering for those who oppose PAD. They write:

> To justify palliative sedation to unconsciousness, in which one aims at unconsciousness until death, one would thus be required to argue that it is better for the dying patient to be unconscious than conscious. And if that is the case, it becomes hard to say how the justification for palliative sedation to unconsciousness differs from the justification for euthanasia….The justification in both cases must be that it is better for the patient to be rendered permanently unable to speak, think, eat, pray, love, or interact with others, whether this is brought about through induced coma or death.[39]

The further danger with this move by Tännsjö is that Battin's criticisms from Chapter 4 of this work become much more salient. She thinks, one is reminded,

[39] Sulmasy and Coyle, "Palliative Sedation and the Rule of Double Effect," 116. It is possible that there could be other ways where this state of affairs could be morally justified. But it does not appear that it can be done so by appeal to double effect reasoning which is the mode of justification in question in this section.

that there is a greater likelihood, or perhaps even an inevitability, of abuse and deception with the practice of terminal sedation or palliative sedation to unconsciousness until death, than with PAD. On the account of terminal sedation with which Tännsjö is working, and the manner in which he employs the conceptual tools in question, it seems that Battin's worries are legitimate when one *aims* to relieve suffering by palliative sedation to unconsciousness until death. If so, then it is not surprising that:

> [t]here have been reports of those who, failing to see the distinction between the justification for euthanasia and the justification for palliative sedation to unconsciousness, have titrated up the sedating drug far past the doses needed to dissociate the patient from his or her symptoms, explicitly in order to hasten death. It is a violation of transparency to "cloak" these latter practices deceptively under the guise of palliative sedation.[40]

It does appear that once deep sedation to unconsciousness until death becomes the *aim in order to relieve suffering*, as Tännsjö claims, "the distinction between *justifiable and unjustifiable doses becomes easier to blur* and the distinction between symptom control and euthanasia becomes more difficult to defend logically." [41] (emphasis mine) And so Battin's counter conceptual slippery slope argument from Chapter 4 appears to have some merit.

Fourth, Tännsjö seems very close to arguing for terminal sedation on demand regardless of whether or not it is clinically indicated. If this is so, then

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[40] Ibid.

[41] Ibid.

terminal sedation is not being appealed to as a last resort as is the standard amongst palliative care experts. Further, if double effect reasoning is to be employed the action one is considering performing should be seen as last resort. The basis for these claims is two-fold. First, given the "ethical and legal controversy about the acceptability of physician assisted suicide and voluntary active euthanasia…terminal sedation [has] been proposed as ethically superior responses of *last resort* that do not require changes in professional standards or the law."[42] The very procedure itself is considered appropriate when all other attempts at managing pain or treating symptoms fail. This is why terminal sedation is often associated with or discussed in the context of dealing with *intractable pain* (i.e. pain that is resistant to relief) or refractory symptoms (i.e. symptoms that are not responsive to standard treatments).

If standard treatments were successful, there would be no need to employ such extreme measures as terminal sedation. If terminal sedation were employed and other less radical treatments were available and reasonably thought to be effective, then one would have a difficult time justifying its use professionally. Furthermore, it would seem that appeal to the rule of double effect would not be appropriate in these situations since it would not meet the

[42] Timothy E. Quill, Bernad Lo, and Dan Brock, "Palliative Options of Last Resort: A Comparison of Voluntary Stopping Eating and Drinking, Terminal Sedation, Physician-Assisted Suicide, and Voluntary Active Euthanasia," *Journal of the American Medical Association*, Volume 278, No. 23, (December 1997): 2099.

proportionality requirement. This would be because the good effect (the relief of suffering) could be achieved with a less invasive means that does not in the first instance aim for unconsciousness. So herein is the two-fold basis for thinking that both terminal sedation and double effect reasoning are employed in palliative care when considering options of last resort. Here, again, is another indication that this conceptual tool is being used in the wrong way.

All of this suggests that palliative sedation to unconsciousness as Tännsjö has conceived it does not meet the necessary criteria for it to be a morally justifiable medical practice under traditional formulations of the rule of double effect. Thus, the claim that Tännsjö uses a *potentially* helpful conceptual tool in the wrong way is reinforced. To be sure, double effect reasoning can be notoriously complex and controversial. We, nevertheless, need to tread carefully here. Certainly, much of what is said and believed in applied ethics, as well as in philosophy more generally, is controversial. The mere fact that there may be deep and widespread disagreement as to the moral importance of some distinction or form of reasoning, say, does not in any way *automatically* make the controversial point in question irrelevant to the discussion. I do think a *version* of double effect reasoning in the end may be defensible and seems to many to

make good sense in *some* cases.[43] However, I do not make appeal to it in Chapter 6 in my formulation of a Wedge Argument.

However, for the purposes here it is enough to affirm that regardless of what one thinks about double effect reasoning, it simply cannot be appealed to in order to justify morally any and every situation in which some acts have unintended yet foreseen consequences. One of the problems with double effect reasoning is that, in practice, some have attempted to apply it too widely. It should not be thought of as a "Get out of Jail Free Card," so to speak. We return to this issue in Chapter 6, "Toward a More Defensible Wedge Argument."

Conclusion

In light of what is discussed in this section, those who hold to traditional formulations of both the sanctity of human life view and double effect reasoning should see terminal sedation as described by Tännsjö and PAD as morally equivalent. In the end, then, it appears that Tännsjö's formulation is a form of PAD. And so it cannot be considered an effective "Wedge Argument."

[43] A helpful treatment and robust defense of this topic referenced above is by Daniel P. Sulmasy, "'Reinventing' the Rule of Double Effect," 114-149. The central question here with respect to double effect and terminal sedation is: Is it needed for moral justification of the practice in a health care context? I discuss this in the next chapter.

If Tännsjö's "Wedge Argument" is inadequate, then the equivalency arguments developed by Battin, Brock, and others that in essence support premise 2 of the "Inconsistency Argument" remain intact, which reads: "There are no morally relevant differences between palliative/terminal sedation and PAD." The conclusion articulated in 5 also holds sway, which reads: "Therefore, palliative/terminal sedation is morally impermissible." So those medical professionals and medical ethicists who reject PAD, for the reasons developed in Chapter 3, must also reject Tännsjö's form of terminal sedation in order to be morally consistent. And herein remains the challenge of the "Inconsistency Argument" for the terminal sedation alternative.

CHAPTER 6

TOWARD A MORE DEFENSIBLE WEDGE ARGUMENT

Introduction

This final chapter attempts a more defensible wedge argument than the one offered in Chapter 5 by Tännsjö to the "Inconsistency Argument" delineated in this dissertation. Along the way, there will be explicit responses to some of the more significant objections made by Battin in making what is essentially her equivalency argument as discussed in Chapter 4. Much of what is said below in reframing the discussion as well as aspects of the explicit responses to Battin serve as an implicit response to some of the ethical and practical challenges raised by Brock in his version of the Equivalency Argument also described in Chapter 4.

The chapter unfolds with the first section providing a more nuanced understanding of palliative sedation. From this frame of reference, I move into the next section to identify what are the distinct features of palliative sedation that distances it, ethically speaking, from PAD. These features in essence are to serve as a response to premise 2 of the "Inconsistency Argument" which says, "There are no morally relevant differences between palliative or terminal sedation and PAD," thereby, blocking the conclusion that claims that if PAD is morally impermissible so is palliative sedation.

Reframing the Discussion

I develop this section in the following six ways. First, I claim that some of the key terms in this debate are ambiguous which leads to some confusion. Next, I highlight three types of palliative sedation. Third, I advocate for the second type, namely, proportionate palliative sedation, going forward in what remains of this work. The discussion then turns, in the final two sub-sections, to how this nuanced version of palliative sedation relates both to the three phases of dying, and to the withholding of life-sustaining treatment. The final sub-section brings all these facets together in order to properly reframe the conversation for developing a more defensible Wedge Argument.

Ambiguity of the Terms

One of the primary reasons that contributes to the complexity of this topic is that terminal sedation suffers from a degree of ambiguity that makes it difficult to assess its moral equivalence or lack thereof with PAD. For example, does the word 'terminal' refer to sedating those patients with terminal illnesses since there remain no more curative options? Or does 'terminal' most likely refer to sedation for intractable symptoms at the end or *terminus* of the life of a dying patient? Or is it that the 'terminal' in "terminal sedation" refers to the fact that the sedation is done in a manner that actually terminates the patient's life?

Many lay people, patients, and those close to them are confused about what terminal sedation refers to, and so are some medical ethicists and health care professionals. This confusion results in much consternation on the part of people trying to evaluate various palliative care options at the end of life. Many working in the hospice and palliative care arenas prefer the term 'palliative sedation' instead of 'terminal sedation' in an attempt to minimize the confusion. This move emphasizes the goal of palliative sedation is in some way to provide comfort to the patient and to palliate certain symptoms at the end of life.

