Symposium 1:

The Arthur case – a proposal for legislation

Diana and Malcolm Brahams *Barrister and solicitor, respectively, practising in London*

Editor's note

Following the acquittal of Dr Leonard Arthur in the case of the Down's syndrome infant the co-authors of the first paper in this symposium prepared a draft bill on the treatment of chronically disabled infants which has since been informally commended by the Director of Public Prosecutions. A second contributor, a law student, also argues for legislation as being the most effective way for society to have its standards clarified and observed. In a final paper Dr Havard, Secretary of the British Medical Association, opposes legislation believing it would raise far more problems than it would resolve. The first article was originally published in the Law Society's Gazette.

The trial and acquittal of Dr Leonard Arthur has posed more problems than it has solved. Moreover, it reveals an alarming divergence between the law on the one hand, and prevailing medical practice and public opinion on the other.

Dr Arthur is a respected senior consultant paediatrician employed at Derby City Hospital. His ordeal began, when, on Saturday 28 June 1980, Mrs Molly Pearson gave birth to a baby boy suffering from Down's syndrome (mongolism), and he was called in to examine the baby. The parents were very distressed by their baby's severe and irreversible handicap, and rejected him. Dr Arthur made a note: 'Parents do not wish it to survive. Nursing care only'. He made out a prescription for DF 118, a morphine-type drug, comprising dihydrocodeine. The drug was to be given orally, not more than four-hourly, in 5 milligram doses, to alleviate the baby's distress as and when it arose. The baby, by now christened John, died 69 hours later at 5.10 am on 1 July. His cause of death was given as broncho-pneumonia due to consequences of Down's syndrome. A member of the society Life contacted the police alleging that the baby had been drugged and starved to death and placed in a side ward to die. Police officers called to ask Dr Arthur about the events which had led to the baby's death, and a post

mortem was carried out by Professor Alan Usher. On 2 February 1981, Dr Arthur was charged with the baby's murder, and on 17 October he was brought to trial at Leicester Crown Court. He pleaded 'Not guilty'.

It was the prosecution's case that the baby had died of lung stasis caused by DF 118 poisoning in a child with Down's syndrome, and that this had been the result of a deliberate intent by Dr Arthur to kill the child; in addition, it was alleged that the child had been deliberately deprived of food and medical treatment, and that from the moment that Dr Arthur wrote his note, he was doomed to die.

The prosecution's evidence largely collapsed when Professor Usher's post mortem studies were found to be incomplete and therefore inaccurate. Professor Emery, the defence expert, who was a paediatric pathologist, had revealed from the histology that the child had calcification of the brain, fibro-elastosis of the heart and congenital abnormalities of the lung. Professor Usher, though a distinguished pathologist, was not an expert in this field of tiny babies, and his conclusions that the baby had been healthy apart from mongolism and had an 80 per cent chance of survival were wrong. The defence contended that accordingly, the prosecution's case had been conceived in ignorance and inaccuracy, and the charge of murder was withdrawn on the direction of Farquharson J, and a charge of attempted murder substituted on 27 October, after the trial had been on foot for ten days. Indeed, the judge remarked: 'It is a prospect one views with some alarm that expert evidence can be given to you in a charge of murder which turns out to be incomplete and inaccurate'. However, he then went on to praise Professor Usher's frankness in admitting the correctness of the defence's further evidence when he was recalled to the witness stand.

Throughout the trial, the prosecution conceded that Dr Arthur's motives were of the highest order; he had adopted the course of treatment he considered the most humane for the baby, and the family. However, the prosecution declared, the time had not come in this country when a doctor could say: 'Because you are mentally-handicapped and your parents do not want you to survive, I'm going to take such steps as to ensure that you do not survive'. This type of behaviour must bring a doctor like Dr Arthur into conflict with the criminal law.

Key words

Law and medical ethics; severely handicapped infants; medical ethics; Down's syndrome infants.

The defence submitted that bringing the case had been a tragic mistake, and it asked the jury to return a verdict that would mean that in the future, parents and doctors could make decisions in such agonising and terrible situations without the fear that an informer would rush to report them to the police.

