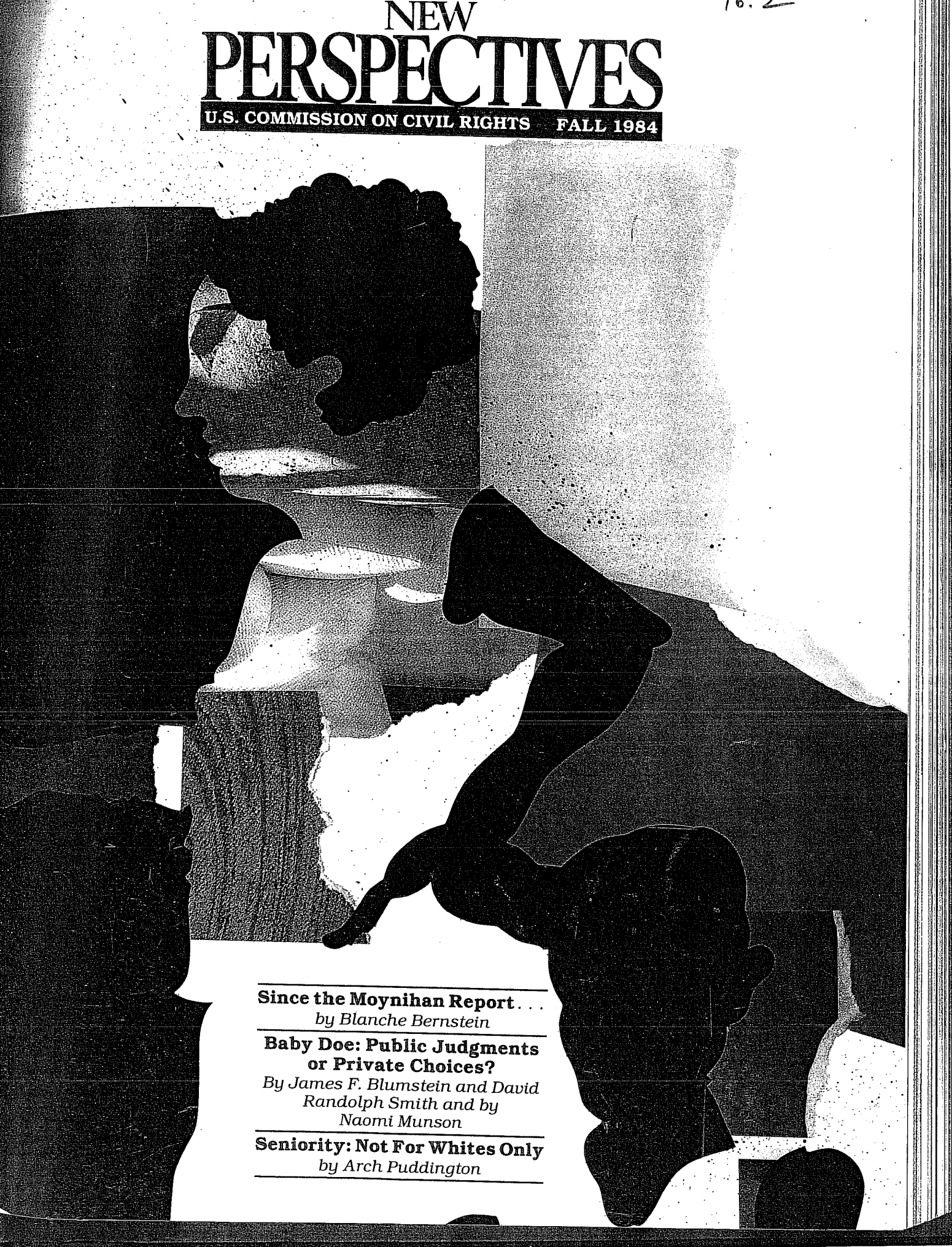


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**Since the Moynihan Report . . .**  
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**Baby Doe: Public Judgments  
or Private Choices?**

