

# Medical murder by omission? The law and ethics of withholding and withdrawing treatment and tube feeding

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**ABSTRACT** – When is it lawful and ethical to withhold or withdraw treatment and tube feeding? In recent years, the courts have handed down important decisions and medical bodies have issued professional guidelines on withholding and withdrawing treatment and tube feeding. A major criticism of these decisions and guidelines has been that while they prohibit the intentional hastening of a patient's life by an act ('active euthanasia'), they permit the intentional hastening of a patient's death by omission ('passive euthanasia'); and they prohibit actively assisting suicide, but permit passively assisting suicide. By focusing on the landmark decision of the Law Lords in the Tony Bland case, and on the guidelines on withholding and withdrawing treatment and tube feeding issued by the British Medical Association, this paper considers whether this criticism is sound, and concludes that it is.

**KEY WORDS:** Bland case, British Medical Association guidance, ethics, euthanasia, medicine and law, tube feeding, withholding/withdrawing treatment

When is it lawful and ethical to withhold or withdraw a life-prolonging treatment? Recent years have witnessed a burgeoning interest in this question, not least because of the increasing technological ability of modern medicine to prolong life. The growing significance of the issue has been reflected by important

judgments handed down by the courts and guidance issued by the British Medical Association (BMA).<sup>1</sup>

## Hippocratic or hypocritical?

These judicial decisions and professional guidelines have generated animated ethical debate. One major criticism has been that the law and guidance are ethically inconsistent. While they prohibit acts which have as their intention (aim) the shortening of a patient's life, they permit intentionally shortening a patient's life by omission. In other words, they are Hippocratic in prohibiting 'active euthanasia' but hypocritical in allowing 'passive euthanasia'. Is the charge of ethical inconsistency justified?<sup>2</sup>

## The law

### Competence

In law, patients are competent to consent to treatment, or to refuse consent, if they have the capacity to understand and retain information and weigh it in the balance in order to arrive at a decision.<sup>3</sup> All adult patients are presumed to be competent, though the presumption can be rebutted. If a competent person refuses a treatment, a doctor who overrides that refusal is liable in battery (unlawful physical contact). The doctor could be sued for damages in the civil courts or even prosecuted in the criminal courts.

The courts appear to have granted competent (adult) patients an absolute right to refuse treatment, even if non-treatment spells death. For example, in the case of Ms B,<sup>4</sup> a paralysed patient was being kept alive by a ventilator. She asked her doctors to withdraw the ventilator; they refused. The court held that as Ms B was competent she had a right to refuse even life-saving treatment and that her doctors were, therefore, acting unlawfully in maintaining her ventilation. The right to refuse treatment established by such cases appears to be unqualified and to extend even to refusals of treatment which are clearly suicidal.

While the right to refuse medical interventions appears to be absolute, the right to consent to such interventions is not. If a doctor were to inject a patient with a lethal dose of potassium chloride, it would be no defence to a charge of murder for the

## Key Points

The law and the British Medical Association guidance relating to withholding and withdrawal of treatment and tube feeding are ethically incoherent

They prohibit doctors from intentionally shortening patients' lives by an act ('active euthanasia'), but allow doctors intentionally to shorten patients' lives by omission ('passive euthanasia')

They prohibit doctors from actively assisting patients to commit suicide ('active assisted suicide'), but allow doctors intentionally to assist patients to commit suicide passively ('passive assisted suicide')

This ethical inconsistency seriously undermines the opposition of the law and the BMA to active euthanasia and active assisted suicide

doctor to plead that the patient had requested it. Dr Nigel Cox, a consultant, was convicted of the attempted murder of one of his elderly patients by administering potassium chloride to her, even though she had repeatedly requested that he end her life.<sup>5</sup>

Similarly, it would not be a defence to a charge of assisted suicide that the patient, to whom the doctor had handed the lethal substance for self-administration, had asked for it. As the case of Diane Pretty confirmed,<sup>6</sup> a patient has no right to assisted suicide and the law against assisted suicide is consistent with the European Convention on Human Rights.

