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From the Director...

It is quite some time since we published our electronic journal, *Health Care Ethics USA*. The delay has been caused by our Center moving building and campus last January. As a result, the Winter issue of 2003 and the Spring issue of 2004 had to be canceled. However, I am pleased to say that our Center for Health Care Ethics has settled into a magnificent Victorian three-level town house at the heart of the main University campus. We fit the space perfectly, with our faculty and doctoral students having excellent space for research etc. We also continue to serve all the major programs in the health sciences (the School of Allied Health Professions, School of Medicine, and the School of Nursing), the University’s Institutional Review Boards, and the University Hospital (via service to the Ethics Committee, consultations, and resident ethics education programs).

In this issue we will carry 2 adverts, which is new for the journal. One advert is for a new book, edited by myself, *Genetics and Ethics: An Interdisciplinary Study* (Saint Louis University press, 2004). This is a collection of essays by experts in the field from around the world; the essays have been written for easy use by health professionals. If you would like a copy, just follow the information in the advert. Also, there is an advert for a new series of web-based interactive programs in ethics education for health professionals, such as ethics committee personnel. A Catholic version has been developed for each program. The company that has developed these programs in partnership with our Center for Health Care Ethics is DIA learning. If you would like access to any of the programs, just follow the information on the advert.

As usual, this issue of *Health Care Ethics USA* has three essays. The first essay by myself is twice as long as usual, offering an analysis of the recent Papal Address on end-of-life care for PVS patients. The second essay is by Mark Repenshek, PhD(c) who is the ethicist at Columbia St. Mary’s in Milwaukee and a senior student in our PhD program; his essay applies the principle of double effect to the use of pain medication. The final essay is by Ann Suziedelis, PhD who is a recent graduate of our PhD program; her essay discusses the questions being raised about society’s duty to rescue the unborn. I hope you enjoy the essays and I look forward to receiving suggestions for topics that we might address in future issues.

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Interpreting Pope John Paul II’s Address on End-of-Life Care for PVS Patients

On March 20, 2004 Pope John Paul II issued a formal statement to clarify the ethics debate about appropriate end-of-life care for patients in a persistent vegetative state (PVS), focusing on the use of artificial feeding. To the puzzlement of many ethicists, this focus upon artificial feeding did not make any comparison with other interventions such as the use of a ventilator: that sort of comparison between the patient’s need for oxygen and the patient’s need for food and fluids could have been very helpful. Some commentators are suggesting that the Papal Address could represent a reversal of the moral tradition of the Catholic Church in assessing whether an intervention is ordinary (proportionate) or extraordinary (disproportionate), and hence morally obligatory or not. Typically, Catholic teaching does not undergo such reversal. However, the crucial question that the Papal Address has led ethicists to ask is how the statement fits with previous Catholic teaching. This essay seeks to address that question as a matter related to doctrinal development. Other health care ethicists have presented excellent arguments for interpreting the Papal Address as a development of previous teaching in the Catholic moral tradition. This essay offers a different analysis that supports this perspective.

Principles

In the Catholic tradition, doctrinal development occurs with some regularity. John Henry Newman explained that development in doctrine typically occurs by making explicit what was previously implicit in church teaching. In 1843 he applied his understanding of “implicit and explicit reason” to describe the process of doctrinal development as “the development, in explicit form, of what was already latent within it” – that is, a process of “developing doctrines” that should “admit both of implicit reception and explicit statement.” And in his famous 1845 work, An Essay on the Development of Christian Doctrine, he added further nuance to the role of implicit and explicit reason when explaining doctrinal development as an application of the development of ideas in general: “if a great idea is duly to be understood, and much more if it is to be fully exhibited … it changes … in order to remain the same. In a higher world it is otherwise, but here below to live is to change, and to be perfect is to have changed often.”

More recently, in 1989, the International Theological Commission applied Newman’s view of doctrinal development to explain its case for determining doctrinal truth throughout history. Adopting Newman’s approach to doctrinal development, this essay considers whether the Papal Address of 2004 can be construed as making explicit what is already contained implicitly in the U.S. Bishops’ teaching. Specifically, the essay examines the teaching in the Ethical and Religious Directives that there should be “a presumption in favor” (ERD, no. 58) of providing artificial feeding to patients, such as those in a PVS. This interpretation hopes to provide practical guidance for Catholic health care in the United States.

A brief summary of the Papal Address situates the ethical debate. The Pope recognized the PVS issue as being very important, with complex scientific, ethical, social, and pastoral implications. He encouraged further efforts in study and research of PVS patients. And he affirmed the intrinsic value and personal dignity of PVS patients, exhorting medicine to cure if possible, and always to care.

