The Legal Concept of Wrongful Life

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THE LAST several decades have brought dramatic improvements in medicine's ability to predict and diagnose genetic and congenital disease. The first prenatal diagnosis of a chromosome defect occurred as recently as 1967, followed the next year by the successful detection of an inborn error of metabolism. Currently, some 200 metabolic and chromosomal disorders can be diagnosed prenatally, and with the rapid development of powerful DNA probes, it may soon be possible to detect all of the 3000 known single-gene defects in humans. This knowledge affords significant benefits to children, parents, and society, but also confers additional responsibilities on the medical profession. With responsibility comes potential liability, so these medical developments have brought a variety of new legally recognized causes for malpractice action.

"Wrongful birth" and "wrongful life" are two new legal concepts that have been developed in the last two decades as a result of prenatal diagnostic capabilities and the right to control reproduction through contraception or abortion. Wrongful birth is a term used to describe malpractice actions in which the parents sue the physician for negligent conduct resulting in the birth of an impaired child. Wrongful birth has also been used in reference to cases in which healthy children were born following negligently performed sterilization or abortion procedures. These cases have been more commonly termed wrongful conception or wrongful pregnancy.1) Under the wrongful birth claim, it is not the defect itself for which the physician is alleged to be responsible; rather, it is the child's birth that is "wrongful." These cases have generally arisen when physicians have failed to offer amniocentesis when indicated or have failed to give accurate counseling on the risks of congenital abnormalities. While there was initial reluctance by the courts to recognize the birth of any child as an injury to the parents,2,3 wrongful birth has been accepted in many jurisdictions.4-6

The concept of wrongful life is more controversial. While these suits may be brought simultaneously with wrongful birth suits or under similar medical circumstances, the difference is that the suit is brought on behalf of the impaired infant rather than the parents. It is the infant's claim that, were it not for the physician's negligent conduct, the infant would not have been brought into existence in an impaired state. The infant does not claim that the physician caused the impairment (which would be covered under traditional tort law), but that the physician was responsible for the infant's very existence. It is life itself that is construed as a harm. The logical and philosophical issues inherent in such a claim have generated considerable discussion in the legal literature and, to a lesser extent, in the medical literature. At the time of this writing, three high state courts have recognized the wrongful life action, while seven have rejected the concept, making this issue one of active controversy in the judicial system.

LEGAL PRINCIPLES

The main purposes of tort litigation are to compensate individuals for legally recognized harms against their interests and to promote public policy goals of restraining injurious behavior. In any negligence suit, a successful action is dependent on the plaintiff's demonstration of three key elements: (1) the defendant must have owed the plaintiff a legal duty; (2) breach of that duty must be demonstrated; and (3) the breach of duty must be the proximate cause of harm to the plaintiff.7 In addition, the courts may require a reasonable formula by which damages can be calculated. Finally, the courts may consider the impact of the verdict on public policy—a case that meets all of the above criteria may be unsuccessful if it appears that the consequences would be contrary to a valued public policy. Each of these elements has been important in the development of the wrongful life concept.

THE LEGAL HISTORY OF WRONGFUL LIFE

The term wrongful life was originally coined in a 1963 Illinois appellate court decision in which an illegitimate child sued his father for the alleged harm of illegitimacy. The court refused to recognize the claim largely on public policy grounds, because of the fear that a flood of suits would result from illegitimate children and others similarly dissatisfied with their situations in life. Other early wrongful life cases brought by illegitimate children did not meet with success, and the terminology has subsequently changed such that wrongful life has come to be associated with cases involving impaired children rather than illegitimate children.

The first wrongful life case involving an impaired infant,
Dolores Park v. Hobson, was decided in 1967. Mrs. Gleitman had an illness diagnosed as rubella during the first month of her pregnancy. On initial consultation with the defendant physicians at that time, gestation, she was allegedly told that the rubella would have no effect on the child. The child was subsequently born with congenital rubella syndrome. Suit for both wrongful birth and wrongful life were brought by the parents and the child, respectively, with the claim that, had the parents been properly informed, they would have aborted the pregnancy.

The Gleitman court had no difficulty in identifying an infant's right to sue for prenatal injuries. The opinion stated, "Justice requires that the principle be recognized that a child has a legal right to begin life with a sound mind and body." The proximate cause requirement was somewhat more troublesome. The court recognized that the conduct of the defendants was not the cause of the infant's condition and that there was nothing the defendants could have done that would have decreased the likelihood that the infant would be born with defects. It was apparent that the infant's claim was not that he should have been born without defects, but that he should not have been born at all.

