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ARTIFICIAL PROLONGATION OF LIFE IN DEFECTIVE AND PREMATURE INFANTS: TECHNOLOGY OUTSTRIPS MORAL AND LEGAL DECISION-MAKING CAPABILITIES

by

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Past controversy concerning the issue of legally protectable "life" has been centered on the unborn child. Because of questions regarding liability for injury to or destruction of the fetus and especially because of questions concerning abortion, it has become necessary to determine at what point the fetus may be considered a legally protectable entity. While the legal debate concerning the point in time that a fetus becomes a person has continued, advances in medical skills have raised additional issues concerning the protectable "life" of a newborn premature and/or defective infant.

Today, through improved medical technology, premature infants who are insufficiently developed at birth have a much greater chance of survival than those born a generation ago. Premature babies, as well as those afflicted with severe birth defects, can be kept alive by artificial means. Under such circumstances, however, there remains the option of withholding treatment and thus allowing the infant to face a natural death.

Advances in medical technology have placed doctors and parents in a position to decide if the use of such extraordinary measures to prolong the life of an infant should be implemented or continued. An examination of the current state of the law with regard to such decisions should be made from procedural and substantive perspectives. As it exists, the law does not provide those in a decision making capacity with the proper criteria and information to make a legally proper decision. Parents, doctors and health care institutions, risk the prospect of incurring civil and criminal liability. Although realistically diminished by the reluctance of prosecutorial agencies to persist in these types of cases, such grave risks will continue to exist until a procedure is developed by which the determinations to artificially continue an infant's life may be made. Such decisions raise legal questions never before encountered, as well as moral, religious, economical, and psychological issues.

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This article will discuss the changes in medical technology in dealing with significant types of defective and premature births, and the resulting problems created by sustaining the life of defective infants. We will review current practices regarding decisions whether to treat the infant, the legal liability of those who make such decisions, and the inadequacy of current law. Lastly, some suggestions are made of approaches to modifying current law.

DEVELOPING MEDICAL TECHNOLOGY

Through improved medical technology developed within the last fifteen years, physiologically immature infants of increasingly smaller weight are being saved in greater numbers in modern intensive care nurseries. These infants are often transported great distances in specially equipped ambulances and helicopters to regular hospitals for care by highly skilled medical personnel with access to the necessary equipment. Once in the care of these specialists, the majority of the infants progress well, although some, particularly the smallest and least mature, may suffer extensive damage to the brain or other parts of the body. Technology exists which allows severely defective infants who have suffered serious complications to be kept alive although the underlying defects may never be corrected. If necessary, the life function of these children may be prolonged indefinitely.

The mortality rate during the early critical weeks of life rises with increasing degrees of prematurity of the newborn infant. Babies who weigh less than one thousand grams (2.2 pounds) at birth, have mortality rates as high as 82% during the first month of life.[1] Of those who survive, defective cardiac, pulmonary, gastrointestinal, and neural development contribute to problems in care and to the possibility of a permanent handicap. In some cases, the machines used to sustain life can also be factors in causing damage.

Studies have reported the occurrence of major handicaps in babies weighing less than one thousand grams at birth to be from 7%[2] to

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[1]Usher, *The Special Problems of the Premature Infant*, NEONATOLOGY, PATHOPHYSIOLOGY AND MANAGEMENT OF THE NEWBORN 57 (G. Avery ed. 1975). At the Royal Victoria Hospital in Montreal between 1966 and 1970, there were 31 infants born alive between 501 and 750 grams in weight, of whom 97% died. The mortality rate decreased for infants of increasing birth weight, and was 72% for babies weighing from 751 to 1000 grams, and .25% for those weighing over 2,500 grams. *Id.* at 170.

