

**Faculty of Philosophy**  
**James Martin Advanced Research Seminar Programme (TT09)**

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**Venue:** James Martin 21<sup>st</sup> Century School, Seminar Room 1, Old Indian Institute, Broad Street

**Date:** 7<sup>th</sup> Week ~ Wednesday 10 June, 3.00 – 5.00 pm

**Speaker:** Dr Dominic Wilkinson (Uehiro Centre for Practical Ethics, University of Oxford)

**Title:** “A life worth giving: the threshold for withdrawal of life support from newborn infants”

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**Abstract:**

When is it permissible to allow a newborn infant to die on the basis of their future quality of life? How severe does future impairment need to be to warrant withdrawal of life support? It is generally believed to be acceptable to allow a newborn to die if they will be severely impaired. But one challenge to this view is that the caregivers of surviving children and adults with severe impairments generally do not believe that the patients' lives are so bad that it would be better for them to die. Should we allow parents and doctors to let newborn infants die whose lives are likely to be worth living?

In this paper I defend the idea that it may be permissible to allow infants to die if they are predicted to have very low (but positive) levels of future wellbeing. I briefly describe the concept of a life-worth-living and its relationship to wellbeing. I highlight some similarities between decisions for newborn infants, and debate about conception decisions. Drawing on this debate I outline two views about treatment withdrawal for newborn infants. The prevailing view is that treatment may be withdrawn only if the burdens in an infants' future life outweigh the benefits: they have negative net future wellbeing. I call this the Zero Line view. An alternative view is that treatment may be withdrawn from infants who fall below a level of future wellbeing that is close to, but above the zero-point of wellbeing; call this the Threshold view.

I present 4 arguments in favour of the Threshold View. Our prima facie duty to sustain the life of a newborn may be attenuated if the newborn is predicted to have very low levels of wellbeing. Secondly, given substantial uncertainty about future wellbeing it is reasonable to set the boundary for permissible withdrawal above the zero-point. This is justified on the basis of an asymmetry of harms and a liberal approach to parental decision-making. Finally, where an infant is predicted to

have very low levels of wellbeing the effect on the interests of others may outweigh the benefit to the infant.

I identify and respond to several challenges to the threshold view. Its adoption would imply differential treatment of newborn infants - it would have implications for the moral status of newborns. It is not unjustly discriminatory. Although the threshold for treatment withdrawal is, in one sense, arbitrary, it is defensible. I conclude that there is more to determining the permissibility of allowing a newborn infant to die than the question of whether the infant will have a positive or negative balance of wellbeing. It is justifiable for parents and doctors to decide that, though a life of severe impairment would be worth living it would not be a life worth giving. The Threshold View provides a justification for treatment decisions that is more consistent, more robust and more practical than the standard view.