

Y3.T22/2:2L62/v.3/ethical

**An Ethical Analysis of Withdrawal From Life-Sustaining  
Technologies and Assisted Death**

**A Report for the Office of Technology Assessment**

**Second Draft  
October 4, 1985**

**James F. Childress  
University of Virginia**

## Table of Contents

Introduction	iii
Task # 1: Analysis of the Distinctions Among Types of Withholding and Withdrawing Life-Sustaining Technologies	1
A. Definition and Description of Types of Withholding and Withdrawing Life-Sustaining Technologies	1
1. Withholding and Withdrawing Treatments	2
2. Direct and Indirect Effects	4
3. Letting Die and Killing	6
4. Ordinary and Extraordinary Means	10
5. Major Issues in Line-Drawing Among Levels and Kinds of Treatment	13
B. Major Considerations in a Typology of Withholding and Withdrawing Life-Sustaining Medical Treatment	20
C. Definition of Suicide and its Application to Cases of Elderly People Receiving Life-Sustaining Technologies	22
D. Analysis of Cases to Illustrate Distinctions and Categories	27
E. Normative Implications of These Distinctions	27
Task # 2: Description of Important Ethical Traditions Relevant to Withholding or Withdrawing Life-Sustaining Technologies and/or Suicide	28
Task # 3: Age-Specific Data on Suicide Among the Elderly	43
Task # 4: Discussion of Prevailing Concepts of Assisted Death	55
A. Concepts of Assisted Death	55
B. Compatibility of Assisting Death with Professional Codes and Practices	56
C. Laws, Policies, and Court Decisions	58
D. Influence of Institutional Setting and Social Context on Assisted Death	62

**Task # 5: Conclusions**

<b>A. Special Significance of the Above Issues for the Elderly</b>	<b>65</b>
<b>B. Feasibility and Desirability of Guidelines</b>	<b>65</b>
<b>C. Issues That Need Additional Analysis and Research</b>	<b>68</b>
<b>D. Priorities for Public Attention Regarding Suicide Among the Elderly in Relation to Life-Sustaining Technologies</b>	<b>68</b>
<b>E. Major Policy Options</b>	<b>69</b>

**References**

**Appendices:**

- I. U.S. Total Population Suicide Rates per 100,000 by Five-Year Age Groups, 1933-68**
- II. Suicide Rates per 100,00 by Five-Year Age Groups, Color, and Sex, US, 1972**
- III. U.S. White Male Suicide Rates per 100,000 by Five-Year Age Groups, 1951-58**
- IV. Suicide Rates in the US in Relation to Age and Race, 1974**

**Cases:**

- # 1 --- pp. 2-3**
- # 2 --- p. 6**
- # 3 --- p. 14**
- # 4 --- pp. 14-15**
- # 5 --- p. 19**
- # 6 --- pp. 22-23**
- # 7 --- p. 24**
- # 8 --- pp. 25-26**
- # 9 --- p. 52**
- # 10 --- p. 53**
- # 11 --- p. 54**

## Introduction

This report is designed to offer an ethical analysis of decisions to withhold and to withdraw life-sustaining technologies from patients in accord with their wishes and interests. Few debates in our society have been as complicated or as confused as debates about life-sustaining technologies over the last ten to fifteen years. Thus, it was not surprising that the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research undertook an examination of decisions to forgo life-sustaining treatment--which was not part of its original legislative mandate-- as a "natural outgrowth" of its studies on informed consent, the definition of death, and access to health care, and as a way to deal with "some of the most important and troubling ethical and legal questions in modern medicine." However, as the chairman, Morris Abram, noted when he submitted the resulting report, Deciding to Forego Life-Sustaining Treatment, the Commission concluded "that the cases that involve true ethical difficulties are many fewer than commonly believed and that the perception of difficulties occurs primarily because of misunderstandings about the dictates of law and ethics" (President's Commission, 1983).

Whether real or only apparent, ethical difficulties, dilemmas, quandaries, or problems are generated by perceived conflicts among ethical principles and values. Thus, it is essential to examine those principles and values, especially as they are reflected in religious and humanistic traditions, legislative actions, judicial decisions, and codes and practices of professional conduct. Without denying different emphases and positions, it is possible to identify several ethical principles and values that are commonly invoked to set and resolve such ethical difficulties. Several of these principles-- especially beneficence, nonmaleficence, utility, autonomy, and justice-- are identified and explicated in Task # 1; they do not presuppose any particular

ethical theory but are compatible with and can be derived from several different religious and humanistic ethical theories. In short, they represent ethical considerations that are widely accepted, even though their proponents frequently differ about their grounds and about their implications for particular cases.

How these ethical principles and values are applied to particular cases often depends on intermediate principles, rules, and distinctions, such as the distinctions between killing and letting die, between direct and indirect effects of actions, and between ordinary and extraordinary means of treatment, all discussed under Task # 1. One major task of ethical analysis is to examine and assess these distinctions in light of the general principles and values and the realities of particular life-sustaining technologies, such as renal dialysis, antibiotics, artificial nutrition and hydration, resuscitation, and mechanical ventilation, in treatment of the elderly. Such an analysis will involve careful scrutiny of representative positions, including the arguments for and against those positions.

Ethical analysis also involves conceptual analysis, since some of the key concepts are often in dispute. For example, several traditions hold that suicide is wrong, but accept some acts that result in one's own death while denying that they are acts of suicide. Other traditions may hold that those acts are justifiable acts of suicide. Thus, it is not enough to know whether a tradition accepts or rejects suicide, but also how it distinguishes suicide from other acts such as refusal of life-sustaining technologies under some conditions. Similarly there are debates about the concept of "assisted death" as well as about the moral acceptability of acts that fall under this concept.

Ethical analysis is often interwoven with other kinds of analysis, such as scientific, political, legal, and economic analysis. Hence, an ethical analysis of policy options regarding life-sustaining technologies will inevitably incorporate scientific data and presuppose political

constraints, such as the system within which the legislation occurs. However, it is possible to concentrate on and to highlight ethical considerations, as this report does, without totally separating ethics and other matters.

2007

**Task # 1. Analysis of the Distinctions among Types of Withholding and  
Withdrawing Life-Sustaining Technologies**

**A. Definition and Description of Types of Withholding and  
Withdrawing of Life-Sustaining Technologies**

Life-sustaining treatment "encompasses all health care interventions that have the effect of increasing the life span of the patient" (President's Commission, 1983), and life-sustaining technologies include all health care technologies that can probably sustain a person's life for some period in the presence of life-threatening conditions. Several distinctions have been developed for the moral assessment of the use of life-sustaining technologies. However, there is widespread recognition that these distinctions rarely provide conclusive moral answers; their primary function is to suggest relevant moral principles and values. The following principles or values have been widely endorsed and applied in somewhat different but largely consistent formulations: (1) Benefitting patients (the principle of beneficence); (2) Not harming--including not killing-- patients (the principle of nonmaleficence, which is sometimes viewed as a subset of the principle of beneficence; see National Commission, 1978); (3) Maximizing welfare for all parties, families and society as well as patients (sometimes called the principle of utility or proportionality); (4) Respect for patients as persons, including their autonomy (sometimes called the principle of respect for persons or the principle of autonomy); (5) Treating patients and others justly (the principle of justice or equity in the distribution of benefits and burdens). (For variations of these principles see National Commission, 1978; Beauchamp and Childress, 1979 and 1983; Veitch, 1981; President's Commission, 1983.) Other independent or derivative principles have been recognized, including privacy, truthfulness, and fidelity in keeping promises and contracts

(Veitch, 1981; Beauchamp and Childress, 1983).

In part, the distinctions that have been developed regarding the use of life-sustaining technologies indicate when the second principle (nonmaleficence) is not violated by actions that result in death (whether those actions were performed by the one whose death occurred or by others) or when its infringement is justified because of other competing principles. Because of the strong prohibitions that are derived from the second principle, which in the Hippocratic tradition of medicine is interpreted as "first of all or at least do no harm," both suicide and mercy killing are prohibited. Death is viewed as a major--often the major--harm, and thus deliberately engaging in actions that bring about, hasten, or cause death is *prima facie* wrong as a violation of the principle of nonmaleficence. This principle is so stringent that most traditions tend to justify killing persons only in self-defense, war, and capital punishment (the last is more controversial) and tend to view acts that cause the deaths of innocent persons, even those who are suffering greatly, as justifiable only if they fall outside the rule that prohibits the direct killing of innocent persons. Thus, much of the debate, as we will see, hinges on whether and which acts can be described and evaluated as not being instances of suicide or mercy killing (euthanasia). The following distinctions are designed precisely to rebut the charge that actions that result in death really violate the principle of nonmaleficence. They appeal to other principles usually not to override the principle of nonmaleficence but to show that actions that appear to violate the principle actually fall outside it and are justified by other principles, such as the decedent's prior request (the fourth principle) or intense suffering (the first principle).

1. The distinction between withholding (not starting) and withdrawing (stopping) life-sustaining technologies. This first distinction, which also figures at least implicitly in some other distinctions, is often felt by physicians and others to be very important, even though it is hard to defend in terms of various ethical traditions, whether religious, humanistic, or medical. Case # 1 indicates how this distinction has an intuitive appeal to some professionals



and others. An attending physician asked me to serve as an ethics consultant for the staff caring for an elderly man, who was suffering from several major medical problems, including terminal cancer, with no reasonable chance of recovery. The patient was clearly incompetent and could not communicate with others; he had no family to serve as proxy decision-makers. The members of the staff caring for the patient had easily and quickly agreed on a "no code" or "do not resuscitate" (DNR) order. They felt comfortable with this decision because of the patient's overall condition and prognosis and because not resuscitating the patient in the event of cardiac arrest could be viewed as withholding (not starting) rather than withdrawing (stopping) treatment. The patient was being maintained by intravenous nutrition and hydration and antibiotics to fight infection. Several members of the team thought that all medical treatments, including artificial nutrition and hydration and antibiotics, should be stopped, but others, perhaps a majority, thought that it would not be right to stop these treatments. However, when an IV line infiltrated, some of the latter group concurred that it was not obligatory to start the line again, especially if it involved a cut-down, because it could be viewed as starting rather than continuing a treatment. However, others sharply criticized this use of the distinction between withholding and withdrawing treatments, on the grounds that it was self-deceptive rationalization or unnecessary sophistry.

The conceptual and normative roots of the distinction between withholding and withdrawing treatments are tangled. Perhaps the most plausible argument is that in beginning a life-sustaining treatment a professional makes a promise, creates an implied contract or covenant, or engenders expectations, which, on grounds of fidelity or loyalty to the patient, require that the treatment not be stopped. However, others contend that the fundamental promise is to act in accord with the patient's wishes and interests (the principles of beneficence and respect for persons), which can nullify or override the promise to the patient. Furthermore, many argue, this distinction between withholding and withdrawing treatments is often

moreally pernicious. Obviously it may lead to overtreatment, but it may also lead to undertreatment, since some professionals have reportedly been reluctant to start treatments in some circumstances for fear of being locked in to their continuation. However, it is often necessary to start life-sustaining treatments in order to gain time and information for a better diagnosis, prognosis, and decision. Thus, it is plausible to argue, as the President's Commission (1983) does, that the burden of proof should be higher for withholding than for withdrawing treatment since a judgment about the latter could presumably be reached on more solid grounds. And the same moral principles are relevant to and conclusive for decisions to withhold or to withdraw life-sustaining treatments: "whatever considerations justify not starting should justify stopping as well. Thus the Commission concludes that neither law nor public policy should mark a difference in moral seriousness between stopping and not starting treatment" (President's Commission, 1983, p. 77).

2. The application of the distinction between direct (intended) and indirect (unintended but foreseen) effects of actions is also controversial. There is general agreement about the prohibition of directly killing patients, for example, through poisoning or shooting them, and there is general acceptance of actions that relieve pain and suffering even though they may hasten death, if they are in accord with a patient's wishes and interests. This distinction has often been used in the Roman Catholic tradition, but in other traditions and contexts as well, to show that some actions that have a harmful effect, such as death, do not always fall under such moral prohibitions as suicide or murder because the harmful effect is indirect, unintended, or merely foreseen and, as such, is justified by other features of the act and its consequences. Traditionally this distinction between direct and indirect effects has involved four conditions: (1) The action in itself must be good or at least morally indifferent; (2) the agent must intend only the good effect and not the evil effect; (3) the evil effect cannot be a means to the good effect; the good and evil effects must follow immediately from the same action (otherwise the

0011

evil would be intended as a means to the good end); (4) There must be proportionality between the good and evil effects of the action, that is, a proportionately grave or serious reason for allowing the evil effect to occur. The evil effect is allowed, not sought; it is foreseen, not intended. (For a summary of the rule of double effect, see Mangan, 1949; Boyle, 1980; Beauchamp and Childress, 1983).

Most often the rule of double effect is invoked when there is a conflict between obligations or values and it is not possible to meet or to realize all of them at that time in the situation. For example, in the care of terminally ill patients, the principle of nonmaleficence establishes a duty not to harm or kill the patients, but the principles of beneficence and respect for persons establish a duty to make the patient comfortable by relieving pain and inducing sleep if the patient desires. However, in some situations it may be possible to discharge the latter duty only by engaging in actions that hasten the patient's death. When the four conditions of the rule of double effect are met, it may be justifiable to engage in actions that can be reasonably predicted to hasten the patient's death; such actions do not count as violations of the principle of nonmaleficence or as homicide. According to the Ethical and Religious Directives for Catholic Health Facilities, "It is not euthanasia to give a dying person sedatives and analgesics for the alleviation of pain, when such a measure is judged necessary, even though they may deprive the patient of the use of reason, or shorten his life" (see also Sacred Congregation, 1980, for a similar statement).

The rule of double effect thus distinguishes between relieving pain at the risk of bringing about death and relieving pain by bringing about death. The distinction between direct and indirect effects cannot do all the moral work that has to be done: (1) Not all actions that foreseeably result in death are justifiable, and (2) some actions that intentionally result in death may be justifiable-- e.g., removing a respirator under some circumstances. The Judicial Council of the American Medical Association (1982) holds that that the physician "should not

6-10-12

intentionally cause death" just after conceding that it is ethical to "cease or omit treatment to let a terminally ill patient die." However, omissions may involve the intentional causation of death, even if they do not always result in death (i.e., the patient may survive despite the intentional omission). According to some critics of the distinction, the question is not whether death is intended as an end or as a means, but how death is brought about, and that the society has moral reasons for excluding some means of bringing about death, even if there is agreement among all the parties, including the patient, that he or she would be better off dead. Some means of bringing about death, such as poisoning or shooting the patient, may be ruled out, on grounds other than the rule of double effect. Hence, the critical question does not concern primary and secondary intentions or even primary and secondary-- or direct and indirect-- effects, but the means of death, particularly the distinction between killing and letting die.

3. Letting die and killing. In one situation (Case # 2) Mr. R, 62 years old, was hospitalized for metastatic cancer of the colon. When it became clear that he would not likely benefit from either chemotherapy or radiation, Mr. R refused further laboratory tests, antibiotics, transfusions, and dialysis, while accepting pain medication, nasogastric suction, and intravenous fluids. Four days later he asked doctors to "speed up" his death, less because of his pain and discomfort and more because he could not endure the dying process any longer and did not want to jeopardize his family's limited financial resources. "In this case," Lo and Jansen (1980) write, "the house staff gave substantial doses of morphine and diazepam, with the agreement of the patient and family." This case cannot be brought under the rule of double effect for "allowed deaths"; the medication was not given to relieve pain at the risk of hastening death. It was not a case of letting the patient die but rather one of directly and actively killing the patient at his request.

Sometimes the distinction between killing and letting die is discussed under other headings, such as omission and action or passive and active, because it is argued that more

descriptive terms are need to replace "killing", which most tend to view as wrong, and "letting die", which most tend to view as right. Thus, the President's Commission (1983) used the descriptive terms: actions that lead to death and omissions that lead to death. Whatever terms are employed, the issues are the same. Most ethical traditions prohibit the direct, active killing of patients as a rule, even though they disagree about the foundations of that rule. Some hold that it is intrinsically wrong to kill innocent persons; others hold that it is not intrinsically and absolutely wrong to do so, for example, when the suffering patient requests "mercy killing," but that a rule prohibiting mercy killing is necessary in order to prevent bad consequences for future patients and ultimately for the society. Thus, many who deny that acts of killing innocent persons are always wrong still support a rule of practice that prohibits such acts in part because of the dangers of abuse, loss of trust between professionals and patients, and subversion of the societal commitment to the protection of human life-- a version of the wedge or slippery slope argument (for several reasons, see Veitch, 1976). Some of the main arguments against appeals to the distinction between killing and letting die focus on claims about the intrinsic wrongness of killing versus letting die; others focus on the application of the distinction (for several arguments, see Steinbock, 1980).

Some critics hold that there is no intrinsic moral difference between killing and letting die; whether there is a moral difference will depend on the circumstances of the case. Thus, in a widely discussed article, James Rachels (1975) contends that the "bare difference" between acts of killing and acts (omissions) of letting die is not in itself a morally relevant difference; he argues for his point by sketching two cases that differ only in that one involves killing, while the other involves allowing to die, and asks whether we would make different moral judgments about the cases. In those cases-- killing a six-year-old cousin or letting him die in order to gain a large inheritance-- both acts are equally reprehensible because of the agent's motives, ends, and actions or nonactions. But those reprehensible cases may obscure the significance

of the distinction in other cases where agents are trying to benefit (rather than harm) patients and where they are also concerned about the broader social consequences of rules that permit or prohibit such actions or omissions. Even though the distinction may not be important in some contexts, it may be important in others because of other moral principles and rules. It may be the best compromise among competing moral considerations: respecting a patient's wishes, relieving the patient's pain and suffering, and protecting the society's commitment not to let innocent people be killed.

The prohibition of direct, active killing of innocent persons is built into the legal system as well as into professional codes and religious and humanistic traditions. Arguments to change this rule often appeal to cases of extreme, intractable pain and suffering, usually from a slow death from cancer. According to critics of the rule, a failure to kill the patient in those circumstances, when the patient pleads for "mercy", is cruel and inhumane. Several responses have been offered.

First, it is not clear that there are many cases of uncontrollable pain and suffering; in the medical setting (perhaps in contrast to the battlefield or an accident) pain can usually be controlled, even if relief hastens death (which is acceptable according to the rule of double effect). (For an examination of these matters, see President's Commission, 1983, pp. 73, 19-20, 275-97.)

