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THE ROYAL AUSTRALASIAN COLLEGE OF PHYSICIANS

OCCASIONAL LECTURE TO NSW FELLOWS

SYDNEY, 11 NOVEMBER 1981, 8 P.M.

THE PHYSICIAN, THE LAW, LIFE AND DEATH

The Hon. Mr. Justice M.D. Kirby
Chairman of the Australian Law Reform Commission

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OF JUDGES, PHYSICIANS AND THEIR LIBERTIES

I was delighted when I was invited to deliver this Occasional Lecture. The invitation came some months ago when I was in the midst of many busy activities. I was invited to nominate a topic. Because at that time, I was considering the implications of medical privacy for three of the projects before the Australian Law Reform Commission, I ventured the topic 'Law Reform, Privacy and Medicine'. Such a title would allow me to range widely, I thought, over a number of themes of interest to the College and to the Law Reform Commission:

- Evidence : Medical Privilege. Our project on the reform of the law of evidence in Federal courts raises squarely the question of whether the physician's patient should have a privilege to decline the disclosure to courts, without consent, of confidences revealed in the course of treatment. A patient's privilege exists, in limited form, in the law of Victoria, Tasmania and the Northern Territory.[1] It does not exist in New South Wales or in the other jurisdictions of Australia, though courts always endeavour to safeguard confidences, so far as they can.

- Privacy of Health Records. The privacy reference of the Commission likewise takes us into an examination of the issue of medical privacy, the computerisation of medical and hospital records, the suggested facility of the right of access by the individual to personal records about himself to ensure that these records (upon which so many decisions of the future will be made) are accurate, fair and up to date. Should such a facility be available for medical records? What limits should govern official access to medical files, say in cases of alleged fraud against the revenue by physicians or their patients?[2]

- Child Welfare : Compulsory Reporting. Our inquiry into child welfare laws raised squarely the issue of compulsory reporting by physicians of suspected cases of child abuse. Though our inquiry was limited, for constitutional reasons, to the Australian Capital Territory, we have secured opinions on the topic from doctors around the country. A number of the jurisdictions of Australia, including the Capital Territory, do not presently provide a system of compulsory reporting. Our report on this topic will shortly be tabled in the Federal Parliament and it would be interesting to debate it for I know it engenders strong feelings amongst physicians.[3]

Judges rarely take liberties. I propose to take the judicial liberty to depart entirely from my self-assigned task. You may choose to consider what follows to be a post-prandial reverie in which my mind wanders to other themes. I am too young and too deliberate to claim that this is a case of absence of mind. Instead, I must plead, in addition to judicial liberties, a desire to say something about matters which have come to notice in recent days and which may be of special interest to this College and its Fellows. Those who are particularly interested to follow the debates about medical confidentiality can have reference to articles on the subject by me, including in the Medical Journal of Australia.[4] I propose to say nothing more about the topic tonight. Instead, I will turn to my new theme, which relates to the physician, the law and death.

THE COLLEGE AND THE PAST

Before I develop this theme, can I identify a few personal links with the College? Its Inaugural Meeting took place in December 1938 in the Great Hall of Sydney University. This was three months before I was born, so the College and I are virtually exact contemporaries. Let us say that the College, if no longer young, is still in the robust years of extremely early middle age.

The first President of the College was Sir Charles Bickerton Blackburn. He was the Chancellor of the University of Sydney when I came up in 1956. It is a matter of pride for me that I attended, as my first meeting as a Fellow of the Senate of the University, the last meeting at which he presided as Chancellor. I had much to do with him in my University days.

His successor was Sir Charles McDonald, also President of the College. Sir Charles McDonald was a scholarly and gentle man. He had a command of the English language which makes his prose wonderful to read. In the Commonwealth Jubilee Number of the Medical Journal of Australia in January 1951, he outlined the history of the College in the context of the development and practice of internal medicine in Australia during the first 50 years of the century.[5] It is an interesting tale which I commend to any of you who have not read it. He traces the change, during the period, from the ascendency of surgery to the pride of internal medicine and the role of the physician. From the early work on the nervous system and respiration, to the discovery of vitamins in 1915 and the pressure of the Great War towards biophysical and biomedical developments, McDonald outlined the union of medicine and biochemistry between the Wars and the enormous therapeutic leap that occurred after the development of the 'sulpha' drugs, crowned by the introduction into medical practice of penicillin. It is interesting to read his comments today:

