Analysis Of The Case Based On Utilitarianism

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Abstract

Utilitarianism evaluates actions by their consequences for well-being, but applying it to neonatal intensive care is ethically difficult because outcomes are uncertain, affected parties experience benefits and burdens differently, and the infant cannot express preferences. This paper analyzes a hypothetical case involving twins born at 26 weeks, one of whom has severe lung complications and two brain hemorrhages. The ethical decision is not properly described as choosing whether to "end the baby's life." Clinicians and parents must decide whether continued life-sustaining treatment offers a proportionate chance of benefit or whether comfort-focused care would better protect the infant from burdensome and nonbeneficial intervention. The paper compares act and rule utilitarianism with best-interest, harm, rights, justice, and shared-decision-making frameworks. It argues that a responsible utilitarian assessment must consider the infant's expected pain, likelihood and range of outcomes, family effects, treatment burdens, resource implications, uncertainty, and the moral danger of devaluing disability. Family distress cannot simply outweigh the infant because the number of affected people is larger. The ethically appropriate process requires updated clinical evidence, repeated multidisciplinary consultation, parental values, palliative-care support, and a wide but not unlimited zone of parental discretion. This analysis is educational and cannot determine care for an actual infant.

Introduction

Neonatal intensive care can sustain infants who would not previously have survived extreme prematurity or severe illness. These advances create difficult decisions when treatment may save life but may also prolong pain, invasive procedures, and dying. Prognostic uncertainty is high because infants with apparently similar clinical findings can experience different outcomes.

The case considered here involves twins born at 26 weeks. One infant is described as relatively stable, while the other has serious pulmonary complications and two intracranial hemorrhages. The original account asks whether clinicians should preserve the infant's life or terminate it to prevent possible future disability.

This formulation is ethically inadequate. Disability is not equivalent to a life without value, and withdrawal of treatment is not the intentional killing of a patient in ordinary neonatal ethics. The actual question concerns goals of care: whether life-sustaining interventions remain beneficial and proportionate.

This paper argues that utilitarianism can illuminate consequences but should not operate as a simple numerical calculation. Ethical decision-making must center the infant while including family, evidence, rights, justice, and uncertainty.

Clinical Context and the Limits of the Hypothetical Case

Gestational age alone does not determine prognosis. Birth weight, sex, infection, antenatal treatment, respiratory status, type and grade of brain hemorrhage, other organ injury, and the experience of the clinical center matter. The phrase “two brain hemorrhages” is too vague for a valid prognosis.

Some intraventricular hemorrhages are small and resolve with limited long-term effect. More severe hemorrhage, ventricular dilation, or injury to brain tissue may create high risks of death or neurodevelopmental impairment. Lung complications also vary from temporary respiratory distress to severe chronic disease.

Ethical analysis must therefore begin with accurate clinical clarification. Decisions should not be made from generalized assumptions about prematurity or disability. The clinical team should explain best-case, worst-case, and most likely outcomes and acknowledge the limits of prediction.

Utilitarianism as a Consequentialist Theory

Classical utilitarianism associates moral action with maximizing overall well-being and minimizing suffering. Jeremy Bentham emphasized pleasure and pain, while John Stuart Mill developed a more qualitative understanding of human welfare (Bentham, 1789/1996; Mill, 1863/2001).

Act utilitarianism evaluates the expected consequences of a particular decision. Rule utilitarianism asks which general rule would produce the best consequences if followed across similar cases. In neonatal care, act utilitarianism might compare continued intensive treatment with comfort-focused care. Rule utilitarianism might evaluate policies concerning parental authority, disability, and treatment judged medically nonbeneficial.

Both approaches require information about probabilities and values. Neither can avoid judgment because pain, relationship, disability, survival, family impact, and institutional trust cannot be reduced easily to one common unit.

Identifying the Relevant Consequences

A utilitarian analysis should consider consequences for the infant first and then for others. For the infant, relevant outcomes include survival, pain, invasive procedures, comfort, capacity for

interaction, future health, and the possibility that treatment merely prolongs dying.