A large number of eminent and respected doctors and specialists went into the witness box to testify on Dr Arthur's behalf; he himself offered no evidence. From these many testimonies, it seemed clear that Dr Arthur's treatment had fallen within the current accepted norms of medical practice. In our opinion, it is well summed up by the evidence given by Dr Peter Dunn, a paediatric specialist: 'Intensive care would be given to any child, regardless of how severely handicapped he was, when it was the wish of the parents. Pressure would not be exerted on the parents by a responsible paediatrician; it was easier to treat a child. But one had to face reality. "Some children are born with such frightful handicaps that we think it is reasonable to accept the parents' decision that in the interest of their own child, prolonging, or long life is not in that interest. It is an extremely complex matter. No paediatrician takes life; but we accept that allowing babies to die – and I know the distinction is narrow, but we all feel it tremendously profoundly – is in the baby's interest at times". The British Medical Association (BMA) *Handbook on Ethics* (1) can be understood implicitly to endorse this view.

The judge's summing-up

Farquharson J's summing-up contained, *inter alia*, the following weights and balances: the case posed serious questions affecting medical practice and it also affected the public interest. The jury were to eschew all emotion and distinguish between Dr Arthur's high motives, and his intentions behind the treatment he prescribed for the baby. Explaining the prosecution case, the judge continued '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 the life and health of the public at large'. After delivering this salutary warning to the jury, the judge dropped this compensating factor into the scales: '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'.

Before the jury retired to consider their verdict, they were advised by the judge to consider the issues in two parts:

1) The jury must decide whether the prosecution had convinced them that Dr Arthur, when prescribing the régime he did, took steps to bring about the death of the child intending that he should die. Did he take

active steps to ensure that the baby would die, with the intention of bringing that event about?

2) If the jury concluded this was proved, then a second question faced them: had the prosecution convinced them that the steps taken by Dr Arthur amounted to an attempt to murder the child?

In just two hours the jury unanimously acquitted Dr Arthur. Notwithstanding, it seems to us that the moral and ethical questions raised in this trial remain legally in issue. The decision establishes little in the way of principle, and to a large extent turns on its own narrow facts. The jury's verdict may, however, be construed as a refusal to convict a doctor of murder for 'allowing a severely handicapped baby to die'. It should be added that the prosecution failed to make out its case that the baby was starved to death; the baby weighed the same at death as it did at birth, 3.23 kgs. A normal, healthy mother does not produce milk for three days and a baby will not suffer if he is given only water, or water and sugar, until the mother's milk flows. Baby John died within three days. He was fed distilled water mixed with DF 118; he was chronically ill and died quickly. No effort was made to save him.

Allowing a baby to die

However, what might the position be if an otherwise healthy child with Down's syndrome did not develop an appetite and was not induced to feed and died after 10–21 days? This, in the doctors' reckoning, would have constituted allowing a baby to die. In so allowing, it is common to aid the process by administering appetite-reducing drugs; this in our view amounts to more than nonfeasance, and is in fact positive malfeasance. It is also said that these powerful drugs such as DF 118 may harm the baby and hasten its end, though they may be given to alleviate the distress it feels from its illness, general condition and, we submit, lack of sustenance. The law of murder and manslaughter is so well established that we do not propose to re-state it in any detail. Suffice it to say that in general the law distinguishes between nonfeasance, acts of omission, and malfeasance, acts of commission. To commit positive acts with the intent to kill or cause grievous bodily harm may amount to murder; by contrast, the criminal law at common law rarely punishes mere nonfeasance or omission. However, once a duty towards a person arises, nonfeasance, if it is wilful and intended to achieve grievous harm or death, may suffice even for murder (*R v Gibbins and Proctor*) (2), though generally, mere acts of omission are chargeable with manslaughter. Where the victim is a child, s. 1 of the Children and Young Persons Act 1933 may apply. In *Gibbins and Proctor* (2) a man and the woman with whom he was living were held guilty of murder of the man's child where the woman with the man's concurrence, withheld food from the child, intending its death or grievous bodily harm. By living with the man and receiving money from him for food, the woman assumed a duty towards the child. Though most omis-