> With the rise of operative surgery that followed the introduction of asepsis, internal medicine lost much of its appeal to the profession. Competition for appointments, whether medical or surgical, to the staffs of clinical schools has, of course, always been keen, but in the first quarter of the century, few graduates desired an honorary position as a physician in a hospital where medical students did not throng the wards. In the late 20s and early 30s, when most non-teaching hospitals divided their visiting staff for the first time into physicians and surgeons, competition was active only for the surgical appointments. Men of inferior capacity or of little influence with hospital Boards swallowed hard and accepted the title of physicians with ill-concealed disappointment. The rise to power of internal medicine, its onwards sweep from one therapeutic triumph to another, and the pride of physicians themselves in their own craft, have turned the wheel full cycle.[6]

In this self same review, McDonald had a few tart observations to make. Thirty years on, some of them seem specially apt:

> What has Australian contributed to this passing show of [therapeutic] progress? Let it be said frankly and at once that Australian discoveries in the field of clinical medicine have been disappointingly few and, compared to those of England and America, of minor importance. Little investigational work has come out of clinical schools and still less from individual physicians. There are doubtless many reasons for this. ... [C]linical laboratories and workshops

> are few and the emoluments of medical practice far outstrip the comparative pittance offered to young men anxious to engage in research. In a country, where universities and hospitals are continuously threatened with financial starvation and where teaching staffs are ruthlessly pruned and equipment is cut to a minimum, the spirit of original investigation quickly languishes. ... Our Floreys and Fairleys are drawn from us by the intellectual seduction of another land. We are grateful when a Burnet elects to remain. ... There must, however, be many men of lesser mental calibre or lesser driving force who, endowed though they are with the capacity and the enthusiasm for clinical research, are soon dispirited by the poor facilities offering and plunge into the maelstrom of professional practice.[7]

In the same year, in his Listerian Oration, Charles McDonald penned a piece on 'The Physician and His Workshop'.[8] His thesis was a simple and typically elegant one:

> The practice of medicine is no mere technical procedure; ... a physician is known and honoured not by the knowledge that comes to him, but by the measure of wisdom that lingers. He sees his patients in his consulting room or by the bedside and yet his real workshop is his own mind — that mind, the complex processes of which, born of innumerable experiences, baffle its own understanding.[9]

It is clear from this Listerian Oration, written 30 years ago by this fine Australian scholar, university man, gentleman and physician, that he recognised most clearly both the power and limitations inherent in the exercise of the physician's art. Take this passage:

> Acton's famous tag that power always corrupts, applies to medical men as much as to tycoons and princes, and the best antidote to this corruption is the humility that comes of our manifold errors and human weaknesses and the warmth of our sympathy for those whom it is our privilege to serve.[10]

Or take this, which he said in conclusion:

> We who play with the forces of birth and life and death should simultaneously be proud of the task to which we are called, and abashed at the disproportion between its immensity and our restricted powers.[11]

It is about the forces of birth and life and death and the responsibilities and powers of the physician, struggling with the dilemmas of 1981, that I wish to speak briefly tonight.

OF BIRTH AND LIFE

Let me say, first of all, a few things about birth and life. Lately, I have interested myself in some of the issues raised by the remarkable technique of in vitro fertilisation developed at Melbourne's Queen Victoria Medical Centre by Professor Carl Wood and his colleagues.[12] I understand the technique has now been translated to the Royal North Shore Hospital in Sydney. Estimates vary, but it is said that 25,000 Australian women, otherwise infertile, may potentially be helped to the satisfaction of parenthood by in vitro fertilisation.

Many in Australian society, most if the opinion polls are to be believed[13], support and applaud the work of Professor Wood and his team. There is a mixture and pleasure in the achievement of birth in a growing number of cases which would otherwise be denied the satisfactions of procreation and family life, and a feeling of pride that the new technology is being pushed forward here in Australia. Articles in the popular media, photographs in the Women's Weekly, television programmes and so on explain the human side of the problem of infertility and the anguish, disappointment and frustration which the in vitro fertilisation program may triumph over.

Not everybody supports in vitro fertilisation. Pope Pius XII in 1956 put it quite bluntly :

> On the subject of experiments in artificial human fecundation 'in vitro', let it suffice us to observe that they must be rejected as immoral and absolutely illicit.[14]

Others question the desirability of opening the door to a world in which human procreation is divorced from the act of married love.[15] Others are afraid of the spectre of Aldous Huxley's human hatcheries. It will be recalled that in Brave New World Huxley promised this eventuality 600 years on. Yet here, not 50 years since he wrote his chilling book, the possibility is technologically almost with us. B.A. Santamaria has called for Federal and State legislation to enforce a 'total prohibition against these anti-human practices'.[16]

Even people who do not take an absolute, religious or humanistic objection to in vitro fertilisation do not find it difficult to list matters which will require attention as Professor Wood's experiments become a routine medical practice. Take just a few of the questions which will need to be considered by society, by the medical profession and, ultimately, by the community and its lawmakers:

- Is in vitro fertilisation to be available for de facto couples, in recognition of many modern stable relationships of this kind? Or should we insist on marriage?

