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Legislation is likely to create more difficulties than it resolves

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The Bill drafted by the authors of the first paper has been commended by the Director of Public Prosecutions (DPP) and it is therefore relevant to consider why a further addition to the already overloaded statute book should have received such high commendation. First, it is highly unlikely that the draft Bill would ever have seen the light of day had it not been for the disastrous decision of the DPP to prosecute Dr Arthur, and we are fairly safe in assuming that the DPP's decision to prosecute for murder would never have been taken had it not been for the campaign waged by certain moralist groups against the paediatric management of babies born with life-threatening disorders. Not only does the production of a Bill seeking to control the clinical management of such cases divert attention away from the circumstances of that unhappy decision to prosecute, but it conveniently side-steps one of the most serious aspects of the Arthur case, namely the highly unsatisfactory way in which the adversarial or accusatorial procedure of English criminal law deals with medical issues involving evidence as to opinion (otherwise known as expert evidence) in such cases.

A decision to prosecute for murder a consultant paediatrician of Dr Arthur's eminence and reputation for compassion to his patients, as a result of medical procedures which to all outward appearances corresponded with accepted medical practice, should have been taken only after a very detailed study of the facts. That Dr Arthur should be charged with the same offence as the Yorkshire Ripper without such a study having been carried out is unthinkable. But the DPP has so far not disclosed what medical advice, if any, was taken in arriving at the decision to prosecute. None of our leading paediatricians will admit to having been involved with that decision. The medical issues were therefore left to be determined under our adversary or accusatorial system in a criminal court of law. The main feature of this system, in a case of this kind, is that success depends primarily on the success with which the prosecution or the defence is able to discredit the expert witnesses for the other side. Part of this game (and it is not for nothing that continental lawyers refer to the English 'sporting theory of Justice') is to take the other side by surprise. Accordingly, the lawyers told Dr Emery (the main expert witness for the defence in the Arthur case) that he was on no account to talk to Professor Usher (who appeared for the prosecution) before he had given his evidence at the trial. I find it surprising that the authors of the first paper have ignored this fact. Whereas it may be explained to the satisfaction of lawyers, it is beyond explanation in terms of any established scientific discipline. It would be difficult to devise a system less likely to arrive at the scientific truth.

The authors of the paper assume that the Arthur case raises such important issues that statutory regulations should be imposed on the medical profession. They cite as precedent the Suicide Act, the Abortion Act, the Sexual Offences Act and certain statutes concerned with divorce. But, with the exception of the Abortion Act, none of these statutes is concerned with regulating medical practices. In the case of the Abortion Act the statutory indications which constitute a defence for the doctor under the Abortion Act are so wide that its effectiveness depends almost entirely on the procedures which the Act requires to be followed. Furthermore, there were nearly 170,000 terminations carried out under the Act in 1981, whereas the number of children born with life-threatening abnormalities in circumstances where decisions of the kind taken in the Arthur case arise, are mercifully very few.

The Bill drafted by the authors is far too detailed in its indications for medical intervention and presumes a certainty of diagnosis and prognosis which bears little relation to actual practice. It is at the same time both far too restrictive and far too permissive. The detailed restrictions will distract doctors from their primary task of reaching a difficult clinical decision whilst at the same time parents who feel they cannot accept a handicapped child will expect the doctor to allow the child to die simply because a statutorily defined indication happens to be present.

No one denies that difficult decisions will continue to be required of doctors as more and more advanced and sophisticated procedures become available to treat babies born with life-threatening abnormalities. But the law is not a suitable vehicle for resolving the problem. The only limitation the profession should be

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prepared to accept is a procedural one, for example, that decisions in these cases should be taken only in paediatric units by consultant paediatricians. However, this is hardly necessary as it happens anyway and was, indeed, the position with the Arthur case.

It should be made clear to enthusiastic legislators that these cases are extremely uncommon and that attempts to control their management in the interests of legislative tidiness will be unsuccessful when it comes to practical application. Any paediatrician who has doubts about this should read the authors' Bill carefully, clause by clause, and consider whether it will be possible, or indeed desirable, to observe all the details which are contained in it, and the position in which he or she will be placed if prosecuted for allegedly failing to meet the requirements of the Bill, under an accusatorial system where he will be at the mercy of the conflicting expert evidence given by his colleagues on the detailed definitions and indications laid down in the Bill.

Not only do medical opinions vary as to what constitutes 'a severe physical or mental disability' (clause 2(ii)) but there is an even wider divergence of opinion whether or not 'reasonably available treatment' would result in 'significant alleviation' of such disabilities (sub-clause (a)). Furthermore, the 'quality of life' to be enjoyed by the baby (sub-clause (b)) may well depend on scientific advances which have not yet been dreamt of. Nor is it at all clear what is meant by the qualifying term 'worthwhile' except insofar as it is covered by clause 3.

The circumstances to be taken into account in reaching the decision (clause 3) are largely of a social nature, paving the way for the displacement of the doctor by a panel of social workers, philosophers, psychologists, theologians, etc, which many moralist groups are known to favour, and the extent to which all these criteria can be determined accurately within the 28 days following birth, to which the Bill is limited (clause 2), is questionable.

One can also detect in the drafting of the Bill the influence of certain fallacies which were associated with the reporting of the Arthur case and with the propaganda issued by the moralist groups who had been pressing the DPP to prosecute paediatricians. The whole of clause 4 is devoted to the feeding of such babies. The baby in the Arthur case died three days after birth, during which period, as the authors themselves point out, many breast-fed babies manage to get very little in the way of sustenance and even most bottle-fed babies lose weight. The baby in the Arthur case weighed no less when it died than the day it was born, although this could have been the result of physiological abnormalities. Furthermore, the degree of pain and suffering experienced by a grossly abnormal infant who is being 'force fed' can be relieved by performing a gastrotomy so as to avoid feeding by mouth. Is it seriously suggested that this operation should be carried out in all such cases? There can be very few paediatricians who would take such an extreme view. Yet one result of the Bill could be to make such operations mandatory.

