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The body as unwarranted life support: a new perspective

# The body as unwarranted life support: a new perspective on euthanasia

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It is widely accepted in clinical ethics that removing a patient from a ventilator at the patient's request is ethically permissible. This constitutes voluntary passive euthanasia. However, voluntary active euthanasia, such as giving a patient a lethal overdose with the intention of ending that patient's life, is ethically proscribed, as is assisted suicide, such as providing a patient with lethal pills or a lethal infusion. Proponents of voluntary active euthanasia and assisted suicide have argued that the distinction between killing and letting die is flawed and that there is no real difference between actively ending someone's life and "merely" allowing them to die. This paper shows that, although this view is correct, there is even less of a distinction than is commonly acknowledged in the literature. It does so by suggesting a new perspective that more accurately reflects the moral features of end-of-life situations: if a patient is mentally competent and wants to die, his body itself constitutes unwarranted life support unfairly prolonging his or her mental life.

It is widely accepted in clinical ethics that removing a patient from a ventilator at the patient's request is ethically permissible. This is often termed voluntary passive euthanasia (VPE), although there is controversy over this terminology and in particular over the idea that ending a patient's life in this way is any less direct than other means.<sup>1</sup> Conversely, voluntary active euthanasia (VAE), such as giving a patient a lethal overdose with the intention of ending that patient's life, is ethically proscribed, as is assisted suicide (AS), such as providing a patient with lethal pills or a lethal infusion. Proponents of VAE and AS have argued that the distinction between killing and letting die is flawed, and that there is no real distinction between actively ending someone's life and "merely" allowing them to die. This paper will argue that, while this is correct, there is a more powerful way of collapsing the distinction between VAE and VPE. If we regard the body of someone who requests VAE or AS as providing unwarranted life support, it is clear that there is no substantive moral difference between turning off a ventilator (for example) and providing or administering a lethal drug.

## TWO CASES

Let us begin by considering two similar cases. In the first, Adam is dying of lung cancer and is on a ventilator. He is in

constant pain and needs help eating, drinking, washing and going to the toilet. He regards his life as no longer worth living and, with the consent of his family, requests that the doctor disconnects the ventilator. In the second case, Brian is dying of stomach cancer. He is in constant pain and needs help eating, drinking, washing and going to the toilet, although he can breathe easily. He regards his life as no longer worth living and, with the consent of his family, requests the doctor to administer a medication that will end his life.

Most doctors, assuming that they subscribed to the dominant ethical view, would grant Adam's request and refuse Brian's (a recent survey showed that non-treatment decisions (VPE) accounted for 30.3% of end-of-life decisions, with VAE and AS accounting for only 0.16% and 0.00%, respectively).<sup>2</sup> A common justification for making this moral differentiation is that, in the first case, the patient has exercised his right to refuse treatment; although granting this request will cause the patient's death, the doctor is required to respect the patient's decision. In the second case, however, Brian has made a request for VAE; in terms of the current legality of granting the request, the doctor would be quite sensible to refuse it, even though this would mean going against his patient's wishes. Given that Adam is competent, a doctor who

refused his request would be guilty of the tort of trespass to the person.<sup>3</sup>

Now let us examine the moral features of the situation more closely. Adam has decided that he no longer wants to live; so has Brian. Adam does not have anything in particular against the ventilator itself; he simply knows that it is keeping him alive and wants it to stop doing so. Brian, similarly, has nothing against his body and merely wants it to stop keeping him alive. As such, Brian's body, like Adam's ventilator, is keeping him alive despite his wishes to the contrary: it constitutes unwarranted life support.

## BRAIN DEATH AND BRAIN LIFE

The problem, for both Brian and the doctor, is that this is not the traditionally accepted way of looking at the situation. The new perspective requires us to accept that we as persons are not identical with our bodies (for more on the mind/body problem, see Robinson<sup>4</sup>). Although this might sound counterintuitive to some, it is clearly the accepted view in biomedical ethics, given that the modern criterion of death is brain death. If the definition of the death of a person is brain death, it follows that "we" as persons are not identical with our bodies. If someone's brain stops working forever, we no longer refer to him or her as a person; this must mean that the body is, in a sense, a life-support system for the person. While this system could continue to function after brain death as the body of a dead person, the body is not the same thing as the patient, and in this vital sense, Brian is not his body; he is his mind. He would be quite happy if there were some quantum leap in stem cell technology and his brain (with his mind intact) could be transplanted into a cancer-free new body cultured from his DNA; this would be a better way of ending his suffering than dying. Although persons obviously have feelings for their bodies that they do not have for external equipment such as a ventilator, such feelings lose all moral power when a patient decides that his or her body is now a burden. If we agree that brain death is the end of a person, we should adopt brain life as the central aspect of personhood in terminal patients and accept that the body is merely another type of life support.