- Is the law to contemplate the use of surrogate mothers, who will bear the child of others? If so, are fees to be permitted? Who will have the right to abort such a pregnancy and on what grounds? Is there a danger that this may become the norm for busy professional women of the future?

- Should research be permitted and, if successful, choice be allowed of embryo gender? In other words should couples be able to choose to have a son? Would this supposed new parental 'right' threaten the natural balance secured in the world between men and women?

- Should other 'desirable' characteristics be available by in vitro fertilisation? A recent newspaper report indicated a sperm bank in the United States, available to suitable recipients to produce the children of Nobel scientists.

- If human life begins at the moment of conception, what is the legal consequence of destroying fertilised human ova surplus to use? Can we really contemplate, as is said to be possible, retention of fertilised embryos, frozen and suspended in nitrogen, for up to 400 years? If this is to be permitted, a child of our generation can be born in 400 years time with serious complications for the distribution of property, to say nothing of an identity crisis that would leave talk of today's 'generation gap' well behind.

- What are the rights to donors to custody of such an embryo? Should they be entitled to insist on their retention against the risk of later accident or disease depriving them of children? If so, what is the consequence of divorce? How can we ensure against a mix-up in the lineage of such a tiny form of life? Are full records to be kept for the identity of the human origins of embryos put away for future use?

The problems that accompany the in vitro programme range from the exotic (what will happen to British titles if a test tube baby of an Earl is born a century later?) to the hard-nosed and practical (how much of the program ought to be publicly funded, given the relatively small numbers involved and the competing claims for the medical dollar?).

I say nothing more about this topic tonight. It clearly deserves the anxiou consideration of this and other Colleges, indeed the consideration of all citizens concerned about the consequences for human life of medical developments presenting in our time.

OF LIFE AND DEATH

Transplant Report. Let me now turn to a number of other issues of a moral character which have pressed upon us in recent years, some of them in recent days, relevant to life and death. First, can I say something about the debate that initially brought the Australian Law Reform Commission, and me, into study of the bio-ethical sphere. I refer to the work we did for the report on Human Tissue Transplants.[17] In that report, the Commission was led by Mr. Russell Scott, whose recent book The Body as Property[18] extends the discussion where the report left off. Sitting at our table, we had a number of distinguished commissioners, including Sir Zelman Cowen, now Governor-General and Sir Gerard Brennan, now a Justice of the High Court of Australia. We also brought together a distinguished team of consultants ranging from experts in numerous medical disciplines relevant to transplantation, but also including the head of the Department of Moral Theology at the Catholic Institute of Sydney (Dr. Thomas Connolly), the Dean of the Melbourne College of Divinity (The Reverend John Henley) and Professor Peter Singer, now playing a leading role in the Centre for Human Bio-Ethics at Monash University.

The Commission's report had to tackle a number of controversial matters relevant to transplantation:

- the definition of death in terms of irreversible loss of the function of the brain;
- the opt-in regime for donations and the alternative regime, adopted in France and other countries, by which all persons at their death are deemed to be donors, unless, in their lifetime, they take steps to exclude this possibility;
- the vexed question of child donations: a matter upon which the commissioners themselves divided;
- the retention of particular organs from autopsy cadavers, for the purposes of the development of a serum or other product profoundly useful to society.

Defining Death. So far as the definition of death was concerned, the Law Reform Commission had no hesitation in proposing a simple definition of death in terms of the irreversible loss of brain functions. It is interesting to observe that a United States Presidential Commission has, in recent months, proposed a definition in terms almost identical to that suggested by the Law Reform Commission in its report. I refer to the President's Commission for the Study of Ethical Problems in Medicine and Bio-Medical and Behavioural Research. Similar definitions have been proposed wherever lawyers and physicians have gathered together to confront the definition of 'death' in today's world.

I do not pretend that the Law Reform Commission's report on Human Tissue Transplants is the last word to be written on the topic. But one measure of its success is the fact that the laws it proposed have already been adopted in three jurisdictions of Australia. I understand it will be shortly be proposed for law in Victoria and is under close consideration in New South Wales and other jurisdictions. The report was praised in the British Medical Journal and in other overseas sources not given to commentary on Australian legal texts. Singled out for special mention were the unprecedented efforts we took to engage a community debate and to raise the perceptions of the legal and medical professions and of the lay community about the dilemmas which were posed in this particular area of operations. Solutions were presented for the consideration of the lawmakers. The lawmaking process was helped to face up to issues that would otherwise be left in the 'too hard' basket. Those who value our institutions of lawmaking and who appreciate a society governed by laws not by the whim of particular people (however sincere and talented they may be) will encourage the notion that we can find institutional means of helping the lawmaking process to face up to the legal and social dilemmas posed by modern medical technology.