However, the Pope also made several observations in the Address that have elicited significant controversy. The most controversial statements appear in sections #4 and #6 of the Address. The Pope insisted upon the PVS patient’s “right to basic health care” including “nutrition and hydration” to emphasize the following points.

“I should like particularly to underline how the administration of food and water, even when provided by artificial means, always represents a natural means of preserving life, not a medical act. Its use, furthermore, should be considered, in principle, ordinary and
proportionate, and as such morally obligatory, insofar as and until it is seen to have attained its proper finality, which in the present case consists in providing nourishment to the patient and alleviation of his suffering.” (Section #4).

“… The evaluation of probabilities, founded on waning hopes for recovery when the vegetative state is prolonged beyond a year, cannot ethnically justify the cessation or interruption of minimal care for the patient, including nutrition and hydration. Death by starvation or dehydration is, in fact, the only possible outcome as a result of their withdrawal. In this sense it ends up becoming, if done knowingly and willingly, true and proper euthanasia by omission.” (Section #4).

“… it is necessary to promote the taking of positive actions as a stand against pressures to withdraw hydration and nutrition as a way to put an end to the lives of these patients.” (Section #6).

The crucial ethical observations about artificial feeding for PVS patients that need to be analyzed include these controversial guiding principles:

1. artificial feeding is a natural means of preserving life whose use, in principle, is ordinary and proportionate;
2. artificial feeding is morally obligatory provided it can attain its proper finality;
3. the evaluation of probabilities is insufficient to justify withdrawing minimum care from PVS patients, including nutrition and hydration: if done knowingly and willingly, the resulting death is euthanasia by omission;
4. actions should be taken to prevent the withdrawal of hydration and nutrition as a way to put an end to the lives of PVS patients.

Discussion

A discussion of the above four points can set the stage for explaining how a form of doctrinal development in the Catholic tradition may be occurring in the Papal Address. The crucial ethical controversies can be clustered together as topics 1-2 and topics 3-4.

Artificial feeding as ordinary care and morally obligatory.

Items 1-2, described at the end of the section on principles, assert that artificial feeding is, at the level of principle, both ordinary care and morally obligatory. Several observations need to be made.

First, artificial feeding is determined to be morally obligatory specifically because it constitutes care that is ordinary and proportionate. This statement by the Pope that artificial feeding is ordinary care will elicit significant scrutiny by ethicists insofar as it seeks to establish a more strenuous claim than has occurred previously. Hence, the ethical controversy revolves around whether artificial feeding constitutes ordinary (proportionate) care in contrast to extraordinary (disproportionate) care. Further analysis by commentators will be needed to interpret the statement that artificial feeding represents a “natural means of preserving life, not a medical act.” One plausible reading is that the text seeks to identify “the administration of food and water” (even if “provided by artificial means”) as natural, in contrast to the insertion of medical instruments through which artificial feeding can be provided. For the analysis in this essay, the crucial debate revolves around artificial feeding being ordinary care and morally obligatory.

Second, it is very important to notice that the words “in principle” indicate that the Papal Address is dealing with a theoretical analysis. The claim of artificial feeding constituting ordinary care “in principle” implies that the ordinary care could become extraordinary care when particular cases and specific circumstances are considered in practice. That is consistent with the Catholic moral tradition.

Third, the potential shift from ordinary care to extraordinary care seems to be specified by the qualifying clause about artificial feeding attaining its proper finality. That is, to the extent that artificial feeding cannot attain its proper finality, it would shift from being ordinary (proportionate) care to becoming extraordinary (disproportionate) care. Conservative commentators unambiguously recognize the possibility of ordinary care becoming extraordinary in concrete circumstances. For example: “Food and fluids may be discontinued when they are extraordinary or disproportionate … there is a presumption in favor of the supply of nutrition and hydration, unless their supply can be
shown to be futile or excessively burdensome. In the Catholic tradition, this shift from ordinary care to extraordinary care has been identified when the care becomes futile or too burdensome in the sense that there is insufficient benefit to outweigh the burdens.

