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To save or let die.

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TO SAVE OR LET DIE : THE  
DOCTOR'S DILEMMA

Research paper for Medico-Legal Law  
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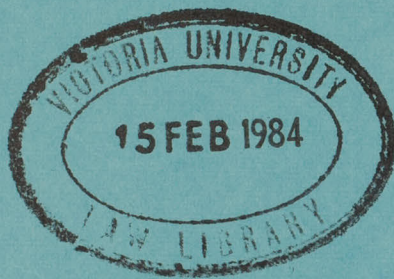
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## 1. INTRODUCTION

Advances in medical technology and discoveries in pharmacology have made it possible for doctors to save and/or sustain the life of individuals who decades ago would have died. But these developments have proved to be mixed blessings. A painful terminal illness or a life severely compromised through handicap are viewed by many as fates worse than death, especially when suffering is prolonged by treatment that can be no more than palliative. In such cases the question arises should the doctor employ the techniques and drugs at his disposal or should he treat selectively?

In most instances this question is resolvable by ascertaining the wishes of the patient. Adults, within certain limits, may decline such treatment and allow nature to take its course, resulting inevitably in an earlier death. Sedatives and analgesics may be used to alleviate pain and it is accepted that their use may hasten death. This practice has come to be known as "passive" euthanasia and is acceptable to most doctors although some regard it as being contrary to Section 164 of the Crimes Act 1961. This section provides that any person who by any act or omission causes the death of another kills that person although the result of the act or omission was merely to hasten death.

"Active" euthanasia, the intentional killing of a person who suffers in the same way, even by request and to relieve suffering, is forbidden at law and may amount to murder or manslaughter. In practice the distinction between active and



passive euthanasia becomes blurred and it is often argued that there is no moral difference between "killing" and "letting die".

Special problems are posed however by those newborn infants who are born with severe defects. They may suffer from paralysis, physical deformity, mental retardation, spasticity, bladder and bowel incontinence and numerous other conditions. Many of these conditions are by no means rare. For example, spina bifida occurs in between one and ten per 1000 births.<sup>1</sup> This results from a failure of the spine to fuse properly and infants with spina bifida are almost always paralysed to some degree, generally below the waist. Mental retardation, owing to hydrocephaly, is also a common defect in spina bifida infants as are incontinence and infections of the bladder, urinary tract and kidneys. This condition cannot be cured by surgery or drugs but in many cases can be mitigated by early and vigorous medical treatment.

Down's Syndrome is another frequent cause of mental retardation occurring in about one in every 600 births.<sup>2</sup>

Anencephaly, a condition in which the brain is partially or wholly absent, occurs in about one per 1000 births.<sup>3</sup> Tay Sachs disease, which leads to progressive spasticity and dementia, and Lesch Nyham disease, which results in mental retardation and self-mutilation, are less frequent.<sup>4</sup> Overall the frequency of major malformations manifested at birth - including stillbirths - is about fifteen per 1000 births.<sup>5</sup>

Among doctors and others concerned with these problems there is a growing consensus that parents and doctors are



morally justified in selecting certain infants for non-treatment and early death. They cite the physical and social pain and suffering the infant will experience in later years; the financial and social costs to the family of having to care for a defective child; and the great drain on resources involved in maintaining the infant's marginal existence.

On the other hand, it is easy to feel (at least) doubtful about the moral permissibility of allowing an innocent baby to die or taking its life, even when it is clear that there is little prospect of the infant leading a meaningful life and despite the fact that the net effects on others appear to favour death.

The practice of withholding treatment from severely defective infants is a matter of medical reality in this country. The parents and doctors involved in these decisions have thus far largely ignored the law primarily because no doctor or parent has yet been prosecuted for withholding care from a defective newborn. Nevertheless under traditional principles of criminal law they are committing crimes that may include murder, manslaughter, child abuse, negligent or conspiracy when they withhold ordinary medical care which leads to the injury or death of a newborn infant.

The discussion which follows will consider both the moral and ethical issues raised by the question of whether it is permissible to withhold medical care from an infant in any circumstances, and the application of the relevant law. In particular whether the doctors involved in a decision not to



treat are acting in contravention of the Crimes Act 1961 and whether they may be tortiously liable for damages. It will also discuss whether New Zealand law should be brought into step with current understanding of the ethics of the matter.

Euthanasia is derived from ancient times when mercy killing was advocated on a compulsory basis on eugenic or utilitarian grounds. Disposal of defective children took place in Greece and Rome, and was advocated by such philosophers as Socrates, Plato and Aristotle.<sup>7</sup> According to Salfon, an historian of Rutgers Medical School, the preponderance of Greek and Roman thoughts made man the master of his own body, with the right to decide his own fate.<sup>8</sup> However the overwhelming weight of Christian tradition and teaching condemns euthanasia. The Roman Catholic Church, in particular, proclaim the belief that God alone should determine how much suffering each person should have. Nevertheless legalising euthanasia was discussed throughout the nineteenth century, although the project made little headway. In 1901 Dr Charles Goddard, a prominent British physician, advocated euthanasia for "those who, [have] no will power nor intelligence of their own, and [are] a burden to themselves and especially to their friends and society, [and] of course, absolutely incapable of improvement".<sup>9</sup> In the 1930's Dr C.K. Millard made it a public issue by challenging the traditional belief that doctors are bound by the Hippocratic Oath to save life at any cost, and stated that though life is sacred "it is not something to be selfishly clung to after it has permanently ceased to be useful, and especially if we have become a burden to others".<sup>10</sup>



## 2. THE MORAL AND ETHICAL IMPLICATIONS

"As to exposing or rearing the children born, let there be a law that no deformed child shall be reared..."

Aristotle "Politics" VII,15.<sup>6</sup>

The concept of euthanasia is derived from ancient times when mercy killing was advocated on a compulsory basis on eugenic or utilitarian grounds. Disposal of defective children took place in Greece and Rome, and was advocated by such philosophers as Socrates, Plato and Aristotle.<sup>7</sup> According to Safron, an historian of Rutgers Medical School, the preponderance of Greek and Roman thoughts made man the master of his own body, with the right to decide his own fate.<sup>8</sup> However the overwhelming weight of Christian tradition and teaching condemns euthanasia. The Roman Catholic Church, in particular, proclaim the belief that God alone should determine how much suffering each person should have.

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In July 1937, Fortune Magazine reported a survey it had made of public opinion regarding mercy killing. In answer to the question:

'Some people believe that doctors should be permitted to perform mercy killings upon infants born permanently deformed or mentally handicapped. Under what circumstances would you approve this?',

45 per cent approved of euthanasia, administered with the permission of the parents and/or a medical board.<sup>11</sup>

The debate over this issue has continued to rage in varying degrees up to the present day. The crucial question is in what circumstances, if any, can a defective infant be killed or allowed to die? Public opinion has nearly always been on the side of those who end needless suffering. For example, in 1962 the famous case of a thalidomide baby in Belgium, Madame Van de Put testified about having killed her eight day old infant. "I just thought you could not let a baby like that live." Public opinion was such that when she was pronounced not guilty, wild applause broke out in the courtroom.<sup>12</sup>

Practice reflects that opinion. A survey conducted of 457 doctors in the United States in 1975 concluded that in practice, physicians need not attempt to maintain the life of every severely impaired newborn infant, simply because they have the technology to do so.<sup>13</sup> In response to the question: "Do you believe that the life of each and every newborn infant should be saved if it is within our ability to do so?", 83 per cent answered "No".<sup>14</sup>



But is withholding treatment or killing such an infant a morally justifiable course of action? Few people would argue that all infants with birth defects should be subject to euthanasia. In most cases, for example, Down's Syndrome, the infant would, under traditional notions of equal respect for persons, have a moral right to be treated. It does not follow, however, that all critically ill or severely handicapped infants should be maximally treated in all cases. For the purpose of this paper it is useful to adopt Eckstein's division of defective infants into four groups:<sup>15</sup>

1. Infants with abnormalities which are incompatible with life if untreated, and total recovery and a normal child can be expected after surgical treatment. Such infants are treated energetically at all times and present no moral or ethical problems.
2. Infants with severe abnormalities which are incompatible with life even with present day treatment. Again no moral or ethical problems arise. Medical treatment is uniformly withheld from such infants because it is futile.
3. Infants with abnormalities from which they would die if untreated but where surgical treatment will preserve life but the child will never be normal. For example, duodenal atresia when associated with Down's Syndrome.
4. Infants with congenital abnormalities which are likely but by no means certain to be fatal and who if untreated may survive with more severe handicap than if untreated. This group fundamentally embraces the whole problem of spina bifida and along with group 3 presents enormous moral and ethical complications.



