

to guide her thought and to know which questions must be answered before she or he can rest comfortably with any moral decision.

Authors' note

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References

- (1) Callahan D. *The teaching of ethics in higher education: a report by the Hastings Center*. Hastings-on Hudson, NY: Institute of Society, Ethics, and Life Sciences, The Hastings Center, 1980.
- (2) Reiser S, Dyck A, Curran W. *Ethics in medicine*. Cambridge, Mass: MIT Press, 1977.
- (3) Brody H. *Ethical decisions in medicine*. Boston, Mass: Little, Brown & Company, 1976: Chapter 2.
- (4) Rynders J, Spiker D, Horrobin M. Underestimating the educability of Down's syndrome children: examination of methodological problems in recent literature. *American journal of mental deficiencies* 1978; 5: 440–448.

Commentary

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This paper gives detailed consideration to two separate ethical approaches to deciding on the management of a newborn baby with Down's syndrome and duodenal atresia: the options considered are curative operation; allowing the baby to die with or without control of distress and actively dispatching it either by quick, slow or painfully slow methods. Logical thinking about each of the main approaches teleological (or utilitarian) and deontological (or moral-duty based) is urged along the steps outlined in Table 1. In the utilitarian analysis the reasoning is supported by numerical ratings of the values to baby, parents and society of the alternative actions which are then multiplied by their probabilities of occurrence to derive a 'utility' score for each of them. These are then added up to give a final set of utility scores (Table 5) first adopting a 'subjective' and then an 'objective' view of what the baby's wishes might or should be. In the deontological analysis the rights and duties of the same three parties are considered without any

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numerical transformation. The authors give no guidance about which their own choice of action would be, they simply urge that their logical processes should be followed, suggesting that these are analogous to the processes by which decisions are taken in clinical diagnosis or treatment or in legal thinking. The ultimate decision, they admit, will depend upon individual value judgements. They propose no way of combining the two analyses nor do they suggest which should be given the greater weight.

This advocacy of logical analysis of ethical quandaries is one which will commend itself to many practitioners in the caring professions. But the basis of and detailed prosecution of their analyses are open to criticism.

i) They pay no attention to the consequences of alternative decisions on the members of the clinical team. For them active euthanasia is ruled out if for no other reason by the risk of a charge of murder as in the recent Arthur case in Derby and of the endless legal disputes that have followed such decisions in the USA. The authors admit that their consideration of the particular example they give is not complete (they ignore, for instance, the diminished life expectancy of a baby with Down's syndrome which will reduce the 'values' of preserving its life). Nor do they consider the alternative of having the baby adopted, after surgery, by foster parents with values quite different from those of the parents in this case.

ii) In the utilitarian analysis the numerical transformations of the three main alternative actions seem both spurious and unnecessary. Even if the crude numbers given to the 'values' and the more securely based probabilities are accepted their combination to produce the utilities have little value for comparison with each other without some estimate of their errors, so that significant differences between them could be determined. The bland statement in relation to Table 5 that the utility figure of 1.29 for surgery is 'greater' than 1.20 for active euthanasia is absurd. Without knowledge of the potential errors of these figures they have no more meaning than a 'simple list of pros and cons' which the authors eventually admit 'will suffice in most cases', (but without saying which sort of cases will benefit from a numerical analysis and why). The dramatic change in the eventual utilities brought about by a change from the 'subjective' to the 'objective' view of the baby's valuation of survival shows how insecure these figures are. They also treat the values of the two parents as one. This is of uncertain validity even if they agree, but what if they disagree?

iii) The authors' claim that their proposed method is akin to that used by doctors and lawyers in reaching their opinions is invalid. I do not think doctors ever give numerical values to the values and probabilities of occurrence of the consequences of alternative diagnostic and therapeutic decisions that they take. If they did they would realise that they should work out some statistical technique to enable them to interpret differences between the numbers.

iv) No explanation is given about how doctors could decide whether passive euthanasia would be rapid or slow. No doctor would permit a slow, painful death for a baby so this alternative is nonsense: it is presumably put in to provide three alternatives for each section of the Table. The objection applies even more strongly to active euthanasia.

v) In their deontological analysis of the problem the authors are concerned with the rights and duties of the child, the parents, and society: given their predilection for numbers it is not clear why they reject numerical ratings here for they are concerned with greater or lesser rights and duties which could be transformed into semi-quantitative scales such as are used by sociologists and psychologists in studies of opinions and moods. Perhaps after all they agree with Wordsworth that 'high Heaven rejects the lore of nicely calculated less or more'. They advance no firm opinion on the rights of a subnormal neonate which, they say, must depend on whether it can be regarded as a 'person'. They conclude only that they 'suspect that most moral reasoners will support the pro-right position'. Nor do they attempt to adjudicate on the conflict of views between those who think that all humans, from the moment of fertilisation to the seventh age 'sans teeth, sans eyes, sans taste, sans everything', have a complete right to life which must be preserved at all costs and those who believe that the quality of life must be taken into account together with the cost in deciding whether to prolong it.

vi) They say that 'at the time of conception' (ie of intercourse?) the parents must have had an expectation of having a retarded child so the parents must now be responsible for rearing it. But at the time of conception they might already have decided that if this happened they would not wish to do so.

vii) The authors present their two ethical approaches to the problem without giving any indication of how they might be combined, nor of how one might be reasoned to be better than the other. Most doctors who do stop to consider the ethics of their decisions before they act, ponder on the moral as well as the practical consequences for harm and benefit of the alternatives which they face. In considering prompt killing of a subnormal neonate (which scores so high in Table 5) they would temper their consideration by wondering if

they had any right or duty to do this. For virtually all of them the moral duty not to kill would outweigh any beneficial consequences of killing. The authors state that 'given the same value judgements and the same factual perception all persons using a single ethical approach 'will reach a similar moral decision'. This is a tenuous supposition; and if both approaches are used and the conclusions differ – what then?

Some readers would have welcomed a more dialectical discussion of these keenly debated conflicts of opinion than the authors' unresolved though interesting presentation of some, but not all viewpoints.

After a doctor's decision to allow a Down's neonate with a tracheo-oesophageal fistula to die in deference to the parents' wishes in April, 1982 in the USA there was nationwide controversy and the United States Department of Health and Human Services issued a letter to hospitals stating that it was unlawful to withhold nutrition, or medical or surgical treatment required to correct a life-threatening condition if such withholding was 'based upon the fact that the infant is handicapped; and the handicap does not render treatment or nutritional sustenance medically contraindicated (1)'. These guidelines have been opposed by paediatricians yet several States are considering juvenile protection acts which will limit doctors' choices (2). If an improved and more effective version of the procedures recommended by the authors were developed perhaps the rights groups might be more willing to accept the decisions of doctors who use them. Certainly if the authors' plea to doctors to think about ethical decisions with the same logical care as they use in reaching their clinical decisions were heeded and if they could persuade members of organisations such as 'Life', who have closed minds on ethical matters, to use critical logic in examining the basis for their prejudices a large step forward would have been taken.

References

- (1) Beauchamp T L, Childress J F. *Principles of biomedical ethics*. Oxford: Oxford University Press, 1983, 2nd edition: 310.
- (2) Duncan G. Squeal rules in the nursery. *British medical journal* 1983; 287; 1204.