Killing vs. Letting Die
A Moral Distinction Before the Courts

By JAMES F. BRESNAHAN

Fundamental to our Roman Catholic moral theological tradition is a distinction we make in the practice of medical care of the dying. Many others who are neither Catholic, Christian nor religious also make it. We distinguish between killing and letting die. We consider it morally permitted—even, under certain circumstances, morally required—that at a patient’s request we let the person die of lethal disease processes by foregoing cure-oriented treatments while continuing to provide relief of suffering in ways needed and wanted by the dying patient (see “The Catholic Art of Dying,” Am., 11/4/95). But we consider it morally forbidden to initiate deliberately a new lethal process consciously intended to precipitate death, whether this is done by patients themselves with help from a physician or by a physician at the request of a patient.

A living witness to the full meaning of these moral convictions about this Catholic art of dying was the last gift to us of “our brother Joseph,” Cardinal Bernardin of Chicago.

The Practical Uses of This Distinction.
Using this traditional Catholic moral distinction, over the last 20 years we have been increasingly able to resist “medical vitalism”—a war against death that too often prolongs the suffering of the dying person. Instead we have promoted the practice of good palliative medicine in the care of the dying, especially by the hospice movement, with its basic commitment “neither to hasten nor to delay death.” Our distinction was accepted as morally meaningful in shaping good care of the dying by the President’s Commission for the Study of Ethical Problems in Medicine, in its March 1983 report, Deciding to Forego Life-Sustaining Treatment. The distinction

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subsequently gained wide, though not universal, acceptance among physicians and other health care practitioners in the United States as they faced frequent moral dilemmas in the care of the dying brought on by the two-edged sword of high technology medicine.

Stopping cure-oriented treatment when its use becomes excessive and substituting appropriate palliative medicine and intensive personal support—these have gradually become accepted in the medical community as appropriate means of caring for the dying. Crucial to that acceptance, however, has been the understanding that, morally speaking, this approach does not involve killing. Rather, this way of caring for the dying accepts death as an unavoidable challenge to the dying and their caregivers to come to terms with suffering and grief.

Indeed, this is a moral distinction that seems to remain persuasive even to many of the physicians who now advocate decriminalization of physician-assisted suicide for the terminally ill. The distinction remains morally meaningful, that is, for those who strictly limit such proposals by explicitly expressing moral disapproval of direct killing by doctors themselves—physician-effected euthanasia. This is true as well for those advocates who insist (as very many do) that a physician’s assistance in the suicide of dying patients should be and will be rarely used, that it is a desperate measure justified only in exceptional cases where every effort has first been made to care adequately for the dying person by other means. Finally, this is a moral distinction that was not explicitly denied moral and legal validity by the 1994 Oregon ballot initiative that authorized, under certain constraining controls, physician assisted suicide of competent dying patients who request it.

The majority opinions in two recent and widely discussed decisions by Federal courts of appeal, however, have explicitly rejected this distinction. They deny not only the legal (constitutional) validity but even the moral meaningfulness of our ethical distinction between letting die and inflicting death.

The Ninth Circuit Court: a Liberty Interest.
In an eight to three decision, the Ninth Federal Circuit Court of Appeals sitting en banc in California affirmed a Federal district court decision declaring unconstitutional a Washington State statute making assistance of suicide a crime (Compassion in Dying v. State of Washington, March 6, 1996). This decision required that a previous contrary two to one decision by a panel of the Ninth Circuit be vacated; the majority opinion of that panel was written by Judge John Noonan and is well worth reading.

In the majority opinion of the “full bench” decision, Judge Stephen Reinhardt argues that, because the 1990 Nancy Cruzan case recognized a “due process liberty interest in terminating unwanted medical treatment,” therefore...
Irish Knit

Row after row ripped back to the mistake.
Afghan. Sweater back. Each row a hundred stitches long. Irish knit, fisherman's knit,

needle in front when it should have been behind.
Counting backwards through horseshoe cable and blackberry stitch: knit, purl, knit—all in one

stitch. Purl the next three together, each knob of fruit, ripped in reverse to stay in the pattern, sweater sleeve, afghan panel. So much easier

to start over, needle pulled out, that tug on the yarn, releasing. No painstaking one stitch at a time, each blackberry

disappearing to re-appear, grief's pace
back through the line of years, what's over my shoulder, coming undone. Never just once

I rip. No promise I'll ever start over, this work, the pattern's promise, never that easy or smooth. Seed stitch. Mock honeycomb.