Three Tales of Death. Let me, with this background, now turn to three recent cases, all of them in Britain, where issues of life and death came before the courts. The three cases are relevant to physicians. In fact two of them involved medical practitioners.

.. An Unwanted Operation. In Britain, in August, the Court of Appeal had to decide in a busy afternoon, an appeal from a decision delivered that morning by Mr. Justice Ewbank concerning the performance of an operation upon a child born with Down's syndrome.[9] The child suffered also from an obstruction which, without operation, would be fatal. If the child had been intellectually normal, the operation would have been instantly and routinely performed.

The parents did not consent to the operation. They believed, and doctors supported them, that it was in the child's interests that she be allowed, under sedation, to die naturally. The Court of Appeal reversed Mr. Justice Ewbank, made the child a ward of court and ordered the operation peformed. Lord Justice Templeman posed the issue:

> Is it in the best interests of the child that she should be allowed to die, or that the operation should be performed? That is the question for the court. Is the child's life going to be so demonstrably awful that it should be condemned to die; or is the kind of life so imponderable that it would be wrong to condemn her to die? It is wrong that a child's life should be terminated because, in addition to being a mongol, she had another disability. The judge erred because he was influenced by the views of the parents, instead of deciding what was in the best interests of the child.[20]

The Case of Exit. The second case involved two members of the British euthanasia society, EXIT, who were charged with aiding and abetting suicide. The case was brought to court at the end of October 1981. The jury in the case had before them the secretary of the Society, an Oxford don aged 34, and a 70-year-old man, Mark Lyons. The latter, Lyons, had been sent to visit eight people contemplating suicide, six of whom soon thereafter died by their own hand. Strangely enough, the secretary was convicted. Lyons was discharged, having already spent some time in prison awaiting trial. The secretary was sentenced to imprisonment for two and a half years. According to press reports, the trial judge sentencing the secretary claimed he had flouted the law and was 'using the society, the object of which is to get the law changed, to jump the gun'. As he was led from the dock at the Old Bailey to serve his term, the secretary shouted 'This shows the idiocy of the present law'. The stated aim of EXIT is the change of the law to allow doctors, if necessary by positive acts, to give a peaceful death to people in great distress and suffering from terminal illness.

Voluntary euthanasia, at least in the case of the seriously ill, incapacitied and dying, is not now (if it ever was) the notion of a few disturbed cranks. In Australia, England and elsewhere, sincere people have taken up the cause as an aspect of their civil liberties. In some parts of Australia attempted suicide is still a crime.[21] When that law was repealed in England in 1961, aiding and abetting another to take his or her own life remained a serious criminal offence. EXIT provoked the British authorities by publishing a book in October 1980 called The Guide to Self Deliverance. It contained a great deal of information specifically aimed at ensuring that those who attempted to end their lives, did so with efficiency and success. The London *Times* and other journals gave a great deal of prominence to the book, urging, in forcefully written editorials, that people who contemplate suicide do not always do so calmly and dispassionately, taking all factors for and against into consideration. The *Times* urged that the book could lead to unnecessary deaths and that its publication should be stopped.[22] The Secretary of the British Medical Association was moved to add his voice to the debate. He urged reconsideration of the publication of the booklet. Countless letters to the *Times* followed, including some by failed suicides.[23] The prosecution of some of the figures associated with EXIT soon followed this noisy and anxious public debate. The conviction of the secretary of EXIT and his imprisonment may well discourage law reformers in this area from taking their convictions beyond intellectual debate!

.. *The Death of a Retarded Baby*. In early November 1981 came the news that Dr. Leonard Arthur, a consultant paediatrician from Derby in England, had been acquitted by the unanimous verdict of a jury of six women and six men of the attempted murder in July 1980 of a mentally retarded baby, John Pearson. The baby, at birth, had been rejected by his parents. Reported medical evidence suggested that with normal medical treatment the baby would have had an 80% chance of survival to adult life. Dr. Arthur had ordered a course of 'non-treatment' for the baby, but also prescribing a pain-killing drug, DF 118, which sedates and depresses appetite. The child lived 69 hours after birth. The defence case was that the drug merely eased the child's inevitable progress towards death. A statement reportedly issued after the verdict by the British Medical Association, the Royal College of Nursing and the Medical Protection Society, urged that it was 'the parents' responsibility to decide what was best for their child. It was the doctor's job to advise and help them. The verdict showed that the public was right in allowing doctors considerable freedom in coping with the burden of handicapped babies'.[24] The report claims that parents may find it a great deal harder from now on to reach a tacit agreement with the doctor that the child should be left to gradually slip out of life.[25] But such an agreement tacit or otherwise could, at least sometimes, run counter to the warning of Lord Justice Templeman that the test is not the best interest of the *parent* but always the best interests of the *child*.