The court was also troubled by the issue of how to measure the damages for the alleged harm. Damages are normally calculated to be compensatory for the harm done; however, under the wrongful life claim, the court stated, "This court cannot weigh the value of life with impairments against the nonexistence of life itself." The wrongful life suit was not allowed on the basis that the physicians' conduct did not give rise to damages that were "cognizable at law." The wrongful birth suit was also not allowed since public policy prohibited abortion at the time.

The Roe v. Wade decision legalizing abortion in 1973 would influence how the courts viewed both wrongful life and wrongful birth cases and was significant to the first successful wrongful life suit. Park v. Chessin, a 1977 New York appellate court decision, Mrs. Park had given birth to an infant in 1969 with infantile polycystic kidney disease. Following the death of the child, the Parks sought the advice of the defendant physicians and were told that the condition was not hereditary and that the chances of another child with a similar defect were "practically nil." In fact, infantile polycystic kidney disease is an autosomal recessive condition—the Parks' second child was born in 1970 with the same disease. In support of the infant's wrongful life suit, the majority held that parents had the right not to have a child with impairments and, further, that "the breach of this right may also be said to be tortious to the fundamental right of a child to be born as a whole, functional human being."

This decision was soon overturned by New York's highest court in an opinion that covered two companion wrongful life cases—Park v. Chessin and Becker v. Schwartz. The companion case was brought by Dolores Becker, who gave birth to a child with Down's syndrome. It was alleged that, despite Mrs. Becker's age of 37 years, the defendant physicians negligently failed to advise her of the risk of Down's syndrome and offer her amniocentesis.

The majority opinion was willing to identify a duty owed to the infants by the defendant physicians and that the breach of the duty was the proximate cause of their births. The court pointed out, however, that there was no precedent for the recognition of a "fundamental right of a child to be born as a whole, functional human being." The opinion held that there were two fundamental flaws in the wrongful life claims:

1. That the first, in a sense the more fundamental, is that it does not appear that the infants suffered any legally cognizable injury. . . . Whether it is better never to have been born at all than to have been born with even gross deficiencies is a mystery more properly to be left to the philosophers and the theologians. Surely the law can assert no competence to resolve the issue. . . . Not only is there to be found no predicate at common law or in statutory enactment for judicial recognition of the birth of a defective child as an injury to the child; the implications of any such proposition are staggering.

2. The second flaw was the inability to calculate damages on a reasonable basis—the law was not capable of calculating damages "dependant upon a comparison between the Hobson's choice of life in an impaired state and nonexistence." The opinion upheld the wrongful birth action and dismissed the wrongful life suit.

Despite these precedents, wrongful life suits have been successful in several jurisdictions. The first decision in favor of the wrongful life action to remain standing was Curlender v. Bio-Science Laboratories, which came before an appeals court in California in 1980. The case arose from the blood tests that the Curlenders requested to determine if they were carriers of Tay-Sachs disease. Incorrect results were returned to the parents, who proceeded with a pregnancy and delivery of a daughter subsequently diagnosed with Tay-Sachs.

The court was willing to recognize duty on behalf of the laboratory to the child and breach of that duty. The problem was whether the breach of the duty could be considered a cause of a legitimate injury. To this the court concluded:

"The reality of the "wrongful-life" concept is that such a plaintiff both exists and suffers, due to the negligence of others. It is neither necessary nor just to retreat into meditation on the mysteries of life. We need not be concerned with the fact that had defendants not been negligent, the plaintiff might not have come into existence at all."

Thus, the court simply dismissed the key logical and philosophical elements of the suit. The court acknowledged that establishing the right not to be born would potentially make parents liable for suits from their children if, having been informed of a serious congenital defect, the parents chose not to abort the child. The court saw no reason why public policy should prevent parents from being accountable for the "suffering and misery which they have wrought upon their offspring." The disturbing thought of children suing their parents for their very existence led the California legislature in 1982 to prohibit wrongful life suits against parents (but not against others).

In 1982, the California Supreme Court, in Turlip v. Sortini, became the first state high court to recognize the wrongful life action. The Turlip obtained a consultation with the defendant practitioner when concerns about their child's hearing arose. His evaluation concluded that the child's hearing was normal when, in fact, she had complete hereditary deafness. The parents allege that they conceived a second child prior to learning of the hearing defect. Their second child was also deaf. Had they been accurately informed of the first child's problem, the parents claim they would not have conceived the second child.