Left twist and right. No two sweaters ever alike, each Irish knit singular
as grief. Down through the ages the women

of Ireland called to shore to claim a sweater, the faceless drowned. Those women. Knitting, all they have to go back to. All I have:

Iulling row upon row, oil in the wool, mohair wisp, warmth in my lap. What to call it, this work I do? So much undoing.

MOIRA LINEHAN OUNJIAN

"we conclude that Cruzan, by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, necessarily recognizes a liberty interest in hastening one's own death." He argues further that helping a patient hasten death by using a doctor's prescription of a lethal substance must be interpreted as simply extending the already accepted practice of stopping what he calls "life-sustaining" treatment. If dying patients request this "emergent right to receive medical assistance in hastening one's death," he says, they exercise a liberty interest protected by due process of law and guaranteed by the 14th Amendment of the U.S. Constitution. Since a state can have no reasonable interest in denying a dying patient the exercise of this right, to threaten criminal penalty against a doctor responding to this patient's request for help is judged a denial of constitutionally protected due process.

The Second Circuit Court: Equal Protection.

A month later a unanimous decision of a panel of the Second Federal Circuit Court of Appeals in New York overturned a contrary finding of a Federal district court and declared unconstitutional a New York State statute making assistance of suicide a crime (Quill v. Vacco, April 2, 1996). The leading opinion by Judge Miner argues that since New York recognizes the right of a dying patient to refuse life-prolonging treatments (again, so-called!), therefore it has "placed its imprimatur upon the right of competent citizens to hasten death by refusing medical treatment and by directing physicians to remove life-support systems already in place." The judge concludes that New York "does not treat similarly circumstanced persons alike: Those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs." So Judge Miner judges such a denial of equal protection of the law to be constitutionally forbidden by the 14th Amendment.
End of the Distinction.

In the view of both of these courts, then, one is “hastening death” whether one ceases to interfere with a dying process by medical interventions that merely prolong the dying or initiates a new lethal process using a medical prescription. In either case, these courts say, one simply hastens death. From a superficial, empiricist view of the matter, of course, death does follow a medical action in either case. But these courts are asserting that, whatever differences one may notice in the causal relationship of the act to the death, as long as doctors act “medically” no moral stigma and no legal penalty should attach. For them, a physician’s aid in self-inflicted death is merely an “emerging” development of an already socially and legally accepted treatment of the dying by hastening death.

These judicial opinions envision, therefore, inflicted death as just another optional medical therapy—if wanted by a competent dying patient. Aiding the suicide of the dying (at least if done by physicians) is not correctly described as killing. If it were, one would have to justify it—by a claim, for instance, of the pressure of extraordinary circumstances—in the way we customarily justify killing when self-defense is proven. (In all fairness, it must be noted that Judge Calabresi, concurring only in the result of the New York decision, expresses a reservation about the scope of the decision. He insists that the State Legislature might be able to justify re-enacting the very same statute now found to be unconstitutional if they presented persuasive reasons for doing so. He does not suggest what these reasons might be.) So these opinions make a physician’s knowing act of assisting suicide at the request of a dying patient just another “standard treatment option”—though perhaps one whose use is to be specially limited by regulations designed to prevent abuse.

Rejection of Clinical Medical Experience.

Justice Oliver Wendell Holmes stated in his classic, The Common Law, “The life of the law is not logic but experience.” The legal reasoning of these appellate judges ignores the medical experience and the moral reasoning based upon that experience of the many physicians who maintain the validity of the distinction between killing and letting die. It ignores as well the medical experience of many physicians who have advocated “physician aid in dying”—many of whom argue that if good care of the dying (especially hospice-style care) is being provided, requests for aid in suicide will be very rare.

