

Wrongful Life and Wrongful Birth: New Concepts for the Pediatrician

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ABSTRACT. Over the past two decades, numerous suits for damages have been brought against physicians for the injury of wrongful life, or wrongful birth. Within the past 5 years, several precedents have been set that broaden the physician's legal obligation to recognize and act upon foreseeable or potentially recurrent genetic, teratogenic, or chromosomal disorders. These precedents may be expected to affect all physicians, but particularly pediatricians, because of the increased frequency of such disorders in the pediatric population. *Pediatrics* 1985;75:65-72 *wrongful life, wrongful birth, genetics, malpractice, ethics.*

Over the past two decades there has been substantial debate in the medicolegal community surrounding the concepts of "wrongful life" and "wrongful birth." "Wrongful life" may be operationally defined as a suit for damages brought on behalf of a child who alleges injury from having been "wrongfully" brought into existence. "Wrongful birth" refers to a suit for damages brought by the parents of children who have been so "wrongfully" born. Such suits have been brought against physicians in the case of healthy but unplanned children born after failed vasectomy, tubal ligation, or abortion procedures, or after failure to diagnose pregnancy in time for an abortion, and in the case of planned but congenitally defective children, for whom the complaint has been that the physician failed to offer the parents a timely forewarning of the possible abnormal outcome. Within the past 5 years, several precedents have been set that broaden the physician's legal obligations to recognize and act upon foreseeable or potentially recur-

rent genetic, teratogenic, or chromosomal disorders. These precedents may be expected to particularly affect pediatricians, due to the greater frequency of such disorders in the pediatric population: as many as 5% of all newborn infants are afflicted with a congenital or hereditary disorder,¹ and as many as one quarter to one third of all pediatric hospital admissions and deaths beyond the perinatal period are due to the effects of such disorders.^{1,2}

As with other forms of medical malpractice, wrongful life and wrongful birth are classified as torts. A tort is defined³ as "a private or civil wrong or injury, other than breach of contract, for which the court will provide a remedy in the form of an action for damages." In order to recover damages in a tort proceeding, the plaintiff must establish four points: first, that the defendant owed a duty to the plaintiff to act in a given manner; second, that the defendant breached that duty; third, that the plaintiff suffered an appreciable injury (not necessarily physical); and fourth, that the plaintiff's injury arose as a result of the defendant's breach of duty. Most of the controversy has surrounded the first and third of these points, namely, defining the extent of the physician's duty, and determining whether legally compensable injury has occurred.

In deciding wrongful life and wrongful birth cases, the courts have attempted to address several issues: Can being conceived actually constitute an injury? Do the positive aspects of even a wrongfully created life outweigh the child's suffering? Do the potentially gratifying experiences of parenthood (even unplanned parenthood or parenthood of a congenitally defective child) outweigh all burden imposed upon the parents by the obligation of caring for a child wrongfully born? Finally, what is the extent of the physician's duty, particularly in the case of children who have been born with potentially foreseeable handicapping conditions? Although these issues have been the subject of much attention among legal commentators,⁴⁻¹¹ they have

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received only limited discussion in the general medical literature.¹²⁻¹⁸ I shall briefly sketch this new body of law and attempt to demonstrate its importance to the practicing pediatrician.

NONMEDICAL ACTIONS FOR WRONGFUL LIFE

The first wrongful life suits under contemporary American law were brought on behalf of children alleging that they had been injured by virtue of their status as illegitimate. Although not directly applicable to the practice of medicine, historically these suits arose first and provided the frame of reference for subsequent cases involving medicolegal questions. The first such suit was the 1964 Illinois case, *Zepeda v Zepeda*,¹⁹ in which an action for wrongful life was brought on behalf of an illegitimate child against his putative father. The child sought damages in compensation "for the deprivation of his right to be a legitimate child." Legal efforts to force the father to marry the mother were precluded by the fact that the father was already married to another woman. The child's complaint, therefore, protested "not only the act which had caused him to be born *but birth itself*" (italics added). Although the court conceded that the father's conduct had indeed inflicted damage upon the child, it also ruled that there was no remedy available under the law for "damages for being born a certain color . . . for being born with a hereditary disease . . . for being born into a too large and destitute family . . . (or) because a parent has an unsavory reputation."

