

A Critique of the National POLST Paradigm through an Analysis of Colorado's New *MOST* Legislation

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Abstract

Colorado recently legalized a new document for use in end-of-life care called a Medical Orders for Scope of Treatment (MOST) form. The legislation exempts from liability to homicide laws caregivers who execute MOST orders for the withdrawing or withholding of life-sustaining procedures. But it drops the requirement that patients be terminally ill before they are free to refuse those procedures. It permits anyone to refuse any medical treatment for any reason; and holds health-care institutions, practitioners, and surrogate decision makers free from liability when they carry out the orders. This essay criticizes the new law together with the view of autonomy implicit within it. The essay proposes six reasons grounded in the requisites of justice and the common good why the new law should be opposed. It recommends that Catholic hospitals refuse to accept MOST-type documents.

On May 26, 2010, Colorado's outgoing governor Bill Ritter Jr. signed into law a bill (HB 1122)¹ introducing into medical use in Colorado a new "living will" type of document called a MOST form (Medical Orders for Scope of Treatment).² The Colorado MOST legislation intends to consolidate into a single form (the "MOST document") several legal provisions formerly dispersed over multiple forms, such as living wills, do-not-resuscitate orders (DNRs), durable powers of attorney for health care, default surrogate provisions, and guardianship provisions.

The Linacre Quarterly 78(2) (May 2011): 157–171.

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0024-3639/2011/7802-0003 \$.30/page.

Like other end-of-life forms, the MOST document is drafted and certified while a person's capacities are intact. It directs medical professionals to carry out, withhold, or remove certain medical procedures in the event that a person no longer possesses decision-making capacities. But the document is unique in that it carries with it a doctor's signature translating a person's end-of-life wishes into an actionable medical order.

Colorado's adoption of the MOST program is part of a larger national initiative (the "POLST [physician orders for life-sustaining treatment] Paradigm Initiative") begun in Oregon in 1991 by a group of concerned health-care professionals and medical ethicists. They wished to draw attention to the fact that patients were routinely subject to forms of life-sustaining treatments they did not want, and denied types of care they did want.³ In developing the new type of advanced directive, the group aimed to ensure that patients' wishes for end-of-life care were more consistently honored.⁴ Several states (including Idaho, Oregon, Washington, Tennessee, Utah, Wisconsin, New York, Pennsylvania, and West Virginia) have introduced MOST programs into state health care using related acronyms such as POST (physician orders for scope of treatment), POLST (physician orders for life-sustaining treatment), PORT (physician orders regarding treatment) and MOLST (medical orders for life-sustaining treatment). Although minor variations exist among different state forms, they all share central core provisions and a similar form design.⁵

Because of the national trend to structure state laws on medical directives in accord with the MOST model, an analysis of one serious weakness with the Colorado statute is in order.

Revision in Colorado Law

Colorado statute HB 1122 abrogates an important condition in existing Colorado law on living wills going back two decades.⁶ The established law authorizes any adult to direct that life-sustaining treatment be withheld or withdrawn "if, at some future time, he or she has a terminal condition or is in a persistent vegetative state, and lacks decisional capacity to accept or reject medical or surgical treatment."⁷ The "if" makes clear that proper compliance with the law requires two simultaneous diagnostic pre-conditions to be met before substituted consent to forgo life sustaining treatments by advanced directive is actionable: first, patients must be unable to make decisions for themselves; second, they are either "terminally ill" or in a "persistent vegetative state" (PVS). Twenty-three other states (45 percent), not including Colorado, impose similar statutory limitations on the removal of life-sustaining treatments, using terms such as "terminal condition," "permanent unconsciousness," and "end-stage condition."⁸ In each case the intention is to limit the carrying out of refusal orders to patients who are at the end of their life.

The Colorado MOST legislation abrogates the condition that a patient must be terminally ill or in a persistent vegetative state before a refusal order lawfully may be carried out.⁹ The only condition for compliance with the law is that an adult lacks “decisional capacity.” The new law permits persons to direct medical professionals to remove or withhold life-sustaining procedures at a future time in which the persons executing the forms are not suffering from a terminal condition or in a persistent vegetative state. Although the bill is rhetorically formulated as bearing upon end-of-life medical decisions, there is no requirement in the law that the refusal of life-sustaining care must be limited to end-of-life conditions.