*By James F. Blumstein and David  
Randolph Smith and by  
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**Seniority: Not For Whites Only**  
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**Baby Doe:  
Public Judgments or  
Private Choices?**

# A Jurisdictional Approach

by James F. Blumstein and  
David Randolph Smith

**W**e are fortunate to live in a time and place where wondrous advances in medicine and science offer the promise of prolonged life. In the case of certain imperiled newborns, however—those with a serious birth defect or an acute acquired illness—the progress of neonatal medicine and technology has created a profound moral dilemma. Parents and physicians confront a tragic choice. To postpone death and thereby prolong a life may result in great suffering and impose staggering burdens and costs on the child, on the child's family and on society. Not to authorize or provide a treatment that might be technologically available, albeit at high financial and psychological cost, places decisionmakers in the uncomfortable position of determining who shall live and what the value of a life—or, as some would have it, a quality-adjusted life—will be. The ethical quandry is like that of Dr. Ridgeon in Shaw's play *The Doctor's Dilemma*.<sup>\*</sup> Thanks to science and technology, we can now often "do something" whereas physicians previously, with only limited therapeutic resources, could only "stand there."<sup>1</sup>

As in the case of many technological advances, fundamental social and ethical dilemmas have emerged in the wake of scientific progress. Now that we can "do something," we must go about formulating understandings of what we can or must do, under what circumstances, and at whose say so. Is greater involvement by courts or by government regulation warranted or appropriate? What approach should health care providers and courts adopt to treatment decisions involving imperiled infants? How should that approach recognize the presumptive responsibility and autonomy of parents to manage the care and treatment of their children? Our conclusion is that, except where parents abuse their authority, private moral dilemmas about the treatment of imperiled infants should remain family affairs, not

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matters of public policy.

**F**or a private ethical dilemma to become an issue of public policy, there must be a legitimate source of government concern. The development of the video cassette recording technology (VCR) enhances the ability of a family to enjoy certain forms of entertainment. Yet, whether a family chooses to or is able to purchase a VCR is not deemed a question of public concern. Nor is a family's choice of one of the competing formats over another a matter that excites the concern of the policy analysis community.

The fundamental—and often overlooked—question is this: Why does government have an interest in the decision concerning the treatment of imperiled infants whereas it has no particular interest in a family's decision about purchasing VCRs? The obviousness of the answer—that human life is at risk in one but not the other situation—should not deter us from asking the question, because thinking about the response helps in the formulation of an approach to the policy problem.

Historically and constitutionally, families are presumed to have primary responsibility for the upbringing of their children. Within broad parameters, families are free to choose their method of childrearing and to pick the values and aspirations transmitted to their offspring.

Yet, in certain circumstances society has determined that the

*Continued on page 15*

<sup>\*</sup> Having discovered a new treatment for tuberculosis, Dr. Ridgeon explains to a prospective patient's wife that he cannot treat her tuberculosis husband without pangs to his conscience:

I have at the hospital ten tuberculosis patients whose lives I believe I can save. . . . Wait a moment. Try to think of those ten patients as shipwrecked men on a raft—a raft that is barely large enough to save them—that will not support one more. Another man bobs up through the wave at the side. Another man begs to be taken aboard. He implores the captain of the raft to save him. But the captain can only do that by pushing one of his ten off the raft and drowning him to make room for the new comer. That's what you are asking me to do.

G. B. Shaw, *The Doctor's Dilemma*, in *Collected Plays With Their Prefaces*, Vol. III (1975), pp. 354-55.

## A Jurisdictional Approach

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legal system must come to the protection of young people—against themselves, against outsiders, and, in some cases, against parents.

Society protects children, for example, against the adverse consequences of making poor contractual decisions by declaring that contracts made by minors are unenforceable by adults. Minors are treated differently than adults in the criminal justice system. Child labor laws protect children against themselves, but also from the prospect of exploitation by venal parents. The same is true of compulsory school attendance laws. Laws on child abuse and termination of parental rights are the clearest manifestations of society's determination that children, at times, need legal protection against their parents.