Second, the caring professions should take more seriously the obligation to relieve pain and suffering and provide medications that will be effective, worrying less about addiction and side-effects in terminal cases (Angell, 1982).

Third, permitting mercy killing will divert attention from finding methods short of killing and institutional and social contexts such as hospice that can reduce the pain and suffering to tolerable levels.

Fourth, in view of the uncertain need to change the rule in order to express beneficence (relieve pain and suffering) and in view of the dangers to the society through abuse, decline of trust within medical relationships, and the threat to the principle of nonmaleficence that prohibits killing, there do not appear to be sufficient reasons to change the rule. Some argue that the burden of proof should be on those who would maintain a rule that infringes the principle of autonomy. However, it is plausible to argue that the policy and practice of prohibiting killing while accepting some cases of allowed deaths has served the society well, though not perfectly, and that the burden of proof should rest on those who argue for changing it; furthermore, many contend, that burden has not been met. Before the society undertakes a major alteration of this rule, it needs strong evidence that the changes are really needed to avoid harms and secure benefits for patients and that the good effects will outweigh the bad effects for all parties, including the society (Beauchamp and Childress, 1983).

Fifth, there are ways to "accept" some exceptional cases of "mercy killing" without changing the current legal and social prohibition-- e.g., prosecutorial discretion, jury findings of not guilty by reason of temporary insanity, and recognition of "mercy" as a factor that mitigates punishment even though it may not exculpate the agent. Even with these informal exceptions, the rule may serve as a valuable reminder of the importance of the principle of nonmaleficence ("first of all or at least do no harm") may provide a valuable cautionary note. Some argue that a regulatory scheme with procedures to make sure that the patient really wants to die would also prevent abuses; however, the formalization of the process would have its own costs because it would involve the society prospectively and directly in deciding and implementing mercy killing.

Even if the distinction between killing and letting die is accepted as a social and legal rule for extrinsic rather than intrinsic reasons, there are still debates about where the line

is and should be drawn between killing and letting die. It is not sufficient to point to the categories of active and passive or action and omission. Nor is it simply a matter of identifying the cause of death-- letting die involving "natural" causes such as the underlying disease as suggested by the language of "natural death"-- for identifying "the cause" in moral and legal settings is in part a normative as well as an empirical matter. It hinges on prior judgments about what will count as causes (President's Commission, 1983). And people can be as responsible-- morally and legally as well as causally-- for omissions as for commissions. Whether omissions will count as causes of death will depend in part on whether there is a moral or legal responsibility to sustain life, which is the question that the distinction is sometimes supposed to resolve. There will always be some ambiguity and uncertainty about the line between killing and letting die, and some health care professionals and others will draw it in different places, as in the conflicts in Case # 1 above. However, there are some clear cases of direct, active killing, as in Case # 2 above, and it is not unreasonable to maintain their prohibition even as the society continues to assess where the line should be drawn, for example, regarding artificial nutrition and hydration. The President's Commission ( 1983, p. 72) found "this limitation on individual self-determination to be an acceptable cost of securing the general protection of human life afforded by the prohibition of direct killing."

4. Ordinary and extraordinary means of treatment. Originally formulated in Roman Catholic moral theology, this distinction, which is expressed in several different terms such as "routine" and "heroic," is now widely adopted in other ethical traditions as well as in legal decisions and professional codes and practices; for example, after prohibiting "mercy killing" or the "intentional termination of the life of one human being by another," the American Medical Association House of Delegates in 1973 held that the patient and/or his immediate family can decide about the "cessation of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent." Similar distinctions have been invoked



in other professional codes and legal decisions. As developed by Roman Catholics to deal with problems of surgery prior to the discovery of antiseptics and anesthesia, the distinction was used to determine whether a patient's refusal of treatment should be classified as a suicide (for the development of the distinction, see McCartney, 1980). Refusal of "ordinary" means of treatment was viewed as suicide, whereas refusal of "extraordinary" means was not viewed as suicide; withholding or withdrawing "ordinary" means from a patient was homicide, whereas withholding or withdrawing "extraordinary" means was not considered homicide. According to Gerald Kelly (1951), one of the most distinguished and influential interpreters of the distinction, "Ordinary means are all medicines, treatments, and operations, which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain, or other inconvenience. Extraordinary means are all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit." As developed by Kelly, the distinction does not refer to properties of medical practice or of the technologies themselves; it rather hinges on two criteria: whether any particular medical treatment offers a reasonable chance of benefit and whether its probable benefits outweigh its probable burdens, including expense and pain.

However, as it is now often used in moral discourse in and about medical care, the language of ordinary and extraordinary means is subject to the criticism that it tends to focus attention on customary medical practice and technologies rather than on the underlying principles and values that the distinction should express in particular cases. Hence technologies are sometimes viewed as "ordinary" if it is "usual" or "customary" for physicians to use them for certain diseases or problems and "extraordinary" or "heroic" if not. The patient as a person often disappears from view. Several other criteria have been invoked to distinguish ordinary from extraordinary means of treatment: their simplicity (simple/complex), their naturalness

(natural/artificial), their expense (inexpensive/costly), their invasiveness (noninvasive/invasive), their chance of success (reasonable chance/futile), their balance of benefits and burdens (proportionate/disproportionate). It is alleged that a technology that meets the first of the paired terms is closer to ordinary, while one that meets the second of the paired terms is closer to extraordinary.

Some ethicists (e.g., Ramsay, 1978; Yeatch, 1976) propose to replace the terms "ordinary" and "extraordinary" with other terms that are less misleading. "Ordinary" could be reconstructed to mean morally obligatory, mandatory, required, or imperative, while "extraordinary" could be reconstructed to mean morally optional, elective, or expendable. Such terms probably reflect the point of the distinction more clearly than the current terms. But if the reconstructed meaning is accepted, there is still the question about which of the above criteria or other criteria can adequately distinguish obligatory from optional treatments in particular circumstances. If the above criteria are relevant-- and some may be relevant-- it is only because they express other principles and values, such as acting in accord with a patient's wishes (the principle of autonomy) and in accord with a patient's interests (the principles of beneficence and nonmaleficence). For example, if an available treatment is simple and natural but not in accord with a patient's wishes and interests, it is hard to see why it should be handled differently than another treatment that is complex and artificial. Furthermore, many of the criteria are unclear. According to one study conducted after the natural death act was implemented in California, physicians in that state generally viewed respirators, dialysis, and resuscitators as "artificial," but split evenly on intravenous feeding, while two-thirds viewed insulin, antibiotics, and chemotherapy as "natural" (Redleaf, et al., 1979). Other criteria, such as the degree of invasiveness (noninvasive/invasive) and cost (expensive/costly), may be morally relevant in view of the patient's overall condition, interests, and preferences. The main consideration for many ethical traditions is consistent with what Kelly

(1951) proposed and with what is now often expressed by the criterion of proportionality (Sacred Congregation, 1980): "Is it necessary in all circumstances to have recourse to all possible remedies? In the past, moralists replied that one is never obliged to use 'extraordinary' means. This reply which as a principle still holds good, is perhaps less clear today, by reason of the imprecision of the term and the rapid progress made in the treatment of sickness. Thus some people prefer to speak of 'proportionate' and 'disproportionate' means. In any case, it will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources."

In general, these several distinctions-- withholding/ withdrawing; direct and indirect effects; killing and letting die; and ordinary and extraordinary means-- do not provide moral answers, although they may reflect important moral considerations. Whether these distinctions are valuable will depend then on whether they direct our attention to and illuminate or distort the relevant moral considerations, particularly the principles and values that have been identified as part of a widespread consensus in a pluralistic society. According to several ethical traditions, the relevant moral considerations are the patient's wishes and interests, in light of his or her condition, and in view of the overall societal allocation of resources and the necessity of some societal rules, such as the prohibition of killing, to prevent bad consequences.

5. Major issues in line-drawing among levels and kinds of treatment. In view of the above distinctions and their underlying principles and values, it is important to turn to levels and kinds of technologies to care for patients, including to sustain their lives. An article by Wanzer, et al. (1984) described several general levels of care: (1) emergency resuscitation; (2) intensive care and advanced life support, including mechanical ventilation; (3) general medical care, including antibiotics, dialysis, and artificial hydration and nutrition; and (4)

general nursing care including pain relief and hydration and nutrition for patient comfort. It is evident that these levels encompass the several types of technology that OTA plans to explore, and it is important to analyze the arguments for and against withholding or withdrawing these levels of care in some situations such as in the following two cases.

In Case # 3, Mrs. X, a seventy-nine year old widow, had been a resident of a nursing home for several years. In the past she had experienced repeated transient ischemic attacks. Because of progressive organic brain syndrome, she had lost most of her mental abilities and had become disoriented. She also had episodes of thrombophlebitis as well as congestive heart failure. Her daughter and grandchildren visited her frequently and obviously loved her deeply. One day she was found unconscious on the bathroom floor of the nursing home. She was hospitalized, and the diagnosis was a "massive stroke." She made no recovery, remaining obtunded and nonverbal, but she continued to manifest a withdrawal reaction to painful stimuli and some purposeful behaviors. Mrs. X refused to allow a nasogastric tube to be placed in her stomach; at each attempt she thrashed about violently and pushed the tube away. After the tube was finally placed, Mrs. X pulled out of restraints and managed to remove it. After several days, her IV sites were exhausted. The question for the staff was whether to do further "extraordinary" or "heroic" measures to maintain fluid and nutritional intake for this elderly patient who had made no recovery from a massive stroke and who was largely unaware and unresponsive. After much mental anguish and discussion with the nurses on the floor and with the patient's family, the physicians in charge decided not to provide further IVs, cut-downs, or a feeding tube, and to allow Mrs. X to die. She had minimal oral intake and died quietly the following week. [This case has been adapted from one presented by Dr. Martin P. Albert, Charlottesville, VA]

In Case # 4, Dr. Hifiker (1983) reports being called at 3:00 AM by the nurse at the nursing home where Mrs T, an eighty-three year old woman, had been confined since her

6-20-81

stroke three years earlier. Mrs. T is now bedridden and aphasic, weighs only 69 lbs., and has decubitus ulcers on her back and hip, and the nurse reports that she has a fever, hasn't been eating much the last few days, and has a little cough. Dr. Hilfiker goes to the nursing home where he examines Mrs. T who peers at him from behind her blank face. His tentative diagnosis is pneumonia, and he asks the nurse to call the technician out of bed for a chest x-ray and also orders a urine culture. Dr. Hilfiker and the nurse note that Mrs. T's only friend in the nursing home who probably knows better than anyone else what Mrs. T. would want has said that she "hoped there wouldn't be any heroics if Mrs. T... got sick again." But the only relative (a distant niece who lives far away) had called to request that "everything possible" be done for her aunt. Dr. Hilfiker reflects, "There in the middle of the night I consider 'doing everything possible' for Mrs. T: transfer to the hospital, intravenous lines for hydration and antibiotics, thorough laboratory and x-ray evaluation, twice-daily rounds to be sure that she is recovering, more toxic antibiotics, and even transfer to our regional hospital for evaluation and care by a specialist. None of it is unreasonable, and another night I might choose just such a course. But tonight my human sympathies lie with Mrs. T and what I perceive as her desire to die... In any event I decide against the heroics. But I can't just do nothing, either. My training and background are too strong. I do not allow myself to be consistent and just go home. Compromising (and ultimately making a decision that makes no medical or ethical sense at all), I write orders instructing the staff to administer liquid penicillin, to encourage fluid intake, and to make an appointment with my office so that I can reexamine Mrs. T in 36 hours."

In case #3 the family and staff decided to let Mrs. X die even though they could have prolonged her life for some time through medical nutrition and hydration. In case #4 Dr. Hilfiker decided to encourage fluid intake and to administer liquid penicillin but not to provide intravenous lines for hydration and antibiotics. He conceded that his "compromise" made no "medical or ethical sense at all." Nevertheless, it clearly represents one way to draw lines in

withholding and withdrawing treatments.

As both cases suggest, one major issue in drawing lines is whether all medical treatments, depending on the circumstances, can be construed as "heroic" or "extraordinary" rather than "ordinary" or as "optional" rather than "obligatory" because out of proportion with the patient's wishes and interests. This question has been examined in several major court decisions and widely discussed in the literature in the last two or three years (see Lynn and Childress, 1983; Callahan, 1983; Capron, 1984; Cassell, 1984; et al.) in efforts to determine whether medical nutrition and hydration by peripheral or central intravenous lines, nasogastric tubes, or gastrostomies are more similar to other medical treatments, such as respirators, or more similar to the provision of food and water by mouth; whether they are needed for comfort and dignity even when they are morally optional for the prolongation of life; and whether they so symbolize care and compassion that to withhold or to withdraw them would threaten the foundation of humane and respectful medical care and ultimately our societal interaction. If nutrition and hydration through medical means is relevantly similar to other medical treatments, then their use can be decided according to the criteria discussed above.

Critics of this position, which I have defended (Lynn and Childress, 1983; Childress, 1985), make several arguments. One argument is that medical nutrition and hydration are significantly different from other medical treatments because they are essential for comfort and dignity even if they are not essential for life-prolongation. However, some means, such as a central IV, involve risks, and some means may require that the patient be physically constrained. In addition, there is evidence that patients who are allowed to die without artificial hydration may die more comfortably than patients who receive such hydration (Zerwekh, 1983). A second argument is that in withdrawing medical nutrition and hydration the agent intends or aims at the patient's death (Meilaender, 1984). However, as discussed earlier, this intention may be present in other cases, such as removing the respirator, and may not be

inappropriate in all cases.

Third, what is probably the major criticism stresses the symbolic significance of medical nutrition and hydration, contending that the similarities among all acts of providing nutrition and hydration are so great that it is impossible to distinguish their recipients (e.g., dying patients from others) or their methods (e.g., a gastrostomy from normal feeding). Such acts are not only means to the ends of sustaining life and providing comfort; they also express the values of care and compassion. However, it may be morally odd to view actions as symbolizing and expressing care when they violate the patient's interests (and thus the principles of beneficence, nonmaleficence, and autonomy). This moral oddity is particularly evident in cases where physicians start and continue intravenous lines but at a rate that will result in dehydration over time (Miccich, et al., 1983); it is possible to follow this approach only by failing to acknowledge that the patient will become dehydrated and malnourished while the IV line maintains a fiction and expresses a symbol.

Finally, concern about symbolic actions also leads several critics to hold that acceptance of withholding and withdrawing medical nutrition and hydration, even in legitimate cases, will lead to terrible consequences. For example, according to Mark Siegler and Alan Weisberg (1985), "Compassionate calls for withdrawing fluids in a few selected cases bear the seeds of great potential abuse....Continuing fluids, even to dying patients, provides an important clinical, psychological, and social barrier that should be retained." Fears about the removal of this barrier focus on a movement or slide from actions in accord with the patient's interests to actions in accord with the society's interests, from the patient's quality of life to the patient's value for society, from dying patients to nondying patients, from letting die to killing, from cessation of artificial feeding to cessation of natural feeding, etc. While some of these fears are exaggerated, some of them have to be taken seriously because of the new threats of under-  
treatment as a result of cost-containment measures in contrast to the earlier threats of

**overtreatment.** There is a danger that the "right to die" may become the "duty to die," even against the patient's own wishes and interests (Callahan, 1983). But it is not clear that this danger can be avoided only by mandating artificial nutrition and hydration in all cases, that is, by adding an external limit to the limits set by the principles back of and criteria involved in distinguishing obligatory and optional means of treatment.

As Cases #1, 2, and 4 suggest, in addition to symbolic actions, another major issue of line drawing is the connection of judgments about one level of care or about one technology to judgments about others. This issue is evident in debates about policies regarding cardio-pulmonary resuscitation, which are particularly important because "cardiac arrest occurs at some point in the dying process of every person" (President's Commission, 1983). Hence, it would be possible to use CPR in an attempt to prolong, at least briefly, the lives of most patients who die in hospitals. Although death is certain unless CPR is administered promptly, there is debate about whether the success of CPR should be measured by immediate or long-term results and whether the long-term results warrant CPR in as many cases as it is currently used, e.g., on cancer patients (Bedell, et al., 1983). Policies regarding CPR have emerged in some independence of other policies about life-sustaining technologies, such as respirators, in part because health care professionals, as in Case # 1, view not providing CPR as withholding rather than withdrawing treatment. Decisions to provide-- and often decisions not to provide-- cardiopulmonary resuscitation are made without advance consultation with patients or their families (see Bedell and Delbeno, 1984; Angell, 1984; Evans and Brody, 1985; Lo, et al., 1985). No adequate justification has been given for viewing decisions about CPR in hospitals as different from decisions about other life-sustaining technologies. Furthermore, it is often unclear to hospital staffs, as well as to patients and their families, what orders not to resuscitate imply, if anything, about other levels of care and other technologies. For example, some patients with DNR orders still receive chemotherapy, surgery, and admission to the ICU,



while others receive no supportive care (Evans and Brody, 1985). It may be appropriate to indicate very concretely what will be provided in case of cardiac arrest and which medical and supportive efforts will be continued and which will not after a DNR order has been given.

In Case # 5, "a 79-year-old widow had had recurrent exacerbations of congestive heart failure and chronic obstructive lung disease. During hospital admission three months previously, she had required intubation and mechanical ventilation. On discharge from the hospital, she had 'absolutely refused' to be intubated ever again. She was readmitted to the hospital for five days for another exacerbation. Only two days after being discharged, she was readmitted to the hospital. She repeated her wish not to be intubated, although she was willing to receive basic CPR if necessary. Pseudomonas pneumonia, oliguria, and episodes of ventricular tachycardia developed. On the 21st hospital day, she said that intubation 'might be considered'. When lucid, she sometimes 'wasn't sure' about intubation, and, at other times, the patient did not want intubation. On day 25, shock, hypoxia, and obtundation developed. Because there were potentially reversible causes for the deterioration of her condition, the physicians intubated her, administered pressor agents, and transferred her to the intensive care unit. On the 31st day, she responded unambiguously and consistently with head nodding that she wanted mechanical ventilation and maximal care. Her condition worsened; on day 40, she was comatose and still required mechanical ventilation and pressor therapy. The physicians judged that no reversible disease was present. With the concurrence of her son, treatment with pressor agents [was] discontinued, a DNR order was written, and she was allowed to die" (Lo and Steinbrook, 1983).

