

Medical Law

Topic 8 (of 10): {Lecture 1 (of 1)}:

Decision-making in respect of selective non-treatment of severely handicapped neonates and young children

Aim:

To outline the legal and ethical issues involved in determining whether treatment of severely handicapped newborn infants and very young children should be given or withheld, given that the latter leads to the neonate's death.

Objectives:

After careful study of this topic you should be able to:

1. Discuss the difficulties associated with decision-making in relation to the selective non-treatment of severely handicapped neonates;
2. Explain, compare and contrast the cases of *Re B* (1981), *R v Arthur* (1981), *Re C* (a minor) (wardship: medical treatment) (1989), and *Re J* (1990);
3. Discuss the cases of *Re A (conjoined twins)*, *Charlotte Wyatt*, and *An NHS Trust v MB*.

Introduction

On Wednesday, March 6th 2002, an agreement was reached between the parents of a baby girl born with *Goldenhar's Syndrome* and the hospital authorities who were treating the baby. The agreement was that the baby would have exploratory surgery for a tracheotomy operation – an operation to which the parents had originally refused to consent. The agreement had been reached via the intervention of the High Court following a three-day police protection order (because the parents had threatened to remove the child from hospital) and then a 24-hour interim care order.

The case represented one of the latest in a long line of cases¹ in which answers to a number of questions have been sought, including; how severe does a handicap have to be before decisions are made as to whether the child shall be operated on to give it a chance to live or whether it should be allowed to die; and who is the ultimate decision-maker – the parents, the hospital authorities, the courts or some combination of the parties if there isn't all-party agreement? The questions are particularly pertinent when there appears to be very little time in which to make a decision to go ahead with what is deemed by the medical profession to be life-saving treatment in respect of a severely handicapped newborn baby (neonate). If it is agreed that there is 'no hope' for the baby, then a decision may be made not to treat (i.e., to omit something), with death being an inevitable consequence: but there is no question of a deliberate act causing death – that would be murder.

¹ See also the 2004 cases of *Charlotte Wyatt* and *Luke Winston-Jones* (deceased) {p9, infra}; and the 2006 case of *Baby MB* (overleaf).

Even when there is ‘no hope’ for a baby, a judgment as remarkable as the one delivered in March 2006 by **Holman J** in *An NHS Trust v MB* may be handed down:

An NHS Trust v MB [2006] 2 FLR 319

The claimant NHS trust (N) sought a declaration that it would be lawful and in M’s best interests for N to withdraw all forms of ventilation from him, and M’s parents applied for a declaration that it should be lawful and in M’s best interests for a tracheostomy to be performed to enable long term ventilation to be carried out. M had been in hospital since the age of seven weeks. He suffered from Type 1 spinal muscular atrophy (SMA) i.e., the most severe type for those who are not born dead. The condition was progressive and degenerative. Even with the continuation of treatment death was inevitable. M could survive for a small number of years or could die suddenly and soon. M had not been able to breathe unaided since before his first birthday and required positive pressure ventilation via an invasive endotracheal tube. It was said that M’s cognitive function was impossible to assess; and that it was very difficult to assess how much discomfort or distress M experienced, but it was inevitable that some interventions were uncomfortable for him. N considered that the quality of life for M was so low and the burdens of living so great that it was unethical to continue artificially to keep him alive. At least 10 doctors and consultants were of the opinion that: M “has an intolerably poor quality of life, and this will only get worse ... The treatments currently provided for M are futile and sadly will not change the outcome of his illness”. (para.26 of the judgment)

Held, It was probable and had to be assumed that M continued to see and to hear and to feel touch; to have an awareness of his surroundings, in particular of the people who were closest to him, namely his family; and to have the normal thoughts and thought processes of a small child of 18 months, with the proviso that because he had never left hospital he had not experienced the same range of stimuli and experiences as a more normal 18 month old. Accordingly, it was not in M’s best interests to discontinue ventilation with the inevitable result that he would die. M had age appropriate cognition, a relationship of value with his family, and other pleasures from sight, touch and sound. Those benefits were precious and real and the routine discomfort, distress and pain that M suffered did not outweigh those benefits. However, it would not be in M’s best interests to undergo procedures that went beyond maintaining ventilation, if they involved the positive infliction of pain and would mean, if they became necessary, that M had moved naturally towards death, despite the ventilation. Those procedures were cardio pulmonary resuscitation, electro-cardiogram monitoring, administration of intravenous antibiotics and blood sampling. It was in M’s best interests and lawful to withhold or not to administer any of those forms of treatment. The declaration reflecting that decision would be *permissive in effect* and therefore would **not** prevent a doctor giving such treatment².

