

Debate

Reply to Lorber, Cusine and Anscombe

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In my discussion of the ethical problems of treating severely handicapped children (1) I criticised the view that so called 'selective treatment' is morally preferable to infanticide. In his reply to my paper John Lorber (2) again defends his practice and his record in the treatment of such children. It is important to stress that I was criticising neither of these; my argument was with his arguments. This may sound like a typically sophisticated philosopher's distinction, but it is a vital one and failure to appreciate it leads both Lorber and Cusine (3) a long way from the point in their replies.

Lorber and Cusine concentrate on the current state of the law and on the prevailing attitudes of most doctors and parents. Given these as brute facts, I think had I been in Lorber's shoes I would have adopted a practice similar to his selective non-treatment and nothing that I said is a criticism of his carrying through such a policy. What I did argue was that the very same features of the predicament of handicapped children which make selective non-treatment seem a good and humane solution, would make active euthanasia a better and more humane solution and the arguments adduced by Lorber and others for preferring selective non-treatment to active euthanasia do not in fact sustain such a preference. My point is and was that reflection on these arguments should lead both medical staff and parents to see that active euthanasia is morally preferable to selective non-treatment and so to change their current attitudes to active euthanasia and to support a change in the law governing these matters.

Thus while the current state of the law and prevailing attitudes of medical staff and parents, may be good reasons for not *implementing* a policy of active euthanasia, they are not good reasons for thinking such a policy ethically unsound, nor are they good reasons against *advocating* such a policy, and so attempting, as I have tried to do, to influence the attitudes of parents and medical staff.

It may well be, as Cusine reminds us, 'abundantly clear from the literature on this subject . . . that doctors are not in favour of (active euthanasia) principally because they regard themselves as being

under an obligation not to take any active steps to end the lives of their patients' (4). But *is* there any such obligation? The question for anyone interested in medical ethics is: can there be a moral obligation not to take *active* steps to end the lives of patients and at the same time no moral obligation not to take *passive* steps to this end? Or, to put the point in the way that it presents itself in the cases we are considering: can it be right to take passive steps to end the lives of patients (as in selective non-treatment) but wrong to take active steps to the same end?

One of the tasks for medical ethics, and it is by no means an easy one, is to try to understand the obligations that we intuitively feel. What for example is the good of such an obligation, what is its point? If the obligation referred to by Cusine is the product of a reverence for human life, then if both active and passive steps lead equally inexorably to death, can a distinction between active and passive euthanasia be part of such an attitude of reverence? If on the other hand the obligation is not so much part of what it is to have reverence for life, but rather is expressive of our care for the welfare and interests of others; then if it is seen to be in their interests to die, we might come to feel that the obligation, in Cusine's formulation of it, is self-defeating in that it leads us to sacrifice, rather than promote the interests of others.

Similarly, the feeling of guilt like the sense of obligation can be misplaced or irrational, so that when Lorber notes that 'the aftermath of thought and guilt complexes in the parents and persons involved' in active euthanasia 'is likely to be much worse than caring for the baby in a humane way until it dies' (5), we must ask whether such guilt is appropriate, whether there is anything to feel guilty about? Indeed, as I suggested in my paper, we might more appropriately feel guilt if we allow such children to die slowly, rather than assist them to a speedy end. The mere fact that guilt is sincerely felt does not mean that there is anything about which to feel guilty, nor of course does the absence of guilt indicate that no wrong has been done. We are all prone to feel guilt irrationally, particularly when we are forced by circumstances to choose between evils. We should not allow the presence of guilt to prevent us from choosing the *lesser* evil.

G E M Anscombe's reply (6) takes a quite different approach. She identifies variants of a 'deep

and important question of medical ethics'. Professor Anscombe asks, 'can't a doctor sometimes say: 'I do not want to treat this patient . . .' or . . . '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 would want to. But I don't want to and I don't have to'. Professor Anscombe does not give any indication of the circumstances in which she supposes a doctor *can* say such a thing. But if this were to be a genuine possibility for doctors, if, for example, they possess the right to say such a thing, then they must be able to say it even where they are say, the only available doctor, so that if they do not treat a particular patient he will die. And here I take it we are thinking of patients who could recover and who want to go on living.

Here is a pretty possibility: doctors turning their backs on patients and saying peevishly or capriciously 'I don't want to and I don't have to' and patients dying in droves. Professor Anscombe is certainly correct to detect in my writing 'a blindness to *such* a possibility' if 'possibility' here indicates that the course of action might be considered morally acceptable.

Professor Anscombe attributes to me the presumption that 'a doctor into whose hands sick people come is *ethically obliged*, (if he can) to treat them with a view to curing them . . . *except* in the case where the doctor would justifiably aim at his patient's death'. I think I would accept this presumption, and not only for doctors, but for anyone who could by his actions avert disasters that were threatening others. Professor Anscombe however does not regard this presumption as universally true but again gives no account of the exceptions she has in mind. I have tried elsewhere (7) and albeit incompletely to give an account of where and why this presumption applies, and in the same place I defend a less extreme version of the final presumption she attributes to me. Not that, as in her words, 'action and omission are everywhere equivalent' but

rather that actions and omissions with the same consequences are morally equivalent unless they differ in some other way which would carry moral weight quite irrespective of whether it was a feature of an action or of an omission.

Thus in the cases we have been discussing we must consider whether a policy of selective non-treatment is morally preferable to one of active euthanasia. Since the expected and hoped for result of either policy is the painless demise of the patient it would be absurd if one policy was morally impermissible solely on the ground that it involved active rather than passive steps toward the same end. As I argued in my paper, the other differences between the two policies so far from showing that selective non-treatment is morally preferable to active euthanasia, show rather the reverse.

Now of course Professor Anscombe finds neither active nor passive euthanasia morally acceptable. Those who are inclined to agree with her must therefore decide whether it is more morally acceptable to condemn the severely handicapped to months or years of pain and suffering which they could be spared, or to hold that there is nothing wrong with a doctor saying to a patient who wishes to live and who will die without the doctors' help, 'I don't want to. And I don't have to'.

References

- (1) Harris J. Ethical problems in the management of some severely handicapped children. *Journal of medical ethics* 1981; 7: 117-120.
- (2) Lorber J. Commentary 1 and reply. *Journal of medical ethics* 1981; 7: 120-122.
- (3) Cusine D J. Commentary 3. *Journal of medical ethics* 1981; 7: 123-124.
- (4) Cusine D J. See reference (3) p 123.
- (5) Lorber J. See reference (2) p 120.
- (6) Anscombe G E M. Commentary 2. *Journal of medical ethics* 1981; 7: 122-123.
- (7) Harris J. *Violence and responsibility*. London: Routledge & Kegan Paul, 1980.