This case illustrates some of the moral and practical difficulties in respecting patients' wishes and meeting their needs, and it indicates some of the difficulties in drawing lines (a) between DNR, limited or partial or slow codes, and full codes, and (b) between decisions about CPR and other life-sustaining treatments. It is possible to argue that, when a patient's wishes and interests are considered, important distinctions can be drawn regarding levels and types of

0-3-80

care, both within CPR and between CPR and other treatments. However, these distinctions cannot be assumed to hold in all cases, because, if the above discussion is correct, no medical treatments as such are always obligatory; whether they are obligatory or optional in a particular case is a judgment call based on the patient's wishes and interests in the context of a (just) allocation of societal and hospital resources as well as social rules to prevent bad consequences.

### **B. Major Considerations in a Typology of Withholding and Withdrawing Life-Sustaining Medical Treatment**

In proposed and possible typologies of withholding and withdrawing life-sustaining medical treatment, the following issues are among the most important (see Childress, 1981):

- a. How is death brought about?
- b. Who brings it about?
- c. Who decides?
- d. Why is death brought about?

The major distinctions to this point have focused primarily on how death is brought about. Although "euthanasia" is sometimes defined by its etymological traces (from the Greek, eu + thanatos = good or easy death), its more common contemporary usage denotes "mercy killing." There are also disputes about whether in both suicide and euthanasia, the death must be brought about actively or whether it may also be brought about passively. The terms "active euthanasia" and "passive euthanasia" are sometimes used and are certainly more common than the terms "active suicide" and "passive suicide." The other issues raised in the previous section, especially direct and indirect effects and ordinary and extraordinary means, are also relevant to

possible typologies of withholding or withdrawing life-sustaining technologies.

Despite some overlap, there is an important distinction between who acts and who decides. Some analysts ignore the distinction between agents in acting in order to concentrate on agents in deciding; thus, Mayo (1983) insists that "voluntary active euthanasia is assisted suicide," and Tonne (1979) suggests that the term "suicide" should be replaced by the term "autoeuthanasia." However, it is important to preserve the distinction in final agency as well as in decision-making; who acts is important when we distinguish suicide from other actions. The line between "assisted suicide" and "voluntary, active euthanasia," both involving killing, is determined by who is the final actor, the patient or someone else. However, the question of who decides remains important in cases of "euthanasia" or "mercy killing," which may be voluntary, nonvoluntary, or involuntary from the standpoint of the patient.

Finally, there are the grounds of the decision, the why of the decision, whoever makes it and whoever carries it out. The major distinction is between patient-regarding reasons and other-regarding reasons, the former concerned with the patient's interests, the latter with the interests of others, such as family or society. These reasons are not always incompatible, but possible and probable tensions should be noted, particularly when a decision is made by someone other than the patient for the interests of parties other than the patient. Thus, it may be necessary to develop procedures to protect patient decision-making and patient wishes and interests (as discussed elsewhere in OTA's study).

There are too many factors and variables in decisions about withholding or withdrawing life-sustaining treatments to permit tight and illuminating typologies, but the above considerations identify themes that are important for describing and evaluating various acts, some of which will also appear in the discussion of suicide and its distinction from and relation to the refusal of life-sustaining treatments.

**C. Definition of Suicide and its Application to Cases of Elderly people  
Receiving Life-sustaining Technologies**

There is no clear, neutral, widely-accepted definition of "suicide." Suicide is always defined within traditions that make normative as well as conceptual points-- the definitions are intended to guide behavior. For example, some traditions hold that suicide is always wrong and then sharply distinguish acts of suicide from other acts that lead to one's own death, while other traditions hold that suicide can be justified under some circumstances and thus do not worry as much about the line between suicide and other acts that cause one's own death. Justified exceptions to a rule prohibiting suicide within one tradition may be built into the definition of the rule in another tradition.

Many definitions are efforts to offer necessary and sufficient conditions of a concept, such as suicide. However, in cases of "open-textured" concepts, it may be possible only to present what Wittgenstein called "family resemblances" in a list of criteria for the application of the concept. Before taking the latter route, it may be possible to identify some necessary conditions before encountering the rough edges of the concept of suicide. At the very least, the concept of suicide involves (a) a person's death, and (b) that person's involvement in his/her death. For an act to be considered a suicide it is necessary for a person to have intentionally brought about his or her own death, but these criteria are not sufficient to define suicide.

The questions and distinctions developed in the previous section suggest some key points:  
Who decides? In suicide, the one whose death is brought about makes the decision for death.  
Who acts? In suicide, the final actor, however much assistance is involved, is the one whose death is brought about. In Case # 6, Ida Rollin, 75 years old, suffered from ovarian cancer,

and her physicians indicated that she had only a few months to live, that chemotherapy would not arrest the cancer, and that her dying would be very painful. The chemotherapy made her bald and resulted in perpetual nausea and vomiting. She indicated to her daughter, Betty Rollin (1985), that she wanted to commit suicide and asked for her assistance in making it as efficient and as painless as possible. The daughter secured the pills and passed on a doctor's instructions about how they should be taken. When the daughter expressed reservations about what they were doing, her husband reminded her that they "weren't driving, she [Ida Rollin] was" and that they were only "navigators." As these metaphors suggest, in suicide, the person whose death is brought about both decides and acts. If the agent did not decide and act voluntarily, that is, apart from coercion by others, her act of killing herself is not an act of suicide (on the criterion of noncoercion, see Beauchamp, 1980). Nevertheless, there are disputes particularly about the intentionality of the act (some of these will be discussed under the heading of why is death brought about). At the very least, knowledge that an action will probably bring about one's own death is usually sufficient for suicide. Kluge (1976) distinguishes "suicidal act" from "acts of suicide." In suicidal acts, such as excessive smoking, drinking, or other risk-taking, an agent may know that his acts will probably result in his death, but this knowledge, along with his voluntary action, does not constitute an act of suicide. In acts of suicide, the agent must also intend to bring about his or her own death.

How is death brought about? In some traditions, when the death is brought about by letting nature take its course rather than by killing, by indirect rather than by direct means, and by forgoing "extraordinary" rather than "ordinary" procedures, the act is not considered suicide, especially if death from disease is inevitable and imminent whatever is done. In general, the more active the means of bringing about death and the closer the temporal association between the action and the death, the more likely the death is to be considered a suicide. Thus, several factors enter in some traditions to distinguish some refusals of treatment

400000

from acts of suicide: (a) whether the person is already terminally ill so that death is inevitable whatever is done and may be attributed to the underlying disease (i.e., nature or God's providence) rather than to the action; (b) whether the death is imminent regardless of what is done; (c) whether the means of death are active rather than passive and involve action rather than omission; (d) whether the death results fairly quickly after the action or omission; etc. Intuitions about these factors play a role in the application of the somewhat negative concept of suicide rather than the neutral concept of refusal of life-sustaining treatment. For example, as Tom Beauchamp (1980) notes, "to the extent that we have unmistakable cases of actions by an agent that involve an intentionally caused death using an active means where there is a nonfatal condition, the more inclined we are to classify such acts as suicides; whereas to the extent such conditions are absent, the less inclined we are to call the acts suicides."

Case # 7: When Barney Clark at age 62 became the first human to receive a permanent artificial heart on December 2, 1982, he also was given a key that he could use to turn off the compressor if he wanted to die. As Dr. William Kolff noted, "If the man suffers and feels it isn't worth it any more, he has a key that he can apply.... I think it is entirely legitimate that this man whose life has been extended should have the right to cut it off if he doesn't want it, if life ceases to be enjoyable...." (Rachels, 1983). Although there would have been vigorous debates about the characterization and evaluation of Clark's actions if he had used the key to end his life, according to most of the criteria that have been identified, it appears that his act should have been characterized as a suicide without necessarily prejudging its morality. According to some traditions, however, it is not possible to characterize an act as a suicide without simultaneously judging it negatively. For such traditions, the most likely response of those who viewed the action as morally acceptable would be that the artificial heart was experimental and extraordinary and that Clark simply acted to end an experiment or terminate an extraordinary treatment.

Why is death brought about? Although Margolis (1975) insists that suicide should include only "the deliberate taking of one's life in order simply to end it, not instrumentally for any ulterior purpose," others hold that suicide may be instrumental. It seems odd to limit the intention and motivation in the way Margolis proposes, since one may end one's life simply to end it, to avoid further pain and suffering, to protect the family's resources, etc. It is useful to distinguish two types of acts of suicide or attempted suicide (a similar distinction would apply to refusals of treatment). Following Max Weber (1967), we can call them "goal-rational" (zweckrational) and "value-rational" (wertrational) or, following David Wood (1980), we can call them "instrumental" and "expressive." In goal-rational or instrumental conduct, an agent attempts to realize some goal or end and to bring about some effect or consequence. In suicides of this type, the language of cause and effect, effectiveness and efficiency, is very important; for example, an agent may attempt or commit suicide because of his belief that death is better than his current or prospective life of pain and suffering or disability. In expressive acts of suicide-- often attempted rather than actual-- an agent conveys a meaning or makes a statement, such as a lack of hope or contempt for life. Some acts of attempted or successful suicide may be both instrumental and expressive.

For example (Case # 8) Jo Roman, a sixty-two year old artist, committed suicide on June 9, 1979 for both expressive and instrumental reasons. Having learned in March, 1978, that she had breast cancer which had spread to her lymph nodes, she underwent 10 months of chemotherapy before stopping and deciding to commit suicide. She finished a book on "Exit House" to argue for a social agency to ensure nonintervention and possible cooperation in "gentle" suicide for the old or terminally ill who want to end their lives, and she videotaped a session on "self-termination" for use on public television. With the help of her family and friends, she fashioned her "life sculpture"-- a pine coffinlike box filled with personal mementos, and then she wrote a farewell letter to 60 friends, said goodby to her family, and

swallowed 35 sleeping pills, washed down with champagne. Her family and friends cooperated. She committed suicide for instrumental reasons (she believed that death was better than suffering from cancer and chemotherapy and in order to publicize her goal of Exit House) and for expressive reasons (she wanted to express her beliefs about "self-termination" and her conviction that "life can be transformed into art"). (Incidentally, an autopsy indicated that her cancer had not spread beyond the lymph nodes to any vital organ.) [This case was drawn from articles in The New York Times, June 17, 1979, and Newsweek, July 2, 1979.]

An agent's motives may also be distinguished according to whether they are other-regarding (i.e., undertaken to benefit others, especially to save lives) or self-regarding (i.e., undertaken to benefit oneself, e.g., by avoiding pain and suffering). Some traditions tend not to characterize sacrificial acts as suicide, e.g., when a soldier falls on a grenade in order to save the lives of his comrades. Sometimes this distinction also reflects the rule of double effect; for example, Catholic moral theologians view the death as one that is accepted as a risk rather than intended or sought (see Task # 2). However, there are limits; in case # 2, even if Mr. R had been able to secure and take the lethal medication himself, rather than having it administered by his physicians, his act would have been a suicide despite his other-regarding reason of not wanting to deplete his family's resources. And, of course, motives may be and usually are mixed. For sacrificial actions and in part for refusals of treatment, Beauchamp (1980) argues that the issue is whether "death is caused by conditions not specifically arranged by the agent for the purpose of bringing about his or her own death." If the agent did not specifically arrange the conditions to bring about his or her own death, he does not commit suicide in dying for others.

**D. Analysis of Cases to Illustrate Distinctions and Categories**

The eight cases already presented in Task # 1 depict typical problems and also illustrate important distinctions, e.g., between suicide and other modes of refusal of treatment.



### **E. Normative Implications of These Distinctions**

The normative implications have necessarily been largely interwoven in the conceptual analysis because most of the concepts themselves have been developed to reflect values. At each point, evaluative issues and debates were identified, and suggestions were offered for their resolution. Basically, the various distinctions regarding the termination of life-sustaining technologies-- withholding and withdrawing; direct and indirect effects; killing and letting die; and ordinary and extraordinary means of treatment-- were developed to express important moral principles and values. Focusing on these distinctions is useful but also potentially misleading unless attention is also paid to the underlying principles and values that may not be adequately expressed in the distinctions under new circumstances, including new technologies to sustain life. These principles and values (see p. 1) establish a presumption in favor of life-sustaining treatments, particularly that life is in accord with the patient's interests and wishes. But this presumption can be rebutted in many cases by appeal to the same principles. The various distinctions are largely (but not completely) attempts to indicate the limits on the obligation to prolong life by available technologies and to set limits on how death may be brought about. Most of the distinctions indicate when actions that result in death do not constitute violations of the principle of nonmaleficence and are justified by other considerations. However, the distinctions do not provide moral answers but point to relevant moral considerations, which are sometimes obscured by concentration on the distinctions. For fuller reflection on their value and deficiencies, see section A above.

## **Task # 2. Description of Important Ethical Traditions Relevant to Withholding or Withdrawing Life-Sustaining Technologies and/or Suicide**

This section will examine the traditions that are particularly relevant for interpreting actions in the pluralistic society of the USA; these traditions may also set limits on what is acceptable and feasible in public policies. For each of these traditions, it is important to identify its conception(s) of a "good" death and the appropriate actions to secure or permit such a death. The distinctions that have already been developed will be used to offer concise expositions of these traditions, which fall into three main groups.

First, there are the major religious traditions that are influential in the USA: Catholicism, Judaism, and Protestantism. It is not unimportant that they share the Hebrew Bible or Old Testament as one of their important authorities, since this scriptural source shapes part of their conception of God, his relation to the world, human life, and death. However, it is not their only authority, and there are important differences not only among three major traditions that are part of what is sometimes called the "Judeo-Christian" tradition, but within each of these traditions. However, decisions about life and death within these three major traditions are shaped in part by a fundamental perspective: God directly or indirectly is in control of life and death and His will, whether expressed through revelation or natural law, should be respected. In general, a good death is one that occurs within the context, including the moral limits, set by this perspective. As Battin (1962) notes, many of the religious arguments against suicide (and, one might add, against mercy killing) draw on analogies, usually between God and human life, on the one hand, and ordinary relationships, on the other. Many of these analogies involve property relationships (e.g., life is a gift or loan from God) and/or personal or role relationships (e.g., human beings are God's children, servants or sentinels). These are

sometimes combined with natural law arguments, as in Roman Catholicism. In general, it is fair to say that these three religious traditions rule out suicide (in most circumstances) and also active euthanasia or "mercy killing" (in most circumstances) (Larus, 1985).

For Judaism, the discussion of suicide and euthanasia, and conceptions of good life and death, must be placed in the context of an active, willing deity's relation to the world and the human beings within it. Human life receives its value from God, who grants it as a gift and who alone can take it away (Siegel, 1979). Through its rejection of suicide, Judaism "affirms its high valuation of life and its belief in the sovereignty of the Creator" (Siegel, 1979), who can sustain human hope; suicide is a denial of God's providence. The texts in the Hebrew Bible that records instances of suicide, such as Samson and Saul, do not explicitly condemn them, and the prohibition of suicide is derived not from the Decalogue ("Thou shalt not kill") but from Genesis 9: 5, which prohibits the shedding of human blood because human beings are created in the image of God. The Talmud holds that the duty to protect human life takes precedence except where murder, sexual immorality (i.e., incest or adultery), or idolatry would be required in order to protect it. Indeed, the duty to protect life takes priority over other religious duties such as keeping the Sabbath holy. According to some Rabbinic texts, Saul's suicide was undertaken in order to avoid profanation of God (Siegel, 1979). Similarly, martyrdom is acceptable under some circumstances, as an affirmation of faith in rather than a denial of God. The rules for rituals of mourning and interment exclude the person who has committed suicide. However, as in other traditions, the critical question is which acts are counted as acts of suicide, as "real suicides." The key criterion is willfulness, and the tradition has developed such detailed rules of evidence for willfulness "that for all practical purposes almost all suicides are treated as individuals who destroyed themselves 'unwillfully'" (Siegel, 1979) and they are accorded the usual rites for the dead. In effect, some deaths that would otherwise be counted as suicides are

removed from that category because of the lack of sufficient evidence of willfulness; since there is a presumption that no one would willfully commit suicide and deny God's sovereignty, the burden of proof to establish suicide is high. Even the presence of fear of pain and suffering, for example, may be sufficient to deny willfulness and excuse the agent by removing the condemnatory label of suicide; by contrast, avoidance of murder, sexual immorality, or idleness could justify the act of suicide.

In general, the Jewish tradition has ruled out mercy killing on the same grounds as suicide; as Maimonides wrote, "He who kills, whether [the victim] be a healthy person or a sick person approaching death, or even a patient already in his death-throws, is treated as a capital criminal" (quoted in Jakobovits, 1978). The tradition has also held that it is not permissible to do anything that might hasten death, but it has permitted removal of anything that might artificially prolong dying, i.e., prevent the soul from departing.

Regarding the dying person (goose), whose death is thought to be imminent (within three days, according to some authorities), the tradition has required that such a person be treated as a living person in all respects and that nothing be done that might hasten his death, e.g., closing the patient's eyes or removing a feather pillow from under his head. After excluding mercy killing, a major text in the tradition says of the dying patient: "Still you may not put salt on his tongue to keep him alive longer." It also notes that "if a person is dying and someone near his house is chopping wood so that the soul cannot depart, then one should remove the (wood) chopper from there" (Roemer, 1972; Weisbard, 1979). The important distinction is between actively hastening death, which is prohibited, and removing impediments to death, which is permitted (Weisbard, 1979). Of course, it always been easy to extend the principles and rules embodied in the tradition to new conditions occasioned by technological developments, such as the respirator and artificial nutrition and hydration. The extension has occurred through analogical

arguments. Even though direct killing and hastening death are ruled out by the Jewish tradition, there are debates about appropriate withdrawal and withholding of life-sustaining treatment. There are both stringent and lenient interpretations. On the grounds of the sanctity of life, some rabbinic authorities "will not allow any relaxation of efforts, however artificial and ultimately hopeless, to prolong life" (Jakobovits, 1978, p. 801); others allow withholding or withdrawing "heroic methods" that only prolong dying. In general, the tradition appears to give strong support to viewing respirators as heroic under some circumstances, but there are more debates about antibiotics and artificial nutrition and hydration. Some interpreters hold that the principles, rules, and precedents in the Jewish tradition permit termination of antibiotics in some circumstances, but they are less sure about artificial nutrition and hydration, which, some hold, might be distinguishable from ordinary, natural means of sustenance (Jakobovits, 1978; Weisberd, 1979).

