Debate: 1

Dignity and cost-effectiveness: a rejection of the utilitarian approach to death

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Author's abstract

Utilitarianism is commonly assumed to be the most appropriate sub-structure for medical ethics. This view is challenged. It is suggested that the utilitarian approach to euthanasia works against the patient's individual advantage and is a corrupting influence in the relationship between the physician and society. Dignity for the individual patient is not easily achieved by assessing that person's worth against the yardstick of others' needs and wishes.

'Doctors' ethical judgements in most cases are derived from a utilitarian approach. Doctors are in other words pragmatists. Their judgement of what is best is determined by outcome in terms of good or harm . . . in practice battles over such issues as abortion or euthanasia are almost always fought on utilitarian and not religious grounds. The appeal of each side is to the outcome; the effect upon the patient, the patient's relatives, staff and society as a whole' (1).

This description of what Swales sees as the standard medical approach to ethical problems, though plainly not intended as sufficient for a definition, is a reasonable description of an ethic based on utilitarianism. In the paper referred to, Swales is not chiefly concerned with arguing the case for the establishment of utilitarianism, but others are. Thus Mooney (2) tells us that 'certain institutional alterations in the NHS [National Health Service] are required in order to promote the type of behavioural change which will *make* doctors act in the interest of the common good to a greater extent than is now the case'. Robertson (3), in a paper that appears to confuse a number of disparate value judgements, refers to 'moderation with teeth' when he says that 'Although doctors may need to give an active lead in the concept of dignity in old age it may well transpire that public opinion will dictate that moderation should not be a soft option'.

Key words

Utilitarianism; medical ethics; euthanasia; dignity.

I do not accept Swales's analysis of the state of various ethical controversies. There are other radically different approaches to medical ethical problems. I consider it is the failure to respect the intellectual integrity of other moral approaches and to understand the levels on which these differ fundamentally from the utilitarian approach that generates much of the heat in ethical controversy within the profession, whilst failing to illuminate the issues clearly. I wish in this paper to analyse critically the utilitarian approach to the solution of individual ethical problems within medicine and will refer specifically, though not exclusively, to Robertson's paper (3) *Dealing with the Brain-damaged Old – Dignity before Sanctity*.

The burden of Robertson's argument runs as follows.

Modern medical technology has created the conditions in which people suffering from chronic organic syndromes of various kinds are able to be kept alive to the point at which disorderly and disturbing behaviour resulting from progressive brain failure leads to a loss of personal dignity. This unfortunate situation is exacerbated by what Robertson describes as 'extreme attempts' to preserve life in the face of intervening, potentially life-threatening conditions (for example, pneumonia). As a consequence financial resources are being expended on this group of patients which public opinion, if it was asked, would rather have spent on younger, 'curable' patients. In addition, elderly patients' families are caused unnecessary distress by extreme attempts to maintain the 'sanctity of life'.

Robertson's solution to this dilemma (3) appears to be based upon 'redressing the balance in favour of nature's way. . .'. This would be done by ' "Selective non-treatment" plus or minus suppression of unwanted symptoms' which we are told will 'more accurately mimic natural dying than the active administration of drugs in lethal dosage'. We are told that 'without invoking anything resembling active euthanasia it is possible to perceive in the process of senile brain decay a series of opportunities to allow natural or near natural dying'.

The full implications of this course of action, which I hope to explore below, are to be partially disguised by encouraging people approaching old age to make a

'living will' in which the individual could express his or her desire not to receive active treatment for any life-threatening condition arising after the appearance of any chronic irreversible and progressive illness which might threaten his or her own personal dignity.

I do not necessarily object in principle to the concept of the living will which I do not propose to discuss further here. Though Robertson appears to have intended his article to be about this issue, there are other matters in his paper which give rise to much greater concern.