In Eckstein's opinion it is quite impossible to kill such infants, but if surgical treatment is withheld he believes it is only reasonable to withhold other forms of treatment such as antibiotics, oxygen and tube feeding.<sup>16</sup>

But is there any real difference between killing an infant and withholding treatment in the knowledge that it will certainly die?

A. To Kill or Let Die?

The distinction between active and passive euthanasia is thought to be crucial for medical ethics. The doctrine accepted by most doctors is that in some circumstances it is permissible to withhold treatment and allow a patient to die, but it is never permissible to take direct action designed to kill a patient. This ethic has been endorsed by the American Medical Association in a statement made in December 1973:<sup>17</sup>

"The intentional termination of the life of one human being by another - mercy killing - is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association. The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family."

Assuming that in some circumstances it is permissible to withhold treatment from a defective newborn in the hope or expectation that it will die shortly, many would argue that it is more humane to kill



the infant and that in reality this is not morally worse than allowing it to die.

James Rachels gives the example that if someone saw a child drowning in a bath it would seem just as bad to let it drown as to push its head under water.<sup>18</sup> It is true that in those circumstances the act is as iniquitous as the omission and the active/passive distinction may be morally irrelevant. But it does not follow that it is always morally irrelevant.<sup>19</sup> The example given by Rachels is not analagous to euthanasia cases.

One important difference arising in the euthanasia context rests in our judgement of medical fallibility and moral responsibility. Discussing the celebrated Quinlan case Beauchamp states:<sup>20</sup>

"To bring about her death is by that act to pre-empt the possibility of life. To allow her to die by removing artificial equipment is to allow for the possibility of wrong diagnosis or incorrect prediction and hence to absolve oneself of moral responsibility for the taking of life under false assumptions. There may, of course, be utterly no empirical possibility of recovery in some cases since recovery would violate a law of nature. However judgments of empirical impossibility in medicine are notoriously problematic - the reason for emphasizing medical fallibility."

Attractive as this argument is, it is not wholly convincing. To kill a patient one must assume



causal responsibility for the death. But similarly, if treatment is ceased and the patient dies, the patient might have recovered if treatment continued.

Another superficially compelling argument for disregarding the distinction is that if a decision not to operate is made then a doctor should be able to relieve "suffering" by killing the infant who could otherwise live for weeks or months waiting to die. The following description illustrates what may happen after a decision is made not to operate on a Down's Syndrome infant with an intestinal obstruction:<sup>21</sup>

"...When surgery is denied [the doctor] must try to keep the infant from suffering while natural forces sap the baby's life away. As a surgeon whose natural inclination is to use the scalpel to fight off death, standing by and watching a salvageable baby die is the most emotionally exhausting experience I know. It is easy at a conference, in a theoretical discussion, to decide that such infants should be allowed to die. It is altogether different to stand by in the nursery and watch as dehydration and infection wither a tiny being away over hours and days. This is a terrible ordeal for me and the hospital staff - much more so than for the parents who never set foot in the nursery."

But whose suffering is going to be relieved by death? Certainly not the infants. An infant is from birth, he would still have been paraplegic but possibly with a normal IQ and vision, and



not fully capable of abstraction. It responds only to relatively simple stimuli with relatively simple internal as well as external behaviour.

"Quite simply 'waiting to die' is a nonexistent thought for an infant."<sup>22</sup>

As illustrated by the above description the suffering to be relieved by death would seem to be that of the medical staff and the family. The killing of an infant is an unacceptable means of alleviating their suffering.

The argument of killing to relieve suffering is more compelling when applied to those infants in group 4 above. For example studies have suggested that ten to sixteen per cent of infants with spina bifida who are untreated are alive at one to two years - so there is a tail-off of survivors.<sup>23</sup> The following case report represents the results of a survivor of non treatment:<sup>24</sup>

An eight year old boy is in a school for the blind and has an IQ of 80. It is difficult for him to sit because of the marked paralytic kyphosis, which also interferes with the ileal stoma so that a collecting device cannot be kept in place. His hips have redislocated: the hydronephrosis is of moderate degree.

He was born with spina bifida and his parents were told that he would die. Thus he was given only routine care. If he had been actively treated from birth, he would still have been paraplegic but possibly with a normal IQ and vision, and



without hydronephrosis. If the goal of the original non-treatment was the death of the child, the child should be considered a non-treatment failure. If the goal was to end the child's suffering then should there have been restrictions on helping the child to die quickly?

Rachels<sup>25</sup> further argues that the retention of the conventional distinction leads to decisions concerning life and death being made on irrelevant grounds. For example, a Down's Syndrome infant with an intestinal blockage will die without an operation. The operation is not difficult but may not be performed because the infant has Down's Syndrome. But if one thinks it is better not to allow a Down's Syndrome infant to live what difference should it make whether its intestinal tract is obstructed or not. Or if the life of such an infant is worth preserving what does it matter if it needs a simple operation? It is the Down's Syndrome, and not the state of the intestines, that is in issue.

However compelling arguments exist for the retention of the active/passive distinction. Firstly the so-called "wedge" argument. This is if killing was allowed even under the guise of mercy a dangerous wedge would be introduced placing all "unworthy" human life in a precarious position,<sup>26</sup> and our basic principles against killing would be gradually eroded. Many point out that this is precisely what occurred during the Nazi era when euthanasia gradually spread



to anyone deemed to be an enemy of the people. An SS man stationed in the Wargenthau sent Eichmann a memorandum telling him that "Jews in the coming Winter could no longer be fed" and submitting for his consideration a proposal as to whether "it would not be the most humane solution to kill those Jews who were incapable of work through some quicker means".<sup>27</sup>

Beauchamp co-joins the above wedge argument with rule utilitarian arguments,<sup>28</sup> rule utilitarianism being the position that a society ought to adopt a rule if its acceptance would have better consequences for the common good (greater social utility) than any comparable rule could have in that society. He looks at the question of which of two moral rules, the no-active-euthanasia rule or a restricted-active-euthanasia rule, if enacted would have the consequence of maximising social utility?

A restricted active euthanasia rule would clearly have some social utility as it would allow the elimination of some intense and uncontrollable suffering. However the disutility of introducing legitimate killing into the moral code outweighs the utility of doing so. It may result in a relaxation on rules in the code which demand a respect for human life. For example if a restricted euthanasia rule were introduced it is plausible that killing defective infants might become common practice to relieve the burden on their families and society as might the



killing of the aged and the anti-social.

"Rules against killing in a moral code are not isolated moral principles; they are pieces of a web of rules against killing which forms the code. The more threads one removes, the weaker the fabric becomes."<sup>29</sup>

Nevertheless our society has shown it can withstand some exceptions to the moral rules prohibiting killing, for example, killing in self-defence and in war-time. Why then can it not withstand one more exception? The answer is clear. The exception of euthanasia is a significantly different situation because it would involve the taking of morally blameless lives. In the case of aggressors it is generally accepted that their actions are blameworthy and justify counteraction.

In conclusion:<sup>30</sup>

"...as a general rule, the common good of society and the rights of individuals seem best served by reluctance to legitimize widespread authority to terminate human life. This reluctance grows not from a pananoid anticipation of extensive infanticide, but from awareness that social practices tend to modify and spread. There are a variety of life situations where speedy death might appear to be a merciful solution to real problems, e.g., severe mental deficiency, profound emotional disorders, and crippling old age. But, in each of these situations, the active euthanasia solution legitimizes a practice



that is theoretically difficult to contain. Unless forms of due process can be devised to contain the practice and give absolute protection to the rights of all vulnerable, voiceless, and "useless" members of society, it seems foolhardy and dangerous to urge a policy of active euthanasia for dying neonates."

B. Quality of Life v Sanctity of Life

Two fundamental principles governing the attitude of doctors to their patients are constantly in conflict. First, that a doctor's duty is to relieve suffering, even at the risk of causing death, and second, that human life itself is sacred and that doctors have a duty to prolong life at all costs. A British Working Party established to consider the ethics of selective treatment of spina bifida reported back in 1975 that:<sup>31</sup>

"...of the two traditional aims of medicine - the prevention of suffering and the preservation of life - the former carries the greater weight. It is the balance of pain and happiness - in other words, the utilitarian principle - which holds sway."