Hence, two important clarifications about the language of “proper finality” in the Papal Address can be made. It is important to emphasize that the Papal Address considered only PVS patients and focused upon the life-sustaining intervention of artificial feeding (and not on other interventions, such as the use of ventilators). On the one hand, the “proper finality” is identified as consisting in part in the “alleviation of suffering.” It should be noted that the mainstream view in the medical literature about PVS patients is that they no longer have a cerebral cortical function, and hence cannot experience pain or suffering. Hence, this element of the “finality” of artificial feeding may, for the most part, already be resolved. On the other hand, the “proper finality” is also identified as consisting in part in “providing nourishment to the patient.” It seems clear from the Catholic tradition that such nourishment cannot be reduced to the merely biological dimension. For example, the U.S. Bishops’ Pro-Life Committee argued in 1992 that “sometimes even food and fluids are no longer effective in providing this benefit” (of sustaining and fostering life) “because the patient has entered the final stage of a terminal condition … medically assisted feeding or intravenous fluids in this case may increase the patient’s discomfort while providing no real benefit…. In other words, the finality of providing nourishment has to be interpreted within the personal realm of the patient’s particular situation, as described above. The Declaration on Euthanasia from the Congregation of the Doctrine of the Faith (1980) emphasizes that discerning “extraordinary means” (the Declaration’s phrase) requires a consideration of the patient’s personal circumstances: “…it will be possible to make a correct judgment as to the means … taking into account the state of the sick person and his or her physical and moral resources” (section 4, on “Due Proportion on the Use of Remedies”).

In sum, the Papal Address does not exclude the possibility of artificial feeding becoming extraordinary care in particular cases and specific circumstances. When artificial feeding shifts from being ordinary (proportionate) care to becoming extraordinary (disproportionate) care, it is no longer considered to be morally obligatory. Typically, in the Catholic moral tradition, that shift occurs when the ordinary care becomes futile or is too burdensome for the patient.

**Withdrawing artificial feeding as tantamount to euthanasia.**

Items 3-4, described at the end of the section on principles, assert that withdrawing artificial feeding as ordinary care could be euthanasia if done knowingly and willingly, and hence measures should be taken to prevent such action. Several observations need to be made.

First, the comment that the evaluation of probabilities cannot justify the withdrawal of minimal care, such as artificial feeding, involves two significant assumptions: that medical certainty cannot be reached in the case under review; and that minimal care constitutes ordinary care. In practice, both of these assumptions can change: medical evaluation can move from mere probability to what is known as a reasonable degree of medical certainty; and, as seen above, ordinary care can become extraordinary care in particular cases or specific circumstances. Some may wonder whether this evaluation of probabilities could infer that, insofar as one patient may have recovered from a PVS diagnosis, other PVS patients must be treated similarly as if they could recover too. However, the Pope does not claim such an inference, nor could it be argued easily from the Catholic tradition. Hence, the Papal Address appears only to adopt the stance that the evaluation of probabilities cannot be used to withdraw minimal care (that is, ordinary care); it does not forbid a reasonable degree of medical certainty as a basis for withdrawing care that has become extraordinary.

Second, the comment that withdrawing artificial feeding as minimal care knowingly and willingly constitutes euthanasia by omission also implies the above assumptions. That is, insofar as artificial feeding constitutes ordinary care and is morally obligatory, its removal as obligatory and ordinary care could be tantamount to euthanasia by omission if done knowingly and willingly. However, this judgment would not pertain if artificial feeding becomes extraordinary care in particular cases and specific circumstances. Pope John Paul II made this very clear in his 1995 encyclical, The Gospel of Life: “To forego extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses the acceptance of the human condition in the face of death” (no. 65). In such cases, there would be no moral obligation to provide extraordinary care, and the death of the patient would not be euthanasia insofar as the death is not intended, even if it is foreseen.
Third, the need for positive actions to prevent the withdrawal of hydration and nutrition as a way to put an end to the lives of PVS patients is a reiteration of the prohibition of euthanasia. That is, if artificial feeding is withdrawn specifically to end the lives of PVS patients, that constitutes euthanasia by omission. Hence, positive actions are needed to prevent this form of euthanasia. However, as mentioned in the previous paragraph, there may be circumstances when artificial feeding shifts from being ordinary care and becomes extraordinary care that can be withdrawn legitimately: when that occurs, even though the patient’s death is foreseen, it is not intended, and therefore would not constitute euthanasia.

Understanding the Papal Address as a form of doctrinal development.

With the above commentary in mind, the Papal Address can be interpreted as adding clarification and nuance to the current teaching of the U. S. Bishops. In the *Ethical and Religious Directives* (ERD), no.58 and no.60, we read:

“There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens to the patient” (*ERD*, no.58).

“Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way” (*ERD*, no. 60).