Proportionate and Disproportionate Means

Why is this a problem? To answer this question it is important to understand the traditional ethical criteria for accepting medical treatments. Catholic teaching holds that if some treatment is “proportionate” to its end, it is “ordinary care” and morally obligatory; if it is “disproportionate” to its end, it is “extraordinary” and non-obligatory. By what criteria do we judge whether a procedure is proportionate or disproportionate? The 1980 Vatican *Declaration on Euthanasia*, authored by Franjo Cardinal Šeper, then prefect of the Congregation for the Doctrine of the Faith, states that making a correct judgment as to whether a medical means is “proportionate” or “disproportionate” requires “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.”¹⁰ In other words, judging rightly requires assessing whether the burdens of a treatment are reasonable to accept in light of the hoped for benefits. If patients with their caregivers “judge that the investment in instruments and personnel is disproportionate to the results foreseen” (i.e., if they judge that the treatment is *futile*) or if they judge “that the techniques applied impose on the patient strain or suffering out of proportion with the benefits which he or she may gain from such techniques” (i.e., it is *excessively burdensome*), they may legitimately refuse it. Reciprocally, a “proportionate” or “ordinary” medical treatment is one that is *not* excessively burdensome *and* offers hope of improvement.

The declaration then states something very important. Refusal of a disproportionate or extraordinary procedure “is not the equivalent of suicide,” which the text, in accord with the tradition, judges always to be wrong. The document defines suicide as “intentionally causing one’s own death.”¹¹ (John Paul II defines it as “the deliberate and morally unacceptable killing of a human person.”¹²) It follows that legitimate refusal necessarily excludes an intention to cause one’s own death. But what if the procedure is a form of life-support? Removing it may hasten death; and that hastening may be foreseeable. Do I not intend all that I

foreseeably cause? Catholic moral tradition answers in the negative. It need not entail an intention to cause one's own death as either an end or a means. It is true that one may refuse treatment with that intention. And if one does, one commits suicide. But one simply may intend to be free of a futile or excessively burdensome form of medical care. One foresees that achieving that freedom (one's *end*) by withdrawing or withholding some treatment (one's *means*) might or will hasten one's death. Another way to speak about the willing of means is in terms of the "moral object." In this case, one's chosen moral object (that is to say, "the proximate end of [one's] deliberate decision which determines the act of willing on the part of the acting person"¹³) is to withhold or withdraw futile or burdensome care. One accepts with resignation the eventuality of death as connected to one's choice to be free from the burden of the treatment. But it is important—indeed, all important—to see that what one is after in this scenario is *not* death. The reason moving one to forgo treatment is to avoid an avoidable burden; death is accepted as a foreseen, perhaps even inevitable, consequence (or side-effect, morally speaking) of achieving that goal. If one were ordering removal *in order to* bring about one's own death, one would be doing what one does *to* die. One would be ordering one's own killing. This is suicide.

Catholic moral teaching and common ethical practice have traditionally accepted these two judgments on a treatment—viz., it is futile or excessively burdensome—as justifying conditions for forgoing it.¹⁴ If the procedure is required to preserve life, the presumption is that a person is already suffering from a terminal condition, is already dying, although perhaps not in the final stages of the dying process. This person wishes to be free from the burden of painful, risky, or futile treatments during his final period of life and to allow his terminal condition to take its natural course.

Refusal of Treatment *in Order to Die*

As already stated, the new Colorado law authorizes patients to direct that life support be removed or withheld, even when they are not suffering from a terminal condition. Why might a person who is not dying order life support to be removed or withheld?¹⁵ If he is not dying, then it is reasonable to presume that the life-sustaining treatment is preserving his life during an interim illness from which remediation is possible (e.g., an aggressive antibiotic regimen for a person suffering from septicemia). So the treatment may not be futile. But it may be excessively burdensome to the patient. The treatment might be very painful, or experimental and risky, or opposed to religious principles. In these cases, a patient may refuse treatment without the intent to bring about death.