[2]Stewart, Turcan, Rawlings and Reynolds, *Prognosis for Infants Weighing 1000 g or Less at Birth*, 52 ARCHIVES OF DISEASE IN CHILDHOOD 97, 102 (1977). Statistics on the frequency of major handicaps among infants weighing one thousand grams or less at birth are not consistent because relatively few infants are studied. During the 10 years of this study from 1966 to 1977, only 148 such infants were admitted to the Neonatal Unit of University College Hospital. The 7% found to have major handicaps derived from only two births. Moreover, follow-up studies that could detect major handicaps not obser-

85%[3] with increasing probability of handicap as the birth weight decreases. Recent two-year follow-up studies have shown major neurological defects such as cerebral palsy and hydrocephalus[4] with extensive paralysis and severe impairment of physical development in 30% of the infants who were less than one thousand grams at birth.[5] Another study reported moderate to severe deficiencies in neurodevelopment in 25% of infants less than one thousand grams birthweight who were studied until 10-36 months of age.[6] Improvements in prenatal care have raised the probability of survival for infants of very low birth weight.[7]

There is hope that the chance of survival of infants with severe birth defects may also be increased.[8] Examples of severe defects include hydrocephaly where a child is born with an enlarged head due to excess free fluid in the cranial activity; anecephaly, which is characterized by a total or partial lack of a brain; spina bifida, which is a deformity of the base of the spine; and Down's Syndrome, com-

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vable at birth are stifled by the low survival rate of these infants. Only 32% survived the neonatal period in this study. *Id.* at 97-98.

[3]Lubchenco, Delivoria-Papadopoulos and Searls, *Long-term Follow-up Studies of Prematurely Born Infants. II. Influence of Birth Weight and Gestational Age on Sequelae*, 80 J. PEDIATRICS 509, 511 (1972). At 10 years of age moderte to severe handicaps such as I.Q. below 89, spastic paralysis, and blindness were observed in 85% of those infants weighing less that 950 grams at birth; 70% in those who weighed 950 to 1,150 grams at birth, decreasing to a 35% occurrence in those weighing 1350 to 1500 grams at birth. *Id.* at 510 (Table II).

[4]Hydrocephalus is a condition characterized by an abnormal accumulation of fluid in the cranial vault, accompanied by enlargement of the head, prominence of the forehead, atrophy of the brain, mental weakness, and convulsions. DORLAND'S MEDICAL DICTIONARY 693 (24th ed. 1965).

[5]Pape, Buncic, Ashby and Fitzhardinge, *The Status at Two Years of Low-Birth-Weight Infants Born in 1974 with Birth Weights of Less than 1,001 gm.*, 92 J. PEDIATRICS 253, 258 (1978). Defects of the central nervous system were closely associated with a neonatal history of intracranial hemorrhage or seizures or both. *Id.* at 253.

[6]Bhat, Raju, and Vidyasgar, *Immediate and Long-term Outcome of Infants Less than 1000 grams*, 6 CRITICAL CARE MED. 148-50 (1978).

[7]*Id.* at 150.

[8]Improvements in care at the Los Angeles County-USC Medical Center from 1965 to 1970 have been described in Teberg, Hodgman, Wu and Spears, *Recent Improvement in Outcome for the Small Premature Infant*, 16 CLINICAL PEDIATRICS 307 (1977). In 1965 there was increased attention to ambient temperature in the nursery. In 1966, blood glucose levels began to be routinely monitored during the first 24 hours in infants of less than 2,250 grams and early institution of fluids by vein was begun. In 1967 formula feedings within the first 12 hours of life became routine. Phototherapy for elevated bilirubin levels began in 1968. In 1969 monitoring on a 24-hour basis of oxygen and carbon dioxide levels in the blood became available. Assisted ventilation for infants was established in 1970. Between 1965 and 1970 the perinatal mortality rate, which includes fetal deaths plus neonatal deaths in the first month of life, fell from 49 to 34 per 1,000 total births. *Id.* at 310.

monly known as mongolism, which is characterized by an abnormally shaped body and mental retardation.