Whereas illegitimacy has since been consistently rejected by the courts as a legally compensable injury,²⁰⁻²² the courts have eventually retreated from the sweeping rejection of all bases for action for wrongful life as enunciated in *Zepeda*. Nonetheless, *Zepeda* was to color judicial arguments over the following decade not only because of its overly broad rejection of all bases of action for wrongful life, but for the unfortunate line of reasoning equating wrongful life with a claimed right "not to be born."

FAILED STERILIZATION/FAILED ABORTION

The largest number of actions for wrongful life or wrongful birth, and the first to involve physicians, have been brought against physicians in instances in which pregnancy has ensued despite vasectomy or tubal ligation, or in which therapeutic abortion has been unsuccessful in terminating pregnancy. With rare exception,^{23,24} the children have been healthy; the only injury claimed was their unwanted status. Although chiefly involving obste-

tricians, these cases are instructive for the light they shed on the legal debate surrounding the consideration of conception per se as a legally compensable injury. Wrongful life suits on behalf of the child have presented a legal quandary that the courts have been reluctant to address, ie, if the wrong had not been committed, the child would not be here to complain in the first place.⁷ Ruling that a healthy life, even if wrongfully caused, is inherently of positive value as compared with the child's alternative state of nonexistence, suits of this type have been uniformly dismissed by the courts.²⁵⁻²⁷ Actions for wrongful birth (ie, brought by the parents) have been subject to much more variable treatment, ranging all the way from complete dismissal,^{25,28,29} to granting the parents the opportunity to sue for all costs for rearing the unplanned child to the age of majority.^{26,30} This inconsistency is largely traceable to varying application of a common law doctrine known as the "benefits rule." The benefits rule holds that in cases in which the defendant's actions have resulted in both beneficial and detrimental consequences to the plaintiff, the value of any benefits conferred upon the plaintiff as a result of the defendant's action may be partly or wholly deducted from any award to the plaintiff for damages. In denying any recovery to parents for wrongful birth, some courts have held that the intangible benefits of parenthood outweigh "any mere monetary burdens,"²⁸ because "the satisfaction, joy, and companionship which normal parents have in rearing a child makes such economic loss worthwhile"³¹

This position has not been without its critics; one dissenting justice has wryly observed that strict application of the benefits rule could lead to "the ridiculous result that benefits could be greater than damages, in which event . . . the parents would owe something (to the physician)."³² The rationale for granting the parents an action for wrongful birth, while at the same time denying the child an action for wrongful life, was most eloquently summarized in the 1981 Illinois case of *Cockrum v Baumgartner*³³:

Even assuming life is an "esteemed right" and one's life is precious *to oneself*, it does not follow that one's existence automatically confers a benefit and no burden on those having a duty to assure one's life is preserved throughout childhood (italics added).

Having thus separated the basis for the parents' action from that of the child, the court had no difficulty in finding:

The allowance of rearing costs is not an aspersion upon the value of the child's life. It is instead a recognition of the importance of the parents' fundamental right to control their reproductivity.

These were to become key points in the debate over awarding damages to handicapped children or their parents.

DEFECTIVE CHILDREN

The third class of wrongful life/wrongful birth cases, and those that directly affect the pediatrician, center upon children born with genetic, chromosomal, or teratogenic handicapping conditions or chronic medical disorders. Wrongful life or wrongful birth actions in such cases are not based upon the occurrence of an unwanted pregnancy, nor do they allege that the physician has caused the disorder. Rather, it is alleged that the physician's failure to detect the possibility of abnormality and give the parents a timely forewarning has denied the parents the opportunity to make an informed decision whether to have a child.