Within broad parameters, determination of what is in the child's and the family's best interests is left to the parents. Where legitimate disagreements exist, family pluralism and autonomy are preserved. Only in areas in which a broad social consensus exists has family autonomy been circumscribed.

Where governmental intrusion on family autonomy exists, it stems from a public concern for the welfare of the child. But such intrusion, especially where family decisionmaking autonomy is displaced, occurs only for very important reasons and only where there is strong reason to believe that parental authority has been abused or is subject to abuse.

Therefore, the case for intrusion on family autonomy—especially coercive intrusion—typically rests on two components, one positive and the other negative: A perceived affirmative societal obligation to provide succor and support to children; and a duty to protect the defenseless from inappropriate adult overreaching. To justify public intrusion, there must be some strong evidence that families are very likely to act or have acted adversely to the child's interests.

In the area of treating imperiled infants, the scope of public obligation has yet to be defined. There is no constitutional right to receive medical treatment, but that issue has never been litigated in the context of an infant. Prisoners, who are dependent on government, do have some constitutional claim to treatment. But the existence and scope of any constitutional right to treatment on the part of imperiled infants is certainly questionable and murky.

In addition, there is no reason to believe that, as a rule, families are unreliable in making treatment decisions for their children. Thus, as a matter of general presumption, families of imperiled infants, together with their advisors (physicians, other health providers, religious leaders, individual and institutional

ethicists) should be permitted to retain their decisionmaking autonomy unless, in a particular case, it can be demonstrated clearly and convincingly that parents are acting against their child's interest as reflected by a general consensus of community conduct. When parental conduct no longer conforms to the expectations of the behavior of a fiduciary, and when parents act outside the realm of consensually acceptable norms, it is appropriate for government to intrude, in its role of protecting the defenseless from inappropriate parental overreaching. Only then should public policy attempt to deal directly with the substantive decisions about the appropriate range of treatment for imperiled persons.

Genuine tragic choice decisions should remain in the realm of private initiative so that public choices about sensitive value issues need not be confronted overtly and decided monolithically. Because government is constrained by a devotion to the symbolic imperative that life is beyond price, public decisionmaking is skewed by concerns about symbolic issues and is susceptible to "symbolic blackmail." The humanitarian self-image of society may be at stake, and we may be willing to expend considerable sums of money, ostensibly to save a life, but also to preserve a valuable myth. For these reasons, an effort should be made to distance government from direct, head-on confrontations with tragic choice issues.

Where parental autonomy must be breached, however, and a person is drawn within the perimeter of public responsibility, an effort should be made to reestablish the authority of non-governmental decisionmaking entities—e.g., by delegating responsibility to non-governmental decisionmakers such as physicians or to institutional entities such as hospital committees.

**N**eonatal intensive care units in hospitals throughout the United States routinely encounter severely impaired infants with major illnesses or defects. Non-treatment of imperiled infants occurs with some frequency.

The realities of neonatal care have provoked a sharp debate concerning the propriety of decisions not to authorize or provide medical or surgical treatment or nutritional sustenance to imperiled infants. For some, prolonging the life of all non-dying infants at all costs (to the infant, to the family and to society) is a categorical imperative with virtually no exceptions. "Right-to-life" organizations argue that parental decisions not to treat imperiled infants constitute "infanticide."

A number of cases challenging parental treatment decisions have been initiated by members of right-to-life organizations. In

Coquille, Oregon, a member of Oregon Right to Life recently reported that a "deformed" baby was being "starved to death." A state court judge ordered intravenous feeding; however, on the tenth day of life the infant died due to congenital brain damage which had caused cessation of breathing.<sup>2</sup> The New York "Baby Jane Doe" case<sup>3</sup> was initiated by a right-to-life lawyer, Lawrence Washburn, a resident of Vermont. The United States Surgeon General, Dr. C. Everett Koop, has also criticized "infanticide" of handicapped newborns.<sup>4</sup>

