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### **Life and Death in the Neonatal Clinic**

In the 18<sup>th</sup> century, in the days before antiseptics and antibiotics, a mother who gave birth to a healthy child and survived herself would consider herself lucky. In the 21<sup>st</sup> century, babies who only decades ago would have been doomed can survive on life-support machines. Yet medical technology is a double edged sword. It can extend life but cannot vouch for the quality of the added time. It can create and prolong intense suffering. As medical technology progresses, a question thus arises: when should we put the machines aside and let extremely premature babies die?

Last week, the Nuffield Council on Bioethics released a report which addresses this question. Its suggestions were as follows: babies born at or before 22 weeks should not be resuscitated or be given intensive care, the same goes for babies born between 22 and 23 weeks unless the parents request treatment, for babies born between 23 and 24 weeks, the parents should decide, and for babies born between 24 and 25 weeks intensive care should be provided unless parents and doctors agree that it is best not to treat. After 25 weeks, intensive care should be the norm.

So why not bother at 22 weeks? The statistics show that 1% of babies born at that time survive to leave hospital. One argument might go that 1% is such a meagre chance that it is best not to treat. There is a 99% chance that the baby's suffering will merely be extended. Since the likelihood of survival is slim, and the likelihood of causing considerable harm is high, we should not treat.

Supporters of this view might point out that even if by some miracle the baby falls within that 1%, its quality of life will be so awful that death would be a blessing. What good is life, they might say, if it consists only of pain, anguish or nothingness. Imposing such a life on people is cruel and inhumane. This belief that life itself is

only valuable if it is accompanied by a modicum of quality is shared by supporters of euthanasia and assisted suicide.

Those in favour of treatment for babies born at 22 weeks or earlier might retort “who are we to say that a 1% chance of survival is hopeless?”. A tiny chance of survival is better than no chance at all. And indeed it is, but a dilemma arises: is it morally preferable to let that one lucky baby die (the 1% in the statistic) and spare the 99 other babies from avoidable distress, or to save the baby at the cost of causing much harm to 99 others? In other words, a policy to treat all babies at 22 weeks or earlier will save a few babies while causing great suffering to many more. As in all true dilemmas, whatever horn of the dilemma we choose, we will be impaled by the other.

Opponents will also question the ‘quality of life’ argument. How can we know with any certainty that even a severely disabled child will not lead a worthwhile life? After all, there are plenty of examples of profoundly disabled people who exude an obvious *joie de vivre*. At what point on the imaginary continuum of life quality should we draw the line: Blindness? Total paralysis? Severe and irreversible cognitive impairment? And if we can’t provide good answers to these questions, should we not ‘play it safe’ and give every baby a fighting chance?

This issue is all the more difficult because decisions have to be made in situations of uncertainty. The statistics can give some indication of survival, but they won’t help the doctor determine the chances in an individual case. Every case will differ in some respects from the next. Guidelines are rules of thumb. They are not set in stone. The Nuffield Council report will not change that fact that doctors will need to exercise careful judgement to weigh the harms and benefits of treatment in a particular situation.

To complicate matters further, there is the controversial issue of cost. Treating premature babies in intensive care is extremely expensive (several thousand pounds per day) and may have significant financial implications for the hospital. In light of the poor outcomes of treatment and the many shortages elsewhere, is it the best use of resources?

Few issues are as emotive as life-and-death decisions affecting babies. Now more than ever, the death of a child is seen as a grave injustice. In the face of such innocence, vulnerability, distress and injustice, the natural tendency is to do everything for the child. The more, the better. Ironically, in some cases, the best and hardest thing to do might be to do nothing.

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