PROBLEMS CREATED IN SUSTAINING IMPAIRED INFANTS

Emotional Stress

Being the parent of a very premature infant can be emotionally trying. Usher, in his book, describes it this way:

> The infant looks like nothing on earth to the new parents. There are tubes and wires all over, and the treatment area is often a frightening hubbub of emergencies. It is difficult to relate to the son or daughter in the incubator and almost impossible to image taking "it" home 2 months later as a healthy infant. The physician can give no assurance of survival, and the parents are afraid to ask about sequelae [aftereffects]. Then follow days or weeks of sudden ups and downs, with every telephone call or personal contact with nurses or doctors beginning with a moment of fright that the news may be bad.[9]

If the premature infant is handicapped with one or more birth defects, there are additional concerns. Some families benefit from the addition of a handicapped child but, unfortunately, many do not. In discussing ethical problems in pediatrics, one author states, "it is clear that the stress of raising a seriously handicapped child is associated with a higher rate of divorce, as well as less measurable indices of family disruption."[10] A study of families of children with the severe defect of meningomyelocele[11] and hydrocephalus, stated that 62% of the parents had adjusted poorly and 46% of the parents were separated or divorced.[12] Studies have also shown that there is a high degree of abuse of infants born prematurely with handicaps. Related to these instances of child abuse is a high degree of isolation and separation of infants from parents in the newborn period,[13] due to extended medical treatment periods. In turn, higher incidence of low birthweights has been found to be correlated to lower economic and social deprivation of the parents. These familial conditions when coupled with the impaired condition of the child tend to suggest that abuse of the infant is quite probable. As more sophisticated methods

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[9]Usher, *supra* note 1, at 183.

[10]Fost, *Ethical Problems in Pediatrics*, VI CURRENT PROBLEMS IN PEDIATRICS, 12, 13-14 (1976).

[11]Meningomyelocele is a hernial protusion of a part of the meninges (the three membranes that envelope the brain and spinal cord) and substance of the spinal chord through a defect in the vertebral column. DORLAND'S MEDICAL DICTIONARY 897 (24th ed. 1965).

[12]Kolin, Scherzer, New and Garfield, *Studies of the School-age Child with Meningolymelocele: Social and Emotional Adaptation*, 78 J. PEDIATRICS 1013, 1015, no. 6 (1971).

[13]Klein and Stern, *Low Birth Weight and the Battered Child Syndrome*, 122 AMER. J.

for sustaining the life of newborns have become available, it has become evident that there may be circumstances in which it is not in the infant's, the family's, or society's best interest to utilize such extraordinary methods.

Economic Costs

The economic cost of hospital care for low-birthweight infants is high. The cost of hospital care for seventy-five infants weighing 1000 grams or less at birth was reported by the Cedars-Sinai Medical Center in Los Angeles. Calculations of the September 1976 average hospital rates excluding doctors' bills, for each of the thirty surviving infants were $450 per diem and $40,287 for the period of treatment. For the forty-five infants who died, the average daily and total costs were $825 and $14,236, respectively.[14] When the total cost of treatment for the entire group (including doctors' fees) was averaged out over the thirty survivors, the cost per normal survivor amounted to $88,058. Developmental and neurological valuations of the survivors revealed that at one to three years of age, 70% were normal.[15] The estimated cost of lifetime "custodial" care for an impaired child was approximately $250,000 (in 1971 values).[16]

Current Practices Regarding Decisions for Nontreatment

Failing to initiate treatment at birth of a defective infant or discontinuing artificial means of sustaining life will probably cause a defective infant to die. The law has viewed failure to treat as less culpable than the affirmative act of discontinuing treatment.[17] Laypersons and medical personnel tend to view the affirmative discontinuance of treatment as the more difficult decision to make. However, some doctors have come to the conclusion that the decision not to initiate life support measures is no different from the decision to discontinue treatment. This seems to be the trend of current medical thought.[18]

DIS. CHILD 15, 17-18 (1971). In Montreal Children's Hospital, 51 cases of battered child syndrome were seen from 1960 through 1969. Twelve (23.5%) were low birth weight infants compared to an expected 7-8% based on the low birth weight rate in the area. *Id.* at 16-17.

