ETHICS & MEDICS
A Commentary of The National Catholic Bioethics Center on Health Care and the Life Sciences

The Direct Killing of the Innocent

There is a growing opinion among Catholic moralists that it may at times be necessary to destroy life in order to save it. These cases concern issues of vital conflict: two lives not only hang in the balance but the prospect of saving one apparently requires the killing of the other.

Rev. Martin Rhonheimer has recently defended the direct killing of the fetus in those instances where it is necessary to save the life of the mother.[1] Germain Grisez has long contended that craniotomy and other direct killings are justifiable under the principles of his new natural law theory.[2] Recently, Christopher Kaczor has come to a similar conclusion.[3]

These moralists do not call these actions "direct killing," as I do here, and would object to my use of the phrase, but I will show that the expression "direct killing" is the most appropriate description. My usage follows Catholic moral tradition and corresponds to common sense. By "direct killing" I mean any action that touches upon the body of another human being in such a way as to bring about that person's death.

Salpingostomy as Direct Killing

Consider the use of salpingostomy to resolve an ectopic pregnancy. In salpingostomy, the surgeon removes an embryo lodged in the fallopian tube by slicing the tube open and excising its contents. The act of disgorging the embryo is a classic example of what used to be called a "direct" action. The surgeon acts on the body of another human being, bringing about its death.

By way of contrast, in salpingectomy the surgeon cuts out a portion of the fallopian tube with the embryo still in it. The embryo dies, but here the action of the surgeon is directed at the tube and does not touch on the body of the embryo itself. This has traditionally been called an "indirect" action. The surgeon resolves the pathological condition by removing the damaged portion of the tube and indirectly brings about the death of the embryo.

Catholic medical ethics has long accepted salpingectomy as a moral course of action. The reason is not that difficult to see. As an action that preserves the life of the mother and only indirectly causes the death of the embryo, salpingectomy is justifiable under the principle of double effect. The removal of a portion of the pathological organ (the fallopian tube) is an action good in itself; the death of the embryo is a foreseen consequence, but not intended; the life of the mother is preserved, not by directly killing the embryo, but by removing the tube; and there is a proportionate reason for the action, namely, preserving the life of the mother.

Rev. Thomas J. O'Donnell, SJ, in his highly-regarded textbook on medical ethics, *Medicine and Christian Morality*, names the Rev. T. Lincoln Bouscaren, SJ, as the first to propose that an ectopic pregnancy

> warranted the removal of the [fallopian] tube, even with the fetus in situ; the moral reason is the removal of a dangerously damaged maternal tissue, and the loss of the fetus is "indirect" or incidental to the surgery. Although this proposal became generally accepted by Catholic moral theologians it is important to note Bouscaren's observation: "It is one thing to remove the tube containing the fetus; it is another thing to remove the fetus directly … it is necessary to emphasize the fact that … the removal of the tube itself, without any interfering directly with the fetus, is the only method which is in any way defended in this thesis" (T. L. Bouscaren, *Ethics of Ectopic Operations*, second edition, Milwaukee, 1944, p. 102).[4]

O'Donnell concludes by noting that, on this reasoning, "one cannot shell out the fetus and leave the tube" as this "would clearly be an abortive procedure."[5]

Thus Bouscaren's reasoning also explains why salpingostomy has been rejected by the Catholic tradition. Salpingostomy involves an action directed against the body of the embryo and thus violates the first and third rules of the principle of double effect. A direct killing of an embryo is not a morally good action, and in this case, that direct killing is the very means by which to achieve the good of saving the life of the mother.

Suppose that I am a physician faced with a patient suffering an ectopic pregnancy. My good intention is to resolve this crisis by removing the pathology. I can do so

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in either of two ways: by salpingectomy or salpingostomy.[6] Although I have the same intention in both cases, the object of my act differs. In a salpingectomy, I indirectly cause the death of the embryo by removing the tube with the embryo inside; in a salpingostomy, I directly cause death by removing the embryo.

