

## Conflicts in Resuscitation: Ethical Dilemmas

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Much work in philosophy is concerned with logical reasoning, and much else with mysterious metaphysical things which might make you agree with Sir Isaiah Berlin, who once said "Philosophers are adults who persist in asking childish questions".<sup>1</sup> Unsurprisingly, there are those who think that asking a moral philosopher to deal with practical ethical questions is rather like asking a psychoanalyst to perform brain surgery: he is completely inappropriate for the task.

Commonly, there are two presuppositions of the view that moral theorising has nothing to say about practical matters: one is that moral theorising is mere theory and is supposed to leave everything as it is, and is therefore of purely formal interest, so that there are no practical implications whatsoever; and the other is that moral theorising does have practical implications, but moral theorists squabble so much that they would produce far too many answers to practical questions, all of them different.

I would not be here if I took either of those views. While it is true that there are many inconsistent approaches to what moral philosophy is, and understanding it all is often rather as Lewis Carroll put it in *Alice through the Looking-Glass*: trying to believe "six impossible things before breakfast",<sup>2</sup> there is one central concern which both the practical and theoretical sides of morality share: that of justification. The essence of an ethical dilemma is that we do not know which side to choose, for neither side is self-evidently the only right choice. In the case of a difficult decision, the right choice will be a justified choice, and the better choice the more justified choice. The study of justification is a traditional philosophical study. We need to understand the kinds of reasons which will justify our choices.

If you want to know what "justification" is you should ask what a "good" justification is. There are two ways of justifying things well. However,

describing these two ways is not straightforward, because many people find the concept of "justification" difficult, and then find the idea of splitting it up into two further kinds even more difficult. I shall therefore begin with an easier idea, the idea of explanation. There are two ways of explaining things well, just as there are two ways of justifying things well. One way of understanding a good explanation is to understand it as removing puzzlement on the part of those hearing it. If the explanation removes such puzzlement, then it is a success. If it does not, and such misunderstanding continues, then the explanation is a failure. We often expect schoolteachers to be good at explaining things in this way.

By contrast, the physical sciences try to explain the way the world works, and we ordinarily think that what makes a scientific explanation a good one is that it gives the true causes of things, or something of the kind. On the other hand, if the explanation says something scientifically false, then it is a bad explanation. But the kind of explanation which gives the true causes of things is in principle very different from the kind of explanation which successfully removes puzzlement. The kind of explanation which successfully removes puzzlement may very well not give the true causes of things, while our best explanations of the way the world works may be impossible for most people to understand. (Indeed, it may be that the correct explanation of the way the world works is impossible for anybody to understand.) It would be intellectually very satisfying if human understanding and objective truth went naturally together, but they are nevertheless different in principle. There are two kinds of explanation. One kind of explanation is

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measured against the existing understanding of people. The other kind of explanation is measured against the way the world is. One kind of explanation is measured by a subjective test. The other is measured by an objective test.

The distinction I have drawn between two kinds of explanation works also for the two kinds of justification. Justification of our moral choices in ethical dilemmas could be measured against either subjective or objective tests. Moral philosophers have spent the best part of three thousand years trying to find objective tests for justification. It would be marvellous if a kind of moral "reality" could be found, a certainty against which we could test our moral beliefs. Philosophers have not succeeded. In consequence, what counts as a good reason for a moral choice has a very great deal to do with what satisfies other people as a good reason. It is this which makes the understanding of law central to the understanding of practical ethical decisions, for in our tradition law commonly represents the outcome of much accepted moral reasoning.