### *Incompetence: advance directive or 'living will'*

If the patient is not competent, the next question is whether the patient was previously competent and made an anticipatory refusal of the treatment. Such anticipatory refusals are often described as 'advance directives' or 'living wills'. Unlike wills, however, no formalities are provided for the making of advance refusals, which may be either written or oral. The courts have held that provided the advance refusal is 'clearly established and applicable to the circumstances' which have materialised, it is legally binding.<sup>7</sup> As with a contemporaneous refusal of treatment, a doctor who overrides a binding advance directive incurs liability for battery even if, it seems, the refusal is clearly suicidal.

### *No advance directive*

If the incompetent patient has made no advance directive, then the legal duty of the doctor is to act in the patient's 'best interests'. This crucial concept lacks legal definition. However, it is widely agreed that it is not in a patient's best interests to be subjected to treatment which is futile, that is, has no reasonable hope of therapeutic benefit. For example, if a dying patient were beyond resuscitation, cardiopulmonary resuscitation (CPR) would clearly be futile. (So too would CPR which would succeed only in resuscitating a patient who is close to death. It would serve only to prolong the dying process, which is not a proper goal of medicine.)

It is also widely agreed that it is not in a patient's best interests to be subjected to a treatment which offers a reasonable hope of therapeutic benefit but which would inflict excessive burdens on the patient. For example, the possible benefits of courses of chemotherapy might be outweighed by their burdensome side effects.

So far, so uncontroversial. But does the law go further? Does it allow a doctor to withhold and withdraw treatment and tube feeding not because the treatment is worthless (either futile or too burdensome) but because the doctor thinks that the patient's *life* is worthless? In 1993, that question was answered by the Law Lords in the Tony Bland case.

### *The Tony Bland case*

Tony Bland was crushed into unconsciousness during a football stadium disaster. He was later diagnosed as being in what would now be called a 'permanent vegetative state' (PVS).<sup>8</sup> He was fed

by nasogastric tube. His parents and doctor wanted to withdraw his tube feeding but because of doubts about the lawfulness of this action the hospital applied for a judicial declaration that withdrawal would be lawful.

The barrister representing Mr Bland opposed withdrawal. He argued that removing Mr Bland's tube feeding would be murder; it would be just like severing the air-pipe of a deep-sea diver. The High Court disagreed, and granted the declaration. Its decision was affirmed by the Court of Appeal and by the Law Lords.<sup>9</sup> Mr Bland's tube feeding was withdrawn and he died.

Why was it not murder? In summary, the Law Lords reasoned as follows:

- Murder consists of the intentional termination of life by an act and may be committed by omission only where there is a legal duty to act. (If a father deliberately let his infant daughter starve to death he could not escape a murder conviction on the grounds that he killed her by omission: parents are under a legal duty to feed their children.)
- Withdrawal of Mr Bland's tube feeding was an omission.
- It was an omission not of basic care (which his doctor might be thought to be under a virtually absolute duty to provide) but of medical treatment or at least medical care.
- His doctor was under no obligation to continue this treatment because it was not in Mr Bland's best interests.
- It was not in his best interests because it was futile.
- It was futile because life in a permanent vegetative state was not a benefit, at least in the opinion of a responsible body of doctors.
- In short, the Law Lords held that Mr Bland's tube feeding was no longer worthwhile because his life was no longer worthwhile, at least in the opinion of a responsible body of doctors. *Indeed, a majority of the Law Lords held that withdrawal was lawful even though they thought that the doctor's intention was to kill Mr Bland.*

### **Professional guidance**

In 1999, the BMA published guidance concerning the withholding and withdrawal of medical treatment (which, like the Law Lords in Bland, the guidance defines as including tube feeding, not uncontroversially). A second edition, lightly revised in the wake of the incorporation into English law of the European Convention on Human Rights, appeared in 2001.<sup>1</sup>

The guidance endorses those court decisions which have granted competent patients a seemingly absolute right to refuse treatment, whether the refusal relates to a currently proposed treatment or treatment during a future period of incompetence.