Terminology, the ‘catalogue of questions’ and decision-making

The *selective non-treatment* of a *neonate* is the intentional omission to provide, perhaps, nutrition and hydration and/or other medical treatment within a medically controlled environment to a severely handicapped newborn infant who is very unlikely to survive without medical intervention. **Mason & McCall Smith** note that ‘the neonate [is] defined as the infant in the neonatal period or the first 28 days of extrauterine life’.

² The death of baby MB was reported on BBC news in December 2006.

Now, if quality of life rather than sanctity of life is to be chosen as the appropriate yardstick for decision-making, then, notwithstanding the failure to provide a single, all-embracing concept of *futility*, **Mason & Laurie** in *Mason & McCall Smith's Law and Medical Ethics*, 7th edition, 2005, (p544) point to:

“A catalogue of [almost unanswerable] questions – ... Who is to determine the minimum quality of life? whose life are we considering - the infant's? or are we also taking into account that of the parents or, indeed, the well being of society? Do we, in fact, *want* a society in which the right to life depends on achieving a norm which is largely measured in material terms? Should the disabled infant whose dying is needlessly prolonged be helped on its way? and, if so, is this help to be a matter of omission or should positive steps be taken to end life”?

As the neonate is not an autonomous person, the initial decision will be that of the parents who are likely to be told by the doctor that the preservation of life is secondary to the main consideration which is the prevention of suffering – though the decision is that of the parents. While it is perfectly permissible for *any person* to make the child a ward of court if the parents' decision is challenged, an editorial comment in an issue of the *British Medical Journal* in 1981 said that ‘in the absence of a clear code to which society adheres, there is no justification for the courts usurping the parents' rights’.

Parents' 'rights' *may* be usurped if it's in the baby's best interests to die

The coupling of a doctor's respect for human life with his consideration for the prevention of the child's suffering would appear to make it ethically acceptable for the medical profession to accept Dr Dunn's evidence in the trial of *R v Arthur* (1981) where he stated that: ‘... no paediatrician takes life but we accept that *allowing babies to die is in the baby's interest at times*.’

Two points, in particular, emerged from this statement, viz;

- i that at some point death as opposed to life is in the *baby's* best interests; and
- ii that there is a significant difference in killing (activity) letting die (passivity) even though the same end – death – results; and that the passive mode doesn't conflict with the *Declaration of Geneva's* ‘*respect for human life*.’

Killing and Allowing to Die

s.1 of the *Children & Young Persons Act 1933* provides that (*inter-alia*) any wilful ill-treatment or neglect by or on behalf of a person who has attained the age of 16 years could result in a criminal offence carrying a sentence of up to 10 years on indictment, and unreasonable refusal to permit a surgical operation may amount to wilful neglect: *Oakey v Jackson* (1914).

Criminal charges could, perhaps, be obviated if the decision of *Vincent J* in the 1986 Australian case of *Re F* was held to be good law, viz;

“No parent, no doctor, no court, has any power to determine that the life of any child, however disabled that child may be, will be *deliberately taken from it* ... [*the*

law] does **not** permit decisions to be made concerning the quality of life, nor does it enable any assessment to be made as to the value of any human being”.

Doctors and potential liability for ‘allowing’ babies to die

In theory, a doctor could face the same charges as any other person in respect of allowing a child to die. However, in 1981 in *R v Arthur*, Dr Arthur was acquitted of attempted murder of a Down’s syndrome baby who had been rejected by his mother and for whom Dr Arthur had prescribed a drug to suppress appetite and “nursing care only”. The judge in the case, *Farquharson J* had said to the jury: “I imagine that you will think long and hard before concluding that eminent doctors have evolved standards that amount to committing a crime”. Hardly surprising, then, that an acquittal resulted. Moreover, the dictum reflected the generally held position at that time that if a doctor acted in accordance with the practice of a body of responsible medical opinion, then legal liability would not attach to his acts or omissions, even though “... *no special law in this country places doctors in a separate category and gives them special protection over the rest of us*” (per *Farquharson J*).