This in turn implies that the distinction between artificial and natural (bodily) means of life support is a false one. The key point, as Beauchamp and Childress say in arguing against the killing/letting die distinction, is that "the forging of the medical technology is validly authorized and for this reason justified ... the validity of the authorization, not some independent assessment of causation,

determines the morality of the action".<sup>5</sup> Applying this reasoning to Brian's situation, we can see that he clearly authorises his death; he actively requests it. No medical technology is involved in Brian's case, but what moral reason can there be for differentiating between a ventilator that keeps the brain working and a body that keeps the brain working?

Adopting a different perspective, Patrick Hopkins suggests regarding a ventilator as part of a person: "when we terminate the function of a person's pulmonary system, we have thereby caused her inability to exchange necessary gases. In doing so, we killed her. Whether labelled artificial or natural it is our disruption of her pulmonary system that prevents her from getting air."<sup>6</sup> This approach collapses the distinction between killing and letting die by viewing the ventilator as an external lung. While this is effective, the more important perspective is that Brian's lungs, like Adam's ventilator, are violating his autonomy by prolonging his life against his will. Adam is lucky inasmuch as he has a right to refuse further treatment; in Brian's case, his mind's desire is being thwarted by his own body.

Although there may be a difference between their situations in medical and legal terms, this is the true moral status of the situation: both Brian and Adam are dying, are in pain, and are requesting the deactivation of something that is keeping them alive against their will. It might be objected that the clear difference is that the ventilator is an artificial device attached to Adam only in the hospital, whereas Brian has nothing to refuse in this way; the doctors can legitimately turn off the ventilator because they connected it to Adam in the first place, but the same is not true of Brian. This is an obvious intuitive response, but it has no power; what if Brian had been fitted with artificial lungs as a baby? The first human to be fitted with an artificial heart, Barney Clark, was given an option most of us don't have: a key to turn it off. Dr Willem Kolff, founder of the artificial heart programme, said that "if the man suffers and feels it isn't worth it any more, he has a key that he can apply ... I think it is entirely legitimate that this man whose life has been extended should have the right to cut it off if he doesn't want it, if [his] life ceases to be enjoyable."<sup>6</sup> If we agree (as it seems we should) that it is acceptable to turn off Adam's external "lungs", and Barney's internal artificial heart, why should we penalise Brian for having an internal natural heart and lungs? It might be argued that Brian's life, unlike Barney's, has not "been extended", because he can

carry on living without intervention. But Brian's life *is* extended in the essential sense that its remainder is undignified and painful, and he does not will its continued extension. Beauchamp points out the problem:

Medicine and law seem now to say to many patients, "If you were on life-sustaining treatment, you could withdraw [permission for] the treatment and we could let you die. But since you are not, we can only give you palliative care until you die a natural death." This position condemns the patient to live out a life he or she does not want—a form of cruelty that violates the patient's rights and prevents discharge of the fiduciary obligations of the physician.<sup>7</sup>

This cruelty is cast in even sharper light when we consider that the body is, in fact, life support for the brain and mind. Viewed this way, the situation is reduced to granting death to one patient on life support but not the other.

### BODIES, MINDS AND MORAL DISTANCE

It is worth considering why some doctors are intuitively opposed to VAE. Could it not be that the remoteness of the ventilator from the patient gives a sense of moral distance from the act of "killing"? The doctor has no qualms about performing the action that will effectively stop Adam breathing, but the fact that he must actually *do something to Brian's body* to give him what he wants makes him hesitate and refuse. In the same way that killing someone from afar with a rifle is likely to be less traumatic (for the killer) than getting close and stabbing the victim, moral queasiness at the more direct intervention necessitated by a request for AS or VAE makes doctors tend to refuse such requests. This is a more physical application of the killing/letting die distinction. Hopkins points out that, "if artificial lungs could be as efficient and as internal as a pacemaker, I suspect the notion that we could turn them off with causal and moral impunity would seem as odd as it really is".<sup>1</sup> Hopkins' point is not that doctors are wrong to turn off ventilators when requested, but that the intuitive distinction between VAE and VPE would disappear if ventilators were an integral part of patients' bodies.