sion cases are founded on neglect, in our view, it is arguable that deliberately withholding food and medical treatment and foreseeing the consequences that the child may die may amount to manslaughter, murder or be chargeable under s.1 of the Children and Young Persons Act 1933. Though the circumstances of *R v Instan* (3) were vastly different from the kind of clinical judgment involved in 'allowing a child to die' there is some analogy to be drawn. In *Instan*, a niece was held to have a moral duty to care for her helpless 73-year-old aunt who for the last ten days of her life was suffering from gangrene in her leg. The niece offered her aunt no food and called no medical help. She was convicted of manslaughter since she had a duty to her aunt, and her failure to offer her food and call in medical help had accelerated her death.

Another seemingly irreconcilable element in prevailing medical practice is that of giving such very great weight to the parents' wishes that a child should be allowed to die. That the parents' wishes should be disregarded because the interests of the child are paramount and there is a duty to preserve life, is well illustrated in *Re B (A Minor)* (4) where a baby was made a ward of court, following her parents' refusal to give consent for a life-saving operation to be carried out. The baby had Down's syndrome. The Court of Appeal gave its consent for the baby to have the operation.

Notwithstanding the law, it seems probable that an English jury will be most reluctant to convict a doctor, who in good faith, with the consent of the parents, 'allows a severely handicapped baby to die' with all the implications discussed above. Further, since the practice is apparently well established, and Dr Arthur's was the first case hauled before the courts, there is an understandable reluctance on the part of the Director of Public Prosecutions (DPP) to prosecute, even when reports of such incidents are submitted to him. This must be a very unsatisfactory state of affairs. The law seems out of step and either goes by default or has evolved double standards to protect a doctor whereas a parent would in similar circumstances almost certainly be convicted of homicide.

Changing ethics and morality in society

Ethics and morality in society are not rigid and the law can be adjusted to take account of changes if those changes are felt to be for the good of society as a whole. The past 20 years have, among other things, seen the passing of the Suicide Act 1961, the controversial Abortion Act 1967, the Sexual Offences Act 1967 (which amended the law in relation to homosexual acts by men over 21 in private) and the various statutes relating to divorce, by which the whole conception of the matrimonial offence has supposedly been replaced with the irretrievable breakdown of marriage. It has been suggested elsewhere that *R v Arthur* might be referred to the Court of Appeal and ultimately to the House of Lords, under s.36 of the Criminal Justice Act 1972 by

the Attorney-General for their opinion on the point of law. A question to the effect of whether a régime which allows a child to die with the consent of the parents may amount to murder or manslaughter might perhaps be framed from the facts and principles lying behind the prosecution, should the Attorney-General be willing to become involved. Though this is a possible solution, we feel that the spectrum may be too broad for such an approach.

We therefore set out below a draft Bill, which is less an expression of our own conviction of how the law should stand, than an attempt to create a statutory framework within which doctors may legally continue what appears already to be widely accepted medical practice in relation to seriously and irreversibly handicapped babies. Medical science and operational techniques have rapidly advanced, and are to some extent responsible for the aggravation of these agonising life and death decisions. How should the law face up to the challenge? Subject to a reference by the Attorney-General (5): 1) It can either do nothing and go largely by default; 2) bring in a new statutory offence for doctors who fail to treat except in cases of incurable illness of infants or where treatment would simply prolong suffering, which would go some way toward enforcing the law as it stands now; or 3) introduce a Bill on the lines suggested below. There is no happy solution, and the only thing in favour of this Bill for Limitation of Treatment is that it does set out to regulate doctors' behaviour and lay down more thorough guidelines and safeguards for the treatment of chronically handicapped babies than exist at present.

Draft Limitation of Treatment Bill

A bill to regulate the conduct of the medical profession and others in the treatment of chronically disabled infants.

