Withholding Versus Withdrawing Treatment: Why Medical Guidelines Should Omit "Theoretical Equivalence"

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I am grateful for all the comments on my target article «Withholding and Withdrawing Life-Sustaining Treatment: Ethically Equivalent? » The comments provide useful contributions to the important debate on this topic. In this paper, I will discuss some of the interesting points raised by the commentators, and the notable challenges raised to my position in the target article. This allows me to clarify and improve the reflections and my position in the target article, to further advance the discussion.

What is going on in this debate? My starting point was that while medical guidelines tend to state that withdrawing life-saving treatment is ethically indifferent from withholding life-saving treatment, surveyed health care personnel (HCP) are sceptical to this assertion. Thus, there seems to be a contradiction between the views of practitioners and the guidelines set for their practice.

This inconsistency lead to the questions: why the disagreement, and who is right? My answer was that the disagreement is the result of attempts to question certain HCP attitudes, but in the attempt, the guidelines unfortunately make use of flawed ethical reasoning. Thus, regarding the purported equivalence, the practitioners are right. The main problem does not lie with medical guidelines questioning the appropriateness of general HCP attitudes in certain specific situations, but in eschewing these attitudes as generally unsound altogether.

In short, my diagnosis was that simplistic ethical theory is used to navigate the complex ethical realities of health care practices. In this paper, I will start by describing the theoretical imaginary of ethical equivalence. My point will be that the "ethical analyses" referred to in medical guidelines is a misnomer. The purported philosophical backing of equivalence referred to in these guidelines is not based on comprehensive ethical *analyses*, rather on narrow ethical *activism*.

Subsequently, I will move on to discuss the relation between withholding and withdrawing treatment in light of the comments received. This relation is complex and calls for nuanced descriptions. A central question is whether any assertion of ethical equivalence is fruitful for guiding medical practice, and moreover if the assertion misses the target and is redundant in making the points of concern in these guidelines. My answer is that the points of concern – most notably cases of illegitimate persistence of upholding life-sustaining treatment – should be addressed directly, without invoking an equivalence with withholding that rests on a number of questionable premises. The conclusion of this paper is that this calls for a rewriting of medical guidelines on this point.

The morality of a parallel ethical universe

Several of the commentators express the view that even if withholding and withdrawing treatment is ethically the same in theory, this equivalence thesis (ET) is only rarely applicable in practice. The commentators still think, however, that ET can be utilized in health care, because “the concept of ethical equivalence, though primarily theoretical, should be articulated since it may well narrow the psychological gap for the family and health care team”. (Furfari and Abbott, 2019) This seems a bit superficial. In order to clarify why and how this attitude is problematic, I will briefly describe the quite extraordinary claims one has to be prepared to endorse to believe in the “theoretical equivalence” of ET.

In their commentary article, Wilkinson et al. state that, “The debate about equivalence and non-equivalence matters because there is a disconnect between ethical theory and the views of health professionals.” (Wilkinson et al., 2019) It is here important to specify this disconnect is restricted to the views of some[1] health professionals and a particular ethical theory, namely utilitarianism – or consequence ethics. There is no initial disconnect here between the views of health professionals and the majority of ethical theories, like duty ethics, virtue ethics, ethics of care, etc.

Still, as Wilkinson goes on to note, most professional guidelines sweepingly refer to ET as established by ethical theory. This is problematic. Why do medical guidelines proclaim a thesis contested not only by medical professionals, but also by ethicists? I suspect that the main reason is that utilitarian ethicists have been keen to discuss all kinds of equivalence, as part of their general programme of showing how ethics is reducible to acts and consequences.[2] Thus, if you go to ethical theory, the main interest in ET comes from utilitarian ethicists. Now, the question is whether utilitarian theory provide an adequate grounding for medical guidelines. Let us have a closer look.

