

Why causing death is not necessarily morally equivalent to allowing to die – a response to Ferguson

Fiona Randall *Christchurch Hospital, Fairmile, Christchurch, Dorset*

Dr Ferguson contends that the law has a “seemingly contradictory approach” to cases which she regards as morally indistinguishable: she compares the Cox case, where the life of an autonomous patient was actively terminated by a lethal injection, to those of Tony Bland and Janet Johnstone, where life-prolonging treatment was withdrawn because it was not thought to be of any benefit to those patients, who were in the persistent vegetative state (PVS).¹ She agrees with Lord Mustill whom she quotes as saying “the ethical status of the two courses of action are, for all relevant purposes indistinguishable”. She argues that the ethical status of administering a lethal injection to a suffering patient, thus intentionally causing death, is the same as withdrawing life-prolonging treatment from a patient in the PVS, where she contends that doctors also intentionally cause the patient’s death. She finds the law’s approach contradictory in that it sanctioned the withdrawal of treatment in the PVS cases while Dr Cox was convicted of attempted murder.

She maintains that the difference in legal approach is based only on the distinction which the law makes between acts and omissions, namely that Dr Cox acted to end his patient’s life by lethal injection whereas in the PVS cases doctors omitted life-prolonging treatment. She goes on to say that it is not clear that the law’s rigid distinction between acts and omissions necessarily reflects a fundamental difference in all circumstances. Specifically, in the circumstances of the Cox and PVS cases as she describes them, she does not see a fundamental moral difference. She finds the different approach of the law in the cases compared to be “ironic” and “not always in line with the morality of the situation”. She thus implies that the law’s approach should always mirror the morality of the situation. These two premises combined lead her to present her **first thesis** which is that the law’s approach is contradictory in that it judges these “morally indistinguishable” cases differently. Her arguments for

her first thesis could be described in the following syllogism:

Morally indistinguishable cases should not be treated differently by the law.

The Cox and PVS cases are morally indistinguishable.

The Cox and PVS cases should not be treated differently by the law.

I shall begin by examining Dr Ferguson’s minor premise that the doctors’ decisions in the Cox and PVS cases are morally indistinguishable. This premise is based on her assertion that in both cases the doctors intentionally caused the patient’s death. She rightly asserts that Dr Cox’s lethal injection was believed to have caused the patient’s death, (but this could not be proved since her body had been cremated and so Dr Cox was charged with attempted murder rather than murder). It is also not disputed that Dr Cox intended to cause his patient’s death.

If a case of murder has to be established in the PVS situation the two conditions of causality and intention must demonstrably be present.

Take first causality. Dr Ferguson seems to be arguing that the withdrawal of artificial feeding from patients in the PVS constitutes the “forbidden situation” of murder, that is, the causing of death. But surely the patient’s death is caused by the underlying severe pathological condition of the PVS, which renders the patient incapable of survival without constant life-prolonging treatment, including artificial hydration and nutrition. The fundamental cause of death is the patient’s condition, not the withdrawal of treatment, which should be regarded as incidental. Death would have been caused by the pathological conditions of the PVS. The life-support treatments merely prevent on a temporary basis the occurrence of death. Such temporary measures give doctors time to assess the situation and to consider whether the body can resume normal functioning. If it cannot, and there is no reasonable hope of recovery of consciousness, further life-sustaining treatment is futile and it is in no one’s interests to continue it. When it is removed the body’s own causality results in death.

Key words

Euthanasia; murder; law; Bland; Johnstone; Cox; act; omission.

If on the other hand this reasoning is rejected and Dr Ferguson's view about causality is accepted, then it must follow that in all cases where doctors have withheld or withdrawn life-prolonging treatment for any reason they have caused the patient's death. Since the available array of life-prolonging treatment is now so extensive, and since the precise timing of so many patients' deaths is now influenced by decisions to forgo all possible life-prolonging technology, Dr Ferguson's approach would imply that doctors actually cause the death of the majority of their patients. For example, she would presumably conclude that doctors cause the patient's death even when they discontinue cardiopulmonary resuscitation because it is futile – she would have to conclude that they, and not cardiac arrest, caused the patient's death because technically they could have kept the patient's circulatory system supported artificially for some time longer. Similarly, she would be committed to asserting that doctors cause the death of patients who die of respiratory failure due to motor neurone disease since death due to respiratory failure can be prevented by ventilation.

Intention

Regarding the second condition to establish the charge of murder – intention – I would argue that since doctors quite reasonably do not consider that the withdrawal of treatment in the PVS case is the cause of death, they cannot logically intend to cause death by withdrawing treatment. It makes no sense to say that doctors intend to cause death when they do not think their decision is the cause of that death.

