

February 1983

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### Recommended Citation

Atkinson, Gary M. (1983) "Deciding for Others," *The Linacre Quarterly*: Vol. 50 : No. 1 , Article 13.  
Available at: <http://epublications.marquette.edu/lmq/vol50/iss1/13>

# Deciding for Others

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One troublesome issue in biomedical ethics concerns the standards to be employed in making life-and-death decisions for those who cannot decide for themselves. After presenting a brief survey of some representative positions by way of background, I shall approach the question using an analytical technique developed by John Rawls<sup>1</sup> and David A. J. Richards.<sup>2</sup> Neither Rawls nor Richards addresses this problem directly, and I do not claim that the position labeled "the rational contractors" would in fact be advocated by either of them. I do argue, though, that that position does follow if one substantive moral point be granted, that the incompetent individual is a human being possessing the same complement of moral rights as that possessed by any competent person. I do not intend to convince those who reject that moral point but only to demonstrate what follows from a commitment to the moral equality of the incompetent. By illustrating the consequences of such a commitment, I can at least show when it is imperfectly carried through, half-hearted, unreflective, or even hypocritical.

## A. Pope Pius XII: Ordinary Means

In 1957 Pope Pius XII delivered an address which was to set the parameters for the discussion even to the present.<sup>3</sup> In that address Pope Pius maintained that both Christian morality and "natural reason" teach that an individual possesses the duty to take steps neces-

sary for the preservation of life and health. Nevertheless, that duty is not absolute, for

normally one is held to use only ordinary means — according to circumstances of persons, places, times and culture — that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be burdensome for most men and would make the attainment of the higher, more important good too difficult. Life, health, all temporal activities are in fact, subordinated to spiritual ends. On the other hand, one is not forbidden to take more than the strictly necessary steps to preserve life and health, as long as he does not fail in some more serious duty.<sup>4</sup>

Later in his address, Pope Pius raises the question of whether a physician is bound to use a respirator even in cases that are judged to be “completely hopeless” by a competent doctor. Pope Pius answers his question in the negative: “The anesthesiologist has the right to act in this manner, but he is not bound to do so, unless this becomes the only way of fulfilling another certain moral duty.”<sup>5</sup> For example, a physician may have promised his patient to use resuscitation and in this way have obliged himself to do so. But barring special circumstances, the physician has no obligation to employ technology where the condition of the patient is reasonably believed to be hopeless.

With regard to the rights and duties of others, Pope Pius holds that the doctor possesses “no separate or independent right where the patient is concerned,” and in general the doctor can take action only if the patient has in some way given permission. Where forms of treatment are morally optional, no one is bound to give the doctor permission to employ them. As for the family, its responsibilities normally depend upon “the presumed will of the unconscious patient if he is of age and *sui juris*,” but the family is usually bound to the use only of ordinary means.<sup>6</sup>

## B. Robert M. Veatch: Reasonable Refusal

Although Robert Veatch agrees with much of Pope Pius’s position, there is one feature that Veatch believes “may dangerously depart from the patient’s perspective.” If a family is bound only to the use of ordinary means, and if such means are those that do not involve any great burden to the patient or to others, then the family could dispense with means that impose a grave burden on the family members themselves. Veatch is quite willing to permit a competent adult patient to decide for himself to have treatment discontinued or not initiated because of its burdensomeness for others. But he opposes granting a similar right to decide for someone else:

While it is reasonable that concern for the welfare of others could well be among patients’ concerns and thus [be a] legitimate basis for patients’ refusal of treatment, do we really want to say that the physician or the agent for an incompetent patient can judge a treatment unreasonable because it is a burden on persons other than the patient (including presumably the physician or agent deciding)?<sup>7</sup>

Veatch proposes, in place of Pope Pius's position, a "patient-centered perspective" which looks exclusively to the welfare of the patient himself. Veatch turns his attention away from the discussion of ordinary means to an analysis of what would constitute reasonable refusal. "For the incompetent patient—the child, the mentally incompetent, the senile, the comatose—it would seem morally acceptable for the patient's agent to refuse treatment when the refusal would seem within the realm of reason to reasonable people.<sup>8</sup> But when would a reasonable person find such a refusal within the realm of reason? Veatch answers this question by turning it around and providing an explanation of what is to count as an unreasonable refusal:

A reasonable person would find a refusal unreasonable (and thus treatment morally required) if the treatment is useful in treating a patient's condition (though not necessarily life saving) and at the same time does not give rise to any significant patient-centered objections based on physical or mental burden; familial, social or economic concern; or religious belief.<sup>9</sup>

Veatch intends this definition of unreasonable refusal (which in turn provides a standard for mandatory treatment) to be importantly different in at least one respect from Pope Pius's standard. In order to count refusal of treatment for another to be reasonable, it is not sufficient that one point to the grave burden for others imposed by the treatment. Rather, one must be able to make a reasonable case for saying that the patient himself would object to the treatment. Justifying refusal, then, would require relating it to the patient's own values and not merely to the fact of grave burden imposed on others.