Yet not all doctors would be in agreement with the report. In 1981 Dr Bartholome, an American pediatrician wrote:<sup>32</sup>

"We owe these dying babies our most compassionate and caring treatment during their short lives. But Duff clearly argues that in addition to this category there is a category of infants



who should not be treated because they have an inadequate quality of life. I would argue that this expression is pernicious and dangerous. If we are not dedicated, as physicians, to the proposition of "equality of life" we risk falling into the swamp that enveloped our profession in Germany only decades ago. The handicapped infant challenges all of us and stretches the moral fabric that holds us together as a society. Duff would ask that we cut a hole in that fabric just large enough to allow a few "defectives" to slide through. All who have struggled to respond to these children and their families can understand this wish. All of us who claim to be servants of children must resist the temptation."

The proponents of the sanctity of life principle argue that there is an absolute moral duty to preserve human life and that this duty supercedes any consideration of comfort or even of expected outcome for the recipient and that in any event no human prognosis is certain. Slogans arise such as "There is no such thing as a life not worth saving" or "Who is the physician to play God?"<sup>33</sup>

On the other hand Theologian Martin Marty was quoted as saying in support of the move to discontinue treatment of Karen Quinlan:<sup>34</sup>

"When in any other age [she] would be dead, then I believe that it is not playing God to



stop extraordinary treatment. In fact, it is playing God to keep her alive."

Most doctors today would accept that their duty to preserve life at all costs is only secondary to their duty to prevent pain and suffering. Nevertheless the British Working Party still believes it is important to emphasise the two principles:<sup>35</sup>

"To argue solely in terms of general happiness provides no safeguard against injustice towards individuals. A newborn child with spina bifida has little to put in the scales of utilitarian balance unless the sheer fact of humanity is respected. No doubt in many cases such respect for its life will be outweighed by the potential misery the child might suffer and cause. But unless there is seen to be at stake a conflict of principles, not just a single principle, the gradual assumption of powers over life and death could become too easy."

C. The Interests of the Infant

The usual justification for non-treatment of a defective infant is that it is in the best interests of the child, who faces a painful life of psychosocial handicap, and that parents and physicians are simply making the choice which the child would make in this situation if able to formulate and express a preference. But every infant born possesses a moral value which entitles it to the medical and social care necessary to effect its well-being.<sup>36</sup>



It is independently valuable. That is, its fundamental work is not a function of how much or little others value it. This conception of the independent and equal value of human beings is basic in modern Western civilisation.<sup>37</sup> Parents bear the principal moral responsibility for the well-being of their infant yet doctors have a duty to take medical measures conducive to the well-being of the infant - patient and may at times be duty bound to resist a parental decision.

An approach to selection based on the best interests of the infant is preferable to one based on the needs of others, for example, the family, but should nevertheless be approached with caution. It is extremely difficult to ascertain the infants best interests. What appears to be a fate worse than death to a healthy, normal adult may be tolerable or a source of pleasure to one who has never known those capacities.

Even normal, healthy adults cannot come to a consensus on what is in the best interests of the infant. Slater states:<sup>38</sup>

"These children are now beginning to come into puberty and adolescence, when their sufferings will really begin. Only the most miserably impaired social life will be open to them; they will be equipped with normal sex drive but no normal sex function; all around them they will see the normal, the vigorous, the healthy. Will they really be grateful to the fates, the



all too human fates, but for whose intervention they would have died before their miseries began?"

Whereas Zachary who has spent much of his life caring for spina bifida children says:<sup>39</sup>

"Some have been regarded as living completely miserable and unhappy lives. Yet when I see them I find happy young people who can respond to concern for their personal welfare."

Many people believe that attempts to preserve life by surgery should be more actively pursued if the prospects for the child's intelligence are good. This view must arise out of either (1) the assumption that some aspect of mental function is an essential human characteristic and therefore at some degree of mental retardation these infants are less than fully human or (2) the assumption that the suffering of the infant will be worse if it is mentally retarded.

In response to (1) I would suggest that it is almost impossible to list the characteristics which cause us to regard a living being as fully human. Campbell states that "in ascribing the status, person, to a living organism with humanoid characteristics it is its capacity to communicate and be communicated with, both at a rational and at an emotional level".<sup>40</sup> By this view a child with Down's Syndrome would be considered a person and should therefore have the right to medical treatment like other infants. However the practice of withholding surgery from Down's



Syndrome infants indicates that others must place more emphasis on rationality and higher functions than Campbell.

If the future suffering of the infant is the main justification for non-treatment I would question the assumption that severe physical handicap (life in a wheelchair and impotence accompanied by normal libido) is more tolerable if the intelligence is preserved than if it is not.

In discussing the fate of a defective infant one must always bear in mind that many severely handicapped people lead worthwhile, fulfilling lives. Thus the decision to withhold treatment in the best interests of the infant must be approached with caution because by it we are drawing a line between life and death.

D. The Interests of the Family

The best interests of the children are almost always inextricably linked to those of their family and often decisions to treat or not to treat an infant will involve sacrificing the interest of one for another. The burden which survival of defective infants imposes on families may include medical and special care expenses, marital disruption, depression, neglect of siblings, and other manifestations of familial pathology. In particular circumstances each of these may appear but their frequency is unclear and their occurrence perhaps preventable.<sup>41</sup> More generous public support for



such families, including counselling assistance, could relieve some of these burdens. It is also possible to separate the interests of infants from those families by foster homes or institutional care although many feel institutionalization is a last resort.

"Even in better institutions where severely defective human beings are "warehoused", conditions are so unavoidably detrimental to any child's interests that it is easy to understand why some loving parents either keep their child at home despite great burdens or sorrowfully choose death for their child..."<sup>42</sup>

The solution to family stress can never be the death of the infant. Consider the hypothetical case of a juvenile delinquent who lies in hospital requiring life-saving surgery. This child has caused, and will continue to cause, a great deal of stress to those living around him. The surgery will be carried out and the child's life saved, for we do not consider death a reasonable solution to those who cause excessive stress to other people. The danger is that: "There is an infinite number of uses for death once its use becomes a legal means of solving a human problem."<sup>43</sup>

With a sense of balance and tragedy it is only right that the family's interests are sacrificed to benefit the child. Diamond, a pediatrician, writes:<sup>44</sup>



"Some of the phrases used to justify the withholding of treatment for defective infants are "siblings right to relief", "threats to the marriage bond", "fear that other children would be socially enslaved and economically deprived", or that "parents would be permanently stigmatized in a state of chronic sorrow." The use of this language suggests that the newborn child does not have rights of its own. It suggests that the birth of a child is not an end in itself but rather a means to an end (which is the fulfillment of parental desire). Pediatricians cannot project themselves in the role of correcting all the inequities of nature. We cannot propose to eliminate all of the social and economic impact of a child's illness on a family by eliminating the ill child himself. There is simply no way in newborn medicine to implement the mercantile principle of "satisfaction guaranteed or your money back"."

E. The Interests of Society

Society has a twofold interest in the decision whether to treat a defective infant or not. Firstly an interest in the proper fulfillment of responsibilities and duties regarding the wellbeing of the infant, that interest being the concern of society at large that individuals respect certain values and fulfill certain responsibilities and duties.<sup>45</sup> Secondly an interest in ensuring an equitable apportionment of limited



resources among its citizens.

The justification for non-treatment arising from the second interest is that there is a limit to what the community can spend on health care, from which it follows that resources expended on one medical problem reduce the amount available for other medical problems. Thus scarce resources which could be put to better use elsewhere, would be consumed in keeping defective newborns alive at state expense. The same charge can, of course, be made against all social programmes providing services to the disabled, elderly, and institutionalised, and it is difficult to see defective newborns as a distinct class.<sup>46</sup>

F. Nature's Sounder Judgement

One further argument must be raised in support of allowing defective infants to die. It is that in this situation the most reliable guidance available is that as the majority of deformed fetuses either abort, are stillborn or live only a short time after birth, that nature did not intend such babies to be viable.