The Prosecution of Dr. Arthur. The prosecution of Dr. Arthur was brought after public agitation by the anti-abortion group in Britain, LIFE. This group claims to have its supporters in hospitals throughout the country, including nurses and other health workers who inform it of doubtful cases. In fact, it was a hospital worker who gave details of the death of the baby John Pearson to LIFE. That organisation informed the police, who referred the case to the Director of Public Prosecutions, who ordered that Dr. Arthur be brought to trial for murder.

Symptomatic of the strong passions raised by cases of this kind are the views expressed by the competing camps. The national administrator of LIFE, Mrs. Nuala Scarisbrick, is reported to be unrepentant and indeed critical of the perceived 'growing unwillingness of people to accept imperfection in their children'. The President of the Royal College of Physicians, Sir Douglas Black, urged that LIFE was helping to destroy the confidence of doctors and nurses by 'attempting to apply simplistic, rigid rules to situations which do not permit the proper application of such rules'.[26] As to the 'information systems' within hospitals, Sir Douglas felt that this would be destructive of the confidence of the medical and nursing profession. 'I feel', he said significantly, 'quite emotional about this'.[27]

The Case of Re B. When the earlier case of the Down's syndrome baby had come before the Court of Appeal, the Times reflected most editorial opinion when it concluded:

> The Court of Appeal decision was certainly the right one in the circumstances. Down's syndrome, sad as it is, is not an affliction that leads inevitably to a miserable life. Many sufferers are cheerful and affectionate, and only moderately disabled. As with spina bifida, it is difficult at present to predict at birth how badly disabled the patient will be. Certainty of prediction always clarifies the ethical issues, and it is one of the most important ways in which medicine can help to relieve the dilemma in the future. The attitude of the parents, though clearly important as a clue to the baby's prospects of affection in life, cannot be a decisive factor against treatment. ... In fact, it must almost inevitably be right for the court to come down on the side of life, wherever there is a division of opinion amongst those directly concerned, so strong that the issue is brought before it.[28]

These words were denounced by Professor John Lorber of the University of Sheffield. He said that society was indulging in hypocrisy here as 300 spina bifida babies were allowed to die in Britain every year. In the 1950s and 1960s heroic efforts had been made by the medical and nursing professions to sustain these babies. Now most of them, grown to adulthood, languished in nursing homes, frequently unloved, unvisited and a costly burden to themselves and to society.

Practice in Australia. We in Australia are not immune from these British debates. This time last year, Professor Singer of Monash University was quoted in the Age as saying that doctors, faced with the dilemma posed by the birth of a child monstrously deformed, were increasingly facing up to the question and saying 'enough is enough':

> What sometimes happens is the parents will leave the baby in hospital and eventually it will develop some form of infection, possibly pneumonia. ... The doctors will then not treat it. They could easily give it a shot of penicillin ... but they let it die.[29]

Sir Macfarlane Burnet, reflecting on the nearly universal taboo about discussion of death in societies such as ours, argues vigorously for the right to die and, in some circumstances, the right to let die. He also asserts as a fact that this is already happening in Australia:

> [C] ompassionate infanticide is already standard practice where the product of birth is such as to justify the term 'monstrous', i.e. where there is a gross and physically disgusting malformation, such as anencephaly (complete absence of brain). Severe spina bifida, where there is no possibility of effective surgery, is not infrequently dealt with by allowing the infant to die under sedation.[30]

Immediately following the acquittal of Dr. Leonard Arthur, medical reporters in Australia approached the Australian Medical Association for comments. An unnamed spokesman for the Association said that the dilemma of whether to intervene or to let nature take its course should be resolved 'by the doctor and, wherever possible, those closest to the patient'.[31] The Director of Medical Services at the Royal Alexandra Hospital for Children in Sydney said that decisions such as these were referred to the hospitals ethics committee. Such committees, typically, comprise doctors, clerics and other like clerics. They meet infrequently. They sit behind closed doors in private. Their rulings, their reasoning and the outcome of their decisions, are but rarely submitted to public and general scrutiny.