But if some treatment promises hope of recovery, and its refusal will result in death, then it is likely that some people who direct that the treatment be removed or withheld will do so because they wish to bring

about death. Perhaps the thought of living with some disability, or with some grave loss, say, a relational loss (perhaps a loved one recently passed away), or financial loss, is repugnant to them: “Living like this,” they judge, “is too burdensome.” The burden in this case is not imposed by some medical treatment from which they wish and seek to be free through refusing it; the burden is living under some state of affairs from which death can free them. They order life-support to be removed or withheld in order to end their lives. If this is the end for the sake of which one refuses treatment, then one “intentionally caus[es] one’s own death.”¹⁶ One intends suicide.

HB 1122 Implicitly Authorizes Euthanasia

The old Colorado law, in situating the lawful refusal of life-support in terms of medical conditions diagnosed as “terminal,” privileged as the normative context of intentionality the motive “to-be-free-from-burdens” (burdens imposed by disproportionate forms of medical care). The new law does not require a person to be diagnosed as terminal to refuse treatment. Of course, any condition from which one would die without intervention is in one sense terminal. But the plain reference to terminal in the old law was to a longer-term condition from which one is already dying (e.g., amyotrophic lateral sclerosis [ALS] and cancer). Life support procedures could be understood as prolonging the dying process. The new law does not assess the conditions for legitimate refusal in terms of futility and burdensomeness. It makes no distinction between letting die and killing or between rightful and wrongful intentions. It empowers health-care professionals to remove life-preserving treatments from patients for whom they are not futile and for whom in many cases the burden would be offset by a reasonable hope of recovery. It therefore juridically extends the normative context of intentionality to include the removal or withholding of life support for purposes of death.¹⁷ Without using the term, the new law authorizes euthanasia.¹⁸

Faulty Conception of Autonomy

Underlying the national initiative to normalize MOST orders is a faulty and dangerous conception of autonomy.¹⁹ Rightly construed, autonomy is a legitimate ethical concept. In fact, respect for patient *autonomy* is one of four master principles (along with non-maleficence, beneficence, and justice) widely affirmed by bioethicists.²⁰ It simply means the quality of being self-governing. Because humans are rational and free, they are capable of making intelligently guided choices. In this sense they are self-determining. To be free is to be in self-possession in a way that an animal can never be. A dog does not deliberate over competing alternatives and decide for itself whether or not to go to the vet; we deliberate and decide for him. But we can and do choose for ourselves. This status of being free and self-possessing is, in the Christian

philosophical tradition, precisely the status of a *person*. Consequently, autonomy is only attributed to persons.

Translated into a bioethical norm, this means that patients should be informed by medical practitioners of all facts relevant to making free and informed decisions for their health care. Not to secure informed consent would disrespect patients as moral agents, that is, would disrespect their autonomy. Let us call this construal *autonomy as moral agency*.

A crucial point in the traditional construal is that autonomy is respected precisely because of the role played by free choice in the human person's achievement of the flourishing to which human nature is capable. William E. May argues that in this sense the moral significance of autonomy is derived from and reflective of its role in shaping people towards authentic fulfillment.²¹ But some choices are clearly contradictory to human good, suicide for example. So claims of autonomy do not extend to such choices.²² May writes: "In other words, human autonomy (self-determination) is not unlimited. Its *rightful* exercise enables us to achieve our fulfillment, our perfection, but it is subservient to our *good as persons*."²³

But a competing sense of "autonomy" has been increasingly active in health care in the past forty years. It understands autonomy as freedom from constraint. Not only should my capacity for free and deliberate choice be respected, but *what* I choose should be respected *because* I have chosen it and not in virtue of the kind of choice it is. Autonomy has become a justifying principle. Let us call this construal *autonomy as liberty*.²⁴

This sense is most dramatically illustrated in the so-called "mystery passage" of the Supreme Court decision *Planned Parenthood v. Casey* (1992). The court ties the meaning of autonomy to the U.S. Constitution's use of "liberty" in the Fourteenth Amendment. As written, of course, liberty in the Fourteenth Amendment is minimal in scope: it guarantees that no person shall be deprived of liberty without due process of law. But the Court tells us that "liberty" entails much more than rightful access to due process. Liberty includes "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life" (and the decision finds precedent for its use of the term in *Roe v. Wade* [1973] and *Griswold v. Connecticut* [1965]). This extreme rendering captures a popular misconception of human agency widely held today and clearly illustrated by defenders of the MOST philosophy: respecting choice and liberty—and hence autonomy—means respecting *what* I choose.