A few other points will complete the main contours of Jewish thought and practice on these matters. First, the Orthodox, Conservative, and Reform Jewish traditions differ in part according to their approach to the Jewish tradition, the Orthodox concentrating on the rules, the Conservative emphasizing that the proper interpretation of the rules depends on attention to the principles or values back of the rules, and the Reform tradition stressing the principles or values, such as respect for persons or autonomy, rather than the rules. Obviously, their approaches to the major rules and principles discussed above will differ accordingly. Second, there are, nevertheless, the rudiments of a conception of a good death as one that occurs in accord with the divine will and providence. Since the Jewish tradition has not emphasized a sharp distinction between spirit and body, it has not been tempted to view suffering as positive or to view medical care as "flying in the face of providence" (Jakobovits, 1978, p. 793). There is a duty to prolong life, but not to prolong dying. (Of course, there are duties to a corpse, but not duties to prolong the functioning of its bodily parts; however, disputes about the meaning and criteria of death are beyond the scope of this report.)

The Roman Catholic tradition has also prohibited suicide, using both analogical arguments and natural-law arguments. For example, Thomas Aquinas (ET, 1981) argued that "life is God's gift to man, and is subject to His power, Who kills and makes to live." Suicide is a "mortal sin" because it is "contrary to the inclination of nature and to charity whereby every man should love himself." Finally, through the act of suicide the agent injures the community of which he or she is a part. Thus, suicide is an offense against the self, nature, society, and God. In general, because of a conviction drawn from the New Testament that it is never right to do evil that good might result, official Church teachings and Catholic moral theologians do not justify acts of suicide. However, as in Judaism, there is a difference between a moral and a pastoral response; the religious-moral condemnation of acts of suicide does not translate into an unqualified negative pastoral response after apparent acts of suicide, in part on grounds of limited personal responsibility.

More significantly from a moral standpoint, the Catholic Church has managed to accommodate some conflict situations, not through excusing agents (the pastoral response) or justifying suicide, but through a clarification of the meaning of the prohibition of acts of suicide so that it does not include some self-sacrificial acts that are instances of charity or neighbor-love. Hence, some acts that might otherwise appear to be acts of suicide are held not to fall under the prohibitive rule. This response to a conflict situation is drawn from the doctrine of double effect (discussed briefly under Task # 1); according to this doctrine, a soldier who falls on a grenade to save his comrades performs a sacrificial, heroic, or charitable act rather than a suicide, because the action itself (falling on the grenade) is morally good or neutral, the evil effect (one's own death) is foreseen but not directly intended, the evil effect (one's own death) is not a means to the good effect (saving the lives of others), and there is sufficient reason (saving the lives of others) to allow the evil effect (one's own death) to occur. This doctrine of double effect has been criticized both inside and outside Roman Catholic thought. Several moral

theologians have replaced it by a doctrine of proportionate reason, but it still holds sway in official Church teachings. When suicide is viewed as intrinsically evil and the doctrine of double effect is used, very few cases other than martyrdom and some self-sacrificial acts would escape the prohibition against suicide; certainly killing oneself to stop pain and suffering from terminal illness, to avoid a poor quality of life, or to reduce the burden to others, would not qualify as justified "exceptions" to the rule.

The Catholic Church has introduced other distinctions, some of which have permeated public consciousness and policy, to permit actions that might appear at first glance to be ruled out by the principle of the sanctity of human life drawn from convictions about God's revealed will and the natural law. First, even though Catholicism has praised suffering for its educative and spiritual value more than Judaism has, and even though it has recognized that voluntary moderation of the use of painkillers may be a conscious association with Christ's sufferings, it has emphasized that "it would be imprudent to impose a heroic way of acting as a general rule" (Sacred Congregation, 1980). The rule of double effect also permits the use of medications to relieve pain and suffering even when their use will hasten death, a foreseen but unintended consequence (see the discussion under Task # 1).

Second, Catholic thinkers developed the distinction between ordinary and extraordinary means of treatment to indicate the limits of the obligation to prolong life; if a patient does not use extraordinary means of treatment, his/her refusal is not tantamount to suicide, and if a professional or a family member withholds or withdraws extraordinary means in accord with a competent patient's wishes or an incompetent patient's best interests, it is not mercy killing (euthanasia). It is not obligatory for patients to accept or for professionals and families to offer and provide all means of treatment that might sustain life at least briefly. Means that are futile or useless or that produce burdens that outweigh their benefits are "extraordinary" or "heroic," and their use is optional, not mandatory (Kelly, 1950; 1951; Sacred Congregation, 1980).

Thus, the Catholic moral tradition permits withholding or withdrawing life-sustaining treatments, such as the respirator in the Quinlan case. The decision may be made by the patient himself/herself or by a proxy as long as the guidelines of the ordinary/ extraordinary distinction are followed.

As we saw earlier (under Task # 1), there is controversy about these guidelines, particularly about what may be included under the calculus of proportionality, the calculus of benefits and burdens-- for example, whether the anticipated poor quality of the patient's life (rather than the burdens of the medical treatment) may be counted as a burden or whether the anticipated poor quality of the patient's life may constitute such a limited benefit as to make further treatments optional even though the life could be sustained indefinitely (McCormick, 1978). In part the issue is whether the categories can be applied to those who are not irreversibly dying. There is also debate about whether all medical treatments that sustain life can be brought under the category of extraordinary means of treatment depending on the patient's circumstances. In recent years, this debate has focused on medical nutrition and hydration; many, but by no means all, Catholic commentators hold with John Kelly (1951) that even medical nutrition and hydration may be optional under some circumstances (McCormick, 1985). (For further analysis of the distinction between ordinary and extraordinary means of treatment, see Task # 1.)

It is important to emphasize that the distinctions between direct and indirect effects of actions and between ordinary and extraordinary means are designed not to justify either suicide or mercy killing, but to deny that some acts that appear to fall under the prohibition of the killing of an innocent person (which rules out both suicide and mercy killing) are in fact covered by them. Euthanasia, understood as "an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated," is intrinsically wrong as the direct killing of an innocent person (Sacred Congregation, 1980).



Along with suicide it is wrong because of its intentions and methods. A "good" death in the Catholic context is thus one that through intention and methods is in accord with the divine will as expressed in scripture and in the natural law. For most people it will be a death that is as free as possible of pain and suffering, short of active killing; however, for some people who choose a heroic way in accord with Christ's sufferings, it may involve conscious reduction of painkillers. It is not a good death if it involves killing, whether by oneself or by others; such killing constitutes a mortal sin.

Even though Catholicism is more diverse than it was before Vatican II, it is still more uniform, at least in its official teachings, than either Judaism or Protestantism. It is rarely possible to identify the Protestant stance on any matter of significance, since Protestantism encompasses so many different denominations and stances from fundamentalism to liberalism. On the whole, Protestants tend to take a more individualistic approach to decisions about life and death than either Catholics or Jews. Even Protestants who emphasize rules drawn from scripture (revealed morality) are often suspicious of the kind of detailed casuistry that they see in Catholicism or Judaism. Some Protestants fear that through casuistry people may believe that they can avoid sin and become righteous instead of recognizing that they are inevitably sinful and must accept God's righteousness (justification by faith). Hence, with such exceptions as Paul Ramsey (1970; 1978), Protestants are less likely to develop the sorts of detailed distinctions that appear in Catholicism and Judaism.

Regarding suicide, some Protestants contend that it is wrong because it violates biblical rules that prohibit killing; others (e.g., Karl Barth and Dietrich Bonhoeffer) hold that it is wrong because it displays a lack of trust in and faithfulness toward God. However, in general, Protestants are less likely to make the prohibition of suicide absolute than are Jews and Catholics. For some Protestants it appears to be *prima facie* rather than absolutely wrong, its actual wrongness depending on various circumstances. For example, reflecting the debate about

the Van Dusens' joint suicide (see Case #10), a pastoral letter of the Presbytery of New York City in 1976 concluded that "It is clear that for some Christians, as a last resort in the gravest of situations, suicide may be an act of their Christian conscience" (Battin and Mayo, 1980).

Two of the most influential and prolific Protestant writers in biomedical ethics are Joseph Fletcher (1954; 1967; 1979) and Paul Ramsey (1970, 1978). Fletcher defends both suicide and active euthanasia, but Ramsey rejects both of them while accepting a wide range of treatment refusals limited by the kinds of considerations that appear in the Catholic doctrines of double effect and ordinary/ extraordinary means of treatment. In his earlier writings Fletcher based his argument for suicide and active euthanasia on personalism and asked which actions would respect persons. In his later writings he based his argument on utilitarianism and asked which actions would maximize human welfare. Explicit theological convictions play only a modest role in his later writings, which also emphasize criteria of quality of life stated in terms of *humanhood*.

By contrast, Paul Ramsey rules out both suicide and mercy killing-- though he appears to recognize some exceptional borderline cases. Ramsey affirms certain limits on the refusal of life-sustaining treatment by *competent* patients; the individual's will does not always triumph, and paternalistic interventions are sometimes justified to protect the patient's best interests. In decisions about *incompetent* patients, Ramsey opposes all judgments about quality of life; for him what is important in the ordinary/extraordinary distinction can be "reduced almost without significant remainder to a medical indications policy" (Ramsey, 1978, p. 155). Thus, to determine which treatment is obligatory and which optional for incompetent patients, it is sufficient to determine which treatment is medically indicated and which is not. For the *dying* patient, the relevant choices are between further palliative treatments and no treatments. For unconscious or incompetent *non-dying* patients, regardless of their quality of life, there is an obligation to use the treatment that is medically indicated. Ramsey's fear is that we are sliding

toward a policy of active, involuntary euthanasia for unconscious or incompetent nondying patients. Against such a policy, he asserts an "undiminished obligation first of all to save life and in the second instance, to use palliative treatments where possible" (1978, p. 165). Above all, he rejects any quality-of-life judgments because they violate the principle of equality of human lives, drawn from God's creation of human beings in his image and his indiscriminate care for all.

Another Protestant theologian, Arthur Dyck (1977) rejects euthanasia on the grounds that mercy or kindness includes both not harming (killing) and benefitting others and that not harming takes priority over benefitting others. Against arguments for beneficent euthanasia by such humanist thinkers as Marvin Kohl (see below), Dyck proposes an ethic of "benemortasia," which would extend the following kinds of care to patients whose death is imminent: relief of pain and suffering, respect for the right to refuse treatment, and provision of health care without regard for ability to pay. Some would argue, against Dyck, that death is not always a net harm even if it is always a harm and that killing may express mercy and kindness in particular circumstances, but some of them and others find arguments against euthanasia convincing if they are stated in terms of rules of practice rather than acts that are always wrong. Still other Protestants focus on the character of agents and reject both suicide and euthanasia because of what they symbolize and express about agents, either individuals or communities (Hauerwas, 1981).

Before turning to other religious and secular positions, it should be noted that while suicide is generally prohibited by all three major strands of the Judeo-Christian tradition, their adherents have different rates of suicide. At least since E. Durkheim's (1897; ET 1951) famous study of suicide in the late nineteenth century it has been observed that on the whole Protestants have a higher rate of suicide than Catholics, who in turn have a higher rate of suicide than Jews. This pattern still holds (Miller, 1979); its explanation is complex since it

does not depend on either the prohibition of suicide or sanctions against suicide (e.g., a mortal sin) but rather, Durkheim argued, on the degree of integration of individuals into the community. Protestantism tends to be more individualistic than either Catholicism or Judaism. Because Durkheim focused on the degree and intensity of social integration, he paid less attention to the individual's commitment to as well as the content of religious beliefs; some recent studies note secularization of beliefs among individuals who adhere to these religious traditions (Sheldman, 1976). Other studies (Jacobs, 1982) suggest that religious beliefs may structure the justifications that people who commit suicide offer in their notes to survivors, particularly in order to resolve the moral prohibition of suicide and to keep open the possibility of a happy afterlife. Some recent studies have found more tolerant attitudes toward suicide among Jews, followed by Protestants, and then Catholics, but they also recognize the role of several personal factors, including the strength of the religious ties (Miner and Brush, 1980).

It would also be useful to have studies of variations in refusal of life-sustaining treatment among the adherents of these traditions. Since the principles developed in these traditions apply to professionals as well as to patients, it is also possible to examine their impact on professional practices. In a study that was conducted in 1970-71 before some major changes had occurred in public policies toward the withdrawal of life-sustaining treatment, Diana Crane (1975) found that liberal Protestant physicians were the least inclined to be activists, i.e., to undertake heroic measures to prolong patients' lives, while Jews were the most inclined to be activists. She found that these tendencies persisted even among people who identified with these traditions but who were not very religious.

The secular traditions of libertarianism and humanism reject the theistic context that structures so much of the argument against suicide and mercy killing and for certain allowed deaths in Jewish and Christian religions, and they tend to reject the kinds of distinctions that evolved in those religious traditions to express the limits of the obligation to prolong life. The

good life and the good death will express those human qualities that these secular traditions emphasize. In general, libertarians recognize and respect a person's autonomous choices as long as they do not harm others; those choices may legitimately include suicide and mercy killing along with refusals of life-sustaining treatment. Libertarians may also argue for eliminating the legal prohibitions against assisted suicide (Engelhardt, 1985; Engelhardt and Malloy, 1982). Rights attach to persons, who may exercise them as they choose as long as they do not violate the rights of other persons.

Humanists tend to include but may not rely as completely on personal liberty and autonomy as libertarians. Whereas some libertarians view respect for autonomous choices (liberty) as the only moral obligation, humanists often recognize kindness or mercy as an obligation, not only as a praiseworthy action. For example, Marvin Kohl (1974; 1977), a humanist philosopher, argues that beneficent euthanasia (painless inducement of quick death resulting in benefit for the recipient) is a prima facie obligation because individuals and societies have a prima facie obligation to treat people kindly and because beneficent euthanasia is kind. Beneficent euthanasia is not limited to cases that involve a patient's request for or consent to euthanasia, the imminence of death, and the presence of pain. The patient's quality of life is a relevant and often decisive consideration.

Many humanists, especially those who emphasize utilitarian ethical considerations, may agree with Kohl (or even libertarians such as Engelhardt) about particular acts, but reject a rule or practice of assisted suicide or mercy killing, even to benefit and to respect patients who request death. They may be convinced that the overall consequences will be worse if society accepts assisted suicide and/or mercy killing than if it maintains its rule against them. Such an argument puts the libertarian and humanist considerations in a broader social setting with particular attention to the dangers of abuse and of the slippery slope (see Beauchamp and Childress, 1983).

Since arguments by religious thinkers are not necessarily religious at every point, some religious thinkers and groups-- some of whom might be described as "religious humanists"-- also recognize the validity of this sort of argument against a rule permitting assisted suicide and active euthanasia, either in addition to or in place of specifically religious arguments. Indeed, such secular arguments are often used in a pluralistic society, whatever other grounds a group may have for supporting rules against assisted suicide and active euthanasia, such as convictions about the intrinsic wrongness of the acts in question. It is rarely possible to argue directly from a conviction that an act is a sin (i.e., an offense to God) to a recommendation for a prohibitive policy.

Some other religious traditions are not as important numerically in the USA as the ones discussed earlier, even though they are as important to their participants. One of these is Islam, which has many affinities with Judaism and Christianity, sharing in particular the conception of a transcendent, active, willing deity, whose will must be followed. With Judaism and Christianity, the Koran notes that "It is not given to any soul to die, save by the leave of God, at an appointed time" (quoted in Smith and Perlin, 1978). This general principle has supported a prohibition against suicide, as has the tradition that the Prophet Muhammed refused to bury a person who had committed suicide. This principle also supports a prohibition of mercy killing. Some commentators hold that it is "tantamount to murder to hasten the death of a patient even when he suffers from endemic pains" (Abdul-Rauf, 1978), but since they also recognize that it is permissible and even obligatory to relieve pain, it is not clear whether they have a principle similar to double effect. Although there is debate about the proper interpretation of the Islamic tradition, some Muslims hold that "the artificial prolongation of the life of a terminal patient who has permanently lost consciousness is morally unjustifiable" (Abdul-Rauf, 1978). As with Jewish and Christian approaches, the question about a good or appropriate death focuses on the divine will as expressed in commandments and providential actions.

0047

Often misinterpreted and distorted by Western thinkers as putting little value on life in this world, the Eastern religious traditions have complex attitudes toward suicide. Early Indian religious traditions opposed suicide, but later Hinduism not only permitted but even commended the heroic sacrifice of the holy person (the *sannyasin*), usually by passive means, such as death by ascetic refusal to eat, rather than by active means (Smith and Perlin, 1978). Suicide by a widow (*suttee*) also developed in India. Early Indian Buddhism prohibited suicide, but later Buddhism also recognized the heroic renunciation of life through passive means. It is fair to say that "Buddhism does not necessarily prohibit suicide, but according to Buddhist sacred texts suicide is meaningless, for by resorting to suicide one cannot save oneself from the miserable condition of mundane existence (or transmigration); karma (actions) are supposed to accompany a person who has committed suicide even after his death" (Nakamura, 1978). In general, for both Hinduism and Buddhism, the attitudes displayed in action and nonaction and their effects on rebirth and ultimate release are critically important in the conception of a good death. The attitude toward suffering rather than suffering itself is central. (Some forms of suicide for honor also came to be praised particularly in Japan, where *harakiri* or *seppuku* has sometimes been chosen over a dishonorable death.) Less has been written about Hindu and Buddhist attitudes toward mercy killing, and attitudes toward refusal of life-sustaining treatment are still in evolution as these traditions confront the new problems occasioned by these technologies.

In conclusion, main religious traditions in the USA tend to oppose direct killing, whether in suicide or active euthanasia. However, they recognize some exceptions (often not considered suicides) and distinguish suicide and active euthanasia from treatment refusals or withdrawals, which are acceptable in many circumstances. In general, these religious traditions, often joined by humanists as well, defend the legal prohibition of assisted suicide and active euthanasia because of their worries about the negative consequences of permitting them,

but they also support laws that allow competent individuals to refuse life-sustaining treatments for themselves and for incompetent patients, under some circumstances (they frequently disagree about the appropriate circumstances). They thus accept a legal right to die and to let die, but they usually oppose a legal right to kill and to be killed. However, significant minority voices in the religious traditions and numerous voices in the humanistic traditions support acts of both assisted suicide and active euthanasia and rules that permit them. These issues will be discussed in more detail in Task # 4, which focuses on prevailing concepts of assisted death.