In theoretical ethics, the discussion of the relation between withholding versus withdrawing treatment has its historical roots in analyses of the ethical relation between acts and omissions. In current law and everyday morality, there is a general difference between failing to prevent and actively causing harm. However, utilitarian ethicists have been eager to argue that – contrary to popular belief – there is no ethical difference between acts and omissions. Since utilitarian ethics is all about consequences, it simply does not matter whether those consequences stem from action or inaction. Consequently, a person can no longer argue in any situation that she did nothing wrong, because she just *omitted* to help: her omission to act is a moral choice like any other.

An ethical analysis just in terms of consequences means that we just assess moral situations in terms of how our choices increase the net sum of beneficial consequences for persons in the world. The only moral assessment we have to make is how our choices make a difference in terms of such consequences, and if there are no differences: We have equivalence. From this basic textbook version of consequence ethics, it is obvious that HCP

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[1] Usually the vast majority. While this is notable and provide a starting important point for my argument, I would still question the significance of such survey results. As the questions of equivalence is unclear, because different practices at different stages of care are hard to compare, it is unclear what the respondents mean by their indicated answers.

[2] Other reasons might be that (1) the often provocative statements based on utilitarianism also make this ethical theory very visible in debates in medical ethics, and (2) that the quantitative nature of the value assessments in consequence ethics makes it easy to relate and refer to, especially in value pluralistic settings.

should prioritise the patient with the best chances of benefitting from treatment, even if it means withdrawing treatment from a patient in care. Likewise, if another boy would benefit more from my help with his homework than my son, the morally right way to act is likewise obvious. It is just a matter of comparing the options in terms of how they increase the net sum of beneficial consequences. Other kinds of concerns do not matter.

In the utilitarian moral universe, we are now *responsible* for considering how to act so that we benefit in the best possible way any other person at all times. We all have the same responsibility towards any other person in the world, regardless of our relation to that person. It would thus be unfair and irresponsible to help someone close to you – for instance a person in your care or a family member – if someone else somewhere else is more in need of your help.

Now, such an ethical analysis puts great strain on our understanding of responsibility. There are at any given moment many things we do not do, but could have done or considered doing. There are many people we do not help, but could have helped or considered helping. Are we responsible for not choosing (to consider choosing) these ways of acting, especially if we thereby could have greatly benefitted or even saved the lives of others?

In current law and everyday morality, we in general say that we are mainly responsible for our acts, and that our responsibilities concerning what we *omit* doing depend on several aspects of a situation, especially how we interfere and relate with other persons. For instance, it makes a difference to our responsibilities whether or not we are taking care of the persons in question, because of a personal or professional relation, like being a father or a teacher.[3] It is also of moral and legal significance if we have taken on some kind of responsibility for a person, for instance by owing the person something or making a promise.

Based on this, we usually say that we have a qualified – not a general – responsibility not to harm others by omission. This responsibility is dependent of our relation to a person, or the nature of the situation, for instance if we are the first to arrive at the site of a traffic accident. Apart from this, we are not in general responsible for all the things we do not do.

To depart from this, and say that we are (within our capacity) responsible for choosing not to do all the things we at any given moment could have done, is to put forward a new and radical understanding of the notion of responsibility. To implement such an understanding of moral responsibility would involve a transformation of current human relations and societal structures on a global scale. Regardless of one's view on such an understanding of moral responsibility, it is clear that this understanding is not a "description", "interpretation", or "analysis" of current morality anywhere in the world. It is instead a theoretical *imaginary of a parallel normative universe* with different norms and practices than the existing ones. If we are prepared to enter this imagined ethical universe, withholding is equivalent with withdrawing.

Several commentators struggle to see exactly how a discussion of the ethics of acts and omissions relates to the discussion of ET. Why is an analysis of the ethical relation between acts and omissions of interest for a discussion of the relation between withholding and withdrawing treatment? These sets of relations are obviously not the same, as any combination of the two pair of terms is possible in accurate descriptions of different

[3] Or, uncle – see the discussion in Ursin, 2019.

situations: It is for instance possible to describe withholding treatment either as an omission to offer life-saving treatment as well as the active offering of comfort care.

