DISCUSSION PAPER

Acts of commission, omission, and demission or pulling the plug

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J R Soc Med 1995;88:18–19

Keywords: *omission; commission; demission*

SUMMARY

The difference between withholding and withdrawing treatment and actively killing is analysed. The intention of the physician and the effect on the patient are similar but the wider effect on others is different. The harmful effects of withdrawing life-preserving treatment which is no longer beneficial can be reduced by clarification of its purpose. This is to prolong life with value to the patient not just existence.

INTRODUCTION

Whether a patient with respiratory failure is denied ventilation, taken off a ventilator, or injected with morphine the result is the same. Death is intended and occurs. The British Medical Association (BMA) agrees:

> We can see no ethical difference between initial non-treatment and withdrawal of a treatment which is shown to be unsuccessful in achieving the desired effect[1] (p170).

The House of Lords agrees:

> We do not therefore distinguish between withholding and withdrawal of treatment in our discussion of treatment-limiting decisions[2].

Medical staff and families do not agree. It feels different.

A distinguished judge said:

> . . . how can it be lawful to allow a patient to die slowly though painlessly over a period of weeks from lack of food but unlawful to produce his immediate death by a lethal injection thereby saving his family from yet another ordeal to add to the tragedy that has already struck them[3].

Nevertheless mercy killing is unlawful.

The difference between causing death by withholding or withdrawing treatment or by actively killing is analysed.

THE INTENTION

When morphine is injected death is always intended and it will be ensured if necessary by a further injection. If hydration is stopped death is equally certain. Sometimes patients survive unexpectedly when ventilation is stopped or withheld. The doctor may or may not be pleased at that, depending on the outlook for the patient. In all three cases death is expected as a result of management. In two situations something is sometimes left to chance and only then are intentions less certain.

THE ACT

If morphine is injected or ventilation stopped there is a positive physical act but this is not the case when ventilation is withheld. However, treatment is really the sum of what we do and what we refrain from doing. There is little moral difference between purposely watching a small child drown in a shallow pond and actually throwing him in. The action and the inaction are equally positive. The Law must punish action more than inaction because there is a continuum between the bystander above and the non-swimmer who declines to assist by leaping into a raging torrent. It is hair-splitting to say that in acts of commission the doctor is the agent of death, but in the other two it is the disease. The doctor is responsible for all he does and does not do for the patient.

THE EFFECT

The real difference between the three ways of helping a patient by killing him is not the direct effect on the patient but the wider or side-effect on everyone else[4].

ACTS OF COMMISSION (EUTHANASIA)

Permitted euthanasia would reduce the general revulsion against killing which protects all[2]. It would weaken the safeguards against involuntary euthanasia. It would reduce the trust in doctors who would have the vets' privilege of putting down as well as treating. Patients might request death because of guilt not pain, or due to real or imagined pressure from family. It would reduce the drive to improve management of the dying[1] (pp154–5). Active termination of one life might benefit that individual but it would ultimately damage many others. It is not in the interest of society.

ACTS OF DEMISSION (PULLING THE PLUG)

It is distressing to nursing, ancillary and medical staff as well as relatives when ventilation, hydration, dialysis or any life-sustaining treatment is stopped. However, all treatment is a

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trial of treatment and there is no dispute that treatment which does not achieve its purpose should be stopped. What then is the purpose of life-sustaining treatment? It is to prolong life with value to the patient, not existence without value to him.

We value life for: the ability to experience physical and emotional pleasure; the ability to interact with other conscious beings, mainly humans[4]; and for the ability to make moral choices. If all these are permanently lost few would value continued existence.

In some tragic instances lives can regress to a state in which they bear no reasonable promise of reflecting their self-chosen values. If such persons must be given intensive medical treatment, we are violating our very belief in the immense value of human beings as reflective deliberators with the capacity to direct their lives according to their conception of well-being[5].

Competent patients with no hope of recovery are free to refuse treatment. Incompetent patients also have the right to have useless treatment which destroys their dignity stopped.

If death is a benefit that competent people can choose, then incompetent people in comparable situations should not be deprived of it[1] (p 154).

The BMA warns that this argument could lead to involuntary euthanasia but in the context of treatment withdrawal this is not a danger. Incompetent patients are obliged to withdraw consent to treatment by an advance directive or through a proxy, usually a relative.

Continuation of useless treatment violates the autonomy of an incompetent patient and prolongs the distress of the family. It deprives other patients of treatment in three ways. First, that particular resource of equipment or professional time is not available for someone else. Second, even if the supply of that resource is not limited the total health care allocation is fixed. Useless treatment for one patient means another is deprived of useful treatment. Third, if doctors cannot stop treatment once started they will be afraid to start treatment on patients who have a limited chance of success but who might benefit[6].

Early clarification of the purpose of the treatment can reduce the distress of family and staff when useless treatment is stopped. The alternative approach of stopping drugs which maintain blood pressure and turning down the oxygen so that the patient dies on the respirator involves deception of the family. Even when deception is possible and remains undiscovered it is ethically doubtful. It cannot be defended if the desired objective can be achieved without it.

A 60-year-old woman was admitted for the tenth time in 1 year with severe emphysema. She developed a tension pneumothorax which was aspirated and she was ventilated. Pleurodesis was successful but it became clear that she could not be weaned from the ventilator. Lengthy discussion with her husband established first her poor outlook, then the impossibility of weaning her from the ventilator and finally agreement that she would not desire permanent ventilation. She was taken off the ventilator and kept comfortable with mild sedation until she died soon after.

QUESTIONS FOR DISCUSSION

(1) Should we have asked the woman above for a decision despite her mild confusion and the inevitable distress it would cause? (2) Triage or using a limited resource for the patient with the best hope of recovery is acceptable. If there is no moral difference between withholding and withdrawing treatment, why can you not stop dialysing a person doing badly in order to use the resource for one with a better prospect? (3) If a doctor secretly helps a distressed and dying person to die faster, the patient is benefited. Society is not harmed by what it will never know. However, all citizens have a duty to uphold the rule of law. Is it right to break the law secretly to benefit an individual?

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(Accepted 11 June 1994)