Three 1981 cases (*Re B*; *Stephen Quinn*; and *R v Arthur*) and two more recent cases (*Re C and Re J*), form the basis for deciding what, if any, treatment should be administered to a severely handicapped neonate and how that baby’s ‘best interests’ are to be established.

Re B [1981] 1 WLR 1421

B was a Down’s syndrome baby who also had an intestinal obstruction. The baby’s parents refused authorisation for the relatively simple surgery required to save her life. In response, the doctors contacted the local authority, B was made a ward of court, and a judge was asked to authorise the operation. He supported the parents and refused. The case then went to the Court of Appeal.

Held: The operation was authorised, the decision being made ‘in the best interests of the child’. *Templeman LJ* said that the Court has to decide:

“... whether the life of this child is demonstrably going to be so awful that in effect the child must be condemned to die, or whether the life of this child is still so imponderable that it would be wrong for her to be condemned to die”.

In this particular case he thought the choice was between: “whether to allow an operation to take place which may result in the child living for 20 or 30 years as a mongoloid or whether ... to terminate the life of a mongoloid child because she also has an intestinal complaint. Faced with that choice I have no doubt that it is the duty of this court to decide that the child must live”. Of course:

“There may be cases ... of severe proved damage where the future is so uncertain 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”. (per *Templeman LJ*).

The significance of a decision based on such ‘a different conclusion’ is that the outcome would reflect a judgment made on a ‘quality-of-life’ standard, not a sanctity-of-life’ standard – a decision that has significance also for those of ‘adult years and sound mind’.

The second of the trio of 1981 cases noted above is:

Stephen Quinn (1981) *The Times*, October 6th, p1

A baby (S.Q.) suffering from spina bifida was allowed to die. The doctor, who allegedly refused to sustain the baby, was reported to the DPP by the police. The DPP announced that no proceedings would be brought against the doctor. It is uncertain whether *Re B* and the case of S.Q. are compatible.

Mason & McCall Smith (5/e) noted the contrasting views as: “On one reading, the two decisions are compatible, so long as it is accepted that baby Quinn would have been not only physically and mentally handicapped but would also have been in considerable pain. Others would say, however, that they are contradictory in that *Re B* shows that the courts are ready to override the rights of the parents, or to ‘interfere’ in the traditional doctor/patient relationship, whereas the *Quinn* affair, by contrast, demonstrates an inherent reluctance to do so”.

The third in the trio of 1981 cases was that of *R v Arthur*:

R v Arthur (1981) 12 BMLR 1

A baby boy was born with uncomplicated Down’s syndrome in the hospital where Dr Arthur was consultant paediatrician. The parents of the baby boy did not wish him to survive. Accordingly, Dr Arthur noted: “Parents do not wish it to survive. Nursing care only”. Dr Arthur then prescribed a sedative drug, DF118, which also suppresses appetite. The baby died within 69 hours of birth. The prosecution alleged that the prescription of the drug would not only suppress appetite but starve the baby to death; that apart from being a Down’s syndrome baby, the baby was otherwise healthy, and that his death resulted from lack of sustenance and the effect of the drug causing him to succumb to broncho-pneumonia.

However, *Brazier* noted that:

- i. “Defence evidence established that the baby suffered from severe brain and lung damage;
- ii. Dr Arthur followed established practice in the management of such an infant;
- iii. that in the first three days of life normal babies take in little or no sustenance and usually lose weight (which the dead baby had not done). The baby patently did not starve to death.

The judge directed that the charge be altered to attempted murder. Summing up on the law for the jury, the judge stressed that there is ‘... no special law in this country that places doctors in a separate category and gives them special protection over the rest of us ... [i.e.] if the doctor gives [the severely handicapped child] drugs in excessive amount so that drugs will cause death then the doctor commits murder’. However, in his summing-up, the trial judge, *Farquharson J*, concluded that the jury would have to think long and hard before deciding that eminent doctors “have evolved standards which amount to committing crime”.