The theory of law involves as many squabbles as other branches of philosophy. There are those who think that law is merely what Parliament commands, and that it is essentially an exercise in force. From this point of view, it is historical luck if our laws overlap significantly with the demands of morality. However, you have to obey it whether it does or not. On this approach, you in medical practice have to comply with the law because the authorities will get you if you don't. And there is no doubt that law at some times and in some countries can make demands backed by force which are very far from what morality would require or permit. Yet we are fortunate in our traditions that law is not merely that which is laid down in some arbitrary way. There are multiple sources of the law, and the reality of its application lies in the courtroom, where a determination is made of the rights and wrongs of particular cases. The highest courts do not mechanically pass on Parliamentary legislation, but draw on traditional conceptions of right and wrong, principles of justice, other decisions in similar cases and the like, all woven together in a reasoned justification of what is required in the particular case. In our tradition, legal decisions are essentially justified decisions. That our legal tradition at its heart involves reasoned justification is one of the central grounds for seeing it as essentially a moral enterprise. While there are no doubt many areas

where the law's demands do not always accord with everyone's conceptions of what would be the morally right outcome, a procedure which essentially embodies a reasoned justification for the outcome is in itself a moral procedure, and the outcome is morally justifiable precisely because it is the outcome of a moral procedure.

This is one lesson we can draw from the shared world of both judicial decisions and moral decisions: that determining the answer to an ethical dilemma is a matter of reasoned justification. We are fortunate that, in the case of many dilemmas in medical ethics, some fine judicial minds have been applied to the required reasoning. That reasoning includes recognising relevant Parliamentary legislation as authoritative, and I shall not consider (this evening) arguments for changes in legislation. I take the moral dilemmas we face in practice to be those which arise within the framework of current law, in situations where clearly established law does not tell us what to do. Both medical practitioners and judges can find themselves having to determine what ought to be done in the light of such uncertainty.

Who ought to decide these matters? A doctor should not try to second-guess what a judge might determine about an ethical dilemma, particularly if the courts have made clear that it is their place to make a decision in certain types of case. What the doctor should do – where the decision is his to make – is adopt the right procedure. This is in effect to ape ideal judicial reasoning by being able to provide justification when called upon, justification which displays a reasoned consideration of the relevant principles. Adopting a reasoned course of justification still leaves room for different people to make different decisions about the same case, but whatever their decision is it may still be justified. It should not be thought that justifiably choosing one horn of a dilemma always means that the other choice would have been unjustified. There is often, in both morality and law, more than one right answer, both justified, and neither more justified than the other. What often matters is merely the making of a decision, rather than what that decision is, although this does not mean that any decision will do.

In the complex moral areas concerning resuscitation of dying and incompetent patients much of the relevant reasoning appears in what is

familiarly known as the Bland case.<sup>3</sup> Anthony Bland was a victim of the Hillsborough football stadium disaster, which left him in a persistent vegetative state, a state in which the cortex of the brain loses all function and activity. With an empty mind and no possible hope of recovery, Bland was kept alive by being artificially fed, and given close nursing and medical care as appropriate to cure or prevent various infections. The family, the consultant concerned and independent doctors all backed the relevant Hospital Trust in asking for a declaration by the courts that they might lawfully discontinue all life-sustaining and medical treatment and artificial nutrition and hydration.

Why go to the courts with this at all? Notice that the doctors did not go to the courts in the first place asking that they might lawfully begin and continue with appropriate treatment and artificial feeding. Yet at first sight they might well have done so. This is because both the treatment and the artificial feeding were – as they would standardly be in such a case – of an invasive kind, and it is a familiar feature of both law and morality that one is not entitled to interfere with the body of another without their consent. Otherwise it is an assault. Doctors know that consent standardly has to be sought. Yet in the case of an incompetent patient such as Bland it was plain that consent would not be forthcoming. In such cases various principles of substituted choice may be morally defensible, but in British law doctors are under an obligation to act *only* in accordance with the patient's best interests.<sup>4</sup>