If the Papal Address is to be construed as a form of doctrinal development, it should be the case that the Papal Address adds clarification or nuance to previous teaching in the sense of making explicit what may have been implicit previously. That case can be made with regard to the U.S. Bishops’ teaching in the ERDs that there should be “a presumption in favor” of artificial feeding for patients, such as those in a PVS. The following points can be made.

First, it is reasonable to argue that there cannot be an effective “presumption in favor” of artificial feeding unless the ERDs already understood that artificial feeding is normally or usually morally obligatory. And, in the tradition of Catholic health care in the U.S., artificial feeding would not be morally obligatory unless it is deemed to be ordinary care. Hence, for example, *ERD* no.56 (also no.32) explains: “A person has a moral obligation to use ordinary or proportionate means of preserving his or her life.” In other words, the “presumption in favor” phrase implies that artificial feeding is perceived to be ordinary care and therefore morally obligatory. These important points, that seem to be implied in the ERDs, are made more explicitly in the Papal Address.

Second, the “presumption in favor” is qualified in the ERDs by the phrase, “as long as this is of sufficient benefit to outweigh the burdens involved to the patient.” Here, the U.S. Bishops recognize that artificial feeding may shift from being ordinary care (where there would be a presumption in favor of providing it), to becoming extraordinary care (based on the burdens and benefits of individual patients). This means the U.S. Bishops are making a statement “in principle” about artificial feeding (there is a presumption in favor of providing it as ordinary care) that is then qualified when applied to particular cases (based on the burdens and benefits of individual patients). The same approach is adopted more explicitly in the Papal Address: a statement is made “in principle” that artificial feeding constitutes ordinary care and is therefore morally obligatory; and there is a concomitant implication that, in practice, the ordinary care can shift to becoming extraordinary care based on practical circumstances, such as when the “proper finality” of artificial feeding cannot be attained.

Third, the prohibition of euthanasia, either by action or omission, is forbidden clearly in the ERDs, just as occurs in the Papal Address.

**Conclusion**

This essay seeks to provide an interpretation of the Papal Address as possibly providing a form of doctrinal development for the U.S. Bishops’ teaching in the ERDs. Typically, doctrinal development occurs when a statement offers explicit clarification or nuance to what is implicit in a previous teaching. In this case, the Papal Address can be construed as clarifying explicitly what is implicit in the U.S. Bishops’ teaching about “a presumption in favor” of providing artificial feeding, especially for PVS patients. There are three specific clarifications that should be emphasized.
First, the seemingly controversial claims in the Papal Address are that artificial feeding for PVS patients both constitutes ordinary care and is morally obligatory. This essay argues that such claims may not be too controversial after all insofar as they can be interpreted as making explicit what is contained implicitly in the teaching of the U.S. Bishops. In other words, the claim by the U.S. Bishops for “a presumption in favor” of artificial feeding means implicitly that artificial feeding both constitutes ordinary care and is morally obligatory, as stated explicitly in the Papal Address.

Second, the Papal Address explicitly states that its claims are made “in principle.” That clarifies the teaching in the ERDs of a “presumption in favor” of artificial feeding as being made “in principle,” especially insofar as the presumption does not pertain in all circumstances, such as when burdens and benefits of individual patients are considered in practice.

Third, the Papal Address reinvigorates the teaching against euthanasia that is presented by the U.S. Bishops in the ERDs. The Papal Address emphasizes that “it is not enough to reaffirm the general principle” against euthanasia; it is also “necessary to promote the taking of positive actions” against any effort to withdraw artificial feeding as a form of euthanasia.

Undoubtedly, the Papal Address presents significant challenges for ethicists as they square its teachings with the Catholic moral tradition. This essay presents a case for interpreting the Papal Address on end-of-life care for PVS patients as a form of doctrinal development that can be construed as providing explicit clarification and nuance to the U.S. Bishops’ teaching in the ERDs. It is important to emphasize that the Papal Address must be understood very narrowly: it only discusses artificial feeding, not other interventions, such as the use of ventilators; and it only addresses PVS patients, not other patients who are dying.

Catholic health ministries may wonder whether the Papal Address necessitates a change in the ERDs for their practice of health care in the United States. While such a decision will be the responsibility of the Bishops, it may help to consider a possible change in the ERDs that arguably would accommodate the main concerns raised by the Papal Address. The underlined text below indicates how the Papal Address could be construed as making explicit what is implicit in the current ERDs. Such a modest revision could be considered as a form of doctrinal development that clarifies Church teaching without involving any change in actual practice for Catholic health care.