### C. Richard O'Neil: Surrogate Agent

Writing in response to Veatch's proposals, Richard O'Neil objects that reasonable refusal is not as patient-centered as it may appear to be when decisions are being made for incompetent patients:

For what the reasonable person would find acceptable may differ from what the incompetent patient would choose if he were able. That is, it is one thing to act as a patient's agent and decide for him what is in his best interests. It is quite another to adopt the patient's perspective, based on what one knows of his past expressed wishes and interests, and choose that course which one believes would be the patient's choice. The former, "reasonable man," standard is appropriate in determining the reasonableness of treatment. The latter, "surrogate agent," standard is appropriate if one is concerned to protect the incompetent patient's right of refusal.<sup>10</sup>

According to O'Neil, that a reasonable person will find refusal of treatment reasonable does not go very far in showing that the patient, with perhaps his own idiosyncratic desires, would refuse that treatment. The former is not patient-centered at all.

O'Neil believes that the surrogate agent standard is preferable to that of the reasonable person standard, since the former (in contrast to the latter) permits and indeed obliges taking account of the patient's own wishes. The person making decisions for the patient is to decide not on the basis of what the normal, reasonable person would find reasonable but on the basis of what the agent believes the patient himself would have wished done:

if a thoroughly patient-centered approach is correct for the competent patient, I see no reason that it should not be correct for the incompetent patient. Incompetent persons have the same rights to autonomy as competent persons. The only difference is that incompetents must exercise their autonomy by proxy.<sup>11</sup>

#### D. Paul Ramsey: Medical Indications

Along lines similar to O'Neil's approach, Paul Ramsey argues for the importance of the distinction between the *discovery* and the *imputation* of a patient's values and wishes. The former would be associated with the surrogate agent standard, where the patient's agent attempts to decide what the patient would have wanted done by appealing to the patient's own earlier expressed wishes. On the other hand, the imputation of a patient's wishes proceeds on the basis of what the average, reasonable person could be presumed to wish under conditions similar to the patient's.

In *Ethics at the Edges of Life*,<sup>12</sup> Ramsey discusses a number of cases related to the treatment of incompetent adults. One, that of Karen Quinlan, involved a previously competent patient, whereas another, that of Joseph Saikewicz, involved a patient who had never been competent. Ramsey believes that in both cases the courts were operating on the basis of imputed rather than discovered wishes. In the former case, the New Jersey Supreme Court had written:

We have no doubt, in these unhappy circumstances, that if Karen were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death. . . .

If a putative decision by Karen to permit this noncognitive, vegetative existence to terminate by natural forces is to be regarded as a valuable incident of her right of privacy, as we believe it to be, then it should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice. The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment, subject to the qualifications hereafter stated, as to whether she would exercise it in these circumstances. If their conclusion is in the affirmative this decision should be accepted by a society the overwhelming majority of whose members would, we think, in similar circumstances, exercise such a choice in the same way for themselves or for those closest to

them. It is for this reason that we determine that Karen's right of privacy may be asserted in her behalf, in this respect, by her guardian and family under the particular circumstances.<sup>13</sup>

Ramsey believes that the *Quinlan* decision goes a long way toward obliterating the distinction between voluntary and involuntary euthanasia, a gap which the "euthanasiasts" have been attempting to bridge for decades. He writes:

The court *imputed* to Karen a will to die; it did not discover it. Then the court permitted others also to impute a will to die to an uncomprehending patient and to act in behalf of the patient's privacy so construed . . . . And as we have seen the court did invoke the concurrence of everyone in our society in the conditions of human existence judged not to be worth preserving.<sup>14</sup>

A second instance of the imputation of values concerns the case of an institutionalized, incompetent patient, Joseph Saikewicz. In deciding not to order painful chemotherapy for the 66-year-old's leukemia, the Massachusetts judge mentioned the quality of life possible for Saikewicz even if a temporary remission were achieved. Ramsey writes:

The trial judge said in an interview: "I think I'd want to die. If I couldn't be cured, I wouldn't want to live." That suggests . . . a radical misuse of the doctrine of substituted judgment. It suggests that Joseph Saikewicz's interests were ascribed to him, not discovered. . . .

