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Schmidt, Andreas

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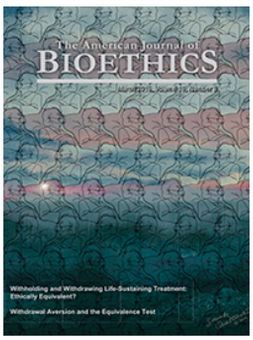

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# Withdrawing and Withholding Treatment: What Do Medical Professionals Owe Their Patients?

Andreas T. Schmidt

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the present studies (Ursin 2019; Wilkinson et al. 2019) are valuable contributions. Ursin points to an important mismatch between the theory (the Equivalence Thesis) well expressed in guidelines and the situations experienced by professionals in clinical practice. Wilkinson and colleagues provide a useful Equivalence Test.

However, if the conditions where the Equivalence Thesis apply are much less frequent due to morally relevant differences breaching with the ceteris paribus clause than thought, the Thesis may be less important than its place in theory and guidelines suggest. If this is correct, we should study the differences more closely than previously done. In particular, to rhetorically label such differences irrational and call moral intuitions "cognitive biases" may be a categorical mistake or in itself be a "moral bias." The argument for ET beyond the ceteris paribus clause appears to be as biased as the argument for the nonequivalence thesis with the ceteris paribus clause applying.

If a well-founded theory for applied ethics is not applicable to clinical cases due to contextual insensitivity, one may consider refining the theory in order to address the contextual issues instead of dismissing them as biases. Ursin as well as Wilkinson and colleagues clearly show that more work is needed. ■

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# Withdrawing and Withholding Treatment: What Do Medical Professionals Owe Their Patients?

**Andreas T. Schmidt,** University of Groningen

Is withdrawing treatment from a patient morally equivalent to withholding it? I understand equivalence as "Other things being equal, it is permissible to withdraw a medical treatment that a patient is receiving if it would have been permissible to withhold the same treatment (not already provided), and vice versa" (Wilkinson and Savulescu 2014, 128).

Of course, much can go on in the "other things being equal" clause, as empirically contingent considerations can make a difference between withdrawing and withholding. But some have tried to reject equivalence based on noncontingent philosophical arguments. One such attempt is the responsibility argument. The argument holds that once treatment has started, medical professionals typically have established a special relationship with the patient. Along with such a special relationship come responsibilities, including the (defeasible) responsibility to continue treating the patient. If so, the moral threshold for withdrawing ongoing treatment is typically higher than for withholding treatment.

In this issue, Ursin defends the responsibility argument, whereas Wilkinson and colleagues reject it (Ursin 2019; Wilkinson, Butcherine, and Savulescu 2019). I here argue that the responsibility argument fails. Afterward, I also


Address correspondence to Andreas T. Schmidt, University of Groningen, Faculty of Philosophy, Oude Boteringestraat 52, 9712 GL Groningen, The Netherlands. E-mail: a.t.schmidt@rug.nl

briefly comment on Ursin's freedom-based argument, which draws on some of my previous work (Schmidt 2016).

Let's first import some theoretical key points on special obligations and responsibility. Special moral obligations are owed to particular individuals or groups and are had in virtue of one's special relationships toward them. Special obligations differ from universal moral duties, such as a duty of benevolence or impartiality. Special obligations can change one's moral landscape. First, special obligations can justify partiality and make it permissible to prioritize a person's interests over others. For example, most people think it permissible to help your children financially, even if you could do more good with this money elsewhere. Second, special obligations are obligations toward a particular person or group and raise the moral stakes in your behavior toward them. For example, some believe that you do not have a stringent duty to share your post-tax income with other people (by, for example, giving it to charity). But most people do think that you have an obligation to use your income to help your partner or children should they be in need.

But what grounds special obligations? Distinguish three models, the first one being:

*The Creation Model*: I acquire or "create" a special obligation to someone by entering a relationship with them.

For example, when you enter a romantic relationship with someone, you create some special obligations toward that person.

The second model seeks to derive the moral status of special obligations from universal moral duties. For example, political philosophers discuss whether our duties of justice are special obligations toward our co-nationals or whether we have duties of global justice owed to all humans worldwide. In this debate, Robert Goodin argues that we do have special obligations, say, to co-nationals, but that these are just specially assigned universal duties (Goodin 1988). Universal duties can only be effectively discharged if we divide up who is responsible for whom. And for that we need special obligations.

*The Assigned Responsibility Model*: There are only universal obligations. Special obligations should be carved up such that the universal obligations are discharged most effectively.

A third model holds that special obligations do not require any further grounding in universal duties or voluntary creation. For example, David Miller thinks that one has special obligations toward one's co-nationals. But unlike Goodin, Miller thinks these obligations do not require a deeper grounding in a universal moral duty.

*The Particularist Model*: obligations and responsibilities are determined relative to the relationships we find ourselves in. Special obligations are part of the fundamental structure of morality and do not require a universalist grounding (Miller 1988, 1995).

Let's return to withdrawing cases. How should we think about the relationship between a medical professional and a patient whose treatment has already begun? We can first take the Creation Model. Doctors take responsibility by starting to treat a patient, as Ursin argues (Ursin 2019). Once a physician starts treating a patient, she acquires a responsibility for the patient she does not owe to the overall population of patients. And part of that responsibility might be a (defeasible) obligation to continue treating the patient.