For parents and family, consequences include grief, hope, caregiving demands, financial stress, relationships, mental health, and the experience of participating in the decision. The healthy twin may be affected by family attention and resources, but predictions about future resentment should be treated cautiously.

Healthcare staff may experience moral distress. Institutions use scarce personnel, intensive-care beds, medications, and equipment. Society has an interest in fair access and public trust.

Recognizing these consequences is appropriate. Ranking them requires ethical safeguards so that the infant is not treated only as a means to family happiness or economic efficiency.

Why the Number of People Does Not Settle the Case

A crude utilitarian argument might claim that the family contains several people, so their emotional comfort outweighs the suffering of one infant. This reasoning is defective. Moral weight does not increase mechanically with headcount, and the infant's fundamental interest in avoiding pain or receiving beneficial care cannot be canceled by counting relatives.

Family interests are relevant because neonatal decisions occur within relationships, but they must be considered proportionately. Parents are not detached observers; they will love, care for, and make decisions for the child. Nevertheless, choosing treatment solely to prevent parental guilt may expose the infant to burdens without benefit. Choosing comfort care solely to avoid caregiving demands may fail to protect the infant's reasonable chance at a worthwhile life.

A serious consequential analysis asks which option promotes ethically defensible welfare, not which option satisfies the largest immediate preference.

Act Utilitarian Analysis

Act utilitarianism requires comparison of expected outcomes in this specific case. Continued treatment may produce survival, relationships, development, and experiences valuable to the child and family. It may also cause pain, repeated procedures, prolonged hospitalization, and severe complications.

Comfort-focused care may reduce invasive suffering when death is highly likely or treatment cannot achieve meaningful physiological goals. It also leads to the loss of any survival opportunity and profound grief.

The decision depends on clinical probabilities and the magnitude of potential outcomes. Under uncertainty, expected-value calculations can conceal assumptions. A low probability of a significant benefit may still justify a time-limited trial when treatment burdens are manageable. The same probability may not justify prolonged invasive treatment when deterioration continues and no endpoint indicates benefit.

Rule Utilitarian Analysis

Rule utilitarianism evaluates broader practices. A rule that requires maximal treatment for every infant regardless of prognosis would create avoidable suffering and remove parental participation. A rule that permits treatment withdrawal whenever disability is predicted would endanger disabled people and undermine trust.

A more defensible rule supports individualized shared decisions based on evidence, proportionality, parental values, and review. Such a rule can improve welfare across cases by reducing arbitrary variation while preserving flexibility.

Rule utilitarianism also supports transparent institutional guidance. Clinicians and families benefit when hospitals provide consistent processes, ethics consultation, palliative care, and second opinions rather than leaving one physician or one distressed parent to carry the decision alone.

Best Interests of the Infant

Pediatric ethics commonly uses the best-interest standard because infants cannot decide for themselves. The standard asks which option most promotes the child's welfare. It includes more than survival and more than avoidance of disability.

Best-interest analysis considers pain, benefit, relationships, future experiences, and treatment burden. It should not assume that dependence or impairment makes life unacceptable. Many disabled people report quality of life that nondisabled observers underestimate.

The standard can be indeterminate when reasonable people weigh outcomes differently. That uncertainty supports shared decision-making and a zone of parental discretion rather than automatic physician authority.

The Harm Principle and Parental Discretion

Parents usually have authority to make medical decisions because they know family values and bear continuing responsibility. Their authority is not unlimited. State or clinical intervention may be justified when a parental choice exposes the child to a serious and preventable risk of harm.

The zone of parental discretion recognizes multiple ethically acceptable options in uncertain cases. A decision can differ from the clinician's personal preference without being harmful enough to override. Lantos (2020) argues that shared decision-making with a wide zone of parental discretion is particularly appropriate for extremely premature infants.

This model reduces the pressure to identify one mathematically correct answer where evidence cannot provide it.

Withholding and Withdrawing Treatment

Withholding treatment means not beginning an intervention; withdrawing means stopping one already in use. Ethically, the two are generally considered equivalent when the treatment no longer serves the agreed goal. Emotional difficulty may differ because stopping feels more active.