[The judge] allowed competent persons to impose their own private standards of life on an incompetent, and the judge imposed his own personal opinion about "the quality of life that the retarded must live" and ruled that it was "not worth continuing when combined with pain when under chemotherapy."<sup>15</sup>

What Ramsey objects to is the shift from a consideration of the length and chance of recovery, as is done with normal patients, to a consideration of Saikewicz's irreparable retardation with his consequently low quality of life. He also opposes what he considers to be a "misuse" of the doctrine of substituted judgment such that treatment for another may be refused on the basis of the low quality of life *we* believe the patient would not want. His position, rather, is that if a treatment would be chosen by most patients, then it should be chosen for the similarly situated retarded person, barring any special knowledge of the patient's wishes. He maintains that Veatch's standard of

general reasonableness, subject as it is to the vagaries and preferences of persons who presume to apply that standard, is an inadequate protection or guide in choosing treatment (or no treatment) for voiceless patients. Both covenant fidelity to the life and interests of another as well as the stringency of fiduciary obligations of familial or medical or legal guardianship require that a medical indications policy alone be applied when another, voiceless, human life is at stake.<sup>16</sup>

By a "medical indications policy," Ramsey means one that pre-scinds from consideration of the patient's quality of life and focuses instead on the treatment to see whether it is capable of improving the



patient's condition. Ramsey cites as an example of such an approach the policy of R. B. Zachary, a pediatric surgeon in England. Zachary does not recommend surgery if the child is dying, regardless of what is done or if the lesion is inoperable. The withholding of treatment is never based on the desire for the child to die or on the fear that the child would live longer with the treatment. Quoting Zachary, Ramsey writes, "The fundamental purpose is not to add years to their lives but to add life to their years." The improved quality of life may still be less than the normal. The operation may serve only to raise the child's level of activity from 10 to 20 percent.

To lift one's head, and not become the object of pity, is better than not to. To sit up is better than not to be able to. To get out of a chair and walk to a toilet is better than not to be able to. The measure is not walking a mile or running to catch a bus. These are the good with which surgical and orthopedic procedures properly deal.<sup>17</sup>

The phrase "the good with which surgical and orthopedic procedures properly deal" is intended by Ramsey to represent the categorical rejection of quality-of-life considerations in deciding whether to treat. Can the patient be benefitted by the proposed treatment? Will the level of activity be raised by treatment? These are the only factors Zachary and Ramsey hold to be relevant. Ramsey writes that

the standard for letting die must be the same for the normal child as for the defective child. If an operation to remove a bowel obstruction is indicated to save the life of a normal infant, it is also the indicated treatment of a mongoloid infant.<sup>18</sup>

#### **E. Richard A. McCormick: Minimum Potential for Human Relationships**

Commenting on earlier statements of Ramsey's position,<sup>19</sup> Richard McCormick emphasizes the ambiguities in a medical indications policy. Treatments that are not curative are said to be not medically indicated. But McCormick denies that there is much clarity about which treatments should be seen as "curative." He believes that this notion has many levels, and may simply mean "staving off death." He says he knows physicians who believe that treatments are "medically indicated" even when only that level of "cure" is possible. But McCormick notes that Ramsey himself opposed use of the respirator for Karen Quinlan as not medically indicated. Clearly, then, Ramsey does not mean "curative" in this sense. McCormick believes that Ramsey's rejection of quality-of-life judgments ultimately cannot be sustained, since one of the "indications" which must finally be considered is the kind of life prolonged by treatment.<sup>20</sup>

If quality-of-life considerations cannot be avoided, then the question arises of what standard should be employed. What standard ought

to be used in deciding whether treatments are to be counted as "curative" or "useful"? McCormick focuses most of his attention on the never-competent patient, the infant or the congenitally mentally defective. Presumably, for the competent patient one should adopt the patient's own standard, at least to the extent of permitting him to act on it. For the once-competent patient one should again adopt the patient's own viewpoint insofar as this can be determined. But the never-competent patient presents a special problem because there are no past statements to go on. McCormick writes:

Where [once-competent adults] are involved, therapeutic and life-sustaining decisions can be individualized to the person. That is, the notion of "benefit to the patient" can be individualized. The adult has a past, perspectives on life and its meaning, aspirations and achievements. . . . The infant is different. The infant has no past on which to build; he has no known perspectives, value judgments, aspirations. He has had no life. Thus, the decision cannot be individualized to such considerations as it can in the case of adults.<sup>21</sup>