However, the Creation Model alone fails to support the Responsibility Argument. First, the Creation Model does not tell us what the special obligations are that medical professionals have toward their patients. Importantly, it leaves open whether such obligations should include non-equivalence or not. Second, the Creation Model does not tell us when a physician has a duty to create special obligations with patients. You have no moral duty to enter a romantic relationship with a particular person. It's your right to reject suitors at will. Yet a physician does not have the right to send away potential patients at will. Doctors have antecedent duties to create special obligations.

Should proponents of the Responsibility Argument then use the Particularist Model instead? They could argue that the special relation a doctor might have with a patient she treats—with the obligations that come with that—does not require an independent justification. However, the Particularist Model is also unsuited for doctor–patient relations in health care. Such relations are fundamentally shaped and governed by the norms, institutions, and goals of the health care system. What shape and content special doctor–patient relations should have is in no way morally self-evident but requires an independent institutional justification.

Accordingly, we should opt for the Assigned Responsibility Model. Health care systems ought to treat all patients effectively and equitably. The health care system overall should thus discharge a universal moral duty (universal relative to the overall population of patients). But to do so, it needs to carve up special obligations. For example, it makes a lot of sense to have oncologists rather than dentists treat cancer patients. But how the overall system carves up special obligations and what form and content such obligations take is downstream from its overall aim. This implies that special obligations between doctors and patients can neither just be grounded on their voluntary creation nor be purely particularist. Medical professionals in principle owe responsibility to all patients. And when obligations are carved up, the goal of the health care system should guide what form and content special relations should take.

Note that the Assigned Responsibility Model for whole health care systems can still allow the Creation Model to play some role therein. For example, while the responsibility of health care systems is toward the overall population of patients, we should allow that individual doctors sometimes create special obligations toward individual patients by entering a patient–doctor relationship with them. GPs might justifiably feel particularly responsible for their own

patients and that can contribute to effective and equitable health care delivery overall. But how far medical professionals can create special obligations, and what kinds of obligations those are, are mainly justified by how far the overall assignment of special relations helps achieve effective and equitable healthcare delivery.

If the Assigned Responsibility Model is the correct model for health care, we should next ask whether non-equivalence would help further a health care system's overall aim. I think including non-equivalence as an inherent part of the special relation between medical professionals and patients makes effective and equitable delivery of health care less likely. Consider two arguments put forth by Wilkinson and colleagues (Wilkinson and Savulescu 2014; Wilkinson, Butcherine, and Savulescu 2019). First, consider situations with limited health care resources where withdrawing treatment from a current patient would allow an intensive care unit to start treatment on a new patient. Assume further that treating the new patient would be much more likely to achieve good results than continuing treatment on the current patient. Switching to the new patient would have better chances of delivering effective and equitable health care. Therefore, any special relationship between a physician and a patient should not make it too difficult to switch to the new patient. Second, non-equivalence might also create incentives for doctors to withhold treatment. Doctors might sometimes not start treatments they should start, because they might know (or think) that once they have started treatment it will be very difficult to stop (Wilkinson, Butcherine, and Savulescu 2019, 5).

If these two points admit of some generalization, we should conclude that including non-equivalence in special obligations could stand in the way—instead of furthering—a health care system's universal duty to all patients.

Let me finally, and very briefly, comment on Ursin's Freedom Argument. In a previous piece in this journal, I argued that the justificatory burdens can sometimes be higher when we remove freedoms that already exist (withdraw) than when we block the addition of new freedoms (withhold) (Schmidt 2016). This can be so, for example, when individuals have attached meanings to those options or integrated those options into their life plans and identity. However, I argued that the weight of those considerations can vary significantly. For tobacco control, for example, I argued that the reasons for seeing withdrawing and withholding as non-equivalent were not strong enough to make a freedom-based case against drastic "endgame" measures, such as banning cigarettes. Ursin now applies this model in support of non-equivalence: In some cases—excluding cases with unconscious patients—a patient who is currently being treated might have already integrated existing options into her conception of the good and life plans in a way that someone whose treatment is withheld has not. I find this application interesting. However, I am not sure it gives strong support for non-equivalence.

First, life and health are fundamental freedoms. Whatever your conception of the good or your life plans, being alive helps to achieve them—and being healthy nearly always helps too. It's thus hard to see why a person's freedom should matter less before treatment has started. Both before and during treatment, people tend to have life plans and conceptions of the good, and such plans were made conditional on being alive (and typically reasonably healthy). Thus, for most of our life plans, identities, and conceptions of the good, it might not matter much whether we are currently being treated or hope to be treated.

Second, freedom as a social value requires considering everyone's interest in freedom. The person who is currently being treated typically has a claim to freedom just as much as the person hoping to get treated. As I argued above a health care system's duty is toward the overall population of patients. We can again imagine cases where withdrawing treatment from one patient would free up resources to treat someone with more favorable chances. In such cases, a concern with people's freedom might push us toward treatments that would increase one patient's freedom (the patient currently not treated) much more than another patient's freedom (the patient currently treated).

Overall, I am skeptical that purely philosophical arguments—such as responsibility and freedom—can establish non-equivalence. Yet there are, as Ursin and Wilkinson and colleagues point out, real-life factors that can sometimes make a difference. Good practical proposals—and Ursin and Wilkinson and colleagues consider some—should help us capture those. At the same time, such proposals should ensure that the withdrawing/withholding distinction does not stand in the way of effective and equitable health care. ■

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