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.

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Commentary 3

D J Cusine *Faculty of Law, University of Aberdeen*

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

permit active euthanasia, although it may treat it leniently. What of passive euthanasia? It must be admitted that it is possible to cause death by omission, but there can be no liability for omissions unless there was a duty to act in the first place. One situation in which there would be a duty to act is where a surgeon has begun to operate on a patient. If he stops before the operation is completed and the patient dies as a result, the surgeon will be liable in law. The reason for that is that by commencing the operation, the surgeon has exposed the patient to danger and so he must do what is reasonable to avert that danger. One can contrast that with the case of a patient who is seriously injured in a road accident and may die whether or not he is treated. The surgeon may operate *eg* to stop internal bleeding but during the operation the patient's heart may stop and be started again and this may happen several times. In such circumstances, there would not be any legal obligation on the surgeon to continue to resuscitate the patient, if he has done all that is reasonable to save the patient's life.

In the case of the severely handicapped infant, a doctor who withholds treatment is criminally liable only if there was a duty to provide treatment. In some cases, the child may be dying and treatment would merely postpone the death. Such cases can be equated with the patient in the road accident. In other cases, the child might live, but life would be 'so intolerable, so painful, so miserable, so difficult and so utterly without reward, that we would not wish to live such a life and . . . it is reasonable to suppose that no one would.'

The question of what ought to be done in such circumstances is not a matter of which the medical profession or the parents are the sole judges, but clearly regard must be had to medical knowledge of such cases in order to determine what is reasonable. Cases on the quality of life have not yet come before the courts of this country and until they do or there is legislation on the matter, doctors and parents are left to make these decisions. As has been said, doctors are not in favour of active euthanasia but since little has been published by or about parents it is not possible to say how they would view doctors taking active steps to kill their child. (If one accepts Harris's argument from brutalisation it would be wrong for parents to order a doctor to kill the child if they could not bring themselves to do it). Given the lack of success which Euthanasia Bills have had both in this country and in the USA, current thinking is against active euthanasia. Even if active euthanasia were legalised, one suspects that many parents would not take active steps to kill their defective newborn child. Ethical arguments and legal arguments might be regarded as irrelevant by the parents. They must come to terms with the fact that their child is seriously handicapped. They must try to understand what it will mean for them and for the child if it is given treatment. If the prognosis is poor and a decision is made not to treat the child, they must come to terms with the fact that the child will die and decide how they should care for it. If it is the wish of the parents that they should care for their dying child over a period of hours or days or months, should anyone attempt to persuade them on other than legal grounds that this course is unjustified?

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