In spite of the difficulty in determining what the child would see as good for itself, McCormick believes that such effort must be made. Writing in an earlier article, McCormick makes this point:

. . . it is the pride of Judeo-Christian tradition that the weak and defenseless, the powerless and unwanted, those whose grasp on the goods of life is most fragile — that is, those whose potential is real but reduced — are cherished and protected as our neighbor in greatest need. Any application of a general guideline that forgets this is but a racism of the adult world profoundly at odds with the gospel, and eventually corrosive of the humanity of those who ought to be caring and supporting as long as that care and support has human meaning.<sup>22</sup>

McCormick's reference to care and support that possess "human meaning" provides his answer to the question of discovering what ought to be counted as good for the child. Precisely because it is impossible to say what the child would wish, the criteria used in deciding whether to treat

must be the strictest possible. That is, the very minimum potential for human experiencing or relationships must be seen as sufficient warrant for attempting to save. Any other view would be a racism of the adult world, and would unjustly deprive not simply one but (by logical generalizability) many infants of their chance at life.<sup>23</sup>

McCormick himself does not provide a detailed rationale for adhering to a minimalist interpretation of what constitutes benefit, but on the assumption that the child possesses the full set of moral rights, it is not difficult to adduce several supporting arguments. First, it seems reasonable to believe that degree of happiness is correlated closely neither with degree of normalcy nor with absence of pain or struggle. People with handicaps are often unhappy, but so are normal persons. Since no one can reasonably predict how happy any particular individual is likely to be, there is no basis for adopting anything but a



minimum level of functioning as a condition sufficient to justify the decision to treat.

Second, we have already noted McCormick's point that decisions regarding the treatment of a child or a never-competent adult cannot be "individualized" or tailored to fit the patient's perspectives, value judgments, and aspirations. Furthermore, the value of a life to its possessor is never simply a function of the objective features or qualities of that life but is always predominantly determined by the person's subjective purposes and desires. Philip B. Heymann and Sara Holtz write that the judgment that the continuation of an infant's life constitutes a net loss, for the infant

is, in the final analysis, more a matter of faith than of factual knowledge. We do not know anything about the individual's crucial "will to live." . . .

Whether it is in the best interest of the patient to live always depends significantly on the will of the patient to live; it is not simply a function of the situation confronting the patient. . . we have no way of knowing how strong a character should be attributed to the newborn.<sup>24</sup>

Many physically normal people display little will to live, and many abnormal people cling to life tenaciously. Any discrimination among persons in the absence of this knowledge regarding their will to live is the expression of personal prejudice and, again, a potential source of rationalization.

Third, the adoption of a standard higher than that of a minimum level could be used to disguise our reasons for not treating. We don't want to assume the burdens of care, and so we decide not to treat. But we disguise our real reasons by saying that it is for the child's own sake that we refuse treatment.

Fourth, McCormick refers to how nearly impossible it is for "healthy adults to extrapolate backwards on what kind of life will be acceptable to the [unhealthy or abnormal] infant."<sup>25</sup> Even if the healthy adult is able to make a reasonable projection regarding degree of handicap (itself an extraordinarily difficult achievement), and even if he is not engaged in selfish rationalization, the very fact of normalcy creates a bias.

Rather than looking at the question of treatment on the basis of whether *we* would be satisfied with being in a particular condition, we need to judge treatment in terms of the values the infant would come to possess were it to survive. To decide what values should be thus ascribed to the infant with a particular handicap, we must begin by discovering the values commonly shared by older children and adults with a similar handicap. We must *not* begin by asking what normal people would want. Although such an approach still has its problems, for individuals with a particular handicap do not always agree, it does provide additional support for adopting a low standard in assessing the prospective quality of an individual's life. It is no doubt true that we

normal people who have experienced the full enjoyment of living an unimpaired existence are likely to view handicaps of various kinds as extremely burdensome or undignified, but those who are not so fortunate mercifully do not always actually feel the lack we feel in imagination. And never having possessed these blessings, the handicapped do not miss them in the way that a normal person would.

#### F. The Rational Contractors: Lowest Plausible Standard

The system developed by John Rawls and David A. J. Richards here called "the rational contractors" is an analytic device for displaying the moral and social implications of the ideas of equality and respect for persons. Both Rawls and Richards are conscious of standing in a tradition that reaches back to the social contract theory of Hobbes, Locke, and Rousseau on the one hand, and to the concepts of moral autonomy and the kingdom of ends in Immanuel Kant on the other.