Proposed legislation would redefine child abuse to include the "denial of nutrition (including fluid maintenance), medically indicated treatment, general care, or appropriate social services to infants at risk with life-threatening congenital impairments."<sup>5</sup> A Senate bill would require a Department of Health and Human Services (HHS) advisory committee to conduct a comprehensive study of decisionmaking procedures used in health care facilities in managing treatment of seriously ill newborns and to make recommendations regarding procedural mechanisms that should be followed by hospitals. After receiving the committee report, the Secretary of HHS would be required to publish proposed regulations, if deemed necessary, to establish decisionmaking procedures within each hospital. The penalty for failing to comply with such regulations would be the denial of federal financial assistance, including Medicare and Medicaid.

A comparable bill passed by the House further requires that: (1) state child protection agencies ensure that nutrition, medically indicated treatment, general care and social services be provided to imperiled infants; (2) a procedure be established by which "interested parties" can report known or suspected instances of the withholding of treatment (e.g., hotlines); and (3) state agencies investigate any reports of such "child abuse."

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**"Thou shalt not kill; but needs't not strive officiously to keep alive."**

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Despite the support in some quarters for involvement by governmental authorities in treatment decisions, a significant body of opinion recognizes the legitimacy of decisions by parents to refrain from ordering treatment which would not be in the infant's best interests. In its report, *Deciding to Forego Life-Sustaining Treatment*, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research ("President's Commission") recommended that parents, as surrogates for the seriously ill newborn, should be allowed discretion to determine, based upon "the best interests of the child," whether life-sustaining treatment should be foregone. The President's Commission recommended that the government encourage hospitals to improve their in-house supervision of such decisions and not become directly involved in treatment decisions.

Various medical societies, including the American Medical Association, the American Academy of Pediatrics and the American Society of Law and Medicine's Committee on the Legal and Ethical Aspects of Health Care for Children, also advance the position that withholding or removing life-sustaining means from imperiled infants is ethical where prolongation of life would

be inhumane and unconscionable.<sup>6</sup> Similarly, the Vatican's 1980 *Declaration on Euthanasia* concludes that it is appropriate, when there is no hope of benefit to the patient, to withhold or withdraw treatment. This moral conclusion is not strikingly new. In the death scene at the conclusion of *King Lear*, Edgar wants to save Lear from the throes of an agonizing death born of grief at the death of Cordelia. The Earl of Kent seeks to dissuade Edgar: "O, let him pass! He hates him, that would upon the rack of this tough world stretch him out longer." Arthur Hugh Clough in his poem, *The Latest Decalogue*, expressed much the same sentiment: "Thou shalt not kill; but needs't not strive officiously to keep alive."

**B**eyond the question of whether it is ever proper not to treat an imperiled infant with all modern medicine has to offer lies the further delicate issue concerning criteria for deciding which infants should or should not receive care. How the question is posed will bear heavily on formulating a response.

The President's Commission concluded that a "best interests of the child" standard should govern treatment decisions and that the interests of parents, siblings and society should not count. Entirely excluding the potential psychic and financial harm to the family seems troubling because the best interests of the child are almost always inextricably tied to the interests of the family. Ignoring the economic costs of neonatal intensive care for imperiled infants is equally questionable. The President's Commission noted that the cost of high technology neonatal care approximates \$8,000 per patient, and that in 1978, \$1.5 billion was spent on neonatal intensive care. Added to this cost is the cost of special care, including perhaps lifelong institutionalized care. Economic realities for the family and society are not irrelevant, but their overt consideration raises fundamental symbolic concerns. Institutional mechanisms should be sought by which such explicit cost calculations can be avoided.

Perhaps the most difficult question in the debate over standards is whether the quality of an infant's life should be a permissible factor for consideration. If the child is not born "dying," to use Surgeon General Koop's taxonomy,<sup>7</sup> and is not in pain, yet has no ability to think or communicate but simply lies in a crib blind, deaf and uncomprehending, can we honestly say that this child's quality of life is of no moral consequence? University of Texas law professor John Robertson has argued that even in such a "worst case"—that is, "the profoundly retarded, nonambulatory, blind, deaf infant who will spend his few years in the back ward cribs of a state institution"<sup>8</sup>—quality-of-life judgments should not prevent treatment.