Moreover, even if Dr Ferguson's assertion that the withdrawal of treatment in the PVS cases is the cause of death were true, and if the doctors (erroneously) believed this to be so, it would not necessarily follow that the doctors intend the patient's death. For it could reasonably be argued that the doctors intend only to withdraw a futile and non-beneficial treatment, and foresee but do not intend the patient's death. This interpretation would concur with our normal view of similar cases; when a surgeon performs an operation he foresees certain risks and harms such as pain, but he does not intend them, and similarly in the "double effect" situation it is commonly accepted that doctors intend only the relief of suffering, not the patient's death, although they foresee that the latter may be hastened.

Thus I would conclude that in the PVS cases the withdrawal of artificial feeding is not the fundamental cause of the patient's death, and since doctors rightly share this view they cannot logically intend the patient's death in ceasing treatment. Moreover, it does not follow that the doctors intend to cause death, although they foresee its occurrence when futile treatment is stopped. The Cox and PVS cases are therefore morally different in crucial ways; Dr Cox intended to cause and may have caused his

patient's death, whereas the doctors in the PVS cases neither caused nor intended to cause the patients' deaths.

It seems to me appropriate that the approach of the law to the cases should be different because they are legally as well as morally different. The PVS cases are not seen legally as murder because both the intention to cause death and the "forbidden situation" of causing death are absent. There seems simply no legal reason to regard them as murder. In contrast, as Dr Ferguson has explained, it seemed that Dr Cox intended to cause his patient's death and may well have done so, and consequently the law regarded his act as attempted murder. Surely the law's difference in approach to the Cox and PVS cases was rightly based on these vital moral differences, rather than on a "rigid" distinction between acts and omissions, as Dr Ferguson claims. Her criticisms of the law in this instance surround a misguided moral assessment of withdrawal of treatment, which she claims was regarded as intentionally causing death. This misguided assessment is described clearly by Dr Ferguson when she quotes Lord Mustill as saying "the ethical status of the two courses of action is for all relevant purposes indistinguishable".

We should also examine her major premise that morally indistinguishable cases should not be treated differently by law. This raises issues about the function of law and its relationship to morality. She states that "the law draws a rigid distinction between 'acts' and 'omissions to act'. It is, however, not clear that this necessarily reflects a fundamental moral difference, in all circumstances." But surely the law is not claiming that in all circumstances there is a necessary and fundamental moral difference between acts and omissions. The law is claiming only that in some cases it is in the interests of justice and protection for all the community that a distinction be made between acts and omissions. The law does not exist to define or encompass all the complexities of morality, but rather to make rules by which people may live together, with mutual protection. Dr Ferguson's premise that morally indistinguishable cases should not be treated differently by law is initially appealing but it is not entirely convincing. For example, suppose person A intended to cause the death of person B by poisoning his coffee, and by so doing killed B, but person C who also intended to cause the death of person D by poisoning his coffee failed to do so because he mistook sugar for the poison, so D was not harmed. These cases are morally indistinguishable, but the law would and should approach them differently.

I have rejected the conclusion of the first syllogism, but let us now consider the consequences of accepting it. Dr Ferguson concludes that the Cox and PVS cases should be approached legally in the same way. If this were to happen the law would have to treat intentional acts to end life, as in the Cox

case, in the same way as decisions to withdraw life-prolonging treatment, as in the PVS cases. Put in Dr Ferguson's chosen terms this would mean treating acts of "causing death" in the same way as omissions aimed at "allowing to die". It would then follow that either both should be prohibited, or both should be permitted. We should examine the consequences of such a legal approach.

Disastrous results

If both were prohibited then "allowing to die" would be prohibited. This would mean that doctors would have to apply all possible means of life-prolonging treatment to all patients, otherwise they would presumably face a sentence of life-imprisonment, the punishment for intentional killing (unless of course they argued that they acted in a state of diminished responsibility). This would result in all patients having their lives prolonged as long as was technically possible. It is not even clear that patients could refuse life-prolonging treatment, because, as Dr Ferguson has pointed out, "one cannot consent to being killed", and if allowing to die is to be treated legally in the same way as being killed, then one cannot consent to or request that life-prolonging treatment be withheld or withdrawn. This would have disastrous results; the autonomy of patients and doctors would be grossly infringed by the law, life-prolonging treatments could not be withdrawn or withheld even if their harms outweighed their benefits, thus increasing suffering, and intensive care units would multiply and consume the lion's share of National Health Service resources and so on.