Here again, while this is a much better choice of words, it would seem that it suffers, too, from some ambiguity. As "many clinicians argue that palliative sedation does not necessarily mandate sedation to total unconsciousness."[1] Palliative sedation could refer to anything from taking Benadryl to address some symptom to palliative sedation with the aim to unconsciousness until the point of death while withholding artificial feeding nutrition and hydration. As Maltoni, et. al. have specified, the range of options

> can vary in terms of level (mild, intermediate, and deep), duration (intermittent or continuous), and pharmacological characteristics…. Other authors classify sedation as sudden or proportional on the basis of whether it is established rapidly. 'Emergency sedation' is made in immediately preterminal patients with overwhelming symptoms for catastrophic events such as massive bleeding, severe dyspnea, agitated delirium, or pain. A further, highly specific but potentially useful subtype of [palliative sedation

[1] M. Maltoni., et. al., "Palliative sedation therapy does not hasten death: results from a prospective multicenter study," *Annals of Oncology* 20, (2009): 1163.

> therapy] is 'respite sedation', a procedure involving temporary and time-limited sedation. Finally, the possibility of using 'routine', 'infrequent' or 'extraordinary' sedation has also been put forward.[2]

Those who work in the areas of palliative, hospice, and end-of-life care are more interested in the procedures as they emerge in the latter stages of the dying process.

Three Types of Palliative Sedation

I identify three primary types of palliative sedation, which are helpful for our purposes going forward. The first is that of *ordinary sedation*. The goal of treatment is symptom relief "without reducing the patient's level of consciousness." It is often used to address disorders as, anxiety, agitation, or insomnia among others. This is considered standard medical practice and is not thought of as particularly controversial.[3]

The second type is *proportionate palliative sedation*. This is a *monitored* procedure where sedating medicines "are progressively increased alongside other symptom-relieving measures, resulting in increasing levels of sedation during both waking and sleeping hours to help relieve suffering."[4] It is most often

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[2] Ibid.

[3] Timothy E. Quill, Bernard Lo, Dan W. Brock, and Alan Meisel, "Last-Resort Options for Palliative Sedation," *Annals of Internal Medicine*, Volume 151, Number 6 (2009): 421.

[4] Ibid.

seen as a last resort begun as a response to otherwise intractable physical symptoms, such as agitated terminal delirium, in those patients where death is imminent. There are two important qualifications that often accompany proportionate palliative sedation. The first is that it uses the "minimum amount of sedation needed to achieve its goal" with the rate of sedation increase being contingent upon "the severity of physical symptoms, usually ranging from hourly to daily." The second is that it sometimes requires that the patient be sedated to the point of unconsciousness, "which is considered a foreseen but unintended side effect when lesser degrees of sedation [are] ineffective."[5]

The last type was introduced in Chapter 5 while critiquing Tännsjö's wedge argument. It is *palliative sedation to unconsciousness*. In this last, and more controversial category, "unconsciousness is the intended goal of the sedation rather than a side effect." If an imminently dying patient finds himself or herself in a situation where severe physical symptoms are intolerable "despite state-of-the-art palliative care, and continuing consciousness under the circumstances unacceptable," then palliative sedation to unconsciousness can be initiated.[6] Quill, Lo, Brock and Meisel describe this practice by noting that "sedation is rapidly increased over minutes to a few hours until the patient is

[5] Ibid.

[6] Ibid., 421-422.

unresponsive, and then is left at that level until the patient dies. Except under very unusual circumstances, artificial hydration and nutrition are not provided."[7]

Advocating Proportionate Palliative Care Going Forward

For those who are opposed to PAD for the kinds of reasons presented in this work, I advocate that something like proportionate palliative sedation is more in keeping with suitable forms of aggressive comfort care. It is crucial to emphasize, at the outset, that the success criterion for proportionate palliative sedation is symptom relief. Whereas the success criterion for PAD just is the death of the patient, albeit, as proponents of PAD argue, for reasons of benevolence.

Identifying the success criterion is important for it can assist with establishing parameters or potential safeguards on the amount of medications needed to attain the desired effect, which is in keeping with the minimalist approach to proportionate palliative sedation. This conception is consistent with the aggressive use of sedating and other kinds of medicines in order to palliate the symptoms. If higher and more frequent doses are needed and clinically indicated, then they should be used. Moreover, it would be morally permissible to do so, and in some situations one may even be morally obligated to do so.

[7] Ibid., 422.

It is important to note for the account being developed that in order for this to be a morally permissible procedure it needs to be: 1) carefully monitored, 2) autonomous, and 3) initiated at an appropriate time in the dying process when it is clinically indicated. A brief line or two about each of these is in order. First, proportionate palliative sedation needs to be carefully monitored since the "level of sedation required to relieve symptoms varies from patient to patient." Therefore, "clinical vigilance is needed to ensure continued relief of suffering and rapid adjustment of therapy if needed." [8] Second, it needs to be autonomous such that the patient or person with durable power of attorney is aware of the goals of sedation, under what circumstances it would be performed, how it is to be performed if the patient and care team are unable to communicate at some point, and the patient or proxy must freely consent to the relevant course of action having understood all of this. This should include discussions of artificial nutrition and hydration. And last, it must not be initiated too soon in the dying process. There is more on this below.

Above I used the phrase, "something like proportionate palliative sedation" is being supported in this context. The words "something like" are used to render a slight qualification to the way Quill, et. al. craft the intent of these

[8] Daniel P. Sulmasy and Nessa Coyle, "Palliative Sedation and the Rule of Double Effect," *End-of-Life Ethics: A Case Study Approach*, edited by Kenneth J. Doka, Amy S. Tucci, Charles A. Corr, and Bruce Jennings (Washington D.C.: Hospice Foundation of America, 2012) 109.

practices. They suggest that the intent of both *proportionate palliative sedation* and *palliative sedation to unconsciousness* is "to relieve suffering." I highlight in Chapter 5 the philosophical concerns with having the relief of suffering as the aim of palliative sedation. The most relevant feature is that for the purposes of moral evaluation the aim of suffering relief is underspecified. Going forward, I slightly modify the wording given by them with respect to the form of *proportionate palliative sedation* that is promoted here.

Those opposed to PAD should self-consciously identify the aim of proportionate palliative sedation as being the relief of intractable pain or other refractory symptoms that cause the patient to suffer. The reason for this narrower understanding is that while the terms 'pain' and 'suffering' are often mentioned together and sometimes used interchangeably, they should be distinguished even though they are related concepts. 'Pain' is a complex physical phenomenon understood as a subjective experience "caused by stimulation of specialized nerve endings."[9] 'Suffering' as understood in the context of palliative care often refers to a "highly personal experience that depends on the meaning of an event such as illness or loss has for an individual." Insofar as this is

[9] *Dorland's Pocket Medical Dictionary*, 25th Edition (Philadelphia: W. B. Saunders Company, 1995), s.v. "Pain."

correct, we can see, then, that "one can suffer without physical pain, and physical pain doesn't necessarily involve suffering."[10]

Given that the nature of suffering is multifarious, sedation may not be proper for *some*, though by no means all, forms of it. If the goal of quality palliative care moves from excellent compassionate comfort care (i.e. suffering with) to "alleviating *all* patient suffering" this could lead to a skewed understanding of what practices should be permitted in order to achieve this goal. Also, by framing the goal of palliative care in terms of the relief of intractable pain or other refractory symptoms that cause suffering, it begins to put some conceptual safeguards in place to limit potential abuse. In short, this is because the success criterion of when the goal has been achieved is different from what it would be if the goal is to alleviate *all* patient suffering regardless of the type and whether or not death is imminent.[11]

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[10] Joan T. Panke, "Difficulties in Managing Pain at the End of Life," *Journal of Hospice and Palliative Nursing*, Vol. 5, No. 2, April–June, 2003, 84. Also see the standard works on this issue by a major proponent of this view: E. J. Cassell, "Life as a Work of Art," *Hastings Center Report* 14, (1984): 35-37; E. J. Cassell, "Diagnosing Suffering: A Perspective," *Annals of Internal Medicine*, Vol. 31 (1999): 531-534; and E. J. Cassell, *The Nature of Suffering and the Goals of Medicine*, Second Edition (New York: Oxford University Press, 2004).

[11] What I have in mind here includes, but is not limited to, a broad category sometimes termed "existential suffering." There is some suffering that results from people having a difficult time coping with new irreversible realities for the remainder of their lives. Or there is some suffering that results from fear of future realities that have not yet obtained or may not obtain. Other kinds of suffering are the result of patients' inability to receive forgiveness from someone whom they may have wronged. While it is debatable, there is some concern that if sufficient care is not taken, medicine may be called upon to extend beyond its traditional scope to address psychosocial issues such as the ones listed above (or as some literature suggests, "spiritual"

Proportionate Palliative Sedation and the Phases of Dying

I noted above that proportionate palliative sedation is a "last resort begun as a response to otherwise intractable physical symptoms in those patients where death is imminent." This brings the discussion to another important juncture to better see the appropriateness of this procedure in addressing suffering from intractable pain and otherwise refractory symptoms. There are universal signs and symptoms that clinicians can use to identify imminent death. For our purposes, we can stipulate three general categories that serve as a canvas in order to better grasp how clinicians make judgments concerning the imminence of death.

First, the "stable" category refers to those who have a terminal or other life limiting chronic illness where death is *near* though not imminent. The decline in life expectancy is noticeable even if the time line for when death will actually take place is indefinite. The second category can be described as a pre-active or perhaps, a *transitional* phase. It is an admittedly subjective designation that involves clinical judgments of medical professionals identifying declining behavioral change in patients that are significant for predicting death within about 1 to 2 weeks. Now while this category is subjective it should not be thought necessarily as idiosyncratic. The third category is what is commonly

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issues, which is not necessarily to be equated with religion) by using pharmacological means before other means have been attempted and when death is not imminent.

called the *active* phase of dying. In the active phase of dying, clinicians are able to identify objective changes in patients such as tachycardia (i.e. rapid heart rate), breathing problems, apnea (being without breath), cold and discolored extremities, no urine output, low blood pressure, etc. These are indications that usually death is within about 3 days.

