

The Withdrawal of Treatment

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Abstract

The withdrawal of treatment is one of the most emotionally challenging and ethically complex aspects of end-of-life care. As our ability to prolong life progresses, the necessity to address issues such as the withdrawal of treatment increases in parallel. This paper approaches the subject from an ethical point of view and aims to establish the utility of ethical frameworks in the 21st century. To achieve this, the withdrawal of treatment is outlined and the arguments both for and against this topic are considered. Ethical frameworks are summarised and applied to the *Airedale NHS Trust v. Bland* [1993] case. The article argues that through asking ethical questions, one seems not to shed light on the matter, but only emphasises its complexity. In conclusion, although a traditional ethical framework may be applied to the issue of the withdrawal of treatment, multiple criticisms accentuate its impracticality and irrelevance in the modern medical world.

Introduction

In my first year of University a close friend of mine was involved in a critical accident. He remained on life support for the following six months before physicians decided that the most appropriate action to take would be to withdraw support. The burdensome experience taught me that end-of-life care, and in particular the withdrawal of treatment, is a challenging issue both emotionally and intellectually. As an aspiring medic, it became a topic that I was keen to explore, and after enrolling on 'Ethics in a Complex World' (a Curriculum Innovations module that is part of Flexible Learning at the University of Southampton), I was provided with the perfect opportunity in which to do so.

In healthcare, four moral principles are used in the analysis of medical ethics: autonomy, beneficence, non-maleficence and distributive justice (Picard & Lee, 2013). Autonomy is defined as a rule that states patients must have a right to control what happens to their bodies, and these decisions must be respected by everyone. The second principle, beneficence, is an action that should

be performed for the benefit of others, thus all healthcare providers must strive to do the most good for the patient. Non-maleficence is one of the principal precepts of medical ethics and involves healthcare providers avoiding causing harm to their patients in every situation. Lastly, justice states that the doctor should try to be as fair as possible when offering treatments to patients and allocating scarce medical resources. The doctor must also be capable of justifying these actions (Winter & Cohen, 1999).

These values (which are neutral between competing religious, cultural, and ethical theories) are able to be shared by everyone. However, the principles do not provide a method for choosing and fail to provide answers as to how to handle a particular situation. The four principles simply offer a common set of moral commitments (Gillon, 1994). In order to address this problem, this paper will enquire whether long established ethical approaches, such as consequentialism and deontology, are more appropriate when dealing with the issue of the withdrawal of treatment. To achieve this, the withdrawal of treatment will be outlined and the arguments both for and against this topic shall be considered.

Ethical frameworks will be studied, and are applied to the *Airedale NHS Trust v. Bland* [1993] case study.

The withdrawal of treatment

The withdrawal of life-sustaining treatment with the deliberate intention of causing death to another provides a definition for passive euthanasia (Keown, 2004). In ethical and medical literature these terms are often used interchangeably; however for the purpose of this paper the 'withdrawal of treatment' shall

Airedale NHS Trust v. Bland [1993] case study

In 1989 Tony Bland was injured in the Hillsborough disaster and this left him in a persistent vegetative state (PVS). Months later, Bland's physician expressed an intention to withdraw all treatment. This proposal was met with warning however from the coroner and police who stated that such action would constitute murder. Despite this, Bland's parents agreed with the physician; in short, they felt there was no benefit to Bland in keeping him alive. It was three years later that the Airedale Hospital Trust made an application to the High Court. Attracting considerable interest, the case eventually concluded; in 1993 treatment was withdrawn and Bland died nine days later.

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be used. In the UK, medical treatment can legally be withdrawn if it is deemed futile (British Medical Association, 2009; General Medical Council, 2013). In practice, however, it is a profoundly difficult decision. This was illustrated by the *Airedale NHS Trust v. Bland* [1993] case.