In relation to incompetent patients, the guidance states that the primary goal of treatment is to benefit the patient by restoring or maintaining health, maximising benefit and minimising harm. Does it take the view that a patient may be better off dead?

On the one hand, the guidance holds that the criterion governing non-treatment decisions should be the worth of the *treatment*, not the worth of the *patient*. Moreover, the guidance

opposes the *active* intentional killing of patients. On the other hand, however, the guidance endorses the law as laid down in the Bland case. It is difficult to see how the guidance can endorse the law without also embracing the notion that the lives of some patients are no longer worthwhile and that it is acceptable to withhold or withdraw treatment (and tube feeding) for that reason, and with intent to kill.

### Three ethical questions

The issues discussed above give rise to at least three major ethical questions.

#### 1 Do the law and BMA guidance permit 'passive euthanasia'?

'Passive euthanasia' is not used here to mean the withholding or withdrawal of treatment which a doctor foresees will shorten the patient's life. A doctor whose intention (aim) is to withhold or withdraw a life-preserving treatment because it is futile or too burdensome, merely foreseeing that the patient will therefore die sooner, is not committing passive euthanasia. Rather, passive euthanasia means the *intentional* hastening of the patient's death by withholding or withdrawing treatment: where causing death is the doctor's *aim*. Passive euthanasia is not stopping *treatments* the doctor thinks worthless, but about stopping *lives* the doctor thinks worthless. The Law Lords in Bland explicitly condoned the intentional termination of the life of a patient which was judged by 'a responsible body of medical opinion' no longer to be a benefit to the patient. The law therefore permits passive euthanasia, at least of patients in a PVS.

This leaves the law, as one of the Law Lords put it in Bland, in a 'morally and intellectually misshapen' state. The law prohibits, as murder, the intentional hastening of a patient's death by an act but permits the intentional hastening of a patient's death by withholding or withdrawing treatment. Yet there is surely no moral difference between giving a patient a lethal injection of potassium chloride, and intentionally starving a patient to death by withdrawing tube feeding.

What about the BMA guidance? In short, it is difficult to read its endorsement of Bland as anything other than an endorsement of passive euthanasia.

#### 2 Are the law and BMA guidance on a 'slippery slope'?

The Law Lords were careful to limit their judgments to PVS. For example, one commented that he expressed no opinion whether his decision would be the same if the patient had 'glimmerings of awareness'. The BMA guidance, however, exhibits no such reservations; it goes beyond PVS and applies to those with advanced dementia and serious stroke.

Nevertheless, it is likely that when a case in which a doctor wishes, say, to withdraw tube feeding from a patient with advanced dementia in accordance with the BMA guidance, the court will declare withdrawal lawful, even if the doctor's intent is to kill.

There are three reasons why the courts are likely to follow the BMA:

- First, the court would be likely to hold that the BMA guidance reflects the views of a 'responsible body of medical opinion' and that a doctor who acts in accordance with it is therefore acting reasonably and lawfully.
- Secondly, the ethical proposition informing Bland is that there are certain patients whose lives are no longer worth living. Once the courts have accepted that such a category of patients exists, it is difficult to see how they can logically limit it to patients in a PVS. The category of 'worthless lives' is inherently arbitrary and liable to slippage.
- Thirdly, courts in cases before and after Bland, cases which have not received as much attention, have held it lawful to withhold or withdraw treatment from patients who have some degree of awareness. For example, in one case the question was whether an infant who was physically and mentally disabled should be ventilated if it stopped breathing. The Court of Appeal held that ventilation could be withheld if the child's 'quality of life' after ventilation would be 'so afflicted as to be intolerable to that child'.<sup>10</sup>

'Quality of life' is a chameleon phrase. In one sense, it can refer to an assessment of the patient's condition as it is now, and as it would be after a proposed treatment, in order to determine whether the treatment would improve the patient's condition and whether the treatment would therefore be worthwhile. Its use in this manner is ethically uncontroversial; it implies no judgement about the worth of the patient's life.

