Making Choices

Matters of Life and Death
David Orentlicher
Princeton University Press 2001, 234 pp
ISBN 0691089477

reviewed by Susanne Gibson

Matters of Life and Death is situated by its author in the gap between theory and practice in bioethics. Instead of engaging in the 'theory vs. cases' debate, Orentlicher considers what happens when we translate principles into practice. His contention is that there are a number of moral concerns involved in making this translation and that they are often overlooked. Further, he suggests that identifying the methods of translation can help us to settle some of the more intractable conflicts around matters of life and death.

Orentlicher proposes three such methods, identified as paradigmatic. These are a) using generally valid rules; b) avoiding perverse incentives; c) the 'tragic choices' model. The book is subsequently divided into three parts, each part assessing one of these methods through its application to a specific issue in bioethics.

Beginning with the use of generally valid rules, Orentlicher focuses on the distinction between withdrawing/withholding treatment and assisted suicide, arguing that the need for generally valid rules can help us to understand and maintain this distinction. But first, why do we need generally valid rules, as opposed to taking a case-by-case approach? Although there is a place for case-by-case judgements, there are a number of good reasons for rule-based decision making. In particular, in the context of medicine, allowing physicians to make case-by-case judgements leaves open the possibility of conscious or unconscious biases influencing the decision making process. In this respect, it is argued that rules are necessary as a means of allocating power appropriately: a generally valid rule diminishes the authority of the physician, or more broadly, of the state. What we need are 'bright-line rules' that tell those with decision making authority what they can and can't do, and those without it what they can and can't expect.

When the argument for generally valid rules is applied to the distinction between treatment withdrawal and assisted suicide, it casts a fresh light on the grounding of this distinction.

Orentlicher examines and rejects some of the more standard arguments for retaining the distinction. Instead, he argues, we should see the distinction as an example of a generally valid rule, the use of which ensures that in practice we are able to sort morally justified from morally unjustified decisions to hasten death. That is, although the difference between treatment withdrawal and assisted suicide is not itself a morally relevant difference, decisions to hasten death by means of the former will tend to be morally justified, since a patient who refuses life-sustaining treatment usually has good reasons for doing so. On the other hand, although in some cases the decision to hasten death by means of assisted suicide is morally justifiable, most cases of suicide are morally problematic. Unless we have adequate practical means of distinguishing between different cases of assisted suicide, we can expect a policy of allowing assisted suicide to result in cases of unjustified killing.

In order to assess this argument, it is necessary to consider the grounds for claiming that an end-of-life decision is justified. As Orentlicher recognises, there are two ways of approaching this. First there is the argument from irreversible illness and suffering, and second the argument from autonomy. Orentlicher claims that, regardless of which of these arguments one takes to be strongest, one is led to accept the distinction between treatment withdrawal and assisted suicide on the above grounds. However, a closer examination reveals that Orentlicher fails to separate the arguments sufficiently, since it appears that the presence of irreversible illness and suffering is in fact the guarantee that an autonomous decision to end life has been made. The argument is as follows. When we talk about allowing the patient the autonomy to choose when to die, we want to be sure that the choice is genuine. Refusal of life-sustaining treatment is likely to be such a choice, since on the one hand the treatment itself might produce intolerable side-effects, and on the other hand, life with a serious and terminal illness might be more of a burden than a benefit to the patient. Thus, we acknowledge that there are sometimes good reasons for exercising the choice to refuse life-sustaining treatment, and therefore the decision is likely to be rational and autonomous. As long as there are no reasons to think that the decision is not rational in a particular case, then we should respect that decision. Conversely, suicide is often if not usually an irrational act. There is thus too high a risk that in any particular case the individual who requests assistance in taking his/her own life will not be acting autonomously. Therefore, although it is sometimes the case that suicide is an expression of autonomy, we need to draw 'a categorical distinction between treatment withdrawal and suicide' in order to ensure 'that a person's choice of death is a genuine expression of the person's autonomy' (p. 64).

Orentlicher's concern is to ensure first that an individual's decision to die is genuine, and second that neither the medical profession nor the state is in the business of making quality of life decisions. However, by snaking the test for autonomy dependent upon quality of life, those decisions inevitably slip back in. It is not the distinction between treatment withdrawal and assisted suicide that is the 'bright-line', but the distinction between the suffering associated with terminal illness and all other types of suffering. Indeed, this is born out by the fact that Orentlicher allows that it might be possible to move the 'bright-line' to allow for assisted suicide in cases of terminal illness, as has happened in Oregon. It is not that it is not possible to defend the distinction between a morally justified and a morally unjustified decision to end life on the basis of terminal illness, but that Orentlicher's argument does not do the work that he wants it to do.

I found the section on 'perverse incentives' to be the least interesting aspect of the book. The basic point is sound enough: a principle or policy that is in itself justified can, when put into practice, produce results that undermine that principle or policy, or some other important moral principle. Orentlicher focuses on the question of whether there ought to be a legal obligation for a pregnant woman to accept life-saving treatment for her foetus. He begins by arguing that there is a limited moral obligation on the part of the pregnant woman. However, because of perverse incentives, it is not clear that this obligation should become a legal obligation. Specifically, there is a concern that a woman who fears unwanted treatment might either fail to seek health care during pregnancy or terminate such care if unwanted treatment was likely to be imposed. Given that this could result in harm to the foetus, a policy of imposing treatment might make a particular foetus worse off than it would otherwise have been.