Some of these physicians (Sherwin Nuland, for instance, a surgeon and the author of the valuable book How We Die) explicitly concede that aiding a dying patient to commit sui-
cide should be honestly acknowledged to involve participation in killing. But, they argue, it is killing that can be morally justified by what they view as rarely encountered, truly desperate circumstances. Nonetheless, many of these physicians also insist that while doctors should be allowed to provide the means of suicide to a dying patient who requests them, they should not actually administer the lethal agent themselves.

In sharp contrast to these various expressions of medical experience in care of the dying, the opinions of the two circuit courts of appeal find no rational validity at all, neither in law nor in morality, for the distinction between killing and letting die. Doctors who assist suicide at the request of a patient are simply recognizing the patient's right to hasten death as the patient sees fit.

It is true that these judges do not deny that a claim of conscience based on this moral distinction will excuse "conscientious objectors" from helping the suicidal dying to inflict death on themselves. We can assume, I think, that they would admit a claim of conscience by religious believers who continue to hold this distinction between killing and letting die. By analogy with conscientious objection to war, this claim would be valid for anyone who for philosophic reasons of "ultimate concern" refuses to kill directly. But since these two appellate court opinions deny that hastening death is really killing, this religious or quasi-religious claim of conscientious objection would be allowed only as an irrational preoccupation that must be tolerated because our Constitution's First Amendment guarantees religious freedom.

Thus, from the perspective of Catholic moral theology and of others who agree with it, these Federal judges give short shrift to widely shared moral experience that there really exists a profoundly felt difference between not persisting in futile, death-prolonging medical treatment against the will of a patient, as contrasted with doing an act that precipitates death. These caregivers experience something many in our society do not experience, or even deny: that the nearer death approaches, even the most sophisticated cure-oriented treatments commonly inflict more harm than benefit. Caregivers know that all medical treatments, however wonderfully life-saving for some patients, must eventually be stopped when they bring the dying patient nothing but intensified and prolonged suffering. A patient rightly considers such treatment useless and harmful because dying is now inevitable. The patient expects to receive and the doctor is obliged to provide intensified palliative medicine. By characterizing such decisions as aimed at hastening death, these two court opinions ignore the moral ingredient in the professional moral experience of letting die.
The World of Medicine Turned Upside-Down.

To characterize the refusal of so-called life-prolonging treatments as merely a hastening of death is, in my opinion, disingenuous at best. This conflation has been shaped by legal abstractions manipulated to justify the moral and legal conclusions favored by the judges. As a moral description it distorts rather than accurately reflects the widely shared clinical medical experience of those who try to care well for the dying in our high technology medical care system. As the basis for moral argument, such a description distorts the experienced meaning of foregoing excessively burdensome, therefore harmful and hence unwanted treatments.

No mention is made of palliative medicine and hospice care of the dying. Practitioners of such care testify that they can now control all kinds of pain. They testify further that intensive personal response to psychological and spiritual suffering of the dying prevents requests for help with suicide. Indeed, it makes the dying experience precious for the patient, family, friends and caregivers. This experience is apparently irrelevant for these judges.

In neither of these decisions do the judges exhibit any awareness of the history of how difficult many caregivers have found it to renounce their unremitting war against death and to accept the moral appropriateness of not beginning and, even more, of stopping so-called life-sustaining treatment—even when they recognize that to continue these cure-oriented treatments would merely obstruct and so prolong, often torturously, an irreversible dying process. To describe their change of heart and practice as accepting an activity aimed at hastening death is to confirm the worst moral scruples of these caregivers, who

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have struggled mightily to shed their misguided medical vitalism. It undermines the moral insight that benefit of suffering is a goal of medicine that can be achieved even when the goal of prolonging life cannot, and this without killing.