Bland became the first patient in English legal history to be allowed to die by the courts through the withdrawal of life-sustaining treatment including artificial nutrition and hydration (ANH). Interestingly, the case significantly contributed to the foundation of the Mental Capacity Act of 2005 (Law Reform Commission, 2009; Szawarski & Kakar, 2012). The topic of ANH however remains controversial to this day, and a comment made by Lord Mustill during the *Airedale NHS Trust v. Bland* [1993] case still seems very relevant

“It would in my opinion be too optimistic to suppose that...in the future the doctors (or perhaps the judges of the High Court) will be able without difficulty to solve all future cases...”

(Szawarski & Kakar, 2012).

The issue of the withdrawal of treatment often evokes an emotional response, particularly from those who are directly involved with such cases. Despite this, a limited number of studies exist detailing how frequently the withdrawal of treatment takes place, or the opinions of physicians regarding this matter. One survey exploring NHS doctors’ attitudes towards end-of-life care found that 91% would consider practicing passive euthanasia (Ward & Tate, 1994). In addition, another study concluded that few UK healthcare professionals believe they give up on patients too soon; staff felt more strongly that sometimes the treatment offered to patients is overly burdensome (Dickenson, 2000).

In contrast, Lynoe and Rydval (2008) found that the general public are less in favour of the withdrawal of treatment and it therefore appears that a consensus is not reached between physicians and the public. It is interesting to speculate whether this reflects the ethical training that doctors undertake, or whether the general public and physicians have a different understanding of the duty of a doctor. Alternatively, it may suggest that the public have higher expectations of what the healthcare system can achieve.

Table 1. Arguments for the withdrawal of treatment

Argument	Explanation
The omission will relieve the patient of his or her suffering.	Some patients have a medical condition for which there is no relief, and they may therefore suffer whilst awaiting natural death.
Hospital resources may become free for those who are able to be treated.	Hospital resources used by those who wish to have treatment withdrawn may cost a large amount. For example, the cost of an intensive care bed is estimated at £1500 per day (BBC News, 2010).

Table 2. Arguments against the withdrawal of treatment

Argument	Explanation
Much of the opposition towards this issue is based on the ‘slippery slope’ argument.	The ‘slippery slope’ argument views decisions as the potential beginning of a trend; the fear is that <i>voluntary</i> passive euthanasia could lead to <i>involuntary</i> passive euthanasia becoming a common occurrence.
There is no definitive way to measure whether a patient’s treatment is futile, or to predict when death will occur.	For example, after Prof. Pullicino took 71 year-old Francisci off the dying pathway (who had treatment withdrawn by weekend doctors days beforehand), Francisci lived for another fourteen months (Donnelly, 2013).
Allowing a patient to die through starvation may cause more harm than if they were administered medication to cause instant death, known as ‘active euthanasia’ (Rachels, 1997).	Death through the withdrawal of ANH, for example, can take up to two weeks to occur (WebMD, 2013).
Other terminally ill patients may feel obliged to have their treatment withdrawn.	If a patient believes they have become a ‘burden’ they may feel pressured to have their treatment withdrawn.
Healthcare professionals may feel uncomfortable with the idea of the withdrawal of treatment.	Some healthcare professionals may not want to be held accountable for the deliberate death of a patient.
The withdrawal of treatment may be used for immoral reasons: When a patient lacks the mental capacity to decide about their healthcare, it must be questioned whether his or her family have the ‘correct intentions’ if advising a physician about what the patient would want.	For example, the patient’s relatives may need inheritance money that would follow after the patient’s death, and they could therefore disregard the patient’s best interests. For some patients this could be avoided by determining the patient’s wishes in advance, but for many this is not possible.
The withdrawal of treatment may be used for immoral reasons: Treatment could be withdrawn <i>purely</i> to generate hospital resources that are in such great demand. Incidentally, if this truly is a desired result, one may propose that this provides a reason for <i>voluntary</i> active euthanasia to be legalised.	Many figures highlight the lack of resources in the UK. For example, there may be just 3.5 intensive care beds per 100,000 people in the UK (BBC News, 2010). Moreover, in the time that it has taken to write this sentence, the estimated net population growth for one day has increased from 122,345, to 122,404, implicating the difficulties that exist for healthcare providers (Worldometers, 2013).