“There should be a presumption in favor of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration (especially PVS patients insofar as this presumption constitutes ordinary and proportionate care that is morally obligatory), as long as this is of sufficient benefit to outweigh the burdens to the patient” (ERD, no.58).

However, if a revision of the ERDs does occur to implement the emphasis of the Papal Address, the change should pertain only to artificial feeding for PVS patients, and not to other end-of-life care interventions for other patients who are dying. After all, the Papal Address does not discuss those other patients and interventions.

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Suggested Readings


Questions For Discussion

1. Should the Papal Address be understood as a form of doctrinal development that makes explicit what is implicit in the U.S. Bishops’ Ethical and Religious Directives for Catholic Health Care Services?
2. Should the Papal Address on PVS care require major change in the practice of Catholic health care in the United States?
3. Should the Papal Address PVS care be applied to other patients and treatments in end-of-life care?

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The Principle of Double Effect and Pain Medication

Has appeal to a principle in bioethics reinforced an unfounded fear about the therapeutic use of opioids? In September of 2003, the Pain & Policy Studies Group at the University of Wisconsin released its report, *Achieving Balance in State Pain Policies: A Progress Report Card*. The report concludes: “the nation remains behind the ideal in providing consistent, balanced policies that ensure the availability of pain-relieving drugs for patients in need while controlling the misuse of such substances.”

Though the report concentrates on a number of criteria to evaluate the effectiveness of state policy in meeting the ideal, this article will focus on a single issue: the belief that death may be hastened by the use of opioids in end-of-life care.

The central question that has captured ethics discourse on the administration of opioids in end-of-life care is the following: Is the therapeutic use of opioids to relieve pain in patients at the end of life morally permissible even when it is foreseen that the drug will indirectly shorten the patient’s life? Traditionally, the principle of double effect (PDE) provided a framework for determining whether it is morally appropriate to administer high-dose opioids to treat a patient’s pain even if it is foreseen that the medication hastens the patient’s death. Yet, it is the contention of the *Progress Report Card* that the therapeutic use of opioids to relieve pain in patients at the end of life does not in fact shorten a patient’s life and the argumentation that supports this traditional understanding “reinforces an unfounded fear about opioids that can itself contribute to inadequate treatment of pain.” An analysis of this contention requires an examination of the PDE to consider whether its use is appropriate in the context of the therapeutic use of opioids.

Principles

The traditional parameters that define the therapeutic use of opioids in end-of-life care are framed by the PDE. The principle aids physicians in clarifying their intent concerning the use of pain medication wherein death of the patient may be foreseen. In other words, according to the PDE, administering high-dose pain medication with the intent of treating a patient’s pain and suffering may be acceptable even if the medication results in hastening the patient’s death. The PDE traditionally consists of four components, all of which must be met to enable a person to act in good conscience. First, the act in and of itself must be morally good or neutral. In the case of administering pain medication the act is morally good. Second, the intention of the agent must be to seek the good and not the harmful effect. In the case of administering pain medication, an intent that seeks the good, attempts to relieve the pain and suffering of the patient. Third, the foreseen good effect must not be achieved by means of the foreseen harmful effect. By way of contrast, choosing a means that is directly aimed at killing the patient in order to relieve the patient’s pain and suffering would be morally illicit. Fourth, the desired good effect must be proportionate to the foreseen harmful effects. Here, the desired good is the relief of pain and suffering, without which most would find the spiritual and psychological dimensions of dying too difficult, even causing them to lose hope and their sense of dignity.

In an attempt to challenge the need for the PDE to determine morally appropriate uses of opioids, a number of recent studies suggest that the medical reality provides little basis which would require use of the principle. In other words, it is not necessary to rely on the PDE to justify giving adequate pain medication to dying patients because de facto the patient’s death is not hastened with their use. Furthermore, such reliance on the PDE actually perpetuates the myth of the “double effect” of pain medication by inadvertently contributing to the undertreatment of pain at the end of life. If it is the case that the therapeutic use of opioids does not, in fact, hasten a patient’s death, does the PDE have any relevance as a framework for clarifying a physician’s intent?