[14]Stern, *Prematurity as a Factor in Child Abuse*, 8 HOSPITAL PRAC. 117, 119, no. 5 (1973).

[15]Pomerance, Ukrainski, Ukra, Henderson, Nash and Meredith, *Cost of Living for Infants Weighing 1,000 Grams or Less at Birth*, 61 PEDIATRICS 908, 909 (1978). The actual cost for infants who survive is greatly underestimated. The figure becomes $61,641.00 per survivor when the total adjusted cost for all 75 infants is used. Although physicians' fees were not included, they represent only 5% of the total bill. *Id.*

[16]Herman, *Priorities, Problems, Funding for the Handicapped Child*, Proceedings of Workshop at Rehabilitation Institute of Chicago, Northwestern University, May 7, (1971).

[17]W. PROSSER, HANDBOOK OF THE LAW OF TORTS, §56 (4th ed. 1971).

[18]A.M.A. NEWS, Dec. 1973, at 15, col. 2.

One southern California neonatologist[19] stated, "If we are going to initiate it (life-support measures) we must be willing to discontinue it."[20] In this discussion, the failure to initiate life-support systems (nontreatment), and discontinuing such support will be treated as equivalent. An examination of some of the considerations involved in decisions for nontreatment and the various types of decision-making procedures follows.

Decisions Made by Medical Personnel

The extent to which the decision for nontreatment is made solely by the doctor or doctors in charge of the infant is surprising. At one time, it was not uncommon for doctors at many hospitals to turn off the respirator "at night, alone, without the parents knowing."[21] Today, some physicians still regard the decision to prolong life or discontinue treatment as a difficult and lonely task but one which, in the last analysis, only the physician himself can make.[22] In an analogous context, doctors treating cancer patients have reported unilaterally deciding not to resuscitate a patient and later informing the family of the decision. One reason offered for their action is that they do not want the family to have to make such a decision while under stress, only to live with possible feelings of guilt afterward.[23] Dr. William J. Winslade, Co-Director of the UCLA Program in Medicine, Law, and Human Values has said, "Doctors don't believe responsibility should be shifted to the patient and family. They don't really think that informed consent is something patients can exercise....[T]here also is a lack of respect for the capacities of patients on the part of people in medicine."[24] In one Los Angeles hospital in which machinery in the newborn intensive care unit is turned off at least weekly, it is viewed as basically a medical decision.[25] Dr. Mildred Stahlman, a Vanderbilt University pediatrician, stated "When to abandon ship, to declare such an infant unmanageable, should remain an individual judgment made at the time, by the *physician responsible* for the neonate's life and care."[26]

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[19]A neonatologist is a physician whose speciality is the art and science of diagnosis and treatment of disorders of the newborn infant. DORLAND'S MEDICAL DICTIONARY 987 (24th ed. 1965).

[20]L.A. Times, Apr. 22, 1979, pt. ii, at 1, col. 1.

[21]*Id.* at 1, col. 4.

[22]Lewis, *Machine Medicine and Its Relation to the Fatally Ill*, 206 J.A.M.A. 387, (1968).

[23]L.A. Times, Feb. 7, 1979, pt. iv, at 6, col. 2.

[24]*Id.* Jan. 8, 1979, pt. i, at 21, col. 3.

[25]*Id.* Apr. 22, 1979, pt. ii, at 5, col. 5.

[26]Stahlman, *Ethical Dilemmas in Perinatal Medicine*, 94 J. PEDIATRICS 516, 517 (1979).

