MATTERS OF LIFE AND DEATH

MAKING MORAL THEORY WORK IN MEDICAL ETHICS AND THE LAW

DAVID ORENTLICHER

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PRINCETON UNIVERSITY PRESS PRINCETON AND OXFORD

Published by Princeton University Press, 41 William Street,
Princeton, New Jersey 08540
In the United Kingdom: Princeton University Press,
3 Market Place, Woodstock, Oxfordshire OX20 1SY

Library of Congress Cataloging-in-Publication Data

Orentlicher, David, 1955–
Matters of life and death : making moral theory work in medical ethics and the law / David Orentlicher.
p. cm.
Includes bibliographical references and index.
ISBN 0-691-08946-9 (alk. paper)
ISBN 0-691-08947-7 (pbk.: alk. paper)
1. Medical care—Law and legislation—United States. 2. Medical ethics—United States. I. Title.

KF3821 .O73 2001
174'.24—dc21 2001019857

This book has been composed in Sabon

Printed on acid-free paper.∞

www.pup.princeton.edu

Printed in the United States of America

10 9 8 7 6 5 4 3 2 1

TO THE MEMORY OF

Jeanette Levin Orentlicher

MUCH LOVED FOR HER KINDNESS AND WISDOM

Acknowledgments

I AM most grateful for the help of my wife, Judy Failer, who contributed exceptionally to this book, both as a scholar of moral philosophy and as my best friend. She was (and is) my most important source of inspiration and critical comment.

Many other people and institutions made important contributions to completing this project. I wrote most of this book at Indiana University, and I am grateful for the support and contributions of many people there, including Norman Lefstein, Eleanor Kinney, Faith Long, and other colleagues and students at Indiana University School of Law–Indianapolis. I also am thankful to Greg Gramelspacher and colleagues in the Program in Medical Ethics at Indiana University School of Medicine for their financial support and intellectual exchange.

I started the formal writing of the book during my year as the Visiting DeCamp Professor of Bioethics at Princeton University, and I am grateful to Amy Gutmann, the Center for Human Values, and the Woodrow Wilson School of Public and International Affairs for sponsoring my visit. My manuscript also benefited from discussions with many colleagues and students, including Jodi Halpern, Victoria Kamsler, George Kateb, and Helen Nissenbaum.

Many of my ideas had their roots in the years preceding my writing of the book, both at Indiana University and before then in Chicago, where I directed the Division of Medical Ethics at the American Medical Association. In those years, I learned from discussions with the students in my seminars at the University of Chicago Law School, with Kathryn Montgomery Hunter and my other colleagues and students at Northwestern University Medical School, and with the Council Members and research associates with whom I worked at the American Medical Association's Council on Ethical and Judicial Affairs.

I am also indebted to Ann Wald for encouraging me to submit this book to Princeton University Press, to Ian Malcolm for guiding me ably through the publication process, to the many helpful suggestions from the anonymous peer reviewers, and to Richard Isomaki, Maura Roessner, and Alison Zaintz for their assistance in bringing this book from manuscript through to completion.

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One

Introduction

If a physician turns off a ventilator, the patient will almost surely die. If patients with liver failure do not have high enough priority to receive a transplant, they will almost surely die. And if an obstetrician performs an abortion, a fetus will almost surely die.[1] Ethical dilemmas in medicine are important for a variety of reasons, but they are particularly compelling because they often involve matters of life and death.

Because the stakes are high and the issues morally complex, medical ethicists have devoted a great deal of attention to identifying the optimal theoretical approach for resolving bioethical quandaries. A substantial literature now exists, and major debates are pursued about the best way to analyze ethical dilemmas in medicine. We might start from fundamental moral theories like deontology and utilitarianism and derive fundamental principles like patient autonomy and physician beneficence that can be applied to specific problems or cases (principlism).[2] Or we might begin with individual cases and, from a careful exploration of the circumstances and nuances involved, incrementally develop a common morality, much as courts have developed bodies of law by deciding cases one at a time (casuistry).[3] If we adopt a principlist approach, we still must choose which fundamental theory to follow. We could be primarily concerned with the consequences of our actions (utilitarianism)[4] or the respect we show for each person (Kantianism),[5] or we could emphasize the character traits that make for an ethical physician and determine the course of action that a morally good physician would take (virtue ethics).[6] Although there is a tendency to try to decide which theoretical approach is "correct," most scholars agree that each approach contributes to our understanding and resolution of ethical dilemmas in medicine.[7]