Discussion
Respiratory depression is potentially life threatening, and as such, is considered the most serious opioid side effect. Patients in pain, however, respond differently to opioids than do persons without pain. Pain acts as a natural antagonist to the respiratory depressant effect of opioids. As such, patients receiving long-term opioid therapy usually develop tolerance to respiratory-depressant effects. Respiratory depression is viewed to be rare when the opioid is carefully titrated. Ground et al., studied the efficacy of the now validated stepwise “WHO Analgesic Ladder” against this claim in 401 dying patients in Germany. They found that of the 70% of the patients who needed opioids to control pain, none showed clinical signs of respiratory depression. Exploring the question of respiratory depression as it relates to the concern of hastening death, Thorns and Sykes retrospectively analyzed the pattern of opioids used in the last week of life in 237 consecutive patients who died in the palliative care unit. They found that there was no difference in survival from admission between the group who had received no narcotic analgesic in their last week and those who had received narcotic analgesic in the final 48 hours. In examining a greater breadth of studies concerning opioid-induced respiratory depression, Susan Fohr argues that “there is no debate among specialists in palliative care and pain control on this issue...there is broad consensus that when used appropriately, respiratory depression from opioid analgesics is a rarely occurring side effect.”

Returning to the question posed at the onset of this article as to whether the PDE has any relevance for clarifying a physician’s intent in the context of the therapeutic use of opioids, a distinction may be helpful. Timothy Quill, along with others, has critiqued the use of the PDE in end-of-life decision making as an inadequate principle to deal with the nuances of a physician’s intent. Daniel Sulmasy has responded to this critique noting that such a position is highly problematic given that “everyday clinical practice depends heavily on the concept of intention...in almost all therapeutic interventions.” It is the very concept of intention that it vital to distinguish among those acts that respect another’s dignity. Right intention is integral to medical practice, given that it is the proportionate benefit of a treatment or therapy that morally justifies its use in the face of undesirable side-effects, risks or alternatives (See Directive n. 33 of the ERD).

The contention of this article, however, is not that the PDE is necessary to help clarify a physician’s intent with regard to the therapeutic use of opioids, but rather that the clinical reality of proper opioid use in end-of-life care may not require the use of the PDE where respiratory complications do not occur. This is not to say that respiratory complications can never occur; rather, there is a distinction between noting respiratory depression that may occur in rare cases and respiratory depression as a secondary effect of opioid use. In the latter case respiratory depression is assumed to be part of the reality of the therapeutic use of opioids; however, the medical literature on this topic questions that basic premise.

Recall that the PDE requires of its use that an act have both a foreseen beneficial and harmful consequence. In the context of the therapeutic use of opioids, use of the PDE may implicitly create a harmful consequence where in fact there may not be one. In other words, if it is the case, as it is argued here, that the therapeutic use of opioids may result in respiratory depression, then, de facto, it is not necessarily the case that the therapeutic use of opioids will result in respiratory depression. The distinction between “may” and “will” is relevant as to whether there is need for the PDE insofar as the PDE assumes that the act in question has both foreseen beneficial and harmful consequences. In the case of the therapeutic use of opioids it is not the case, necessarily, that a harmful effect will result. Hence, respiratory depression may be more akin to a rare side-effect than an immediate consequence of the use of therapeutic opioids. In other words, if a serious side-effect is not expected in the given case, then it is unnecessary to appeal to the PDE. In fact, as indicated in the referenced studies, the respiratory-depressant effect is not expected in the vast majority of cases.

Conclusion

The relevance of the PDE in the justification of opioid use in pain management has been overestimated, and may even be misleading, given that respiratory depression as a side-effect of opioid use in pain management does not seem to be as significant a concern as was once thought and is not supported by medical evidence nor grounded in clinical reality. This in part, seems to be the assertion of the Pain & Policy Studies Group at the University of Wisconsin in its report, Achieving Balance in State Pain Policies: A Progress Report Card. A study by Solomon et al., would substantiate this claim in that although 89% of physicians and nurses agreed that “sometimes it is appropriate to give pain medication to relieve suffering, even if it hastens a patient’s death,” 41%
agreed that "clinicians give inadequate pain medication most often out of fear of hastening a patient’s death."\footnote{19}

The critique that this article offers is not to say that the PDE is irrelevant as Quill and others have asserted. Rather, because respiratory depression as a result of opioid use is a rare event, it may be better to classify such an event as an unexpected side-effect rather than as a foreseen consequence of opioid use. In this way, in such instances where the therapeutic use of opioids would hasten death, their use would still be justified via PDE (not that opioid pain relief can only be justified by PDE). Furthermore, because one cannot be absolutely certain that the therapeutic use of opioids in any given particular case will not have a respiratory-depressant effect that may lead to death, the PDE would still be appropriate in such rare instances. In the context of the therapeutic use of opioids, it is essential therefore, that the PDE be used appropriately such that respiratory depression not be misconstrued as de facto a consequence of their use.