Proportionate Palliative Sedation and Life-Sustaining Treatment

It must be acknowledged that in many, if not most, appropriate instances of proportionate palliative sedation artificial nutrition and hydration are *usually* withheld. One study "shows that when [proportionate] palliative sedation is being initiated, the oral intake of foods and/or fluids is reduced to a minimum."[12] If it is carefully monitored, the patient has given prior consent, and the procedure is initiated at a point in the dying process where if food and water were provided it would be more burdensome to the patient than without it, then proportionate palliative sedation accompanied by the withholding of artificial nutrition and hydration should not be considered especially controversial.

[12] Patricia Claessens, et. al., "Palliative Sedation, Not Slow Euthanasia: A Prospective, Longitudinal Study of Sedation in Flemish Palliative Care Units," *Journal of Pain and Symptom Management*, Volume 41, No. 1, (January 2011): 21.

Palliative care patients tend to eat and drink less the more they approach the ends of their lives."[13]

Proportionate palliative sedation while withholding artificial nutrition and hydration may seem problematic to some clinicians since they "might worry that while the actual practice of palliative sedation can be distinguished from euthanasia, coupling decisions to withhold or withdraw life-sustaining treatments to the decision to sedate makes the whole package deal tantamount to euthanasia."[14] But this is not the case. In hospice and other end-of-life palliative care contexts, many patients have ceased eating and drinking at the end stages of the dying process as a direct result of the illness or disease. As some palliative care experts rightly have pointed out, "one should keep in mind that an average patient in that stage of his or her illness only takes little sips of fluid and, in most cases, no food whatsoever. Withholding little sips of water because of the decision to sedate (and to withhold artificial hydration) has no proven life-shortening effect."[15]

Not only are there physical changes that have taken place in dying patients, that make it difficult to eat and digest food, but also there is oftentimes

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[13] Ibid., 22.

[14] Sulmasy and Coyle, "Palliative Sedation and the Rule of Double Effect," 118. This was also a concern that was expressed by Battin in Chapter 4.

[15] Patricia Claessens, et. al., "Palliative Sedation, Not Slow Euthanasia: A Prospective, Longitudinal Study of Sedation in Flemish Palliative Care Units," 21-22.

a corresponding lack of *desire* for food and water as well. To continue feeding a patient at the point when he or she is no longer able to tolerate it would cause discomfort. This is, obviously, in conflict with the goals of palliative care. "Additionally, hydration can worsen distressing signs such as the 'death rattle' and make it difficult to handle the patient's secretions."[16] The reality for patients and clinicians is that "administering artificial fluids to terminal patients has a rather baleful influence on patients' conditions." And this "suggests that starting artificial fluids during palliative sedation is futile" if not harmful.[17] There is a point where artificial feeding and hydration are no longer beneficial to a dying patient given the physiological deterioration of the body as a result of disease progression. This is a common phenomenon at the end of life.

However, in those circumstances where patients are capable of physiologically tolerating feeding and hydration and when they perhaps could be of some benefit to a patient, nutrition and hydration certainly can be continued after proportionate palliative sedation has commenced. "The withholding of artificial nutrition and hydration in a patient who is sedated at the end of life is [to be] justified independently, even though the decision must be

[16] Sulmasy and Coyle, "Palliative Sedation and the Rule of Double Effect," 119.

[17] Patricia Claessens, et. al., "Palliative Sedation, Not Slow Euthanasia: A Prospective, Longitudinal Study of Sedation in Flemish Palliative Care Units," 22.

made in light of the fact that sedation has been chosen as a treatment option for controlling intractable symptoms."[18]

It is not a necessary condition for proportionate palliative sedation to withhold artificial nutrition and hydration as a matter of due course. So we must keep in mind that in "deciding to withhold or withdraw artificial fluid (in cases of palliative sedation) is a totally different discussion from that of deciding to start palliative sedation."[19] These are withheld if it would be more burdensome than beneficial, but *could* be continued if not. Yet, these are usually withheld because in most instances they become unproductive or overly burdensome. In such circumstances, this should not be thought controversial but as a *clinically indicated* reason for ceasing these kinds of life-sustaining treatments. To be sure, contra the claims of Battin and Tännsjö (in Chapters 4 and 5), "withholding or withdrawing food and/or fluid is not an intrinsic part of palliative sedation and, therefore, should not be integrated in a definition of palliative sedation."[20]

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[18] Sulmasy and Coyle, "Palliative Sedation and the Rule of Double Effect," 119.

[19] Patricia Claessens, et. al., "Palliative Sedation, Not Slow Euthanasia: A Prospective, Longitudinal Study of Sedation in Flemish Palliative Care Units," 22.

[20] Ibid., 22.

Bringing it All Together

We have reached another important juncture and must ask, "What is the relationship of proportionate palliative sedation and artificial nutrition and hydration to the various stages or phases of dying?" For each of the phases, if proportionate palliative sedation is done intermittently, there is little, if any, ethical controversy. "Intermittent" in this context describes the process where the level of sedation is adjusted or titrated up or down in order to determine whether or not the patient is able to tolerate their condition while simultaneously being aware of their surroundings at a given point in the process of dying.

But what are we to think about proportionate palliative sedation that *ends up* being *continuous* until the point of death instead of intermittent? In what follows, I primarily have in view implications for those medical professionals who reject PAD while advocating proportionate palliative sedation. Let's begin with the stable phase. Proportionate palliative sedation done in this category, if it were deemed clinically indicated, would need to be *intermittent*. This should be the case whether artificial feeding and hydration are withheld or not for those who want to distance the practice from becoming a form of slow euthanasia. Since the time of death in the stable phase is indeterminate, it is much more likely that if a patient is *continuously* deeply sedated all at once while at the same time being denied artificial nutrition and hydration, then death is much more likely to occur by starvation or dehydration as opposed to

the underlying disease process. In such a scenario, proportionate palliative sedation was initiated too early in the dying process. This would typically be considered ethically impermissible, as it would appear to introduce a "lethal mix" into the existing pathology of the professional health care relationship.

With respect to the pre-active transitional phase, while one perhaps is not morally obligated to withhold artificial nutrition and hydration when performing proportionate sedation here, it certainly is ethically permissible under the conditions described above if eating and drinking have ceased. For example, patients often stop eating due to many of the bodily changes that occur during the transitional phase of dying. Clinical judgments need to be made at the suitable time as to whether or not there are medical indications for what turns out to have been *continuous* proportionate palliative sedation until the point of death. For the most part, this should not be seen as controversial or ethically problematic, just a matter of professional judgment. Certainly, *continuous* proportionate palliative sedation while withholding life-sustaining treatment should not be thought of as morally problematic during the active phase of dying for intractable pain and refractory symptoms, all things being equal. To be sure, proportionate palliative sedation must not be done in a manner such that more sedating drugs are used than needed to attain the desired effect at this stage. To state the obvious, it would be, then, no longer proportionate.

And so by way of conclusion to this section, proportionate palliative sedation with its various conditions, qualifications, and applied contexts as discussed above is the nuanced understanding that is to be evaluated in relation to PAD. The peculiar features of proportionate palliative sedation, I suggest, serve in the development of a more defensible Wedge Argument.

Two Distinctions that Make a Moral Difference

For those who deem that PAD is ethically inappropriate in a health care context, the practice of proportionate palliative sedation differs morally from PAD in two related yet distinct ways. First, the purpose of proportionate palliative sedation is the relief of intractable pain or other refractory symptoms that cause suffering by using carefully monitored sedating drugs along with other clinically indicated medication in the imminently dying.[21] Thus, an agent performing proportionate palliative sedation should intend, in the narrow sense, as his or her aim to act in a way that is in keeping with the stated goal and purpose of this medical practice. This significantly distinguishes the moral meaning of

[21] Clinically speaking, "A variety of drugs can be used for palliative sedation, depending on the symptom being targeted; sometimes a combination of agents is selected. Commonly used agents include benzodiazepines, barbiturates, neuroleptics, and anesthetics. Frequently one or more of these drugs may be added to the patient's background of around-the-clock opioids already prescribed for the management of pain and/or dyspnea." Daniel P. Sulmasy and Nessa Coyle, "Palliative Sedation and the Rule of Double Effect," *End-of-Life Ethics: A Case Study Approach*, edited by Kenneth J. Doka, Amy S. Tucci, Charles Corr, and Bruce Jennings (Washington, D.C.: Hospice Foundation of America, 2012) 109.

proportionate palliative sedation from PAD given the reasons why the latter practices are thought to be wrong.[22]

The second distinction that makes a moral difference between these two practices is, when administered appropriately by skilled palliative care professionals, proportionate palliative sedation should not be thought of as the cause of death. There is evidence to suggest that it actually does not hasten the death of patients. The same cannot be said with respect to PAD regardless of whether one thinks it should be deemed morally permissible or not. Therefore, proportionate palliative sedation differs from instances of PAD in its moral meaning in a fundamental way.

