Is the Equivalence Thesis valid?

Before going much further, we need to consider whether withholding treatment (that is, never starting) is ethically the same or different from withdrawing treatment. As predictable, there are two schools of thought.

The dominant opinion currently favours the Equivalence Thesis. This states that: If it would have been morally permissible to have withheld a therapy (that has in fact already been started), then it is now morally permissible to withdraw that therapy and, if in the future, it would be morally permissible to withdraw a therapy (that has in fact not yet been started), then it is now morally permissible to withhold that therapy. While the ethics gurus have mostly pronounced that there is no moral difference between withholding and withdrawing, most clinicians do not concur. A Non-Equivalence corollary might sound like this: All things being equal, it would at least sometimes be ethical to withhold critical treatment from a patient whereas it might not be ethical to withdraw the same treatment if already started.

People who oppose the Equivalence Thesis use a number of arguments to justify their position. One theory holds that a person who acquires a holding in accordance with the principle of justice in acquisition is entitled to that holding. (Nozick’s Principle of Original Acquisition of Holdings).

This certainly fits with the way many or even most clinicians think. An example of this could be constructed using the following scenario:

There is one last bed in ICU and two requests for that single bed. Both patients will likely die if not given the bed. The one patient is Jack, who is 25 years of age and has a predicted intact survival with ICU of 70%. The other is Harry, 65 years of age and he has a predicted intact survival of 30%. Dr Sensible, the ICU consultant, opts for Jack based on distributive justice and utilitarian principles. By doing so, he effectively withdraws treatment from Harry.

However, prior to the admission to ICU, the family of Jack decide to transfer him to a facility in another city, closer to home and thus Harry gets the bed. Harry has a stormy course but is hanging in there on a ventilator and his prognosis for intact survival is still about 30%.

Enter another patient, Tertius. He is young, with a good prognosis (70%), and needs ICU to survive. The ICU registrar, Dr Uppity, argues that if withholding and withdrawing are ethically equivalent then Harry should be removed from the ICU bed and palliated and Tertius should get the bed. Understandably Dr Sensible overrides this.

What an unmanageable situation would exist if ICUs were managed by withdrawing treatment from a patient when someone with a better prognosis came along! In this scenario, using Nozick’s Principle, Harry is entitled to hold on to the bed that he originally and justly acquired.

Best interest standard

Adults who have the capacity to make their own rational decisions are judged as ideally positioned to assess their own best interests and they are protected under the law and ethically from treatment that will inappropriately prolong their lives. In fact, in SA, treatment of such persons against their will or without their consent would legally constitute assault. The physician does however have an advocacy and oversight responsibility to assess the patient’s understanding of the
medical condition. Is the patient’s decision to decline treatment a decision that many or most rational people might make under the circumstances; or is their decision something that few or no rational persons might make? If the latter, then is their decision evidence of an acute lack of capacity?

Capacity (or in old terminology competence) should not be simply assumed. It is best assessed by a third party and this function is often delegated to a psychiatrist. There are many factors that may affect competence. Besides obvious elements such as intellectual capacity, education and knowledge, factors such as fear, depression or substance abuse may acutely impair capacity.

**Persistent vegetative state (PVS)**

Many of the widely publicised cases involving withdrawal of treatment involve patients in a PVS. A vegetative state is defined as a clinical condition of complete unawareness of the self and the environment, accompanied by sleep-wake cycles, with either complete or partial preservation of hypothalamic and brain-stem autonomic functions. In addition, patients in a vegetative state show no evidence of sustained, reproducible, purposeful, or voluntary behavioural responses to visual, auditory, tactile, or noxious stimuli; show no evidence of language comprehension or expression; have bowel and bladder incontinence; and have variably preserved cranial-nerve and spinal reflexes.

The persistence of such a state should be for at least one month to satisfy the definition. In various cases, both surrogates and care-givers have applied to the courts for legal authority to continue or withdraw life-supporting or life-sustaining treatments for patients with PVS. Usually the arguments have invoked ‘death with dignity’, ‘patient’s best interests’, ‘conditions worse than death’ and/or ‘futility’.

Although a patient in PVS is apparently beyond personal concern for dignity, it goes without saying that those who love and care for them should uphold their dignity during life and as death nears and this should not be used as a reason for shortening the process.

The best interests of the patient standards can also not logically be applied to someone who in the nature of the condition can have no interests, best or worse.

It is not ethically acceptable that a patient, especially one with an apparently futile prognosis, be left to suffer severe pain or discomfort: but these situations can be managed. Consensus on what constitutes futility has not been reached but in each case there should be general medical consensus on futility of further management by a medical team.

Of course, loving family members, especially those with fervent religious beliefs, would hope and pray for a miracle cure. In an increasing secular society, it is unacceptable that such beliefs should be pervasive with regard to withdrawing treatment. As Savulescu has stated; the elephant in intensive care is distributive justice. He recognises the convenient fiction we use when we tell patients and surrogates that treatment is not in their interests because we can’t face up to the elephant of distributive justice and the inevitable limitations of our medical resources.

**Children**

Children are not supposed to die. The Royal College of Paediatrics and Child Health has produced a booklet governing the choices for withdrawing or withholding treatment in children. This is a comprehensive and useful document. It suggests five situations where withdrawal or withholding treatment may be pertinent. These are:

- The brain dead child
- The permanent vegetative state
- The ‘no chance situation’
- The ‘no purpose situation’
- The ‘unbearable situation’.

The authors emphasise that where uncertainty exists then the care-givers should always safeguard the life. Decisions should not be rushed and the most senior opinions obtained. There should always be attention to palliation and terminal care needs which includes symptom alleviation and care, and which maintains human dignity and comfort.

**References**

1. Wilkinson D & Savulescu J. A costly separation between withdrawing and withholding treatment in intensive care. Bioethics; ISSN 5 JUL 2012, DOI: 10.1111/j.1467-8519.2012.01981.x