Held: Dr Arthur was acquitted.

When comparing *Re B* (“baby Alexandra”) and *R v Arthur*, *Mason & McCall Smith* (5/e) asserted that: “Legally it seems impossible to reconcile the reasoning in *Re B* with what

must have affected the jury in *R v Arthur*; it is difficult to see why the parents' wishes as to the death of their offspring should be overruled when major surgery is involved yet be regarded as ultimately decisive when it is not. If it be agreed that this is all part of accepted medical procedure, one could then ask *what it is that particularly justifies death by omission which is, by definition, a prolonged process; might it not be held that positive action is a logical and, possibly, better alternative?*"

[It has been noted that American case law has been equally as inconsistent with judgements ranging from *Re McNulty* (1980) where it was stated that: 'If there is any life-saving treatment available, it must be given regardless of the quality of life that will result' to *Re Infant Doe* (1982) where the decision was that the value of parental autonomy outweighed the infant's right to live when 'a minimally adequate quality of life was non-existent'.]

A decision to allow a child to die will be sanctioned by the courts when it is in the child's best interests as there is no prospect of any meaningful life for that child:

Re C (a minor)(wardship: medical treatment) [1989] 2 All ER 782

Baby C was born with hydrocephalus. She suffered from 'gross and abnormally severe' damage to the cortex of the brain. The damage was irreparable and the prognosis for the child's life was 'hopeless': death was inevitable. There was 'no prospect of a happy life for this child'. She was blind, probably deaf and suffered from generalised spastic cerebral palsy of all four limbs. She was made a ward of court because the local social services department had formed the view that her parents would be unable to properly care for her. An operation to relieve pressure on the brain was authorised by the court and duly took place. The questions then arose as to what further treatment should be provided and whether she should be treated as a non-handicapped child or in a manner appropriate to her condition.

Held: (C.A.) The hospital authority was to be allowed 'to treat the baby to allow her life to come to an end peacefully and with dignity'; and that 'the opinion of the local nurses and carers should be taken into account' [because] if they believed she was in pain or would suffer less by a particular course of action, it would be correct to consider that course of action, always bearing in mind the balance between short-term gain and needless prolongation of suffering'.

As Derek Morgan noted: "This is the first time an English court has acknowledged and condoned the paediatric practice of managing some neonates towards their death, rather than striving with heroic interventions to 'save' or 'treat' at all cost".

Another controversial case on the treatment of a severely handicapped – but not dying – neonate, is *Re J* (1990):

Re J (a minor) (wardship: medical treatment) [1990] 3 All ER 930

J, a ward of court, had been born nearly 13 weeks prematurely. At birth, J was not breathing; he was immediately placed on a ventilator, drip fed and given antibiotics to counteract infection. He was taken off ventilation after a month though he required additional oxygen at irregular intervals. He was epileptic, and the consensus of the medical evidence was that he was likely to develop serious spastic quadriplegia (i.e.

paralysis of both arms and legs) and that he would be both blind and deaf. He was unlikely ever to be able to speak or to develop even limited intellectual abilities but he would experience pain. The prognosis was that any further collapse which required ventilation would be fatal. However, he was neither on the point of death nor on the point of dying. The question arose whether if he suffered further collapse the medical staff at the hospital where J was being cared for should reventilate him in the event of his breathing stopping.

Held: (C.A.) The appropriate course was that J should not be ventilated were he to cease breathing again. In determining the best interests of the child, **Lord Donaldson** said that:

“What doctors and the court have to decide is whether ... a particular decision as to medical treatment should be taken which as a *side effect* will render death more or less likely. ... What can never be justified is the use of drugs or surgical procedures with the *primary* purpose of doing so”.

To this end, **Lord Donaldson** approved a passage from a decision of the Supreme Court of British Columbia, Re Superintendent of Family and Child Service and Dawson (Re Stephen Dawson) (1983) which, itself, was approving the dictum of **Asch J**, in an American case, where he (**Asch J**) had put forward the “subjective” test, i.e. “the court must decide what the patient would choose, if he were able to make a sound judgement”.

[As **Derek Morgan** noted: “The subjective test seems particularly *inappropriate* in the case of neonates, very young children and persons with learning difficulties. There is no character to reconstruct whose values can be applied to the circumstances which have arisen.”]