"Nature makes few mistakes in her vast "reproduction factory". Where she does on occasion fall into error, then surely it is better and more humane to support rather than strive against her sounder judgement".<sup>47</sup>



In conclusion the only possible moral justification for denying an infant medical treatment in the hope that it will die is that it is in the best interests of the infant that it die soon after birth rather than live. The respective interests of family and society can only be secondary to those of the infant. To find otherwise would be to undermine the basic conception of our society that each human being is independent and of equal value. Before it is permissible to withhold medical treatment it must be ascertained beyond reasonable doubt that this course of action is in the best interests of the infant, that its life would not be worth living and that it would undergo significant amounts of suffering if allowed to live. It is admitted that in many cases it is difficult to predict in the first hours after birth the potential of the infant. In such cases I submit we must err on the side of caution and actively treat the infant.

Substantive criteria for non-treatment are those that define a class of infants from whom necessary medical treatment may be withheld. In essence, the criteria represent a moral judgement that this class of infant are not so important that we need expend further medical resources on keeping them alive.<sup>49</sup> Procedural criteria on the other hand specify how to go about deciding whether an infant falls within the class from whom treatment can be withheld, raising such questions as who shall decide and how shall the decision be reached.<sup>50</sup> Procedural criteria ensure that the substantive criteria are applied correctly and thus provide



### 3. CRITERIA FOR SELECTION

A policy of selective non-treatment of defective infants can only be safely adopted if substantive and procedural criteria are developed for non-treatment decisions. If they are not, the current haphazard, arbitrary selection for non-treatment is likely to continue with parents and doctors continuing to decide in haste according to their own value standards.<sup>48</sup> In New Zealand there are no guidelines laid down as to who should make the decision and on what grounds. Pediatricians and other doctors facing this situation rely on their own experience and moral values, and the criteria adopted, both substantive and procedural, are varied. There is the possibility that some may err on the side of under-treatment, thus causing the death of infants who have the right to live.

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a further protection for the infant.

A. Substantive Criteria

Concerning substantive criteria for non-treatment, it is interesting to note that recently the courts have begun to enunciate and articulate patient-centred grounds, in cases like Quinlan,<sup>51</sup> Saikewicz,<sup>52</sup> and Dinnerstein<sup>53</sup>. They focus on the patient's needs and interests not on those of doctors, family and society, asking such questions as: what is the best interest of the patient? What will benefit this patient? What would this patient want if he was competent to speak?

This emphasis on patient-oriented criteria is reassuring. We are not merely sacrificing patients who are powerless to protect themselves in order to benefit others. But just asking what is in the best interests of the infant is not enough. More specific guidelines are needed to enable the decision makers, whether they be doctor, parents, hospital committee or courts, to be consistent in their practice and to safeguard the interests of infants who for example might be in the "grey" area but whose parents do not wish to be burdened with their upbringing.

Campbell and Duff<sup>54</sup> believe that the most important medical criterion is the degree of abnormality, disease or damage to the central nervous system, especially the brain. If there is little or no brain function sufficient to allow a personal life of meaning and quality and no potential for human relationships



non-treatment seems to be indicated. For example, nearly all would agree that the anencephalic infant is without relational potential. On the other hand, the same cannot be said of a Down's Syndrome infant. The difficult task arises in the grey area between such extremes.

It is essential I believe that guided by the above criterion decisions be made on a case-to-case basis rather than attempting to place an infant in a diagnostic pigeon-hole. This view was shared by a majority of pediatricians and pediatric surgeons surveyed in the United States in 1975.<sup>55</sup> The decision must be based on the potential for human relationships associated with the infant's condition and to guide grey area decisions doctors must try to identify those biologic conditions that probably provide negative indicators. If the doctors are of the opinion, beyond reasonable doubt, that the infant has little or no such potential then non-treatment is indicated. However as McCormick points out:<sup>56</sup>

"...mistakes will be made. Some infants will be judged in all sincerity to be devoid of any meaningful relational potential when that is actually not quite the case. This risk of error should not lead to abandonment of decisions; for that is to walk away from the human scene. Risk of error means only that we must proceed with great humility, caution, and tentativeness.



Concretely, it means that if we err as we must at times, it is better to err on the side of life - and therefore to tilt in that direction".

B. Procedural Criteria

Procedural criteria are necessary to ensure that the substantive criteria are properly applied to individual cases. If none are specified then any criteria enunciated for non-treatment may not affect the behaviour of doctors and others to any great extent. The usual form of rule enforcement, complaint by an individual wronged, will not work here, and some infants may wrongly be deprived of care that they have a right to receive.

Before discussing who is in the best position and who has the right to make the decision to withhold treatment we must recognise that no-one can make a totally conflict-free decision in this situation. Many recognise the conflicts facing parents in this situation but the potential for conflict arises with other possible decision makers. For example hospital committees must be sensitive to the utilitarian issue of high costs and low benefits; courts must be more concerned about legal doctrine than about the interests of a particular child; and doctors have a long history of using the sick to learn about diseases, to transmit knowledge, and to make a living, all being important "latent" functions



which often are in competition with the manifest function of patient care.<sup>57</sup>

Many believe that parents and doctors should carry the ultimate responsibility for deciding whether or not to withhold treatment. But can parents make a proper decision concerning the non-treatment of their own child or do they have so great an interest in the outcome and are so emotionally traumatized by the birth that they are incapable of acting impartially. Fost writes that:<sup>58</sup>

"In the turmoil of the newborn period, parents are often ignorant of the facts which are relevant to the child's future, and unable to assimilate these facts until the initial period of shock has subsided,"

and Sherlock is particularly cynical:<sup>59</sup>

"...this reliance on parental judgement allows for the worst and most arbitrary factors to be determinative of whether the infant lives or dies. For example, it is well established that parental religiosity correlates highly with a willingness to care for a defective child. Do the authors therefore wish us to adopt a policy that allows the child to live or die simply as a result of the religious convictions of the parents?"

It is admitted that the birth of an infant with a congenital abnormality will cause the parents



tremendous emotional upset and that in such a state it may be difficult to make coherent rational decisions about a dilemma which is completely new to them. But I am in agreement with Duff when he writes:<sup>60</sup>

"Being emotionally troubled does not make parents unintelligent nor does it prevent them from using the intelligence they have. This is demonstrated by the fact that parents are emotionally upset (...) precisely because they have a painfully adequate general understanding of the situation. True, parents cannot assimilate and understand all the technical data (which even experts only partly understand and about which they often disagree), but that is not necessary for them to make informed judgements about care... It is only necessary that parents be reasonably knowledgeable of the personal and social meaning of biologic circumstances to themselves and their children in a moral order which they (parents) have helped to create and urgently need to continue creating in order to adapt".

In deciding how much weight to give to parental preferences it is useful to see on what theory of parental authority it is based. In New Zealand it would seem that parents act as trustees for their children, and their opinion should therefore only be relevant insofar as it represents a reasonable proxy



for the child's best interests. This view is reflected in our child abuse laws<sup>61</sup> where the state may intervene when the parents act in a way which threatens the child's healthy upbringing. Thus for infants the best course is that the parents have primary decisional power although the responsible doctor will usually share or assume this in order to help the parents with the burden.

The risk remains that not all parents will always act altruistically in caring for their children, although this could be minimised if the attending doctor reliably reviewed parental decisions. He should be more detached than the parents and could effectively screen out improper parental decisions either through further discussion with the parents, reference to a hospital ethics committee or judicial intervention.

If a dispute does arise between the parents and their doctor then it should be referred to an impartial third party. This third party would ideally be comprised of a committee of two medical practitioners, a lawyer, and two members of the general public. They are likely to give a more detached, careful review of the relevant information and would represent societal consensus as to the propriety of non-treatment. Such a committee would be of particular importance in those borderline cases in which the attending doctor is uncertain of the prognosis of the infant and in doubt whether to treat or not. He could



acquire immunity in making a decision if the prognosis was first confirmed, for example, by the suggested committee.

An important aspect in the decision making process if it were not a clear-cut case would be the need for someone to speak for the child, who is, after all, the party that stands to lose the most from an erroneous decision. A neutral party such as a guardian ad litem should always be appointed if the decisions of the parents to withhold treatment is disputed.

The courts should only be available as an appeal body and thus reference to them would be a last resort.