Dr. John Beveridge, the Director of the Prince of Wales Childrens Hospital, said that he believed that decisions 'to make a baby comfortable but not to prolong its life' should be made by the doctor, together with his colleagues, the nursing staff, the parents and if necessary the welfare department. A spokesman for the Doctors' Reform Society said that ultimately 'the doctor had to assess the best possible course of action and that he was morally responsible for his decision'.[32] The President of the Down's Syndrome Association said doctors should use every available means to save a child's life, whether it was normal or handicapped. The Anti-Discrimination Act in New South Wales may well require nothing less.

The case of Dr. Leonard Arthur may illustrate little more than the well known fact that it is difficult, at least in countries like Britain and Australia, to secure from a jury the conviction of a doctor for a criminal offence arising out of a difficult decision reached sincerely in the course of the daily performance of the specially onerous responsibility that doctors have to face. It may mean that the Director of Public Prosecutions in Britain (and by analogy, those who make like decisions in Australia) will be more hesitant to bring proceedings of this kind in the future. But the basic problem presented by the Arthur case will not go away. We are told by the English Court of Appeal that the test must always be the best interests of the child, not of its parents. We are told by Sir Macfarlane Burnet and by Professor Singer that cases already occur in Australia where the decision is made not to give lifesaving drugs or other assistance that would routinely be offered to a normal child. We are told by the Reform Society that the issue is ultimately the doctor's personal, private, moral responsibility. Such statements as refer to the involvement of parents refer to their involvement 'if possible'. The medical profession urges that the decision just be left with the doctors and with the nursing professionals.

<u>Obstinate Problems.</u> Conceding that these are intensely difficult decisions, and that they must be made quickly, in highly charged circumstances and often with the knowledge of the special pain that will be suffered by the relatives, a moment's reflection will indicate how unsatisfactory is the current state of things:

- <u>Accepted morality.</u> In earlier times, there was a fairly common, accepted community morality, applied with a good degree of uniformity and interpreted and elaborated by generally accepted church teachings. This is not the case today. Lord Justice Ormrod, a Lord Justice of Appeal of England and himself a trained physician, asserts that the ability to choose in the area of morality, though it imposes immense responsibilities, represents 'one of the greatest achievements of humanity'.[33] Possibly the real achievement of modern man is not in the mere claim to have a choice in the area of morality but in offering a conscientious, well thought out answer to moral dilemmas. The fact remains that without a common morality, leaving it to the doctor's personal moral decision, without more principled guidance, invites disuniformity and inconsistency in the approaches that will be taken from doctor to doctor and from hospital to hospital.

. Differing Hospital Policy. In fact, this has already happened. Doctors in one London hospital refused to operate, against the parents' wishes, in the case of the Down's syndrome baby which recently came before the Court of Appeal in England. Doctors from another hospital had to be found who were willing to perform the operation. Doctors in differing hospitals merely reflected different community and individual approaches to the moral dilemmas posed by the case.

. Murder includes Omissions. We have still to receive and study in Australia the charge to the jury by the judge in the Arthur case. In particular, we have to consider the reasons why he ordered that the matter should proceed only as a case of attempted murder and why he ordered an acquittal on the charge of murder itself. Statutory definitions of 'murder', in Australia at least, typically include reference to omissions as well as positive actions:

> Murder shall be taken to have been committed where the act of the accused, or the thing by him omitted to be done, causing the death charged, was done or omitted with reckless indifference to human life, or with intent to kill or inflict grievous bodily harm upon some person ...[34]

Although commentators may seek to draw valid moral and legal distinctions between positive acts and passive refusal to act in order that nature might 'take its course' these distinctions are not always easy to sustain in practice or to apply to medical conduct in a particular case. Although arguments may turn on whether it was the omission which 'caused' the death, this too is an unsatisfactory debate where omissions expand, ever so slightly, into positive facilitating actions. Did the painkilling drug DF 118 used by Dr. Arthur to sedate the baby John Pearson also have the deliberate and conscious and intentional effect of suppressing his appetite, thereby advancing his death? Who could doubt that failure to nourish a child would result in his death? Would similar treatment of a child not born with Down's syndrome ever be regarded as acceptable medical practice? If not, was this child in truth being allowed and even helped to die because of Down's syndrome? Certainly, it is arguable that the failure to give nourishment, or the failure to provide a routine operation or the failure to give 'a shot of penicillin' fall within the present legal definition of 'murder', provided the requisite intent exists. We do not know Dr. Arthur's specific intention. He exercised his legal right not to give evidence and so was never himself examined or cross examined. It may be unreasonable to doctors to expose them, unguided by society, to accusations of murder. But it may be equally unsatisfactory that decisions of this vital kind, made by doctors, should be left to the vicissitudes of unstructured moral determinations varying from individual to individual and from hospital to hospital : made without any clear guidance at all or, at best, with the help only of a closed hospital committee or appeals to the traditional 'medical way of doing things'.