Decisions Made by Parents, or Parents in Consultation with Physician

The most common method of making the decision for nontreatment appears to be a joint decision by the parents and the physician in charge.[27] Commentators have suggested that the final decision must rest with the parents and the physician. Nevertheless, it must be recognized that the physician may, in effect, still be making the actual decision. In any event, the parents' consent will generally be based heavily on the prognosis given by him for the child's survival.[28]

In some cases, the parents will simply decide not to have their newborn treated and the physician will acquiesce in this decision, even though he or she would have acted otherwise. An example was found where a viable, but mongoloid baby starved to death because the parents did not want him and the child's physicians merely assented to the parents' wishes.[29] An unknown number of parents neglect to treat infants afflicted with a variety of disorders and defects by not consulting physicians. Instances where a child is in need of institutional care, but not placed in a medical facility, are usually brought to light in criminal proceedings.[30]

Decision by Committee

In contrast to a decision made soley by the parents and the physician in charge, the decision may also be made by others. In the major newborn centers in Los Angeles, the decision of nontreatment is one generally made collectively by a group composed of the parents, the attending physician, and other staff physicians.[31] Some hospitals have set up an "Ethics Committee" to decide whether to treat a child.[32] However, there appears to be little uniformity in the composition, authority, or effectiveness of these committees at this time.

The committee decision approach has been judicially approved in

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[27]L.A. Times, Apr. 22, 1979, pt. ii, at 4, col. 1.

[28]Duff and Campbell, *Moral and Ethical Dilemmas in the Special-Care Nursery*, 289 NEW ENGLAND J. MED. 890, 894 (1973). Forty-three of 299 consecutive infant deaths occurring in a special care nursery were related to withholding treatment. The authors insist this issue cannot be decided by default. The decision to withhold treatment is awesome in its finality but necessary if families are to avoid the devastating effect of maintaining infants incapable of leading meaningful lives. Unless physicians are to become "cruel masters of human beings instead of their servants", they should be held accountable for outlining all the management options and possible consequences available to the parents. *Id.*

[29]Gustafson, *Mongolism, Parental Desires, and the Right to Life*, 16 PERSPECTIVES IN BIOLOGY AND MEDICINE 529 (1973).

[30]*See, e.g.*, State v. Perricone, 37 N.J. 463, 471, 181 A. 2d 751, 759 (1962) *cert. denied* 371 U.S. 890 (1962).

[31]L.A. Times, Apr. 22, 1979, pt. ii, at 5, col. 2.

[32]*See, e.g.*, Matter of Quinlan, 70 N.J. 10, 35, 355 A.2d 647, 671 (1976).

the case of *In the Matter of Karen Quinlan.*[33] Karen Quinlan's condition was characterized as a "chronic persistent vegetative state" with "no cognitive function."[34] In this well-known case Ms. Quinlan's father sought express power as his twenty-one year old daughter's guardian to authorize discontinuance of all extraordinary[35] procedures for sustaining her vital processes. The New Jersey Supreme Court concluded that the father's concurrence, as guardian, in the decision made by attending physicians and the hospital ethics committee to withdraw support systems was permissible, and that the procedure would circumvent any civil or criminal liability on the part of any of the participants.[36]

Judicial Intervention in the Decision-Making Process

Not all jurisdictions view the hospital ethics committee as a proper decision-making panel. In complete contrast to the *Quinlan* holding a Massachusetts court, in the case of *Superintendant of Belchertown v. Saikewicz,*[37] rejected the committee approach to the decision-making process for terminating treatment of an incompetent, mentally retarded adult dying of cancer.[38] Although the Massachusetts court expressed that a judicial tribunal would find the considerations and advice of the committee of great assistance, it should not be required to accept or to require a committee procedure. The court stated:

> We take a dim view of any attempt to shift the ultimate decision-making responsibility away from the duly established courts of proper jurisdiction to any committee, panel or group, ad hoc or permanent. Thus, we reject the approach adopted by the New Jersey Supreme Court in the *Quinlan* case of entrusting the decision whether to continue artificial life support to the patient's guardian, family, attending doctors, and hospital "ethics committee."[39]

The *Saikewicz* court was obviously of the opinion that the state should assert its countervailing interests in the decision-making process. Those interests indicated by the court were "1) the preservation of life; 2) the protection of interests of innocent third parties; 3) the prevention of suicide; and 4) maintaining the ethical integrity of the medical profession."[40]

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[33]70 N.J. 10, 355 A.2d 647 (1976).