Salpingostomy as Indirect Killing

Why do certain Catholic moralists now reject this reasoning? An effort to explain the moral theories of others rarely does them justice, especially when it must be very brief, but the reader deserves some overview. Here are three representative positions:

(1) Rhonheimer argues that the embryo cannot be the subject of justice because it will die no matter what is done. Thus the death of the embryo does not fall under the direct intention of the surgeon, whose aim is to save the life of the mother.[7]

(2) In his amazing defense of craniotomy, Grisez states that the crushing of the skull of a baby stuck in the birth canal "need not be a direct killing." (This conclusion also applies to salpingostomy.) "To understand this proposal," he says, "it helps to notice that the baby's death contributes nothing to the objective sought; indeed, the procedure is exactly the same if the baby has already died." [8]

(3) Kaczor contends that even if the actions of the surgeon directly harm or kill the embryo, this does not necessarily mean that the death of the embryo was intentional.[9] We sometimes directly inflict harm on the bodies of others without meaning to. Thus, a pilot who drops bombs in war will inevitably and unintentionally harm innocents.

In reply to these arguments, I would say: (1) the fact that the embryo faces certain death does not eradicate our duties of justice; (2) one cannot fail to intend what one directly does, and so the direct killing of the child is indeed a part of the surgeon's "proposal"; and (3) the analogy with dropping a bomb does not hold—the surgeon is targeting the embryo and takes direct aim at its body.

What is theoretically novel in these opinions is that they shift the terms "direct" and "indirect" from the object of the action to the intention of the agent. Earlier moralists had used this distinction to describe what was done, not what was intended. What some are saying today is that one can remove the embryo by excising it from the tube because the embryo's death is not a part of one's immediate (or direct) intention.

The true intention, we are told, is to save the life of the mother, and given that the surgeon does not want to kill the embryo, he does so unintentionally. But the raw fact remains that a surgeon directly dislodges a human being from the place where it lives and that this action on the body of another causes death.

What we have here is not a development of the tradition but an innovation in terminology. The salpingostomy procedure has not changed since Bouscaren's time, though it is now done more efficiently. Salpingostomy is still the excising of the embryo from where it lives. The procedure therefore is still rightly called a direct killing, at least under the traditional usage of the terms "direct" and "indirect," which apply to the object (what is done). What is new is the claim that one can directly kill another human being unintentionally, even though one comes into immediate contact with that person's body.

Set aside for a moment the particular circumstances of this case and simply ask, if I were to cause the death of another human being by subjecting his body to some immediate and fatal change, could I reasonably say that my action was unintentional? Surely it is common sense that I intend to do what it is that I do. It is self-evident that the surgeon, who directly kills the embryo, does so intentionally.

Object, Not Intention

Cases of vital conflict are sometimes excruciatingly difficult. Thankfully, they are also rare. How to think about these cases is a duty of Catholic ethicists. For this ethicist, who applies the terms "direct" and "indirect" in the traditional manner, salpingectomy is clearly a correct moral course. Salpingostomy is not.

According to *Veritatis splendor* n. 78, the object is what principally determines whether an action is good or bad. The object describes what we do. We cannot decide the morality of our actions by claiming that we do not intend to do the actions that we in fact carry out. One of the firmest principles of Catholic moral theology is that one can never directly destroy an innocent human life. Salpingostomy violates that standard.

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[1]Martin Rhonheimer, *Vital Conflicts in Medical Ethics: A Virtue Approach to Craniotomy and Tubal Pregnancies*, ed. William F. Murphy Jr. (Washington, DC: Catholic University of American Press, 2009), 84–87.

[2]Germain Grisez, *The Way of the Lord Jesus*, vol. 2, *Living a Christian Life* (Quincy, IL: Franciscan Press, 1993), 499–503.

[3]Christopher Kaczor, "The Ethics of Ectopic Pregnancy: A Critical Reconsideration of Salpingostomy and Methotrexate," *Linacre Quarterly* 6.3 (August 2009): 265–282.

[4]Thomas J. O'Donnell, *Medicine and Christian Morality*, 2nd ed. (New York: Alba House, 1991), 166.

[5]Ibid., 167.

[6]Physicians prefer salpingostomies because they preserve fertility. In a salpingectomy, one of the two fallopian tubes is lost. This important consideration cannot override the fact that the embryo is directly destroyed in a salpingostomy.

[7]The "act of killing" in such a case, Rhonheimer says, "can genuinely be equated, from the moral point of view, with a natural event or a simple 'dying.'" Rhonheimer, *Vital Conflicts*, 87.