Arguments for and against the withdrawal of treatment

The withdrawal of treatment is undoubtedly a complex issue. To demonstrate this, it is important to explore the arguments for and against the withdrawal of treatment.

A number of the points listed in opposition to the withdrawal of treatment were recently used against the Liverpool Care Pathway (LPC). This system was originally implemented in the late 1990s to allow terminally ill cancer patients to die with dignity and in as little distress as possible. Since then, the LCP had been extended to allow the withdrawal of treatment for all dying patients. By many, the pathway was widely accepted as good practice for end-of-life care; however it became controversial due to multiple allegations about its use. An investigation found that the Cambridge University Hospitals NHS Foundation Trust was 'in line for a one million-pound bonus from the Government for promoting end-of-life care, including the LCP'. Once more, in a national dying audit, it was reported that not even two thirds of patients had their care plan discussed with relatives or carers (Sturdy, 2013). In July 2013 an independent review recommended the LCP be phased out in England within the next six to twelve months (Department of Health, 2013).

The withdrawal of treatment leads one to ask a number of ethical questions;

- Who should decide whether the withdrawal of treatment is ethical?
- Should a doctor's duty always be to preserve life?

The Hippocratic Oath was written to guide ethical decisions such as these. The Oath embodies the duties and obligations of doctors and includes the promises to "...do no harm..." and to "...keep secret..." whatever is seen or heard in the lives of the physician's patients (Rampe, 2009). Although written over 2400 years ago (and therefore thought of as irrelevant by many in the modern medical world) some view a newly modified version of the Hippocratic Oath as critical in guiding the ethical code for physicians. Despite this, the Oath fails to specifically address the issue of the withdrawal of treatment.

Inspired by the Hippocratic Oath, the WMA Geneva Declaration is both current and internationally acceptable; but again, this does not directly address the withdrawal of treatment. A quote from

the text which states to "...maintain the utmost respect for human life" is ambiguous and leads the topic open to interpretation (Rampe, 2009). Furthermore, the Good Medical Practice guide, that sets principles to which a UK doctor must abide, is also ambiguous regarding the ethics of end-of-life care. This states the doctor should "take all possible steps to alleviate pain and distress whether or not a cure may be possible" (General Medical Council, 2013); could this constitute the withdrawal of treatment?

Religion and cultural differences further complicate decisions relating to the withdrawal of treatment as the beliefs of major religious groups, such as Christianity (Catholic), Christianity (Protestant), Judaism, Islam and Hinduism, vary considerably when regarding this matter and values even differ within each faith (Ankeny et al, 2005; Firth, 2005; Donovan, 2011). Furthermore most religiously-based arguments become irrelevant in the eyes of a non-believer. For these reasons, this paper suggests that perhaps a traditional ethical framework, such as a consequentialist approach, should be considered when addressing the issue of the withdrawal of treatment.

Applying an ethical approach

Consequentialism is a type of moral theory that guides decisions by the value of their consequences (Jacquette, 2004). The best acknowledged and widely accepted form of consequentialism is utilitarianism. Utilitarianism was advocated by philosopher and jurist, Jeremy Bentham, who is known for his principle "the greatest happiness of the greatest number" (Anderson, 2004). Bentham used the word 'happiness' to refer to maximal pleasure and minimal pain, and believed that happiness could be measured as a matter of quantity. The greatest happiness principle refers to the fact that a person can only be so happy if the people surrounding them are also happy.

John Stuart Mill, an English philosopher, fully accepted Bentham's dedication to the greatest happiness principle; however he was keen to reformulate the utilitarian theory to show that not all pleasures are of equal value. Mill believed in two classes of pleasure: higher and lower (Fieser, 2001). These were used to refer to a patient's intellect and body, respectively. Since Mill, the utilitarian framework has been developed further. For example, Peter Singer, a contemporary

utilitarian, is concerned to maximise the satisfaction of preferences. Instead of defining moral actions as those which maximise pleasure and minimise pain, preference utilitarianism promotes actions that fulfil the interests of those involved.