A Difference of Purpose and Clinical Intention

This part of the chapter begins with *general* reflections on *some* of the theoretical issues involved in appealing to clinical intentions. I make use of an account of intention and the significant role it plays in moral assessment developed by T. M. Scanlon that in the end does not appeal to a form of double effect reasoning. Then, I underscore and respond to some of the concrete worries raised by the practical problems of the internal and external discernment of intentions. I conclude with an application of the details

[22] The distinction between the broad and narrow senses of "intention" along with the notion of the moral meaning of an action or event is discussed below.

developed in this section to Battin's fear that terminal or palliative sedation obscures the true intention behind the practice such that genuine consent is not possible.

Theoretical Issues Concerning Appeal to Clinical Intentions

Clinical intentions play a central role in evaluating and understanding the meaning of particular moral events in a health care context. They also matter in judging the culpability of some human actions. But two questions emerge: How exactly should the notion of intention be understood? And moreover, how are intentions relevant in moral assessment of an action or event? I'll take briefly each of these questions in turn.

The difficulty of providing a full-orbed analysis and account of intentionality that responsibly incorporates relevant discussions in action and event theory, models of causation, their relations to propositional attitudes and so forth is well known in philosophical circles. All of this is notoriously difficult. It is not the central thrust of this project to work out a robust account of intentionality. The goal here simply is to say enough so one can conceive the notion of intention in a way that gets at its basic thrust and how it is relevant for moral assessment.

Despite its vast complexity, one can, following T. M. Scanlon, make some distinctions that may prove helpful in understanding the basic notion of intention

and intuitive appeal of the centrality of intentions in moral assessment. To begin, "When we say that a person did something intentionally, one thing we may mean is simply that it was something that he or she was aware of doing or realized would be a consequence of his or her action."[23] This description of intentional action is contrasted with unintentional action in that the latter is something the agent did not realize he or she was doing. This is the *wider* or *broader* sense in which intentional and unintentional actions are portrayed and is the sense in which the terms often are used. The broader sense of 'intention' "is in the first instance a matter of what the agent understands herself to be doing rather than what her reasons were for doing it."[24] However, there is another sense, a *narrower* one, in which 'intention' is commonly used that has more to do with the reasons for which one is acting. As Scanlon describes it:

> To ask a person what her intention was in doing a certain thing is to ask her what her aim was in doing it, and what plan guided her action—how she saw the action as promoting her objective. To ask this is in part to ask what her reasons were for acting in such a way—which of the various features of what she realized she was doing were features she took to count in favor of acting in this way. This narrower sense of intention is at least very close to the sense of intention involved in the distinction, central to the doctrine of double effect, between consequences of one's action that are intended (as ends or chosen means) and those that are merely foreseen.[25]

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[23] T. M. Scanlon, *Moral Dimensions: Permissibility, Meaning, Blame* (Cambridge, MA: Harvard University Press, 2008) 10.

[24] Ibid., 11.

[25] Ibid., 10-11.

This brings us to the second question raised above which is: "How are intentions relevant in moral assessment of an action or event?" Scanlon appeals to another distinction in unpacking the notion of intention for moral evaluation by differentiating moral permissibility and the moral meaning of an action. The permissibility of an action does in a sense depend upon the intentions of the agent. Yet Scanlon thinks that the "way in which intent can be relevant to the permissibility of an action is in an important sense derivative."[26]

Permissibility is primarily derived from the action's *meaning,* which he understands to be "the significance, for the agent and others, of the agent's willingness to perform that action for the reasons he or she does."[27] Scanlon explains how he sees moral permissibility and moral meaning relating to each other in the following way:

> If it is impermissible for me to treat you in a certain way, then my treating you in that way has a certain meaning: it indicates a failure on my part to give proper weight to those considerations that make such treatment impermissible. But the meaning of an action can vary independently of its permissibility. Injuring you intentionally and negligently inflicting the same injury are both impermissible but have different meanings: the former reflects outright hostility to your interests, the latter only a lack of sufficient care.[28]

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[26] Ibid., 12-13.

[27] Ibid., 4.

[28] Ibid., 55.

As noted, Scanlon thinks that the narrow sense of intent is primarily about an agent's reasons for acting. And so, while moral permissibility may not *always* be tied directly to an agent's intent (as is the case with most formulations of double effect), the moral meaning clearly is. In those situations where it appears that moral permissibility or impermissibility depends on the intent of the agent (or an agent's reasons for acting), they are really circumstances where moral permissibility or impermissibility depends on the moral meaning of the action.[29] The forgoingsummarily portrays how Scanlon sees intentions as being relevant for the moral assessment of some action or event.

The plausibility of his points can be captured in our reflections on particular cases even if all of the difficult issues in action theory are not fully resolved. Of course, thought experiments can't do all of the needed philosophical work. But they can prove helpful nonetheless. Take for example a case presented by an ethicist that asks us to consider two scenarios involving two dentists, the compassionate Dr. Fill and the nasty Dr. Drill.

> [D]r. Fill drills out decay in your tooth and fills the cavity, in accordance with good dental practice, even though both you and [D]r. Fill foresee that you will suffer from pain. The following week [D]r. Drill drills out decay in another of your teeth and fills the cavity. But whereas [D]r. Fill merely foresaw that you would inevitably suffer pain, [D]r. Drill intends you to suffer pain. Clearly, whereas [D]r. Fill has done nothing morally questionable, [D]r. Drill has. And the reason is solely to be found in [D]r. Drill's intending the bad consequence rather than simply foreseeing it as

[29] Ibid.

> an inevitable side-effect of the good consequence, namely repairing your tooth. This is irrespective of the fact that the bad consequence, the pain, is precisely the same in both cases.[30]

Regardless of identical outcomes, most would judge the *scenarios* as being morally dissimilar in that the *meaning* of the moral events are not ethically on par. It takes more than equivalent outcomes to have moral equivalence.[31] It seems clear that the difference in the intentional states of mind or the internal dispositions toward their respective patients and the reasons why Dr. Fill and Dr. Drill acted in said cases conditions the moral meaning of their actions. And this is significant for evaluating the nature of the moral events in question.

There is a challenge that this line of thinking must face: if one says that Dr. Drill's action is morally wrong, then what should he have done instead? One could say, Dr. Drill should have done the same *act* (i.e. same movements with his hands using the same dental instruments in the mouth of the patient to drill out the decay) but from a different benign motive. Then one could say that we have a different *action* with a different moral meaning. This is where a distinction that W. D. Ross makes between an "act" and an "action" may be helpful. In addressing the confusion that sometimes emerges in ethics by using the phrase "right action," he writes in response:

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[30] John Keown, *Euthanasia, Ethics and Public Policy: An Argument Against Legislation* (New York: Cambridge University Press, 2002) 18-19.

[31] Fiona Randall and R. S. Downie, *End of Life Choices: Consensus and Controversy* (New York: Oxford University Press, 2010) 166.

> [A]dditional clearness would be gained if we used 'act' of the things done, the initiation of change, and 'action' of the doing it, the initiating of change, from a certain motive. We should then talk of a right act but not of a right action, of a morally good action but not of a morally good act. And it may be added that the doing of a right act may be a morally bad action, and that the doing of a wrong act may be a morally good action; for 'right' and 'wrong' refer entirely to the thing done, 'morally good' and 'morally bad' entirely to the motive from which it is done. A firm grasp of this distinction will do much to remove some of the perplexities of our moral thought.[32]

If Ross's thinking is in some way right-headed, then we could say that Dr. Drill performed the '"right act" but a "morally bad action." So there is reason for people to avoid acting from bad motives and so reason for, say, Dr. Drill to avoid acting from the motives he has. Although his act is not wrong, because it benefits his patient while causing the least suffering possible, he has a *moral reason* to avoid doing what he does from the reason (motive) he acts upon. This could explain why many think that defenders of the Rule of Double Effect are mistaken about what makes *acts* right or wrong but correct in saying that the nature of the person's motives bears on what *moral reasons* there are, or are not, for acting in certain ways from certain motives. This Rossian distinction gains further traction, it seems, when one recalls the components of a moral event as stipulated in Chapter 2. A moral event contains at least five elements, namely,

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[32] W. D. Ross, *The Right and the Good*, edited by Philip Stratton-Lake (New York: Oxford University Press, 2002) 7. (originally published in 1930) Stratton-Lake highlights in the editor's notes on this section that Ross shifted in his *Foundations of Ethics* where he later thought that in reference to "the thing done" that "what we should do is not certain acts, but 'set ourselves' to do certain acts." (Ibid. 175)

the agent, the act, the circumstances, the consequences, and the agent's intentions for acting.[33] Therefore, any moral event or action is morally complex.

The thought experiment provided above does make appeal to the intended/foreseen distinction. While not all medical ethicists or clinicians accept this, nevertheless, many professional organizations do think that the intention/foreseen distinction is important given the nature and practice of medicine. As one medical ethicist and physician noted, "the distinction between the intended and the foreseen is of critical importance to any account of the practice of medicine."[34] One does not need to be an advocate of double effect reasoning to accept these claims on the role of intention and its various distinctions identified by Scanlon. In fact, the point that I am trying to make in this section just is that Scanlon is "intentionally," on the *narrow* sense of the term, developing an account that identifies the relevance of intention for moral assessment differently than proponents of double effect reasoning do. And further Scanlon's distinction can be used to differentiate the morality of the act from that of the action (in Ross's terminology), or equivalently, the morality of the act from the moral assessment of the motive and the agent, which both are part of the action. In contrast, the defenders of the Rule of Double Effect try

[33] See page 31 in Chapter 2, "The Nature of Physician-Assisted Death in a Health Care Context."