In fact it seems that Dr Ferguson is suggesting that "causing death" and "allowing to die" should both be permitted, in those circumstances where she considers they are morally indistinguishable, such as the PVS and Cox cases. Remember that she describes the PVS cases as those where doctors have intentionally caused the patient's death because they consider that "a person's quality of life is so poor that he or she should not be kept alive". It logically follows that if allowing to die is permitted in the PVS cases *as she sees them* then so must non-voluntary euthanasia be permitted. This would mean that if it was thought that a person's quality of life was so poor that he or she should not be kept alive by means of life-prolonging treatment, then a deliberate act to cause the death of that person should also be permitted. It would then follow that doctors, and indeed perhaps anyone, would be permitted to kill such patients. This would severely weaken the prohibition against killing which currently protects such vulnerable patients.

At the end of her paper Dr Ferguson suggests there is a moral obligation to administer lethal injections to patients whose quality of life doctors feel is so poor that they should not be kept alive. She argues that the law should consider this because she thinks it is more humane than omitting

life-prolonging treatment such as feeding. Her argument for this **second thesis** is described in the following syllogism:

There is a moral obligation in medical practice to act only in the most humane way.

It is more humane to give patients with a poor quality of life a lethal injection than to withdraw life-prolonging treatment.

There is a moral obligation to give patients with a poor quality of life a lethal injection.

The major premise is over-simplistic. The moral life in medical practice is more complex than this. When making decisions regarding treatment of an individual patient doctors must have regard to the requirement for the most humane treatment possible for all patients. Many examples are seen in the area of resource allocation where the best and therefore the most humane treatment may not be available for all patients, so various conscientious compromises must of necessity be sought. Dr Ferguson admits that there are good reasons for maintaining society's prohibition of "positive acts which are intended to end life", and I would argue that in the interests of providing the most humane treatment possible, bearing in mind the circumstances of all patients, the prohibition against such acts must be maintained.

Dr Ferguson's minor premise is also open to dispute. It is dangerously misleading to say that PVS patients are "starving to death" because such a phrase is associated with a painful state of consciousness which is not present in such patients. Patients in the PVS do not perceive hunger or thirst if artificial feeding is withdrawn. Moreover, in some instances where life-prolonging treatment is withdrawn in other clinical conditions, for instance when ventilation is discontinued, the patient may not die and this may turn out to be a more humane outcome than having life ended by a lethal injection. It is probably best not to cloud this issue, which centres around the patient's best interests, with a discussion about what is in the best interests of relatives or the rest of society.

'Moral obligation'

Dr Ferguson concludes in her second thesis that there is a "moral obligation" to give patients with a poor quality of life a lethal injection, rather than to withdraw life-prolonging treatment. She goes further by suggesting that this moral obligation "ought to be given legal recognition". She had earlier asserted that the law should reflect and follow moral reasoning. If in fact the law did follow *her* moral reasoning it would be legally obligatory to administer lethal injections to those patients whose quality of life was considered so poor that life-prolonging treatments

ought to be withheld or withdrawn. Her arguments when combined would then inevitably lead to compulsory non-voluntary, and indeed involuntary, euthanasia of such patients. Furthermore, since in law others, besides doctors, have a duty of care towards patients, it may follow that if doctors have a legal obligation to end the patient's life, so might anyone else who has a duty of care, for example nurses or relatives. I would suggest that even the most staunch proponents of euthanasia would not support this view, which would horrify the public and health care professionals alike.

I have argued that Dr Ferguson's premises are either unconvincing or clearly false. Furthermore, if

her conclusions were accepted and enshrined in law there would be far-reaching moral and legal effects on society which the vast majority of people would consider disastrous.

Fiona Randall, FRCP, is Consultant in Palliative Medicine, Chrischurch Hospital, Fairmile, Christchurch, Dorset.

References

- 1 Ferguson PR. Causing death or allowing to die? Developments in the law. *Journal of Medical Ethics* 1997; 6: 368-72.

News and notes

Ethics and palliative care

An advanced European Bioethics Course on ethics and palliative care will be held from 2-4 April 1998, in Nijmegen, the Netherlands. Specialists from different countries will discuss ethical aspects of palliative care. Subjects: Evolution of palliative care; Ethics and pain management; Limits of palliative care; Futility of medical treatment; Palliative care and euthanasia. Lecturers: Dame C Saunders (UK), Z Zylicz (Netherlands), S Husebø (Norway), HAMJ ten Have

(Netherlands), W Dekkers (Netherlands), B Gordijn (Netherlands). Language: English.

For more information: Dr B Gordijn, Catholic University of Nijmegen, 232 Dept of Ethics, Philosophy and History of Medicine, PO Box 9101, 6500 HB Nijmegen, the Netherlands. Tel: [31] 24-3615320. Fax: [31] 24-3540254. E-mail: b.gordijn@efg.kun.nl Internet site: <http://www.azn.nl/fmw/maatschp/pallial.htm>