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PARENTAL REFUSAL OF CONSENT FOR TREATMENT OF HANDICAPPED NEWBORNS: COMPARING CASE RESULTS IN ENGLAND AND THE UNITED STATES

William L. Bouregy

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Your children are not your children  
They are the sons and daughters of Life's longing for itself  
They come through you but not from you  
And though they are with you yet they belong not to you.  
—Kahlil Gibran, *The Prophet*, 1923

I. INTRODUCTION

Among the legal dilemmas resulting from major advances in medical technology during the past quarter century is the issue of whether parents can refuse consent for treatment of handicapped newborns.¹ Historically, the practice of allowing or causing the death of newborns with birth defects was commonplace throughout western civilization.² The advent of neonatal intensive care units (NICUs) and other medical technological advances, however, has presented legal systems with a quandary of how much treatment the law requires, or indeed, if treatment is required at all.³

This Note will compare the two leading cases on parental treatment refusals in England and the United States. In England, the Court of Appeal decided *In re B. (A Minor)*⁴ on August 7, 1981. The infant,

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² See generally Moseley, *The History of Infanticide in Western Society*, in 1 ISSUES IN LAW & MED. 345, 351 (1986). The limits of such practice hold interesting views for the future, as well. For an example of the possibilities, see *Stillborn Ends Infant Transplant Case in California*, N.Y. Times, Dec. 24, 1988, at B10, col. 3.

³ The first experimental NICUs were developed in Toronto, Montreal, and London in 1961-62. By 1963, a unit was developed at Vanderbilt Medical Center in Nashville, Tennessee. NICUs were established steadily on both sides of the Atlantic until, by 1973, they appeared in most larger hospitals. See J. Lyon, *Playing God in the Nursery* 97-100 (1985) Mr. Lyon's book begins with a narrative account of the “Baby Doe” case in Bloomington, Indiana, and continues with an in-depth overview of the topic, as well as chronicling the relative cases pertinent to the issues discussed herein. Events described in the book are mostly derived from the court transcripts and interviews with the parties involved. *Id.*

ten days old at the time of appeal, was born with Down's syndrome and intestinal blockage. Weber v. Stony Brook Hospital, a 1983 case in the New York State courts, involved an infant seventeen days old at the time of final appeal, born with myelomeningocele (spina bifida), microcephaly and hydrocephalus. In both cases, health care personnel reported the parents' refusal of consent to the surgery necessary to prevent the infants' deaths.

The issues raised, battled over and balanced in these cases go right to the heart of familial relationships, privacy and individual autonomy. These cases both involved situations where the courts were called upon to review a parental decision regarding the care of their infant. The courts had to decide whether the parents' decisions not to treat life-threatening birth defects with the most extensive surgical remedies were consistent with the infants' best interests. If not, the courts then had to decide if they would replace the parents' decisions with an order to have surgery performed.

Ostensibly, the paramount issue is the newborn's right to live or, as an incompetent, to be allowed to die. The infant's right to life is the same as that of any other individual, and grounded in common law and statutes in England and the United States. For the infant in New York, there are also federal and state constitutional protections of such rights.

These cases, however, represent a departure from the issues argued in well-known cases involving refused medical treatment which would result in the death of the patient. Those issues are framed by

5. 95 A.D.2d 587, 467 N.Y.S.2d 685 (2d Dep't), aff'd per curiam, 60 N.Y.2d 208, 456 N.E.2d 1186, 469 N.Y.S.2d 63 (1983).

6. Microcephaly is a congenital condition where the head is smaller than normal. Taber's Cyclopedic Medical Dictionary 891 (14th ed. 1981). Hydrocephalus is an enlargement of the head resulting from the pressure of fluid buildup within the skull. Id. at 676.


8. In England, see C. v. S., [1987] 1 All E.R. 1230 (Q.B.). In the United States, see Scholendorff v. Society of New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914) (common-law right of a competent adult to determine what is done with one's own body includes the right to refuse medical treatment, even if death will result).

9. U.S. Const. amend. V, XIV, cl. 1; see N.Y. Const. art. 1, § 6, cl. 3; see also Riga, Euthanasia, the Right to Die and Privacy: Observation on Some Recent Cases, 11 Lincoln L. Rev. 109, 133 (1982).

an assertion of the individual’s rights against countervailing state interests. The individual’s rights may be based on common law,\textsuperscript{11} federal and state constitutions,\textsuperscript{12} and state statutes.\textsuperscript{13} The countervailing state interests may be based on common law, federal and state constitutions, and state statutes. The countervailing state interests may be based on common law, federal and state constitutions, and state statutes.
interests are the preservation of the lives of its citizens, prevention of suicide and protection of health care professionals and institutions from criminal and civil liability.\textsuperscript{14}

For competent persons, the right to die in England and New York is inherent in the common-law right to refuse medical treatment.\textsuperscript{15} Without consent, even the administration of life-saving medical treatment violates the patient's legal rights.\textsuperscript{16} In the case of an incompetent, however, the right to die is circumspect because of the legal inability to obtain consent. This right has been recognized for incompetents in a number of jurisdictions variously based upon an extension of the common-law right, as in New York,\textsuperscript{17} or the doctrine of "substituted judgment."\textsuperscript{18}
At first blush, these theories seem applicable to newborns because they are incompetents. Both theories, however, present weak arguments in a newborn's case because each theory relies to some degree upon a previous history of the intentions and attitudes of the incompetent.\(^1\) Judicial gloss on the common-law rule requires clear and convincing evidence as to the incompetent's desire, made while competent, to have medical treatment withheld or withdrawn.\(^2\) Newborns clearly fall outside that rule. Even a substituted judgment theory falls short in the case of a newborn because the decision-maker is supposed to decide based upon what decision the incompetent himself would have made.\(^3\)

