Killing and allowing to die in medical practice

Anne Slack (née O'Donnell)  Leeds Social Services, Headingly

Author’s abstract

This paper examines some of the issues related to the distinction between acts and omissions. It discusses the difficulties involved in deciding whether there is any moral significance in this distinction, particularly when it is applied to cases which involve killing or allowing to die. The paper shows how this problem relates to some of the current issues in medical ethics. It examines the issues raised by the widely publicised cases of selective treatment of handicapped children and argues that such decisions are taken and have to be taken in the context of wider ethical theories.

Most people do not consider themselves responsible for evils which they did not actively or intentionally bring about. This attitude is reflected in moral language and in English law, which will not prosecute for failure to help another, for example no one can be prosecuted for failing to throw a lifebelt to a drowning man.

In general, it is held that if a person fails to perform an action which would prevent evil consequences, he is morally less blameworthy than he would be if he performed an action which resulted in the same evil consequences. The moral distinction between acts and omissions does seem to be deeply embedded in our attitudes and seems to correspond to our intuitive responses in many cases. This doctrine has been severely criticised by utilitarian writers. They argue that the distinction is difficult to justify and that its widespread acceptance does have evil consequences.

The principle of utility states that ‘an action is right in so far as it tends to produce the greatest happiness of the greatest number’. This can be interpreted in a variety of ways but in all forms of utilitarianism, it is the consequences of an action which are important. The course of action which produces most good effects and least bad effects is held to be the best action to take and the action which is morally right. All the consequences of an action and all the alternatives including non-action have to be considered.

This approach to ethics contrasts with what might be called a ‘human rights’ approach. Those who believe in human rights assert that human beings have certain rights which should not be violated. These rights have been listed in the United Nations declaration on human rights and have been widely accepted in theory if not always in practice. This approach does not accept that abuses of human rights can be justified by considering overall good consequences.

I will later consider how these two approaches to ethics are employed in making decisions on particular questions in medical practice.

A utilitarian sees each act or omission as morally right or wrong in so far as it brings about an overall balance of good or bad consequences. For the believer in human rights, an omission is wrong only if there is a right to what has been omitted.

In order to consider the acts and omissions doctrine it is useful to look at cases where the distinction is between killing and allowing to die. The problems associated with this distinction frequently arise in the practice of medicine.

A simple example of this occurs in psychiatric practice. How do we respond to a manipulative patient who threatens that if he is not admitted to hospital immediately he will kill himself? If he is refused admission, told that it is his decision whether or not to kill himself and he acts on his word, have we allowed him to die? Are we responsible for his death?

Clearly in this case, being refused admission was a causal factor in the patient’s decision to commit suicide. If the acts and omissions doctrine is not accepted then the problem to be considered is whether the psychiatrist who refused admission is morally responsible for this patient’s death. This problem can also be illustrated by considering how the distinction between killing and allowing to die is used in J J Thompson’s argument in favour of abortion (1). She claims that even if it is conceded that the fetus is a person, abortion could still be justified in some cases. I will use the word child instead of fetus in the discussion of this argument because it is important to think in these terms to understand the argument. Thompson’s argument is based on the idea that by choosing abortion the mother is not killing the child,
but allowing it to die simply by refusing it the use of her body. The child cannot survive outside the womb; by removing him from her body she effectively allows him to die. She argues that the right to life does not include the right to the use of another person's body, even if the person concerned will die without it.

Again what is at issue is what the right to life amounts to. Does it include the right to the means to life whatever these may involve? Does it include certain basics such as nutrition? In the abortion case if it is accepted that the child's right to life includes the right to nutrition, then the mother does have a moral obligation to allow him the use of her body because she is the only person capable of fulfilling the duty which corresponds to the child's right to life.

The problem of what the right to life amounts to also arises in cases where euthanasia is being considered. If there are no limits on the means to life then belief in the right to life would commit us to using all available techniques to maintain life. There are considerable difficulties in deciding how the means to life should be interpreted.

On the other hand the consequences of accepting only a very narrow view of the right to life will be unacceptable to most people if such a view leads to denial of responsibility for those who cannot support themselves. It may however be possible to agree on minimum requirements for inclusion in the right to life. There appears to be fairly widespread agreement on our intuitive responses to cases of omission where what has been withheld is something regarded as a very basic requirement for life. I would suggest that the right to nutrition and an adequately sheltered environment may be an acceptable minimum. This of course enables us to provide satisfactory responses to cases where perhaps children or old people are dying from starvation or neglect but it leaves many questions unanswered in the euthanasia debate. Acceptance of such a minimum does not avoid the philosophical difficulties involved in determining what the 'right to life' should include. However, if it is accepted intuitively by many people it can be used persuasively in discussion of various issues.