Indeed, important advances in understanding have been made as discussants bring broader perspectives to bioethical analysis. For example, some ethicists have noted that leading theories often ignore the perspectives of powerless groups in society and have called for greater consideration of those perspectives, for example, by taking into account the role of race and sex in shaping ethical principle and practice.[8] Other ethicists have discussed the need for greater consideration of empirical data and other realities of daily life, on the ground that ethical theory is often out of touch with the concerns of patients and physicians and the way people actually behave (empiricism and pragmatism).[9]

In this book, I will argue that an additional moral concern is given insufficient attention in the analysis of questions in medical ethics. Theoretical analysis (even when grounded in empirical realities) often fails to consider the moral considerations involved in translating moral principle into ethical and legal rules or judgments.* For many issues in medical ethics, there will be important impediments to the implementation of what principle indicates is morally correct. Accordingly, when principle is translated into practice, rules and judgments will seemingly differ from what would be predicted from principle alone. In such cases, it is common for scholars to argue that the rules or judgments are misguided, that they reflect moral misunderstandings, and that they therefore need to be changed so they are consistent with moral principle.

However, I will argue, the apparent inconsistencies between principle and practice can often be explained by a fuller accounting of moral theory. When principle is translated into rules or judgments, important moral considerations influence the nature of the translation. For example, if one believes that competent adults should have the right to control the way in which they die, a straightforward application of that principle could yield a right to assisted suicide. Accordingly, strong proponents of patient autonomy often argue that bans on assisted suicide are misguided. Yet such logic neglects important steps that are necessary for implementing patient autonomy in the context of assisted suicide. For example, even if a right to assisted suicide exists, society still needs to ensure that the patient is engaged in a genuine exercise of self-determination rather than acting out of depression, coercion, or irrationality. If one questions whether physicians have the expertise necessary to distinguish the rational and voluntary choice of suicide from the involuntary or irrational choice, even a strong belief in patient autonomy might not result in a rule that permits physician-assisted suicide.[10]

To judge the appropriateness of ethical or legal rules and judgments, then, we need to give adequate consideration to both the undergirding

* By rules, I mean authoritative statements that apply to a broad range of cases. With judgments, on the other hand, I refer to statements that are authoritative for a particular case and that implement one or more rules. An example of what I mean by an ethical rule is the following: competent adults have the right to refuse unwanted life-sustaining treatment. This rule can be derived from deontologic theories that rest on respect for persons, on utilitarian considerations, or on other theoretical premises. An example of what I mean by an ethical judgment would be something like this: primary custody of Baby M was rightly given to William and Elizabeth Stern rather than Mary Beth Whitehead because they were better situated to provide a good home for the child. Note that this judgment is designed to implement the rule that custody disputes should be resolved in terms of the child's best interests.

moral principles *and* to the moral issues involved in taking the step from principles to rules or judgments.* By extending our theoretical analysis this additional step, we gain important insights into how we should handle ethical dilemmas in medicine. For example, we might conclude that our rules and judgments are the best we can do in terms of implementing moral principle. Or we might better understand how our rules and judgments should be changed to bring them closer into line with morality. In short, the theoretical analysis includes three important components—the fundamental principles at stake, the method of translating principles to practice, and the rules and judgments developed for specific ethical problems.

Other scholars have emphasized the role of moral concerns in making the move from principle to practice. For example, Guido Calabresi and Philip Bobbitt provided an important analysis in this area in *Tragic Choices*,[12] when they discussed how societies employ methods of decision making that ostensibly deny the existence of a moral conflict in order to make resolution of the conflict possible. Similarly, in *Playing by the Rules*, Frederick Schauer has carefully considered the role of rules in implementing moral principle.[13] Yet discussions of specific issues in medical ethics frequently give inadequate consideration to the methods of translation for the move from principle to practice. Often, an ethical or legal rule or judgment is proposed as a direct application of a particular moral principle. Physician-assisted suicide should be permitted because patients should exercise autonomy over end-of-life decisions, or physician-assisted suicide should be prohibited because doctors must not cause the deaths of their patients.