When the Colorado Catholic Conference in spring 2010 proposed to the Colorado legislature amending HB 1122 to reintroduce the long-standing condition of terminality,²⁵ the bill's sponsors (who referred to themselves as Colorado Advanced Directives Consortium²⁶ [CADC]) vigorously opposed the initiative. They argued that limiting the "right" to refuse life support to terminally ill patients "contradicts and restricts"

the liberties of competent patients “to determine a course of treatment without interference from the state or a particular set of religious beliefs”;²⁷ and again, the conference’s initiative “attempts to restrict the choices and deny the decisions of persons on the basis of religious commitments.”²⁸ But no “set of religious beliefs” or “commitments” were adverted to by the amendment’s defenders; and the Colorado Catholic Conference did not argue from specifically Catholic premises. It argued that the statutory sanctioning of such an unrestricted concept of a patient’s right to refuse treatment was not in the interests of the field of health care or the common good. The Colorado Advanced Directives Consortium even erroneously asserted that the limitation imposed by the amendment “defies longstanding Colorado law allowing adult competent persons to refuse any medical treatment at any time for any reason.”²⁹

A Liberal Justification for Restricting Right-to-Refuse

Does the law have reasons rooted in liberal political principles for attempting to limit certain expressions of the right to refuse life support? Are limitations compatible, say, with John Stuart Mill’s “harm principle”?³⁰ It is important to repeat that what is under dispute in the new Colorado law is not in principle the liberty to refuse life-sustaining measures. What is contested is legally sanctioning an overly permissive conception of the right to refuse treatment and requiring medical institutions to comply with morally problematic medical orders.³¹ Should the law limit refusal orders to patients who are terminally ill in such a way as legally to contextualize the refusal of treatment to the avoidance of burdens associated with futile or harmful procedures? Apart from any private value that might attach to such laws, public interests alone—the requisites of justice and the common good—seem sufficient for their justification.³²

Five Public Goods

What public goods would be facilitated by limiting the right to refuse treatment in the way I have suggested? I briefly suggest five.

The first good is the protection of vulnerable patients who might opt to refuse treatment with a suicidal intent out of the weakness of depression rather than from a free and informed choice. The London-based Royal College of Psychiatrists, in a statement on physician-assisted suicide in 2006, noted:

In the general population, suicidal thoughts and urges are common symptoms of depression, and serious suicidal thoughts rarely arise apart from depression.... [These thoughts] can generally be relieved by appropriate support and by effective treatments for depression.... Once a person’s depression is treated effectively most (98–99 [percent]) will subsequently change their minds about wanting to die.³³

The Royal College concluded that “requests for PAS [physician-assisted suicide] should trigger effective treatment of depression and its causes—not actual PAS [physician assisted suicide].”³⁴

The second public good is avoiding in the law the blurring of the distinction between the rightful refusal of treatment and suicide. Suicide is a form of homicide. Whether or not the law should criminalize it requires an argument of its own. But removing from the law conditions meant to distinguish the two risks obscuring them in law and the public’s mind. Because of the great good that homicide laws aim to protect, such obscuring is an unacceptable harm to tolerate.

The third public good is the protection of the historical role of medicine as healing. Refusal of futile or excessively burdensome life-sustaining treatments aims to remove burdens from patients. Its emphasis is a better, or at least a less burdened life. Refusal of treatments that promise a patient hope of recovery without disproportionate burdens opens the purposes of medicine to include the facilitating of death. This is likely to harm medicine as well as the doctor-patient relationship.

The fourth public good that legally disadvantaging suicidal intents achieves is contributing to the preservation, at least in law, of a sense of the unique dignity of human life. Human dignity is not an uncontroversial concept. Harvard’s Steven Pinker in 2008 published a rant against it in *The New Republic* titled “The Stupidity of Dignity,”³⁵ and bioethicist Ruth Macklin did something similar in a now-famous editorial in the *British Medical Journal* (2003) titled “Dignity Is a Useless Concept.”³⁶ Both think that dignity is essentially a religious concept smuggled into secular discourse to privilege conservative views that otherwise cannot be justified on reason alone. They believe that the four master bioethical principles mentioned above (autonomy, non-maleficence, beneficence, and justice) are sufficient to do all the beneficial work done by dignity but without the baggage. Thus dignity should be dropped from bioethical discourse.