The hospices which care for the terminally ill distinguish between killing and allowing to die. Their policy is that they will not kill their patients, but they will allow them to die by withholding treatment, for example by failing to treat pneumonia with antibiotics. An important factor here is consent, the patient would seem to have the right to refuse treatment, but would the doctor have the right to refuse treatment, either because he thinks that the rest of the patient's life will not be worthwhile or because the treatment is expensive and he thinks resources could be better spent?

In failing to administer a treatment which will prolong life, is the doctor failing to carry out a duty which corresponds to the patient's right to life? John Harris, in his book Violence and Responsibility, discusses a very interesting example which brings out the difficulty in establishing whether there is a moral difference between killing and allowing to die (2). He considers two people X and Y. X needs a lung transplant and Y needs a heart transplant. Without these operations both of them will die. They suggest to the doctor that he kill a healthy person B in order to get the organs required for the transplants. They argue that if he fails to do this, then the doctor is responsible for their deaths. They can say that they did not cause their own illnesses and their lives are as important as person B's. They can say that if the doctor's aim is to save lives, he will save more lives by doing as they ask.

An intuitive rejection of such a suggestion seems to rest on the belief that there is a difference between killing and allowing to die. It could perhaps be rejected by an appeal to rights. A narrow view of the right to life would prohibit killing B and could state that X and Y's rights to life do not include the right to kill B. In order to justify saving X and Y the means to life would have to be stretched to include the right to kill someone else. At first it seems possible to exclude this from our interpretation of the means to life but this may lead to the conclusion that killing in self-defence is unjustified. It is difficult to reconcile killing in self-defence with rejection of killing B to save X and Y.

The doctor may try to avoid killing B by saying that he has a right to act according to his conscience to maintain his personal integrity. He does not agree with the killing and they cannot legitimately demand that he does this.

The right to conscientious objection is recognised by those who take a human rights view, but it would not therefore follow that they could avoid accepting that the doctor should kill B. The doctor's right to conscience conflicts with X and Y's right to life if their right to life includes the right to kill someone else when this is necessary for survival.

In particular cases the right to conscientious objection would have very little appeal to utilitarians because they can reasonably ask whether the integrity of one individual can ever be important enough to weigh against the suffering or even the death of others.

In deciding whether allowing to die is morally preferable to killing we must first look at why within each of these two moral theories it is generally believed that killing is wrong. For the utilitarian, killing is wrong to the extent that it reduces happiness or promotes misery. For the advocate of human rights, it is wrong because it violates the right to life. In theory then, this distinction implies that the utilitarian cannot justify killing more often than the upholder of human rights. Belief in the right to life would allow killing only when the right to life conflicted with the rights of others. In practice, however, consideration of possible side-effects would usually lead the utilitarian to the same conclusions as the believer in rights.

Selective treatment

The acts and omissions doctrine plays an important role in distinguishing between killing and allowing to die. The classical contribution to the debate on the right to life is the doctrine of double effect. This can be applied to the example of the doctor who makes a diagnosis of pneumonia. The doctor's intention is to save the patient's life, not to cause her death. If the treatment he gives is a successful treatment of pneumonia, then there are two effects: the patient's life is saved and she dies. The patient's right to life is fulfilled, but she is also dead. The doctor will be acting within his right to life, as he intends to save the patient's life, not to cause her death. The two effects are independent: he has no intention of causing the patient's death, so it is not a case of double effect. But the doctrine also allows for the possibility of the two effects being dependent: the doctor may have intended to save the patient's life, but also intended to cause her death, because he believed that the patient's life would not be worth saving in any case. In such a case, the two effects are dependent, and the doctor cannot claim that he has acted within his right to life.
role in the issue of selective treatment of handicapped babies. I would like to consider three cases which have been publicised in recent years.

The first case is the one in which a Down's syndrome baby girl needed an operation to remove an intestinal blockage (3). The parents refused permission for the operation and the child was a ward of court in order to get permission for the operation to go ahead. In this case could it be said, if the child had not been operated on, that the parents had allowed the child to die? Does the child's right to live include the right to an operation of this type? If we accept that the child has a right to be fed, does she also have the right to an operation which would make feeding possible? It is again a question of what we include in the right to be fed.