The notion of "best interests" is fertile ground for moral dilemmas. To begin with, the obligation to act only in accordance with the patient's best interests is ambiguous. It might mean that a doctor must act whether he likes it or not, but only in so far as it is in the patient's best interests; or it might mean that a doctor may or may not act as he chooses, but if he does then it must be in the patient's best interests. The principle of the sanctity of life drives the matter here, but in the *Bland* case Lord Keith remarked that the principle of the sanctity of life is not an absolute one. He said, "It does not compel a medical practitioner on pain of criminal sanctions to treat a patient, who will die if he does not, contrary to the express wishes of the patient".<sup>5</sup> In addition to refusal of consent, there are other grounds for defeating the principle of the sanctity of life, such as killing in self-defence. So the principle of the

sanctity of life can be defeated, but it stands if it is not defeated, and it is plain that, if it is not defeated (by a patient refusing consent, for example), it directs doctors to act in the patient's best interests where they are able to do so. One would not therefore need the court's explicit permission to act in a patient's best interests, since that permission is in effect already given in terms of the legal principle of the sanctity of life. Yet note that this is only permission to do that which is in the patient's best interests. If it was not in Bland's best interests to be artificially fed and treated then the doctors doing so were not justified. So it is not the case that a doctor needs legal permission to stop treating the PVS case but does not need it to start; on the contrary, legal permission is required both to start and to stop. The legal permission to start already exists in the principle of the sanctity of life. That legal permission lapses when the treatment is no longer in the patient's best interests. One goes to court, in such circumstances, for an explicit direction as to what is and what is not in the patient's best interests.

But why go to court about this? It is sometimes wrongly thought that it is for medical practitioners to determine, in such cases, what is in a patient's best interests. Thus Lord Justice Neill in a different case referred to "that which the general body of medical opinion in the particular specialty would consider to be in the best interests of the patient in order to maintain the health and secure the well-being of the patient".<sup>6</sup> Here the words "best interests" are not well-chosen. In ordinary parlance "best interests" marks a superlative, an ultimate good; it would normally be taken to refer to the end, goal or final purpose of some course of action. At the extreme it is life itself which is the highest aim in medical care. All this is misleading. It is plain from Lord Justice Neill's remarks, examined carefully, that "best interests" refers, not to the end, but to the means towards the end. For Neill, the "means" is the medical determination of "best interests" towards an "end"; the "end" is "health and well-being". It follows that, while "best interests" is to be determined by the general body of medical opinion, this is only in so far as "best interests" is a means, not an end. Lord Mustill in *Bland* put it differently: "best interests" refers both to the medical determination of the means and also to the ethical determination of the end. It is an ethical and legal matter that, for example, a long

healthy life is in the patient's best interests, but a medical matter how that goal is to be achieved. With regard to the ethical matter, Lord Mustill said, "there is no reason in logic why on such a decision the opinions of doctors should be decisive". Doctors are concerned with means, not ends. In the *Bland* case, the problem was not the medical one of the best means to be adopted, for so far as was known all that could be medically done for Bland was apparently being done, without any disagreement of substance. The doctors were under a duty to act in Bland's best interests, but faced an ethical and legal problem whether the outcome for Bland of the best medical attention was in fact in Bland's best interests. The problem was the end, not the means.

The determination of what is in Bland's best interests is in principle a completely different matter from any criminal considerations which might arise. One can imagine a legal system in which doctors were never liable for any criminal sanction for actions undertaken in the course of their work. In such a system the problem of what was in Bland's best interests would still arise. "Best interests" in some cases might not be a life-threatening issue at all. But when the hospital in *Bland* asked for a determination that it would be "lawful" to withdraw life-sustaining treatment they were not asking directly what was in Bland's best interests but asking what they could do without committing a crime, and the courts argued much of the material on the basis of this quite distinct question.

It is plain enough, legally and morally, that doctors are not allowed deliberately to kill people. Legally the crime of murder standardly involves two elements: what is called the "actus reus", or evil act which brings about death, and the "mens rea", which is the evil intention so to do. If the doctors in *Bland* deliberately acted so as to bring about Bland's death then they would be guilty of murder, and this has nothing whatever to do with the question whether Bland's best interests would be served by dying. But what if the doctors deliberately withdraw artificial life support measures? Is this an act which causes death, or is it an omission which allows death to be caused naturally?