At face value this argument from “secular reason” might seem plausible, but on deeper inspection it must be rejected. Although the normative scope of the concept of dignity does include terrain covered by the four bioethical principles, dignity is more than a normative concept.³⁷ It is also and more fundamentally a metaphysical concept signifying the substantive value that humans possess by virtue of being the kind of creatures they are. The kind of creatures they are is, of course, a matter of disagreement between those committed to a Christian worldview and those committed to principles of secular humanism. It should be noted however that secularist accounts necessarily draw upon underived—non-empirical—premises when faced with ultimate questions, such as the nature and destiny of human beings, and the problem of evil, the answers to which have considerable bearing on what kind of creature one takes the human being to be. To this extent, secularist accounts have no a priori plausibility over and against Christian accounts.

Thus a prudential judgment must be made concerning which account the law will implicitly prefer, or at least, which one, if one it must be, the law will not implicitly oppose. It seems to me that given the central role that Christian philosophical and theological anthropology and morality have played in establishing the epistemological conditions for the possibility of the arising of the Enlightenment conception of individual liberty, which secularists jealously defend, dispensing with the concept of dignity, notwithstanding the concept's origins in a Christian worldview, is profoundly short-sighted, like burning the bridge upon which one is standing.

The final public good is providing a statutory barrier to the full legalization of physician assistance in suicide. I would argue that the new Colorado law establishes a legal precedent that ineluctably includes in its prospective scope the explicit legalization of physician-assisted suicide. It is not unreasonable to think that in a few years the Death with Dignity people will come in and say:

Since the introduction of the MOST paradigm, Colorado law has empowered physicians to carry out medical procedures with the aim of bringing about the death of patients. Prescribing a lethal dose of meds is no more than carrying out a medical procedure with the aim of bringing about the death of patients; therefore, ...

This concern is not alarmist, since this was precisely the rhetorical strategy used by the majority in the Montana assisted suicide case filed on December 31, 2009.³⁸

Would reintroducing “terminality” as a condition for refusing life-support prevent some patients who are not terminal from a rightful expression of self-determination through refusing treatment? Say, for example, a Jehovah's Witness wishes to refuse a blood transfusion on conscience grounds, but needs one to live. Should he or she be forced to accept it? Or again, suppose an elderly woman is suffering from severe dementia, her feeding tube causes her severe discomfort, and she is prone when conscious to tear out her tubes. Could a refusal order for artificial nutrition and hydration be licitly followed? In both cases, the condition of excessive burden is clearly fulfilled and refusal of life support need not entail any illicit intention.

I do not know how presently the twenty-three states with conditions limiting refusal to end-of-life situations deal with situations of these sorts. I expect that existing conscience statutes may cover the situation with Jehovah's Witnesses. In refusing blood transfusions, they need have no specific intent to die, but rather to avoid what they believe is evil. Providing for such requests does not seem to involve health-care providers in illicit cooperation.³⁹

One simple way to amend the law to prevent unreasonable restrictions of patient self-determination is to formulate the law according to the norm taught in the Congregation for the Doctrine of the Faith's

Document on Euthanasia: patients rightfully forgo means of life support when in the patient's judgment they do not offer a reasonable hope of benefit or they entail an excessive burden.⁴⁰

Should Catholic Hospitals Accept the MOST Document?

At their fall 2009 meeting, the U.S. bishops revised their *Ethical and Religious Directives* to rule out one wrongful expression of the refusal of care by asserting (through dir. 58) that in principle there is an obligation to administer nutrition and hydration to all patients, including those in the persistent vegetative state.⁴¹ One central provision of the MOST document is to order that artificially administered food and water be withheld. Ordinarily, this provision could not rightly be carried out by a Catholic institution.