But 'quality of life' can also be used in another, ethically controversial, sense, as part of an assessment whether, however successful the treatment, the patient's life would be worth living.

It was clearly in this second sense that the phrase was used by the Court of Appeal. It was the baby's life, not the ventilation, which it regarded as 'intolerable'.

#### 3 Do the law and BMA guidance permit passive assistance in suicide?

The right to refuse futile or excessively burdensome treatments is ethically uncontroversial. But a right to refuse treatment in order to kill oneself is not. The right to refuse treatment conceded by the law and the guidance, because it is unqualified, appears to extend even to suicidally motivated refusals. The law and guidance therefore appear to endorse a right to commit suicide. This inevitably undermines the opposition of the law and the BMA to active assistance in suicide. For, if there is a right to commit suicide, why is it wrong intentionally to assist someone to exercise this right?

Indeed, the courts and guidelines appear to allow doctors intentionally to assist suicidal refusals. That is, they appear to allow doctors to withhold or withdraw treatment in accordance with a clearly suicidal refusal even if the doctor's intention is to assist the patient's suicidal enterprise. In other words, they appear to allow passive assistance in suicide.

## Conclusion

By reasoning that to cause Tony Bland's death by withdrawing his tube feeding with intent to kill was not murder, because it was an omission and not an act, the Law Lords were distracted from the sound moral distinction between intending and foreseeing death by the morally irrelevant distinction between killing a patient by an act and killing a patient by omission. Hence the 'morally and intellectually misshapen' state of the law, and of the BMA guidance which has embraced it.

The courts' and the BMA guidance's apparent endorsement of suicide and assisted suicide by omission follow the same irrelevant moral distinction between acts and omissions.

The courts and the BMA would have avoided moral and intellectual misshapeness had they reasoned as follows:

- that doctors are under an absolute duty not to try to kill their patients, whether by act or omission
- that it is proper to withdraw futile treatments, even if an earlier death is foreseen as certain
- and either that tube feeding patients in PVS is futile (because it cannot serve the core purpose of medicine of restoring the patient to health), and may therefore be withdrawn
- or that tube feeding a PVS patient is, at least once it has been instituted, basic care which must, in general, be continued
- that competent patients have a right to refuse treatment, but no right to commit suicide or to be assisted in suicide
- that doctors should not intentionally assist suicidal refusals.

## References

- 1 British Medical Association. *Withholding and withdrawing life-prolonging medical treatment: guidance for decision-making*, 2nd edn. London: BMA, 2001. [www.bmjp.com/withwith/ww.htm](http://www.bmjp.com/withwith/ww.htm). Guidelines have also been issued by other bodies, eg General Medical Council. *Withholding and withdrawing life-prolonging treatments: good practice in decision-making*. London: GMC, 2002. [www.gmc-uk.org/standards/default.htm](http://www.gmc-uk.org/standards/default.htm); Royal College of Physicians. *The vegetative state: guidance on diagnosis and management*. London: RCP, 2003.
- 2 The issues in this paper are explored at greater length in Keown J, *Euthanasia, ethics and public policy*. Cambridge: Cambridge University Press, 2002. See especially Part VI.
- 3 *Re C* [1994] 1 All ER 819
- 4 *Re B* [2002] 2 All ER 449
- 5 *R v Cox* (1992) 12 BMLR 38
- 6 *Pretty v United Kingdom* (2002) 35 EHRR 1
- 7 *Re T* [1992] 3 WLR 782
- 8 Royal College of Physicians. *The vegetative state: guidance on diagnosis and management*. London: RCP, 2003.
- 9 *Airedale NHS Trust v Bland* [1993] AC 789.
- 10 *Re J* [1991] 1 Fam LR 366.