As in the case of healthy but unplanned children, the courts initially dismissed such claims altogether. The first basis for rejecting these claims rested upon the court's difficulty in construing conception as an injury, or in measuring damages, either to the child or the parents. One of the first and most widely quoted of such cases was the 1967 New Jersey case of *Glietman v Cosgrove*.³⁴ *Glietman* stemmed from the birth of a deaf and blind child who had congenital rubella syndrome, and whose mother had continued her pregnancy despite exposure to rubella on the alleged reassurance of her physician that there was no risk to the fetus. In attempting to apply the benefits rule, the court stated:

The infant plaintiff would have us measure the difference between his life with defects against the utter void of nonexistence, but it is impossible to make such a determination. The court cannot weigh the value of life with impairments against the nonexistence of life itself. By asserting that he should have not been born, the infant plaintiff makes it logically impossible for a Court to measure such damages because of the impossibility of making the comparison required

Having framed the issue thus, the court went on to conclude that neither the child nor its parents were entitled to any recovery.

Similarly, in the 1978 New York case of *Becker v Schwartz*³⁵ (in which the physician allegedly failed to advise a 37-year-old woman of the availability of amniocentesis, following which she bore a child with Down syndrome), the court denied the child's claim for wrongful life, finding:

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 . . . a cause of action brought on behalf of an infant seeking recovery for wrongful life demands a care-

ful calculation of damages dependent upon a comparison between . . . life in an impaired state and nonexistence. This comparison the law is not equipped to make.

The parents' own suit for emotional damages was also disallowed; the court ruled that the parents "may yet experience a love that even an abnormality cannot fully dampen."

The courts have also attempted to apply the benefits rule to the question as to whether the positive attributes of life (even an impaired life) are sufficient to offset completely any suffering entailed by the child because of his disability. In the 1979 New Jersey case *Berman v Allan*³⁶ (another child with Down syndrome, with facts similar to *Becker*), the court denied the child's action for damages, finding that the child "by virtue of her birth, will be able to love and be loved—emotions which are truly the essence of life and which are *far more valuable than the suffering she may endure*" (italics added). The parents' suit seeking recovery for extraordinary medical expenses was also denied, on the basis that it would represent a "windfall to the parents," that would place "too unreasonable a financial burden upon physicians."

The second basis for rejecting claims following the birth of impaired children has rested upon the court's concept of the scope of the physician's duty. The 1977 New York case of *Howard v Lecher*³⁷ stemmed from the birth of a child with Tay-Sachs disease following failure of the physician to offer prenatal metabolic screening to parents of Eastern European Jewish background. The court refrained from placing obstetricians in the role of genetic counselors; the implication was that the physician's duty did not extend to forewarning the parents of possible genetic disease. Because no duty to the parents existed, the physicians could certainly not be held liable for any breach of duty. Similarly, the 1977 New York ruling in *Karlsons v Guerinot*³⁸ rejected the argument that the physician had a duty under the doctrine of informed consent to forewarn an elderly gravida of her risk of bearing a child with Down syndrome, although the parents were allowed to recover for pain, suffering, and mental anguish.

The past 5 or 6 years have seen a substantial reversal of this pattern, such that most courts presently grant the parents some right to sue for special damages (eg, emotional pain and suffering, or out-of-pocket expenses for extraordinary medical, educational, or custodial costs.) The parents' right to seek recovery for general damages (ie, total rearing costs) has varied widely, depending upon whether damages have been offset by an amount determined to represent "the benefits of parenthood" bestowed upon them by the child, or by whatever expenses

the parents would have entailed in raising a normal child.

There have been three instances to date in which the courts have granted the child's action for wrongful life, independent of the parents' suit for wrongful birth. In permitting these suits to go forward, the courts have reworked the basic concept of wrongful life as originally defined in *Zepeda*. The first of these new precedents came from a 1980 California appellate court decision in the case of *Curlender v Bioscience Laboratories*,³⁹ which arose from a child who had Tay-Sachs disease. The child's parents had been reassured that their children would be normal based upon a false-negative carrier screening test from the reference laboratory. In breaking with *Zepeda*, the court stated:

We reject the notion that a "wrongful life" cause of action involves any attempted evaluation of a claimed right *not* to be born 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 the defendants not been negligent, the plaintiff might not have come into existence at all. The certainty of genetic impairment is no longer a mystery