In his judgement in *Bland*, Lord Browne-Wilkinson referred to Professor Glanville Williams's *Textbook of Criminal Law* as support for his view that withdrawing life support is an

omission. Williams explains the difference between an act and an omission: "A crime [he said] can be committed by omission, but there can be no omission in law in the absence of a duty to act. The reason is obvious. If there is an act, someone acts; but if there is an omission, everyone (in a sense) omits".<sup>8</sup> If this is right, the difference between an act and an omission is much easier to make than many philosophers have thought. If there is an act, then it will be the act of a particular person who in ordinary circumstances can be readily identified. But if there is an omission, it will not be the omission of a particular person unless it is possible to identify the person who had the duty to act. So if everybody in the world (apart from the doctors) had omitted to treat Bland intending that he should die naturally, and he did, then nobody has committed murder, for while the mens rea existed on the part of all these people there would have been no actus reus. But what happens if the doctors deliberately withdraw life support knowing that this will be followed by Bland's death? Only if they have a duty to act and do not do so, only then do we have a situation where we can identify the source of the omission. A crime can be committed by omission; is this one of those cases?

In the *Bland* case, if the withdrawal of artificial life support is an act, then this act, together with the undoubted knowledge that this would bring about Bland's death, is one of murder. There is both actus reus and mens rea. If, on the other hand, the course of events constituted an omission, then this course would still amount to murder, but only if those involved were under a duty to ensure as best they could that Bland did not die. If those involved were not under a duty to ensure as best they could that Bland did not die then we cannot identify anyone or any action as being at fault. There is then no actus reus and no murder is involved.

Lords Browne-Wilkinson and Goff<sup>9</sup> made it clear that removing the nasogastric tube necessary for feeding was not an act but an omission. This, however, does not solve the problem since the doctors concerned may have been under a duty to ensure as best they could that Bland did not die, and if that were so then the acts/omissions distinction will not help them. This point was made clear by Lord Mustill.<sup>10</sup> The question is then, were the doctors under a duty to ensure as best they could that Bland did not die? They were certainly under a duty of "care", but this, as we

have seen, requires only that doctors act in the “best interests” of the incompetent patient. The question comes down logically to this: Is it in the best interests of Bland that he be prevented by the doctors from dying? This question is quite different from asking whether it is in the best interests of Bland that he die. This is not a case where the doctors need to argue that Bland would be better off dead; it is merely a case where they need to argue only that Bland would be no worse off dead.

To provide a succinct summary of the argument, the position is that Bland’s PVS condition is such that he has nothing left to lose. He would be no worse off dead, even if he would be no better off dead. It is not in his best interests that he be kept alive because he does not benefit from it. The doctors’ duty of care is restricted to Bland’s best interests. Therefore they are not justified in continuing with the invasive life support system. Therefore since it is unjustified they have a duty to withdraw it.

All these arguments depend on Bland having nothing left to lose. I described Bland as having an empty mind, but how true is that? Bland’s brain was, as one judge summarised it, a “mass of watery fluid”.<sup>11</sup> It may be thought that a clear relationship between mind and brain is assumed in the legal decision: that with no brain there is no mind. Is this assumption right?

We must accept that we know very little about consciousness and the nature of mind. Whatever beliefs we may have about the issue, there is no demonstrably certain knowledge whether consciousness or mind can exist independently of physical existents like the brain. I think our best understanding is probably that conscious experience as we know it, which is consciousness of the physical world around us, depends on having the physical brain and sense organs that are familiar to us. But while this may be wrong, it need not be a moral concern. For if conscious life can exist independently of the physical body, then it need not worry us if we are unable or unwilling to preserve or prolong the life of the physical body. If, on the other hand, consciousness cannot exist independently of the physical body, then if the physical matters on which consciousness depends, like the brain, have already dissolved, we are already too late. Given his physical state, nothing we could do for Bland could possibly affect his conscious state. The

upshot is that the *Bland* case is easier than it might be.