By contrast, Richard A. McCormick, a distinguished Catholic moral theologian at the Kennedy Institute of Ethics, believes that quality-of-life considerations are legitimate. McCormick sees life as a value to be preserved only in so far as it contains some potentiality for human relationships (to think, to love and to communicate). When that potentiality would be totally subordinated to the mere effort of survival, then the withholding of treatment would be justified.<sup>9</sup>

McCormick is not alone in advocating taking into account the quality as well as the extent of the life to be sustained. In a recent California case involving the prosecution of two doctors for

discontinuing treatment of a comatose incompetent adult, the California Court of Appeals recognized the appropriateness of attention to quality-of-life considerations. In discussing the surrogate's decision to withhold treatment from a comatose adult patient the Court stated: "If it is not possible to ascertain the choice the patient would have made, the surrogate ought to be guided by the patient's best interests. Under this standard, such factors as the relief of suffering, the preservation or restoration of functioning and the quality as well as the extent of life may be considered."<sup>10</sup>

Given the wide array of well-considered moral stances concerning treatment decisions and criteria for selective treatment, we now face a public choice. Should society rush to reformulate law and social policies by enacting new child abuse laws, "Infant Doe" regulations, or new criminal codes; or is the best course to reserve judgment given the disparity of our heart-felt ethical views and allow a consensus to develop? In our view, wisdom counsels against regulating absolutism when reasonable minds have profoundly divergent views of questions relating to morals, life, and the family. We should not codify a particular moral or ethical belief which substantially intrudes on the autonomy of the family without a confident conviction that the chosen course is both popular and wise. The current public debate reflects little consensus and much introspection. As with so many decisions in life, perhaps it is best to wait and think it over a bit more before imposing a monolithic approach.

**T**he case for reserving judgment on the question of what to do about treatment of imperiled infants may appear paradoxical in the face of existing criminal prohibitions against murder, manslaughter and child neglect. Robertson,<sup>11</sup> for example, has argued that withholding treatment from "defective newborns" violates numerous criminal laws including those for murder, involuntary manslaughter, conspiracy, child abuse and neglect. The perceived illegality is overstated, however. Selective treatment can co-exist with current criminal laws.

While criminal charges have occasionally been instituted against doctors or parents for withholding treatment, the results have been either acquittal or dismissal for lack of evidence. In Danville, Illinois, on June 11, 1981, the parents of Siamese twins and their physician were accused of attempted murder. The grand jury failed to indict. On October 13, 1981, Dr. Leonard Arthur, a pediatrician in Derby, England, was tried on murder charges (later reduced to manslaughter) for withholding food and treatment from an infant born with Down's syndrome. The jury acquitted Dr. Arthur after deliberating two hours.<sup>12</sup>

The results in these cases and the paucity of criminal charges in this area stem from a reluctance on the part of prosecuting authorities and juries to impose criminal sanctions when physicians and parents act in good faith and exercise reasonable judgment. As the Massachusetts Supreme Judicial Court noted in 1980 in *In the Matter of Spring*:

Little need be said about criminal liability: there is precious little precedent, and what there is suggests that the doctor will be protected if he acts on a good faith judgment that is not grievously unreasonable by medical standards.<sup>13</sup>

The *de facto* decriminalization of good faith and reasonable decisions to withhold treatment received recent approval in *Barber v. Superior Court*.<sup>14</sup> In issuing a writ of prohibition to bar the prosecution of two physicians on murder charges for discontinuing life support equipment and intravenous feeding of a comatose adult patient, a California Appeals court reasoned:

Murder is the *unlawful* killing of a human being, with malice aforethought . . . . A physician has no duty to continue treatment, once it has proved to be ineffective . . . . [To determine whether treatment will be effective a] . . . . rational approach involves the determination of whether the proposed treatment is proportionate or disproportionate in terms of the benefits gained . . . . In summary we conclude that the petitioners' omission to continue treatment under the circumstances [at the written request of the patient's wife], though intentional and with the knowledge that the patient would die, was not an unlawful failure to perform a legal duty.