But what a tradition says about suicide or refusal of treatment from the standpoint of either the individual agent or public policy may not enable observers to predict any individual's actions regarding suicide or refusal of treatment. Too many other factors, such as the individual's level of commitment to the tradition, may be important. Nevertheless, more studies are needed, particularly of expressed attitudes in these traditions and of correlations between religious beliefs and practices, on the one hand, and acts of suicide and refusal of life-sustaining treatments, on the other. In addition, studies are needed of the impact of religious beliefs and practices on families and professionals who must decide whether to withhold or withdraw life-sustaining treatments from incompetent patients. In any study, it is important to consider traditions as viewed and lived by their practitioners. For example, in many public discussions surprise is sometimes expressed about the latitude in decisions to withhold and to withdraw life-sustaining treatments in Roman Catholicism, which is widely viewed as "pro-life." But that latitude falls within the range of discretion allowed by the categories that have been developed in this tradition and that were discussed above.



### **Task # 3: Age-Specific Data on Suicide Among the Elderly**

**"People 60 and older represent 18.5 percent of the United States population, but commit 23.0 percent of all suicides" (Miller, 1979, p. 1). Despite such statements, there are major difficulties in obtaining accurate and helpful statistics about the incidence of suicide-- and also of refusal of life-sustaining treatment-- among the population at large and especially among the elderly. One source of difficulty that is common to all age groups is conceptual: exactly which acts count as acts of suicide? As we saw earlier, definitions of suicide tend to include the agent's intention along with the nature and circumstances of the act. Since "suicide" is not a theory-neutral or value-neutral concept, what counts as an act of suicide varies from theory to theory and value-system to value-system. Among the numerous other reasons for underreporting suicides, Miller (1979) identifies four as especially important: (1) not wanting to stigmatize survivors; (2) allowing survivors to collect larger life insurance benefits; (3) not being aware of the decedent's intentions because the family or friends destroyed or hid suicide notes; (4) the tendency of some coroners to certify a death as a suicide only when a note has been found (despite research findings that most suicides do not leave notes).**

**The moral opprobrium or stigma that clings to suicide in most communities-- in part because suicide appears to be an act of aggression against others or at least to signify the failure of others-- leads to two different efforts to deny that the agent committed suicide. First, there is an effort to deny that the agent was responsible for his or her acts; if the agent was not competent, did not understand what he or she was doing, or did not act voluntarily, he or she was not responsible, and however much the act resulting in death resembles "suicide," it was not finally an act of suicide. This interpretation appears in religious communities that operate with a distinction between moral and pastoral responses to suicide, affirming morally that suicide is**

40050

wrong and often affirming pastorally that the agent was not responsible for his/her acts and thus did not commit suicide, a blameworthy act. This interpretation is supported in part by the common psychiatric view of suicide as the result of mental illness. One implication of this approach is to deny that people who attempt suicide are acting rationally.

Although the first effort has only subtle effects on the accuracy of suicide statistics, the second effort has a major impact and greatly reduces their reliability. It avoids the harm that might result from the label of suicide by not counting doubtful cases as acts of suicide. For example, some countries include "probable" suicide in their statistics, while others list such cases under the rubric "Cause of death unknown" (Brooks, 1974). Coroners differ greatly on the amount of evidence they require to view an act as one of suicide; for example, as mentioned above, some coroners insist on the evidence of suicide note, which statistically appears in less than half of the deaths currently counted as suicides and even less frequently in suicides by the elderly. In doubtful cases, it is often easier and less troubling to count the death as an "accident," rather than as a suicide, and yet studies indicate that many so-called accidents probably resulted from the agent's intention to die or to take or create a high risk of death.

Because suicide is generally viewed as a single act, rather than as a process (Miller, 1979, p. 18), it excludes such extended acts as noncompliance with a physician's orders regarding the use of medications or delaying medical treatment, which may be acts of slow suicide if they are undertaken by competent people with understanding and voluntariness. Some acts such as excessive consumption of alcohol or drug abuse may be suicidal acts without being acts of suicide (Klug, 1975). Because acts of suicide are generally viewed as active rather than passive-- even though there are clear exceptions-- some refusals of life-sustaining treatment, particularly when death is imminent, would not be counted as suicide. Unfortunately, there are not, to my knowledge, any good statistics on refusals of life-sustaining treatment, as distinguished from suicide. Even though it is not difficult conceptually to

distinguish suicide from active euthanasia because the final agency is different, it is more difficult to distinguish suicide from refusal of treatment in all cases.

In addition to these general reasons for the inadequacy of available statistics regarding suicide, some reasons apply specifically to the elderly as a group. Even though there are problems with the statistics, the statistics are clear and certain enough to establish some of their own limitations. As a group, elderly people who commit suicide tend not to communicate their intentions in advance or to leave notes; in addition, they tend to be successful (Miller, 1979).

Despite their limitations, the available statistics may be useful, if interpreted with carefully and cautiously. In general, suicide rates increase with age, and the rate of suicide is higher for elderly Americans than for any other age group (see Appendices; Miller, 1979; Sherman, 1980). It is important to note that the rate of suicide attempts among the elderly is roughly the same as the rate among younger age groups, but that the elderly succeed at a higher rate (Berde, 1977, p. 26): their attempt-completion ratio is two to one, while the ratio is twelve to one for the general population. These figures suggest that the elderly attempt suicide to bring about death rather than to communicate with and control others. When suicide rates per 100,000 are examined by five-year age groups from 1933-1968 and 1972 (see Appendices), the increase in suicide rates as people grow older is clear. The increase is not totally even, since, in 1968, for example, there is an increase to age 55-59, a decline through 75, and another increase over 75. For most of the years covered by these statistics, the highest suicide rate is found in the group 75 and over. For those over 65, the suicide rate has usually been at least two and sometimes three times the national average for all groups (see also Sherman, 1980). (For further breakdown by age, see Appendices.) In 1975, of the 27,063 suicides certified across the USA, people 60 and older committed 6,228 of them (Miller, 1979).

However, in view of the incompleteness of the statistics and the probable underreporting of suicide for reasons indicated earlier, some have estimated that this figure for people 60 and older must be at least 10,000 (Miller, 1979).

Some long-term trends should be noted. First, the suicide rate among people over 65 declined gradually from 1950 to 1970; it has levelled off or declined slightly since 1970. There is debate about the cause of this decline, particularly since the suicide rates among younger people increased at the same time. Although most commentators identify several possible causal factors, many agree that the provision of increased social support as a right is a major factor in the decline of suicide among the elderly (Miller, 1979, pp. 2-3; Sherman, 1980). Second, because of the continuous increase in the number of elderly persons, there is also an increase in the number of elderly suicides, despite the decrease in the rate per 100,000 elderly persons. Third, the percentage of suicides within the total number of deaths for a cohort decreases with age. Even though the suicide rates increase with age, the death rates by all causes also increase; thus, suicides constitute a larger proportion of the total number of deaths for the young than for the elderly (Beachler, 1979).

Presented as statistics about the elderly as a group, the figures to this point are seriously misleading because they fail to distinguish specific groups among the elderly. Of particular importance are the differences between sexes and races: The high suicide rates among the elderly can largely be attributed to white males. As Miller (1979) notes, "It is only among white males that the suicide rate increases throughout the life cycle." The suicide rate for older white males is almost four times greater than the average for the US as a whole (Miller, 1979). In general, females attempt more suicides, males complete more suicides. This gap increases significantly among the elderly: For ages 65-69, males complete four to every one for females; by age 85, the figure is twelve to one (Miller, 1979, p. 3). This difference between elderly male and

6-3085

female suicides has been attributed to several factors, including the perceived decline in male independence and status through retirement, illness, loss, etc., but there is no consensus about these factors.

While non-white suicide rates are roughly equal to those of whites until age 35--and may even be higher for American Indians and blacks from ages 15-29 (Miller, 1979, pp. 4-5)--there is a substantial gap after that point (Sherman, 1980, p. 31). Some theorists attribute this difference to the greater relative deprivation of status, power, and influence experienced by aging white males through retirement, etc., since blacks have experienced greater absolute deprivation all through their lives. There is also some evidence that blacks in the US even acquire improved social status as they grow older (Butler and Lewis, 1973; Miller, 1979). Because of the major statistical differences between suicides by white males and others, most studies concentrate on white males.

What are the main characteristics of elderly suicides? In particular, do any characteristics reflect factors that are also significant in refusal of life-sustaining treatment, such as physical illness and poor quality of life? First, elderly suicides that are recognized as such tend to be committed by active and violent means that support claims of intentional behavior; typical acts are shooting, jumping, hanging, and drowning (Miller, 1979, p. 18). Suicide by gunshot is the most common.

Second, there is debate about the whether mental and/or physical illness is an antecedent and causal factor in elderly suicides. Some studies, as indicated earlier, suggest that mental illness is a primary factor in many elderly suicides (see Batchelor, 1957; Miller, 1979, p. 33; Robins, 1981). Yet there are widespread and vigorous debates about the meaning and criteria of mental illness. If a person is mentally ill, it is usually considered appropriate to intervene to stop the attempted suicide; if a person is not mentally ill (and satisfies other

conditions), it may be more difficult to justify intervention to stop what might be considered a rational suicide by competent person acting with awareness and voluntariness.

Physical illness is often an antecedent factor in suicide; whether it is a causal factor is more difficult to determine-- i.e., whether the person committed suicide because of the physical illness (for one case in which physical illness apparently played a major role, see Case #9).

The dispute has been summarized: "Some of the informants felt that physical illnesses had played important roles; others felt that they had played only minimal roles; still others were uncertain about their significance" (Robins, 1981). In one study, eighty-five percent of the people over 60 who committed suicide had a serious physical illness at the time of their deaths (Dorpat, et al, 1968; quoted in Ranik and Cantor, 1970). In another study, "more than 60 percent of the men...committed suicide because of extreme illness" (Miller, 1979, p. 26); approximately one-fourth of these cases involved terminal illnesses. Some studies are marred because they fail to distinguish the presence of a disease from knowledge of the disease and both from fear of a disease, which may or may not be present or known. And yet all of them may vary independently and may not even be correlated with the experience of illness. In retrospective studies, autopsy records permit investigators to identify actual diseases as antecedent factors but not necessarily as causal factors. Some researchers have found that approximately 75% of those who committed suicide had been under the care of a physician shortly before their act (Miller, 1979, p. 69); but such information is not helpful without other information and comparison with people of the same age who did not commit suicide.

There is evidence that people tend to commit suicide when they find their situations "unbearable" (Miller, 1979), that is, when they experience loss, which might be physical, social, etc., and past, present, or future (i.e., anticipated), and when they believe that they have no alternatives or options (Perlin, 1985). For example, in one case (Perlin, 1985), an

elderly women committed suicide after being told that she had terminal cancer, that no treatments were available, that her only relative, a sister, could not care for her, and that there was a three-week waiting list for the hospital. Many professionals now emphasize that antidepressants might be appropriate even if the news that is given to the patient-- e.g., terminal illness and no options-- would naturally lead to depression; medication may be helpful even if the depression is rational in view of the bad news and absence of options (Perlin, 1985).

There is some evidence that the institutional setting makes a difference in reported attitudes of elderly patients to survival (Perlin, 1985); for example, patients in hospitals are more likely to report that they want to live than patients in nursing homes. It is more difficult to correlate attitudes with particular life-sustaining treatments. Studies in the late 1960s and early 1970s suggested that increased suicide rates (not merely among the elderly) tended to be correlated with dialysis treatment for end-stage renal disease (Abrams, 1970); with improvements in dialysis treatment, these figures have reportedly declined. But the anticipation of a long, lingering death under the control of strangers in impersonal institutions with various tubes and machines, all generating the image of helplessness and loss of control, has led some elderly people to commit suicide, even though there are no helpful statistics to indicate the magnitude of the problem. One clear case that has been widely discussed involved the Van Duens (See Case # 10). In terms of the distinction introduced earlier, such suicides may be both instrumental and expressive. The role of religious convictions and practices in elderly suicides appears to be similar to its role other suicides: There are ascending suicide rates among Jews, Catholics, and Protestants for reasons discussed earlier (Miller, 1979).

What about assisted suicide, especially among the elderly? Miller (1979) contends that "many geriatric suicides could not be accomplished without the assistance of a cooperative spouse." However, because "assistance" covers so many actions and nonactions, it is even more

difficult to determine its role than to determine that a suicide has been committed. In one study of spouse-assisted suicides (usually wives assisting husbands because of the larger number of elderly male suicides), Miller (1979) identified three main patterns: (1) spousal nonintervention in their husbands' impending suicides despite long advance notice because they approved the acts to end devastating illnesses (see Case #11); (2) spousal failure to take any appropriate action after discovering suicide notes (or being told by the husband) prior to the actions sometimes because they didn't believe that the notes (or oral comments) were serious; (3) delay in seeking help after act, but before the death has occurred. All of these involve omission rather than commission, nonintervention rather than intervention. They fall short of other kinds of assistance, such as providing the means of suicide, and despite anecdotal evidence about other means of assistance, we lack the statistical data. We also lack statistical data about the assistance by parties other than spouses-- e.g., physicians.

In conclusion, there is a great need for additional and reliable statistical data. Not only is it probable that the incidence of suicide among the elderly is greatly underreported, but we lack helpful information about refusal of life-sustaining treatment. Regarding suicide, it would be helpful to have better studies of the various conditions, such as mental and physical illness, that may be antecedent factors and studies to determine whether they might also be causal factors. In addition, it would be helpful to have correlations with social settings for the treatment of illnesses, such as homes, hospitals, and nursing homes, and with the technologies to treat life-threatening illnesses. It is probable that in many if not most cases suicide will continue to have negative emotional and sometimes financial repercussions for survivors; any research should be designed to avoid causing harm while generating needed information. Information about the degree and kind of assistance by others would also be helpful but perhaps impossible to generate, especially in view of the threat of legal liability.



Regarding refusal of life-sustaining medical treatment, research should be designed to provide the kind of information just identified for suicide. It will be important to identify attempted as well as successful refusals (just as it is important to identify attempted as well as successful suicides). Questions are rarely raised about a patient's competence to consent to treatment if he or she accepts the treatment; but when a patient refuses a treatment that the physician believes should be accepted, then questions of competence emerge (Carlton, 1978). Hence, many attempted refusals are unsuccessful because of paternalistic and other interventions (Childress, 1982). Here again the reasons for the refusals are important and need to be identified, particularly as they relate to the nature and severity of the illness, chances of successful treatment, anticipated quality of life, social and institutional setting, and types of life-sustaining treatment. Now that advance directives are available for refusal of treatment in a large number of states, further research should be conducted about their use by the elderly.

Case # 9

Mr. B.'s mother died when he was 2 years old. As a result, he was raised by an uncle and was never close to his father. Although he was 64 years old when he took his life, his physical condition had deteriorated to that more commonly associated with a much older man.

Mr. B. had been a salesman and a diabetic most of his adult life. The majority of his physical problems had not become severe until five years before his death. He then began experiencing such a rapid physical decline that even ten operations could not restore his health.

Hemorrhaging caused him to become almost blind and problems with his ears caused him to become virtually deaf. A stroke left one side of his face distorted and made it difficult for him to eat or walk.

A week before he took his life he had undergone another unsuccessful ear operation. The morning before his death he said "Something has popped in my head" and after it burst he screamed to his wife of forty years: "Don't leave me! Don't leave me!" The night before his suicide he said: "They've messed me up again. I'm not going to put up with this."

On the last morning of his life Mr. B. "looked and acted very peacefully." He ate an unusually large breakfast and "seemed contented." After eating, Mr. B. called a taxicab, went to a nearby bank, withdrew some money, and returned home. He later took another taxi, apparently purchased a gun, and returned home "with a brown paper bag."

A neighbor saw Mr. B. walk to the side of his house where he normally never walked. He removed the gun from the bag and shot himself in the head. The neighbor witnessed his suicide and shouted at him to stop, but it is doubtful he heard her or would have complied with her request if he had.

Although his widow was obviously relieved that her husband no longer had to suffer, Mrs. B. was unable to say she would have rather he were out of his misery than still alive and living with her.

[Marv Miller, Suicide After Sixty: The Final Alternative (New York: Springer Publishing Co., 1979), pp. 30-31]

**Case # 10**

**Dr. Henry Pitney Van Dusen was internationally renowned as an ecumenical leader, who helped to found the World Council of Churches in 1948, and as a theological educator, who was president of Union Theological Seminary in New York City from 1945 to 1963. A person of great vitality and will, he was severely restricted during the last five years of his life because of a major stroke that limited his physical activity and hampered his speech. Mrs. Van Dusen carried the burdens of her husband's illness for five years although her arthritis seriously handicapped her. She saw that she would not be able to care for him much longer. Both of them were members of the Euthanasia Society, and they entered a suicide pact rather than face the prospect of further disability. She died the night they took an overdose of sleeping pills; he vomited up many of the pills but died fifteen days later on February 13, 1975.**

**[This case has been drawn from John C. Bennett, "The Van Dusens' Suicide Pact," Christianity and Crisis, Vol. 35, no. 5, March 31, 1975.]**

When Mr. P. was 25 years old, married, with a young child and his wife pregnant again, he was told he had muscular dystrophy. He eventually developed other painful conditions, such as ulcers, hemorrhoids, and arthritis of the spine.

A very active man when he was younger, Mr. P. had become overwhelmed by his illnesses and confined to a wheelchair for the last ten years of his life. He referred to the wheelchair as "his coffin on wheels."

Mr. P. apparently had a good marriage until three years before his death, when he became increasingly paranoid. He accused his wife of seeing other men, who existed only in his imagination, and became abusive when she would deny his accusations. He would check on her whereabouts while she was working.

Realizing he was venting much of his frustration on his wife, he grew deeply depressed and voluntarily sought a psychiatrist's assistance. The doctor attested to Mr. P.'s paranoid condition. He became remorseful about his abuse of his wife and told her shortly before his suicide, "I can't keep doing this to you."

Mrs. P. worked only blocks from their home. Every morning when she left for work, her husband sat by the window and waved goodbye to her. That was his daily morning ritual, but never at lunchtime, even though his wife came home for lunch every day. However, on the day he killed himself, Mr. P. sat by the window and waved goodbye to his wife when she returned to work after lunch. As she left he said to her, "Be sure my glass is out." He was referring to the only glass his weak hands could still hold.