I don’t think I have asked any childish questions yet and thus have not lived up to Berlin’s standards for a philosopher. To make up for this, I will conclude with a brief speculation about some of these mysterious things. I have said that we do not understand consciousness. We do not have the right explanatory language which will make mind fit in with the other things which we think we do understand, such as those which the natural sciences cover. Like the scientists who thought that atoms were like billiard balls and that heat was a fluid, like the cognitive theorists who think that the mind is a computer, we think about the mind in terms of metaphors. We have given up some metaphors in our understanding of mind, such as Descartes’ mental substance, but we still use the metaphor of a “point of view”. Much of our imagining in the case of PVS patients and others similarly placed consists in trying ineffectually to see things from their point of view.

Computers exist for engineering design: one may design a car, for example, and plan the top, front, rear and side views. Enter such plans in the computer, with specified dimensions and parameters, and the computer can then present on its monitor a three-dimensional image of the car. This image may then be rotated so as to present the car’s appearance from different points of view. The computer may fail in some way, and leave one looking at the offside rear of the car instead of from some other desired perspective.

It is plainly a mere contingency that I cannot, like such a computer, move my point of view around the three-dimensional world which I inhabit. Granted that, my eyes being where they are, a certain position is (so far as I know) “causally” natural and no doubt useful, still the world which I see is underdetermined by my immediate experiences and necessarily involves some imaginative input on my part. Like the designer’s computer which shows the car from different standpoints, only some technicality stops me from being able to move my point of view, given the information which my brain currently has, from its present location behind my eyes to the opposite side of the room, or even as if it were positioned in your body which just happens to be in my perceptual range. It is true that I lack experiential information about what is, from my present point

of view, the far side of objects, but I would supply the deficiency in an automatic way on the basis of memory (as I do now in many situations), and the results would at worst be no more odd than some of the results of split-brain operations. Illness, like the computer failure, might leave one with an unexpected point of view, and this may explain that reported phenomenon of people “leaving their bodies” when close to death. If I moved my point of view, then I could operate my body apparently from a distance. Maybe evolution could give us these skills. I leave you to imagine just how different our understanding of the relationship between mind and brain would become if these serious possibilities came into being. Perhaps they will.<sup>12</sup>

## REFERENCES

1. Quoted in *The Philosopher Magazine*, Preview Edition, February 1997, p. 6.
2. *Through the Looking-Glass*, Lewis Carroll, Chap. 5.
3. *Airedale NHS Trust v Bland* [1993] 1 All E R 821, (1993) 12 BMLR 64 (HL).
4. See Chapter 4 of *Medical Law: Text with Materials*, 2nd edn., I Kennedy and A Grubb, London: Butterworths, 1994, particularly pp. 282ff.
5. I Kennedy and A Grubb, *Medical Law: Text with Materials*, 2nd edn. London: Butterworths, 1994, p.1199.
6. Re F, I Kennedy and A Grubb, *Medical Law: Text with Materials*, 2nd edn. London: Butterworths, 1994, p. 322.
7. I Kennedy and A Grubb, *Medical Law: Text with Materials*, 2nd edn. London: Butterworths, 1994, p. 1227.
8. 2nd edn, at pp. 148-9, as reproduced in I Kennedy and A Grubb, *Medical Law: Text with Materials*, 2nd edn. London: Butterworths, 1994, p. 1208.
9. I Kennedy and A Grubb, *Medical Law: Text with Materials*, 2nd edn. London: Butterworths, 1994, p. 1209-1210.
10. I Kennedy and A Grubb, *Medical Law: Text with Materials*, 2nd edn. London: Butterworths, 1994, p.1210.
11. Lord Keith, in I Kennedy and A Grubb, *Medical Law: Text with Materials*, 2nd edn. London: Butterworths, 1994, p. 1224.
12. The outline of some of the implications of the metaphor “point of view” which appears in the last two paragraphs here was first expressed in J L Gorman, “Some Astonishing Things”, *Metaphilosophy* 22, 1991, at p. 35, and is used in other publications in non-medical contexts.