Apparently in this case if this had been a normal child the operation would have gone ahead without question. If we are looking at the issue in terms of rights we could also ask if there is a right to equal treatment. If a normal child would have the right to this operation by virtue of his right to life, then the handicapped child would surely have the same right by virtue of his right to life, and failure to operate on the handicapped child would be just as culpable as failure to operate on a normal child.

The distinction which is made to justify non-treatment of the handicapped is that the handicapped do not have worthwhile lives, in comparison to others. The concept of a worthwhile life plays a crucial role in decisions of this type and I will discuss it more fully later.

The second case is that of a spina bifida baby, Louise, whose parents decided that they wanted her to be allowed to die (4). The case was widely reported and the parents were interviewed on television. Louise died after three weeks. The doctor who treated her stated that the cause of death was starvation, dehydration and a urinary infection which was not treated.

The third case I wish to consider is the Dr Arthur case, where a Down's syndrome baby, John Pearson, was rejected by his parents (5). He was prescribed 'nursing care only' and a strong painkilling drug, DF118. The manufacturers of this drug recommend that it is not used on children under four years of age. In overdosage the drug can cause severe respiratory depression. John Pearson died three days after his birth from various causes including bronchial pneumonia.

In all these cases the idea that these children did not have worthwhile lives played an important role in the decisions made regarding their treatment. In the last two cases it was stated that these children had been allowed to die.

I shall return to the issues associated with the idea of allowing to die later, but I will look first at the methods of reasoning used to reach these decisions and compare this with the method of argument employed by those who disagree with this practice.

In order to see the differences between these two approaches, it is useful to look at two articles which were published together in the Nursing Mirror. Both discuss selective treatment of spina bifida babies. One was written by Dr John Lorber (6), the other by Professor R B Zachary (7). The views of these two doctors appear to be representative of the two opposite lines of thought on this issue.

Dr Lorber believes that severely handicapped infants should be allowed to die. This opinion is based on consideration of three main factors. The first is that such a child will not have a worthwhile life. The second is that if such a child lives, he will cause considerable hardship and suffering to his parents and family, especially if they reject him. The third is the cost to society of maintaining such a child. Dr Lorber estimates that by the time a child with spina bifida has left school he will have cost the State some £100,000.

The argument for selection then appears to be utilitarian in character as it is based on consideration of all the consequences of the act or omission.

Dr Zachary, on the other hand, concentrates more on the rights of the handicapped child. He believes that such children should be given as good a chance of survival as any other babies and he disputes the claim that handicapped children's lives are not worthwhile. He writes:

'Just because a child is severely handicapped, this does not mean that his life and that of his family are going to be devoid of happiness. Handicap is not synonymous with unhappiness (8)'.

He also states that he has found people with spina bifida to be happy people who respond well to concern for their welfare.

Both these doctors believe there should be some selection of patients for operation and some for non-operative management. There are two main areas of disagreement.

The first is in the criteria for selection. The second concerns what non-operative management actually entails.

Criteria for selection

Let us first look at the criteria for selection. Dr Zachary lists the categories of patients whom he would regard as not suitable for operation. These are those who will die within a few days whether they are operated on or not; those who have poor chances of healing after the operation and whose prospects may be better without the operation; and those who are unlikely to improve after the operation.

Dr Lorber's list of criteria against active treatment covers a much broader range of patients. He includes gross paralysis of the legs, a severe spinal deformity known as kyphosis and Down's syndrome.

The differences in these lists can be explained partly by the differences in the reasons put forward to justify each approach and partly by differences in opinion about when a life is not worthwhile.
In the arguments in favour of selection, the question of whether or not the child’s life is worthwhile is obviously important, but the effects on the family and the cost are also considered. Arguing within a utilitarian framework, it is possible to decide against treatment even when the child would have a worthwhile life if factors such as the effects on the family and the cost were taken into consideration.

Dr Lorber’s list includes mongolism, which is a condition not generally associated with a life of pain and suffering. It is, however, associated with considerable strain on parents.

Those who accept Dr Lorber’s criteria do seem to regard the wishes of the parents as decisive in many cases. Dr D Garrow, who was the doctor in charge of the spina bifida baby, Louise, stated:

‘If the parents of a spina bifida baby ask me to arrange for operations and all the things that are required to save life, come what may, then I will try to arrange for these things. I will give support and help to the parents, and I have many lovely children who have severe disabilities who are living and I hope are happy, but in spite of the sort of difficulties, in spite of having valves, in spite of having bladder trouble and paralysis, are able to live full and happy lives and these I have supported and continue to support (9).’