[34]*Id.* at 24, 355 A.2d at 654.

[35]*Id.* at 31, 355 A.2d at 651.

[36]*Id.* at 55, 355 A.2d at 672.

[37]370 N.E.2d 417 (Mass. 1977). *See also* Eichner v. Dillon, 73 App. Div. 2d 431, 426 N.Y.S.2d 517 (1980).

[38]370 N.E.2d at 434.

[39]*Id.*

[40]*Id.* at 425. *See also* Application of the President & Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir. 1964) *cert. denied,* 377 U.S. 987(1964); John F. Kennedy Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670 (1971); Raleigh Fitkin-Paul Hosp. v. Ander-

In those circumstances where the courts have placed themselves in the decision-making role, a procedural mechanism known as "substituted judgment" has been utilizied.[41] Basically, the court representing the state as parens patriae, decides what it deems to be in the best interest of the individual. Thus the court is in a position to consider subjective values and desires of the affected individual.[42]

Legal Liability of Decision-Makers

With the exception of the court-sanctioned processes, the participants in any other type of decision-making procedures are, in most instances, acting illegally, given current law. Every state has a statutory civil remedy for wrongful death as well as criminal sanctions for homicide.[43] The civil statutes usually provide that the action can be maintained for "any wrongful act, neglect or default" which causes death, including both intentional and negligent torts.[44] It is possible that the parents, physicians, hospital board, or other parties to a decision for nontreatment could be held liable under these statutes for the withholding of medical care.[45] Criminal charges could also be brought against such parties in the event of the infant's death.

Inadequacy of Current Law

Today, treatment is denied or withdrawn from deformed infants by a variety of decision-makers with very little guidance or uniformity. The participants in these decisions face serious risks of legal liability under current law. Yet there has been little application of the law in this area, apparently because society, represented by prosecutors, judges, and juries, does not believe that the persons involved have acted in such a manner as to incur criminal punishment or be subjected to civil liability. One easy means of avoiding application of the law is to attribute the death to factors other than withdrawal of treat-

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son, 42 N.J. 421, 201 A.2d 537 (1964), *cert. denied*, 377 U.S. 985 (1964); State v. Perricone, 37 N.J. 463, 181 A.2d 751 (1962), *cert denied*, 371 U.S. 890 (1962).

[41]*See, e.g.*, Eichner v. Dillon, 73 A.D.2d 431, 426 N.Y.S.2d 517, 548 (1980); In Re Boyd, 403 A.2d 744, 749 n.10 (D.C. 1979); Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417, 430-31 (Mass. 1977).

[42]370 N.E.2d at 430.

[43]W. PROSSER, HANDBOOK OF THE LAW OF TORTS § 127 at 902 (4th ed. 1971). Wrongful death statutes overcome the common law prohibition against recovery by third persons who have lost the services of the decedent. Most statutes create a new cause of action for the death in the decedent's representative for the benefit of designated persons. *Id.*

[44]*Id.* at 903.

[45]For an excellent analysis of the legal grounds for civil and criminal liability, see Robertson, *Involuntary Euthanasia of Defective Newborns: A Legal Analysis*, 27 STAN. L. REV. 213, 217-44 (1975).

ment.[46] Another has been to appeal to the sympathies of a court or jury, hoping they will not find liability.[47] Because the current law offers little, if any, real guidance to parents or physicians, and because the law currently is easily evaded and ignored, it is inadequate to safeguard the rights and prerogatives of all concerned, including the infants.

APPROACHES TO DECISION-MAKING REGARDING NONTREATMENT

Common Law Approach

Due to the absence of legislative enactments, the approach now in use concerning medical nontreatment in general is to make decisions on a case-by-case basis. The two principal issues to be considered are: the procedural requirements for decision-making; and, the standards which the decision-makers must apply. The courts in many earlier cases did not squarely face these concerns, but attempted to find "justice" without articulating their reasoning or by trying to fit the unique facts into a traditional legal pigeon hole.