Also, in Re J, **Taylor LJ** said that:

“Two decisions of this court have dealt with cases at the extremes of the spectrum of affliction [viz.,] Re C ... [and] the earlier case of Re B ...

“Those two cases ... decide[d] [that] where the child is terminally ill the court will not require treatment to prolong life; but where, at the other extreme, the child is severely handicapped although not intolerably so and treatment for a discrete condition can enable life to continue for an appreciable period, albeit subject to that severe handicap, the treatment should be given.

“ ... the phrase ‘condemned to die’ which occurs twice in the passage cited from the judgement of **Templeman LJ** is more emotive than accurate. As already indicated, the court in these cases *has to decide, not whether to end life, but whether to prolong it by treatment without which death would ensue from natural causes*.

“It is to be noted that **Templeman LJ** did not say, even *obiter*, that where the child’s life would be bound to be full of pain and suffering there would come a point at which the court should rule against prolonging life by treatment. He went no further than to say there may be cases where the court might take that view. ...

“I consider that the correct approach is for the court to judge the quality of life the child would have to endure if given the treatment and decide whether in all the circumstances such a life would be so afflicted as to be intolerable to that child.”

That *Taylor LJ* should also adopt the utterly baseless position of associating ‘intolerability’ with a consideration of what the child in question, *if capable of exercising sound judgement*, would deem to be an intolerable life, brings nothing but discredit on the Court of appeal’s judgement. To seek the impossible cannot be meaningful at any time: to seek a rational decision from a severely handicapped neonate is beyond the bounds of credibility. Moreover, *McKenzie J* in *Re Superintendent of Family and Child Service and Dawson (Re Stephen Dawson)* (1983) {noted above, in *Lord Donaldson’s* judgment} had made it clear that the child at the beginning of life would have no yardstick by which to judge this ‘intolerability’ when he said that the child:

“ .. would not [be able to] compare his life with that of a person enjoying normal advantages. He would know nothing of a normal person’s life having never experienced it”.

More Recent (i.e., post-Re J) ‘Re C’ cases

In the second *Re C* case (the first was discussed, *supra*), *Re C (a baby)* [1996] 2 FLR 43, the President of the Family Division, *Sir Stephen Brown*, permitted a declaration on behalf of the medical profession and the child’s parents to discontinue the ventilation of a baby girl experiencing ‘almost a living death’ {The baby had become blind and deaf and was suffering repeated convulsions after contracting meningitis}. The medical profession were able to terminate the treatment as soon as they thought appropriate.

Even if the parents disagreed with the medical profession – as was the case in the third *Re C* case, *Re C (a minor)(medical treatment)* (1997) 40 BMLR 31 – a declaration permitting the medical profession to refrain from reventilating a child who had suffered a respiratory relapse and who was in a ‘no chance situation’ would be appropriate because:

“[To be subjected to parental determination] would be tantamount to requiring the doctors to undertake a course of treatment which they are unwilling to do. The court could not consider making an order which would require them so to do”. (*per Sir Stephen Brown P*).

Decision-making is made in the ‘baby’s best interests’

It has been decided that neither parental wishes nor provisions of the *European Convention on Human Rights* can prevail over the best interests of the child if those interests are best served by avoiding resuscitation and initiating treatment enabling the child’s life to be ended peacefully and with dignity: *A National Health Service Trust v. D* [2000] 2 FLR 677. This resulted from:

“The court’s prime and paramount consideration [being concerned with] the best interests of the child. This of course involves ... consideration of the views of the parents concerned ... [but] those views cannot themselves override the court’s view of the ward’s best interests”. (*per Cazalet J*).

Cazalet J decided that *Art.2 ECHR* (‘Everyone’s right to life shall be protected by law’) was not infringed because the decision was based on D’s best interests, and that *Art.3 ECHR*

(‘No one shall be subjected to ... inhuman or degrading treatment ..’) encompassed the right to die with dignity.