What binds these discussions together is rather the shared assertion that two kinds of acts or practices that are widely regarded as ethically different, "on closer inspection" turns out to be ethically speaking identical: Omissions are acts, withdrawing is withholding. There is thus a relation of *analogy* between these discussions. There is also a relation in terms of the moral significance of omission in respect for natural events. In several of the commentaries, it is interesting to note how the moral and legal significance of abstaining from interfering in the life of someone else, and leave it to nature to take its course, resonate with different cultures and calls for a "global dialogue". (Nakazawa et al., 2019, McGee and Truog, 2019, and Ravitsky and Steinberg, 2019)

In the imagined parallel normative universe, however, there is no ethical difference between our acts and omissions based on special relations or natural events. The stipulated definition of ethical acts as the choices that optimize good consequences, rules out any moral significance of leaving it to nature to take its course, for instance in the dying process of a patient.

Normativity and context-sensitivity

If we erase all map details on how we specifically relate morally to other persons and to natural events, it becomes impossible to read the moral landscape as making any room for moral difference between withdrawing and withholding treatment.[4] All that matters is to choose the (in-) action that produce the best consequences in any situation, for any person. If one is prepared to endorse these claims, the "theoretical equivalence" withholding and withdrawing holds.

Of course, ethics is importantly more than descriptive. Ethics is essentially normative, and compels us to argue what *should* be the case, not just what *is* the case. In challenging current normative practices, however, it is still fundamental to understand and describe the acts, articulations and assessments involved in an accurate way. Otherwise, the theoretical imaginaries constructed are of little use and relevance to improve on current morality.

To arrive at such accurate descriptions is a vast task. Normative practices involve fine distinctions and connections that often are unarticulated and hard to reconstruct in a precise and coherent manner. Usually, several considerations go together and partially overlap to ground the specific normative assessments of practices and situations. To get it right, the theoretical reconstructions need to reflect the practical richness.

In my target article, I sketch a theoretical reconstruction of the ethics of withholding and withdrawing treatment. I propose two general and ethically significant differences between these practices, relating to patient autonomy and professional responsibility. Andreas Schmidt is "sceptical that purely philosophical arguments – such as responsibility and freedom – can establish non-equivalence". (Schmidt, 2019) So am I – in addition to being sceptical that philosophical arguments can establish equivalence.

Philosophical arguments need context-sensitivity. Schmidt provides a case in point in arguing that while removing existing freedoms (withdrawing) in general can interfere more

[4] Except, perhaps, for cost-effectiveness reasons, cf. Sandman and Liliemark 2019.

heavily with someone's life plans (and need heavier justification) compared to not introducing the same freedoms (withholding), this is not the case in the present context. Because all life plans obviously presuppose being alive, withdrawing life-saving treatment is not restricting someone's freedom more than withholding.

This is a good point, but not context-sensitive enough. In the relevant health care settings, it is not a matter of keeping the patient alive in order to retain the autonomy of the patient or relatives. As remarked by Furfari and Abbott, this perspective "fails to resonate in clinical scenarios because death is not a negative result". (Furfari and Abbott, 2019) The matter is rather whether lifesaving already might disrespect the autonomy and values of the patient or relatives, and if (or how) later withdrawal is ethically permissible given the then established commitment of parents to a rescued child or a patient to a demanding life-sustaining regime. The crucial point, as argued in my target article, is that a decision to start life-saving treatment radically changes the ethical situation for those involved.