[8]Grisez, *Way of the Lord Jesus*, 502. What the surgeon proposes in a craniotomy, according to Grisez, is not to kill the child, but simply to alter the physical dimensions of the baby's head. Though this obviously kills the child, Grisez contends (rather astonishingly) that "the death of the baby is not intended" (503).

[9]Kaczor, "The Ethics of Ectopic Pregnancy," 270. Kaczor argues that one could remove the embryo in a manner that leaves it physically intact. When this happens, there is no direct killing; hence, this procedure would be moral. But the embryo cannot survive even if it is removed physically intact. So this is a distinction without a morally relevant difference.

POLST Orders Are Not Dangerous

In her article, "The Danger of POLST Orders: An Innovation on the DNR," Lisa Gasbarre Black cites several dangers she sees as inherent in the use of Physician Orders for Life-Sustaining Treatment (POLST).[1] I cannot comment on the Black's experience in Ohio, but her observations do not describe our nearly twenty years of POLST experience in Oregon Catholic health care. On the contrary, it has been our experience that, when informed by and executed in a manner consistent with sound medical practice, the *Ethical and Religious Directives for Catholic Health Care Services* (*ERDs*), and Church teaching, POLST orders protect the sacred value of human life by providing a greater opportunity for patients to make ethically sound medical decisions.

The original and ongoing purpose of POLST, and the manner in which it is used in Oregon Catholic health care, is to address the medical needs of a limited group of patients: those with *terminal* illness, those with *chronic and critical* illness, and those with *advanced* illness. That is to say, POLST orders are for those patients whose medical conditions are such that judgments can be made in advance about whether there is a "reasonable hope of benefit" from a given intervention or whether that intervention will entail "excessive burden."[2]

When the POLST order indicates that interventions such as cardio-pulmonary resuscitation or intubation are to be withheld, death is not hastened by forgoing ordinary means of preserving life. Rather, natural death is allowed to unfold because the patient's medical condition is such that it is known that the intervention would be extraordinary and thus morally optional. The result is clinically and morally good patient care at the end of life.

Examples of Proper Use

Black speaks of POLST orders being used for those who are "chronically *but not* terminally ill" who are hastening their deaths by forgoing "ordinary and proportionate means" of preserving life, that is, means that are routine.[3] This use may be true of the Ohio statute, but it is not the case in Oregon; and there would seem to be no reason why the use of POLST orders cannot be limited to situations in which death is not hastened by forgoing ordinary means of preserving life.

Suppose a patient's underlying medical condition, advanced chronic obstructive pulmonary disease, indicates that there is no reasonable hope of benefit from resuscitation in the event of pulmonary failure. In this case, a POLST order to refrain from such an intervention assures that the patient will not experience the "excessive burden" of this intervention at the end of life. At the same time, if there is reasonable hope of benefit for a different patient with a different advanced illness, a POLST order can assure that the intervention is applied despite the patient's otherwise fragile medical condition or family members objections that "mother really would not want this." As such, POLST orders are not unique from other medical orders for those with terminal illness, those with chronic and critical illness, or those with advanced illness who may or may not benefit from a clinical intervention when in the hospital. Where POLST orders are uniquely helpful is that they have standing outside a hospital facility, helping to assure that these patients will receive interventions for which there is reasonable hope of benefit and will not receive interventions that entail excessive burden at home or in an outpatient care facility.

This is especially important for patients on home/outpatient hospice who wish to receive only those medical interventions consistent with both their wishes and their overall medical conditions as natural death unfolds. If family or caregivers panic and dial 911—which happens more often than one might imagine—the emergency medical response team will have the authority to treat the dying person's symptoms and to not subject that patient to the "excessive burden" of the trauma of hospital transfer and the associated risk of dying en route when there is no reasonable hope that hospitalization can offer benefit.

Similarly, patients living at home or in a care facility and receiving palliative care because of chronically critical or advanced illness can receive medical interventions consistent with their wishes and medical condition in complex medical situations. For example, a patient with end-stage renal disease receiving dialysis may also suffer from advanced congestive heart failure for which cardiopulmonary resuscitation would offer no reasonable hope of benefit in the event of sudden cardiac failure. Additionally, this same patient's POLST order may indicate that antibiotics should be used if there is reasonable hope of benefit, for instance, if the patient would recover from pneumonia and return to activities of daily living despite renal failure and congestive heart failure.