We are to conceive of a group of individuals who come together to choose a set of principles for their society, principles which will be *binding on all in perpetuity* and will govern their relationships with one another. The principles chosen will thus determine the basic features of their political, legal, and moral systems. Furthermore, the principles must be agreed to *unanimously*, in this way laying the foundation of political and social authority in the "consent of the governed."

In order to discover what principles would, in fact, be chosen by the contractors, it is necessary to specify the conditions under which the contractors would be carrying out their deliberations. First, the contractors are rational, that is, they choose the most effective means available to them for the achievement of their goals. Second, the contractors are self-centered in that they are directly concerned to promote only their own values, goals, and plans. In their reasoning, the contractors possess no altruistic or malicious motivations whatsoever. It may appear that such a condition generates a form of ethical egoism, but this appearance is misleading. We shall see that the principles agreed to by the self-centered contractors are not themselves egoistic and that the motivation for any normal person's adoption of these principles would not be selfish. Third, the contractors are omniscient regarding the general features of human nature and human living. This condition is based on the need to relate morality to human good and harm. Fourth, and most striking, the contractors are ignorant of the particular features of their own condition, i.e., of whatever would bias the choice of principles in their own favor. For example, the Rational Contractors are ignorant of their idiosyncratic set of values and life plans, their age, sex, race, level of intelligence and other natural abilities, their health, social status, income, nationality,

religion. The constraint of ignorance about such features reflects and gives expression to the prior moral conviction that an individual's moral status of fundamental equality is not affected by one's values, age, sex, etc.

The choice of principles, then, is made behind what is called the "veil of ignorance." Such a condition could never exist in reality, since normal people cannot be unaware of these features of their own make-up. But the rationale for the veil is clear: if a certain fact about oneself is held to possess the potential for introducing unjust bias, then the knowledge of that fact is withheld from the contractors as they deliberate. Furthermore, we can enter the veil of ignorance, at least in thought, by the sincere (though not easily achieved) attempt to exclude from our moral reasoning all considerations relating to our personal characteristics, beliefs, and values.

The rational contractors are capable of sophisticated forms of reasoning, but this system is simply an analytic device for getting at the implications of the notion of moral equality. Thus, if we wish to analyze the belief that the mentally defective are to be treated as morally equal to the mentally normal, we can translate this belief into the requirement that the contractors be ignorant of their mental status: they must choose principles that will be binding on them whether they be mentally normal or subnormal. The same point holds for the question of physical defect. It is important to appreciate that this approach cannot demonstrate moral equality, but serves only to explicate the consequences of ascribing such equality.

We are interested, then, in understanding the implications of the contractors' ignorance of whether they will ever come to possess an articulated set of values and plans. This question is addressed directly neither by Rawls nor by Richards. What is interesting about their system, though, is that they provide an analytical framework within which this and a host of other questions can be addressed. Furthermore, Richards (and Rawls to a lesser extent) do argue for several principles which provide some guidance for our discussion.

The first of these principles Richards calls the principle of *non-maleficence*, which requires that persons are not to be cruel to or injure or kill others, unless it is a case of necessary self-defense or the person being harmed or killed has rationally and voluntarily requested such harm or death. The principle also requires persons to take steps to insure that they do not harm or kill others accidentally.<sup>26</sup>

The rationale and justification for each of Richards's principles is the same: the principle in question would be adopted unanimously by the rational contractors deliberating as they are under the restrictions placed upon their knowledge. Knowing as they do the general features of the human condition, the contractors understand how certain purposes can be furthered by killing or injuring others against their will, so that such killing and harming *can* be rational, depending on

one's circumstances and goals. But they also understand how one is affected by being harmed or killed. Furthermore, the contractors are ignorant of their own goals and particular situation. They do not know, for example, whether they are strong and able to harm others or weak and at others' mercy. Richards believes that under these conditions the rationally preferable strategy is to adopt the principle of non-maleficence and thus protect oneself from being harmed even though doing so may curtail one's freedom to harm others. The adoption of the principle is rationally sound because the "cost" of observing the principle (i.e., of restraining oneself from injuring or killing others) is relatively small compared to the "benefit" of physical security and peace of mind.

