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be unorganized workers to act as a magnet for companies when their own employees get into a position to make unwelcome demands.

Thus, even though in the short run workers in South Carolina or Korea might benefit from Ohio plant closings — and might benefit from them more, economically, than Ohio workers are harmed — over time, corporate autonomy in shutdown decisions is a setback for labor, not an advance. This is even more obvious if we think not only in the narrowest economic terms: not simply in terms of dollars but also in terms of self-respect and the ability to determine important aspects of one's own life. What workers who would gain (in the short run) from plant closings would gain are jobs and money — nothing to sneeze at, to be sure. But what they would not gain, and what Ohio workers and ultimately all workers would lose, is the power to affect in any way a crucial aspect of their lives, their work, and livelihood. For they would be forever at the mercy of employers who can say: take it or leave it.

Conclusion

We began by mentioning two (not unrelated) kinds of arguments for the conclusion that workers ought to have a say in decisions about plant shutdowns and relocations. The first, rooted in the labor theory of property, supports the view that not only owners but workers may come to have property rights in their workplaces. The other argues that in view of relationships developed over years and even generations, companies come to have certain obligations to workers that are incompatible with abrupt withdrawal. We hope to have dispelled pragmatic objections to these arguments.

Our conclusion is that the company's ownership of the factory cannot settle the issue of its responsibility in plant closings. "It's mine" is no longer an argument-stopper. We can interpret this in either of two ways: (1) It may be yours, but that doesn't mean you can do with it whatever you please; (2) It may have been all yours once, but other people have now acquired rights in it, so it is no longer just yours to do with as you please. The first interpretation grants the original owner an exclusive property right, but asserts that it has been limited or qualified by his or her own actions; the second interpretation denies the original owner an exclusive property right.

The practical conclusion is the same in either case: companies should not be permitted to make decisions about plant closings and relocations unilaterally. This conclusion is supported by a variety of moral considerations, having to do with fairness, self-respect, autonomy, and the interests of workers in general over the long run. It is, in addition, a conclusion that seems to survive the harsh scrutiny of economics.

— Judith Lichtenberg

This article was drawn from "Workers, Owners, and Factory Closings," which will appear in Moral Rights in the Workplace, a forthcoming collection of essays edited by Gertrude Ezorsky, under the sponsorship of the Society for Philosophy and Public Affairs.

Life-Support Decisions for Newborns

Baby Jane Doe is only the most recent, and certainly not the last, of the extraordinarily difficult and troubling cases about life-sustaining treatment for seriously handicapped newborns to gain the attention of the courts, the media, and ultimately the public. Baby Jane Doe was born with spina bifida, a condition in which the spinal column is exposed, commonly resulting in lack of bowel and bladder control, paralysis below the waist, and mental retardation. The degree of disability can vary widely. Her parents decided, together with their physician, not to provide maximally aggressive treatment which might have permit-

ted the infant to live to perhaps age 20 and without which she was likely to die by age two.

Public and government attention had been focused on this area nearly two years earlier in the so-called "Baby-Doe" case in Bloomington, Indiana, when an infant who suffered from Down's syndrome was allowed to starve to death after its parents refused to permit surgery to repair its esophagus. The Reagan administration, in an initially heavy-handed response to the very real problem, put hospitals on notice that withholding nutritional sustenance or medical or surgical treatment to correct a life-

threatening condition in an infant because the infant is handicapped is unlawful and in violation of Section 504 of the Rehabilitation Act of 1963. The notice was accompanied with threats of loss of all federal financial aid to the hospital, the establishment of a hotline for confidential reporting of purported violations, and Baby Doe squads to investigate possible violations.

In the face of successful court challenges and widespread opposition, the administration partially backed off from its initial position and suggested, among other things, that hospitals establish ethics committees to review such decisions. The President's Commission for the Study of

Birth is a problematic point at which to draw a great moral difference in the wrongness of killing. Newborns may be seen as occupying a moral status somewhere between that of unborn fetuses and adults. And unborn fetuses are often considered replaceable. . . .

Ethical Problems in Medicine also recommended in its report, "Deciding to Forgo Life-Sustaining Treatment," that hospital ethics committees be established to review decisions to forgo life-sustaining treatment for defective newborns. Recently passed federal child-abuse legislation dealing with life-sustaining treatment for seriously ill newborns included a similar recommendation. Neither the administration, the President's Commission, nor Congress wished such committees to replace parents and physicians as decision-makers about care. But because of the significant potential for conflict of interest between such infants and their parents, who commonly will assume the often enormous burdens of care involved, the President's Commission believed that regular review of such decisions was desirable. Since very few of the nation's hospitals have ethics committees, our experience with them is necessarily limited and their potential effectiveness in this area uncertain. Nevertheless, experience over the last 15 years with the establishment of Institutional Review Boards charged with reviewing the protection of human research subjects suggests that ethics committees might successfully play a similar review role here. Thus, I believe the administration and Congress's recommendation for ethics committees to review these decisions, unlike some other aspects of their response to this problem, is basically sound. Improving procedures by which such difficult and important decisions are made is surely to be welcomed, perhaps especially where there is no consensus regarding the proper decisions to appeal to in responding to public concern.

Nevertheless, I believe it would be a mistake to expect that improved procedures, with review of decisions by hospital ethics committees, will put the controversy to rest. It should be emphasized that most decisions to stop life support for newborns do not raise troubling moral issues. Most involve infants who are known at birth to be non-viable, incapable of living beyond a few weeks or months, or who in the course of treatment, usually for

conditions associated with extreme prematurity and low birth weight, reach a point where they have become non-viable. In each of these cases, a point comes at which further life support is futile. But questions arise about providing life support that will result in a life of seriously diminished quality. This kind of case, exemplified by some instances of Down's syndrome, spina bifida, and extreme prematurity, touches areas of deep moral uncertainty and disagreement in our society. Some of the controversy concerns appropriate decision-making procedures — most importantly, the legitimate role, if any, for government and the courts, and the degree of decision-making discretion properly accorded to parents — but the controversy extends beyond these. I want to suggest briefly what some of the issues are which make these decisions so morally intractable, whatever our confidence in decision-making procedures.