‘Best interests’ and the cases of Charlotte Wyatt & Luke Winston-Jones

Both sets of parents of the severely handicapped neonates opposed applications for declarations that it would not be unlawful to withhold ventilation, should it be required. The judges agreed with the medical prognosis in each case, however, and against parental wishes. Luke Winston-Jones died shortly after the hearing in his case whereas Charlotte Wyatt remains alive and the initial order in her case has been relaxed. She went into foster care when she was released from hospital, however, as she ‘no longer ha[d] a stable home to go to’ following the separation of her parents and the reported drug overdose her father took ‘after his wife walked out with their other three children’: “Baby Charlotte faces foster care as parents separate”, (2006) *The Sunday Times*, February 12th, p3.

The anomalous position of Re T :

Re T (a minor) (Wardship: medical treatment) 1 All ER 906

As in the third Re C case, there was a disagreement between the medical profession and the child’s mother – only this time it was the mother that didn’t want the child to be treated when the medical profession thought that there was a good chance of a successful transplant and that the operation would be in the child’s best interests. Indeed, even in the absence of a transplant, the child might live for 2½ years. However, the mother’s wishes prevailed given ‘ ... the prospect of forcing the devoted mother of this young baby to the consequences of this major invasive surgery ...’.

The point about the last case is that it has introduced an uncertain delimitation between what is ‘acceptable’ as selective non-treatment in the best interests of a neonate and what constitutes euthanasia for an older person.

The Unique Case of Re A (Children) (Conjoined Twins: Surgical Separation) [2001] Fam 147

The Court of Appeal upheld the first instance decision of *Johnson J* in permitting the separation of conjoined twins knowing that in doing so one of the twins, ‘Mary’, would die: her heart and lungs had no capacity to sustain her life independently of her sister, Jodie, and the severance of the shared aorta through which blood was pumped from Jodie’s heart through Mary’s body had the inevitable impact of bringing about Mary’s death.

The Court of Appeal held that Johnson J had been correct to override the objections of the staunchly religious parents who wanted the twins to die if both couldn’t live. However, the reasons for the lawfulness of the operation to separate the twins were based on necessity not, as Johnson J had decided, that Mary’s life would be worth nothing to her. The sanctity of life doctrine, enshrined as a fundamental principle of law, commanded such respect that it had to be accepted that each life had inherent value in itself however grave the impairment of some of the bodily functions of the particular individual.

The inevitable death of Mary following the separation of the twins would not result in a charge of murder as it was a necessity given that; “[Mary] sucks the lifeblood of Jodie, and her parasitic living will [in the event of not operating] soon be the cause of Jodie ceasing to live. The sad fact is that she lives on borrowed time, all of it borrowed from her sister. She is incapable of independent living. She is designated for death”. (per *Ward LJ*).

Summary

- When a baby is born severely handicapped, *Templeman LJ* expressed the dilemma that prompts the life-or-death debate by asking:

“... whether the life of this child is demonstrably going to be so awful that in effect the child must be condemned to die, or whether the life of this child is still so imponderable that it would be wrong for her to be condemned to die”.

- The major cases are:
 - *Re B* – severely handicapped, but not intolerably so, - treat;
 - *Re C* – terminally ill – life-prolonging treatment not required;
 - *Re J* – neither dying nor on the point of death – here the quality of life was judged on the basis of a *substituted judgment*; *contrast*
 - “The matter must be decided by the application of an ***objective approach*** or test” (*An NHS Trust v MB* (2006), para.16(iv)); and “The test is one of best interests, and the task of the court is to balance all the factors”. (*An NHS Trust v MB* (2006), para.58)
- Decision-making is made in the best interests of the baby;
- Decisions are based on a quality-of-life standard: the sanctity of life is not the paramount consideration;
- “All these cases are very fact specific, i.e., they depend entirely on the facts of the individual case” (*An NHS Trust v MB* (2006), para.16(ix)); and
- The courts are the ultimate arbiters.

Addendum

The *Brazier Report, Critical Care Decisions in Fetal and Neonatal Medicine*, was published in November 2006. It recommended that premature babies born after only 22 weeks in the womb or earlier should not be routinely resuscitated.

The Report noted that it is “extremely rare” for babies born before 22 weeks to survive and only around 1% of babies born between 22 and 23 weeks survive to leave hospital.

