Debate

Selective non-treatment of newborns

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Among those who have defended a policy of selective non-treatment of defective newborns, none have been as forceful or direct in stating and defending their views as have Duff and Campbell. It may therefore be presumed that they have worked out a coherent, plausible policy that answers to the most serious objections of their critics. In my estimation, however, their statements on these issues are notable for the lack of a coherent policy, plausibly justified and able to meet objections. The current article does nothing to remedy these deficiencies and in this response I propose to show why this is the case.

The fundamental weakness in this article comes from the authors’ unwillingness to give us any idea of just when an infant becomes a candidate for non-treatment or merely palliative care. Looking at their section ‘Options for care’ one might guess that this is purely a medical judgement with care being withdrawn only from those infants who are actually dying and only limited treatment offered to those who are unlikely to benefit from more aggressive measures. This interpretation, however does not square with the rest of the paper nor with other published papers of these same authors. Even in this paper we are reminded of lives ‘severely compromised through handicap’ which are a ‘fate worse than death’. Put in other terms the authors seem to claim that there are some lives that are not worth living and that for infants burdened with such handicaps parents should have the right to decide against treatment.

The problem is that are never told just what these handicaps are or what the criteria are that distinguish those infants whose parents should be allowed to discontinue care from those whose parents should not have any such request honoured. Surely the authors do not hold that parents should, for any conceivable reason, be allowed to let their children die, eg should a parent be allowed to starve a normal child to death or let a normal infant die on religious grounds? Nowhere have the authors said that they favour such a massive transformation of our moral convictions and legal constraints as to permit these acts to be done without fear of punishment. Yet until they provide some reasonable criteria for distinguishing the above cases from those they will include in a non-treatment régime, the argument they have advanced logically commits them to respecting parental choice in the above cases.

The authors’ response to this sort of query is that since cases vary so much no such criteria will be possible. This is an interesting claim but it is hardly sufficient. There are several reasons for this. First, there is simply the logical point that if it is true that no one would wish to support the parental activities noted above, then there are some cases in which parental requests should not be honoured. The authors therefore must explain just which cases are so out of line that a parental right to withdraw or not begin therapy should not even be considered.

Secondly, this reliance on parental judgement allows for the worst and most arbitrary factors to be determinative of whether the infant lives or dies. For example, it is a well established fact that parental religiosity correlates highly with a willingness to care for a defective child. Do the authors therefore wish us to adopt a policy that allows the child to live or die simply as a result of the religious convictions of the parents? Such a result is completely at odds with many of our most basic social and legal policies regarding the rights of parents and children as well as the moral convictions that lie behind these policies.

Following directly from the above point we must note that the policy here proposed leads directly to outcomes that will not square with even the most minimal notions of fairness or justice. Suppose, for example, we have two infants with the same medical status and prognosis. If we believe that these infants have a life not worth living then to allow one set of parents to choose non-treatment while another chooses life-saving therapy is hardly even minimally fair to the second infant. If death is really better than life for these infants why should we entertain a parental request to ‘inflict’ continued life on one infant?

The final consideration that should lead our authors to develop the criteria that they have not yet provided is more practical. As the study of Professor Robertson has shown, the activities outlined in the article with respect to non-dying but defective
infants are currently illegal in American law. Given this state of affairs the authors certainly would want to see the law changed. However, one cannot change the law without providing some criteria for distinguishing the cases where non-treatment is possible from those where it is not, unless one wishes to repeal all legal prohibitions against child neglect and abuse.

The above reflections suggest that the authors cannot avoid the central question of what it is that makes a life one that is not worth living. Until they do provide an answer to this question their policy remains unworkable, vague and very implausible.

There is, however, a second crucial issue that the authors have not dealt with, one that may be as serious as the first: why should we adopt this policy just with regard to infants? Surely neonates are not the only human beings with severe developmental abnormalities. In institutions all over the western world there are hundreds of thousands of persons with the very same conditions that the authors suggest justify a decision not to treat. Furthermore, an assessment at birth of the prognosis and life prospects of the child is notoriously uncertain. So too is any judgement about the impact of this child on the family. While these problems are not eliminated they are certainly diminished if we are considering 5–10 year old children, especially those in institutions where the environmental factors can be closely controlled. We surely would have a better view of their lives and potential and the impact on the family. In short, if there is any justification at all for what Duff and Campbell propose for newborns then there is better justification for a similar policy with respect to children at any age.

Yet do these authors wish to propose that if children at an institution contract a potentially fatal illness such as pneumonia they should not be treated in the hope that they will die? Or, if, as is often the case, those with the severest problems begin to choke on their food should the physicians and nurses stand by and watch them die? Frankly, I seriously doubt that they wish to endorse such a serious transformation of our moral attitudes and social policies. But the objection remains. Until the authors can distinguish what they do propose from these cases, the policy that they have suggested logically commits them to support a policy of death, not better care for severely retarded children.

The authors, of course, suggest that many safeguards exist that will protect us from bad decisions, but the only effective safeguard will be a clear, consistent statement of just when and why parents should be allowed to choose death for their children. Vague appeals to ‘suffering’ or ‘burden’ or ‘hardship’ will not do, for parents also suffer with a 10 year old severely retarded child and an adolescent burned out on heroin. As we know, some parents will choose death for any number of questionable reasons. (Jehovah’s Witnesses’ cases are only the cream of a much more bizarre crop from the religious underworld). Until we know, for example, just why parents should not be allowed to choose death over transfusion for a normal child, the statement that there are safeguards will be meaningless.

In sum, the authors must show us what the precise range of cases is, in terms of age and disability, in which they would honour a parental request for non-treatment. Furthermore, they must offer a plausible rationale for such a set of criteria, one that goes beyond vague appeals to ‘suffering’ or family burdens. Without such a development in their argument the policy they wish us to adopt commits us to courses of action in relevantly similar cases that are at odds with the moral convictions of a great many well informed and sensitive physicians and policy makers and much current law and social policy as well.

Frankly, I seriously doubt that an effective answer is to be found to the objections I raise. At least no answer has yet been forthcoming from the many writers who seem to agree with these authors. Some have simply resigned themselves to identifying who should make the decision; others have proposed vague guidelines and criteria, arbitrarily drawn, and logically applicable to a far greater range of cases than those that a given writer wishes to consider for non-treatment. Unless those who favour selective non-treatment for defective infants can develop more precise guidelines and rationales the fundamental weakness of their position will remain: it will commit us to courses of action and to social policies that are at odds with some of the oldest and most basic moral principles in the medical profession—to provide life saving therapy to all of those who need it.

References and notes

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