Much less do these opinions acknowledge how very many medical caregivers feel about providing a lethal prescription for their patients. The idea is morally repulsive. These are professionals who are willing to stop excessively burdensome cure-oriented treatments, who are willing then to focus strenuous efforts on effective measures to eliminate pain and on demanding personal efforts to relieve the mental and spiritus suffering of the dying. They are willing to face death with the patient but are not willing to inflict death.

I think this moral revulsion stems from the fact that these professionals see that the use of medicine for this end camouflages violence. It is especially felt by surgeons and others who do obviously life-endangering medical invasions of the body. These doctors and those who assist them are vividly aware of how such medical activity involves taking the life of a patient into one's hands and risking that life in a particularly dramatic way in order to achieve healing. These judicial opinions simply discount thefelt moral difference between such risk-taking, which medical caregivers try to perform responsibly for their patients, and directly causing a death—even when the latter might be claimed to be an act of mercy. As medical professionals, they strive constantly to achieve a precarious balance of intention and action—to avoid undue risk, yet to take prudently calculated risks in doing what may nevertheless produce an unwanted death. Authorizing death as a treatment for the dying disputes and may even discourage such moral striving to take risks but avoid precipitating death.

Morality by Judicial Decree.

In my opinion, the judges of the Ninth and Second United States Circuit Courts of Appeal have gone beyond mandating a new legal interpretation of a particular medical activity that they characterize as "merging" in treatment of the dying under high technology health care. They have in effect decreed the abrogation in the public sphere of the intellectual, moral and legal respectability of traditional religious and medical thinking about the moral distinction between letting die and killing. Their decree legally establishes a new morality for medical practice—one with its own religious overtones.

This new medical morality has been advocated by those who emphasize patient autonomy—which patients may exercise no matter how harmful the acts chosen are to others and to their autonomy. Some of these single-minded advocates of individual liberty also believe, in a quasi-religious way, that self-killing is really the morally best way to meet death when it approaches ("One ought not leave a mess for others to clean up"). What rights, then, remain in the public square for those of us who believe, as a matter
of ultimate moral integrity, that we must do everything possible to relieve suffering, but that we must not kill?

The Catholic Response.

Catholic believers and many who agree with us will, of course, not cease to view an act of killing as a terrible and desperate measure, one to be taken only fearfully and reluctantly and mournfully—and as an act morally justified only if it is a last resort in circumstances of necessary self-defense against unjust aggressors. But, we also have much sad experience with the historical aftermath of what we regard as morally justified killing in self-defense in war and domestic policing. This painful experience tells us that every act of killing, even when claimed to be morally justified, appears inevitably to bring with it new forms of uninhibited violence. When we confront killing, our view of history tells us that we do not deal here with a fictional slippery slope.

We cannot be passive, therefore, when we contemplate the possibility that inflicting death may now be legally authorized as just another medical intervention—one that patients must be informed about, that doctors must be free to recommend to their patients, that families will be free to urge upon their dying members and that harried medical caregivers will be free to urge a suffering patient to consider seriously. It may even be one that administrators of managed care will eventually choose to make mandatory for some patients in some situations as a condition of payment for care. We have solid reason to doubt that constraining conditions such as those mentioned in the Oregon referendum will prevent frequent tragic abuse of this “treatment.”

Legal endorsement of homicide as one more optional treatment for the suffering of the dying thus threatens our Catholic, faith-inspired moral practices in caring for the dying. I foresee formidable obstacles to our ways of caring for the dying within a medical care system that increasingly practices death as a treatment. Done as a medical “quick fix” for the sufferings of the dying, assisted suicide will transform health care institutions into places of threatened violence and the moral danger of guilty cooperation with violence. Such a medical system will be ever more deeply suspect to many people in crisis. And it will be increasingly subjected to stress in its efforts to preserve its traditional moral ideals of self-risking altruism.

These two Federal appeals court decisions are now being reviewed and argued before the U.S. Supreme Court. We shall see how the legal reasoning of these decisions will fare in that forum. We can hope that the outcome will modify if not eliminate the circuit courts’ negation of the intellectual respectability of the vital moral distinction between killing and letting die.

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