"Since courts are obliged (rightly) to focus on laws applicable to all people and since they use an adversary approach to debate (...), they must be slow to act and rigid. They are unlikely to understand the sensitive feelings and complex inner values, (some religious in nature) of individual family members and to act in harmony with them. Such failure is non-caring, will stifle creativity, will disrupt adaptation, and will foster helplessness."<sup>62</sup>

Although not in full agreement with the above extract it makes the point that the courts are not in a position to review the majority of decisions that are regularly made not to treat defective newborns. Each case will be different and the



factors to be taken into consideration will depend on the circumstances peculiar to the birth of a particular infant. The court cannot review each and every one of these decisions, nor would it be proper for it to do so. The decision not to treat is primarily that of the parents of the infant and the attending doctor. The court's role arises solely in the context of interpretation of the proposed statute and consideration of any other legal issues that might arise.

The defective infant, who is alive and fully separate from the mother, is in the eyes of the law a person with legal rights, the subject of legal duties, and entitled to the full protection of the criminal law.

...at the moment of her birth there does exist a human being entitled to the fullest protection of the law. The most basic right enjoyed by every human being is the right to life itself.

Causing the death of an infant by intentional withholding of food or necessary medical treatment by a doctor who has undertaken to treat the infant, may constitute a variety of crimes ranging from murder and manslaughter to conspiracy and breach of duty to provide the necessities of life.

The existence of potential criminal liability is no guarantee that doctors will in fact be prosecuted, nor that any prosecution will be successful.

## 4. THE LEGAL CONSEQUENCES

A. Criminal

The practice of medicine raises peculiar problems for the criminal law. An integral part of a doctor's job involves decisions that will affect the life span of his patient. It is therefore important that the law be neither too strict nor too lenient. If it is too strict it will make doctors criminally responsible for man's mortality; if it is too lenient it will give doctors a "licence to kill".<sup>63</sup>

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The existence of potential criminal liability is no guarantee that doctors will in fact be prosecuted, nor that any prosecution will be successful. No



doctor has yet been convicted of murder or manslaughter for withholding treatment from a defective newborn infant, but this is not a reliable guide for the future. As the practice becomes more openly acknowledged, pressure may build to prosecute and convictions may result. In recent years the courts have occasionally reviewed non-treatment decisions in cases in which disagreement arose between parents and doctor, and the decisions have almost uniformly required treatment for the infant.<sup>65</sup>

Homicide is defined in Section 158 of the Crimes Act 1961 as being "the killing of a human being by another, directly or indirectly, by any means whatsoever". An infant becomes a human being within the meaning of this section when it has completely proceeded in a living state from its mother's body, whether it has breathed or not, whether it has an independent circulation or not, and whether the navel string is severed or not.<sup>66</sup>

Homicide is only an offence if it is "culpable"<sup>67</sup>, and it is culpable when it consists in the killing of any person by an omission without lawful excuse to perform or observe any legal duty.<sup>68</sup>

The death of the person must take place within a year and a day after the cause of death.<sup>69</sup>

The doctor who withholds life-saving treatment from an infant under his care may be in breach of a legal duty imposed by Section 151 of the Act and thus prima facie guilty of culpable homicide, which will amount to murder if his intention was to cause the death of the infant. Section 151 imposes a legal duty on doctors in favour of their infant patients. It reads:

"Everyone who has charge of any other person unable, by reason of ... age ..., to withdraw himself from such charge, and unable to provide himself with the necessaries of life, is (...) under a legal duty to supply the person with the necessaries of life, and is criminally responsible for omitting without lawful excuse to perform such duty if the death of that person is caused, or if his life is endangered or his health permanently injured by such omission."

If a doctor is in breach of this section and the infant dies he is liable on a charge of murder or manslaughter. The charge will be murder if the doctor "means to cause the death" of the infant killed.<sup>70</sup> Culpable homicide not amounting to murder is manslaughter.<sup>71</sup> If the infant's life is endangered or his health permanently injured by a breach of Section 151 the doctor would be liable for up to seven years imprisonment.<sup>72</sup>



To establish the duty it must firstly been shown that the doctor has charge of the infant, that is, that he has the onus of care for it. It is clear that the doctor attending at birth, in accepting the task of delivering the infant, also accepts the infant as being under his care<sup>73</sup> and the doctor cannot thus contend that the parents constitute the proper authority and therefore the onus of care falls upon them.<sup>74</sup>

The second element of an offence under Section 151 is failure to provide the "necessaries" of life. In the Canadian Court of Appeal decision in R v. Lewis<sup>75</sup>, Moss CJO held that what is to be included in "necessaries" is to be determined upon the circumstances of each case.<sup>76</sup> They without doubt include food and clothing, and also medicine and medical treatment in cases where ordinary prudent persons would obtain them.<sup>77</sup> Thus it would not be open to a doctor to maintain as a defence under this section that in the case of a Down's Syndrome infant with an intestinal blockage, it was impossible to nourish the infant because of the blockage. In such a case surgery would amount to a necessary of life.

There are several defences which may be raised, however, to a charge under this section. The first is that the doctor believes that the potential quality of life of the infant is such that he ought not to provide treatment on moral grounds and thus

he has a "lawful excuse"<sup>78</sup> to withhold medical care. There is little guidance as to the meaning of "lawful excuse" but reference may be made to Wong Pooh Yin v. Public Prosecutor<sup>79</sup> and the other cases cited therein. The following passage from that judgement was cited with approval by the Court of Appeal in Burney<sup>80</sup>:

"There Lordships doubt if it is possible to define the expression 'lawful excuse' in a comprehensive and satisfactory manner and they do not propose to make the attempt. They agree with the Court of Appeal that it would be undesirable to do so, and that each case requires to be examined on its individual facts."

The withholding of the necessities of life for quality of life reasons has thus far not been considered by a court to constitute a "lawful excuse" under Section 151 and is not likely to be in the future.

In R v. Lewis<sup>81</sup> the court stated:

"...the law of the land must be obeyed, and it must be obeyed even though there be something in the shape of belief in the conscience of the person which would lead him to obey what in his state of mind he may consider a higher power or higher authority.

And especially must there be obedience where ... the subject of the judgement to be exercised is a child of tender years unable to exercise any judgement of his own. ...the offender cannot



escape punishment because he holds a belief which impels him to think that the law which he has broken ought not to exist or ought never to have been made."

It is apparent that the court in that case would not excuse an offender because he believed that his act or omission was morally justifiable.

A second argument against liability for withholding treatment under this section is that the duty owed to the infant encompasses only ordinary means of care as opposed to extraordinary care. Ordinary measures are taken to mean those not causing grave hardship to the patient and which offer a reasonable hope of success whereas extraordinary measures are those involving great expense, inconvenience or hardship to the patient and which offer no reasonable expectation of success or benefit to the patient.<sup>83</sup>

This distinction was expressly recognised in the Quinlan case in relation to terminally ill adults.<sup>84</sup>

The distinction derives from the scope of the duty owed by the doctor who undertakes the care of a newborn infant. The law demands only the provision of care that society may reasonably expect, given the risk, available means and likelihood of benefit in the circumstances.<sup>85</sup>

"The law does not demand the unreasonable or extraordinary, for few people could live up to such a standard, and fewer would try."<sup>86</sup>

In the case of the defective infant it is often difficult to determine what are ordinary as opposed to extraordinary means. Some would argue that all necessary medical care becomes extraordinary in the case of infants born with major defects. But this is based on the conclusion of the doctor as to the quality of life that will be experienced by the infant after treatment and has little support in law.

In many cases treatment of a newborn will entail great expense or inconvenience to the family, and pain to the infant, but often prolongs life for a significant period. There is only lack of reasonable hope of benefit if life itself is not seen as a benefit for the child, a judgement for which there is little legal precedent. Thus it is apparent that where the procedure or treatment will substantially prolong the life of a defective infant, it must be considered ordinary medical care. If the doctor fails to render medical care in these circumstances then pursuant to Section 151 of the Crimes Act 1961 he is criminally responsible if the infant is permanently injured or dies.

A doctor might also argue that withholding medical care from the infant was necessary to avoid the psychological, economic and physical suffering of the infant, its family and society, greater harm than would ensue from the death of the infant. But it is apparent that the doctrine of necessity cannot apply



in this situation. In R v. Dudley and Stephens<sup>87</sup>, the Queen's Bench rejected the defence of necessity on a charge of murder, when it was raised by two survivors of a shipwreck. To save their own lives they had killed a seventeen year old boy and eaten his flesh. The court held that there is no unqualified privilege to preserve ones life and said:<sup>88</sup>

"Who is to be the judge of this sort of necessity? By what measure is the comparative value of lives to be measured? Is it to be strength or intellect or what? It is plain that the principle leaves to him who is to profit by it to determine the necessity which will justify him in deliberately taking another's life to save his own. In this case the weakest, the youngest, the most unresisting was chosen. Was it more necessary to kill him than any of the grown men?"