For years Mr. P. had collected pills for what he called his "suicide kit." Finally, at age 61, he ingested a lethal dose of drugs while his wife was at work. On the way home that evening Mrs. P. sensed her husband would be dead when she arrived. She found Mr. P. in a coma, with his suicide note nearby, and quickly summoned two of his physicians. After examining him and taking his medical history into consideration, they decided not to attempt to save his life. Mrs. P. completely agreed with the doctors' decision.

When Mr. P.'s closest friend found out about the suicide, he remarked, "I'm only sorry I didn't know he was trying to kill himself so I could have helped him to do it."

**Task # 4. Discussion of Prevailing Concepts of Assisted Death**

**A. Concepts of Assisted Death**

The phrase "assisted death" covers numerous possibilities of action and inaction. Let us start with the cases of active killing that involve both the patient and some other party-- assisted suicide and voluntary active euthanasia. These differ only by virtue of who finally acts, the patient or someone else, and the difference is thus one of degree and kind of assistance. The decision-maker is the same in both cases since we are concentrating on voluntary euthanasia along with suicide.

Assistance in the implementation of a decision for suicide could include arrangement of the location or setting, provision of information about the means of bringing about death, provision of the means themselves, withholding or withdrawing life-sustaining treatments, comforting the patient in the process of dying, etc. This range is sufficient to indicate the limited utility of the concept of assisted death; it is too broad to be helpful in debates about policies or actions. The cases identified earlier involved the provision of information and means (the Rollin case # 6, pp. 22-23), support and encouragement (the Roman case # 8, pp. 25-26), the provision of the means of ending life along with the treatment (the Barney Clark case # 7, p. 24), and nonintervention (# 11, p. 54). Some of these are controversial. For example, it is not clear that the physicians who gave Barney Clark the key to turn off the power to his artificial heart would have been viewed as assisting his "suicide" if he had used it (and there are debates about whether his action would have been a "suicide"). Furthermore, cases of nonintervention, such as # 11, are particularly problematic, because it is not clear whether letting die by not intervening should count as "assisted death," or, in this context, "assisted suicide."

Some would argue that it is "allowed death," not "assisted death." However, as indicated in Task # 3, Mary Miller (1979) views several types of nonintervention as "assisted suicide" and contends that many geriatric suicides are not possible without the assistance of others. In general, omission or nonintervention should count as assistance only where there is some moral or role relationship between the parties (e.g., it would be odd to say that a passerby who did not attempt to stop someone from jumping from a bridge "assisted" in the person's suicide), but even where there is such a relationship, nonintervention should not always be construed as "assistance." Furthermore, as the above cases suggest, "assistance" may include both acceptable and unacceptable acts.

Assistance is not necessarily limited to implementation of a decision that has already been reached; it may occur at the level of decision-making itself, i.e., whether to bring about death or not. Assistance at the level of decision-making may also include both acceptable and unacceptable acts, ranging from solicitation, such as encouraging, requesting, or commanding, to manipulation, and to discussion to clarify the patient's options (Francis, 1980).

The concept of "assisted death" is not very helpful because it encompasses too many different possibilities regarding who decides and who acts, as well as how death is brought about (e.g., actively or passively) and why it is brought about (e.g., whether to benefit the one whose death is brought about or others). More precision is required on each of these points.

#### **B. Compatibility of Assisting Death with Professional Codes and Practices**

The Hippocratic Oath expressly prohibits some ways of assisting death: "I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect." However, other parts of this oath are now ignored, including the prohibition of abortion and

surgery by a Hippocratic physician, and some principles embedded in the oath -- e.g., the duty to benefit the patient--and others that have been emphasized since then-- e.g., the principle of respect for persons-- could lead to a different policy in the context of major developments in the technologies to prolong life.

The Principles of Medical Ethics of the American Medical Association do not directly address these issues, which are rather addressed through interpretations and applications of the principles. For example, in 1973, after prohibiting "mercy killing" or the "intentional termination of the life of one human being by another," the AMA House of Delegates held that cessation of life-sustaining treatment is morally justified when the patient and/or the patient's immediate family, with the advice and judgment of the physician, decide to withhold or to stop the use of "extraordinary means to prolong life when there is irrefutable evidence that biological death is imminent." The Opinions of the Judicial Council of the AMA (1982) hold that the physician "should not intentionally cause death"-- a prohibition that excludes mercy killing. However, the Opinions also recognize the physician's "discretion" to resolve the conflict between the commitments to prolong life and to relieve suffering. They allow necessary medical treatment to alleviate severe pain (presumably even when it may hasten death), and they allow withholding or withdrawing life-sustaining treatment "to let a terminally ill patient die." The physician may also discontinue "all means of life support" for an irreversibly comatose terminally ill patient consistent with the maintenance of comfort and dignity.

Even though the principles in the International Council of Nurses Code for Nurses (May, 1973) and the American Nurses' Association Code for Nurses( 1976) do not explicitly address these questions, they represent a shift away from obedience to the physician and the institution to protection of the patient's interests and rights. In practice, these principles appear to have been interpreted to authorize letting patients die under some circumstances but also to rule out mercy killing ( though the evidence about mercy killing is in part based on the lack of evidence

for a shift away from the traditional prohibition). However, because of their close and constant interaction with patients, nurses hear requests for active and direct euthanasia more frequently than physicians do (Brown, 1971).

Finally, the Patient's Bill of Rights of the American Hospital Association (1973) includes the patient's "right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his action."

In general, these oaths and codes require actions that are consistent with the legal system, which prohibits mercy killing and assisted suicide, but the legal system's interpretation of what is permissible also depends in part on customary practice. Unfortunately, the evidence about professional practices is largely anecdotal, and the few available studies do not offer the kind or quality of information that is needed (see Crans, 1975). Codes that codify practices often lag behind changes in the practices themselves. Nevertheless, it is accurate to say that the codes rule out some forms of "assisted death," particularly those that are illegal, while accepting some other forms that were sketched in Task # 1.

### C. Laws, Policies, and Court Decisions

The act of suicide has been decriminalized, but "a suicide attempt-- regardless of a person's motive-- is a basis for active intervention by public officers and for the deprivation of liberty (through involuntary psychiatric observation and treatment)" (President's Commission, 1983, p. 37). And aiding and abetting suicide remains illegal in most states-- some treat it as a separate offense; some bring it under homicide statutes; and others make it a form of manslaughter (Francis, 1980). Often, however, there is unclarity about what counts as aiding and abetting suicide. In one famous case (People v. Roberts, 211 Mich. 187, 178 N.W. 690, 1920) a woman was bedridden with advanced multiple sclerosis and asked her husband to put a



cup of poison by her bed so that she could kill herself. When she took the poison and died, he was prosecuted and convicted for murder on the grounds that he had assisted a suicide (Francis, 1980; Robertson, 1983). For a period Texas did not prohibit assisting suicide, and one study has argued that there is no evidence that abuses and other bad consequences occurred (Engelhardt and Malloy, 1982).

Although "mercy killing" is illegal in every state, mercy killers are not always prosecuted, indicted, or convicted. For example, they are sometimes found not guilty by reason of temporary insanity, as in the Zygmantak case in New Jersey (Mitchell, 1976), and their motives sometimes mitigate the punishment even though they do not legally justify the act, as in several recent cases.

In general, then, there are legal prohibitions of mercy killing and assisted suicide, though, as we have seen, there is often debate about what will count as killing in either type of case as well as what will count as assistance. Few physicians have ever been tried for "mercy killing," and up to 1983 the two who had been tried had been acquitted by juries (President's Commission, 1983, p. 35). The range of legal responses to family members involved in "mercy killings" has already been indicated. However, all of these cases are to be distinguished from cases of withholding or withdrawing treatment at the patient's request. The President's Commission (1983) noted that it had "not found any instances in which criminal or civil liability has been imposed upon health professionals or others (such as family members) for acquiescing in a patient's refusal of life-sustaining treatment." More controversial in recent years has been decision-making about incompetent patients, who could not or did not speak earlier for themselves in the form of advance directives. In a 1983 California case a superior court dismissed murder charges against two physicians who with the permission of the patient's spouse discontinued a respirator and intravenous feeding tubes from a brain-damaged, comatose patient [Barber v. Superior Court of California, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983)].

Natural death or living will acts, which are now in effect in at least thirty-six states after a flurry of legislative activity in the last few years (the first one was passed in California in 1976), permit patients to make advance directives to refuse some forms of life-sustaining treatment under some circumstances, usually in connection with terminal illnesses. These statutes distinguish the patient's refusal of life-sustaining technologies from suicide, and actions by others in accord with advance directives from aided suicide and mercy killing. They also exempt professionals who rely on these directives from civil and criminal liability for withholding or withdrawing life-sustaining technologies (Robertson, 1983). Advance directives may take one of two forms: (1) specification of standards, e.g., "I do not want to be kept alive under X circumstances," or (2) designation of decision-makers, e.g., "I designate Y to make decisions for me if I become incompetent." Although some natural death or living will acts permit (2) as well as (1), (2) is also possible under some durable power of attorney statutes (see the Society for the Right to Die, 1984, 1985).

In connection with OTA's interest in particular technologies, it is important to note that over half of the thirty-six natural death or living will acts exclude some technologies from the patient's advance directives. Most statutes focus on advance directives about life-sustaining technologies, variously defined as artificial, extraordinary, prolonging the moment of death, etc. But over half use more specific language to exclude some technologies. For example, Florida's statute indicates that life-sustaining technologies "shall not include the provision of sustenance or the administration of medication or performance of any medical procedure deemed necessary to provide comfort or to alleviate pain." This statute reflects the most common exclusions: sustenance (other statutes use the language of nourishment, nutrition and hydration, food and fluids, food and water) and procedures to provide comfort (care) and to alleviate pain. It is possible that some of the statutes exclude sustenance because of the belief that it is essential for patient comfort. Some also appear to distinguish natural from artificial means of nutrition and

hydration; for example, the Tennessee statute excludes the "withholding of simple nourishment or fluids," and the Oregon statute excludes "the usual and typical provision of nutrition which in the medical judgment of the attending physician a patient can tolerate" (see Society for the Right to Die, 1984, 1985). To my knowledge, none of the other technologies being studied by OTA are excluded from the patient's advance directives by any statutes.

The series of major court cases since Quinlan in New Jersey in 1975 has extended the range of permissible decisions and actions to let patients die. For example, while the Quinlan case allowed the removal of a respirator in some circumstances, the 1985 Conroy decision, also in New Jersey, allowed the removal of a feeding tube in some circumstances (although not in the Conroy case itself). Many of these decisions involve line drawing, and some are still controversial, perhaps especially those involving artificial nutrition and hydration. Each of the technologies of interest to OTA in this project has been the subject of court decisions, often but not always involving the elderly. Since the legal decisions are being analyzed elsewhere by OTA, I will only indicate examples: courts have authorized withholding or withdrawing dialysis from an elderly patient (e.g., Spring); the respirator-- the subject of most of the decisions (e.g., Quinlan, Perlmutter, Eichner, Colyer, Leach, Bertling, Foster, and Tune); antibiotics (e.g., Severns, a case that included several technologies but not dialysis and artificial nutrition and hydration); resuscitation (e.g., Dinnerstein, and Severns); and artificial nutrition and hydration (e.g., Conroy, Barber and Natjl, and Hier, which involved surgery to insert the feeding tubes). These examples are intended only to suggest that some legal decisions support withholding or withdrawing each of the technologies in question in some circumstances; these examples cannot, however, convey some other important disputes, particularly about incompetent patients and such conditions as chronic vegetation.

**D. Influence of Institutional Setting and Social Context on Assisted Death**

Dramatic changes have occurred in the institutional setting and the social context of death in the USA. Earlier in this century most deaths occurred at home, but now they occur in institutions, especially hospitals and nursing homes. In 1949, fifty percent of the deaths were in institutions; in 1958 that figure climbed to sixty-one percent, then in 1977 to over seventy percent, and now it is perhaps over eighty percent (President's Commission, 1983). In contrast to the home, the hospital or nursing home provides a more impersonal and public context for dying. In addition, deaths occur among an older population, usually from chronic conditions that were diagnosed months earlier, and the dying occurs over a longer period. Some of these characteristics of contemporary dying are evident in cases presented earlier, especially cases # 3 and # 4 (p. 14-15). Different institutional settings and social contexts influence the use of life-sustaining treatments in several ways, particularly the decision to accept or to withhold/withdraw life-sustaining technologies and the implementation of that decision.

As noted earlier, it has sometimes been argued that social support for the elderly influences the rate of suicide. It is also plausible to hold that these institutional settings of the nursing home or hospital sometimes make death appear more attractive than life to older patients. In addition, each institutional setting sets constraints on decisions and actions for death, including assisted death. Some of these institutional constraints reflect the constraints identified earlier-- for example, the society's allocation of resources for and within health care; the society's rules, including its legal rules, such as the prohibition of mercy killing and assisted suicide; and the codes of various professionals who practice within the institutions. But within these social contexts, different institutions have their own special constraints, often involving their distinctive purposes, rules, and allocations of resources. Thus, for example, a

patient's desire to have a life-sustaining technology used may not be implemented because of the limited number of beds in intensive care and the institution's allocation policies. Or a hospital affiliated with a religious community may reflect that community's beliefs about the use of life-sustaining technologies.

It is possible to draw some rough distinctions among institutional influences. As the President's Commission (1983) noted, "acute care hospitals have a dominant predisposition to prolonging life; nursing homes have a weaker and more variable commitment to prolonging life; and hospices are characterized by an acceptance of death." Policy-makers outside and inside these institutions should (a) be aware of these tendencies and of the implications of their policies for decisions about life and death, (b) consider these constraints in the light of the moral principles and categories discussed earlier, and (c) ensure that patients and families receive adequate information about these constraints so that they can better determine the appropriate institutional setting. Once a patient is in an institution, characterized by certain constraints, it may be difficult to make some decisions without changing settings.

Nevertheless, institutions can and should be more flexible than the above distinctions suggest. Their decisions "should be governed by the principles and practices of good decision-making," and not only by their institutional imperatives (President's Commission, 1983). Even though their development is complicated and ambiguous, such institutional mechanisms as hospital ethics committees may provide possibilities to withhold or to withdraw life-sustaining treatment in accord with a patient's wishes and interests, despite the institution's tendency to treat. Furthermore, under the impact of cost-containment measures, institutions may now be subject to external and internal pressures to undertreat, rather than overtreat. Hence, it may be necessary to develop mechanisms to ensure adequate treatment in accord with a patient's wishes and interests.

It is not possible on the basis of available studies to determine the actual influence of different parties, such as family and health care practitioners, whose own decisions and actions also occur within and may be limited by their institutional setting and social context. Both families and health care practitioners are themselves influenced by the traditions identified earlier in this report, e.g., religious traditions and professional codes. And their assistance in a patient's death, whether in the decision or in its implementation, does not follow set patterns. (See the discussion in Task # 3 of spousal assistance, at least through omission, in elderly suicides.)

Even in the absence of empirical evidence about the influence and cooperation of various parties, it is possible to suggest ways in which the influence and assistance may be or should be limited in accord with the moral principles sketched earlier. A competent patient should have the right to make his or her own decision, in advance or at the time, not to have life-sustaining technologies. But in addition to the internal limit of the patient's incompetence to decide and act in some circumstances, there are appropriate external limits, such as the society's and the professions' prohibition of mercy killing and assisted suicide. Just allocation policies by the society and the institution also set appropriate external limits on patient and family choices. Finally, the principle of respect for persons implies that the clinician is not a mere tool or instrument of the patient's wishes; for example, natural death acts generally recognize the physician's right of conscientious refusal to assist death as the patient wishes. However, the physician's duty to refer or to transfer the patient is stronger.

## **Task # 5. Conclusions**

### **A. Special Significance of the Above Issues for the Elderly**

Many of the above issues have special significance for the elderly, in part because of the increasingly large numbers of elderly people, the development of technologies that can sustain life longer (e.g., before antibiotics pneumonia was viewed as "the old person's friend"), the public, institutional context of dying under the care of strangers, the frequent loss of competence by elderly patients, and the limited quality of life that often results from the technologies. Nevertheless, special caution is needed, because it may be discriminatory to treat the elderly, even the sick elderly, as a class, when there are numerous individuals with various interests and wishes that require respect and assistance. For example, it is unfair to view the elderly as a class of individuals who are unable to make their own decisions, because of the wide variations among the elderly. At any rate, many elderly people are especially vulnerable because of their dependence and limited autonomy and power.

### **B. Feasibility and Desirability of Guidelines**

The next three questions all deal with the feasibility of guidelines, and I assume that desirability, which is broader than feasibility, should also be addressed. A major question about guidelines is whether they should be procedural (i.e., indicate who should decide and act) or substantive (i.e., indicate what may and may not be decided and done, particularly how death may be brought about). In a pluralistic society, the tendency is to resort to procedural guidelines to allocate authority for deciding and acting, and this tendency is evident in the natural death acts that give people the authority to make advance directives before they become incompetent and

unable to decide. However, substantive guidelines are also important, and it is necessary, if the above arguments are correct, to maintain some limits on decisions and actions -- certainly to prohibit "mercy killing" and perhaps, but less clearly, to prohibit "assisted suicide," at least in some of its forms. Both limits are already in place in state legislation and court decisions, but, in view of the lack of uniformity and clarity, it might be useful to seek uniform legislation in these areas. The following questions address substantive limits on what may be done.

1. Guidelines to help distinguish suicide from other acts of withholding or withdrawing life-sustaining treatment. Guidelines have already emerged and are evolving in legislation (e.g., the natural death acts), in court decisions, and in practice. For example, as noted earlier, the natural death acts carefully distinguish the refusal of life-sustaining treatment under specified conditions (often in the context of terminal illness) from suicide, and withholding or withdrawing treatment from homicide. There is a question about whether federal action is needed, particularly in view of the dramatic increase in state natural death acts and in court decisions that further define the competent patient's right to refuse treatment and the proxy's right to refuse treatment for incompetent patients. Again clarity and uniformity across the nation might be desirable for all parties.