Of course, part of the problem is the very close connection between the body and brain: in a sense, it is even closer than that between body and heart, as we know that hearts can be replaced without

changing the person. This presents intuitive problems for doctors, who most of the time are dealing with people who want their brain activity to continue for as long as possible. Such patients also obviously want their bodies to keep working, as their brains are dependent upon these life-support systems. For patients requesting AS and VAE, the situation is inverted: they want their brain activity to cease (assuming a new body is not an option) and it is their troublesome bodies that are causing the problems. In this case, the appropriate "treatment" is one that stops the body working so that the brain (and person) will die. In refusing VAE and AS requests, it is almost as if doctors are obeying the "wish" of the patient's body rather than the patient's mind, as keeping bodies functioning is what doctors are habituated to. This attitude is understandable, but it is not ethical.

### ORDINARY AND EXTRAORDINARY TREATMENT

Another way of looking at the problem is via another supposed distinction: that between ordinary and extraordinary treatment. Some doctors argue that a ventilator constitutes extraordinary treatment and that discontinuing ventilation is therefore acceptable, whereas ordinary treatments such as food and water cannot be discontinued. Quite apart from the classification problems this approach entails, given different definitions of "extraordinary", what use is this distinction when the patient's desire is for *all* treatment to cease? Adam wants his body to stop keeping him alive, so his ventilator is unplugged; Brian, on the other hand, has no such external "button" so he must continue to suffer.

Nevertheless, supporters of the distinction between ordinary and extraordinary treatment might say that if we accept that the body, regarded as a life-support system, is a sort of treatment for the brain, it must be classified as an ordinary treatment, because it requires no intervention from staff. As such, they might argue, it is not permissible to withhold treatment, which in this case would mean taking the necessary steps to cause death. But once again, whether a treatment is ordinary or extraordinary is not important: from the point of view of the patient's mind and desires, a ventilator, food and the body all have the same status as life-prolonging burdens that should be discontinued. Beauchamp and Childress state that "the principal consideration is whether a treatment is beneficial or burdensome, not what its classification is."<sup>5</sup> I would go further and say that whether it is a treatment or the

patient's body is not important: if the body is a burden, it should be discontinued, just like a burdensome treatment. Beauchamp and Childress further state that "no morally relevant difference exists between the various life-sustaining technologies" and "the right to refuse medical treatment for oneself or others is not contingent on the type of treatment".<sup>5</sup> If we accept this, then opponents of my argument must indicate what the moral difference is between a treatment and Brian's body when either could be keeping him alive against his will.

The British Medical Association's guideline *End-of-life decisions* states that

Medical treatment can legally and ethically be withdrawn when it is futile in that it cannot accomplish any improvement, when it would not be in the patient's best interest to continue treatment (because, for example, it is simply prolonging the dying process) or when the patient has refused further treatment."<sup>8</sup>

Adam's case fulfils all three criteria (and, given the phrasing, it appears that any one would be sufficient). The ventilator cannot improve his condition, it is simply prolonging the process of dying and he has refused further treatment. If we accept that Brian's lungs do constitute unwarranted life support, in the sense

that his mind does not want his body to keep it alive, then his case also fulfils all three criteria: his lungs cannot improve his condition, they are simply prolonging the process of dying and he has refused further treatment, at least in the sense that he wants his lungs to stop working.

### CONCLUSION

I have sketched the outline of a new perspective for regarding cases of competent terminal patients who want to die. If we accept this new perspective, it becomes clear that there is no moral difference between VAE and VPE, as both consist of deactivating life support to the brain. (Whether doctors have an obligation to provide VAE or AS is another question, but if there is really no moral difference between VAE and VPE, it follows that doctors have a duty either to perform both or to perform neither.) Fundamentally, the fact that Brian's brain is "hard-wired" into its support system makes not the slightest moral difference, however counterintuitive this may seem. Patients should not be condemned to a slow death simply because their systems of life support are natural rather than artificial.

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