This philosophy was upheld by the California State Supreme Court in the 1982 case *Turpin v Sortini*,⁴⁰ in which a wrongful life action was brought on behalf of a congenitally deaf child. The child's complaint alleged that her wrongful life was due to negligence of the defendant audiologist, who had failed to make the diagnosis of genetic deafness in the plaintiff's older sibling. As a consequence, the plaintiff herself was conceived and born deaf. In granting the child's action for special damages, the court held:

It is hard to see how an award of damages to a severely handicapped or suffering child would disavow the value of life . . . it would be illogical and anomalous to permit only the parents, and not the child, to recover for the cost of the child's own medical care. If such a distinction were established, the afflicted child's receipt of necessary medical expense might well depend on the wholly fortuitous circumstance of whether the parents are available to sue and recover such damages or whether the medical expenses are incurred at a time when the parents remain legally responsible for providing such care . . .

This philosophy was reaffirmed in the 1983 Washington State case *Harbeson v Parke-Davis Inc.*⁴¹ In *Harbeson*, the mother sued government physicians and a drug manufacturer for having failed to warn her of the teratogenic potential of phenytoin sodium (Dilantin), following which she gave birth to two successive children with fetal hydantoin syndrome. In granting the affected children the right to sue for damages, the court noted simply "the child's need for medical care and other

special costs attributable to his defect will not miraculously disappear when the child attains his majority."

Of more immediate importance to the pediatrician than the legal distinction between wrongful birth and wrongful life, is the shifting emphasis of the antecedent medical facts leading to such suits in the first place. Whereas most suits in the 1960s and 1970s derived from the physician's failure to offer prenatal counseling based on parental risk factors (eg, advanced maternal age, Jewish ethnicity, exposure to rubella), the focus has since broadened to include failure of the physician to recognize clinical expression of disease in the living patient (Table 1). The first such example occurred in the 1977 New York case of *Park v Chessin*.³⁵ Mrs Park gave birth to an infant who died at 5 hours of age with polycystic kidneys. Before conceiving another child, the Parks consulted their obstetrician, who allegedly advised them that their recurrence risk for this disorder with both autosomal dominant and autosomal recessive forms was "practically nil." The Parks went on to have a second child with the infantile form of polycystic kidney disease, and they were granted a basis for a wrongful birth action against their obstetrician. In the 1981 New Jersey State Supreme Court case of *Schroeder v Perkel*,⁴² suit was brought against two pediatricians for failure to make the diagnosis of cystic fibrosis in a couple's first child until the child was approximately 6 years of age, by which time the mother was 8 months pregnant with their second child, who also turned out to have cystic fibrosis. Echoing the defense in *Howard*, the physicians contended

TABLE 1. Disorders for Which Actions for Wrongful Birth or Wrongful Life Have Been Brought*

Genetic	
Tay-Sachs disease (AR)	^{37,39,49,50}
Cystic fibrosis (AR)	⁴²
Polycystic kidney disease (AR, AD)	³⁵
Neurofibromatosis (AD)	²⁴
Deafness (AD, AR, X)	^{†40}
Larsen syndrome (AD)	⁴³
Muscular dystrophy (X)	^{‡47}
Congenital microcephaly (AR)	^{‡60}
Multiple polyposis of colon (AD)	^{‡61}
Chromosomal	
Down syndrome	^{35,36,38,51,52}
Cri-du-chat syndrome	^{§48}
Teratogenic	
Congenital rubella syndrome	^{34,53-57}
Fetal hydantoin syndrome	⁴¹

* Abbreviations used are: AR, autosomal recessive; AD, autosomal dominant; X, X-linked.

† In the present instance, AR (Joseph Stretch, personal communication).

‡ Action dismissed (statute of limitations expired).

§ Action dismissed (amniocentesis not routine in 1969).

that they had no duty to Mr. and Mrs. Schroeder to advise them that their infant child was suffering from cystic fibrosis. The implication is that, if defendants had no duty to Mr. and Mrs. Schroeder, then defendants cannot be depriving them of the decision of not having another child.