CONCLUSIONS

Where does all this lead? Can we be entirely satisfied with the outcome of the three cases I have mentioned? Was the English Court of Appeal right to insist, against the wishes of the parents and the initial team of treating doctors, that the baby girl born in August should have the operation, though it inevitably meant that she would see out her days as a Down's syndrome child? The Times thought the decision was correct, indeed inevitable. The Lancet was dubious about the intervention of legal process. The Lancet's reaction was not confined to the medical profession. Professor Glanville Williams, one of Britain's leading legal academics, urged that 'there is a strong argument for keeping the law out of these cases'. But he conceded:

> [I]t can be kept out only by specific legislation or by a considerable shift of attitude on the part of the judges. When a question is so much a matter of opinion as this one, the criminal law should stay its hand. The decision of the parents should prevail.35

The case of Dr. Arthur suggests that a similar conclusion was reached by the jury of English citizens. After all, Dr. Arthur did not adopt his course of treatment until the parents rejected the child. A commentary in the Times on 6 November 1981 took a bold stand that may well command community support in Australia:

> The question of handicapped infants is the most difficult [question] of all, for one thing because the probabilities are harder to assess. A strong case might have been made for not allowing any of the Thalidomide babies to live, but one knows that many of them have developed into reasonably happy children. A great deal depends here on the attitude of the parents. I am inclined to say that the child should be allowed to live if the parents resolve to care for it lovingly, though there is the danger that they may be over-estimating their own strength of purpose.[36]

This author's conclusion?

> I believe very strongly that when the circumstances are such as those in the case of Dr. Arthur, a doctor who acts from purely humane motives ought not to be either morally or legally condemned.[37]

But how far can this principle be taken? Are we to abandon the traditional rules that in the criminal law we look not only to the intention of a person but also to his acts? Are we to be so concerned about intention that we ignore acts, even where they are acts which terminate life, because they were done with a kindly heart and merciful intent? If this liberty is to be extended generally to doctors, by what principle is it to be withheld for paramedical staff, from members of the loving family or even from friendly people whose assistance is sought, as was the case with the secretary of the British euthanasia society, now gaoled?

There seems to be a strong view in medical writing and in lay opinion that the wishes of the parents should predominate in cases involving the birth of profoundly handicapped children. But at the moment, the law would seem to state a somewhat different test, namely what is objectively in the best interests of the child. Whilst the wishes of the parents will usually be most relevant to the best interests of the child, they cannot be determinatant of it. If we are to move frankly to the simpler and more readily ascertainable criterion of parental wishes, we will probably require reform of the law to do so. Many would oppose such a reform, fearing where it might end.

Whilst I fully understand the anxiety of the medical profession about the growing evidence of intrusion of the law into the sensitive and difficult questions I have been examining, I regret that I cannot share the view that the law should be kept out of these cases. In fact, it is already there. Law exists on these matters. The law of murder forbids not only acts but also certain deliberate omissions causing death. The law of negligence, assault and other criminal laws impose duties on medical practitioners. I can fully appreciate that people (whether they be government administrators, trade-union officials or medical practitioners) unused to observing detailed legal rules, will wish to maintain a regime of very wide personal discretions, generally unreviewed and often virtually unreviewable. I can also understand that decisions affecting life and death are painful, must often be made quickly, are not susceptible always to fine definitions and are generally much better made in a hospital than in a courtroom. A very large number of Australians, quite possibly the majority, would believe that mentally handicapped or profoundly physically handicapped children should never be supported at birth but should be allowed simply to 'drift out of life', painlessly if possible, so that they and their parents and the community are relieved of the burden of their life. The position has been reached that we now know that cases of the kind that confronted Dr. Arthur in England arise routinely in Australian hospitals. Decisions must be taken. Uncertainty exists as to the precise criteria upon which those decisions are to be taken. Variety exists from hospital to hospital and from one doctor to another. The religious views of some may dictate one course. The humanist sympathies of others for the parents or for society, may dictate exactly the opposite.

It is normal for the law to interest itself in these questions precisely because the profoundly important matter of human life is involved. Whatever may be the differences that divide our community about abortion, the cases I am addressing are cases where a child has actually been born. If we are to sanction procedures by which, in certain cases, grossly deformed or profoundly retarded children are not to be given the medical facilities which would be routine and unquestioned in a normal child, we may, in practical terms, be deciding that the deformed and retarded children will die. That may be the right decision. The community which has to contribute significantly to the support of such a child may have its own legitimate moral claim to be heard on the subject. But, as it seems to me, these decisions should not be left to unarticulated judgments of individual medical practitioners. They should not be left to secret in-house rules designed by hospitals or their ethics committees and varying among them. They should not be left to the undefined collective of the medical frofession still less should they respond to strident appeals for confidence in medical professionalism. Decisions of life and death, even of a retarded or disabled child, even of an old person on the brink of death, are too important to be abandoned in this way.