The gravity of harm to be avoided with respect to a defective infant clearly does not outweigh the harm of killing another human being. The harm sought to be avoided is merely the inconvenience shame and economic burden of caring for an abnormal infant.

Despite the fact that no doctor has yet been convicted of murder or manslaughter for withholding care from a defective infant charges have been laid on several occasions. In July 1917 Doctor Harry J. Haiseldon of Chicago allowed a baby girl born

with a microcephalic head to die when he could have saved her life. Forty other doctors had examined the child and agreed with Dr Haiseldon's decision. He was acquitted of all charges in November 1917.<sup>89</sup>

More recently in June 1981 the parents and attending doctor of siamese twins born in Danville, Illinois were charged with conspiracy to commit murder. An order that the twins be given no food or water - "Do not feed in accordance with parents wishes" - had been written on their medical chart. The case was subsequently dismissed for lack of evidence as none of the nurses were willing or able to link the parents and doctor directly with the order to withhold food.<sup>90</sup>

On June 28, 1980 a woman gave birth to a Down's Syndrome infant with no further clinically detectable congenital abnormalities. The attending doctor was Doctor Leonard Arthur, a senior consultant paediatrician. He made a note: "Parents do not wish it to survive. Nursing care only", and prescribed a morphine-type drug to alleviate distress as and when it arose. The infant died sixty-nine hours later. On February 2, 1981 Doctor Arthur was charged with the murder of the infant.<sup>91</sup>

The prosecution alleged that there was no medical justification for administering the drug to the baby, and that the purpose of so doing was to stop the baby sucking and therefore feeding, restrict its breathing, and cause the onset of pneumonia.



After ten days of the trial the charge of murder was withdrawn from the jury and the charge of attempted murder substituted. The prosecution's medical expert witness had failed to give sufficient evidence to support the murder charge.<sup>92</sup> Farquarson J. summed up to the jury with the following statement:<sup>93</sup>

"Certainly, in this country no individual is given sole power of life or death over another...All must be alive to the danger of giving too much power to anyone, in the medical or other professions to exert influence over life and health of the public at large...Whatever ethics a profession might evolve they could not stand on their own or survive if they were in conflict with the law...I imagine you will think long and hard before concluding that doctors of the eminence we have heard here have evolved standards that amount to committing a crime."

The jury acquitted Doctor Arthur in two hours.<sup>94</sup>

However it cannot be suggested that this verdict establishes the legal right of a doctor to withhold treatment from an infant and allow it to die. For one thing, the jury's decision on the facts of a particular case create no legal precedent. Secondly the acquittal was in a large measure the result of a bungled prosecution and because of the way in which they presented their case "non-treatment" was never the issue. Furthermore in the subsequent case of McKay v.

Essex Health Authority<sup>95</sup> Stephenson LJ stated:<sup>96</sup>

"It is still the law that it is unlawful to take away the life of a born child or of any living person after birth."

Although a clear basis for prosecution exists, no parent or doctor has yet had criminal charges laid against them in New Zealand for withholding ordinary medical care from a defective infant. There are several possible explanations for this. Firstly the extremely low visibility of the practice. Nobody complains to the police because the parties involved agree that the best course of action has been taken. Secondly, one might say that the prosecuting authorities, through the exercise of their discretion, have informally delegated to parents and doctors authority to decide the fate of defective newborns,<sup>97</sup> because they believe that in some cases withholding treatment is a desirable practice. If such is the de facto policy of the police in New Zealand it is illegitimate because the police have a duty to the public to enforce the law. In Ex Parte Blackburn<sup>98</sup> Saloman LJ stated:<sup>99</sup>

"In my judgement the police owe the public a clear legal duty to enforce the law - a duty which I have no doubt they recognise and which generally they perform most conscientiously and efficiently. In the extremely unlikely event, however, of the police failing or refusing to carry out their duty, the court would not be



powerless to intervene. For example, if, as is quite unthinkable, the chief police officer in any district were to issue an instruction that as a matter of policy the police would take no steps to prosecute any housebreaker, I have little doubt but that any householder in that district would be able to obtain an order of mandamus for the instruction to be withdrawn. Of course, the police have a wide discretion as to whether or not they will prosecute in any particular case. In my judgement, however, the action I have postulated would be a clear breach of duty. It would be so improper that it could not amount to an exercise of discretion."

Whatever the reasons for lack of prosecutions in this area one cannot conclude that doctors will be safe in the future. As the practice is more openly acknowledged and publicly debated some prosecutions will inevitably occur.

B. Civil

To argue that it is morally permissible to procure the death of a defective infant in certain circumstances is not to argue that it is morally wrong not to do so. But if it is, the question arises, whether a defective infant who is not allowed to die in a case in which it was morally permissible to allow it to do so could at a later date sue for damages from the person responsible for its continued existence. A question closely analogous to this

one has emerged in the "wrongful life" cases.

Wrongful life is the label used to describe an emerging tort theory in which a child brings a cause of action alleging that due to the defendant's negligence he was born. The term has been applied to two factually distinguishable situations. The first is where a healthy child brings a suit against his parents because he is dissatisfied with the circumstances of his birth, for example, an illegitimate child suing his father seeking damages for deprivation of his right to be born legitimate.<sup>100</sup> This type of suit has been uniformly rejected. The second involves severely handicapped children bringing suits against a hospital, doctor or genetic counsellor because they have been born defective.

It is important to distinguish an action for "wrongful life" from an action for "wrongful birth" or an action for "wrongful pregnancy". An action for wrongful birth involves the parents bringing a suit against a doctor alleging that his negligence was the cause of the child's birth. That is, the doctor negligently failed to inform them of the possibility that their child would be defective and had they known this they would have chosen to abort. In an action for wrongful pregnancy the parents allege that the doctor's negligence was the cause of conception itself, for example, where a doctor negligently performs a sterilisation operation.<sup>101</sup>



A "wrongful life" action involves a defendant whose medical advice leads parents to believe that their fetus will be born healthy, resulting in their decision not to abort. When the child is subsequently born in a defective state, the child as plaintiff claims the resulting injury to be his own life which was caused by the defendant's lack of due care in advising his parents.<sup>102</sup> The plaintiff is not claiming that the defects per se are a result of the defendant's negligence but that the injury is the birth with such defects.

The tort of wrongful life suggests that quality of life is now of grave importance. In some cases, where on balance, the quality of life may total out in the negative, the concept of wrongful life suggests that a decent death should be allowed for children for whom the only possibility is protracted painful dying. If this concept is accepted it is only logical that it be extended to a concept of tort for wrongful continuance of existence.

In the past courts have continually rejected the wrongful life cause of action which presents them with the question of whether under any circumstances a child can claim that his birth is an injury. A severely defective child first pursued this cause of action in 1967.<sup>103</sup> The child's mother contracted rubella during her pregnancy and was advised by her doctor that the rubella would not adversely affect the fetus. The child was born severely

handicapped and sued the doctor for negligently advising his mother. The court denied the cause of action on the grounds that it was logically impossible to measure the damages because this would require a comparison of the child's present condition with that of non-existence.

In the following year a "wrongful life" action was again denied to a defective child on the grounds that (1) since birth with defects was better than non-existence the child had suffered no harm, and (2) to allow the cause of action would be to approve abortion.<sup>104</sup> The court stated:<sup>105</sup>

"A plaintiff has no remedy against a defendant whose offence is that he failed to consign the plaintiff to oblivion. Such a cause of action is alien to our system of jurisprudence.

More recently in December 1977 the court in Park v. Chessin<sup>106</sup> decided that the infant plaintiff had stated a cause of action and was entitled to damages. The court threw aside major arguments against the judicial recognition of the theory of wrongful life without addressing them. Instead, in its relatively brief rationale, the court stated that inherent in the abortion legislation is a public policy consideration that gives potential parents the right not to have a child. The breach of that right was said to be tortious to the fundamental right of a child to be born as a whole functional human being. However the case was reversed within a



year. The appeal court held that public policy precluded the granting of the wrongful life cause of action. That because society placed a high value on life to declare any life to be a harm, regardless of the degree of deformity, would be to circumvent that belief. They also expressed concern that the line of recovery could not be reasonably drawn.