The court recognized that the key question was whether life in an impaired state could be construed as a harm in comparison to nonexistence. The opinion stated that while the legal system places the highest value on human life, it was not accurate to suggest that, in all circumstances, impaired life was preferable to nonlife. The court also pointed out that public policy has supported the rights of individuals to make a determination about the relative value of their own lives and that it is the right of parents to make this determination on behalf of their children. Thus, when the parents are deprived of the necessary information on which to base a decision about the child's welfare, the court stated, both the parents and the child are harmed.

Ultimately, the court agreed with the weight of previous arguments in denying that the wrongful life action could be
successful for the award of general damages or for pain and suffering. This was based on two factors: first, although in principle life was not always preferable to nonlife, it was impossible to determine in any reasonable fashion if being born impaired constituted an injury in comparison to not being born; second, it was “impossible to assess general damages in any fair, nonspeculative manner.”

An award for special damages was a different matter. (General damages usually pertain to nonspecific damages such as pain and suffering, while special damages are usually awarded to cover specific expenses such as medical bills.) The court cited the precedents for successful wrongful birth suits and then stated that it would be “illogical and anomalous” for only parents to recover damages for the child's medical expenses. Further, they stated that without the wrongful life awards, adequate medical care for the child would be dependent on the parents' availability to sue and such care provided through the parents' award might not continue after the child reached majority. The court held that the child could receive an award for special damages in an amount equal to the economic cost of her care and treatment. A dissenting opinion by Justice Mosk (in support of general damages) noted that the majority's opinion was internally inconsistent in denying general damages yet awarding special damages for the very same tort.

Most recently, the New Jersey Supreme Court recognized wrongful life in Procanik v. Cillo in 1984. The infant plaintiff in this case suffered from congenital rubella syndrome. The mother had contracted rubella in the first trimester and, because of an inaccurate interpretation of the rubella titer, she was reassured by her physician and the pregnancy continued to term. The parents in this case were barred from a wrongful birth suit because of a two-year statute of limitations, so only a wrongful life suit was brought.

The court was not impressed with the logical or philosophical problems that had deterred other courts in the recognition of this action. The opinion stated that while logic was essential in the law, it should not become an instrument of injustice, and that barring recovery for the child while permitting it for the parents would be clearly unjust. The court reasoned that the child should not be denied adequate medical care just because the parents were precluded from suing by the statute of limitations. Finally, the court denied that the verdict was dependent on a finding that life had no value, but rather was a response to “the call of the living for help in bearing the burden of their affliction.” Like the Turpin case in California and the Harberson court in Washington (the other high state court that has recognized wrongful life), the majority denied general damages but awarded special damages to the infant.

This trend toward the recognition of the wrongful life action was reversed by the decisions of two state supreme courts in 1986. Both the Pennsylvania and the Illinois supreme courts ruled that infants with congenital disease could not recover since (1) the court could not determine if the child would have been better off if he had not been born, (2) the physicians did not cause the disease, and (3) there was no way to calculate damages.

**COMMENT**

These case histories demonstrate a mixed and, at best, incomplete acceptance of the wrongful life action. The courts and legal commentators have articulated a number of problems with the wrongful life concept; however, there has been little apparent dissent within the medical community. I will suggest that the fundamental problems in the wrongful life concept relate to the physician's alleged duty to the fetus and the concept of life as a harm.

**The Physician's Duty**

The preceding case histories demonstrate the varied conceptions of the fetus' rights and the corresponding legal duties for those providing prenatal counseling. Several of the opinions have simply assumed a duty of the counselor to the fetus based on established precedent that prenatal injury is an actionable offense. Others have referred to the “right to begin life with a sound mind and body” or a “right of a child to be born as a whole, functional human being.” The Turpin court and others\(^2,5,6\) have suggested that it is the counselor's duty to properly inform the parents based on the child's right to have the parents make decisions in his or her best interests. These diverse characterizations reveal the importance of more clearly conceptualizing our duties to the parents and to the fetus in order to most appropriately use our prenatal diagnostic capabilities.

The concept of duty based on the child's right to have informed parents is effectively argued by Capron\(^7\) and is the correct foundation for any duty of the physician to the fetus in these cases. It is indeed the provision of information that is the central theme in the wrongful life cases. We need to more fully define both the extent and the limits of this duty and the implications for the fetus, the parents, and the physician.

When we speak of rights, it is often important to distinguish between positive and negative rights. Positive rights are those that require others to assist in their fulfillment, while negative rights demand only that others not interfere with our exercise of those rights. In this respect, abortion is clearly a negative right based on the principle of autonomy. It is only required that we do not interfere with a woman's right to obtain an abortion—we are not generally compelled by law or morality to assist in the process. The successful wrongful life and wrongful birth cases, however, establish prenatal counseling as a positive right for the fetus and the parents, respectively, but the appropriate limits of these rights remain unclear.