[34] Daniel P. Sulmasy, "'Reinventing' the Rule of Double Effect" *Oxford Companion to Bioethics*, edited by Bonnie Steinbock (New York: Oxford University Press, 2007) 137.

to use the distinction to distinguish the morality of different acts, that is, the moral permissibility or impermissibility of those acts.

So what does the preceding discussion mean for the topic under consideration? I want to say that the intentions of the agent in performing proportionate palliative sedation, when it is in keeping with the discrete purposes of the practice, has a different moral meaning than that of PAD. This is especially so, though not exclusively, for those medical professionals who generally are opposed to PAD. It does not violate the general prohibition of intentionally participating in causing the death of the patient. If physicians were to accede to the moral permissibility of PAD, it would "amount to a change in the meaning of their medical practice. It would alter the relations that exist between them and their patients. And the relationship that physicians have with their patients is a matter of obvious moral importance to them."[35]

But what if proportionate palliative sedation to address unmanageable pain was foreseen though not intended, narrowly speaking, to cause the death of a patient in some way? In these cases there is, of course, moral responsibility incurred, but the agent may not thereby be morally culpable, that is, if it was done within the parameters described above. This point is not justified necessarily by appeal to double effect reasoning. Instead, it is substantiated by

[35] Lynn A. Jansen, "Disambiguating Clinical Intentions: The Ethics of Palliative Sedation," *Journal of Medicine and Philosophy*, 35 (2010): 29.

making use of another important ethical consideration in the practice of medicine, namely the notion of proportionality. Consider the formulation by Dan Brock, who is not a proponent of double-effect reasoning, when he writes:

> Physicians have moral and professional obligations to promote their patients' best interests or well-being and to avoid causing unnecessary harm. The concept of proportionality requires that risk of causing harm must bear a direct relationship to the danger and immediacy of the patient's clinical situation and the expected benefit of the intervention. The greater the patient's suffering, the greater risk the physician can take of potentially contributing to the patient's death, as long as the patient understands and accepts that risk.[36]

He goes on to say, "Although proportionality is an important element of the doctrine of double effect, it can be applied independently of this doctrine. All plausible moral theories accept that, other things being equal, the benefits from our actions should where possible exceed their harms."[37] It would appear that Brock would need to go a bit further. Bruce Russell rightly points out that Brock should be prepared to say, "the *expected* benefits should exceed the *expected* harms. Proportionality requires taking into account probabilities as well as the value/disvalue of possible outcomes."[38] And one would presume from an advocate of proportionality that the agent *narrowly* intends the benefits and not what is perceived to be the harms. Accordingly, if the agent were able

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[36] Dan Brock, "Physician-Assisted Suicide as a Last-Resort Option," *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice*, edited by Timothy E. Quill and Margaret P. Battin (Baltimore, MD: The John Hopkins University Press, 2004) 140.

[37] Ibid.

[38] Bruce Russell in private correspondence.

to bring about the benefits without harm, he or she would do so. This does not appear at all to be unreasonable and generally speaking, seems right-headed.

Of course, the language of intended/foreseen does not emerge in Brock's explanation of proportionality but one can see the affinities that lie between the account given by him above and the broad and narrow senses of intention. The goal of medical professionals is to act in a manner in which the patient's well being is accomplished. To be sure, moral and legal limits exist that determine exactly how this can and should be done. Regardless, even within what is deemed morally permissible parameters, there still remain numerous challenges in attempting to accomplish the goal of end-of-life palliative care.

Situations arise in the context of end-of-life health care such that an action or course of conduct, say, may have some associated risks with them that are not ideal. (It must be kept in mind that the very context in which these practices are being considered is not ideal and the dying process can be quite muddled.) Yet these potential burdens associated with extraordinary palliative care may be outweighed by perceived corresponding benefits. It appears that various philosophical accounts seek to capture the basic intuitive notion that intentions do matter in *some* way in order to determine, at the very least, the moral meaning of *actions* or *events* if not the acts themselves.

Of course, many of the dialogue partners in the discussions surrounding the ethics of various palliative care options reject the intention/foreseen

distinction associated with double effect reasoning. Even so, it would seem that most would be hard pressed to deny the role that intention plays in the moral meaning of human actions and the evaluation of states of affairs brought about by them. And so for many medical professionals the *purpose of proportionate palliative sedation* and its corresponding *success criterion* should be viewed as distinctions that make important moral differences in accepting proportionate palliative sedation while rejecting PAD for the reasons outlined in Chapter 3.

Practical Problems of *Internal* and *External* Discernment of Intentions

Apart from the difficult philosophical analysis of intentions as mentioned above there remain other issues. I will call these the practical problems of *internal* and *external* discernment of intentions. The first, *the practical problem of internal discernment of intentions*, is the difficulty of health care professionals discerning their own clinical intentions. Well-known advocate of physician-assisted death, Dr. Timothy Quill, has forcefully made this point. In an article in the *New England Journal of Medicine* titled "The Ambiguity of Clinical Intentions," he writes:

> Medical ethicists place great weight on the intentions of clinical actions….Giving high doses of narcotic analgesics to a dying patient to relieve pain and suffering is considered ethical even if it inadvertently hastens death, provided the clinician did not intend to help the patient die. Death may even be foreseen as a side effect of the intervention as long as it is not intended. On the other hand, should a clinician even remotely intend to help a patient die, even when death is desired by a

> terminally ill patient with irreversible suffering, that same act would be considered unethical—a form of medical killing.
>
> From this idealized ethical perspective, intentions are clear and distinct. My training about intentions, however, comes from clinical medicine and psychodynamic psychiatry. When probing intention in these domains, one rapidly learns they may be complex, ambiguous, and often contradictory. Ethical discourse about intentions often appears idealized and superficial, reminiscent of early sessions in psychotherapy before intimacy is developed. Once trust is established, an exploration of true intentions often reflects the multilayered complexity of human life. If we explore the gap between idealized ethics and actual experience, we may uncover some of the complex reasons why many clinicians continue to undertreat pain and suffering even when they know a patient is dying.[39]

Any of us who have been in contexts where difficult end-of-life decisions have had to be made can certainly affirm many of the points expressed by Quill.[40] There just are many scenarios where our intentions for acting are clear even in light of the complexities often faced at the end of life in a health care context. Be this as it may, it is also just as obvious that applied ethics in this area can be extremely complicated when dealing with so many converging factors.

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[39] Timothy E. Quill, "The Ambiguity of Clinical Intentions," *New England Journal of Medicine*, Volume 329, Number 14, September 30, 1993, p. 1039.

[40] To address an important point Quill raises here even though not germane for the development of this section, I don't think hospice and other palliative care professionals should ever undertreat *pain*, that is, unless the patient explicitly requests the contrary. When all else fails, palliative care professionals can and should employ *proportionate* palliative sedation when clinically indicated in as an aggressive manner as needed in order to attain the goal of relief of the suffering caused by intractable pain or other physiological induced refractory symptoms. This seems to many medical ethicists and health care professionals an ethical and professional obligation.

These waters often times are difficult to navigate, and so, for the most part, Quill's points are well taken even if some of them are a bit overstated.

Nevertheless, the emphasis on the importance of clinical intentions for judging moral events in a health care context is not to say that there will be no difficulties or ambiguities. The vexing existential issues involved in caring for dying patients creates tensions that we would all prefer to be without. But this neither absolves us from the responsibility of trying to discern intentions, nor does it somehow discount the fact that they remain a necessary, though not a sufficient, condition for assessing a moral event.

So the question now is "Can intentions be disambiguated?" I think it is *conceptually plausible* to think that this can be done. This does not appear to be just a decent theory, but is also *practically possible* since many medical professionals have done it. How so? There are mental steps that a clinician can go through in order to discern better her intentions.

This process of self-examination commences with an awareness of the broad and narrow senses of intentions and how they apply to these kinds of decisions. This is an important first step. Take a situation in which death is thought to be the result of a clinician performing some medical procedure. The confusion or ambiguity that some medical professionals may have regarding their true intentions could be a "function of the fact that the word 'intention'

can be used to refer to either of these two senses of the concept."[41] Consider the confusion that could result, for example, if a medical professional is asked, "What were your intentions for proceeding as you did?" If the physician has the wider sense of intention in mind, then she may be baffled about exactly what she was trying to accomplish. She was aware of the various consequences that could be potential outcomes from her actions. The two senses of 'intention' need to be clear and distinct in the minds of medical professionals engaging in extraordinary palliative care.

At the next step in this process of self-examination, the clinician "could ask herself whether she intends, on the narrow sense of intention, to kill her patient. In asking this question, she would, in effect, be asking whether the death of the patient was part of her plan in acting."[42] In order to better come to terms with one's intentions, further questions may be asked at this point. These questions are counter-factual ones designed to help her understand exactly what she is committing to when embarking on a particular course of conduct. "For example, she could ask whether bringing about the death of the patient was itself something that guides her action in the sense that she would be prepared to adjust her conduct if it became apparent that it would not bring about this

[41] Lynn A. Jansen, "Disambiguating Clinical Intentions: The Ethics of Palliative Sedation," *Journal of Medicine and Philosophy*, 35 (2010): 24.