The objections to the Bill as drafted are considerable, but they do not answer the question whether legislation is necessary. The answer to that question must take into account the practical need to allow the paediatrician in charge of the case the widest possible discretion. It is neither desirable nor practicable to determine in advance the legal criteria which should be taken into account. The medical profession will simply retreat into defensive medicine and we will arrive at the situation apparently existing in parts of America, where anencephalics are kept 'alive' linked up to highly sophisticated resuscitation procedures for fear of the legal consequences of discontinuing the 'treatment' (1).

Furthermore, the previous history of legislation on ethical issues governing medical procedures associated with decisions of life or of death such as the Abortion Act and the Infant Life Preservation Act show that detailed preparation is essential in the form of inter-departmental committees, working parties, etc, and the drafting of a Bill is therefore premature. The nearest analogy to the issue we are considering is euthanasia, although there are, of course, important differences. Nevertheless, not only has the medical profession consistently opposed legislation on euthanasia, but none other than the Criminal Law Revision Committee, having studied the subject, has dropped the issue as being 'too difficult' (2). Had we adopted the enlightened and realistic approach to these issues of the Australian Government (where a Law Reform Commission heavily weighted with practitioners who actively deal with the issues concerned, has made excellent progress) the outlook for legislation might be more promising. However, groups concerned with the reform of the criminal law in this country are invariably over-weighted with academics, judges and lawyers, so that the outlook is not reassuring.

According to the report of an exclusive interview granted by the DPP to a *Daily Telegraph* reporter he is known to favour the creation of a 'new statutory' criminal 'offence' for doctors confronted with issues of this nature. It seems that the current penalty of life imprisonment is so severe that he anticipates difficulty in getting juries to convict doctors of homicide in such cases. The report in the *Daily Telegraph* (3), which received the *nihil obstat* of the DPP's own press office, created so much concern in the medical profession that it was the subject of a leading article in the *British Medical Journal* (4), with much ensuing correspondence (5). The DPP later qualified his bald statement that 'doctors who speed death are liable to life imprisonment' when it was pointed out that this was directly contrary to Lord Devlin's very sensible direction to the jury in the Bodkin Adams case (6), on which the medical profession had relied for years. The authors of the paper are not in favour of a separate offence and they have rejected that approach in favour of a Bill

setting out the circumstances in which failure to treat a handicapped baby will provide a defence to a criminal prosecution. Unfortunately, legislation, whether in the form of a new offence or in the form of a special defence to an existing offence, is not the solution to this problem as it will create far more difficulties than it will resolve.

The solution lies in those responsible for bringing criminal prosecutions for homicide in this country instituting the most careful enquiries into reported cases before prosecuting, and carrying out these enquiries with the aid of expert advice. The prospects for treating babies with life-threatening abnormalities can, and have, changed rapidly and it is impossible for a parliamentary Bill, however skilfully drafted, to anticipate what may happen in the future. All that would happen as a result of this Bill is that paediatricians would be forced into defensive medicine and the indications for treatment would become legal and not medical. Should that occur the main sufferers would be the patient and relatives, and not, as the moralist groups so fervently wish, the doctors and nurses who must assume responsibility for the clinical management of these difficult, and fortunately rare, cases.

In conclusion, it is important to understand that decisions which confront the medical profession in these cases are not regarded by doctors (as they are by Mr Ferguson) as issues of paternalism versus autonomy in the treatment of 'defective neonates'. In the first place, from the medical point of view the issue only arises, or should only arise, where the child is suffering, or is suspected to be suffering, from a life-threatening abnormality. If the child does not qualify within that definition the same treatment is given as would be given for any other child. If the child does fall within that definition, as the Arthur child did, the child is made as comfortable as possible while the full extent of the abnormalities is assessed in order to determine the feasibility of further treatment. If the child has been born without a brain the institution of highly technical and sophisticated life-support mechanisms is hardly justified. The difficulty arises in the grey area where the extent to which these procedures (which may involve repeated surgical operation and much associated suffering for the child) is clinically justifiable is uncertain. If society decides that the taking of such a decision by a paediatrician represents unacceptable paternalism within the terms of Mr Ferguson's paper, so be it. But I profoundly disagree with his conclusion that legislation is preferable, and the main grounds of my disquiet are the practical consequences of legislation, particularly those which would follow the passing of a Bill such as that drafted by the authors of the first paper.

References and notes

(1) This particular allegation was made by an American doctor at the 1981 British Medical Association meeting in San Diego. It was not denied by any of his American colleagues.
(2) Criminal Law Revision Committee. *Offences against the person*. 14th report, 1980: Command No 7844; para 115.
(3) *Daily Telegraph* 1982 Feb 15: 6 (col 2).
(4) *British medical journal* 1982: 284: 612–613.
(5) *British medical journal* 1982: 284: 898–900, 1120, 1562, 1633.
(6) R v Adams 1957: Criminal law review 365. The judgment made clear that the doctor 'is entitled to do all that is proper and necessary to relieve pain and suffering even if the measures he takes may incidentally shorten life'.

News and Notes

Name change

D Reidel Publishing company of Dordrecht, Holland have announced that as from this year *Metamedicine* will be called *Theoretical Medicine*. However, the format of the journal will not change: it will remain a forum for interdisciplinary studies.