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Editorial

Withholding and withdrawing life-prolonging treatment – moral implications of a thought experiment

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In this issue of the journal Drs Sulmasy and Sugarman offer a thought experiment which they believe demonstrates that withdrawing a life-prolonging treatment from a patient may be morally worse than withholding the same treatment (1). This goes counter to much contemporary bioethical reasoning, which argues that for any given patient there is no intrinsic moral difference between withholding and withdrawing life-prolonging treatment. The authors' claim is, however, consonant with widespread medical feeling that while it may be justified to withhold a life-prolonging treatment (LPT) from a patient, once that patient has been started on the LPT it becomes morally more problematic to withdraw the treatment.

The case offered by Drs Sulmasy and Sugarman concerns two in all ways identical twins who urgently need oxygen but for whom there is only one respirator. The emergency doctors toss a coin and intubate the winner. The parents arrive very soon afterwards and demand that the other twin, who is their favourite because she cries less, gets the respirator. Drs Sulmasy and Sugarman argue both that it would be morally impermissible for the doctors to accede to the parents' request and that, if this is so, it shows that the moral equivalence thesis is false, and that withdrawing an LPT once started can be morally worse than withholding it in the first place.

There are various counter-arguments available to their position. As Professor Harris argues in his reply, the reason for rejecting the parents' request to transfer the life-saving equipment from Prima to Secunda is that it would be unjust to do so (2). A fair (random allocation) method has resulted in Prima getting the LPT in the first place and it would be simply unjust to transfer it to Secunda without clear moral justifications for doing so (for example, that it was rapidly discovered that Prima could not after all benefit from the LPT). In this context the widespread – though also arguable – assumption is accepted that mere parental preference for one of their children over another does not constitute a morally relevant difference for overturning the original just decision.

But as Professor Harris points out this obligation of justice in the distribution of scarce life-saving resources would have been equally stringent had the parents argued before the original allocation that the LPT should be *withheld* from Prima, simply because Secunda cried less than Prima and they therefore preferred Secunda. The coin-tossing mechanism was a device for ensuring equality of opportunity for Prima and Secunda given that they were moral equals, and that there were no morally relevant differences favouring allocation to one rather than the other. Thus in this thought experiment it seems clear that while Drs Sulmasy and Sugarman are right to say that the emergency doctors should resist the parents' pressure to change the allocation that chance had provided for Prima, they are wrong to suggest (though they do not actually state it) that the doctors would have been justified in acceding to such parental pressure had it occurred before the original allocation.

Whether before or after a scarce life-prolonging treatment has been allocated, some just method of allocation ought to be adopted for withholding or withdrawing it. There is nothing in this example to show that withholding LPT from either of the twins would have been justifiable given arbitrary parental pressure to do so, while withdrawing LPT because of the same parental pressure would have been unjustifiable. Rather, this thought experiment seems to reinforce the equivalence thesis that it is supposed to undermine, for it shows that, given the absence of other morally relevant differences, mere parental preference is not a basis for just medical allocation of life-saving resources, whether by withholding or withdrawing them. The thought experiment also reinforces the obvious corollary that once such a just allocation has been made it should not be changed unless there is further moral justification for overturning the original decision.

Drs Sulmasy and Sugarman try to invoke a principle relied on by the American libertarian philosopher Robert Nozick, notably that justly acquired 'holdings' should not be removed from their owners without their consent. While they 'reject the broad application of Nozick's Principle of Original Acquisition of Holdings, in the circumstances of this particular case Nozick's principle

seems to explain Prima's claim on the respirator'. But they have no need to invoke Nozick's principle for this case – they simply need to acknowledge that just decisions should not be overturned in the absence of sound moral reasons for doing so.

Suppose, however, that there were sound moral reasons for overturning the decision – for example, if it became rapidly clear that Prima was *extremely* unlikely to benefit from the respirator while Secunda, if she was immediately put on the respirator was *highly* likely to benefit – then as the authors seem to acknowledge, it would be unjust to maintain Prima on the respirator at the cost of Secunda. Yet by Nozick's entitlement theory the respirator, having been allocated justly to Prima and thus being her justly acquired holding, should not be taken from her even though she was very unlikely to benefit from it and even though someone else would be very likely to benefit from it.

Towards the end of their paper Drs Sulmasy and Sugarman state that their argument 'is that there is always an intrinsic moral difference between withholding and withdrawing therapy' and that it lies 'in the patient's *prima facie* claim to continue therapy once it has been started'. Let us assume – counterfactually – that the case of Prima and Secunda did show that the doctors would have been justified in accepting parental pressure to deny Prima LPT in the context of withholding it but unjustified in accepting parental pressure to deny Prima LPT in the context of withdrawing it. Even this assumption would not justify the authors' universal claim that there is *always* a moral difference between withholding and withdrawing treatment, nor that any such difference is *intrinsic* to the withholding/withdrawing distinction. At most it would have justified the far more modest claim that withholding and withdrawing are not always morally identical.

