Ethical issues

Euthanasia and clinical practice

The report of a working party of the Linacre Centre

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Many people felt that the 1967 Abortion Act would be the thin end of a long and serious wedge—the worry was that once society accepts that it is both morally and legally right to destroy the deformed or unwanted fetus, it would not be long before the same argument would be applied to those born handicapped, and later to the old. In some ways these fears have been fulfilled. Recently there have been attempts to legalise euthanasia of some handicapped newborn infants in certain American states and the term ‘paediatric euthanasia’ has entered paediatric literature. As far as the United Kingdom is concerned the law still stands as ever it was. There has been no change and it is unlikely that there will be in the forseeable future. The Exit group for the elderly is not winning any ground and its public image has received a battering recently.

The problems of handicapped newborn infants are most complex in nature and the ethics of different forms of treatment need to be discussed from time to time. There is a considerable body of paediatric opinion that believes that certain grossly handicapped children should be spared the trials of life or alternatively fitted by doctors to live out an existence. The rigours of living with a handicap are known in their fullest extent only to the handicapped themselves. The rest of us require eyes to see their problems and time for inner eyes to imagine what life must mean for them. There are good reasons why doctors and students should ‘stop and stare’ over the problems of the severely handicapped. Our thoughts lead to our actions, which have profound effects upon children, their families, and ourselves. It is important therefore that we should consider and discuss these matters.

Times are different: surgical triumphs and powerful pharmaceutical agents can have profound influences upon both the quality and length of life. The support systems and monitoring processes make today’s outlook vastly different from that of yesterday. The very low birthweight baby of 20 years ago was unlikely to live long enough to get over its intraventricular haemorrhage. A decade ago we were unlikely to be certain that our clinical hunch of an intraventricular haemorrhage was correct, short of needling. Ultrasound scanning has altered all that; but when we are certain what should we do? Does the knowledge alter the management—and should it? The modern practitioner must now balance the many aspects of medical care and family and society support, which together with his and their commitment and beliefs about treatments affect the advice he gives. Faced with weighty clinical and ethical problems, today’s doctor often has difficulty in obtaining the moral values which he needs to help him decide what course to take.

The present post-Christian era in Great Britain has dispensed with most of the 10 commandments and is floundering in the process of making acceptable guidelines based upon reason and previous guidelines handed down. The medical student learns the many organic facets of disease processes but rarely receives help in thinking his way through them or a sure intellectual foundation upon which to build his operational decisions—the sweet reason of today is very personal. Attitudes are often moulded to the view that action for the handicapped should be guided largely by the quality of life expected for the individual. More recently other factors have been reintroduced such as the sanctity of life, the purpose of life, and the type of life lived within the limitations of the individual human frame. Christians of various denominations are making their voices heard on these aspects of life and this report is an important Roman Catholic contribution to the thinking behind moral attitudes and actions for handicapped people.1

Euthanasia and clinical practice1 is the report of a working party that studied health care ethics within the Roman Catholic moral tradition. The working party met for approximately 3 years to produce the report, designed to clarify some of the points of Roman Catholic belief on these matters and also to help in the ‘tradition of common morality in face of a range of questions which arise for clinicians and patients’. Members of the working party were from many disciplines including philosophy, nursing, law, medicine, and moral theology.
The group was brought together partly because of concern that euthanasia in one form or other was not only freely discussed but that there was increasing evidence that it was more freely practised in either a passive or active form. The definition adopted was that, 'there is euthanasia when the death of a human being is brought about on purpose as part of the medical care being given him.'

Some advocates of euthanasia believe that death is of benefit to certain patients and perhaps to those who have to care for them. The report presents evidence which suggests that euthanasia is now more common in specialised fields of care. That there is an increase in this practice in the handicapped newborn is deduced from British and American published reports. The examples quoted include doctors withholding information from parents about children with Down's syndrome who had lethal malformations such as duodenal atresia. A report by the American Academy of Pediatrics in 1975 found that in this situation 24% of surgeons and 13% of paediatricians would seek to persuade parents not to have surgery on their baby. The working party suggests that the percentage of paediatricians in the UK trying to influence parents against operation is higher and quotes an article of 9 years ago stating that 'when maximum treatment was viewed as unacceptable by families and physicians in our unit, there was a growing tendency to see early death as a management option'.

The report discusses the relation between active and passive measures. The passive view of letting a child die may mean giving sedatives in such a quantity that the child does not take food and dies of lack of nutrition. It discusses strong emotive statements such as, 'killing may in some circumstances be an obligation for a clinician'. The report comments stringently upon some clinicians' notions of selection for surgery for children with certain illnesses such as spina bifida that are inspired by judgements on the value of human lives. It is acknowledged that there is less evidence for euthanasia for other handicaps, although the debate about criteria implies that it is either practised or sought. One of the points that is discussed currently is whether quantifying the natural capacity of the child, the family, and social resources available should be used in the decision for certain treatments.

Statements like these are interpreted in a variety of ways by different people. They caused the group considerable concern, and become enshrined in some doctors' thinking and amplified by sympathisers in society. The Linacre Centre report is designed to provide another viewpoint and to get serious men and women to think about the vital issues. It believes that the loudest voices in the debate have been largely from those in favour of one form or another of euthanasia or neglect, and that it is time for a considered contrary view.

The members have put their weight and energy into the debate and have produced a report that makes good if at times difficult reading. The philosophical arguments about what constitutes murder and the nature of responsibility, guilt, and intent are the central issues. It argues that euthanasia is murder. A chapter is devoted to the concept of murder by omission and the morality of killing as a side effect of an action not designed expressly for that purpose. It is quite difficult to follow some of the legal and philosophical arguments. The Christian tradition combines the 2 themes of the gift of life coming from God and the commandment 'do not kill' or 'do not murder'. Life comes from God. It is a great gift. Man's responsibility is to respect this gift of God and thereby demonstrate his worship of Him. The Roman Catholic view is that life is sacred, and it is opposed to euthanasia in any form.

There is a good discussion and some fine arguments upon when treatment is or is not obligatory, the burdensomeness of treatment, and the parent's right to refuse it. Incompetent patients have rights and we have duties towards them. After a considerable theoretical discussion the group finally applies this to the practice of medicine in certain specialised fields and real life situations such as babies with Down's syndrome and duodenal obstruction, or spina bifida. At the end of the day the treatment advocated is that practised, one would guess, by most paediatricians, save perhaps for spina bifida where that adopted 20 years ago (that is, early operation for most) is considered morally right. Operation is not advocated for all patients because children with severe malformations should be left, but the strict criteria proposed by one of the group's former colleagues are resisted. Passive or active euthanasia is roundly condemned. The group indicate the sorts of omission of treatment which in their view are justifiable. These are clearly laid out but in the very nature of things eventually demand quality judgements by the doctor.

The report does not make easy reading and requires a cool, clear head. It is a brave attempt to advocate the rights of life for children who are heavily handicapped, it provides much food for thought, and is to be recommended for all those, whether Christian or not, who care for children.

Reference
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