The principle of non-maleficence is a principle of not causing harm. Two other principles concern the positive rendering of help. The first of these principles Richards calls the principle of *mutual aid*, which requires one person to render assistance to another if, at relatively little cost to himself, he can avert or relieve great harm for another. The point here is that the cost of providing aid be relatively little in comparison with the benefit produced.<sup>27</sup> Great sacrifices would not be required by this principle, nor would the provision of slight benefit, though such actions would be commendable and worthy of praise. As with the principle of non-maleficence, there are costs associated with the principle of mutual aid, but these seem well worth the benefits promised. On the other hand, to require a person to help another whenever the costs of doing so are less than the benefits of being helped would require us to spend most of our time and resources helping others. Such a Herculean requirement might be acceptable to a pure altruist, but it would not be adopted by the contractors who are concerned to develop principles that are likely to assist them in the furtherance of their own goals.

### Third Principle Relevant

A third principle is relevant here, one that may be seen as supplementing the second. Richards calls this the principle of *paternalistic guidance*, and it applies in cases where an individual lacks either the developed capacity for rational deliberation and choice or the opportunity to exercise this capacity. The principle requires that if this lack is likely to result in a substantial and irrational frustration of the individual's interests, then a second person should prevent such frustration and assist the first to develop his capacities.<sup>28</sup> Again, owing to the balance of benefits over costs associated with this principle, the contractors, ignorant of their own rational capacity, would find the

adoption of such a principle a reasonable way of protecting themselves in the event of their lacking such a capacity or the opportunity of using it.

The discussion of these three principles illustrates one important, theoretical point: although the rational contractors are themselves self-centered, it by no means follows that the principles agreed to are egoistic, or that the motivation that would lead *us* to adopt the reasoning of the contractors is egoistic as well. After all, we know our sex and race and so would have no egoistic motivation for discounting that information. Rather, we adopt this form of reasoning which discounts certain kinds of information because it shows what ought to be done when one looks at matters from the "moral point of view." And it is this dispassionate and impartial point of view that is given operative expression by conjoining self-interest with the ignorance of the rational contractors.

Richards's principles of non-maleficence, mutual aid, and paternalistic guidance are presented by him as *strict rules governing behavior*, with a carefully worked out order of precedence to take care of possible conflicts among the various rules when they are applied in particular situations. For the sake of simplicity, we shall be considering principles which should be understood merely as *rules of moral relevance*, rules that specify what factors ought or ought not to be taken into account in making moral decisions. The argument here will be to the effect that the contractors would agree to the appropriateness or unjustifiability of citing others. No attempt will be made here to resolve possible conflicts among different principles except to indicate that some of the principles would be viewed as having special weight or moral significance. The approach employed here, then, is simply intended to answer this question: if we grant that the infant or never-competent adult possesses a moral status equal to that of the normal adult, what factors ought we to take into account and what factors ought we to disregard?

The reasoning of the rational contractors as applied to the case of the never-competent person runs as follows. We are to imagine ourselves as ignorant of our age and mental condition. We know ourselves to be born, and nothing else. (We could examine the question of abortion by seeing what follows from the denial of even this knowledge.) We may be infants (normal or defective) or mentally defective adults, or we may be competent adults. If we are competent adults, we don't know what our values and attitudes are. We may be parents with children who may be seriously defective. We may be professionals assigned to the care of children or the mentally defective. We may be persons whose care competes for the scarce medical dollar with the care of the never-competent. Or we may simply be taxpayers who willingly or unwillingly finance public medical care.



(1) *Rule of Special Benefit*: The contractors would find it rationally (and thus morally required) to give special weight to the interests of those who have not yet experienced any (or relatively few) of the goods of life. The reasoning here is that the contractors would find it desirable to make a special effort to assure that no one fails to experience at least some of the joys of living. The implication is that the child, who has his entire life ahead of him, has a special claim on the help of others, regardless of his mental condition, provided only that his continued existence is consistent with some of the goods of living. This would also imply that the mentally defective adult who has experienced fewer of life's goods would also possess a special claim. Furthermore, because accurate prognoses are extremely difficult to come by and can seldom be made with certainty, the contractors could find it rational to approve a policy which in some cases rejects unfavorable prognoses in hopes that they will turn out to have been mistaken.

The implications of *special benefit* run directly counter, then, to those of an approach that would view the infant as an individual *growing* in moral worth from the time of birth through infancy up until childhood (or even beyond). According to *special benefit*, it is *more* (rather than less) difficult to "let a child go" the younger he is, a difficulty that is not reducible to the greater difficulty of obtaining accurate early prognoses. The younger the child is and the less he has experienced the goods of life, the more claim he has on our help. Furthermore, the contractors would appreciate the special vulnerability to which they would be subject were they an infant or an incompetent adult, and so might wish to adopt some sort of protection against the possibly arbitrary or self-interested decisions of parents or physicians. This is not to say that parents would never have the right to decide about the care of their children but only that the contractors would wish some oversight of parental decisions if they thought there was a significant risk that *special benefit* might be violated.