To be sure, scholars commonly invoke moral concerns involved in translating principle into rules or judgments through discussion of "slippery slope" problems. For example, opponents of organ retrieval from living persons might concede that there are some cases in which it is morally permissible to take the heart or liver of someone before death (e.g., organ retrieval under the terms of a permanently unconscious person's living will). However, they argue, we cannot permit organ retrieval from living persons in some cases without opening up the practice to other, noncompelling cases.

Slippery slope arguments are important, but they are less helpful than they might appear. Slippery slope arguments cut both ways.[14] If we cannot take organs from permanently unconscious persons because it might lead to organ retrieval from other disabled persons, the same logic would reject

* Some writers use principles to refer to rulelike guidelines (e.g., one must not steal), but I use the word *principle* to refer to important basic values (e.g., patient self-determination should be respected).[11]

organ retrieval from brain-dead persons since such a practice might lead to organ retrieval from permanently unconscious persons. In other words, slippery slope arguments can make it difficult to take any action.

Slippery slope arguments are inherently problematic in additional ways. If there are moral grounds to distinguish between organ retrieval from permanently unconscious persons and organ retrieval from other living persons, we ought to be able to rely on those grounds to prevent the slide down the slippery slope.[15] If, on the other hand, we cannot really distinguish other living persons from permanently unconscious persons for purposes of organ retrieval, we would not want to limit the practice only to those who are permanently unconscious. Permitting organ retrieval from living persons more broadly would not in fact reflect a slide down the slippery slope.

Finally, slippery slope arguments are limited in scope. They do not come close to exhausting the universe of moral concerns involved in translating principle in practice. Other approaches play a more critical role in addressing the move from principle to practice.

In this book, I aim to provide a fuller account of the concerns involved in translating moral principle into ethical and legal rules or judgments. I will identify three paradigmatic methods or approaches used to make the move from principle to practice, and I will do so in the context of matters of life and death.

First, I will discuss the model of rejecting individualized decisions in favor of "generally valid rules," in which society avoids moral difficulty by restricting the authority of public representatives to make important social decisions. For example, instead of permitting physicians to make case-by-case judgments on matters of life and death and taking the chance that the physicians will bring invidious biases into the decision-making process, society often establishes categorical, generally valid rules that largely decide each case. Organ allocation guidelines illustrate this model.

For the second paradigmatic approach, I will consider the fact that society often rejects the apparent implications of a theoretical principle because rules and judgments take on a life of their own. This is the "perverse incentives" concern. Once society adopts a particular rule or judgment, the decision will change the incentives that people face when they decide how to act. Consider, for example, what happens when a state decides to require premarital HIV testing. Instead of ensuring that couples discover their HIV status before marriage, the law causes many couples to evade testing by obtaining a marriage license in a neighboring state.[16] Because of their undesirable incentives, many potential rules or judgments are not adopted. Rather than serving the intended moral value, the rule or judgment undermines that value or another social value.

Finally, I will discuss the "tragic choices" model of Calabresi and Bobbitt, in which society chooses to disguise its justifications for making difficult life-and-death decisions, in order to avoid a paralyzing social conflict over disparate values. For example, organ allocation rules are often characterized in medical terms to give them a veneer of neutral objectivity, even though the rules ultimately reflect nonmedical value judgments in which some values take priority over other values. Thus, with allocation of kidneys, the emphasis on tissue matching[17] between donors and recipients can encourage the public to think incorrectly that a scientific, value-neutral method of selection is being used, when in reality a choice has been made to favor patients who will gain the most years of benefit from a transplant over patients who have been waiting longest for a transplant or patients who do not tolerate kidney dialysis very well.[18] To be sure, papering over conflict is a controversial approach, but it is important to recognize its role in societal decision making and to consider whether and to what extent its role is legitimate.