In addition, because of other problems posed by the absence of the condition of terminality from refusal orders, institutions would be burdened by the need to sort out licit from illicit orders. Since other forms of advanced directives are available to patients for expressing their rightful will in end-of-life care, it is advisable that Catholic institutions refuse to accept MOST-type documents as valid.

Could a doctor sign a MOST order if he knew in advance that a patient wanted treatment withheld precisely in order to die? This would seem to me to constitute formal cooperation in the bad intention of the patient. One who prescribes something immoral is an "efficacious cause" of the wrongful act.⁴² He shares in the bad will of the one who does the act.⁴³ But doctors who have no reason to suspect illicit intentions may conscientiously cooperate in refusal orders by signing MOST-type forms.

Do health-care workers always formally cooperate in the patient's suicide when they comply with (i.e., execute) such an order? I do not think they necessarily formally cooperate. They might only intend to comply with the law's provisions by carrying out a patient's orders.

Pope Pius XII and the Duties of Doctors

One might object saying that refusing to carry out the orders of some advanced directives is contrary to the duties of a health-care worker. After all, does not Pope Pius XII teach that doctors have an obligation to take action in accord with a patient's wishes? This is a misreading of the papal teaching. In an address to an International Congress of Anesthesiologists in 1958, the pope taught that "the rights and duties of the doctor are correlative to those of the patient. The doctor, in fact, has no separate or independent right where the patient is concerned. In general he can take action only if the patient explicitly or implicitly, directly or indirectly, gives him permission."⁴⁴ The pope here teaches only that a doctor may not subject patients to treatments without their (at least implicit) consent. But it does not teach that a doctor must positively carry

out a patient's wishes even if immoral. If a patient commands a doctor to give him a lethal dose of morphine, or smother him with a pillow, or provide him an illicit substance, the doctor has an obligation to refuse the direction. A doctor also has a duty to refuse to carry out a patient's intention to die through an order to remove or withdraw life support.

Conclusion

Since the view of autonomy as justifying self-killing is not yet normalized in mainstream medical practice, some might think that the concerns expressed here about the new MOST legislation are alarmist. Most patients who order the withholding or withdrawing of critical care will do so in accord with upright moral principles, and most doctors who sign off on the documents will resist the irresponsible will to die of their patients. Therefore to stigmatize the new law as euthanasia-friendly is to characterize a complex piece of legislation in relation to an interpretation that very few people are likely to give to it.

Although I agree that most people, at least in the first years of the document's implementation, are unlikely to use the liberties secured by HB 1122 to kill themselves, it is neither unfair nor unconstructive to isolate and criticize this law's, or any law's, clear statutory provisions. By removing the requirement of terminal illness, it authorizes doctors to carry out the intentions of their patients for death. It is naïve to think that some patients, especially those with an exaggerated conception of autonomy and a repugnance for some disability or limitation, will not order their self-killing through the removal of life-sustaining care, and that some doctors, sharing their philosophical views, will not be willing to execute their order.

Notes

¹ The 2010 bill, HB 1122, titled *Concerning Medical Orders Determining the Scope of Treatment an Adult Wishes to Receive under Certain Circumstances*, is available at http://www.leg.state.co.us/CLICS/CLICS2010A/csl.nsf/fsbillcont3/DE4DE1E5036873A8872576AA00695175?Open&file=1122_enr.pdf.

² See Alan Meisel and Kathy L. Cerminara, *The Right to Die: The Law of End-of-Life Decision Making*, 3rd ed. (Frederick, MD: Aspen Publishers, 2008), supplement, 1A–54.

³ The Iowa Physician Orders for Scope of Treatment (IPOST) has a helpful summary of the national initiative; see Iowa Physician Orders for Scope of Treatment (IPOST) Pilot Project, *The Report of the Patient Autonomy in Health Care Decisions Pilot Project* (January 2010), 4, http://www.idph.state.ia.us/hcr_committees/common/pdf/patient_autonomy_pilot/patient_autonomy_pilot_report.pdf.

⁴ A brief history of the POLST Paradigm Initiative as developed through the Center for Ethics in Health Care at Oregon Health & Science University can

be found at the POLST website: <http://www.ohsu.edu/polst/developing/history.htm>.