The intent of the physician-patient relationship in this context, as in any other clinical context, is the promotion of the patient's well-being. The provision of appropriate information to the patient (or guardian) is an integral part of the relationship and allows patients to make informed decisions about their health care goals. But there is a clear limitation to this information process that is relevant here. In the words of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research,\(^8\) the well-being principle circumscribes the range of alternatives offered to patients: informed consent does not mean that patients can insist upon anything they might want. Rather it is a choice among medically accepted and available options, all of which are believed to have some possibility of promoting the patient's welfare.

Thus, the positive right to information is generally limited by the physician's obligation to promote the welfare of the patient and is not an unlimited obligation to provide whatever information the patient might wish for his or her own purposes. Of course, it is society at large that defines the limits of patient choice and not the opinion of the individual practitioner.

The duty to promote the patient's welfare is the duty of beneficence. My contention here is that the duty to provide prenatal counseling is based on this ethical principle of beneficence. It is the obligation of counselors to provide that information to the couple that society has determined is of potential benefit to the parents and the child. This conception is consistent with the verdicts in the successful wrongful birth cases to date.

In contrast, it might also be argued that this duty to the parents is grounded on the principle of autonomy rather than
beneficence. This would suggest that parents have the right to any and all information that they may deem appropriate for control over their reproductive lives. I would suggest that such a grounding is undesirable and inconsistent with present practice. Prenatal counseling is currently only offered to those in high-risk groups. Obviously, how one defines “high risk” is subjective—all pregnancies are at estimable risk for adverse outcomes. If we were taking autonomy seriously, we should be offering the full range of testing and services to all pregnant couples. Why can’t a 25-year-old couple with an infant with Down’s syndrome sue (successfully) for wrongful birth if they were not told of their risk? The answer appears to be that society has not seen a benefit in exposing a normal fetus to a greater risk (through amniocentesis) than the parents face in experiencing an adverse outcome. Without a proportional benefit, a duty to “low-risk” couples has not existed. Whether the parents would balance these same risks in the same fashion is not ascertained. This suggests that the current policy is based on a perception of beneficence (for both the parents and the fetus) and not strictly on the parents’ autonomy. We must also consider the implications of this conception given continued improvement in prenatal diagnostic capabilities. If or when we develop the ability to fully characterize the genetic endowment of the fetus, parents may be able to selectively abort fetuses for criteria with no medical significance. Obligating the provision of this service would be an assault on the integrity of the medical profession.

While the grounding of the physician’s duty to the parents may be controversial, a parallel debate over the grounding of the duty to the fetus does not arise. The fetus is not autonomous, nor do the parents have complete autonomy to speak for the fetus. Our positive duties to the fetus are not dictated by the parents alone but are defined by what can reasonably be expected to promote the welfare of the fetus. It is the role of public policy to define what information from the physician to the parents might reasonably be of benefit to the fetus. The question then becomes whether it is reasonable to construe nonexistence as a benefit.

Life as a Harm

The crucial question here is not whether, in certain circumstances, life is more burdensome than nonlife. The common occurrence of suicide and the increasing use of “living will” documents attest that many individuals would choose to die rather than to live with certain burdens. The courts will respect such decisions under certain circumstances when made by individuals in reference to their own lives.

Children, and those who are incompetent and have not previously expressed their wishes, require a different approach to decision making. The crucial ethical question is whether it is acceptable under any circumstances to conclude that the life of another is too burdensome for continued existence. Such a determination has clear potential for abuse through the gradual development of policies for the termination of a variety of patients where the relevant burdens come to be defined more in terms of social utility rather than individual benefit. The Nazi program for the “destruction of lives not worth living” should remain a potent memory. Nevertheless, the fact that we commonly perceive situations for ourselves where life would appear to be too burdensome suggests that, in principle, such a state is conceivable for those who cannot make such determinations for themselves.

Traditionally, the parents have had the responsibility to decide what is best for their children. However, the parents’ right to make such decisions is not absolute: parents have only the right to choose between reasonable medical and legal alternatives. Thus, the parents might claim and sincerely believe that life has no value for their child, but others are not legally or morally bound to agree with this assessment. For this reason, the “best interest” standard has been proposed as a reasonable approach to decision making in these circumstances. In essence, this approach entails the assessment of life and future prospects from the perspective of the patient.