However in 1980 the California Court of Appeal in Curlender v. Bio-Science Laboratories<sup>107</sup> in a decision based mainly on public policy allowed a cause of action in wrongful life to a severely defective child. The plaintiff child was born with Tay-Sachs disease, suffered severe mental retardation, gross physical deformity and had a life expectancy of four years. Genetic testing to determine whether either of the parents were the carrier of the disease was performed negligently and revealed a negative result. The child claimed that her mother would have chosen to abort the pregnancy had the test correctly shown her parents to be carriers of the disease.

The court rejected the reasoning of previous cases and allowed the wrongful life action in cases where the genetic test is capable of disclosing a high probability that a severely impaired child would result and that due to the defendant's negligence a severely handicapped child does result, on the following grounds:

1. Public policy dictated the need for a wrongful life action. Four factors contribute to this:<sup>108</sup>

- (a) abortion being legal, the medical profession have a duty to provide parents-to-be with an opportunity to decide whether to abort, based on accurate information;
- (b) a need to ease the national health care burden;
- (c) the need to protect the public from the medical profession's negligence would be accomplished by the deterrent effect of litigation;
- (d) the need to provide a remedy where a substantial number of plaintiffs were claiming injury. "Fundamental in our jurisprudence is the principal that for every wrong there is a remedy and that an injured party should be compensated for all damage proximately caused by the wrong-doer".<sup>109</sup>

2. Defective birth itself is an injury. "The reality... is that such a plaintiff both exists and suffers due to the negligence of others...We need not be concerned with the fact that had the defendant not been negligent the plaintiff might not have come into existence at all."<sup>110</sup> The court thereby rejected the argument that no injury had been suffered since existence with defects was better than non-existence.



3. The court rejected the argument that it was impossible to measure the child's damages because this would involve a comparison between his present condition and non-existence. It set forth the measure of damages as follows:<sup>111</sup>

"[We] construe the wrongful life cause of action...as the right of such child to recover damages for the pain and suffering to be endured during the limited life span available to such child and any special pecuniary loss resulting from the impaired condition."

The scope of liability under the Curlender decision is uncertain. The court did not specify the degree of defect necessary to recover damages. The only guideline is that the child involved in that case was described as "severely" defective. However if courts in the future continue to rely on the public policy grounds given in Curlender for allowing such a cause of action the scope of liability must be extended.

"If the public requires a recourse to negligent genetic counselling and the proper role of the judicial system is to deter future negligence, the extent of deformity should not affect recovery. Whether one child is born

missing only a finger and another is missing his eyesight, it matters not if deterrence and social protection is the ultimate goal that is to be reached."<sup>112</sup>

In contrast the Court of Appeal in McKay v. Essex<sup>113</sup> the first reported authority in England, held recently that the common law did not recognise that a defective child had a cause of action for wrongful life. The claim arose from the fact that the plaintiff child was born disabled by rubella which infected the mother in the early months of her pregnancy. The plaintiff alleged that the Essex Health Authorities Laboratory was negligent in testing the mother's blood samples with the result that she was misled as to the advisability of an abortion, and that the doctor was negligent in failing to advise the mother of the desirability of an abortion.

The Court of Appeal discussed the many American cases including Curlender, but dismissed the latter as not providing "any answer to the reasoned objections to this cause of action".<sup>114</sup> They held:

1. That the only duty owed to the unborn child by the defendants was a duty not to injure her and this duty had not been breached. To say that the defendants were negligent in allowing her, injured as she was to be born was to say that they had a duty to procure her abortion. The court stated:<sup>115</sup>



"There is no doubt that this child could legally have been deprived of life by the mother's undergoing an abortion with the doctor's advice and help. So the law recognises a difference between the life of a fetus and the life of those who have been born. But, because a doctor can lawfully by statute do to a fetus what he cannot lawfully do to a person who has been born, it does not follow that he is under a legal obligation to a fetus to do it and terminate its life, or that the fetus has a legal right to die...To impose such a duty towards the child would...make a further inroad on the sanctity of human life which would be contrary to public policy. It would mean regarding the life of a handicapped child as not only less valuable than the life of a normal child, but so much less valuable that it was not worth preserving..."

2. "...If difficulty in assessing damages is a bad reason for refusing the task, impossibility of assessing them is a good one."<sup>116</sup>

The Court of Appeal also referred to the Congenital Disabilities (Civil Liability) Act 1976 which was enacted in July 1976. This effectively deprives the child of a right of action for wrongful life and imports the assumption that, the child would

have been born normal and healthy (not that it would not have been born at all).<sup>117</sup>

The possibility that such a cause of action will be recognised by the courts of New Zealand in the future is remote. The English Court of Appeal's decisive decision in the McKay case would be very persuasive in New Zealand. It must also be emphasised that the Curlender decision is the only case in which recognition has been granted to the defective infant's right not to be born.

Nevertheless assuming that a wrongful life claim would be recognised in New Zealand are there any logical reasons for denying its extension to cases of defective infants claiming that they should have been allowed to die at birth. Such an infant would first have to establish that the doctor owed a duty to it to allow it to die or in other words that the infant had a right to be allowed to die.

Clearly such a right cannot exist at the present time in New Zealand because allowing an infant to die by withholding medical treatment can attract the sanctions of the criminal law. On the other hand it is equally clear that in certain cases of infants with severe disabilities it is morally and ethically permissible for a doctor to withhold medical treatment. If the criminal law was brought into line with current medical ethics and practice, as proposed later in this paper, then this objection



no longer exists. Would a defective infant then have a right to die?

In America such a right has been recognised by courts in respect of incompetent adult patients. In the Saikewicz case<sup>118</sup> the Massachusetts Supreme Court upheld the decision of the state institution to withhold chemotherapy treatment from a sixty-seven year old patient with a mental age of approximately two and a half years. In so holding the court stated:<sup>119</sup>

"It is clear that the most significant of the asserted State interests is that of preservation of human life. Recognition of such an interest, however, does not necessarily resolve the problem where the affliction or disease clearly indicates that life will soon, and inevitably, be extinguished. The interest of the State in prolonging a life must be reconciled with the interest of the individual to reject the traumatic cost of prolongation. There is a substantial distinction in the State's insistence that the human life be saved where the affliction is curable, as opposed to the State interest where, as here, the issue is not whether but when, for how long, and at what cost to the individual that life may be briefly extended."

Similarly, in In re Quinlan the court stated:<sup>120</sup>

"We think that the State's interest contra weakens and the individual's right of privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest"

However the difficulty with defective newborns is that although the "bodily invasion" required to preserve life is great, the prognosis is good, in the sense that the infant's life expectancy will be good although they will often experience severe mental and physical handicaps. The Court in Saikewicz rejected the view that quality of life should be a factor in the decision, but this is not the view taken by England courts. In Re B (A Minor) Templeman J said obiter:<sup>121</sup>

"There may be cases, I know not, of severe prolonged damage where the future is so certain and where the life of the child is so bound to be full of pain and suffering that the court might be driven to a different conclusion."

In McKay v. Essex Health Authority, Stephenson LJ commented on Re B:<sup>122</sup>

"Like this Court when it had to consider the interests of a child born with Down's Syndrome in Re B (A Minor), I would not answer until it is necessary to do so the question whether the life of a child could be so certainly 'awful'



and 'intolerable' that it would be in its best interests to end it and it might be considered that it had a right to be put to death."

It is apparent from the above two extracts that the courts do not completely dismiss the notion that an infant might have the right to die.

Assume then that New Zealand courts will recognise the wrongful life action, that in certain circumstances an infant has a right to die and that it is not a crime for a doctor to withhold treatment from that particular infant. A doctor who continues to deliver life sustaining treatment to that infant may be liable to that infant for damages in tort. This is not a very likely scenario considering the strong policy reasons behind the England Court of Appeal's rejection of the wrongful life cause of action in McKay's case, but a possibility nevertheless.

A question would then arise, peculiar to the New Zealand context of whether such an action would be barred by Section 28(1) of the Accident Compensation Act 1982. This section provides that:

"...where any person suffers personal injury by accident in New Zealand or dies as a result of personal injury so suffered...no proceedings for damages arising directly or indirectly out of the injury or death shall be brought in any Court in New Zealand independently of this Act, whether by that person or any other person, and whether under any rule of law or any enactment."