⁵ Susan E. Hickman et al., “The POLST (Physician Orders for Life-Sustaining Treatment) Paradigm to Improve End-of-Life Care: Potential State Legal Barriers to Implementation,” *Journal of Law, Medicine & Ethics* 36 (2008): 120.

⁶ Colorado Revised Statute (CRS) 15-18.101–113; titled *Colorado Medical Treatment Decision Act*, the statute was revised in 2010, but the provisions for refusal of life-sustaining procedures were essentially the same.

⁷ Colorado Revised Statute 15-18.104.

⁸ Hickman et al., “The POLST Paradigm to Improve End-of-Life Care,” 121.

⁹ HB 1122 amends Title 15 by replacing article 18 with 18.7.

¹⁰ Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (1980), IV, http://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_19800505_euthanasia_en.html.

¹¹ *Ibid.*, I, n. 3.

¹² Pope John Paul II, encyclical letter *Evangelium vitae* (1995), n. 65, http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html.

¹³ Pope John Paul II, encyclical letter *Veritatis splendor* (1993), n. 78, http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_06081993_veritatis-splendor_en.html.

¹⁴ This standard is repeated in the United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Facilities* (ERDs), 5th ed. (Washington, D.C.: USCCB, 2009), dirs. 56–57, http://www.usccb.org/meetings/2009Fall/docs/ERDs_5th_ed_091118_FINAL.pdf:

56. A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community.

57. A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient’s judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose an excessive expense on the family or the community [citing Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, IV].

¹⁵ The norms of the legitimate removal of life-sustaining procedures have also been formulated by John Paul II, *Evangelium vitae*, n. 77; Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, IV.

¹⁶ Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, I, n. 3.

¹⁷ The condition of terminality does not exclude the possibility that a patient could order the removal or withholding of life support for the purpose of death. But by requiring a diagnosis of terminal illness, the law situates refusal in the context of a patient’s wishes while he or she is dying. It does not itself either implicitly or explicitly support a suicidal intent. The law tolerates possible abuse

knowing that although imposing certain conditions can privilege licit intents, the law cannot ensure that patients' intentions will be or remain upright.

¹⁸ The following statement in HB 1122 is included at 15-18.7-104, (6) (a): "nothing in this article shall be construed to modify or alter any generally accepted ethics, standards, protocols, or laws for the practice of medicine or nursing, including the provisions in section 15-18.6-108 concerning euthanasia and mercy killing." This statement, of course, does not alter the fact that the law removes a critical legal safeguard against the use of refusal orders to bring about death.

¹⁹ The IPOST, *Report of the Patient Autonomy in Health Care Decisions*, 1–35, although a clear and helpful document in many respects, presupposes throughout the construal of autonomy that I criticize here; see note 4 above.

²⁰ These four principles were made prominent by Tom L. Beauchamp and James F. Childress in their text *Principles of Biomedical Ethics* (New York: Oxford University Press, 2008), now in its sixth edition.

²¹ William E. May, *Catholic Bioethics and the Gift of Human Life* (Huntington, IN: Our Sunday Visitor Press, 2008), 270–272.

²² May references the text of a British Task Force replying to the question of autonomy: "What best makes sense of the ideal of respect for human autonomy is the role played by free choice in the achievement of that fulfillment to which our nature is directed; for self-determining choice is integral to that achievement. But if the moral significance of autonomy is understood in that way, then the value of autonomy is derivative from, and reflective of, that which gives value to our humanity. So it should be clear that the claims of autonomy cannot properly extend to choices which are inconsistent with recognizing the basic worth and dignity of every human being." British Task Force, *Euthanasia, Clinical Practice and the Law*, ed. Luke Gormally (London: The Linacre Centre for Health Care Ethics, 1994), 132.

²³ May, *Catholic Bioethics*, 271.

²⁴ John P. Safranek, "Autonomy and Assisted Suicide: The Execution of Freedom," *Hastings Center Report* 28 (1998): 32–36. The author distinguishes between autonomy in the "descriptive" sense (roughly equivalent to my "autonomy as agency") and in the "ascriptive" sense (roughly equivalent to my "autonomy as liberty").

²⁵ HB 112 L.007, Senate Committee Report, Health and Human Services, State of Colorado, March 25, 2010, lines 2–7.