[42] Ibid., 26.

event."[43] Or another way this may be put is to ask oneself, would I think that the medical procedure that I have embarked upon was *unsuccessful* if it did not bring about death *but did relieve suffering*?

If the answer to either of these questions is "yes," then she could conclude that the death of the patient was intended, narrowly speaking, by her actions. If the clinician can *honestly* answer the questions with a "no," then one could affirm that the death of the patient was not the aim. This is true, even if, death may be foreseen given the complex nature of aggressive end of life palliative care. What if the answer to the counter-factual questions, genuinely, is "I don't know"? In this situation, if medical professionals are still unsure after engaging in this kind of proposed self-examination, there still remain other courses of action.

This is where I think a properly functioning ethics committee in a health care context can be of tremendous benefit in working through these issues, including aiding health care professionals in discerning their own intentions for acting. The importance of this function of an ethics committee should not be minimized given that for many medical professionals this is a matter of moral and professional integrity. "There is in intent," on the account developed in this work, "a kind of union between the agent and the act which links the agent to

[43] Ibid.

the moral quality of the act."[44] If there is some question surrounding the moral quality of some acts, say, instances of PAD, then these clinicians may want to distance themselves from PAD if they take them to be morally questionable acts in the first place.

These kinds of committees ideally should not be set up to be judge and jury whose primary responsibility is to second-guess the decisions and actions, and perhaps even the feelings, of clinicians. Instead, an interdisciplinary team approach, insofar as it is capable, should help health care professionals with their own concerns while promoting the best interests of patients. This may not be done flawlessly in every instance, but it may be the best we can do in some situations.

The kind of self-examination that is required here is not exceedingly demanding. It does, however, require "posing well-formed questions to one's self and it requires that one thinks clearly [and honestly] about them. There is no reason to think that physicians are incapable of this kind of activity." [45] Furthermore, it is *ethically necessary* to attempt to disambiguate ambiguous intentions as part of one's professional duties when dealing with end of life medical decisions. As Lynn A. Jansen writes: "the physician may have a duty to

[44] Edmund D. Pellegrino, "The Place of Intention in the Moral Assessment of Assisted Suicide and Active Euthanasia," *Intending Death: The Ethics of Assisted Suicide and Euthanasia*, edited by Tom L. Beauchamp (New Jersey: Prentice Hall, 1996) 164.

[45] Jansen, "Disambiguating Clinical Intentions," 26.

clarify her intentions or at least come to a better understanding of them. This seems particularly the case when the issues at stake are of great moral importance, such as the life and death issues that arise in the context of extraordinary palliative medicine."[46]

The second practical problem, *the external discernment of intentions*, deals with knowing exactly what someone else's intentions actually are in some situation. Clinicians not only may be unclear about their own intentions, but also may be dishonest in order to accomplish what they think to be the more ethical action. Those medical professionals who fall into this category sometimes are drawn in this direction if they perceive it to be expedient or if it is thought to circumvent some rules or laws that seem unjust, arbitrary, or overly cumbersome. If so, then some may worry about the usefulness of the appeal to one's intentions given that we cannot know for sure what they may be for any given individual. Can we really know what the true intentions of a person *actually* are? If not, then how can it play such a central role in moral assessment as many ethicists and medical professionals, perhaps naively, claim?

John F. Kavanaugh points out the importance of the intended/foreseen consequences distinction in relation to one's character when he writes, "This distinction is as crucial as it is a test of one's honesty. It is crucial because we consistently choose courses of action that have unintended results. It is a test of

[46] Ibid.

one's honesty because no one but ourselves can examine our intent."[47] His comments point out an important issue. Employing this kind of moral reasoning ought to take into account some aspect of virtue or character development.

Nonetheless, we must tread carefully here. The claim Kavanaugh makes that "no one but ourselves can examine our intent" may not be wholly accurate. We expect jurors to discern the intent behind some actions of defendants in a court of law by examining evidence that suggests a defendant purposefully acted in some way with a particular aim in mind. To be sure, we may never know for *certain*, but perhaps it is not unreasonable to think to some degree we can discern others' intentions.

For our purposes, it *may* not be as difficult on proportionate palliative sedation for persons other than the agent to discern clinical intentions. On the description provided above, if a physician gives too much sedating medications resulting in the *direct* death of the patient, then there are several options or some combination of these that may explain what happened. These include:

i. The clinician is intentionally trying to harm the patient. (a case of murder)

ii. The clinician is intentionally trying to hasten the patient's death because it is judged that he is "better off" dead than suffering as such. (a case of PAD)

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[47] John F. Kavanaugh, S. J., *Who Counts as Persons? Human Identity and the Ethics of Killing*, Washington D.C.: Georgetown University Press, 2001, p. 123.

iii. The clinician is medically incompetent or negligent. (a case of medical malpractice)

iv. The clinician made a mistake (a case of medical error)

It very well may be possible to rule out several of these options given the specific details of a particular case. This can be done by identifying what the standard practices are in keeping with quality care, examining the past practices by a clinician in similar situations, looking back at charts to see if an order was entered incorrectly, and so on and so forth. This does not need to be done in every situation in which something has gone wrong. But primarily in those scenarios where there is some question as to whether or not some action was morally and professionally justified. Again, on the account of proportionate palliative sedation advocated here, it becomes just a little more difficult to abuse this practice. That is, if one carefully titrates up as needed in order to gain the desired effect. Of course, as is the case with this practice or any other, abuse remains possible, but it can be minimized. The degree of responsibility and culpability incurred would be determined by how egregiously or not the medical professional acted outside the clinically indicated standard practice for cases of a similar nature.

It seems to me that what I have called the practical problems of *internal* and *external* discernment of intentions both suffer from a more fundamental issue. It may be confusing the categories of ontology and epistemology. In other

words, it is one discussion to say what something is (ontologically speaking) and another discussion to determine how we know something. We ought not confuse the claim that an agent's intention is a necessary condition for moral assessment, generally speaking, with how we can *discern* it in some particular situation. This would be like questioning the existence of love as part of what counts in having meaningful human relationships because it can be difficult to know whether someone loves you or not in a particular instance.[48]

It seems that Battin's criticisms leveled against terminal sedation as discussed in Chapter 4 of this work do not really touch the account of proportionate palliative sedation argued for here. She seems to have a different view of the purpose of terminal or palliative sedation at work, which is the object of her analyses. The account of terminal sedation that Battin describes distracts us from a less controversial understanding of the practice that is more clearly distinguished from instances of PAD.

Based on her essay, it appears that she takes terminal sedation as an act that medical professionals engage in that in effect actually *terminates* the patient. She further thinks the shift in nomenclature to "palliative" from "terminal" only adds to the confusion. One recalls a key concern for her is that of patient autonomy and consent being respected when she writes:

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[48] Keown, *Euthanasia, Ethics and Public* Policy, 21.

> The new euphemism, "palliative sedation," now often used instead of the more distressing "terminal sedation," only reinforces [the problem of patient consent being misdirected by focusing on avoiding pain and not on causing death which is where it *should* be]. By avoiding the word "terminal" and hence any suggestion that death may be coming, the most important feature of this practice is obscured and terminal sedation is confused with "palliative care."[49]

Her claims here are misconstrued. The linguistic shift is to bring into focus with a greater level of precision the purpose of palliative sedation and under what circumstances it is appropriate. "Contrary to Battin, the use of the term 'palliative sedation' should not be understood as being a 'new euphemism' to take the edge off of a controversial practice nor as an illegitimate attempt to avoid the similarities with physician-assisted death."[50]

Instead, 'palliative' is used to reflect the goal and intent of sedation, which is to provide comfort to patients by alleviating otherwise unmanageable symptoms as opposed to terminating the patient. And 'proportionate' is used to indicate that it is the minimum amount of sedating drugs needed to achieve that goal. These are important features that contribute to a proper understanding of the procedure and its ethical permissibility.

For all intents and purposes this linguistic shift to palliative sedation in general, and proportionate palliative sedation in particular, is similar to the one

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[49] Margaret P. Battin, "Terminal Sedation: *Pulling the Sheet over Our Eyes*," *Hastings Center Report* 38, no. 5 (2008): 28.

[50] Patrick T. Smith and James S. Boal, "Pulling the Sheet Back Down: A Response to Battin on the Practice of Terminal Sedation," *Ethics & Medicine: An International Journal of Bioethics*, Volume 25:2, Summer 2009: 70.

many have advocated to "physician-assisted dying" from what is sometimes understood to be more unfavorable terminology like that of "physician-assisted suicide." The use of 'physician-assisted dying,' it seems, is to indicate that engaging in voluntary active euthanasia and PAS is an exercise of compassion and honoring of patient autonomy. And so one wants to find and use language that circumvents negative connotations that can skew the important ethical discussions that need to take place. Battin is an example of one scholar who prefers this kind of shift. For she states in the editor's introduction of another work on PAS:

> [W]e use the term *physician-assisted dying* because it is descriptively accurate and carries with it no misleading connotations….Although suicide can be considered heroic or rational depending on setting and philosophical orientation, in much American writing it is conflated with mental illness, and the term suggests the tragic self-destruction of a person who is not thinking clearly or acting rationally. Although distortion from depression and other forms of mental illness must always be considered when a patient requests a [PAD], patients who choose this option are not necessarily depressed but rather may be acting out of a need for self-preservation, to avoid being destroyed physically and deprived of meaning existentially by their illness and impending death…[I]n general we use the more neutral term *physician-assisted death* for this reason….[51]

So I do not think that it is inappropriate to stress the notion of "palliative sedation," and, in particular, the account of "proportionate palliative sedation" being developed here, over against "terminal sedation." This will be especially

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[51] Margaret Battin, "False Dichotomy versus Genuine Choice: The Argument over Physician-Assisted Dying," *Physician-Assisted Dying: The Case for Palliative Care and Patient Choice*, edited by Timothy E. Quill and Margaret P. Battin (Baltimore, MD: The Johns Hopkins University Press, 2004) 1-2.

true because a modification like this brings conceptual clarity to the discussion in the same way that Battin's use of "physician-assisted dying" is preferable to "physician-assisted suicide" for reasons of conceptual clarity.