2. Guidelines to help distinguish acceptable from unacceptable acts of withholding or withdrawing life-sustaining treatment. Several distinctions developed under Task # 1 have evolved to distinguish acceptable from unacceptable acts that result in death; unfortunately, applying those distinctions does not complete the moral task and may even distort it. All of them rest on more fundamental principles and values that must be applied directly to cases. Only the distinction between killing and letting die was found to be particularly useful for public policy in the sense that it is appropriate to prohibit mercy killing (though not suicide), but the distinction may be misleading if it suggests that all cases of letting die are acceptable, for clearly they are not. One possible approach is to maintain the substantive limit of the



prohibition of euthanasia or mercy killing (and perhaps of assisted suicide) and then to pursue a procedural solution: (1) competent patients, who are informed and acting voluntarily, may refuse any life-sustaining treatments if their decisions and actions would not harm others, and (2) competent proxies may refuse any life-sustaining treatments for incompetent patients subject to review by physicians, hospital ethics committees, etc., to make sure that the decision does not violate the patient's interests. This procedural solution allows competent patients wider latitude than proxies for incompetent patients because of the dangers of conflicts of interest. Opponents of such a policy would include those who would limit competent patients' decisions to cases in which they are terminally ill, imminently dying, etc.

3. Guidelines to help professionals determine their appropriate roles in assisted deaths. Whatever guidelines are developed for professionals, it is important to allow room for conscientious objection and refusal because people draw lines at different places. For example, professionals should not be forced to participate in what they believe to be an act of suicide, as in the case of Elizabeth Bouvia. In many states the natural death acts allow physicians not to carry out the patient's advance directive but require him or her to make a good faith effort to transfer the patient to the care of someone else. That may be an appropriate compromise. The guidelines on appropriate roles could legitimately distinguish the types of assistance identified under Task # 3, excluding mercy killing and perhaps even assisted suicide, while permitting professionals to relieve pain and suffering with appropriate medication even if it hastens death and to refrain from providing life-sustaining treatments refused by competent patients and (within the limits set by the patient's best interests) refused by proxies for incompetent patients. In short, the guidelines should reflect the fundamental ethical principles identified earlier: professionals may and should act in accord with the competent patient's wishes (autonomy) and interests (beneficence/nonmaleficence/ utility), and the incompetent patient's interests, subject to the constraints of just allocation of health care resources (justice) and societal rules to prevent bad

consequences (utility/justice/ autonomy). Thus, these guidelines would directly address the questions of who decides, who acts, for what reasons (why), and how.

**C. Issues That Need Additional Analysis and Research**

Several empirical questions of elderly suicide and refusal of treatment as correlated with illness, social and institutional context, and particular technologies need further attention-- particularly the impact of social policies, such as social security, on perceived quality of life and options under various conditions; competence of the elderly to make decisions; possible conflicts of interests between decisionmakers and elderly patients; the use by the elderly of the mechanisms provided by natural death acts and durable power of attorney statutes for decisions about termination of treatment; the probable effects of alterations in various professional, social, and legal rules that currently structure practices of allowed and assisted death; the probable impact of cost- containment measures on the care of the elderly.

**D. Priorities for Public Attention Regarding Suicide Among the Elderly in Relation to Life-Sustaining Technologies**

Problems of patient interests, wishes, and control of decisionmaking in the context of societal allocation of resources and rules to prevent abuse and other bad consequences; current and possible measures to satisfy the relevant moral principles; and the inevitability of some compromises of principles in a workable policy in a pluralistic society. Although suicide is a problem among the elderly (see Task # 4), it is not clear to what extent it is connected with the use of life-sustaining technologies, and more research is needed on this subject, as well as on decisions to refuse life-sustaining technologies that would not be counted as suicide.

## **E. Major Public Policy Options**

Several options have been identified in the course of this report, and only a few of them will only be highlighted here.

1. Formulation of guidelines discussed under B above, with particular emphasis on the continued prohibition of mercy killing and perhaps assisted suicide, on the rights of treatment refusal by competent patients (either in advance or in the situation), on the rights and limits of treatment refusal by proxies for incompetent patients, and on the appropriate roles of professionals in such decisions and actions. Attention to both procedural and substantive standards, in light of the major ethical principles and values that are relevant to these problems, and consideration of whether further clarity and uniformity across the country are desirable and possible, particularly regarding what is ethically unacceptable even if it is not possible to indicate what is ethically preferable in these matters.

On the whole, it does not appear to be desirable to attempt to differentiate various life-sustaining technologies. One of the major criticisms of the traditional distinction between ordinary and extraordinary means of treatment (see Task # 1) is that it attached moral significance to particular technologies and practices rather than to patients' interests and wishes. However, some technologies, particularly those providing nutrition and hydration, appear to many to be essential for patient comfort and for symbolizing and expressing care. Even though several natural death acts apparently exclude them from advance directives regarding life-sustaining technologies, there is continued debate about their use. For example, several court decisions have viewed artificial nutrition and hydration as relevantly similar to other life-sustaining technologies and have held that decisions about their provision should be made in the same way. A major concern is that withdrawing or withholding nutrition and

hydration, even when provided through medical means, will lead to a violation of patients' interests and rights. In response to this version of the wedge or slippery slope argument, some contend there are alternative ways to avoid these dangers. In view of the vigor of the debate, it may be premature to attempt to resolve this dispute through public policies at this time.

2. Attention to the right to health care, particularly because of the new threat of undertreatment under societal and institutional pressures for cost containment (in contrast to the earlier threat of overtreatment) and because of the studies that suggest that elderly suicides (and perhaps refusals of life-sustaining treatments) declined with the provision of increased social services as a right and that elderly suicides are often correlated with disclosure of bad news such as diagnosis of serious disease and poor prognosis in conjunction with a perception of limited options. Without attention to this part of the social context, recognition of the patient's right to die based on autonomy will be construed as indifference and perhaps even encouragement or manipulation (see Battin and Mayo, 1980) of suicide or refusal of treatment.

## REFERENCES

- Abdul-Rauf, M., "Contemporary Muslim Perspective," in Encyclopedia of Bioethics, W. T. Reich, ed. (New York: Free Press and Macmillan, 1978).
- Abram, H. S., Moore, G. L., and Westarvelt, F. B., "Suicidal Behavior in Chronic Dialysis Patients," American Journal of Psychiatry, 1971.
- American Nurses Association, Code for Nurses with Interpretive Statements (Kansas City, Mo.: American Nurses Association, 1976).
- Angell, M., "Respecting the Autonomy of Competent Patients," N. Eng. J. Med. 310: 1115-1116, 1984.
- Angell, M., "The Quality of Mercy," N. Eng. J. Med. 306: 98-99, 1982.
- Aquinas, T., Summa Theologica, Dominican trans. (Westminster, Md.: Christian Classics, 1981).
- Beachler, J., Suicides, Barry Cooper trans. (New York: Basic Books, 1979).
- Batchelor, I. R. C., "Suicide in Old Age," in Clues to Suicide, E. Schneidman and N. Ferberow, eds. (New York: McGraw-Hill, 1957).
- Battin, M. P., Ethical Issues in Suicide (Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1982).
- Battin, M. P., and Mayo, D. J., eds., Suicide: The Philosophical Issues (New York: St. Martin's Press, 1980).
- Beauchamp, T. L., "Suicide," in Matters of Life and Death, T. Regan, ed. (New York: Random House, 1980).
- Beauchamp, T. L., and Childress, J. F., Principles of Biomedical Ethics (New York: Oxford University Press, 1979, 2nd ed., 1983).
- Beauchamp, T. L., and Perlin, S., eds., Ethical Issues in Death and Dying (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1978).
- Bedell, S. E., and Delbanco, T. L., "Choices about Cardiopulmonary Resuscitation in the Hospital," N. Eng. J. Med. 310: 1089-1093, 1984.
- Bedell, S. E., Delbanco, T. L., Cook, E. F., et al., "Survival After Cardiopulmonary Resuscitation in the Hospital," N. Eng. J. Med. 300: 138-140, 1979.
- Behnke, J. A., and Bok, S., eds., The Dilemmas of Euthanasia (Garden City, N. Y.: Anchor Press/Doubleday, 1975).
- Berdes, C., Social Services for the Aged Dying and Bereaved in International Perspective (Washington, D.C.: International Federation on Ageing, n. d.).

- Boyle, J. M., Jr., "Toward Understanding the Principle of Double Effect," Ethics 90: 527-538, July, 1980.
- Brooke, E. M., Suicide and Attempted Suicide (Geneva: World Health Organization, 1974).
- Brown, N. K., et al., "How Do Nurses Feel About Euthanasia and Abortion?", Am. J. Nurs. 71: 1415-16, 1971.
- Butler, R., and Lewis, M., Aging and Mental Health (St. Louis: Mosby, 1973).
- Callahan, D., "On Feeding the Dying," Hastings Center Report 13: 22, October, 1983.
- Capron, A. M., "Ironies and Tensions in Feeding the Dying," Hastings Center Report 14: 32-34, October, 1984.
- Carlton, W., "In Our Professional Opinion.... The Primacy of Clinical Judgment over Moral Choice" (Notre Dame, Ind.: University of Notre Dame Press, 1978).
- Cassell, E., "The Nature of Suffering and the Goals of Medicine," New Eng. J. Med. 306: 639-645, 1982.
- Childress, J. F., Priorities in Biomedical Ethics (Philadelphia: The Westminster Press, 1981).
- Childress, J. F., "When Is It Morally Justifiable to Discontinue Food and Water?" to be published in proceedings of a conference on artificial nutrition and hydration, Joanne Lynn, ed. (Bloomington, Ind.: Indiana University Press, 1985).
- Childress, J. F., Who Should Decide? Paternalism in Health Care (New York: Oxford University Press, 1982).
- Crane, D., The Sanctity of Social Life: Physician Treatment of Critically Ill Patients (New York: Russell Sage Foundation, 1975).
- Dorpat, T. L., Anderson, W. F., and Ripley, H. S., "The Relationship of Physical Illness to Suicide," in Suicidal Behavior: Diagnosis and Management, H. L. B. Resnik, ed. (Boston: Little, Brown and Co., 1968).
- Durkheim, E., Suicide: A Study in Sociology, J. A. Spaulding and G. Simpson, trans. (Glencoe, Ill.: Free Press, 1951).
- Dyck, A. J., On Human Care (New York: Abingdon, 1977).
- Elsendrath, S. J., and Jonsen, A. R., "The Living Will," JAMA 249 (15): 2084-88, April 15, 1983.
- Engelhardt, H. T., Jr., Bioethics (tentative title) (New York: Oxford University Press, 1985, forthcoming).
- Engelhardt, H. T., Jr., and Malloy, M., "Suicide and Assisting Suicide: A Critique of Legal Sanctions," Southwestern Law Journal 36 (4): 1003-37, November, 1982.
- Evans, A. L., and Brody, B. A., "The Do-Not-Resuscitate Order in Teaching Hospitals," JAMA 253 (15): 2236-2239, April 19, 1985.

- Fletcher, J., Humanhood: Essays in Biomedical Ethics (Buffalo, N.Y.: Prometheus Press, 1979)
- Fletcher, J., "In Defense of Suicide," in Suicide and Euthanasia: The Rights of Personhood, S. E. Wallace and A. Esar, eds. (Knoxville, Tenn.: University of Tennessee Press, 1981).
- Fletcher, J., Moral Responsibility (Philadelphia: The Westminster Press, 1967).
- Fletcher, J., Morals and Medicine (Princeton, N.J.: Princeton University Press, 1954).
- Francis, L. P., "Assisting Suicide," in Suicide: The Philosophical Issues, M. P. Battin and D. J. Mayo, eds. (New York: St. Martin's Press, 1980).
- Glover, J., Causing Death and Saving Lives (New York: Penguin Books, 1977).
- Grisz, G., "Suicide and Euthanasia," in Death, Dying, and Euthanasia, D. J. Horen and D. Mell, eds. (Washington, D. C.: University Publications of America, 1977).
- Hauerwas, S., "Rational Suicide and Reasons for Living," in Rights and Responsibilities in Modern Medicine: The Second Volume in a Series on Ethics, Humanism, and Medicine, M. Beeson, ed. (New York: Alan R. Liss, 1981).
- Hauerwas, S., Truthfulness and Tragedy (Notre Dame, Ind.: University of Notre Dame Press, 1977).
- Handin, H., Suicide in America (New York: W. W. Norton & Co., 1982).
- Hilfiker, D., "Allowing the Debilitated to Die: Facing Our Ethical Choices," New Eng. J. Med. 308: 716-719, 1983.
- Jakobovits, I., Jewish Medical Ethics, 2nd ed. (New York: Bloch Publishing Co., 1975).
- Jakobovits, I., "Judaism," in Encyclopedia of Bioethics, W. T. Reich, ed., vol. 2 (New York: Free Press and Macmillan, 1978).
- Judicial Council of the American Medical Association, Opinions (Chicago: American Medical Association, 1982, reprinted in President's Commission, 1983).
- Kelly, G., "The Duty of Using Artificial Means of Preserving Life," Theological Studies 11: 203-20, June, 1950.
- Kelly, G., "The Duty to Preserve Life," Theological Studies 12, December, 1951.
- Kluge, E. H. W., The Practice of Death (New Haven, CT: Yale University Press, 1975).
- Kohl, M., The Morality of Killing (New York: Humanities Press, 1974).
- Kohl, M., ed., Beneficent Euthanasia (Buffalo, N. Y.: Prometheus Books, 1975).
- Larus, G. A., Euthanasia and Religion: A Survey of the Attitudes of the World Religions to the Right-to-Die (Los Angeles: The Hemlock Society, 1985).

- Lebeck, K., and Engelhardt, H. T., Jr., "Suicide," in Death, Dying and Euthanasia, D. J. Horan and D. Meil, eds. (Washington, D. C.: University Publications of America, 1977).
- Lo, B., and Jansen, A. R., "Ethical Decisions in the Care of a Patient Terminally Ill with Metastatic Cancer," Annals of Int. Med. 92: 107-111, 1980.
- Lo, B., Seika, G., Strull, W., et al., "'Do Not Resuscitate' Decisions: A Prospective Study at Three Teaching Hospitals," Arch. Intern. Med. 145: 1115-1117, June, 1985.
- Lo, B., and Steinbrook, R. L., "Deciding Whether to Resuscitate," Arch. Intern. Med. 143: 1561-1563, 1983.
- Lynn, J., and Childress, J. F., "Must Patients Always Be Given Food and Water?" Hastings Center Report 13: 17-21, October, 1983.
- McCarthy, J. J., "The Development of the Doctrine of Ordinary and Extraordinary Means of Preserving Life in Catholic Moral Theology before the Karen Quinlan Case," Linacre Quarterly 47: 215ff, 1980.
- McCormick, R. M., "The Quality of Life, the Sanctity of Life," Hastings Center Report 8, February, 1978.
- Maguire, D., Death By Choice (Garden City, N. Y.: Doubleday, 1974).
- Mangan, J. T., "An Historical Analysis of the Principle of Double Effect," Theological Studies 10: 41-61, 1949.
- Margolis, J., Negativities: The Limits of Life (Columbus: Charles E. Merrill, 1975).
- Mayo, D. J., "Contemporary Philosophical Literature on Suicide: A Review," in Suicide and Ethics, M. P. Battin and R. W. Maris, eds. (New York: Human Sciences Press, 1983).
- Meileander, G., "On Removing Food and Water: Against the Stream," Hastings Center Report 14: 11-13, December, 1984.
- Micetich, K. C., Steinecker, P. H., and Thomsma, D. C., "Are Intravenous Fluids Morally Required for a Dying Patient?" Arch. Intern. Med. 143: 975-980, May, 1983.
- Miller, M., Suicide After Sixty (New York: Springer Publishing Co., 1979).
- Miner, J. D. and Brush, L. R., "The Correlation of Attitudes toward Suicide with Death Anxiety, Religiosity, and Personal Closeness to Suicide," Omega 11, 1980.
- Mitchell, P., An Act of Love: The Killing of George Zygmanski (New York: Alfred Knopf, 1978).
- Nakamura, H., "Buddhism," in Encyclopedia of Bioethics, W. T. Reich, ed. (New York: Free Press and Macmillan, 1978).
- National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research, The Belmont Report: Ethical Guidelines for the Protection of Human Subjects of Research, DHEW Publication No. 1(05) 78-0012 (1978).



- Perlin, S., Psychiatrist at George Washington University, Washington, D.C., personal communication, June, 1985.
- Perlin, S., ed., A Handbook for the Study of Suicide (New York: Oxford University Press, 1975).
- President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-sustaining Treatment (Washington, D.C.: U.S. Government Printing Office, March, 1983).
- Rachels, J., "Active and Passive Euthanasia," New Eng. J. Med. 292: 78-80, January 9, 1975.
- Rachels, J., "Barney Clark's Key," Healings Center Report 13: 17-19, April, 1983.
- Ramsey, P., Ethics at the Edges of Life: Medical and Legal Intersections (New Haven, CT: Yale University Press, 1978).
- Ramsey, P., The Patient as Person (New Haven, CT: Yale University Press, 1970).
- Reuleaf, D. L., Schmitt, S. B., and Thompson, W. C., "The California Natural Death Act: An Empirical Study of Physicians' Practices," Stanford Law Review 31: 913-945, May, 1979.
- Reanik, H. L. P., and Cantor, J. M., "Suicide and Aging," Journal of the American Geriatrics Society 18: 152-158, February, 1970.
- Robertson, J. A., The Rights of the Critically Ill (New York: Bantam Books, 1983).
- Robins, E., The Final Months: A Study of the Lives of 134 Persons Who Committed Suicide (New York: Oxford University Press, 1981).
- Rollin, B., Last Wish (New York: Linden/Simon and Schuster, 1985).
- Roman, J., Exit House: Choosing Suicide as an Alternative (New York: Seaview Books, 1980).
- Roemer, F., Modern Medicine and Jewish Law (New York: Yeshiva University Press, 1972).
- The Sacred Congregation for the Doctrine of the Faith, Declaration on Euthanasia, Vatican City, May 5, 1980.
- Shneidman, E. S., "Introduction," in Suicidology: Contemporary Developments, E. S. Shneidman, ed. (New York: Grune and Stratton, 1976).
- Sherman, K. G., Suicide and the Elderly (Denton, Texas: Center for Studies in Aging, North Texas State University, 1980).
- Siegel, S., "Suicide in the Jewish View," Conservative Judaism 32 (2), Winter, 1979.
- Siegler, M., and Weisbard, A. J., "Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued?" Arch. Intern. Med. 145: 129-131, January, 1985.
- Smith, D. H., and Perlin, S., "Suicide," The Encyclopedia of Bioethics, W. T. Reich, ed. (New York: Free Press and Macmillan, 1978).