The fact that doctors will operate at the parents’ request even if they think it is going to lead to more suffering for the child does seem to suggest that the quality of the child’s future life is a factor in the decision which can be outweighed by other considerations.

This type of reasoning would not be accepted by those who take the human rights approach. If the child would have a worthwhile life then the cost and the burden to the parents would not be accepted as valid reasons against treatment.

It is important to recognise that the arguments employed are based on these wider ethical theories and to take care that we do not accept arguments for or against selective treatment which we would not accept in other contexts.

Worthwhile life? Who decides?

The judgement about whether or not a handicapped child’s life would be worthwhile is crucial in decisions about selective treatment. How is such a decision to be made?

Elizabeth Anscombe answers:

‘The way you make the decision is: see what you’d think of a proposal that you would swap your life for this sort of life. If the idea is horrid, if you’d rather die, then to die is in the best interests of the being you are considering – not a medical decision of course; it is done just by imagining a proposition (10).’

The prediction of future suffering and discomfort associated with particular handicaps is clearly the responsibility of the doctor and is something which his experience equips him to do. However, deciding whether a person who suffers would prefer to be dead is not a clinical decision. We must consider whether such a choice can be made for another person, and if it can, in what circumstances. A difficulty here is that we cannot assume that death is preferable to a life of misery. It is certainly rational to suppose that when life offers only hardship and suffering, death would be the more attractive option. However, many people have led and are living such lives. People do live in conditions which most of us would find intolerable and the suicide rates are nowhere near as high as we could rationally expect. Of course, there could be various explanations for this, but we should bear in mind that when making decisions about important matters in their lives people do not always behave rationally and it is therefore very difficult to decide for someone else that he or she would prefer to be dead.

Dr Lorber, then, would select more babies for non-treatment than Dr Zachary would. This difference in criteria for selection reflects their differing approaches to ethics. Dr Zachary is less inclined to believe that life for the handicapped is not worthwhile. This indicates that there is considerable scope for disagreement in making decisions of this type, even amongst doctors who specialise in this area.

It is difficult to decide whether a handicapped child would be better off dead and it is not at all clear that doctors are better equipped than anyone else to make such decisions.

Selective treatment in practice

I have discussed how the decision on selection is made and how opinions differ on this. However, the way in which the policy of selection is practised is more severely criticised than the method of selection.

Dr Lorber states:

‘The untreated child is treated most humanely by normal nursing care, which includes feeding on demand and the use of mild sedatives to avoid any pain or discomfort. They are not tube fed, are not given oxygen and are not resuscitated. They are not given antibiotics and have no operations of any kind (11).’

Dr Zachary points out that these babies die not as a result of their handicaps, but as a result of their management. He has argued that the case for selection has gained support because people [wrongly] believe that if a handicapped child is not operated on he will die.

He writes:

‘There is a widespread myth that if you operate on a child with spina bifida the child will live, if you do not operate the child will die. This is nonsense. They will
not all die spontaneously. How is it then that those who write about the value of selection can point to a higher mortality, usually 100 per cent in those that they have selected out?...we must look at the exact method of management of those who have no treatment (12).'

In the case of Louise, starvation and dehydration were named as causes of death. The administration of sedatives makes it less likely that the child will demand food. Feeding on demand combined with sedation will eventually lead to starvation and dehydration.

Dr Zachary explains:

'These babies are receiving 60 mg/kg body weight of chloral hydrate not once but four times a day. This is eight times the sedative dose of chloral hydrate recommended in the most recent volume of Nelson's Paediatrics and four times the hypnotic dose, and it is being administered four times every day. No wonder these babies are sleepy and demand no feed, and with this regime most of them will die within a few weeks, many within the first week (12).'

John Harris, in his article on selective treatment (13), argues that this method of selection is not morally preferable to infanticide. He believes that to bring about death by deliberate omission is morally on a par with killing. He writes:

'The only palpable differences demonstrated by Lorber are that non-treatment takes longer to bring about death than would active euthanasia and is minimally less certain to result in death. Both these features seem to count against rather than for selective non-treatment given the reasons which justify its being undertaken at all.'

Even those who do not wish to abandon the doctrine of acts and omissions would find it difficult to argue that not feeding a child is preferable to killing it. If what Dr Lorber describes as 'normal nursing care' was practised on a healthy child it is likely that it would be seen as starving to death rather than 'allowing nature to take its course'. Similarly, if heating was deliberately withheld from an elderly person and this resulted in death from hypothermia, we would hardly say they had simply been allowed to die. This, of course, relates to the question of what the right to life amounts to. If it does include at least nutrition and adequate shelter then these cases are clearly abuses of the right to life.