(2) *Rule of Qualitative Benefit*: The contractors would find it rational (and therefore morally required) to adopt the *lowest plausible standard* for judging a life to be sufficiently valuable to its possessor to be worth preserving. This is because the contractors are ignorant of their own set of values, ignorant of their own crucial "will to live" which is so important in determining the worth of one's own life to oneself. Not having experienced many of the goods of life, the *infant* has formed no conscious set of values. But it is *the contractors* who must make their choice of principles, and it seems reasonable to believe that they would find it rational to risk a life at a level found unacceptable to its possessor rather than run the risk of rejecting a life that would have been found acceptable. Also, the contractors would be concerned to protect themselves from the risk of injustice arising



from the strong and powerful's decision regarding what is in the "true" interest of the weak and defenseless and voiceless.

In deciding what is to be counted as the "lowest plausible standard," we must appreciate that we are not presenting arguments intended to show that a particular standard is, in fact, correct. Rather, we are only showing what standard the contractors would think they *might actually* hold. The requirement here is quite minimal, and in view of this it seems reasonable to believe that the lowest plausible standard is mere bodily existence. If the person is merely being kept alive, that (in contrast to McCormick's view) should by itself be seen as doing some good.

At least three reasons may be offered for this view. First, since we do not know what the alternative to life is, we do not know what good is being done by keeping death at bay. Death may be horrible or at least unpleasant, so that the mere prevention of death could constitute some good. Second, a person who is thought to be unconscious may indeed be aware of his surroundings at least to some degree. So, even if the mere prolonging of life were of no value in itself, we cannot be certain that this is all that is being accomplished by treatment. Third, it does not seem odd on the face of it to say that a person is being harmed by being killed even if he is unconscious and will never regain consciousness. If one rejects any form of dualism and identifies a person with his living body, then the good of the person is not completely separable from the living body. The first and third considerations may tend to cut against each other, but the point is that the contractors are ignorant of their own beliefs and so must take all reasonable beliefs into account.

(3) *Rule of Comparative Benefit*: The contractors would find it rational (and thus morally justified) to admit *comparative* judgments of value, judgments to the effect that the quality of certain lives is higher than that of others. The reasoning here is that such comparative judgments are relatively non-problematic and lie at the basis of medicine. As Ramsey says, "To sit up is better than not to be able to. To get out of a chair and walk to a toilet is better than not to be able to." *Comparative benefit* is consistent with the previous rule, for what *qualitative benefit* forbids is the adoption of a certain quality of life as the necessary condition for a life worth living. It does not forbid such things as acting to *improve* the quality of life by medical procedures.

(4) *Rule of Comparative Burden and Benefit*: The contractors would find it rational (and therefore morally justified) to permit comparisons between the expected benefit to the patient and the cost or burden placed on others of providing care. *Comparative burden*, then, is simply a special application of the principle of mutual aid. If the contractors knew that they were going to be defective children needing special care, then the prohibition of such calculations would be rational. But the contractors are ignorant of this and so lack the

information that would justify tailoring principles giving absolute weight to the interests of the never-competent patient. Furthermore, the permissibility of calculating relative benefits and costs means that the prognosis of a high quality of life could justify the assumption of burdens that would not be justified were the prognosis not so favorable. On the other hand, the fallibility of such prognoses cannot be denied, and there is the danger of simply disregarding the interests of the weak, so we find ourselves sometimes in an uneasy tension between conflicting considerations.

(5) *Rule of Special Burden*: The contractors would find it rational (and thus morally justifiable) to require certain persons to assume rather great burdens in the care of the weak and defenseless, parents and guardians in particular, without rejecting *all* calculations of relative benefits and burdens. The principle of mutual aid requires only the assumption of relatively *small* burdens for the production of *significant* benefit, but the contractors would find it reasonable to require certain people to do more. The principle of mutual aid applies, as it were, in a "state of nature," a duty each person owes everyone else alike, friend or foe, stranger or intimate. But certain conditions are so fraught with peril that the requirement of special help is reasonable. The helplessness of childhood or incompetency are archetypal of these special situations. But parents are people, too, and the contractors can only impose burdens they could live with were they parents. On the other hand, the contractors could justify the imposition of special burdens on parents because they have freely consented to become parents for the sake of the good of children and presumably knowing the possible burdens of parenthood. Furthermore, the special burden of having a defective child could be significantly reduced by the adoption of programs (both governmental and privately run) that are designed to support parents in the care of their children.