Given the rarity of prosecutions and the recent judicial trend toward acceptance of private decisions to forego treatment in cases involving incompetent comatose adults,<sup>15</sup> there is scant justification for following suggestions to either enforce present criminal sanctions more fully or to enact legislation permitting non-treatment. Gearing up the machinery of criminal prosecutions is at odds with prevailing practice and moral attitudes; legislative validation of the "physician's death-dispensing role" carries unpleasant social costs.<sup>16</sup> In addition, a dollop of uncertainty in this area serves as a constructive constraint on abusive practices. Here perhaps, the law, like Milton's common man, serves best "to only stand and wait."

**H**ow one poses a question helps to shape perceptions about an issue. For example, in the area of imperiled infants, the issue is often framed as follows: If selective treatment occurs, by whom and by what process should treatment decisions affecting imperiled infants be made? At first reading this question appears entirely reasonable. But the question is actually quite loaded. It assumes the propriety of deeming family decisions on treatment as matters of public policy. Implicitly, that formulation of the issue establishes the legitimacy of public review and publicly-mandated rules of decision on matters that, presumptively, should remain within the private realm of family pluralism and autonomy. By implication, posing the question in that way invites governmentalized, centralized procedures and sets of criteria, thereby wresting responsibility for children from parents and imposing no significant duty on government to justify the displacement of the traditional rule of parental autonomy. As the Supreme Court observed in *Santosky v. Kramer*,<sup>17</sup> however, parents possess a "fundamental liberty interest . . . in the care, custody, and management of their child." Indeed, the United States Supreme Court many times has recognized the broad authority of parents to make decisions affecting the welfare of their children.

The failure to understand the presumption in favor of parental responsibility and choice is the true lesson of the New York "Baby Jane Doe" case. As the New York Court of Appeals wrote:

It would serve no useful purpose at this stage to recite the

unusual, and sometimes offensive, activities and proceedings of those who have sought at various stages, in the interests of Baby Jane Doe, to *displace parental responsibility for and management of her medical care* . . . . There was a failure in this instance to follow the statutory scheme contemplated by the Legislature for the protection of children [child neglect proceedings] (emphasis supplied).

Instead of posing the public policy question in terms of when to treat and when not to treat, perhaps a more helpful way in which to frame the inquiry is: Under what circumstances should the primary "jurisdiction" of parents to govern the treatment of their infant children be ousted? Additionally, the inquiry should assess whether the circumstances justifying ouster are established by clear and convincing evidence.

A jurisdictional approach to treatment decisions involving imperiled newborns comports with an emerging consensus favoring the presumption of private choice by parents and physicians as opposed to judgments by courts or legislative fiat. The President's Commission urged that decisions on treatment for seriously ill newborns be made by parents unless the parents are disqualified by decisionmaking incapacity, an unresolvable disagreement between them, or because their choice of a course of action is *clearly* against the infant's best interest. In short, only if the family cannot decide or if its decision does not reflect a legitimate selection among tragic alternatives should family decisionmaking autonomy be displaced by public intervention.

### **It is parents, not judges, who must live with the consequences of their decision.**

A recent public opinion survey conducted by the American Hospital Association and released in March, 1983, indicates broad support for family autonomy in treatment decisions. Sixty-seven percent of those asked felt that the patient's family should decide whether terminally ill patients should be kept alive.<sup>18</sup> The proponents of reserving authority for treatment decisions of imperiled infants to parents and physicians include: the Judicial Council of the American Medical Association;<sup>19</sup> the American Academy of Pediatrics' Committee on Bioethics;<sup>20</sup> the Association of American Medical Colleges;<sup>21</sup> the American Society of Law & Medicine's Committee on the Legal and Ethical Aspects of Health Care;<sup>22</sup> the *New England Journal of Medicine*;<sup>23</sup> the *British Medical Journal*;<sup>24</sup> the *New York Times*;<sup>25</sup> the *Wall Street Journal*;<sup>26</sup> and numerous commentators.<sup>27</sup>