A classical utilitarian approach may be used to address the issue of the withdrawal of treatment. For this purpose, it shall be assumed that treatment is withdrawn with good intention only.

Case study 1 – Applied withdrawal of treatment

In the case of Tony Bland, if the physician was to have followed a utilitarian approach, he would have concluded that the withdrawal of treatment is morally acceptable. For a patient who is no longer capable of intellectual pursuits (pleasure), and physically suffers (pain), Mill would state that the withdrawal of treatment to end the patient's life would maximise happiness and minimise pain. Moreover, the family and friends will be spared the pain of watching the patient suffer through a terminal illness, and hospital resources will be free for those with a more treatable condition.

Case study 2 – Voluntary withdrawal of treatment

In the case of *voluntary* withdrawal of treatment, the traditional utilitarian justifications that would exist against killing do not apply. As Singer p77 (2011) states, the hedonistic utilitarian would defend a prohibition on killing as this will increase the happiness of people who would otherwise worry about being killed. However, providing that it is practiced lawfully, the withdrawal of treatment is only performed for patients who wish for their life to be ended. In his own words, "...if we do not wish to be killed, we simply do not consent" (Singer, 2011). Consequently, patients need not live in the fear that their lives could be taken from them. Singer, a preference utilitarian, would also favour voluntary passive euthanasia and may claim that a patient's desire to die is a reason for allowing the withdrawal of treatment.

There are many advantages of following a utilitarian approach when addressing a complex issue such as the withdrawal of treatment. The framework avoids appeal to divine revelation and therefore many use this ethical system in order to live a moral life apart from religion (Rae, 2000). In addition, some already use a form of a consequentialist framework in everyday

decision making procedures. Therefore, making moral decisions using a utilitarian approach appears just a natural extension of using a similar method to help make non-moral decisions.

Despite this, there are also many criticisms of the framework. Firstly, it cannot be dismissed that the utilitarian approach requires one to make a decision based on the outcomes of an action, and it is never possible to understand the complete set of consequences that an action may produce (Slowther et al, 2004). In the case of the withdrawal of treatment, one would expect the outcomes to be the dignified death of a patient and the freeing up of hospital resources. But what if the withdrawal of treatment inflicted considerable, unexpected suffering on the patient? And what if the patient (in a conscious and sane state) would not have wanted his or her treatment withdrawn, yet was unable to express this? Furthermore, what if a lifesaving drug was developed several months after the patient's life had been terminated? Since it is not possible to know what is going to happen in the future, it may be wrong to base ethical decisions on this.

However, a utilitarian would argue that this is not a reason for dismissing the withdrawal of treatment. Instead, a utilitarian would acknowledge that one is not able to predict the future with certainty, and therefore should follow the path that is believed to most likely bring about the best consequences. Although it is possible that a cure could be developed within the few months after a terminally ill patient's death, this cure would probably not be available for distribution for many years. Consequently, a utilitarian would state that the considerable pain a patient would suffer during these months would far outweigh the pleasure of the few individuals who may benefit from such unexpected treatments.

Secondly, the approach appears to have no room for special moral obligations to one's family and friends (Montgomery, 2000). For example, if the son and daughter of a terminally ill patient were opposed to the idea of the withdrawal of treatment, yet the patient wished for the omission, then a utilitarian would argue that the greatest happiness would come from allowing the withdrawal of treatment as this would benefit not only the patient, but the rest of society. The son and daughter in this situation would have their wishes ignored. Using this framework, the motives or character of the de-

cision maker is also irrelevant.

Bentham calls for one to assign values to various pleasures and pains; yet it is not possible to know the level of pain or pleasure that could be inflicted due to a decision (Yeo & Moorhouse, 1996). Measuring the values of certain benefits and harms is not simple. How must one go about assigning value to a life? And how would one compare the value of hospital resources to the value of human dignity? Utilitarianism appears to reduce morality to simple maths; this seems wrong when regarding such an ethically complex issue.