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**Suggested Readings**


**Questions For Discussion**

1. Does the principle of double effect apply in the context of the therapeutic use of opioids?
2. What framework would serve to determine ethically appropriate uses of opioids?
3. How does your health ministry respond to physicians or nursing staff concerned that they have hastened the death of a patient through the use of opioids?
Raising Questions About Society's "Duty to Rescue" the Unborn

Our society faces ethical questions today about both the extent of a mother's ethical obligation to save her unborn child and the difficulties society faces in determining its duty to intervene to rescue the unborn from those choices. It is the latter that is focused upon here, and four cases suggest the kinds of incidents in question. The first is that of Angela Carter, who refused a Caesarean section in 1987, as she lay dying of cancer. She had fought to remain pregnant, but at 26 weeks physicians felt the baby could no longer survive in her body. In 1999, a pregnant and intoxicated Deborah Zimmerman told a Wisconsin obstetrical nurse that if she was discharged from the hospital she would "just go home and keep drinking and drink myself to death—and I'm going to kill this thing [her unborn baby] because I don't want it anyway." In the third case, again in 1999, 29-year-old Angela Wolf tested positive for cocaine use throughout her pregnancy, unable to control her addiction. In the final case, Melissa Ann Rowland—a woman with a long history of mental illness—refused to undergo a C-section in January of 2004, in the last weeks of her pregnancy, even though doctors argued that it was necessary to save the lives of her unborn twins. How society should respond to these cases is especially challenging, both legally and ethically, in a nation where even late abortions are often legal.

Principles

Four moral principles come to mind in evaluating society's obligation in these cases. The first, respect for human life, is central to the debate, and concerns the essential nature of the parties involved. At one extreme are those who hold that each case involves only one human person, who has all the attendant legal rights of personhood, and who carries within her a fetus that bears only the potential of human personhood, thus having no legal rights. At the other end of the spectrum are those who argue that there are two fully human beings present, the mother and the unborn child, and that there is an ethical imperative to balance the rights of the two, even under law. The U.S. Supreme Court, however, has rejected any single theory of life, concluding in Roe v. Wade that a fetus is not a "person" under the 14th Amendment. This is the position of most pro-choice activists. The Catholic Church, on the other hand, turning its focus from the specific philosophical question of "personhood," teaches that even the smallest human embryo should be regarded not as a potential human being, but as a human being with potential. Part Four of The Ethical and Religious Directives points out that Catholic health care ministry witnesses to the sanctity of life "from the moment of conception" until death, and that the Church's defense of life specifically encompasses even the unborn. This position is widely embraced by pro-life activists.

Between these positions one can find a wide range of views, as well as many persons who are at a loss about what to think. Even those who support the position of the Church are not always comfortable with the practical and ethical ramifications of deciding against pregnant mothers in all such cases. One concern that restrains them is the second ethical principle, that "like cases should be treated alike." It dictates, for example, that a person who commits a certain crime under certain circumstances should receive roughly the same sentence as another who commits the same crime under the same circumstances.

The third moral principle is the "duty to rescue." Individual Americans almost never have a legal obligation to act as Good Samaritans, except through mandatory taxes that fund fire, police, welfare, and military services. The question here is whether there exists a moral obligation on the part of society to rescue a fetus from the womb of a mother who behaves in a manner that threatens its unborn life. This leads inexorably to the fourth relevant principle, autonomy, which has been critical to bioethical discussion since U.S. Supreme Court Justice Cardoza found in 1914 that "every human being of adult years and sound mind has a right to determine what shall be done with his own body." In the cases considered here, this brings us back to the competing views about who is involved; are there two human beings to consider or only one. When another human body is at stake, can a mother ethically be allowed to focus only on her own?
Direct intervention to save the life of a fetus can be undertaken in two ways. The first requires the medical invasion of the mother's body, through C-section or fetal surgery, for example, while the second protects the fetus by restricting the mother's individual liberty. To date, this has meant her liberty to consume alcohol or use illegal drugs. Both kinds of intervention violate the mother's autonomy, but if one embraces the belief that both mother and fetus are fully human beings, then the mother's rights must be balanced against those of the fetus. Obvious questions arise about society's obligation to intervene as it does to save the life and protect the well-being of a born child. On the other hand, if it is held, as many pro-choice proponents believe, that only one human being exists, then the issue should be settled; the fetus is not a human being, and thus has no rights. It does not appear that much of U.S. society finds the issue to be so cut and dried.

