Commentary 1: The right to refuse treatment

John H Tripp *Department of Child Health, University of Exeter*

The author suggests that by providing ventilators (or other equipment) with a mechanism which would automatically switch them off, (thus allowing the patient to die without the intervention of another human being switching the machine off) doctors would somehow be spared the moral dilemma and responsibility of acceding to a patient's request for a life-support system to be withdrawn.

This "legalistic" moral position is apparently consistent with the author's discussion in relation to acts of omission or commission. Moral responsibility is taken by a clinician acceding to a patient's request to allow him/her to die, whether taken as agreement not to commence life support or to terminate provision of care which requires continuous maintenance and supervision from medical and paramedical staff. According to the author's premises, while it would not be ethical to switch off a ventilator it would be ethical, after receiving a request to terminate life support by ventilation, to cease maintaining the patient on the ventilator. This would allow, for example, the endotracheal tube to become blocked with secretions and the patient to die a lingering and painful death over a period of hours, days or weeks.

I agree with the author, that acts of omission and commission may sometimes be morally indistinguishable but they are, I imagine, legally pragmatic. If failure adequately to care for a patient on a ventilator resulted in his or her untimely death, this would, by an act of omission, be manslaughter. According to the argument of the author attaching somebody to a machine which would automatically switch itself off would be ethical, yet as a planned act of commission could be deemed to be murder. The legal distinction between acts of omission and

commission is not in this circumstance useful in making an ethical decision.

The moral reasoning is not dependent on the legal position though clearly a clinician's actions will be influenced both by ethics and legality. If in a particular circumstance where it appears ethically correct to allow someone to die it were not possible to distinguish morally between this and causing someone to die, then the conclusion might be that murder was ethically acceptable. It is for pragmatic reasons that I welcome the current distinction between acts of omission and commission. This allows the doctor to act in the patient's best and considered interest without breaking the law. At the same time the legal prohibition against acts of commission acts as an important safeguard against the possibility that doctors would have "licence to kill". Such licence would be an unenviable position both for the doctor and the patient while freedom not to be obliged to apply medical skills to cause to live appears acceptable and desirable for both.

In discussion with patients or their parents, I take the view that where medical intervention is required to support the continuation of life, then the person(s) responsible for the provision of that care (normally delegated to the senior doctor, although actually many members of a highly professional medical team) has to make a moral decision as to whether it is right to use his or her skills to cause that patient to live; without the application of those skills the patient would die.

The author rightly draws attention to the fact that making this decision in conjunction with a conscious patient is a relatively rare phenomenon but is perhaps the ultimate example of where the patient's wishes can be clearly established, making the task of the person providing the treatment remarkably clear.

John H Tripp, is Senior Lecturer in Child Health in the Department of Child Health, Postgraduate Medical School, University of Exeter.

Key words

Patients' rights; consent; euthanasia; life-sustaining technology; termination of treatment; acts and omissions.