Furthermore, it could be argued that one does not have the time to ponder over complex ethical approaches in this way (Fieser, 2001). However, a contemporary utilitarian would state that if the problem has been faced many times before and has always led to the same conclusion, then one may forgo the calculus and act immediately. To continue, not everyone may agree on the decision that would lead to the greatest happiness for the greatest number. Fortunately, in the UK, although the physician has the responsibility of withdrawing treatment, the views of relatives and other health professionals are taken into account to ensure that a well-informed decision is made (Bewley, 2000).

In addition, the utilitarian views all happiness as equally good, regardless of who receives it. Therefore making a 'bad' individual happy, for the utilitarian, is just as important as making a 'good' person happy. Lastly, every human has a different definition of happiness and we all have different preferences (Maris & Jacobs, 2011). Preference utilitarianism is often criticised on the grounds that some preferences may be misinformed or fanatical; a patient could 'prefer' to die simply because they are clinically depressed.

Hence, a utilitarian ethical approach may be used to address the issue of the withdrawal of treatment, but the multiple criticisms of this framework appear to render it impractical in everyday life. Alternatively, a non-consequentialist approach may be applied; briefly, deontological (duty-based) ethics shall be considered. Immanuel Kant is well known for his theory of duty-based ethics (Christians & Merrill, 2009). Kant believed that motive is the key to morality and subscribed to the fact that the Categorical Imperative, good will, and duty are the foundations for moral actions.

Kant's Categorical Imperative teaches

that to be moral, one must act in such a way that they would be willing for those actions to become a universal law (Socio, 2012). In the case of Bland, a Kantian ethicist would state that the physician must only withdraw treatment from a patient if he or she is willing for this to become a universal law, so that the withdrawal of treatment may be performed for all patients in a PVS. The physician under Kantian law must feel that the omission is the right thing to do out of rational duty. However, this approach is again not without its weaknesses; for example, it requires the deontologist to understand the duty of a doctor, and this is a matter which is frequently debated.

Discussion

When evaluating a medical issue it appears that traditional ethical frameworks, such as classical utilitarianism, may arrive at the most moral decision, yet their criticisms seem to render them impractical. For instance, the utilitarian approach requires one to make a decision based on the outcomes of an action, yet it is never possible to understand the complete set of consequences that an action may produce. Moreover, when addressing ethically challenging dilemmas, it seems that more questions materialise in comparison to answers. If, for example, one were to enquire whether a doctor's duty is to prolong life, Singer (2012) may state that the role is to do whatever is in the patient's best interests (Singer, 2012). However in answering the question, it has provided a new set of queries; what are a patient's 'best interests'? And who defines these?

In addition to those highlighted above, this article has generated a number of important questions that require further attention:

- Can we ever accurately define medical treatment as futile? At this point, are we stating that life is futile? Perhaps an alternative term such as 'inadvisable' could be used to define the status of treatment as this is easier to apply.
- Who has the rights to our bodies? A doctor? The government?
- Is it fair for some to be allowed to die when others (despite an equally poor quality of life) are made to live because they require *active* euthanasia rather than the withdrawal of treatment?
- Who should decide whether the withdrawal of treatment is ethical for a patient without mental capacity? Will the

family or friends of a patient always act in the patient's best interests? Perhaps there should be an impartial panel, similar to a jury?

• Do ethical frameworks actually help in real life?

These questions have been asked many times before, yet (as we find with many ethical issues, such as abortion and active euthanasia) the multiple arguments for and against each topic make it difficult to arrive at a definitive conclusion, and the topic remains very much open for discussion. The issue of the withdrawal of treatment is evidently as complex as ever.

Conclusion

In defying death, modern medicine has generated a vast number of ethically sensitive issues.

This paper has addressed the benefits and disadvantages of withdrawing treatment, and in doing so, has established that it is a controversial issue. Through asking ethical questions we only emphasise its complexity. An understanding of contrasting perspectives also appears to complicate the matter more. Yet if an ethical approach is applied, this does not seem to alleviate the problem. To conclude, whilst a traditional ethical framework may be applied to the issue of the withdrawal of treatment, criticisms accentuate its impracticality and irrelevance in the twenty-first century.

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