The four cases outlined here suggest the ethical and legal quandaries of the issue. In the cases of Angela Carter and Melissa Rowland, doctors sought to intervene, via C-section, without the mothers' consent. (Complicating these particular cases was the fact that Carter's judgment may have been impaired by impending death, and Rowland's by mental illness.) In Carter's case, a District of Columbia judge ordered the C-section, but an appellate court later decided that her refusal, supported by her surrogates, should have ended the discussion, despite the fact that doctors held surgery to be the child's sole chance to survive. When Rowland's son was stillborn after she belatedly acquiesced to surgery, she was arrested and charged with criminal homicide, and eventually accepted a plea to two counts of third-degree felony child endangerment.

Angela Wolf was reported to authorities for violating state child abuse laws for her continued cocaine use, and ordered into treatment when lower courts ruled that her 36-week fetus met the definition of a child. The Wisconsin Supreme Court disagreed, finding that the legislature would have to have expressly included the word "fetus" for one to be considered a "child" under abuse laws. Deborah Zimmerman, who expressed a determination to kill her child, had a blood alcohol level of .302 (well above the legal limit of .10) when she gave birth, and her baby was born with a level of .199, and diagnosed with fetal alcohol syndrome. As a result, Wisconsin authorities filed attempted first-degree intentional homicide and first-degree reckless injury charges against her. In her appeal of the charges, Zimmerman's attorneys argued that her abuse of alcohol was directed toward her own body and the "fetus" she carried—and thus was by legal definition not against another "human being." The appeals court found that she was guilty of no crime, since "the term 'human being' was not intended to refer to an unborn child." Still, the matter has not been put to rest.

The legal waters are churning, as society strives to do what may be impossible—to develop legislation that fully protects both maternal autonomy and fetal well-being. This leads to the logical inconsistency of rulings such as that of the Utah Supreme Court, that the state's criminal homicide statute applies to unborn children at all stages of development, yet exempts the killing of a fetus during an abortion. And while the decisions in Roe v. Wade—and in the cases of Angela Carter and Deborah Zimmerman as well—clearly state that the unborn are not human persons, and imply no ethical duty on anyone to rescue them, contradictory legislation has been passed. A new federal law signed by President Bush on April 1, 2004, makes it a separate and distinct federal crime to end the life of a fetus—defined as "a member of the species [H]omo sapiens, at any stage of development, who is carried in the womb"—during a violent attack on the mother. Here again, though, prosecution is specifically excluded when a legal abortion is performed. Pregnant women in South Dakota who abuse alcohol or other drugs now face involuntary detention in treatment facilities, and a law in Wisconsin allows juvenile court judges to intervene on behalf of the unborn to detain and restrict the liberty of such mothers. In 2003, Regina McKnight, a homeless drug addict with an IQ of 72, who abused cocaine during pregnancy and whose child was stillborn, lost a bid in the United States Supreme Court to reverse her conviction. She is now serving a 12-year prison sentence for homicide.

Conclusion

From both practical and ethical perspectives, determining where the line should ultimately be drawn is perplexing. If one agrees with the legal sanctions outlined in the cases discussed here, then at what point should they extend to other mothers with habits that jeopardize their fetuses? What about the pregnant CEO who refuses to reduce her work load, or the mother-to-be who undereats in an effort to maintain her trim figure? Should these women also be somehow detained? If their refusal to comply with medical advice leads to the premature birth and/or health problems or death of their fetuses,
should they too be convicted of child abuse or murder? If not—if some mothers are allowed to risk the well-being of their fetuses, but others are not—the ethical dictate to treat likes in a like manner is violated. If a viable fetus is not rescue—and is thus allowed to die as the result of a mother who refuses medically indicated intervention—the principle of respect for human life is not upheld. On the other hand, if a competent mother is forced to submit to medical intervention without her consent, the principle of autonomy is violated. For those who believe that two human lives are at stake in these cases, serious reflection on these competing principles will continue to be a moral challenge.

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**Suggested Readings**


**Questions For Discussion**

1. Why are poor drug addicts and alcoholics more likely than professional women to be the targets of judicial restraint and punishment when they jeopardize their fetuses?
2. What other, more sensitive methods might be employed to protect poor women who abuse alcohol and other substances and their fetuses? In the long term, would those methods be more effective?
3. What ethical problems exist in confining a woman who drinks alcohol when pregnant, if no person who is not pregnant would be confined in otherwise similar circumstances?
4. It is suggested that women such as Deborah Zimmerman and Angela Wolf might be encouraged by social workers to have abortions. Why might this be so?
5. Do you believe that all pregnant women should be constrained in whatever way necessary to protect their fetuses? If so, how could such laws be fairly enforced?