²⁶ See website for *Colorado Center for Hospice and Palliative Care*, <http://www.cochpc.org/MOST>.

²⁷ Colorado Advanced Directives Consortium, *Summary/Comparison of Current Medical Decision Making Forms and Processes with Respect to Medical Orders for Scope of Treatment* (HB1122), April 2010, distributed at court proceedings and on file with author.

²⁸ *Ibid.*

²⁹ *Ibid.* This is in flat contradiction to the existing "Living Will" statute CRS 15-18.101-113.

³⁰ “The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others.” J.S. Mill, “On Liberty” (originally published 1859), ch. 1, in J.S. Mill, *On Liberty and Other Writings*, ed. Stefan Collini, (Cambridge, U.K.: Cambridge University Press, 1989), 13. This is commonly referred to as Mill’s “harm principle”: the state’s coercive power is rightly exercised against me only when I threaten harm to others. The principle should not be misunderstood to assert that the community has an obligation to positively affirm and facilitate my personal wishes. It is a principle of political toleration, not of moral affirmation.

³¹ Rev. John Tuohey, “POLST Orders Are Not Dangerous,” *Ethics & Medics* 35.10 (October 2010): 4. Touhey, director of the Providence Center for Health Care Ethics in Oregon and defender of the MOST philosophy (called POLST in Oregon), argues that POLST orders pose no more danger of “moral hazard” than any medical order presently implemented in health care. His defense of the MOST philosophy seems to me naïve since it entirely ignores the clear statutory widening of the law to protect medical orders to refuse treatment in order to die. Whether in Oregon this provision is often used or ever used is irrelevant to the question of whether the law should sanction such a provision.

³² Common morality has long held that suicide is a type of injustice, not to oneself, but to the community—to the public good (Aquinas’s *res publica*); see Aquinas, *Summa theologiae (ST)* II-II, q. 59, a. 3, ad 2.

³³ Royal College of Psychiatrists, *Statement from the Royal College of Psychiatrists on Physician Assisted Suicide*, a response to the “Assisted Dying for the Terminally Ill Bill,” April 24, 2006, par. 2.4; see also John Keown, “Should We Legalize Voluntary Euthanasia and Physician Assisted Suicide? A Review of the Ethical Arguments and of the Empirical Arguments from the Netherlands and Oregon” (2009), *Insight: Family Research Council*, <http://www.frc.org/insight/should-we-legalize-voluntary-euthanasia-and-physician>.

³⁴ Royal College of Psychiatrists, *Statement on Physician Assisted Suicide*, par. 2.4.

³⁵ Steven Pinker, “The Stupidity of Dignity,” *New Republic* (May 11, 2008).

³⁶ Ruth Macklin, “Dignity Is a Useless Concept,” *British Medical Journal* 327 (2003): 1419.

³⁷ See Gilbert Meilaender’s helpful treatment of the concept in *Neither Beast nor God: The Dignity of the Human Person* (New York: Encounter Books, 2009).

³⁸ See the Montana Supreme Court decision, *Baxter et al. v. State of Montana*, http://www.patientsrightscouncil.org/site/wp-content/uploads/2011/03/Montana_Opinion_12_31_09.pdf.

³⁹ This is not to say that an adult member of the Jehovah’s Witnesses licitly imposes the prohibition against blood transfusions upon children or on others who are unable to make their own decisions.

⁴⁰ Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, IV.

⁴¹ Dir. 58 uses the term “in principle” because practically speaking occasions arise when food and water no longer effectively sustain life, or their administra-

tion is excessively burdensome to a patient. In such cases their administration becomes “extraordinary care” and no longer is obligatory. See United States Conference of Catholic Bishops, *Ethical and Religious Directives*, dir. 58.

⁴² Aquinas, *ST II-II*, q. 62, a. 7, corpus and ad 1.

⁴³ See Grisez’s chapter on cooperation in Germain Grisez, *The Way of the Lord Jesus*, vol. 1, *Christian Moral Principles* (Quincy, IL: Franciscan Press, 1983), ch. 12, q. G.

⁴⁴ Pope Pius XII, “To an International Congress of Anesthesiologists” (November 24, 1957), *Pope Speaks* 4 (1958): 395–398, sec. “The Prolongation of Life.”