If utilitarian views are accepted then there are good reasons for selective treatment. There are also good reasons for abandoning the distinctions between acts and omissions. However, those who advocate selective omission are unwilling to accept that this method of allowing to die is morally on a par with infanticide. One explanation for this is that it is more practical to present the practice as allowing to die as many people would not accept infanticide. Widespread support for selection does seem to depend on leading people to believe that it is not a positive step aimed at the death of the child.

Dr Zachary illustrates this:

'At a meeting of doctors, social workers and theologians another paediatrician explained his method of asking the registrar to administer morphine. He claimed that the parents were taken fully into his confidence and were one hundred per cent behind him. When closely questioned he admitted that he did not tell them that the child would receive morphine - merely that the child would die (12).'

John Harris believes this sort of self deception cannot be justified. He writes:

'One might say that there is a moral requirement that in matters of such importance where the lives of others are at stake, we should be absolutely sure that we have faced squarely the full import of what we are doing. Whereas if we disguise the facts from ourselves by various distancing strategies, we may permanently shield ourselves both from full awareness of what we are about and from the possibility of thinking through all the implications of such consequential decisions (14).'

Those who advocate selection do appear to rely on appeals to a significant moral distinction between killing and allowing to die. As the foregoing discussion shows, this distinction is difficult to defend in utilitarian moral theory and few of those who believe in human rights can accept that the practice of selection is morally preferable to infanticide. Only those who interpret the right to life very narrowly could accept such a view. If the right to life includes the right to food, at least for those who are unable to provide for themselves, then the practice of selection clearly violates this right.

It seems that both ethical theories lead us to conclude that selective treatment as it is now practised is morally equivalent to infanticide. The question of whether or not infanticide can ever be justified has still to be considered.

The arguments used to recommend selection could also be applied to infanticide. It may be possible to defend such a practice within a utilitarian system but there would be several difficulties in any attempt to do this. Possible side-effects may weigh against such a policy. It is difficult to decide when, if ever, a life can be deemed not worth living. There are also problems in deciding how the burden on the parents, and the cost to the State can be weighed against the child's life, particularly in cases where it is not clear that the child would be better off dead.

Within the human rights framework, infanticide for those whose lives are worthwhile can never be justified. Unless one accepts a right to be killed it would not be possible to argue in favour of killing children whose lives are not worthwhile, assuming such cases could be
The problems related to the distinction between killing and allowing to die have been considered in the context of medical practice. What a right to the means to life should include was discussed in the context of problems such as suicide threats, abortion and euthanasia and the example of the two men requiring transplants; the latter example illustrated clearly many of the problems in determining whether allowing to die is less culpable than killing.

The last section of this paper compared the views of those who advocate and those who oppose the practice of selective treatment of handicapped children. It argued that the reasons given for this practice were utilitarian in character whilst those who opposed it generally based their arguments on belief in human rights. However, the acceptance of selective treatment did appear to depend on a moral distinction between acts and omissions, a distinction which is rejected within the context of utilitarian ethics. Both ethical views then led to the conclusion that selective treatment was morally equivalent to infanticide.

I conclude then that although the utilitarian can argue persuasively that the acts and omissions doctrine should be abandoned, especially in cases where we consider failure to save life, it is much more difficult to accept this in cases where it is argued that we should kill to save life, as in Harris's example of the two men who required transplants.

It may be that the move to abandon this doctrine stems from dissatisfaction with a human-rights-based moral theory which tends to emphasise only negative duties. A stronger theory of human rights which stresses the positive duties to provide at least some of the means to life, will yield more satisfactory responses to the many cases where failure to save life appears to be morally culpable.

Utilitarian moral theory concentrates on maximising goods whereas traditionally the moral theory based on human rights emphasises not doing harm. The development of a more positive interpretation of belief in human rights will mean that in applying theory to practice there will be more agreement between utilitarians and believers in human rights.

References

News and notes

Congress on ethics in medicine
Beth Israel Medical Center, New York and Ben Gurion University of the Negev are sponsoring their first joint International Congress on Ethics in Medicine. The congress will take place at Beersheva, Israel from March 10–13, 1985.

For information, please contact: Office of Medical Education, Beth Israel Medical Center, 10 Nathan D Perlman Place, New York, NY 10003: (212) 420–2849.