In discussing the three models for translating principle into practice, I will demonstrate their role through examples of specific types of life-and-death decisions. For the generally-valid-rules approach (part 1 of the book), I will discuss the example of the distinction between a withdrawal (or withholding) of life-sustaining treatment and physician-assisted suicide. I will argue that the decisive moral basis for the distinction (in fact) is the need for a generally valid, categorical rule rather than a more general rule or a case-by-case analysis to guide decision making when patients wish to die.

In making this argument, I will show that the usual justifications for distinguishing between treatment withdrawal and suicide (or suicide assistance) fail. The key issue is our inability to make individualized distinctions between morally justified and morally unjustified patient deaths (and this points holds however one defines a morally justified patient death). Because individualized decisions are not feasible, society has relied on the categorical distinction between treatment withdrawal and suicide to sort in a general way the morally justified death from the morally unjustified death. More specifically, the typical treatment withdrawal represents a morally justified death, while the typical suicide does not.

By analyzing physician-assisted suicide in terms of the translation of principle to practice, I will show that the recognition by society of a limited right to assisted suicide would represent a continuation rather than a rejection of long-standing moral principle. Permitting assisted suicide for terminally ill patients, as in Oregon, creates a new categorical rule that sorts suicides that are likely to be morally justified from those suicides that are likely to be unjustified.

To illustrate the concern about perverse incentives (part 2), I will discuss the imposition of medical treatment on a pregnant woman when the treatment would be life-sustaining for the woman's fetus. I will argue that, at the level of moral principle, the usual arguments against a legal obligation are not strong enough to exclude a limited legal obligation for pregnant women to accept unwanted treatment. Many scholars reject a legal obligation on the ground that pregnant women would be given requirements to accept unwanted treatment that no one else is given. At the level of principle, however, one can justify an obligation of pregnant women to accept at least some unwanted treatments. Specifically, if pregnant women must accept some treatments that are beneficial to the health of both the woman and the fetus, they would assume the kind of obligation that society imposes elsewhere (e.g., on matters of public health).

Still, the analysis is not complete. I will also argue that a critical moral consideration in the final analysis is whether rules or judgments requiring women to accept unwanted treatment will have the unintended and perverse effect of deterring women from seeking prenatal medical care. A limited legal obligation may in principle serve the goal of promoting fetal health, but its unintended consequences could be counterproductive to that goal.

For the tragic choices approach (part 3), I will discuss the question whether physicians can deny life-sustaining care to patients on the ground that treatment would be futile. I will argue that the resolution of this dilemma turns in large part on whether society needs practices that allow it to hide the tragic choices entailed in the rationing of health care. Commonly, opponents of futility misjudge the analysis by neglecting the tragic choices concern. For example, many discussants argue that physicians err when they deny life-sustaining treatment on grounds of medical futility. Futility judgments convey the idea that medical treatment would be ineffective at prolonging life, but, in this view, futility is invoked in fact because of cost concerns. The treatment could prolong life, but the brief length and poor quality of the extended life are insufficient to justify the cost of the care. Since the denial of care is based on an unfavorable benefit-cost ratio rather than on a total lack of effectiveness, it is argued that physicians should be honest with their patients and invoke principles of rationing rather than principles of futility when they deny the care.

The problem with this critique of futility is that it overlooks the tragic choices problem. The likelihood of unresolvable social conflict means that it is often not possible to engage in rationing explicitly when life-and-death decisions are being made. Accordingly, societies commonly look for implicit ways to ration. The use of futility can be seen as an implicit rationing strategy that makes it possible for doctors to deny life-sustaining care in appropriate cases.

In short, I will argue that, for each important life-and-death question, the debate is incompletely analyzed when scholars give inadequate consideration to the role of moral concerns involved in translating principle into rules or judgments. Often, what is cited as a gap between principle and practice is instead a case of an apparent gap that disappears when one takes into account the move from principle to practice. My aim in this book is to show that important debates in bioethics can be better understood by taking into account moral concerns that are frequently overlooked—the moral factors involved in translating principles into ethical and legal rules or judgments.[19]

Part I

THE APPROACH OF USING GENERALLY VALID RULES