The work of the Law Reform Commission in its report on Human Tissue Transplants shows that it is possible to face up to the difficult questions presented by modern medical science. It is possible to do so in consultation with all branches of the medical profession, philosophers, theologians and beyond. It is possible to do so in consultation with the whole community. It is possible to prepare legislation which still leaves ample room for professional discretion, whilst at the same time providing a general framework within which profoundly important decisions of life and death may be made.

Neither the cumbersome procedures of the criminal trial nor the hurried civil proceedings of the earlier appeal are the ways in which the law should be developed to cope with the problems I have been surveying. Alternative institutional procedures are available to develop the law here. I hope that they will be used so that as a society we can ensure that sensitive answers, reflecting current moral views, are offered to the persistent hard questions which must daily be faced by our doctors.

FOOTNOTES

1. Evidence Act 1958 (Vic), s.28. Evidence Act 1910 (Tas), s.96. Evidence Act 1980 (NT), s.12. See Australian Law Reform Commission, Discussion Paper 16, Reform of Evidence Law, 1980.

2. Australian Law Reform Commission, Discussion Paper 13, Privacy and Intrusions, 1980; Discussion Paper 14, Privacy and Personal Information, 1980.

3. Australian Law Reform Commission, Child Welfare (ALRC 18), 1981.

4. See e.g. M.D. Kirby, 'Medical Privacy and Research : A Very Modern Anxiety', in Medical Journal of Australia, 2 May 1981, 442.

5. C.G. McDonald, 'Internal Medicine : Its Development and Practice in Australia During 50 Years', in Medical Journal of Australia, 6 January 1951, 1.

6. id., 5.

7. id., 2-3.

8. C.G. McDonald, 'The Physician and His Workshop', Listerian Oration, Medical Journal of Australia, 23 June 1951, 889.

9. id.,, 893.

10. id., 890.

11. id., 893.

12. M.D. Kirby, 'Law For Test Tube Man?', Address, Queen Victoria Medical Centre, 29 September 1981. See also M.D. Kirby, 'The Law and Modern Technology', Geelong Lecture, Deakin University, 22 October 1981.

13. Survey on test tube babies conducted for Queen Victoria Hospital by the Roy Morgan Research Centre Pty Ltd, June 1981.

14. Pope Pius XII, cited L. Walters, 'Human In Vitro Fertilisation : A Review of the Ethical Literature', Hastings Center Report, 9(4), 1979, 25.

15. B.A. Santamaria, Newsweekly, 15 April 1981.

16. Santamaria, Newsweekly, 22 July 1981.

17. Australian Law Reform Commission, Human Tissue Transplants (ALRC 7), 1977.

18. Russell Scott, The Body as Property, Alan Lane, 1981.

19. Re B (a Minor), Times Law Report, 8 August 1981, 15.

20. ibid.

21. See Suicide Act 1961 (UK), s.1. Cf. Canadian Criminal Code, s.224. The Crimes Act was amended in Victoria in 1967, in the Criminal Code in Tasmania in 1957 and in Western Australia in 1972. In New South Wales and South Australia it is a common law misdemeanour to attempt to commit suicide. Despite recommendations for reform, no reform has been enacted.

22. The Times (London), 18 October 1980 ('The Road to Dusty Death').

23. See for example the Times, 24 October 1980, 13.

24. Sydney Morning Herald, 7 November 1981, 4.

25. ibid.

26. Sydney Morning Herald, 7 November 1981, 4.

27. ibid.

28. The *Times*, 10 August 1981.

29. Cited the *Age*, 19 November 1980.

30. Sir Macfarlane Burnet, *Endurance of Life : The Implications of Genetics to Human Life*, 1978, 96. Cf. P.J. Kearney, *Medical Wisdom and Ethics in Treatment of Severely Defective Newborn and Young Children*, ed D. Day, Eden Press, Montreal, 1976, 60.

31. *Sydney Morning Herald*, 7 November 1981.

32. ibid.

33. R. Ormrod, 'A Lawyer Looks at Medical Ethics', in (1978) 46 *Medico-Legal Journal*, 18, 21.

34. Crimes Act 1900 (NSW), s.18(1)(a).

35. G. Williams, 'Life of a Child', the *Times*, 13 August 1981, 9.

36. A.J. Ayer, 'Why the Doctor Arthur Verdict is Right', the *Times*, 6 November 1981, 14. See also leading article, 'When a Child is Born', id., 15.

37. Ayer, 14.