

Commentary 2: Thesis correct: argument unconvincing

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I agree with the proposition set out in Susan Lowe's title: the right to refuse treatment is not a right to be killed. I agree also that the "acts and omissions" distinction is irrelevant to the discussion, while I believe that there are contexts in which the distinction is valid and of moral worth. I believe that the arguments which the author advances to support her proposition to be flawed; and their constant repetition does not make them convincing. Professor Kennedy may be allowed to defend his own position on the relevant law. My own difficulties stem from the author's misuse, as I believe it to be, of key words and of analogy.

It is not true that a patient's request to have a ventilator switched off is "a request to be killed". It is rather a request that the prevailing morbid condition be allowed to run its course and the patient be allowed to die. The respirator is a restraint upon, and impediment to, that process, the withdrawal of which the patient is entitled to request. The physician complying with this request would not be committing murder. Rather, if he or she ignored it, his continuance of a treatment to which consent had been refused would constitute an assault – as it would if he forcibly fed a prisoner on hunger strike who had chosen rather to die.

Morally these legal presumptions stand on the respect due to the integrity of the human person, in defence of a liberty to live free from molestation or interference without consent.

The analogy with the cutting off, at his own request, of a deep-sea diver's life support is false. The air-line supports the diver's lungs in their natural function; to remove it would be to kill him,

an unlawful act. The respirator sustains a ventilated patient in an otherwise lethal condition: to remove it is to allow him to die from the disease process. The general precept of law cited, that "a person cannot consent to his own death", pertains to unlawful killing; it cannot be supposed to forbid the voluntary acceptance of a death which medical intervention can only postpone – the physician having been discharged from the normal presumptive duty to intervene by the patient's withdrawal of consent.

And what is the morality of the author's "alternative solution" – "the ventilator programmed to switch itself off after a designated period of hours or days"? At once there comes to mind the analogy of the time-switch on the terrorist's bomb, programmed, no doubt, not so much to escape moral responsibility as to allow getaway time and so avoid detection. The analogy must be resisted because here the author goes on to specify that the programming of the respirator would be precisely to enable the clinician to avoid moral agency, his responsibility for complying with the patient's expressed wish to be allowed to die. The "solution" is not thought through. The doctor, according to the text, is to be allowed to switch on again, after each interval of hours or days, if the patient does not refuse. In whose interest is it to encourage doctors to employ mechanical devices to excuse themselves from that moral agency which their profession both entitles and obliges them to bear; or to lay upon moribund patients responsibility for decisions in time of deepening enfeeblement which, in full liberty, they thought they had taken while competent? The defence of a good thesis should not bring us to such a pass.

Key words

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

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