Even nearer the end of their paper, Drs Sulmasy and Sugarman briefly offer not an imaginary example but a real one (or a more real one), concerning two patients needing the one available intensive-care-unit ventilator. One patient has a predicted 50 per cent chance of survival if given the ventilator, the other has a predicted 90 per cent chance of survival. Both will almost certainly die without the ventilator. The authors point to an important and plausibly likely difference in medical behaviour between withholding and withdrawing the ventilator. Before either patient has received the ventilator doctors would, they plausibly assert, be very likely to allocate the ventilator to the patient with the high probability of surviving. But if a patient with a 50 per cent probability of surviving were already on the ventilator and another patient arrived with a 90 per cent probability of surviving, then doctors would be extremely unlikely to withdraw the ventilator from the one in order to allocate it to the other. 'Despite the difference in the probability of a good outcome, the patient who is already on the ventilator has at least *some* claim to continue treatment. And, if that is so, withholding and withdrawing are not morally equivalent in such a situation' (1).

Theirs is an important empirical observation about likely medical behaviour. But even if it is true (which seems probable) it does not support the earlier claim that 'there is always an intrinsic moral difference between withholding and withdrawing therapy'. At most it supports the claim that in some circumstances doctors perceive there to be a moral difference – not necessarily always and not necessarily an intrinsic moral difference. A possibility at least worth considering is that while such medical tendencies to differentiate the two types of case undoubtedly exist, they are morally unjustified. Instead, if moderately low probability of good outcome can justify *withholding* scarce life-saving treatment from one patient in favour of another patient with high probability of good outcome, then so too can it justify *withdrawing* such treatment from one patient in favour of another with high probability of good outcome.

In practice there seems little doubt that when the probability of good outcome is *sufficiently* low many doctors are likely to withdraw a ventilator from a patient if another patient with a high probability of good outcome requires it. If, for example, a patient, despite being on a ventilator, none the less has a predicted 90 per cent probability of dying, many doctors would and do withdraw the ventilator in favour of a new patient who has a 90 per cent chance of surviving (assuming that both are predicted to die without the ventilator).

None the less, when the predicted outcomes are less clear either way, and when the differences in predicted outcome are smaller, there does seem to be a widespread medical intuition that while it may be acceptable to allocate a ventilator to the patient with the moderately better predicted outcome, thus withholding LPT from the patient with moderately worse predicted outcome, if the patient with the same worse predicted outcome is already on the ventilator then it would be unjustifiable to withdraw the LPT in favour of the same patient with moderately better predicted outcome.

Furthermore, there seems likely to be an element in this intuition, as Drs Sulmasy and Sugarman claim, according to which prior possession of the ventilator justifies at least some moral bias in favour of continued possession, so long as such possession is beneficial. But is this intuition morally any different from the even more widespread claim that 'possession is nine tenths of the law'? The appropriate legal response to the latter is that actual possession does not of itself determine legal possession. Similarly, the appropriate moral

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remains morally relevant. See: Bleich J D. The Quinlan case: a Jewish perspective. In: Rosner F, Bleich J D, eds. *Jewish bioethics.* New York: Sanhedrin Press, 1979: 266–276, especially note 2: 275–276. In contrast to the Orthodox position, conservative Jewish teachings vary on this issue, believing that while withholding and withdrawing medical therapies are morally different, it may be justifiable to withdraw life-sustaining medical therapies in certain instances. See: Dorf E N. A Jewish approach to end-stage medical care. *Conservative Judaism* 1991; 43: 3–51, especially pages 32–33.
(6) Nozick R. *Anarchy, state, and Utopia.* New York: Basic Books, 1975: 150–155.
(7) Rawls's difference principle states that an increment in resources for the well-off is only just if it also results in an increase in resources for the least well-off. Under the zero-sum conditions of this case, a gain for one side entails a loss for the other side. Therefore Rawls's difference principle is not applicable to our case. See: Rawls J. *A theory of justice.* Cambridge, Massachusetts: The Belknap Press of Harvard University Press, 1971: 75–83.
(8) Styron W. *Sophie's choice.* New York: Random House, 1979.
(9) Ashley B M, O'Rourke K D. *Healthcare ethics: a theological analysis* [3d ed]. St Louis, Missouri: The Catholic Healthcare Association of the United States, 1989: 384.
(10) The President's Commission. *Decisions to forego life-sustaining treatments.* Washington, DC: US Government Printing Office, 1983: 73–77.

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response is that actual possession does not of itself determine who ought to possess.

Drs Sulmasy and Sugarman have pointed to a real dilemma in practical medical ethics. Their theoretical resolution of that dilemma, despite ingenious thought experimentation, will not, alas, convince all their readers.

References

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