This is not to be seen as taking a philosophical "cheap shot" at Battin. The attempt here is not to discredit Battin's view by a charge of hypocrisy, say. It is instead an attempt to illustrate that the reasoning behind stressing the shift in language is the same in both cases. So I don't think this observation makes me guilty of a *tu quoque* fallacy on this score. I do understand why she resists the shift from terminal sedation to palliative sedation. It is because, as noted in chapter 4, she thinks that the true nature of the intent of palliative sedation is obscured. And so, if language is clouding the issues instead of clarifying it, then such moves should be resisted. Perhaps the practice as she understands and describes it, would be the equivalent of taking a mustard label off of a mustard jar and then putting it on a ketchup bottle and then calling the contents contained therein mustard instead of ketchup. And so she would oppose, and I think rightly, such a blurring. But on the proportionate palliative sedation account developed in this chapter, this is not the case. Proportionate palliative sedation is not as easily identified with euthanasia or as potentially abused as, say, palliative sedation to unconsciousness might be.

Proportionate Palliative Sedation Does Not Hasten Death

The second distinction that makes a morally relevant difference between PAD and proportionate palliative sedation is that when administered assiduously by skilled palliative care professionals, proportionate palliative sedation should not be thought of as the direct cause of death, and there is no evidence to suggest that it actually hastens the death of the patient. The growing consensus of empirical clinical evidence actually points in the other direction.

Ethical controversy often surrounds the use, at times aggressive use, of the kinds of medications for palliation at the end of life. There is widespread "concern that any doses of drugs sufficient to control symptoms of terminal illness inevitably, or at least frequently, hasten the patient's death."[52] Many have simply called it "slow euthanasia."[53] It is thought that there needs to be appeal to double effect reasoning in order to justify the use of palliative sedation therapies at the end of life.

This is not only an assumption held by what might be thought as medically inexperienced lay people or clinically uninformed moral philosophers and ethicists, but also by many physicians. This is the case even for those physicians

[52] Nigel Sykes and Andrew Thorns, "Sedative Use in the Last Week of Life and the Implications for End-of-Life Decision Making," *Archives of Internal Medicine*, Volume 163, February 10, 2003: 343-344.

[53] J. A. Billings and S. D. Block, "Slow Euthanasia," *Journal of Palliative Care*, Winter 12(4), 1996: 21-30.

who want to disavow that palliative sedation therapies in principle are forms of euthanasia. They still sometimes fear that the practice "may hasten death and fall back on the doctrine of double effect to keep the two approaches separate and to justify the use of [palliative sedation therapy]."[54] The assumption that death is hastened by the use of palliative sedation therapies and the subsequent appeal to double effect reasoning in order to justify morally palliative sedation therapy, acts "as a tacit admission that good symptom control is lethal."[55]

But is this line of thinking right-headed? Is it the case that "good symptom control" is in fact lethal such that double effect must be appealed to in order for the practices to be morally justified? In the section above it was argued that double effect reasoning was not essential in order to justify the form palliative sedation therapy described as proportionate palliative sedation. It was also noted above, that even if there is a risk of death being hastened, one could, following Dan Brock, appeal to the notion of proportionality for moral justification of proceeding with palliative sedation therapy in particular circumstances, that is, I want to add, when it is clinically indicated to do so. Further, and more important for this section of the chapter, is the assumption

[54] M. Maltoni., et. al., "Palliative sedation therapy does not hasten death: results from a prospective multicenter study," 1167.

[55] Sykes and Thorns, "Sedative Use in the Last Week of Life and the Implications for End-of-Life Decision Making," 344.

that death is hastened when using palliative sedation therapies, which primarily drives many criticisms and concerns of aggressive palliative care, correct? There is mounting empirical evidence to suggest that it is not.

First let us consider the research study by Sykes and Thorns aimed to determine "how sedative doses change at the end of life and how often the doctrine of double effect might be relevant."[56] Their research yielded that there were only 2 cases out of 237 "where the doctrine of double effect *may* [emphasis added] have been implicated." In the two cases they cited, it was not entirely clear that double effect necessarily needed to be appealed to at all.[57] The overall conclusion of their data is that "Sedative dose increases in the last hours of life were not associated with shortened survival overall, suggesting

[56] Sykes and Thorns, "Sedative Use in the Last Week of Life and the Implications for End-of-Life Decision Making," 341.

[57] After describing the two cases in some detail where double effect may have been invoked, they summarize their discussion of them by writing: "because of the severity of the patient's delirium, the rate of increase of sedative dose was high enough to raise concern that life might have been shortened, and in one of these cases the attending physician clearly foresaw the risk. One of the patients had a history of mental illness, and in both of them their agitation had the severity described… [as]…'terminal agitation.' A characteristic of this clinical picture is that the patient usually dies within 24-72 hours. How much this outcome is shaped by the use of sedation is impracticable to investigate, as the severity of distress and the risk of harm to self and others do not permit an ethical option of refraining from sedative use." (Ibid., 344) It seems that it would be just as legitimate to appeal to the notion of proportionality to justify the potential risk given the patients' conditions.

that the doctrine of double effect rarely has to be invoked to excuse sedative prescribing in end-stage care."[58]

It is also important to point out that their findings are in keeping with the form of proportionate palliative sedation being advocated in this chapter. To be sure, as is the case with any medication, "it is possible to hasten death by heavy sedation. On the other hand, the aim for the patients studied [in their research] was not unconsciousness but relief of their symptoms, and the doses of medication used were proportionate to that aim."[59] So the aim or the purpose of proportionate palliative sedation is not the death of the patient but the relief of refractory symptoms.

To further buttress this last claim here concerning the significance of the proportionate aspect in "proportionate palliative sedation," consider the words of other researchers in another independent study on the same matter when they write:

> This study clearly shows that, in most of the patients, palliative sedation starts as a mild sedation and evolves over time to a deep and/or continuous form of sedation. This illustrates how important and present the *principle of proportionality* is in the decision-making process. The intensity and nature of the suffering determines which form of sedation, and more specifically, what dosage of sedatives will be administered to the patients. Thus, palliative sedation does not presuppose that a patient is sedated until unconsciousness. Palliative sedation means that sedative drugs are

[58] Ibid., 341.

[59] Ibid., 344.

> administered in dosages and combinations required to reduce consciousness as much as necessary to adequately relieve one or more refractory symptoms. This notion of proportionality is crucial in distinguishing palliative sedation from euthanasia.[60]

Moreover, the timing of when the sedation is commenced in the dying process is also important on proportionate palliative sedation. In the cases observed by Sykes and Thorns, "Most episodes of sedative use are brief, and there is no evidence that they precipitate death. Rather, they are a response to features of a dying process that has already begun."[61] As mentioned above, many palliative care professionals see it as their ethical obligation to be as aggressive as needed to treat otherwise unmanageable pain in patients at the end of life. What Sykes and Thorns have established in their study is that "For those who need such treatment, it is entirely possible to provide ongoing sedation at a level that is both therapeutically effective and safe."[62]

The findings of Sykes and Thorns should not be thought to be an isolated outcome. Many other independent studies have come to the same conclusions. Another example is one that focuses on those who are terminally ill due to

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[60] Patricia Claessens, et. al., "Palliative Sedation, Not Slow Euthanasia: A Prospective, Longitudinal Study of Sedation in Flemish Palliative Care Units," *Journal of Pain and Symptom Management*, Volume 41, No. 1, (January 2011): 21. The way "proportionality" is used in this quote is in relation to *proportionate* palliative sedation. It is not referring the notion of proportionality that Brock and I advocate with respect to weighing the risks with corresponding benefits of some action or other.

[61] Sykes and Thorns, "Sedative Use in the Last Week of Life and the Implications for End-of-Life Decision Making," 344.

[62] Ibid.

cancer. This particular patient population is where both hospice and palliative care historically have been prevalent and have developed as a specialty. Palliative sedation therapy is often "indicated for and used to control refractory symptoms in cancer patients undergoing palliative care."[63]

The study by Maltoni, et. al. sought to evaluate whether palliative sedation therapy had a detrimental effect on survival of terminally ill cancer patients. A unique feature of their research, is that it is, perhaps, the "first study to prospectively match sedated patients (cohort A) with nonsedated patients (cohort B) in such a way that the two arms differ only in terms of one characteristic, i.e. sedation."[64] This approach by Maltoni, et. al. is in contrast to the retrospective designed studies of Sykes and Thorns and others. Their overall conclusion is consistent with other research programs. It was found that palliative sedation therapy, especially what is being described as proportionate palliative sedation, "does not shorten life when used to relieve refractory symptoms and does not need the doctrine of double effect to justify its use from an ethical point of view."[65]

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[63] M. Maltoni, et. al., "Palliative sedation therapy does not hasten death: results from a prospective multicenter study," *Annals of Oncology* 20, 2009: 1163.

