history of treating severely affected babies will prove to be a very short one. Everyone will be glad when it is over.

References

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Commentary 2

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It is a pretty scene: a doctor deciding that it is in a child's best interests to die. Similarly is Dr Harris making the same decision, though in a more abstract and generic kind of way. The way you make the decision is: see what you'd think of a proposal that you should 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're considering—not a medical decision of course; it is just done by imagining a proposition. What a lot of creatures you have reason to kill under that method of reckoning! They have only to be incapable of consent, and you'd have a *sufficient* reason.

'But no!' it may be replied, 'It's got to be your business, and it *is* the doctor's business, for these are his patients.' To repeat, this is not a medical decision, even if in making it the doctor refers to some medical facts. In the case in hand, it is a reversion to the ancient human tendency to kill unwanted children. This is cloaked in the language of moral concern. But it is a decision about the worthwhileness or value of a life, and medicine tells us nothing about that. Dr Lorber happened to be in a position of *power* because of his profession. But essentially he was no more justified in deciding to kill babies by neglect and starvation than I would be entitled to kill some incompetent who fell into my hands, and who I thought would be better off dead.

As Dr Harris reports the matter, Dr Lorber *aimed* at the death of the children; it was to be accomplished by non-treatment and sometimes by starvation. As Dr Harris indicates, if you are aiming at someone's death it hardly makes a difference whether you bring it about by omission of treatment and failure to feed, or if you do it more actively. The infamous thing is to aim at the patient's death.

Clearly it isn't enough for Dr Harris to have people killing (on purpose) by omission; he wants to get them doing it by commission. Now while there isn't much difference in the wicked intent (the only one I can see is that in adopting the method of neglect you leave it longer open to change your mind), yet there is *some* difference about what you do.

For wilful starvation there can be no excuse. The same can't be said quite without qualification about failing to operate or to adopt some course of treatment. There is a question here which needs discussion: whether, when and why a doctor has an obligation to do anything for someone? I mean: to do anything in the way of medical treatment. Has he such an obligation simply because of (say) the existence of a National Health Service, and because he belongs to it? Can't a doctor sometimes say: 'I do not want to treat this patient, I actually don't want him as a patient of mine?' Can he sometimes, or can he never, say the following?: 'I do not want to prolong this person's life by taking medical measures to do so. I am not saying it is *better* not to; I would say nothing against another practitioner who might want to. But I don't want to. And I don't have to.'

This is a deep and important question of medical ethics, which has perhaps been discussed. I have not seen discussions of it.

I think I perceive in the writing of Dr Harris a blindness to *such* a possibility of non-treatment. This may be because of an assumption that the doctor into whose hands such people have somehow come, is ethically obliged *either* to aim at their cure *or* one way or another to seek for them not to be cured. Perhaps the assumption (which I am attributing to Dr Harris) should be limited to people who will die of their sickness if medical measures are not taken. Either way such an assumption seems absurd.

Suppose we consider a different assumption: a doctor into whose hands sick people come *is ethically obliged (if he can) to treat them with a view to curing them.* This Dr Harris does not believe; but I think he believes it is true *except* in the case where the doctor would justifiably aim at his patient's death. But, forgetting about *that* exception, I am still disposed to think the assumption is *not* universally true, though setting limits to it is not easy. Of course, a doctor might not allow people to 'come into his hands', and it is another question when he is entitled, or not entitled, to refuse to let this happen. But if they somehow *have* come into his hands—by being born to patients, for example—that is where there is need to examine the particular assumption I have mentioned.

Another presumption I seem to detect in Dr Harris's writing, is the presumption that action and omission are everywhere equivalent. Philosophers, I fear, often seem to think that *either* omission is never equivalent to positive action that has the same

result, *or* it always is. Glover (1), at least, thinks that he has demonstrated the latter by disproving the former. Now if you have an obligation to do something positive, the intentional omission of it for the sake of some result (such as death) may very well deserve the same blame as positive action to produce the same result. But it by no means follows that we ought always to be calculating the expectable consequences of every non-doing of something we could do, along with those of every possible positive action, and that we are responsible for every upshot that is less than the best possible by such a comprehensive calculation. Indeed, such a proposition is obviously absurd. (Which does not mean that, within certain limits of practicable policy, with cut-and-dried possibilities, such a calculation may not be required. This must sometimes be the case in medicine.)

If Dr Harris has reported Lorber correctly, Lorber claimed to be aiming at the death of the children by non-treatment. This was sometimes, though not always, supplemented by starvation. We have heard of this elsewhere since 1975 (2). It looks as if Dr Lorber may have been a bit confused between a policy of not trying to cure—not operating, for example and a policy of aiming at death, by omission. In the former case it makes sense, even though a rather vague sense, to speak of 'letting nature take its course'. It is a question, as I have said, whether, and when, *such* an omission of treatment is admissible. It is not the same thing as aiming at death, if the children receive ordinary care—are fed and kept clean and warm, saved from choking brought on by some accident, etc. The distinction between ordinary care and surgical or medical measures to cure their condition is not at all meaningless. I am disposed to think that good practice would demand that the best available means be adopted to cure them; but as I have said, it is debatable; it may only *usually* be so, and a contrary decision is not yet the same as a decision to aim at their death.

It is possible that Dr Lorber was indeed aiming to kill by omission, and if so his action is only to be discriminated from 'positive euthanasia' by unclarity about his actions. Such unclarity is more difficult when positive action is taken to kill. And I should judge that the contempt for human lives is therefore greater with positive action.

Dr Harris is misinformed about the Nazis. Positive euthanasia began as a privilege which was accorded to Aryans.

References

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Commentary 3

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In considering what ought to be done about children who have been born alive, but with a severe physical or mental handicap or both, it should be borne in mind that there are at least three different types of case. In one category are children who are so grossly deformed or disadvantaged that they cannot meaningfully be described as human beings (in the past, they would have been called 'monsters'). Most people would not consider it appropriate to take any steps to preserve such a child's existence and many would go further and take steps to end the child's life immediately. It is probably not difficult to identify children who come into this category. One example would be a child born without a brain.

Another category includes those handicapped children for whom every effort should be made to reduce the burden of their disability, so that they can live with as little discomfort and inconvenience as possible. Children who are physically disabled but without mental handicap would clearly come into this group.

The third group consists of those who are so severely handicapped that they will be in continuous pain or will be unable to have any meaningful existence. Inevitably, there will be doubts about whether a particular child is within this category as can be seen clearly from the Stinson case (1), but if it is accepted that the prospects for the child are poor or nil, and that in Dr Harris's words, they 'would be better off dead', then two courses of action are open.

The first of these is to kill such children immediately the prognosis is clear or agreed upon—active euthanasia. This is the course which Dr Harris advocates. The alternative is to indulge in 'selective non-treatment'—passive euthanasia. Presumably, these infants will receive normal forms of care, for example being kept clean and free from pain, but no steps will be taken if their effect would be to delay the process of death.

It is abundantly clear from the literature on this subject, *eg* the articles by Duff and Campbell (2) and Lorber (3), (4), that doctors are not in favour of adopting the first course principally because they regard themselves as being under an obligation not to take any active steps to end the lives of their patients. However, what is equally clear is that they need not and will not struggle for ever to preserve a patient's life, which is probably the main reason why they adopt the practice of 'selective non-treatment' in relation to severely defective newborn children.

That distinction which exists in medical practice is also recognised in law. A doctor who brings about the death of his patient by some positive step would be guilty of murder. The law therefore does not