- 1) Where apart from the provisions of this Act it would otherwise be an offence it shall not be an offence if a registered medical practitioner fails to administer or ceases to administer to a patient under his care, treatment necessary to preserve and/or prolong the life of that patient in the circumstances set out in s.2 below.
- 2) Where the patient is an infant under the age of 28 days and;
 - (i) All persons having the rights of a parent or guardian over the patient have consented in writing to cessation or limitation of treatment by the medical practitioner.
 - (ii) Two medical practitioners acting in good faith (one of whom may be the patient's own doctor) and at least one of whom shall be a qualified paediatrician as hereinafter defined and both of whom shall be of not less than seven years standing shall certify in writing that the patient is suffering from a severe physical and or mental disability which in their opinion (having regard to the state of medical knowledge at the time) is
 - (a) irreversible or for which no treatment reasonably available to the patient would result in the significant alleviation of the said disability or

(b) of such gravity that the patient (after receiving all reasonably available treatment) would enjoy no worthwhile quality of life.

3) In considering whether the disability is of such a character as that referred to in s.2(ii)(b) of this Act the two medical practitioners shall be required to take into account:

(i) The degree of pain and suffering (both mental and physical) likely to be encountered by the patient should his life be prolonged

(ii) the ability and willingness of the parents of the patient to provide the care and facilities appropriate to the patient's condition

(iii) the likely effect on the mental and physical health of the parents and other members of the patient's family of the need to provide such care and facilities to the patient during his probable lifetime

(iv) the likely treatment and conditions which would be available to the patient in the event of failure by his family to provide such care and facilities

(v) the additional pain and suffering likely to be encountered by the patient arising from the need for frequent and repeated surgery required to preserve life

(vi) the likely ability of the patient

(a) to communicate

(b) to be aware of his surroundings and his condition

(c) to perform unassisted at least some basic bodily functions

(e) to achieve a degree of mobility taking into account

the use of such artificial aids as are normally available to disabled people.

4) Nothing in this Act shall entitle the medical practitioner to withhold food or sustenance from the patient unless in the opinion of the practitioner formed in good faith the provision of such food or sustenance shall directly increase the degree of pain and suffering occasioned by the patient.

5) No person having a conscientious objection to the cessation of treatment authorised by this Act shall be under any duty to sign a certificate under s.2(ii) aforesaid.

6) (Definitions of 'medical practitioner' and 'paediatrician' etc).

(Commentary begins on page 18)

References and footnotes

- (1) British Medical Association (BMA) *Handbook on ethics*. 32, para 5, entitled Severely malformed infants.
- (2) R v Gibbins and Proctor (1918) 13 Cr App (Court of Appeal) 134
- (3) R v Instan (1893) 1 QB 450. See also R v Stone (1977) QB (Queen's Bench) 354.
- (4) Re B (A Minor) 1981 Weekly law reports 1421 CA.
- (5) Since this article was first published, in *The Law Society's gazette*, the Attorney-General has chosen not to refer any questions to the Court of Appeal in that he has felt that the law on murder and manslaughter was clear and that the Arthur case turned on its own facts.

News and notes

MA in practical reasoning at Essex University

The University of Essex invites applications for an MA in Practical Reasoning. The degree is made up of courses in: General philosophy (action, rationality and morality); Justice, rights and obligations; Colloquium in practical reasoning, and a dissertation.

Since the positivist denunciation of value judgments as 'literally meaningless', say the organisers, studies of reasoning in ethics, law and politics have seldom been brought together or connected. But the publication recently of books such as H L A Hart's *Concept of Law* and J Rawls's *A Theory of Justice* has revived a concern with the fundamental features of practical reasoning of various types. One sign of this influence is the increasing body of philosophical work devoted to discussing practical moral, social and legal problems. The quality of such discussions, however, depends crucially on an

awareness of underlying philosophical concerns. Therefore, besides attending to these discussions the MA aims at a systematic study of the nature of the various types of practical thought, including prudential and moral reasoning as well as reasoning about public policy and legal issues.

Applications are welcome from those with undergraduate degrees in philosophy and other relevant disciplines such as politics and law.

Applicants who are not considered fully prepared for the MA can be offered admission to a qualifying year of study and applications to study on a part-time basis will be received sympathetically. For further information and application forms write to: Director of Graduate Studies, Department of Philosophy, University of Essex, Wivenhoe Park, Colchester, Essex CO4 3SQ.