One need not be actively dying to determine, in light of one's overall medical condition, whether there may or may not be reasonable hope of benefit from an intervention in the face of a sudden catastrophic event. For patients with complex advanced or chronically critical illnesses, POLST orders allow both the pursuit of those interventions that offer reasonable hope of benefit and avoidance of those that will pose an excessive burden.

The POLST form is a set of a physician's orders *about* life-sustaining interventions. It is not, by definition, an order to *forgo* life-sustaining interventions. It is not Oregon's experience of POLST, nor would it seem inherent in POLST, that anyone be at risk of hastening death by forgoing beneficial interventions. As with all medical orders, POLST orders can be medically appropriate, ethically informed, and properly executed. In Oregon, POLST orders can provide an opportunity to comply with the *ERDs* by helping to assure that patients receive care that respects the clinical possibility and moral obligation to use ordinary or proportionate means of preserving life.

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ETHICS & MEDICS

VOLUME 35, NUMBER 10
OCTOBER 2010

Views expressed are those of individual authors and may advance positions that have not yet been doctrinally settled. *Ethics & Medics* makes every effort to publish articles consonant with the magisterial teachings of the Catholic Church.

Various POLST Safeguards

Black's article states: "POLST theory seeks to elevate patient autonomy to the level of an enforceable, legal right." [4] This is not our experience with the Oregon statute. Patient autonomy is certainly a factor with a POLST order but no more so than it is with any other physician's order requiring consent. Autonomy is important because consent is involved,[5] but it is not paramount. There will always be a subjective element to decisions about care, but subjective desires are in all settings necessarily constrained by the parameters of clinically objective facts. There is nothing unique about POLST orders that prevent them from being written in a way that is consistent with the *ERDs*.

Black also asserts that the POLST form "mandates compliance" by health care workers, including emergency responders.[6] This would seem to be an exaggeration. For reasons of professionalism, quality of care, and patient safety, medical orders are generally to be followed from the moment they are written. Just as an order for IV vancomycin cannot be ignored by medical professionals, so too POLST orders cannot be simply ignored. Having said this, no set of physician's orders is to be blindly followed. Because a physician's orders relate to a specific clinical scenario, it is possible that the actual facts as they unfold may impose new medical and ethical obligations not foreseen when the initial order was written.

In Oregon, POLST orders are periodically reviewed to make sure they are consistent with patients' dynamic medical conditions. Just as a physician will change an antibiotic order from methicillin to vancomycin upon determination that the patient has methicillin-resistant *Staphylococcus aureus*, so too a physician may determine that in the present situation a particular POLST order needs to be changed. Rather than suggest POLST orders "mandate compliance," it is perhaps more appropriate to say POLST orders "require professional compliance." As with all physicians' orders, POLST orders should be followed by health care professionals unless there are sound medical reasons for not doing so. In Oregon, we have not seen anything inherently dangerous in following or modifying POLST orders.

Is there a danger and risk of noncompliance with the *ERDs*? Any medical order can raise the specter of moral hazard—just as it can raise the specter of medical hazard. That risk is inherent in medicine itself and in our experience is not unique to POLST orders. The concerns raised about POLST orders can equally be said about state advance directive laws, popular end-of-life forms such as "Five Wishes," and even hospice programs in general. Medical situations will always carry some degree of moral hazard in so far as there are always medical and moral decisions that need to be made. Our Oregon Catholic health care experience suggests that POLST orders are not uniquely morally hazardous for the Catholic physician, the Catholic patient, nor Catholic health care, and eyeing POLST programs with undue suspicion or concern is likely more harmful to good patient care than it is helpful.

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[1] Lisa Gasbarre Black, "The Danger of POLST Orders: An Innovation on the DNR," *Ethics & Medics* 35.6 (June 2010): 1–2.
[2] US Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, DC: USCCB, 2009), n. 56–57.
[3] Black, "Danger of POLST Orders, 2, emphasis added; and USCCB, *Ethical and Religious Directives*, n. 56.
[4] Black, "Danger of POLST Orders," 1.
[5] See USCCB, *Ethical and Religious Directives*, n. 26.
[6] Black, "Danger of POLST Orders," 1.

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