The Court disagreed, finding this argument

too myopic a view of the responsibilities of a physician treating a child with a genetically transferable disease A physician's duty . . . may extend beyond the interest of a patient to members of the immediate family of the patient who may be adversely affected by a breach of that duty.

The same rationale was followed by the court in the 1981 Florida case of *Moore v Lucas*,⁴³ in which a woman's physician was alleged to have erroneously reassured her that her own affliction with Larsen syndrome (autosomal dominant, multiple skeletal abnormalities) could not be transmitted to any children she might bear. The 1982 California case of *Turpin v Sortini* (hereditary deafness) has already been mentioned.

DISCUSSION

In deciding actions for wrongful life or wrongful birth, the courts have been confronted by social and philosophical, as well as technical questions. From a societal viewpoint, these cases have been played out against a backdrop of judicially sanctioned increasing parental autonomy in all aspects of procreative behavior. Early decisions such as *Glietman v Cosgrove* denied the parents' action for wrongful birth at least in part because the only remedy available to avert the birth of their child with congenital rubella syndrome—abortion—was illegal at the time (1967). Conversely, the 1965 US Supreme Court decision, *Griswold v Connecticut*⁴⁴ (striking down as unconstitutional a Connecticut law banning use of contraceptives), the 1972 Supreme Court decision *Eisenstadt v Baird*⁴⁵ (striking down a Massachusetts law limiting the sale or distribution of contraceptives), and the 1973 ruling in *Roe v Wade*⁴⁶ (upholding unrestricted access to first trimester abortion) have all been reflected in more recent decisions such as *Cockrum v Baumgartner*, which granted the parents' action for wrongful birth as a corollary of their "fundamental right to control their reproductivity."

The philosophic question as to whether life (planned or unplanned, healthy or impaired) is more or less desirable for the child than the alternative state of nonexistence remains unanswered (indeed, unanswerable). In granting parents an action in tort for wrongful birth, the courts are beginning to separate this existential question from the more concrete issue of parental autonomy over their

own procreativity. Parents are entitled to recovery for wrongful birth because information that might have materially affected their childbearing behavior was not disclosed to them, whether this information pertained to the risk of unwanted conception following surgical sterilization or to the risk of congenital abnormality in a wanted child. Granting handicapped children a basis for action in wrongful life independent of the parents' suit for wrongful birth, while not yet a widespread judicial practice, is nothing more than pragmatic recognition of the fact that the child's special requirements will not "miraculously disappear" at the age of majority. (Indeed, the best way to avoid a "windfall" to the parents might be to place greater judicial emphasis upon the award to the child. One commentator has suggested placing all awards in a trust fund set up in the child's behalf.¹⁰)

One possibility left open by granting the child a right to sue for wrongful life is that a congenitally defective child might sue his own parents. Unlike *Zepeda*, in which the child claimed injury because of its illegitimate status, it is not inconceivable that a congenitally defective child might bring suit against its parents, particularly if the parents had been adequately counseled beforehand and had decided to go through with the pregnancy nonetheless. In California (one of only two states that have thus far upheld actions for wrongful life), legislation specifically designed to protect parents from this type of suit has been enacted.⁶²

The physician's duty to recognize potentially recurrent disorders is now established, although the exact boundaries encompassed by this principle remain indistinct. Physicians will no longer be judged by the "locality rule" (ie, a standard of care based on the performance of colleagues just within their home community), but rather will be held to norms based on the performance of similarly trained colleagues nationwide. Even more significant is a trend toward holding physicians not just to a standard based upon their colleagues' performance, but rather to expect physicians to impart to parents all information that might materially affect the parents' procreative decisions.⁶ This would parallel the expectations of disclosure in any other type of informed consent process, in which the burden is on the physician, rather than the patient, to anticipate whatever might constitute pertinent information:

The elements of an action based on the informed consent doctrine [are] . . . the existence of a material risk unknown to the patient, the failure to disclose it, [and] that the patient would have chosen a different course if the risk had been disclosed⁴¹

The duty to disclose potentially foreseeable risks

is no longer in doubt; the question remains, however, foreseeable by whom? That the implementation of this principle may be rather difficult is suggested by the following examples, drawn from my own consulting practice in developmental disabilities:

1. J.B. was an 8-year-old boy referred for evaluation of school failure. His cleft palate had been repaired during infancy. Examination revealed bilateral lower lip pits, impaired fine motor praxis, and subtle cognitive defects. The patient's father had also undergone cleft palate repair as a child.