To enhance the ability of parents to make infant treatment decisions in a careful and informed manner, many groups have suggested that parents and attending physicians consult with institutional ethics committees or that such committees conduct prospective or retrospective review of parental choices. As the President's Commission noted: "When the benefits of therapy are [unclear], an 'ethics committee' or similar body might be designated to review the decisionmaking process."<sup>28</sup>

Such entities can provide a check on private decisions and yet preserve an important sphere of family autonomy, allowing

government to avoid direct involvement. As with many such innovative institutions, however, care must be taken to see that the role of these committees does not become overextended.

Like civil courts, hospital ethics committees that review parental treatment decisions should apply a jurisdictional approach. The primary jurisdiction of parents to manage the treatment of their children should not be ousted or supplanted by committee decision absent clear and convincing proof that (1) the parents are themselves incompetent; or (2) the parents are in unresolvable disagreement; or (3) the parent's choice is clearly against the infant's best interests (recognizing various burdens and values, including quality-of-life considerations).

Reducing the number of infant treatment cases which are brought to court and limiting the judicial inquiry to whether the record clearly justifies ousting parents as decisionmakers are desirable policy goals. Courts such as New Jersey's Supreme Court in the noted *Quinlan* case candidly acknowledge that they are ordinarily "inappropriate" for making actual decisions on treatment or non-treatment. Such matters are particularly ill-suited to resolution in individual adversarial proceedings. In addition, decisions by parents and physicians, unlike those announced by courts, do not create judicial precedents and do not carry an imprimatur of public policy, with all the attendant symbolism. Perhaps the most significant drawback to judicial resolution of infant treatment decisions is that it separates power from responsibility.

Routinely vesting courts with the power to impose mandatory treatment nullifies parental authority but does not alter the continuing responsibility of parents for long-term care and custody, at least in the absence of a clearly defined public duty to provide resources for judicially imposed treatment. Courts lack both an immediate and long-term stake in the individual case; parents and physicians, however, are closely involved in every nuance of the case from the moment of birth. In the final analysis it is parents, not judges, who must live with the consequences of their decision. And, in the absence of clear parental overreaching, parental autonomy should be respected. □

#### End Notes

1. Davis, "Ethical Issues in Pediatric Practices," *Journal of the Royal Society of Medicine*, Vol. 76, 1983, p. 727.
2. Paris & Fletcher, "Infant Doe Regulations and the Absolute Requirement to Use Nourishment and Fluids for the Dying Infant," *Law Medicine & Health Care*, October 1983, p. 211.
3. *Weber v. Stony Brook Hospital*, 60 N.Y.2d 608 (1983).
4. Koop, "Ethical and Surgical Considerations in the Care of the Newborn with Congenital Abnormalities," *Infanticide and the Handicapped Newborn*, D. Horan & N. Delahoyd, eds., 1982, p. 89.
5. S. 1003, 98th Cong., 1st Sess. (1983); H.R. 1904, 98th Cong., 2d Sess. (1983).
6. See "American Medical Association Judicial Council 1982 Current Opinions," *American Medical News*, April 1, 1983 (parents should decide whether to exercise maximal efforts to sustain life based upon what is best for the infant, taking into account quality-of-life factors); American Academy of Pediatrics Committee on Bioethics, "Treatment of Critically Ill Newborns," *Pediatrics*, Vol. 72, October 1983, p. 565 ("withholding or withdrawing life-