Robertson's proposal as outlined above, can I believe, be shown to be basically utilitarian in a fairly simple form which would have been easily recognisable to John Stuart Mill or his contemporaries. Thus the basic approach is to be the search for what Mill would have described as 'The greatest happiness of the greatest number'. In Robertson's format this appears as the search for the avenue leading to the least *collective* distress and most *efficient* allocation of resources across the health service after consultation with various 'interested' parties. It is ironic, therefore, that this problem has arisen, according to Robertson, largely because of advances in medical technology. Mill himself tells us, optimistically, that 'most of the great positive evils of the world are in themselves removable. . . Even that most intractable of enemies, disease, may be indefinitely reduced in dimensions by good physical and moral education, and proper control of noxious influences; while the progress of science holds out a promise for the future of still more direct conquests over this detestable foe' (4).

Perhaps therefore, the pursuit of the greatest good for the greatest number is not quite as simple as Mill and Robertson would have us believe. It has, indeed, often been objected of utilitarianism that a) the 'greatest good' cannot easily be demonstrated to be the fount of all moral virtue and an appropriate basis for ethical decisions, and that b) we are not always so blessed with prescience as to know which particular course of action will lead to the best outcome in terms of 'happiness for all'. These are old, but not irrelevant, objections it would appear.

Robertson implies that when faced with a disturbed, demented patient, or one suffering from a potentially life-threatening condition, we should decide our course of action on the basis of a number of factors. These are to include:

- i) The previously expressed wishes of the patient.
- ii) The distress caused to the relatives by the patient's undignified behaviour.
- iii) By implication, the distress caused to other patients, by the same.
- iv) The financial implications for other groups of patients that are the responsibility of the health service.
- v) A desire to promote the patient's 'dignity'.

Presumably we may also add, though Robertson does not do so explicitly, the desire to keep the patient alive if possible.

This, of course, is not a solution to the ethical problem it is merely a restatement of it. Robertson offers us no advice on how much weight to assign to each of the above factors. How much indignity is worth a dialysis machine for somebody else? How much 'persistent shouting or screaming' entitles you to withhold an antibiotic from the screamer or to sedate him to the point where this 'treatment promotes the development of a life-threatening condition' (3)? How many relatives must be distressed and to what degree before one is entitled to promote the death of their undignified grandmother?

This last question may sound emotional. It is in fact a brutal truth. Robertson himself quotes the lucid paper by Harris (5), the thrust of which is that where euthanasia has been decided upon it should be pursued by the most rapid and effective means. As Robertson (3) says 'Euthanasia in any form, for example selective non-treatment, is essentially a deception which prolongs the very event (dying) which is the cause of concern'. I am aware of no argument countervailing this, though Robertson appears to favour 'selective non-treatment' on the grounds that it 'more accurately mimics natural dying'. This is logically a very difficult position for a doctor to hold, particularly one who favours the diversion of financial resources to younger age groups. Dialysis machines can hardly be said to favour the mimicry of 'natural dying'; a concept of evanescent meaning in the setting of modern medicine.

It may be objected that Robertson intended his approach to the 'senile elderly' to be applied only where the patient's wishes had been made known explicitly in terms of a written document. If, however, we are to respect absolutely the autonomy of the patient thus expressed, it is difficult to see why we should pay any attention to some of the other factors listed above, such as financial considerations and distress caused to relatives. Are these factors to be ignored if the unfortunate (? fortunate) patient has not had the foresight to make out a 'living will'? How does one run a ward where such factors influence ethical decisions in some cases but not in others?

It is plain to me that Robertson has confused a number of ethical issues in this paper. There is no compelling logic connecting acceptance of the 'living will' concept and its use to facilitate euthanasia of the brain-damaged elderly. A subsequent paper (6) deals far more explicitly, though without considering the practical implications in any way satisfactorily, with the issue of the living will. Only in the final paragraph of this second paper is the 'need to ration life' allowed to slip in; a statement that can only be understood in the context of the utilitarian approach adopted more obviously in his earlier piece (3).