2. A.D. was a 2½-year-old boy, referred to rule out mental retardation. A physical examination revealed deafness, ocular hypertelorism, and medial flaring of the eyebrows. The child's mother and 4-year-old sister were noted to have similar facies. The mother also had premature graying of the hair and vitiligo, and the 4-year-old daughter had heterochromia irides. Both had normal hearing, although family history revealed three maternal aunts with congenital deafness.

3. A.R. was referred at age 20 months for evaluation of developmental delay. Examination revealed an open fontanel, depressed nasal bridge, slight coarsening of the facies, hypoplastic toenails, and significantly delayed cognitive development. This child was similar in appearance to her two older sisters, one of whom also had delayed closure of the anterior fontanel. Upon questioning the mother, it came to light that she herself was epileptic, and was taking 500 mg of phenytoin daily.

In the first example cited, would it have been reasonable to hold the child's general pediatrician to the duty of recognizing Van der Woude's syndrome (autosomal dominant cleft palate with lip pits)? The same question could be asked of the plastic surgeon who repaired the cleft palate.

In the second example, the mother and both of her children have Waardenburg's syndrome. This autosomal dominant form of deafness is associated with dystopia canthorum (widely spaced inner canthi) and pigmentary changes of the eyes, skin, and hair. Due to variable expressivity, however, fewer than 25% of affected individuals are deaf. What duty did the pediatrician have to recognize this genetic disorder in the first, asymptomatic child, or, for that matter, in the mother? Family history was instructive in both the first and second examples, and might have led to a genetic evaluation before the birth of the index cases. What was the pediatrician's duty to obtain such a history?

In the third example, all three children probably have varying degrees of expression of the fetal hydantoin syndrome, although only the third child is intellectually impaired. What was the pediatri-

cian's duty to elicit a history of drug intake from the mother, and at what point in time? It is on the basis of answers to questions such as these, rather than a debate on the conceptual merits of wrongful birth or wrongful life per se, that juries will be awarding damages to handicapped children or their parents.

For the individual pediatrician, the implication of the foregoing analysis is that children with "incurable" defects (eg, mental retardation, profound deafness, major structural anomalies, etc) should be the object not just of palliative therapy for the defect, but of an intense investigation to determine the underlying etiology. If the primary physician is uncomfortable with this task, then appropriate consultations should be obtained. Similarly, pediatricians should be alert to the patient with partial expression of an autosomal dominant disorder, as well as the risk of teratogenic exposure during pregnancy. It would be unreasonable to hold the general pediatrician responsible for recognizing all known genetic or teratogenic disorders, which now number in the thousands.^{57,58} Identification of specific syndromes often hinges on highly idiosyncratic information (eg, the association between lip pits and cleft palate), which could not be extrapolated from a more general knowledge base. Nonetheless, there are certain generic settings in which the physician should suspect a genetic or teratogenic disease, for which a formal evaluation should be initiated (Table 2). Some of the historic indications for such a work-up (eg, recurrent fetal wastage, chronic maternal illness) are usually thought of as

TABLE 2. Examples of Circumstances Under Which Evaluation for Genetic, Chromosomal, or Teratogenic Disorders Should Be Considered

History
Recurrent fetal wastage
Unexplained previous neonatal deaths
Advanced maternal age
Acute or chronic maternal illness during pregnancy
Maternal drug or alcohol use during pregnancy
Racial or ethnic high-risk groups
Consanguinity
Family history of congenital anomalies, deafness, mental retardation, or known genetic disorders
Physical examination
Intrauterine growth retardation
Microcephaly
Neonatal illness suggestive of an inborn error of metabolism
Major congenital anomalies
Multiple minor congenital anomalies
Deafness
Blindness
Mental retardation
Unexplained neuromuscular impairment
Unexplained chronic medical disorder

obstetric, rather than pediatric issues. The pediatrician, however, is more likely to be in the position to recognize defects in affected offspring, and to warn the parents of possible future recurrences.