- sustaining treatment is justified only if such a course serves the interests of the patient."); American Society of Law & Medicine Committee on the Legal and Ethical Aspects of Health Care for Children, "Comments and Recommendations on the 'Infant Doe' Proposed Regulation," *Law Medicine & Health Care*, October 1983.
7. Koop, The President's Commission for the Study of Ethical Problems in Medicine, *Deciding to Forgo Life-Sustaining Treatment: A Report on Ethical, Medical and Legal Issues in Treatment Decisions*, Comm. Print, March 21, 1983, p. 219, footnote 81 (From Statement before Hearings on Handicapped Newborns, Subcommittee on Select Education, Committee on Education and Labor, U.S. House of Representatives, September 16, 1982).
  8. Robertson, "Involuntary Euthanasia of Defective Newborns: A Legal Analysis," *Stan. L. Rev.*, Vol. 27, 1975, p. 254, from *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417, 432 (Mass. 1978) (quality-of-life considerations not relevant in making treatment decisions).
  9. R. McCormick, "To Save or Let Die: The Dilemma of Modern Medicine," *Journal of the American Medical Association*, Vol. 229, No. 2, July 8, 1974, p. 1972.
  10. *Barber v. Superior Court*, 147 Cal. App. 3d 1006 (Cal. 1983).
  11. J. Robertson, "Dilemma in Danville," *Hastings Ctr. Rep.*, Vol. 5, October 1981; Robertson, *supra* note 14.
  12. See Brahams, "Acquittal of Pediatrician Charged After Death of Infant with Down's Syndrome," *The Lancet*, Vol. 101, November 14, 1981.
  13. *In the Matter of Spring*, 380 Mass. 629 (Mass. 1980).
  14. *Barber v. Superior Court*, *supra* note 10.
  15. In addition to *Barber v. Superior Court*, see *John Kennedy Memorial Hospital, Inc. v. Bludworth*, No. 63,769 (Fla. Sup. Ct., May 24, 1984) (relatives of incompetent and terminally-ill patients can halt medical treatment without first getting court approval), noted in *National Law Journal* (June 11, 1984); *In the Matter of the Welfare of Bertha Colyer*, 99 Wash. 2d 114 (Wash. 1983); *Severens v. Wilmington Medical Center, Inc.*, 421 A.2d 1334 (Del. 1980); *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728 (Mass. 1977); *In re Quinlan*, 70 N.J. 10 (N.J. 1976); *In the Matter of Claire Conroy*, 188 N.J. Super. 523 (N.J. 1983); *rev'd*, 190 N.J. 453 (N.J. 1983) (appeal to N.J. Sup. Ct. pending).
  16. See Burt, "Authorizing Death for Anomalous Newborns," A. Milunsky & G. Annas, eds., *Genetics and The Law*, 1976, p. 435.
  17. 455 U.S. 745, 753 (1982); see also *In re Phillip B.*, 92 Cal. 3d 796 (Cal. 1979), *cert. denied sub nom., Bothman v. Warren B.*, 445 U.S. 949 (1980), (in refusing to declare a Down's syndrome child dependent of the court for the purpose of performing cardiac surgery to which the parents had refused consent the court noted "It is fundamental that parental autonomy is constitutionally protected.").
  18. *American Medical News*, April 1, 1983.
  19. See *supra* note 6.
  20. *Id.*
  21. Ass'n. of American Medical Colleges, Memorandum #84-8 (February 17, 1984) (government agencies should not intervene in what "should be a family decision made in consultation with physicians and others involved with the child.")
  22. See *supra* note 6.
  23. "Handicapped Children: Baby Doe and Uncle Sam," *New Eng. J. Med.*, September 15, 1983, p. 659.
  24. "Death Without Concealment," *British Med. J.*, December 19-26, 1981, p. 1629.
  25. "Society's Duty at Birth," *New York Times*, April 2, 1983, p. 16.
  26. "Babies and Big Brother," *Wall Street Journal*, February 28, 1984, p. 32; "Big Brother Doe," *Wall Street Journal*, October 31, 1983, p. 20; "Saving Babies," *Wall Street Journal*, March 21, 1983, p. 20.
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  28. The President's Commission, *supra* p. 227.