Personal injury by accident is defined in Section 2 of the Act to include "medical misadventure". The meaning of the phrase has been considered in various cases, both by the corporation and the Courts. In L v. M<sup>123</sup> Cooke J said obiter:<sup>124</sup>

"The 1974 amendment has made various additions to the definition of personal injury by accident. In particular the phrase now includes "medical misadventure". I think there was a medical misadventure here. It is arguable that under the new definition this would be enough to bring Section 5(1) into play - that it is unnecessary to show as well anything that would ordinarily be called a personal injury."

Thus it would seem that although the 'injury' complained of in the case of a defective newborn life itself does not come within the ordinary meaning of the words "personal injury", this is no bar to it being considered a "personal injury by accident" within the meaning of Section 2 of the Act. Despite this the case of a defective infant would not fall within the term medical misadventure. It was defined by the Accident Compensation Appeal Authority as including:<sup>125</sup>

"a mischance or accident, unexpected and under-  
signed, relating to medical treatment..."

This definition has been approved by the High Court in Accident Compensation Commission v. Auckland Hospital Board & M<sup>126</sup>. There is no mischance or accident in the decision by a doctor to treat a



defective newborn infant. It is part of his duty as a doctor to preserve life. The Act does not provide a guarantee of complete success in medical treatment. Where there is an unsatisfactory outcome of treatment which can be classified as merely within the normal range of medical or surgical failure, this would not be held to be a medical misadventure.<sup>127</sup>

Consequently the Accident Compensation Act would afford no protection to a doctor from a potential tort action for wrongful continuance of life. However if a doctor withholds treatment from a defective infant because in his or her judgement the infant's life would not be worth living, and the infant continues to live in a more impaired state than it would have had it received treatment immediately after birth, any tort action for damages would be barred by Section 27(1) of the Act. The decision to withhold treatment resulting in further injury to the infant falls clearly within the term "medical misadventure" the injury being an unexpected result of the medical decision. Death was the expected result.

If, however, a non-treatment decision is made by a doctor without the consent of the parents and the infant dies the parents might sue the doctor for negligence, wrongful death, abandonment, or breach of an implied contract to do whatever is necessary to sustain life.<sup>128</sup> It is clear that in these circumstances

the Accident Compensation Act would provide no protection for the doctor. The death of the infant in these circumstances is the expected result of a medical decision and thus not a personal injury by accident.

This is by no means an exhaustive list of possibilities for civil liability of doctors in infant euthanasia cases but illustrates that those doctors who participate in "no treatment" decisions incur the risk of civil, as well as criminal, liability.



## 5. A PROPOSAL FOR LAW REFORM

It is apparent that doctors who participate in the practice of withholding treatment from defective newborns may be guilty of crimes ranging from conspiracy, to murder, and tortiously liable for damages in some cases for the consequences of their decisions. Should doctors continue to carry risks of criminal and civil liability for decisions to withhold treatment which are generally thought to be morally and ethically permissible?

According to Burt<sup>129</sup> the answer is yes even though the position may seem hypocritical. He states that this double standard is necessary to protect us all and quotes in support a passage from Lord Coleridge in R v. Dudley and Stephens:<sup>130</sup>

"It must not be supposed that in refusing to admit temptation to be an excuse for crime it is forgotten how terrible the temptation was; how awful the suffering; how hard in such trials to keep the judgement straight and the conduct pure. We are often compelled to set up standards we cannot reach ourselves, and to lay down rules which we could not ourselves satisfy."

He goes on to argue that if there is a socially sanctioned mechanism for ending the lives of deformed infants the question will insistently be posed for every deformed child and his parents: why have you inflicted this monstrosity on our community?<sup>131</sup>

But this is no justification for the current situation in which doctors are forced to act with great uncertainty about their ultimate legal safety. As Duff and Campbell argue

"...if working out these dilemmas in ways we suggest is a violation of the law...the law should be changed."<sup>132</sup>

I would propose that the Crimes Act 1961 be amended to sanction the current practice of doctors with respect to defective newborns and that a new statute be introduced to establish procedures for the review of parental and medical decisions regarding the treatment of defective newborns.

Section 151 of the Crimes Act should be amended by the addition of subsections (3) and (4) in the following form:

(3) No one is under a legal duty to provide the the necessaries of life to a severely defective infant under his charge unless requested to do so by the parents or guardians of the infant.

(4) A severely defective infant is one who cannot survive infancy without medical intervention and whose prognosis for cognitive sapient life, even assuming this intervention, is poor.

A new statute should be passed along the following lines:<sup>133</sup>



Section 1 A severely defective newborn is one who is not likely to survive infancy without medical intervention and whose prognosis for cognitive sapient life, even assuming this intervention, is poor.

Section 2 (1) In all cases where a severely defective newborn is in need of life-prolonging medical treatment and the parents or guardians of such child refuse to consent to that treatment, if the attending doctor concurs with the parents or guardians decision then, subject to subsection (2) of this section, such treatment shall be administered.

(2) If any member of the medical staff involved with the care of the child disagrees with the decision of the parents or guardian to refuse treatment, he may refer the matter to the Medical Treatment Panel for hearing.

Section 3 In all cases where a severely defective newborn is in need of life-prolonging treatment and the parents or guardian of such child refuse to consent to that treatment, if the attending doctor favours treatment, then the matter shall be referred to the Medical Treatment Panel for hearing.

Section 4 (1) All cases referred to the Panel shall be set down for an immediate hearing.

(2) In all cases the panel shall appoint a guardian ad litem to represent the interests of the child.

(3) The Panel shall order treatment to be withheld if it can be proved by clear and convincing evidence that such withholding of treatment is in the child's best interests, considering the probability of recovery with the proposed treatment, the potential side effects of the treatment, and the nature of the treatment.

(4) A majority vote of the Panel shall be sufficient on which to base findings and an order.

Section 5 Any party to the Panel hearing may, within two days after the date of an order made by the panel, appeal on grounds of law to the High Court.

Section 6 In all cases where a severely defective newborn is in need of life-prolonging treatment and the parents or guardian of such child request the treatment, the attending doctor must administer the treatment.

Section 7 No person who makes a decision in relation to the treatment or non-treatment of an infant pursuant to this Act shall be liable in tort for damages for the consequences of that decision.



Section 8 (1) Every hospital board shall establish a Medical Treatment Panel which shall consist of five members:

- (a) one pediatrician ;
- (b) one other registered medical practitioner ;
- (c) one lawyer ;
- (d) two members of the public who are not lawyers and who, at the time of their appointment, are not engaged in or licenced to practice medicine.

(2) No person may serve on a Panel if the person has a professional or personal interest in a case under consideration.

## 6 CONCLUSION

Modern medical science has given us the power to preserve and sustain the lives of seriously defective newborns. This power inevitably includes the power to deny life. Doctors currently involved in these life or death decisions, which are ethically and morally acceptable within the medical profession, risk criminal sanctions and civil liability. The proposal for law reform contained in Part 5 of this paper is an attempt to remedy this situation while still preserving some protection for the rights of the infant.

The suggested amendment to the Crimes Acts would relieve doctors of the fear of possible murder or manslaughter charges by removing their duty to provide the necessities of life for a severely defective infant unless requested to do so by the parents.

Whereas the proposed statute gives the parents of the infant the prime responsibility in the decision. The infant's interests are adequately safeguarded by a mandatory referral to a panel consisting of two doctors, a lawyer and two members of the public, in any case in which the attending doctor or any other medical person involved with the care of the infant, does not agree with the parents decision to withhold treatment. The appointment of a guardian ad litem to represent solely the interests of the infant is a further protection of the infant's rights.



These proposals to reform the law will not solve the problems of parents and doctors who must decide the fate of a newborn infant. Until medical science can prevent or cure spina bifida, Down's Syndrome and other debilitating diseases, these difficult ethical questions will remain. They do, however, bring the criminal law into step with current practice and provide a procedure, including protections for the interests of the child, for reaching the final decision.

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 "Everyone who as a parent or person in place of a parent is under a legal duty to provide necessaries for any child under the age of 16 years, being a child in his actual custody, is criminally responsible for omitting without lawful excuse to do so, whether the child is helpless or not, if the death of the child is caused, or if his life is endangered or his health permanently injured, by such omission."
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