The *Quinlan* and *Saikewicz* courts faced the issues involving the withdrawal of life support or the failure to utilize life-prolonging treatments. With regard to the procedural requirements, the court in *Quinlan*, in deference to the family and medical community, required that physicians and guardians of the patient concur in the nontreatment decision. If there was concurrence of opinion, the decision then was to be referred to the hospital "Ethics Committee" or a similar body. If the committee agreed that treatment ought to be terminated, the court held that there would be no civil or criminal libility.[51] The court in *Saikewicz* rejected the view that the decision could be entrusted to the guardian, family, attending doctors, or hospital ethics committee and instead held that the decision must be made by the courts.[52] Thus, through common law development, the courts are establishing procedural requirements. The developing common law will determine the procedure required for a recommendation of nontreatment for a severely abnormal newborn.[53]

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[46]L.A. Times, Apr. 22, 1979, pt. ii, at 1, col. 2. Prosecutor declined to file charges against doctors who disconnected life support apparatus from an infant that had suffered irreversible brain damage due to auto accident. The basis for failure to file charges was that the death was caused by the auto accident. *Id.*

[47]MacMillan, *Birth-Defective Infants: A Standard for Nontreatment Decisions*, 30 STAN. L. REV. 599, 615 n. 84 (1978).

[48]Robertson, *supra* note 45 at 217-18.

[49]Matter of Quinlan, 70 N.J. 10, 355 A.2d 647 (1976).

[50] Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417 (Mass. 1977).

[51]70 N.J. at 35-36, 355 A.2d at 671-72.

[52]370 N.E.2d at 434.

[53]For scattered references to unreported cases where courts required treatment of

Building upon common law background, various theories of nonliability could be developed by the courts on a case-by-case basis. Several such theories have already been advanced. For example, as discussed previously, one theory of nonliability might be based upon the belief that the nontreatment was not the actual cause of the infant's death.[54] However, this theory would have to be rationalized with case law in some states holding that even if an infant is certain to die from its deformities, the accelerating of a certain death is homicide.[55]

A second, but less defensible approach would be to expand the doctrine of "necessity" as a defense to either a civil or criminal charge. This doctrine provides that one may harm another, even including the killing of another, if the act of harming the other is necessary to prevent an equal or greater harm to the actor.[56]

A third approach would be for a court to examine the degree of deformity in an infant, and if the deformity is extreme, to find the infant to lack sufficient intelligence to be considered a legal "person." Therefore treatment could legally be withheld. In *Quinlan*, the court held that life support could be withdrawn if there was no reasonable possibility of the patient ever emerging from her present comatose state to a "cognitive, sapient state."[57] The United States Supreme Court, in *Roe v. Wade*,[58] determined the point at which a fetus could no longer be aborted was the time at which the fetus was presumed to be viable. The Court stated, "This is so because the fetus then presumably has the capability of *meaningful* life outside the mother's womb."[59] Thus, a tenuous argument can be made, based on these opinions, that only "meaningful" life is to be protected and that an infant without the capability of intelligence is not a meaningful life.

The approach taken in *Saikewicz* was to invoke the doctrine of "substituted judgment" and, in effect, have someone try to anticipate how the patient would decide the question of nontreatment if he were able to decide for himself. An extension of this doctrine might be fashioned to include the case of the malformed infant. The infant, through the substituted judgment by a guardian or parents would have the right to decide whether the use of life sustaining apparatus should be discontinued. This extension of the doctrine of substituted judgment would, in part, be based on the constitutional "right of

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seriously defective infants, see Brown and Truitt, *Euthanasia and the The Right to Die*, 3 OHIO NORTH. L. REV. 615, 632 (1976).

[54]*See* text accompanying note 33 *supra*.

[55]*See, e.g.*, State v. Mally, 139 Mont. 599, 604, 366 P.2d 868, 873 (1961).