Society for the Right to Die, Handbook of Living Will Laws, 1981-1984 (New York: Society for the Right to Die, 1984).

Society for the Right to Die, The Physician and the Hopelessly Ill Patient: Legal, Medical and Ethical Guidelines (New York: Society for the Right to Die, 1985).

Steinbock, B., ed., Killing and Letting Die (Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1980).

Stengel, E., "Definition and Classification of Suicidal Acts," in Proceedings of the 6th Conference for Suicide Prevention, Dec. 5/8, 1972, R. E. Litman, ed. (Ann Arbor, Mich.: Edwards Brothers, Inc., 1972).

Tonne, H., "Suicide: Is it Autoauthenesis?" Humanist 39: 44-45, July/August, 1979.

Veitch, R. M., A Theory of Medical Ethics (New York: Basic Books, 1981).

Veitch, R. M., Death, Dying, and the Biological Revolution (New Haven, CT: Yale University Press, 1976).

Welton, D. N., Ethics of Withdrawal of Life-Support Systems (Westport, CT.: Greenwood, 1983).

Wenzer, S. H., Adelstein, S. J., Cranford, R. E., et al., "The Physician's Responsibility Toward Hopelessly Ill Patients," N. Eng. J. Med. 310: 955-959, 1984.

Weber, M., Law in Economy and Society, M. Rheinstein ed. (New York: Simon and Schuster, 1967).

Weisbard, A. J., "On the Bioethics of Jewish Law: The Case of Karen Quinlan," Israel Law Review 11 (3): 337-368, 1979.

Wood, D., "Suicide as Instrument and Expression," in Suicide: The Philosophical Issues, M. P. Battin and D. J. Mayo, eds. (New York: St. Martin's Press, 1980).

Zerwekh, J. V., "The Dehydration Question," Nursing 83, 47-51, January, 1983.

Appendix I

U.S. TOTAL POPULATION SUICIDE RATES PER 100,000 BY FIVE-YEAR AGE GROUPS, 1933-1968\*

Year	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-75	≥75	≥65	All Ages
1933	0.3	4.2	10.6	12.8	15.0	18.8	24.6	31.5	35.3	41.3	44.9	44.9	47.4	42.7	45.0	15.9
1934	0.4	4.5	10.6	13.5	15.5	17.9	22.6	27.4	32.0	35.6	38.9	39.6	42.0	38.4	40.0	14.9
1935	0.4	4.2	10.3	13.1	15.5	17.6	21.1	27.1	30.3	34.2	35.7	35.7	35.4	36.5	35.8	14.3
1936	0.5	4.3	9.6	13.0	16.0	18.1	21.9	25.7	29.8	33.8	34.3	35.6	33.0	35.8	34.8	14.3
1937	0.6	4.0	10.2	13.0	15.9	18.5	23.6	28.8	31.4	34.3	36.6	35.5	32.6	36.4	34.8	15.0
1938	0.3	4.1	9.5	13.0	16.0	18.6	24.1	28.5	33.0	36.6	38.3	35.8	32.1	34.4	34.1	15.2
1939	0.5	3.7	8.3	11.4	14.6	17.3	20.9	25.6	31.1	33.3	35.7	33.8	34.1	34.0	33.9	14.2
1940	0.4	3.5	8.9	12.2	15.0	18.1	20.7	26.1	29.5	34.0	34.9	33.1	33.4	33.3	33.2	14.4
1941	0.4	3.5	8.2	11.3	13.7	16.2	18.2	21.5	25.2	29.0	30.7	29.9	32.0	32.9	31.6	12.8
1942	0.5	3.1	7.1	9.8	13.2	14.7	17.6	20.0	22.7	28.3	28.5	26.7	29.2	31.8	29.2	10.0
1943	0.5	3.0	5.8	7.5	10.1	12.2	13.8	15.8	19.5	22.7	25.1	24.8	26.7	30.2	27.2	10.0
1944	0.4	2.7	5.3	7.2	9.4	11.9	14.3	15.8	18.9	21.5	22.0	22.0	24.3	28.8	25.0	9.5
1945	0.4	2.6	5.6	7.3	10.9	13.3	15.7	17.7	21.6	23.0	24.7	24.5	27.8	29.2	27.1	10.1
1946	0.5	2.9	7.3	8.8	11.1	14.0	16.6	18.9	23.5	24.7	27.9	24.1	28.8	28.9	27.2	11.3
1947	0.5	2.9	6.3	8.1	10.9	13.7	16.6	20.0	22.5	26.2	27.9	27.6	28.0	33.0	29.5	11.4
1948	0.4	2.8	6.6	7.8	10.3	12.8	16.4	19.6	22.7	25.7	27.2	25.3	29.5	30.0	28.2	11.2
1949	0.5	2.5	6.5	7.8	9.9	13.6	17.1	19.0	23.0	27.0	29.4	28.9	27.7	30.4	29.0	11.5
1950	0.3	2.7	6.2	8.1	10.2	13.1	15.9	19.5	23.0	25.9	28.8	29.0	29.9	30.8	29.9	11.4
1951	0.4	2.6	6.1	8.0	9.1	11.5	15.2	17.8	19.8	21.8	24.8	26.7	27.8	28.9	27.8	10.4
1952	0.3	2.8	5.6	7.9	9.0	11.3	13.5	16.7	20.0	20.9	24.3	25.0	26.5	29.1	26.8	10.0
1953	0.5	2.8	6.0	8.4	8.6	11.0	14.3	17.4	20.3	21.0	24.0	24.7	26.5	28.7	26.6	10.1
1954	0.3	2.4	6.0	8.5	9.0	10.8	14.4	17.9	20.8	22.2	25.8	24.5	26.0	28.3	25.6	10.1
1955	0.3	2.6	5.6	7.9	8.9	10.3	14.5	17.6	21.9	24.4	25.2	25.2	24.7	28.6	26.1	10.2
1956	0.4	2.3	5.9	7.6	9.4	10.6	13.8	17.2	20.1	23.4	25.1	25.4	25.1	28.1	26.2	10.0
1957	0.5	2.5	5.8	7.6	9.7	10.9	14.6	16.4	20.3	22.2	22.6	23.1	24.4	27.5	25.0	9.8
1958	0.5	3.0	7.0	9.2	10.3	12.0	15.6	18.9	22.8	23.5	24.7	24.4	26.0	28.5	26.3	10.7
1959	0.5	3.4	6.8	9.1	10.5	12.3	15.0	18.1	21.7	23.9	24.8	24.3	25.2	28.8	26.1	10.6
1960	0.5	3.6	7.1	9.0	10.9	13.2	15.2	19.1	22.6	23.6	23.8	21.4	25.0	28.9	25.1	10.6
1961	0.4	3.4	7.1	9.2	13.3	13.2	15.6	18.6	22.2	23.8	22.3	21.7	22.3	27.2	23.7	10.4
1962	0.6	3.7	8.2	9.9	12.6	13.8	16.3	19.4	22.8	24.0	23.3	21.9	22.6	28.4	24.3	10.9
1963	0.6	4.0	8.5	11.0	12.6	15.5	16.6	19.1	23.3	24.6	22.4	21.5	23.4	26.2	23.7	11.0
1964	0.5	4.0	8.5	10.7	13.1	14.6	16.5	19.5	21.7	23.5	21.7	22.1	22.1	25.0	23.0	10.8
1965	0.5	4.0	8.9	11.3	13.3	15.8	17.5	18.7	22.8	24.7	22.8	22.3	21.6	25.0	22.9	11.1
1966	0.6	4.3	9.2	11.4	13.3	14.6	16.9	19.0	21.1	23.0	22.8	21.6	21.5	24.7	22.6	10.9
1967	0.6	4.7	9.7	11.8	12.9	15.7	17.5	18.2	21.0	22.6	22.1	19.4	20.3	21.8	20.5	10.8
1968	0.6	5.1	9.6	11.4	12.8	15.2	17.1	18.6	20.7	22.1	21.4	19.6	19.6	21.4	20.2	10.7

\*Source: James C. Diggory, "United States Suicide Rates, 1933-1968: An Analysis of Some Trends," Suicidology: Contemporary Developments, edited by Edwin S. Schneidman (New York, Grune and Stratton, 1976) (5, pp. 48, 49).

[Reproduced from Karen Grove Sherman, Suicide and the Elderly (Denton, Texas: Center for Studies in Aging, 1980), pp. 14-15]

Appendix II

600054

**SUICIDE RATES PER 100,000 BY FIVE-YEAR AGE GROUPS, COLOR, AND SEX:  
UNITED STATES, 1972\***

Group	Total	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	≥85
<b>Total Population</b>	12.0	0.6	6.9	14.0	14.8	14.7	16.1	17.4	20.6	19.2	21.3	21.6	20.8	19.9	20.6	24.6	20.5
<b>Male</b>	17.5	0.7	10.9	21.2	21.2	20.5	21.0	23.3	28.2	27.8	30.2	33.1	35.3	36.7	39.6	54.2	50.0
<b>Female</b>	6.8	0.4	2.8	6.8	8.5	9.1	11.4	11.8	13.5	11.2	13.1	11.6	9.2	7.7	7.9	7.1	5.4
<b>Whites</b>	12.8	0.6	7.0	13.5	14.9	15.3	16.7	18.6	22.0	20.8	22.7	23.1	22.5	21.2	21.7	28.0	22.2
<b>Male</b>	18.5	0.9	11.1	20.5	21.0	20.7	21.3	24.5	29.8	29.6	32.1	35.2	38.0	39.1	42.1	58.0	54.5
<b>Female</b>	7.3	0.4	2.7	6.6	8.8	9.9	12.3	12.8	14.6	12.2	14.0	12.5	10.0	8.2	8.1	7.2	5.9
<b>All Others</b>	6.6	0.2	6.5	16.6	14.4	10.7	11.5	8.5	9.6	6.6	7.5	7.6	5.6	6.8	7.9	8.5	3.0
<b>Male</b>	10.3	...	9.5	26.0	23.1	18.4	18.5	13.1	14.6	11.6	11.0	12.9	10.6	13.1	12.1	13.0	7.8
<b>Female</b>	3.3	0.4	3.4	8.2	6.9	4.2	3.8	4.6	5.2	2.2	4.4	3.0	1.5	1.5	4.7	5.4	...

\*Source: U.S. Department of Health, Education, and Welfare, Public Health Service, Health Resources Administration, National Center for Health Statistics, Vital Statistics of the United States, 1972, Vol. II (Washington, Government Printing Office, 1972) (10, pp. 1-24).

[Reproduced from Euren Grove Sherman, Suicide and the Elderly (Denton, Texas: Center for Studies in Aging, 1980), p. 23]

Appendix III

U.S. WHITE MALE SUICIDE RATES PER 100,000 BY FIVE-YEAR AGE GROUPS,  
1951-1968\*

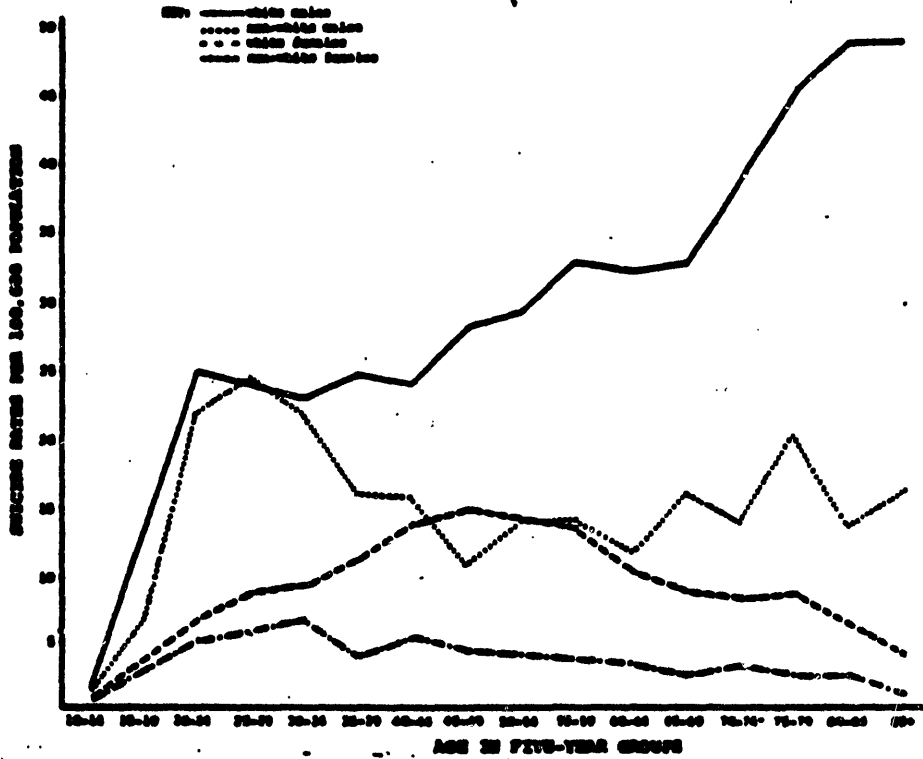
Year	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	≥75	All Ages
1951	0.7	3.8	9.7	11.9	13.7	17.5	23.8	29.0	31.8	37.0	42.8	48.2	53.4	57.4	17.3
1952	0.5	4.7	9.2	11.9	13.3	17.7	21.7	26.8	33.2	35.0	42.4	43.2	50.0	60.0	16.9
1953	0.8	4.2	9.9	12.9	13.1	17.5	23.8	28.7	33.8	35.2	42.0	43.4	50.5	58.5	17.3
1954	0.5	3.8	10.3	13.0	14.1	17.2	22.7	30.5	35.9	38.4	45.2	44.7	48.3	54.5	17.5
1955	0.4	4.0	8.7	12.5	12.8	16.3	23.5	28.0	36.1	41.7	44.0	45.0	46.3	57.7	17.2
1956	0.7	3.5	9.6	11.3	14.4	16.2	22.1	27.5	33.3	40.1	43.0	45.6	47.5	59.8	16.9
1957	0.8	4.1	9.4	10.9	14.3	16.7	23.6	26.8	34.4	37.4	38.9	41.1	46.7	59.0	16.5
1958	0.8	4.7	11.2	13.6	15.0	18.8	25.6	30.9	37.6	40.2	43.9	43.6	48.7	60.9	18.0
1959	1.0	5.4	11.0	12.8	15.9	19.3	24.0	29.8	36.2	40.7	43.1	43.2	47.4	60.7	17.7
1960	1.0	5.9	11.9	13.8	15.9	19.6	24.3	30.2	37.6	39.9	40.6	38.5	46.7	59.2	17.6
1961	0.7	5.5	11.0	13.0	16.2	20.1	24.7	29.8	36.2	40.7	38.0	38.2	42.1	57.5	17.1
1962	1.1	5.8	12.6	14.5	18.4	20.8	24.9	30.2	37.0	41.4	39.4	40.1	42.8	59.2	17.8
1963	1.0	6.3	12.9	16.2	17.7	22.2	25.0	29.4	37.0	41.4	38.7	37.8	43.4	54.7	17.8
1964	1.0	6.6	12.8	15.2	18.9	20.0	24.5	30.0	33.8	39.3	37.5	37.8	40.6	55.5	17.2
1965	1.0	6.3	13.9	16.5	18.9	21.8	25.0	26.7	35.2	40.3	38.9	37.8	41.2	53.4	17.4
1966	1.1	6.7	14.2	16.1	18.4	21.0	24.4	27.5	32.8	37.6	39.3	37.8	40.0	54.8	17.2
1967	1.0	7.5	14.9	16.9	17.5	22.2	25.4	26.8	31.8	35.7	37.4	32.2	37.9	48.1	16.8
1968	1.0	8.3	15.0	16.3	18.3	22.0	24.2	27.0	30.8	35.8	36.5	35.6	37.0	48.0	16.9

\*Source: James C. Diggory, "United States Suicide Rates, 1933-1968: An Analysis of Some Trends," *Suicidology: Contemporary Developments*, edited by Edwin S. Shneidman (New York, Grune and Stratton, Inc., 1976) (3, p. 59).

[Reproduced from Karen Grove Sherman, *Suicide and the Elderly* (Denton, Texas: Center for Studies in Aging, 1980), p. 32]

000000

SUICIDE RATES IN THE US IN RELATION TO AGE AND RACE (1974)



Source: The National Center for Health Statistics

[Reproduced from Marv Miller, Suicide after Sixty: The Final Alternative (New York: Springer Publishing Co., 1979), p. 4]

Congress of the United States  
Office of Technology Assessment

LIFE-SUSTAINING TECHNOLOGIES AND THE ELDERLY  
WORKING PAPERS, VOLUME 3:  
LEGAL AND ETHICAL ISSUES, MANPOWER AND TRAINING,  
AND CLASSIFICATION SYSTEMS FOR DECISIONMAKING

July, 1987

**An Ethical Analysis of Withdrawal From Life-Sustaining Technologies and Assisted Death**, by James F. Childress, Department of Religious Ethics, University of Virginia, Charlottesville, VA.

**Distributive Justice and the Allocation of Technological Resources to the Elderly**, by Robert M. Veatch, Kennedy Institute of Ethics, Georgetown University, Washington, DC.

**Life-Sustaining Technologies and the Elderly: The Legal Issues**, by Connie Zuckerman, Montefiore Medical Center, Bronx, NY.

**Geriatric Expertise in the Context of Critical and Terminal Care**, by Patricia Barry and Lawrence Markson for the American Geriatrics Society, New York, NY.

**Manpower for Selected Technologies**, by Ruth S. Hanft, Catherine C. White, and Linda E. Fishman, Ruth Hanft Associates, Washington, DC.

**Classification Systems for Decisionmaking for Critically Ill Elderly Patients**, by Robert W. Gage, Stanley Lemeshow, and Jill S. Avrunin, University of Massachusetts, Amherst, MA; and Daniel Teres, Baystate Medical Center, Springfield, MA.

These are contractor documents prepared for OTA's assessment, Life-Sustaining Technologies and the Elderly. The complete set of contractor reports for this assessment consists of five volumes. OTA makes contractor documents available for the use of readers desiring a more detailed or technical discussion of an issue than that which is included in the final report. These contractor documents, they have not been reviewed or approved by the Technology Assessment Board. The findings and conclusions expressed are those of the authors and do not necessarily reflect the views of OTA, the Advisory Panel, or the Technology Assessment Board.