Guidelines put forward recommend that intensive care should not be given to babies born before 22 weeks and babies born between 22 and 23 weeks should not, in normal practice, be given intensive care unless parents make a request and doctors agree. Professor *Margaret Brazier*, who chaired the committee that produced the guidelines, said:

“Natural instincts are to try to save all babies, even if the baby’s chances of survival are low. However, we don’t think it is always right to put a baby through the stress and pain of invasive treatment if the baby is unlikely to get any better and death is inevitable.”

There’s always an exception ...

The recommendations in the *Brazier Report* should be contrasted with the report in *The Times*, February 21st 2007, entitled ‘*Tiniest baby is heading for home*’, where it was reported that :

Amillia Taylor should not have been born until next month. Incredibly, she is already four months old and should soon be at home with her parents after a phenomenal fight for survival.

She was born in October after only 21 weeks and six days in her mother’s womb, and is *the first baby to survive delivery at less than 22 weeks*.

Her parents, who went through in-vitro fertilisation treatment to conceive, chose the name Amillia for their 10oz (300g) infant because they read that it meant “resilient”. Now aged 17 weeks, she has lived up to her name and beaten the medical odds. She weighs 4½lbs (2kg) and doctors are ready to let her go home.

References

Books

- Brazier, M.** *Medicine, Patients and the Law*, 3/e London: Penguin, 2003, Ch.14 (pp339-355);
- Mason, K & Laurie, G** *Mason & McCall Smith's Law and Medical Ethics*, 7/e. Oxford: OUP, 2005, Ch.16 (up to p574);
- Montgomery, J.** *Health Care Law*, 2/e. Oxford: OUP, 2002, Ch.18;
- Stauch, M, Wheat, K and Tingle, J.** *Text, Cases & Materials on Medical Law*, 3/e. London: Routledge-Cavendish, 2006, pp662-667.

Articles

- Read, J and Clements, L.** *Demonstrably awful: The right to life and Selective Non-treatment of Disabled Babies and Young Children* (2004) 31 J Law & Soc 482.
- McHaffie, H et al,** *Deciding for Imperilled Newborns: Medical Authority of Parental Autonomy?* (2001) 27 J Med Ethics 104

See also:

- “Outcry over Mensa call to kill ‘defectives’”, (1995) *The Times*, January 12th;
- “Lung bypass is shown to halve baby death rate”, (1996) *The Times*, July 12th;
- “Mother wins right to stop son’s surgery”, (headlines, p1 (1996) *The Times*, October 25th); and the law report relating to the headlines, viz.; *In re T (a minor) (Wardship: Medical Treatment)* (1996) *The Times*, October 28th – reported in [1997] 1 All ER 906;
- “Doctors told when to let children die”, (1997) *The Times*, September 21st;
- “MP tells how he let leukaemia child die”, (2000) *The Times*, January 29th;
- Articles on the conjoined twins, August – November, 2000;
- “Hospital seeks right to treat disfigured baby”, (2002) *The Times*, March 6th; and “Parents agree to baby’s surgery” (2002) *The Times*, March 7th;
- Articles on **Charlotte Wyatt**, 7th October 2004-10th February 2005; and the case *Re Wyatt (a child) (medical treatment: parents’ consent)* [2004] EWHC 2247 (Fam);
- Article on **Luke Winston-Jones**. Times Online, 12th November 2004; and
- The website devoted to **David Glass** (see infra for the URL).

Websites:

- <http://www.healthdemocracy.org.uk>
- <http://www.nhsmurders.co.uk>
- <http://members.tripod.com/davidglass1/>

Workshop / Potential Examination Questions

1. If a baby is born severely physically and mentally handicapped and two doctors are of the opinion, formed in good faith, that the prognosis for the child's life is 'hopeless', and the parents confirm that they do not wish the child to live, then that wish should be decisive. No other interests need be considered since the decision, in essence, is merely an extension of *s.1(1)(d)* of the *Abortion Act 1967*.

To what extent, if at all, would you agree with these assertions?

2. In *Re J (a minor)(wardship: medical treatment)* [1990] 3 All ER 930, *Taylor LJ* asked:

“At what point in the scale of disability and suffering ought the court to hold that the best interests of the child do not require further endurance to be imposed by positive treatment to prolong its life?”

By way of analyzing decided case law, answer *Taylor LJ's* question.