[56]*See* W. PROSSER, HANDBOOK OF THE LAW OF TORTS, § 24 (4th ed. 1971).

[57]70 N.J. at 35, 355 A.2d at 671.

[58]410 U.S. 113 (1973).

[59]*Id.* at 163 (emphasis added).

privacy" reserving certain decisions concerning personal integrity to the individual.[60]

Difficulties Inherent in Common Law Theories

The weaknesses in the above theories of nonliability become apparent with little analysis. For example, the typical factual setting for invoking the doctrine of necessity in defense to a criminal charge is too far removed from the question of whether a concerned parent should be permitted to decide whether life support should be withdrawn from a severely deformed infant. The doctrine of substituted judgment may be useful, for example, when managing the financial matters of a normal minor; but it is the purest fiction when a court, as in *Saikewicz* or *Quinlan*, attempts to anticipate what the malformed premature infant would decide if he were capable of such decision. Similarly, it would be difficult to make any sense out of an argument that it might be an invasion of the privacy *of an infant* to terminate the infant's life support.

A workable theory of nonliability might be developed on a case-by-case basis, but this approach would prolong the agony and risk of those involved in making these difficult decisions. Society is simply faced with a new problem brought about by new technology and what is needed is a deliberate and well-considered legislative approach.

It has been said, the law always lags behind the most advanced thinking in every area. It must wait until theologians and the moral leaders and events have created some common ground, some consensus.[61] Whether this is true in the case of nontreatment of infants remains to be seen. It is interesting to compare the factors physicians consider in making their decisions with the legal approach outlined above. A 1975 survey of pediatricians by the American Academy of Pediatrics revealed that more than 80% did not believe that extraordinary means should be used to save the life of each and every newborn infant. When asked to list the factors to be considered when deciding whether to withhold surgery in such cases, the pediatricians listed potential quality of life as the strongest criterion. The next most important criteria were possible adverse effects on the family, infant's possible IQ, the parents' willingness to raise the child, and the cost to society.[62]

The gap between what the medical profession is utilizing in prac-

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[60]Eisenstadt v. Baird, 405 U.S. 438, 453 (1972); *See* Stanley v. Georgia, 394 U.S. 557 (1969).

[61]Burger, *The Law and Medical Advances*, 67 ANN. INT'L MED. 17 (Supp. 1967) *quoted in* Elkinton, *The Dying Patient, the Doctor and the law*, 13 VILL. L. REV. 740 (1968).

[62]L.A. Times, Apr. 22, 1979, pt. ii., at 4, col. 1.

tice and the thinking of the courts is illustrated by the tendency of the courts to reject "potential quality of life" as a relevant factor in the decision for nontreatment. The court in *Saikewicz* stated that if quality of life is to be equated with value of life, they were rejecting quality of life as a criterion.[63]

CONCLUSION: LEGISLATIVE ENACTMENTS

The lack of standards for nonliability for nontreatment and the growing confusion and risks call for a legislative response. The common law evolution of the law has merits, inasmuch as the law can develop based upon concrete factual cases. However, this process is time consuming and grossly unfair in that it unnessarily subjects well meaning and innocent parties to the risk of criminal and civil liability.

The two questions to be resolved by legislatures are: What is the proper decision-making process by which a decision of nontreatment can be made; and what are the relevant factors to be utilized by the decision-makers? The possibilities for the decision-making process range from letting the parents alone decide the fate of their child to a system whereby such a decision is made jointly by parents, the attending physicians and some sort of detached body or "Ethics Committee." Removing the decision to the courts or to some independent body is also a possibility. The numerous factors which might be considered relevant to the decision-makers include the quality of life the infant would enjoy if treated, as well as the economic cost and emotional suffering which have to be endured by both the parents and the child.

Such questions are difficult. The law as it exists today and the process by which it is being changed are both inadequate to meet the task. Only through sound and comprehensive analysis of this problem will answers be developed to meet the needs of premature, malformed infants, their parents, and the physicians who treat them.

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[63] 370 N.E.2d at 432.