In their discussions of patient autonomy and the interesting aspects of professional responsibility, Schmidt and Wilkinson et al. unfortunately change the subject to questions of rationing and equal access to health care. This is not what is central to ET[5], except in special circumstances. (Iserson, 2019) What is central is the social and ethical implications of a decision to start life-sustaining treatment for the development of relations of care and commitment to pursue a shared goal. (Wightman and Diekema, 2019, Char and Hollander, 2019) Here, the question is what is right at the different stages of the treatment and caring relation, and how decisions made influence what is right, most often explicitly regardless of rationing concerns. Indeed, as recently argued (Emmerich and Gordijn, 2019), withholding and withdrawing are not just different decisions, but are part of quite different medical practices.[6]

By contrast, the point of ET is to say that there is no difference between withholding and withdrawing treatment, because we at all times just choose to act in the situation we are currently confronted with. Consequently, there is no such thing as withdrawal, there is just withholding, or even better; just treatment options to consider. Therefore, the significance – not only ethical, but also descriptive – of the term "withdrawal" is challenged by ET proponents. We should stop thinking in terms of a dichotomy of withdrawing and withholding treatment, and move on to talk about various treatment options.

It is, however, easy for everyone to agree to this. It is more accurate to drop comparing disparate practices of "withholding" and "withdrawing", and reframe the decisions instead simply in terms of making choices between options of life-sustaining, no-escalating (Batten et al., 2019) and palliative treatment at different stages. Such reframing makes it natural to stop bothering with tricky calculations of equivalence of outcomes, moving to process-oriented analyses (Haward and Janvier, 2019) that enable those involved

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[5] In fact, I (and most doctors) take the suggestion (by Wilkinson and Savulescu, 2012) that HCP are obliged to stop treating patients in their care if someone else turns up that might benefit slightly more from the treatment, to be a *reduction ad absurdum* of a strict ET position in that regard. Morality is not – and should not be – reducible to a means of maximizing survival rates.

[6] The value of asking – and answering – questions concerning equivalence suffers from this. Survey questions concerning equivalence will typically be radically underdescribed, so the value of such surveys is very limited – just like with the usefulness of any "equivalence test".

to concentrate fully on the values and intuitions involved in decision-making in different situations and practices.

Does anyone care whether ET is valid?

Two quite interesting general features of the promotion of ET are (1) that it seems quite impossible to falsify ET statements, and (2) that the usefulness of ET seems more important than its validity. Firstly, for ET to work, the situations of withholding and withdrawing need to be the same. This means that for any critique of ET pointing out that the actual cases of withholding and withdrawing involve ethically relevant differences regarding situations, practices, considerations, etc., the ET proponent can always just say that, "Well, that is true, but it does not undermine ET, since ET presuppose sameness in situations, and in this case there are ethically relevant differences." This means that ET always can be argued to hold *in principle,* even if it never holds in the real world. Again, ET just holds in a theoretical imaginary of a parallel universe with different norms and practices than current ones, as described above.

So, why insist on ET? For one, the insistence can be part of a general argument for an ethical revolution, where current norms are replaced by the norms of the theoretical imaginary of utilitarianism. Another motivation is to insist on ET in order to create backing for HCP in making and communicating hard decisions in clinical care, as illustrated by the first quote from Furfari and Abbott above. Here, it is the usefulness and not the validity of ET that is important; what is important is to refer to some "theoretical equivalence" in order to make it easier for patients and parents to accept withdrawal of treatment.

This latter motivation has joined forces with former, but unfortunately on false terms. The title of the article by Wilkinson et al., "Withdrawal Aversion and the Equivalence Test", points to this uneasy mix of motivations in promoting ET. The article contains an "Equivalence Test", but the purpose of this test is not to test equivalence, but to avoid "Withdrawal Aversion". As it reportedly often is hard to withdraw treatment, sometimes too hard, anything that can help those involved to balance the decision-making seems to be welcome – even referring to an abstract and controversial piece of ethical theory.

Concluding remarks

Medical guidelines should thus delete any references to a spurious "theoretical equivalence" purportedly shown by ethical analysis. There is no agreement on any such theoretical equivalence in ethical theory. The usefulness of constructing ethical equivalences between different situations and practices in health care is doubtful, and diverts focus from the complexity of the situations where important treatment decisions have to be made. There is no need to counter undue reluctance to withdraw life-sustaining treatment by using contested theoretical theses. Instead, medical guidelines should promote balanced decision-making by emphasising careful considerations of the specific ethical aspects of any situation where treatment choices are made.

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