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Purpose, Palliative Care, and Respect for Human Life

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Aiding the deliberate destruction of human life has no place in the doctor's job description.

The Massachusetts Medical Society recently [voted to affirm its opposition to physician-assisted suicide](#). This vote matters because a movement is now afoot to de-criminalize assisted suicide in Massachusetts (and elsewhere). If successful, this movement would enlist physicians to assist in acts of self-murder. The physicians want no part in that. The president of the Massachusetts Medical Society, Lynda Young, stated, "Physicians of our Society have clearly declared that physician-assisted suicide is inconsistent with the physician's role as healer and health care provider." Aiding the deliberate destruction of human life has no place in the doctor's job description.

Equally important is the Society's affirmation of its commitment to palliative care. The policy, according to Young, expresses "support for patient dignity and the alleviation of pain and suffering at the end of life," and encourages physicians "to contribute to the comfort and dignity of the patient and the patient's family." As the Society acknowledges, palliation is an important part of the doctor's vocation. Doctors rightly provide comfort to the dying, even when they know that death inevitably approaches. Unlike assisted suicide, palliative care is not inconsistent with the physician's commitment to life and health.

Physicians in Massachusetts thus grasp a fundamental distinction that proponents of assisted suicide elide. That is the difference between choosing to cause death and choosing instead to provide comfort, knowing, but not intending, that death might be hastened as a result.

Proponents of assisted suicide obscure this distinction by focusing exclusively on consequences and ignoring purpose and intent. They observe that a terminally ill patient, who qualifies for physician-assisted suicide in those states that now allow it, is going to die no matter what. Why should it matter whether that death comes about as a result of a deliberate act or rather in the natural progression of the disease? Indeed, they insist, it is uncaring not to help the patient kill himself, to leave the patient exposed to the pains of a debilitating illness.

The choice between suicide and suffering is a false choice. Physicians do and should act with a purpose to relieve pain. Palliative care expresses respect for the lives of suffering patients, including those patients who are about to die. To acknowledge that death is inevitable is not to choose death; the fact that death occurs is not itself morally significant. But whether we choose death or not *is* morally significant.

A physician who helps her terminally ill patient live out his last days with as little pain as possible, even if this means hastening death, has not failed morally. Her action is every bit as reasonable as an act of self-defense, prosecution of a just war, or any other act that results in

death, [where the death is a foreseen consequence but is not intended](#). In other words, [the principle of double effect](#) applies [to healthcare providers](#), just as it applies to everyone else.

By contrast, one's *purpose* with respect to death is extremely important. It is the choosing of death, acting with a purpose that death will result, that is morally problematic. Death is not something to be chosen, least of all by doctors. A physician who adopts the death of her patient as the purpose for her action has become a different kind of physician. Indeed, she has become a different kind of person. She has become a person who chooses death over life.

A person who purposely chooses to cause death, who makes death a reason for his actions, is not oriented toward the good. This is because choosing has a creative, self-making significance. To adopt by free choice a reason for one's action is to make that reason part of one's projects and commitments. By choosing life, one becomes a person oriented toward life. By choosing death, one becomes a person oriented toward death.

A person who is oriented toward life is going to act very differently than a person who is oriented toward death. Once one has adopted death as his purpose, death becomes a potential reason for action in later instances. One who considers purposeful death as an option will consider it reasonable to weigh the deliberate destruction of life against more costly alternatives, such as extended palliative care. If death itself is a reason for action, then [nearly any hardship in life](#) is sufficient to justify death. Addressing the underlying cause of the hardship is viewed as merely one option, and self-murder is often a less costly alternative.

For these reasons, the availability of assisted suicide [is the enemy of palliative care](#). Perhaps this is why some have found [that palliative care is declining in Oregon](#), where physician-assisted suicide has been permitted for several years. Indeed, there is good reason to believe that opposition to assisted suicide and concern about patient suffering, far from being enemies, actually go hand in hand. Respect for the intrinsic value of life provides a motivation to alleviate pain at the end of life. And a commitment to improving palliative care [might eradicate demand for assisted suicide](#).

Human beings have value simply by virtue of their being alive. This does not mean that the value of life is absolute, that measures should always be taken to prolong life, or that one should never take any action that might hasten death. But we should not ask physicians to act with a purpose to bring about the death of their patients. We could not so alter the role and character of physicians without causing serious harm to their profession and to those whom they serve.

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