This best interest standard is not without its limitations, not the least of which is the conceptual difficulty of seeing life through the eyes of the ill or seriously handicapped. Nevertheless, such an approach limits the “tyranny of the normal”—the intuitive (but incorrect) feeling that the value of life is embodied in the capabilities that we ourselves enjoy. The task of a jury in a wrongful life case would be to use such a yardstick in the valuation of children’s lives.

What would be the results of this valuation process? If rigorously applied, one clear result would be the finding that the majority of those plaintiffs involved in wrongful life cases to date—those with deafness, Down’s syndrome, congenital rubella syndrome, and fetal hydantoin syndrome—have lives of significant value despite their handicaps. Suits for wrongful life could not be successful for such children because it is simply not credible that children in each of these diagnostic classes perceive life as a harm. This does not preclude a decision at the bedside that a particular child who is severely affected by congenital rubella syndrome has a life that constitutes a harm, only the decision that all those who share the same diagnosis will have lives devoid of value.

At the other extreme are those unfortunate children with devastating malformations such as anencephaly, trisomy 18, or trisomy 13. Here the impairments are so profound that the children lack even the rudiments of self-awareness. As such, these children have no interests in life and thus it cannot be claimed that they are in any sense harmed by their lives.

The difficult cases will be those that fall in between these extremes. Can we, or a jury, say with any assurance that all children with Tay-Sachs disease experience lives devoid of value? May not the love of family compensate for the progressive decline in mental function? Is not a glimpse of life better than no life at all? I would not presume to answer these questions—the truth is that we will never know. The best interest standard, or any other standard, will not provide us with clear answers in these tragic circumstances.

Without a rational standard on which to rely, I would contend that the valuation of life for a class of individuals is not an appropriate task for a jury. As was recognized by the Tarpin court, these determinations are simply too speculative to provide a basis for public policy. Added weight is given to this conclusion by the risks inherent in establishing policies that would define lives without value. The determination of the best interest of a handicapped child will continue to be appropriate at the bedside, where treatment issues for the individual are in question—not damages for existence. Prenatal counselors should be permitted to presume that life is of potential benefit to children and their efforts should be directed to the promotion of the legitimate interests of the parents.

Despite essential agreement with these latter comments, several courts have been compelled to find for special damages out of compassion for the impaired child. These are unassailable sentiments, but they do not necessarily make for good law. As Justice Schreiber argued in his dissent to the Procanik majority, “Sympathy for a handicapped child and his parents should not lead us to ignore the notions of responsibility, causation, and damages that underlie the entire philosophy of our system of justice.”

These conclusions do not suggest that the physician’s negligence should go unpunished nor that those harmed by the negligence should not be compensated. The negligence in
these cases was real, but the harm was borne only by the parents. The wrongful birth action is addressed to this tort and should be seen as appropriate and just within the limits discussed. The existence of this tort provides strong incentive to physicians to prevent inaccurate and untimely advice in prenatal counseling and thus fulfills the public policy goal of restraining malpractice.

Two other reasons have been advanced to suggest that infants should be able to recover in addition to parents. The first relates to the statute of limitations. In the Procunier case, the parents filed after the two-year limitation had expired, and so, the court contended, the infant would have been denied necessary resources in the absence of the wrongful life action. Clearly, impaired children require care and resources beyond what the average family can provide, but this is an obligation of society at large and not the obligation of physicians and their insurance companies in the absence of a legitimate breach of duty. We should realize that the pressure on the courts to recognize this malpractice action out of compassion for the child would be alleviated if our health care system ensured handicapped children the care and services they require. Our society should not rely on malpractice litigation to fund the special needs of handicapped children.

A second claim is that the awards to the parents alone may not benefit the child if the parents relinquish custody of the child or if the child reaches majority. This problem might best be handled on procedural grounds by establishing a trust fund to be used by the parents for child care expenses. Adoption would eliminate the trust, but the trust would be maintained beyond majority if the parents had continued responsibility for the child.

The wrongful life concept is still young in the legal system. Its acceptance in three state supreme courts and our expanding prenatal diagnostic capabilities guarantee that more state courts will confront its conceptual challenges. Two state legislatures (Minnesota and South Dakota) have enacted bars to wrongful life suits and a third, California, has barred suits of parents by impaired infants. The rejection of the wrongful life action will not reduce the responsibility of physicians to provide accurate and timely prenatal counseling, but it will reaffirm the respect our judicial system has traditionally shown for the intrinsic value of life. Children with disabilities will not be better served by the further development of the concept of a life without value.

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