John Robertson expresses criticisms of any position that would permit the calculation of relative benefits and burdens, which he considers to be an unacceptable form of utilitarianism:

... even if such comparisons could reliably show a net loss from treatment, the fact remains that the child must sacrifice his life to benefit others. If the life of one individual, however useless, may be sacrificed for the benefit of any person, however useful, or for the benefit of any number of persons, then we have acknowledged the principle that rational utility may justify any outcome. As many philosophers have demonstrated, utilitarianism can always permit the sacrifice of one life for other interests, given the appropriate arrangement of utilities on the balance sheet.<sup>29</sup>

Robertson's objection is misplaced. He confuses the judgment that a person's life is of little value to the person himself with the judgment that the person is of little use to others. The second judgment would indeed enter into a utilitarian calculus, whereas the benefit being con-

sidered by the contractors is the benefit the individual derives from his own life. The contractors are self-centered and are not out to maximize utility. There are some risks it is irrational to run, even though running them can be expected to maximize utility in the long run. The point is that for the contractors there is no "long run"; they have only one life to lead, and they must design principles they can accept whatever their own condition. So, the calculations of relative benefits and burdens which the contractors undertake are not a prelude to the attempt to maximize net utility, but are rather steps in the process of assuring (to the greatest extent possible) that no one will suffer a great loss owing to the failure of someone else to shoulder a relatively small burden. Again, the contractors would find it rational to require certain key persons to assume difficult burdens for the sake of protecting the weak and voiceless, but that would not require ruling out calculations of benefits and costs altogether.

(6) *Rule of Imposed Burden*: In addition to permitting taking account of the burden placed on others of providing care, the contractors would find it rational (and therefore morally acceptable) to allow the providers of care to withhold treatment if it would impose an *excessive* burden on the patient himself. As with *comparative burden* and *special burden*, *imposed burden* would permit relative quality-of-life judgments to be used in deciding whether the burden imposed on the patient by treatment is excessive. What the contractors are concerned to avoid is the adoption of idiosyncratic standards in judging whether a life is worth living or of benefit to its possessor. Such judgments are fundamentally arbitrary and contain the risk of abuse. If a plausible case can be made for saying that a life at a certain level is worth living, then it is arbitrary to act on the judgment that it is *not* worth living. On the other hand, comparative judgments of relative value are not arbitrary, for the practice of medicine itself depends on them. And it is not arbitrary to say that all lives are worth living but that we do more good by restoring a life to normal functioning than by sustaining one at a reduced level. Each life is of net value, but there are some lives whose levels are so low that our sustaining them at great cost to the patient himself is not of net benefit to him.

It must be admitted that there is some risk of abuse here, as there is with *comparative burden*: we simply set the net value of life so low that practically *any* burden of care placed on the patient himself or on others becomes excessive. If the contractors thought there was really a significant risk of abuse here, they might well reject *comparative burden* and *imposed burden*. But it is important to appreciate what would be involved in doing so. It would mean that if a most burdensome treatment would be proposed for otherwise normal infants, that treatment would be obligatory for abnormal or defective humans, *no matter how poor the prognosis*, provided only that there were a comparable chance of survival with the treatment. The only reason that

could justify the adoption of such a policy would be fear of significant abuse.

The presentation of the position of the rational contractors has not been concerned to develop specific criteria for use in deciding whether to treat the never-competent patient. It has dealt with a consideration of the factors that should be taken into account if we grant a commitment to the moral equality of the infant or never-competent adult. Such a commitment involves giving special weight to those who have experienced relatively little of the goods of life, and it could require the provision of special protections to assure that the weak and defenseless are not subjected to injustice and self-serving rationalizations from others (1). This commitment to the fundamental moral equality of all (born) human beings is consistent with the adoption of quality-of-life assessments provided that the standard employed is the lowest plausible one (2). Furthermore, it is permissible to use relative quality-of-life assessments in deciding whether the burdens of treatment imposed on others (3), (4), (5) or on the patient himself (6) are excessive. These comparative assessments are no doubt risky and subject to abuse, but that does not mean that it is *per se* immoral or unjust to use them.

I have not argued that the never-competent human being possesses all the moral rights of a normal human being. The principles merely show what follows from such a position. They can also be used to suggest contexts in which that thesis is not being respected and acted upon.

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