[64] Ibid., 1164.

[65] Ibid., 1163.

These points are reinforced yet again and some new ones made in a recent edition of the *Journal of Pain and Symptom Management*. An article recorded the findings of a research study that aimed "to assess the need and effectiveness of sedation in dying patients with intractable symptoms, and the thoughts of relatives regarding sedation."[66] It was found that:

> Although the principle of double effect provides moral reassurance, its ambiguity may induce the suspicion that death is hastened and that may act as a deterrent to the provision of good symptom control. Opposing this concern, the majority of studies of interventions with potent drugs, including high dosage opioids and sedatives to treat suffering in the last days of life, did not demonstrate that the treatment hastened death, if carefully administered by skilled professionals. The relatively short period of time between start of sedation and death is consistently reported in the range of 24-72 hours, indicating that the need for sedation is an indicator of impending death rather than a cause of premature death. The results of the present study are consistent with this observation. Median sedation-death time was about one day, with only one patient sedated for more than four days. Patients who were sedated had a longer survival when compared with patients who were not sedated. Moreover, most patients had already stopped eating, were unable to swallow or cough, and had severe fatigue. In these conditions, sedation cannot be said to hasten death through dehydration and starvation.[67]

These conclusions appear to diverge in a significant way from the kinds of claims Battin makes with respect to palliative or terminal sedation. She thinks that "Patients who are sedated to the degree involved in terminal sedation cannot eat or drink, and without 'artificial' nutrition and hydration will necessarily

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[66] Mercadante, et. al., "Controlled Sedation for Refractory Symptoms in Dying Patients" *Journal of Pain and Symptom Management*, May 2009, p. 771.

[67] Ibid., 775.

die, virtually always before they would have died otherwise."[68] Based on what has been claimed up to this point about the timing of proportionate palliative sedation and why artificial nutrition and hydration often are withheld (though not always), I am not sure if she takes as a genuine option that the patient is more likely to die of the underlying disease before getting to the point of dehydration.

However, to be charitable to Battin's claim, perhaps what she has in mind concerning palliative sedation is something different. Perhaps she is envisioning as a common practice a medical procedure where patients are sedated until they are comatose before the active or transitional phases of dying. They are then maintained in this condition until they die, "in order to relieve them of the experience of conditions found to be unacceptable, at the same time…ensuring that they are deprived of food and fluids *in order to hasten their deaths*."[69] If so, then this is problematic. It is quite reasonable that some involved in palliative care have not performed this procedure properly. I do acknowledge, along with others, that "The use of sedation for relief of symptoms is…open to abuse and it cannot be denied that some physicians ostensibly administer medication to relieve symptoms, but with a covert intention of

[68] Battin, "Terminal Sedation: Pulling the Sheet over Our Eyes," 28.

[69] Luke Gormally, "Terminal Sedation and the Doctrine of the Sanctity of Life," 81.

hastening the patient's death."[70] It must be acknowledged that any medical procedure, that otherwise is unproblematic from an ethical perspective, can be subject to abuse and misuse.

Based on why PAD is considered morally problematic in this work, the role of intention in determining moral meaning, and the criteria as to the timing of proportionate palliative sedation, the potential state of affairs described in the previous paragraph very well may be considered an instance of PAD. To be sure, there are cases where things are not so straightforward when it comes to medical practices that are often referred to as terminal/palliative sedation. And so I am in full agreement with Battin that in these situations, there very well may not be any ethically relevant distinguishing features between the moral meanings of these two states of affairs. This is especially so for those who reject PAD. But the account of proportionate palliative sedation developed and advocated in this chapter is very different and does seem to resist easy identification with instances of PAD and its corresponding wrong-making properties as claimed by PAD's opponents.

All of the empirical conclusions presented in this section suggest that the data points to the fact that properly administered proportionate palliative sedation does not result in a hastened death. If death is not hastened by these

[70] Maltoni, et. al., "Palliative sedation therapy does not hasten death: results from a prospective multicenter study," 1164. See my comments on this in the section on the "Practical Problems of Internal and External Discernment of Intentions" on pages 208-220 of this chapter.

practices, then the base assumption that grounds many of the other criticisms leveled by Battin and Brock in chapter 4 is undermined. It also redirects the kind of indefensible "Wedge Argument" that Tännsjö seeks to develop since he, too, embraces this fundamental assumption. But again, if death is not hastened by proportionate palliative sedation, there is no need to appeal to double effect reasoning. Further, in appropriate circumstances patients do not die from dehydration or starvation as a result of proportionate palliative sedation. Thus, the withholding of life-sustaining treatment along with proportionate palliative sedation should not be understood to constitute a "lethal mix."

Summary Conclusion

If medical professionals practice proportionate palliative sedation appropriately, it does not violate the moral principles that were said to undergird the arguments given against the moral permissibility of PAD in a health care context. One recalls that there are two basic arguments given in Chapter 3. The first is the *Argument from the Prohibition of Killing Innocents* and second, the *Argument from the Integrity of the Medical Profession*.

The former argument had as its moral principles:

MP_2: It is morally wrong intentionally to kill innocent human beings.

MP_3: It is morally wrong intentionally to kill innocent human beings without sufficient moral justification.

The corresponding wrong-making properties of the *morally complex* actions of killing innocents are: first, it disregards the inviolability of life and stifles genuine human flourishing of human communities, which nurture the inalienable right to life. And moreover, in most cases, it is thought to harm human beings and the status of our collective life together.

The *Argument from the Integrity of the Medical Profession* has as its professional moral principle:

> PMP: It is always wrong in a health care context for a health care provider to intentionally cause, or bring about, the death of another person.

The wrong-making property with respect to the *Argument from the Integrity of the Medical Profession*, rightly or wrongly, is said to be that PAD violates an ethical obligation inherent to the medical profession and professionals to care for patients and not participate in killing them intentionally.

Both of the distinguishing factors between PAD and proportionate palliative sedation as specified above do not, as such, violate MP_2, MP_3, or PMP. First it is to be observed that proportionate palliative sedation does not have as its aim the death of the patient. And second, it is not an act of killing. Further, when it is done appropriately, it does not introduce a lethal agent into the professional-patient relationship. So for those who think PAD is morally impermissible on the bases outlined in Chapter 3, they can affirm consistently that proportionate palliative sedation is not subject to the same criticisms.

Hence, the two practices are rendered as morally distinct in the purview of those who are opposed to PAD. If so, then medical professionals are not being inconsistent if they embrace proportionate palliative sedation while rejecting PAD.

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ABSTRACT

A DISTINCTION WITHOUT A *MORAL* DIFFERENCE? AN ESSAY ON THE DIFFERENCE BETWEEN PALLIATIVE SEDATION AND PHYSICIAN-ASSISTED DEATH

by

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Professionals engaged in palliative care have a responsibility to treat their patients by aggressively managing pain and certain kinds of suffering within legal and professional ethical boundaries. Many medical professionals and ethicists, rightly or wrongly, have considered the practices of euthanasia and physician-assisted suicide, which can be categorized as instances of physician-assisted death (PAD), to be beyond the scope of ethically appropriate health care. Many of these same individuals who oppose PAD, and the professional organizations they sometimes represent, often embrace, at the same time, the practice of palliative/terminal sedation at the end of life. Palliative sedation is thought to be an advance in palliative care that has alleviated the need for PAD when managing otherwise intractable pain in dying patients. However,

there is some question as to whether this procedure is sufficiently distinct, ethically speaking, from instances of various forms of PAD and that it actually constitutes a compromise. It may be argued that if there is no legitimate moral distinction between the two sets of practices, then instances of PAD should be legal and morally legitimate end-of-life treatment options for patients along with palliative sedation. If this view is correct, then those who support the use of sedation in end-of-life palliative care should have no problem with the practice of PAD. If they were to think or act otherwise would be ethically and professionally inconsistent.

The primary question of this dissertation is to determine whether or not medical professionals and others invested in this area are ethically consistent if they reject PAD while embracing the practice of palliative/terminal sedation. So this project is to be considered a work in applied analytic bioethics. I argue that there are both conceptual and empirical reasons for maintaining that there are morally relevant differences between PAD and palliative/terminal sedation for those who have some reasons to think the former is ethically problematic. Therefore, those who are morally and professionally opposed to PAD for *certain* reasons are not *necessarily* being inconsistent in their support of palliative/terminal sedation as a legitimate treatment at the end-of-life when the latter is carefully defined, understood, and practiced.

AUTOBIOGRAPHICAL STATEMENT

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Patrick is on the faculty of Gordon-Conwell Theological Seminary in South Hamilton, MA just outside of Boston. He has specific interests in the areas of ethical theory, religious epistemology, analytic philosophical theology, end-of-life medical ethics and hospice palliative care. He received an academic appointment as a Research Fellow in Medical Ethics through the Department of Global Health and Social Medicine at the Harvard Medical School for the academic year 2013-2014. His formal education includes a Bachelor of Science in Business Administration from Auburn University (AL), a Master of Divinity from Trinity International University (IL), and a Master of Arts degree in philosophy from Wayne State University.

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