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Guest Editorial



The AMA and Infanticide: An Unfortunate Guideline

In 1970, the House of Delegates of the American Medical Association, was petitioned by the New York delegation to revise the AMA Code of Ethics. The problem posed by the New York delegates was that abortion, while legal in their state, was unethical under the AMA Code of Ethics. The resolution of this dilemma was a landmark in the AMA's pragmatic retreat from principle. The decision of the House of Delegates was to tie the AMA's Code of Ethics to the local law. If you practiced medicine in a state where abortion was legal, the AMA held that it was also ethical to perform abortions in that state. To perform an abortion in a state where abortion was illegal was also unethical by professional standards. The American medical profession was thus placed in the same untenable position as the German medical profession in the Third Reich. Defendants in the Nuremberg doctors' trials were to plead, predictably, that what they were doing was not illegal in Germany at the time.¹ The thesis that cooperation in final solutions, in euthanasia programs for the handicapped, and in immoral human experimentation could be justified as the actions of a loyal citizen and "good soldier" was, of course, not sustained by the Allied Tribunal. It was held that a learned profession had duties to patients which transcended any merely political purposes. In contrast to the

actions of the German physicians, large numbers of Dutch physicians refused to cooperate in the holocaust. The AMA hierarchy and its House of Delegates seemed to abandon the Hippocratic tradition in favor of utilitarianism. Instead of identifying itself as the voice of corporate conscience for a proud profession, the AMA retreated to protectionism. The small minority of medical entrepreneurs who engaged in the performance of abortion in New York abortion mills were cloaked with the mantle of official ethical approbation despite a long and unbroken official opposition to abortion by the AMA up to that time. This confirmed a trend toward utilitarianism first noted in 1971 when official AMA spokesmen sanctioned the notorious Willowbrook experiments by a classical end-justifies-the-means rationale.²

A continuation of this trend can again be detected in the recent publication, *Current Opinions of the Judicial Council of the American Medical Association, 1981*. Article 2.10, entitled "Quality of Life," addresses the highly volatile issue of decisions for the treatment of seriously deformed newborns. Their recommendation reads as follows:

In caring for defective infants, the advice and judgment of the physician should be readily available but the decision whether to treat a severely defective infant and exert maximal efforts to sustain life should be the choice of the parents. The parents should be told the options, expected benefits, risks, and limits of any proposed care; how the potential for human relationships is affected by the infant's condition and relevant information and answers to their questions.

The above statement relegates the physician to the peculiar isolation of a mere consultant. It deprives him of his traditional role as the patient advocate in various proxy consent situations. It concedes to parents more rights than they have under the law because it is implicit in the above recommendation that parents will have control of situations in which therapy will be both effective and indicated in a child born handicapped but not dying. There has been a growing consensus in both the medical and legal literature in recent years regarding the accepted limitations of proxy consent.^{3, 4, 5, 6} In essence, parents cannot consent to anything which injures their child.⁷ John Robertson, one of the most widely respected and authoritative experts on legal issues related to the care of defective newborns, has summarized his opinion of the AMA guideline as follows:

This guideline raises, in my view, several ethical and legal problems. Ethically, it is open to question on at least two grounds. First, it assumes that "a severely defective person" has no moral or ethical worth, or a life worth preserving. While this position may be tenable with the most extreme cases, "severely defective" is a vague term that covers a multitude of mental and physical handicaps, few of which alone would render the life, from the patient's perspective, not worth living. Unless this term were greatly narrowed to the specific conditions which from the child's perspective might justify non-treatment, it is likely to lead to parents authorizing non-treat-

ment and death for a variety of handicaps, few of which really warrant such an outcome.

Second, the guideline gives priority to the interests, concerns and needs of the parents over those of the patient, to whom the doctor traditionally owes a primary duty. If there is conflict between the interest of parent and child, there is no obvious reason why the interests of parent should be elevated over those of the child. As long as the child has an interest in living, there is no cogent reason why the parental interest in being free of the burden of caring for a handicapped child should allow parents to cause the child's death by having necessary treatments withheld. While not an ideal solution, as a matter of ethics, the question of medical care must be separated from the question of custody. Parents who want to be relieved of custody of handicapped children should not also be free to override the physician's duty to treat a patient in need, where non-treatment will lead to death or serious injury.