A time-limited trial can address uncertainty. The team begins intensive treatment, identifies measurable goals and warning signs, and reviews progress at a specified time. If the infant improves, treatment continues. If treatment only prolongs deterioration or suffering, the goals may shift toward comfort.

Withdrawal does not mean withdrawal of care. Warmth, pain and symptom management, parental holding, spiritual care, memory-making, and bereavement support continue. The focus changes from prolonging biological function to protecting comfort and relationship.

Disability and the Risk of Biased Prediction

Disability ethics is central because clinicians and families may imagine future impairment primarily through fear. Quality-of-life judgments made by people without the condition can be systematically pessimistic.

The relevant question is not whether the child will meet an ideal of normality. It is whether the child can experience benefits and relationships and whether treatment burdens are proportionate. Severe unrelievable suffering and permanent inability to benefit from intervention may be ethically relevant, but disability by itself is not evidence that life lacks value.

Families should receive balanced information, including access to professionals and, when appropriate, people with experience raising children with similar disabilities.

Justice and Resource Allocation

Neonatal intensive care uses costly resources, and justice requires fair allocation. However, bedside decisions should not use hidden economic judgments. Clinicians should not deny an individual infant

beneficial treatment because the family is poor, marginalized, or expected to need support.

Resource-allocation policies should be public, consistent, and institutionally governed. Society must also consider whether families receive adequate disability, home-care, and financial support. It is unjust to describe a future as excessively burdensome while withholding the services that would reduce the burden.

Communication and Shared Decision-Making

Parents often receive information while the mother is ill, the infant is unstable, and time is limited. Percentages can be difficult to interpret under stress. Clinicians should use plain language, repeat conversations, check understanding, and present both survival and mortality perspectives.

Shared decision-making combines medical expertise with parental values. The team explains options and recommendations; parents explain what outcomes they fear, hope for, and consider acceptable. A recommendation can be compassionate and appropriate, provided it does not disguise uncertainty.

Interpreters should be used when needed. The team should avoid coercive language, ableist assumptions, and statements that imply parents are responsible for outcomes they cannot control.

Ethics Consultation and Multidisciplinary Review

Complex decisions benefit from neonatology, nursing, neurology, palliative care, social work, psychology, chaplaincy, rehabilitation, and ethics expertise. Nurses often have detailed knowledge of the infant's daily comfort and family interaction.

Ethics consultation does not replace decision-makers. It clarifies values, conflicts, policy, and process. A second clinical opinion can reduce uncertainty about prognosis and treatment options.

Documentation should record information provided, parental questions, clinical changes, goals, and reasons for the plan.

Structured Ethical Analysis

Question	Required consideration
What is known clinically?	Gestation, hemorrhage severity, lung status, other injuries, treatment response

Question	Required consideration
What remains uncertain?	Survival, developmental range, pain, duration of treatment
What benefits can treatment achieve?	Survival, recovery, interaction, time with family
What burdens does treatment impose?	Pain, procedures, complications, prolonged dying
How do parents understand the options?	Values, hopes, fears, culture, caregiving context
Is disability being devalued?	Distinguish impairment from intolerable suffering
Would either choice cause serious preventable harm?	Defines the boundary of parental discretion
Can a time-limited trial reduce uncertainty?	Set goals and scheduled review

Conclusion

Utilitarianism can help neonatal decision-makers examine consequences, but it does not justify a simple calculation in which the emotional interests of several relatives outweigh one infant. The infant's welfare is central, and predictions about disability must be protected from bias.

Continued intensive treatment may be ethical when it offers a reasonable chance of benefit at proportionate burden. Comfort-focused care may be ethical when treatment cannot achieve meaningful goals or imposes suffering without sufficient prospect of benefit. The correct description is a decision about goals and proportionality, not a choice to value or discard a life.

The most defensible process combines best-interest analysis, shared decision-making, parental discretion, multidisciplinary evidence, and repeated review. Utilitarian concern for welfare is valuable when constrained by rights, justice, and respect. In uncertain neonatal cases, ethical quality lies not only in the final decision but in the honesty, compassion, and fairness of the process used to reach it.

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