In my opinion Robertson's paper (3) exemplifies many of the problems associated with the adoption of a utilitarian approach to ethical decisions about individual patients. While Robertson himself, quite logically in this respect, calls for a widening of the ethical debate and the involvement of public opinion in

the setting of standards, others are less charitable. Thus Havard (7) talks of 'the campaign waged by certain moralist groups against the paediatric management of babies born with life-threatening disorders'. If, however, the utilitarian approach is adopted it is difficult to see how one can object to the intervention of any group, since we all have a vested interest in the 'greatest happiness of the greatest number' and we are all served, for good or ill by the National Health Service. Havard's paper is a critical analysis of proposals for legislation to control the circumstances in which a paediatrician may elect to withhold treatment from a severely handicapped child shortly after birth. This proposal followed on the acquittal of Dr Leonard Arthur, a decision obviously supported by Havard. The Arthur case actually turned on its own peculiar set of facts but it is clear that the defence witnesses supported Dr Arthur's behaviour on utilitarian grounds, citing for example, the effect that a baby born with severe irreversible handicap has upon its family (8).

There are further problems, which seem to follow the utilitarian approach as night follows day. When dealing with questions of 'euthanasia' the utilitarian ethic necessarily involves considerations of harm and benefit accruing to individuals other than the patient. In recent literature this has invariably been expressed in terms of 'the family's inability to cope', 'the relatives' distress', 'the financial implications for other patient groups' etc. These are all considerations of harm 'done' to others by permitting the patient to live. That is to say, they are factors militating in favour of the patient's death. Utilitarianism tends in practice, therefore, more than an 'individualistic' ethic, to decisions for death rather than life, when applied to the patient.

Such decisions are taken either by or with the approval of, those who stand to benefit from them. This is potentially an uncomfortable position, to put it mildly. As a result a good deal of deception and pretence is practised. Robertson again (3) deals with this problem honestly; 'the finality of acute active euthanasia would risk provoking complex psychological reactions in doctors, nurses and relatives as the result of assuming the position of executioner or executioner's assistant. It is inherently harsh and dangerous'. It would also be honest. The alternative, as Harris (5) points out is to allow the death which is being sought to proceed in a more lingering fashion than would otherwise be necessary.

In addition, in order to preserve the psychological well-being of relatives and doctors, a false and corrupting moral dichotomy is set up between acts of omission and commission. Thus, 'There is an important distinction between allowing a baby to die and taking an action which will accelerate or cause death. . . The doctor indeed has a duty to order feeding, but if he orders food to be withheld, and he does it with the knowledge and wish of the parents, then that is permissible' (9). As can be shown (10) this

differentiation is usually morally unacceptable and may be legally so as well. Indeed, if one considers Campbell's advice applied by a father to a healthy toddler its moral unacceptability becomes clear to all.

Beyond these immediately relevant considerations of the practical effects of the utilitarian ethic, other, more sinister, possibilities float into view. If it is permissible to terminate the life of an individual, at least in part because of the advantages accruing to others, or the disadvantages which they will thereby avoid, there is no logical point at which this must stop. Anyone whose 'quality of life' (11) is deemed, by whoever considers himself the appropriate authority, to be in negative balance may be in danger the moment his continued existence poses more problems for those around him than would his termination. This no doubt sounds alarmist; which probably reflects the alarm I feel at contemplation of a profession that has casually espoused the ethics of a philosophical system which it appears not to understand any too clearly and the implications of which it will not face.

I believe that a reappraisal of recent trends in medical ethics is well overdue. It is perfectly possible to base an acceptable ethic for the solution of problems with individual patients upon the Hippocratic/ 'individualistic' approach. There is not space to do so here but for such an attempt see 'Euthanasia and Clinical Practice' (10). The utilitarian approach has much validity when it deals with questions of resource allocation between different groups of patients. Such decisions, however, are basically political in nature and I believe that Mooney (2) is quite wrong to confound them with decisions taken by individual doctors about individual patients where they should not regularly have any relevance.

It is plain that a more profound examination of our ethical views is required; one which will allow us to get beyond the use of arresting, but misleading phrases. Robertson's 'death with dignity' (3) has an attractive ring to it, but disguises the fact that its ethical foundation rests on the acceptance of one's own life being counted as a pawn to be measured against another's distress. Whilst the quest for dignity as a death approaches is one which all doctors could share, it is difficult to see how it is to be furthered by accounting the patient's life simply as a bead on the abacus of profit and loss. Dignity does not require that life be relentlessly supported; it does require that it be respected. Dignity has never shown itself to be a cheap alternative.

References

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