Legal authority for the guideline is also open to serious question. The legality of parental non-treatment decisions depends in the final analysis on whether treatment would benefit the child. Although there are few cases squarely on point, generally parents are not free to deny medical treatments that would benefit their children, and could be subject to a variety of sanctions, from having treatment ordered against their wishes to criminal prosecution for homicide or child abuse if they cause a child's death through non-treatment.

The legality of the guideline thus will turn on whether "severely defective" children would benefit from treatment and continued living. Since it is in the interest of many severely defective children, from their own perspective, to live (even though there may be extreme cases where this is not so), the guidelines may lead physicians to acquiesce in non-treatment decisions that are without legal authority, and which could lead in certain cases to criminal liability for parents and even physicians.⁸

It seems clear from the above and from the published opinions of other legal scholars, that the AMA guideline may actually be encouraging illegal activity on the part of its membership. A physician who cooperates in the withholding of needed and effective care is almost certainly in violation of child abuse statutes and may very well incur criminal liability. When there is a legal duty to provide care and a child dies as a result of failure to provide care, a charge of murder or involuntary manslaughter could be made.^{9, 10} In addition, any institution tolerating such activity on its premises will be in violation of Section 504 of the 1973 Federal Rehabilitation Act which reads as follows: "No otherwise qualified handicapped individual shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." Section 504 upholds the constitutional principle of equal protection.¹¹ It protects the right of handicapped persons to receive the same level of medical care which would be accorded to a non-handicapped person in a similar medical circumstance. This will not happen, obviously, if the physician is to allow parents to overrule needed therapy in situations

where the therapy is effective but the intention is that life saving measures not be used. This would occur in circumstances where the parental intention is that a child should not survive to lead a life limited by serious handicap.

This is not to say that all kinds of extraordinary care be given in every instance. Paul Ramsey has made the distinction well.¹² If a child is born dying, measures which merely prolong his death need not be used. If a therapeutic procedure will not effectively alter the fatal outcome of a handicapping condition, it need not be carried out. In a conflict situation, however, where the parents refuse consent for a medical procedure that will effectively correct a medical problem in a child born handicapped but not dying, the attending physician has more than the advisory obligation which the AMA would accord him. His duty to the infant patient obligates him to seek legal redress by having a guardian-ad-litem appointed for the infant to give consent for care. The paradigmatic situation is the not-uncommon case of duodenal atresia in the Down's Syndrome newborn. If the parents refuse consent for surgery in such a case, the attending physician has a legal obligation to circumvent the parents' decision which injures their child. While it is true that the courts have identified a parental right to privacy in the Becker case,¹³ the medical circumstances in this case involving cardiac surgery in an older Down's Syndrome child are much more conflicting and less clear-cut than in the newborn Down's Syndrome situation.

Recent AMA publications lament the declining membership of this once powerful national organization and most observers would concede that its prestige and political influence have declined out of proportion to its loss of numbers. In its abortion position, the AMA has turned away from an anti-abortion stance which was over a century old.¹⁴ This recent guideline of the Judicial Council again raises the question as to what image the AMA wishes to establish for itself in a similarly controversial area involving infanticide.¹⁵ Since there are medical publications which call for the approval of active killing of defective neonates (not just withdrawal of extraordinary care),^{16, 17, 18} it is incredible to have the largest professional group in organized medicine call for less activism by physicians on behalf of the right to life of liveborn handicapped infants.

Dr. Leo Alexander who was the official American medical representative at the Nuremberg doctors' trials had an important warning for physicians everywhere when he wrote:

Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings, at first, were a subtle shift in emphasis in the basic attitudes of physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived.¹⁹

A logical inference to be drawn from the AMA Judicial Council guideline is that if parents decide, for a variety of reasons, that their child's life is unworthy to be lived, the attending physician will honor their wishes. This is a perilous and ill-advised role for any physician to play, both ethically and legally. The guideline should be withdrawn and revised at the earliest practicable time.

— Eugene F. Diamond, M.D.

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