What is unsatisfactory about Orentlicher's argument at this point is his failure to draw any conclusion as to whether or not there should be a legal obligation for pregnant women to accept unwanted treatment. On the one hand there is some evidence to suggest that such a policy might lead to perverse incentives - there are documented cases of women removing themselves from the health care system in order to avoid unwanted caesarean sections. On the other hand, it is suggested that it is doubtful whether women in general would risk the health of the foetus in order to avoid a low risk of enforced treatment.

This failure to reach a conclusion reflects a more general problem with the utilitarian reasoning that Orentlicher employs at this point: because we are inevitably dealing with counterfactuals, we cannot know whether more or less good would have come out of a policy other than the one that we have in fact employed. Further, even if the utilitarian was able to determine that one rather than another policy would produce the most good, a robust deontologist might still object that this is to miss the point. A stronger right to bodily integrity than the one that Orentlicher allows, for example, would undermine the justification for enforcing treatment in the first place. Conversely, a claim that the foetus has an absolute right to life might justify a much more interventionist approach than the one suggested. Of course, either claim would need arguing for: what Orentlicher fails to acknowledge is the considerable room for disagreement in this area.

Finally, the section on 'tragic choices'. This is perhaps the most controversial of the three sections. A tragic choice arises where two or more values come into irresolvable conflict. Orentlicher uses the example of health care rationing to illustrate this. We can allocate resources according to need (who is sickest?), or we can allocate according to efficiency (who will benefit most?), but we often cannot do both at once. Yet both approaches reflect important social values. We have, then, a tragic choice. Some people will die, not because they cannot in principle be treated, nor because they are not deserving of treatment, but because we cannot treat everyone.

If we accept that making these choices is an unavoidable aspect of health care, what can be done about it? Rather than trying to resolve the problem of just allocation, Orentlicher focuses on the way in which this conflict of values ought to be managed. His suggestion is that tragic choices sometimes need to be hidden from the general public, and in the case of choosing between candidates for life-sustaining treatment

this can be done via the concept of 'medical futility'. Indeed, Orentlicher argues that the concept of futility is already used in this way, claiming that 'very few treatments that are currently provided are truly futile' (p. 133). A treatment is only futile if *no* meaningful benefit would result from it, but what we often mean when we say that it is futile is that the benefits of the treatment are too meagre to justify the cost. Thus, it is argued 'one way to distinguish futile from nonfutile care is to ask whether the treatment would be denied if it were inexpensive' (p. 138).

The justification for using the concept of futility to disguise rationing decisions seems to be simply that a) physicians have to make rationing decisions and b) making these decisions explicitly would cause social discord. Therefore, rationing decisions have to be made implicitly.

Orentlicher recognises that there might be both pragmatic and ethical objections to instigating a policy based on deception, which to some extent overlap. The policy will only work so long as the general population is unaware that futility is being used to cover up rationing decisions, and as such depends on a ongoing and deliberate deception by one part of the community of another part of it. In terms of whether such a deception would be sustainable, Orentlicher considers that his own action in proposing the tragic choices model is not conducive to such a deception, remarking in a footnote that 'There is some incongruity in trying to justify a tragic choice method for its virtue as a subterfuge. Subterfuges work as subterfuges only as long as their true nature is hidden. Still, it may be possible for there to be professional discussion without broad public awareness' (p. 223). Is it naive to suggest that this seems unlikely in a liberal democracy?

As Orentlicher recognises, it is one of the fundamental principles of health care ethics that physicians do not deceive their patients. The argument that this constitutes an exception to the rule is simply not strong enough. An appeal is made to Sisela Boles suggestion that deception can be permissible where it is authorised in general and in advance by those who are to be deceived - for example allowing the use of unmarked patrol cars to catch those committing traffic offences. However, since the success of a policy of using futility to disguise tragic choice depends on its not being made generally known that this is what is going on, it is not possible to extend Bok's argument to cover this case. Orentlicher recognises that this is so, yet fails to see that his argument is thus undermined. A second argument is offered to the effect that the physicians themselves believe their decisions are made on grounds of futility rather than on the grounds of finite resources. Therefore the deception is not intentional and as such is not a lie. Without getting into the debate over whether this mitigates the immorality of deception, and without considering whether in fact the physicians are not aware of what they are doing, there is still the problem that once they have read this book, they will no longer have recourse to this particular means of justification!

One further question that struck me when reading this section was, why does the North American public have such difficulty in facing tragic choices? This is something that Orentlicher takes for granted, and while providing some evidence that this is the case, does not address the question of why it is the case.

In conclusion, I found *Matters of Life and Death* to be a hugely stimulating read. I found much to disagree with and consider that some of the more controversial points especially call for further and more substantial argument. However, this book is a valuable contribution to the field of bioethics, casting original

light on some of the most controversial areas of debate. I would particularly recommend it to teachers of bioethics, and those studying at postgraduate level.

Address correspondence to:

Susanne Gibson
Department *of* Religion and Ethics
St Martin's College
Lancaster LA1 3JD, England, UK.

Back to current electronic table of contents