First is the fundamental question of whether it is as seriously wrong morally to allow a newborn infant to die, or to kill it, as it is a normal adult human. The law in general gives a newborn the same legal protections regarding life as an adult. But there are reasons to believe that the moral issue is not as straightforward. One reason is familiar from the abortion controversy. Birth is a problematic point at which to draw a great moral difference in the wrongness of killing. Newborns may be seen as occupying a moral status somewhere between that of unborn fetuses and adults. And unborn fetuses are often considered replaceable; if amniocentesis indicates that a fetus is defective, for example, many believe that it is permissibly destroyed, in order to try again for a normal pregnancy. A second reason lies in one plausible account of why killing a normal adult human is a serious moral wrong. That is that in doing so we deprive that person of most of what he or she desires — to have a future and to pursue his or her aims in that future. But a newborn infant is probably unable to conceive of itself as having a future and in turn to have any desires about its future that might

. . . a newborn infant is probably unable to conceive of itself as having a future and in turn to have any desires about its future that might be frustrated by its being killed.

be frustrated by its being killed. This first question, then, concerns whether infanticide might be morally permissible in some circumstances in which killing an adult person would not be.

Second is the question of what role quality of life considerations properly have in decisions about sustaining life. One interpretation of the recent federal legislation is that the expected quality of the infant's life may play no role in such decisions. However, such a view is morally problematic. Competent adults do commonly weigh the expected quality of their lives in deciding whether to accept or reject life-sustaining medical treatment. Some



competent adults also say that they would want their lives ended if they should ever be in conditions similar to those of many handicapped newborns. Of course, these adults have a normal life behind them and experience these new reduced circumstances as a loss, whereas a handicapped newborn may never know a different quality of life and so may adjust to the life it is given in a way adults might choose not to do. On the other hand, there is a powerful moral tradition that all human lives are equally valuable, and equally to be protected. But this is a difficult view to sustain with the most defective newborns, such as those born anencephalic, that is, missing all or most of their brains. And if considerations of the quality of life are relevant, which ones and in what way? Do we weigh prospects for pleasure and pain, capacities for social interaction, possibilities for eventual self-sufficiency? Sometimes an appeal to the likely quality of these infants' lives represents an unjustified discrimination against the handicapped, but it need not always be that. Sometimes it represents genuine moral uncertainty about the relevance of quality of life to decisions about sustaining or taking life.

A third general difficulty is what role hardships and costs to others, in particular to other family members and the larger society, should be allowed to play in these decisions. The hardships are real and often overwhelming, and it would be callously insensitive to deny their existence. The limited availability of continuing support services for seriously handicapped children exacerbates the burdens placed on family members.

And the general societal costs for supporting such persons are often very high, with many handicapped unable ever to make normal social contributions. In utilitarian moral views such considerations are not in principle irrelevant to whether life must be sustained or may be taken. On the other hand, many believe there is a serious moral right not to be killed, or in these cases allowed to die, one point of which is precisely to make such effects on others, whether family or society, morally irrelevant to these decisions.

Fourth is that several controversial distinctions concerning the moral permissibility of forgoing life-sustaining treatment generally arise also in the case of newborns. Let me illustrate with the case of turning off a life-sustaining respirator. Is doing so killing the infant, or is it "merely" allowing it to die? In the usual circumstances in which it occurs, many would characterize this as turning off the respirator and thereby allowing the infant to die. Yet if the very same action were done for a different reason, say to protect an inheritance instead of to end the infant's suffering, it would be understood as killing. So it is controversial whether such decisions result in killing or allowing to die because it is unclear just what the difference is. But it is also unclear whether it matters morally in itself whether this is killing or allowing to die. Many believe that killing is, in itself and apart from any other features of the action, morally worse than allowing to die. Others, myself included, hold this view to be mistaken. And so this controversy, too, intrudes itself into the general debate about sustaining the lives of handicapped newborns. But matters

are worse still, for problematic distinctions abound in this area, such as the distinction between not starting and stopping treatment, between ordinary and extraordinary and heroic treatment, and so forth. In my view, none of these distinctions, as they are usually understood, is in itself morally important, but whether that is correct further complicates decisions about life-sustaining treatment for handicapped newborns.

Throughout all these issues lurk concerns about the possible well-intentioned misuse or ill-intentioned abuse of public or legal policies permitting non-treatment of handicapped newborns. Even if one believes that considerations of quality of life or burdens to others could sometimes justify forgoing treatment, one might consistently oppose public policy permitting non-treatment on these grounds, because of worries that such policies would be misapplied more often, or in more serious ways, than not. But, of course, it is very uncertain to what extent any changes in policies would actually lead to more abuse, that is, to what extent the "slope" from here to an overall worse situation is indeed sufficiently slippery to warrant not moving onto it at all.

I would emphasize that I have not sought to defend any particular view here about when forgoing life-sustaining treatment for handicapped newborns is justified. On the contrary, if I am correct that the issues to which I have drawn attention are deeply implicated in this controversy, then a far more detailed and lengthy argument than could be attempted here is needed. Hospital ethics committees are, I believe, a step in the right direction in providing regular review and continuing discussion of these decisions. But some decisions not to treat seriously handicapped infants raise such complex and controversial issues that they will undoubtedly remain deeply troubling and tragic.

— Dan W. Brock

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