It has been suggested by some commentators that the term wrongful life be abandoned, in favor of the less metaphysical appellation "genetic malpractice"⁸ (although strictly speaking this is a misnomer, because teratogenic and chromosomal aberrations would be included under the rubric "genetic"). The basic injury to the child and his or her parents would be conceived as stemming from the failure of the physician to provide the parents with information with which to make adequately informed procreative decisions. The tort of "genetic malpractice" would then fit within the doctrine of informed consent, and would avoid the judicial necessity of weighing the value of a child's life against nonlife. This circumvents the ethical questions of "quality of life" or "sanctity of life," which have arisen in cases in which withholding or termination of life support have been at issue, because an award for damages for genetic malpractice does not cast "an aspersion upon the value of the child's life."³³ In cases of genetic, teratogenic, or chromosomal disorders, the nuclear family, not the individual, becomes the unit of treatment, and the pediatrician's responsibility to this collective "patient" must be effectively discharged.

SUMMARY

Illegitimate or healthy but unplanned children currently have no basis under the law to seek recovery for damages arising from their illegitimate or unwanted status. Parents of unplanned but healthy children have been granted a basis to seek recovery for damages in the event of conception following sterilization, or failure of an abortion procedure to interrupt pregnancy. Such actions for damages are usually termed "wrongful birth." The extent of the parents' recovery varies from jurisdiction to jurisdiction, depending upon whether the courts have seen fit to offset damages by an amount representative of the "benefit" bestowed upon the parents by the child's birth.

Parents of children suffering from foreseeable genetic, chromosomal, or teratogenic disorders are now generally granted a basis to seek recovery for damages in the event that the physician or other health care professional failed to counsel them in a timely fashion regarding the procreative risks involved. In some instances the afflicted child has been granted a legal basis for action as well. These latter cases are currently termed "wrongful life," but might be more properly consolidated with the

claims of the parents under the rubric of "genetic malpractice." Physicians have a clearly defined obligation, not just to advise screening procedures on the basis of parental risk history, but also to recognize foreseeable or potentially recurrent clinical syndromes in children or their parents. These obligations will affect all physicians, but will probably be felt most strongly by pediatricians, because they are the physicians most likely to encounter patients with these types of disorders.

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ANNOUNCEMENT OF 1985 PEDIATRIC CARDIOLOGY EXAMINATION

The Sub-Board of Pediatric Cardiology of the American Board of Pediatrics will administer its next certifying examination on Friday, July 12, 1985.

The following criteria must be met to qualify to sit for the examination:

1. Certification by the American Board of Pediatrics;
2. Two years of full-time graduate training in an accredited pediatric cardiology program;
3. Verification of training and recommendation by Pediatric Cardiology Program Director.

Each application will be considered individually and must be acceptable to the Sub-Board of Pediatric Cardiology.

Candidates who achieve a qualifying score on the written examination will be eligible for the oral examination. The oral examination will be held in October, 1985 in San Antonio, TX. A candidate must be successful on both the written and oral portions of the examination in order to be certified.

Registration for this examination will extend from DECEMBER 1, 1984 until FEBRUARY 28, 1985. Requests for applications received prior to the opening of registration will be held on file until that date, at which time application materials will be sent to those who have requested them.

The application fee for the written examination is \$750 (\$175 processing and evaluating + \$60 registration + \$515 examination). Candidates who are not approved to take the examination will be refunded the \$515 examination fee. The processing and evaluation fee and the registration fee will be retained. An *additional* fee of \$450 will be payable upon receipt of an appointment for the oral examination.

Please direct inquiries to:

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Wrongful Life and Wrongful Birth: New Concepts for the Pediatrician

James Coplan

Pediatrics 1985;75:65

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