This may explain why cases of parental refusal of consent for treatment of defective newborns do not present arguments over the infant's right to die, but rather over the parental right to choose medical treatment for the child. The courts in the topic cases did not address the mainstream treatment refusal issues. Instead, the primary issue ad-

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1. 70 N.J. at 39, 355 A.2d at 663; cf. In re Joseph v. Gardner, 534 A.2d 947 (Me. 1987); Top Maine Court Backs Right to Die, N.Y. Times, Dec. 6, 1987, at A41, col. 1. The Supreme Judicial Court of Maine, in a four-to-three decision, ruled on Dec. 3, 1987 that the parents of a man who had been comatose for two years could order the termination of artificial feeding by tube. While the court based its opinion upon the constitutional right to privacy, and not on the common-law right to refuse medical treatment, it nonetheless required clear and convincing evidence as to the desires of the patient, made before becoming comatose, to be disconnected from life-support systems in such a situation. The Quinlan precedent does not require the clear and convincing evidence standard. The Maine case represents, therefore, a hybrid rule, combining judicially required indicia of both the substituted judgment theory and the common-law doctrine of the right to refuse medical care. For the New York Court of Appeals's refusal to follow such a rule see the discussion of Storar, supra note 18.
dressed was the autonomy of parental rights, which includes the right to choose medical treatment for their children, when there is a claim that the parents' decision is incongruous with the child's best interests. When these conflicts arose, the strong, countervailing state interests compelled the courts to review the decision not to treat and consider restricting the autonomy of parental rights. Secondary issues, important to the courts' reasonings, include the effect of support of responsible medical authority for the parents' decisions, the use of quality-of-life considerations in the decision-making process, and the extent of the courts' equitable authority under the doctrine of parens patriae. Tertiary issues, which are a backdrop to all cases of medically based litigation, are the interests of the physicians, hospitals and the health care industry in protection from liability for their professional conduct. While their ethical obligation is the preservation of life and health, there are legal duties to respect patients' wishes, obtain consent, and respect patient/physician confidentiality.

Ultimately, to resolve all these conflicts, the state through its court system, is called upon to exercise its authority. The fulcrum upon which all these interests are balanced is the best interests of the child. Because that doctrine lacks clear rules and concrete guidelines, the best interests of the child are decided on a case-by-case basis. The following discussion demonstrates how two courts in different countries handled such a decision in cases where the results are life and death. The different results the courts reached reflect how the situs of the conflict is less important than the development of a responsible international approach to the dilemma of medical decision-making for the treatment of handicapped newborns. Indeed, the authority of the government to interject itself into the treatment decision-making is one of the major issues.

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22. See infra notes 113-19 and accompanying text for a detailed discussion of the best interests of the child doctrine.

23. See infra notes 320-29 and accompanying text for a detailed discussion of the parens patriae doctrine.


II. THE CASES: In Re B. (A Minor) & Weber v. Stony Brook Hospital

Only two cases involving parental refusal of consent for treatment of handicapped newborns have reached the level of appellate review in England and the United States.26 The courts reached opposite conclusions on whether to treat based upon their reasoning as to what constituted the best interests of the child.27 These cases, therefore, exemplify the opposite conclusions reached in the small universe of cases concerning treatment refusal for handicapped newborns. There have been eleven such other cases, all at the trial court level only, all in the United States, and most of which have gone unreported officially.28


28. Of the 11 cases, only one decision, In re Cicero, 101 Misc. 2d 699, 421 N.Y.S.2d 965 (Bx. Co. Sup. Ct. 1979), appeared in a court reporter. The infant girl was born with spina bifida. Id. at 699-700, 421 N.Y.S.2d at 966. The court appointed a guardian to consent to corrective surgery. Medical evidence indicated that the life of the infant was not hopeless. Id. at 702-03, 421 N.Y.S.2d at 968. In an interview with the court-appointed guardian ad litem, Simon Rosenzweig, Esq., at his office at 122 East 42nd Street, New York, New York on Apr. 9, 1987, Mr. Rosenzweig recalled that several physicians who were treating the child had agreed unanimously that non-treatment was not a valid medical alternative [hereinafter Rosenzweig Interview].

In an effort to protect the anonymity of the infants, the other ten courts sealed their records of the cases. Thus, none of these were officially reported. Nonetheless, the events received substantial press coverage and were also the focus of those with legal and medical interests. Authors of books and periodicals in which articles about the cases appear relied on interviews with parents and other family members, hospital personnel, attorneys and judges, as well as media accounts of the trials themselves, for substantive information about the cases. The citations below reflect those sources in which the cases are mentioned or discussed.

The “Baby Ashley” case (unreported), discussed in 1 ISSUES IN LAW & MED. 5 (1985) (citing the Idaho Statesman, Sept. 27, 1983, at 1.) The case involved an abandoned infant afflicted with hydronencephaly. The court denied her physician's petition to discontinue life-sustaining treatment. The infant died five days later.

In re Baby F, No. J928 (Cir. Ct., Coos County, Or., 1983) (unreported), noted in D. MEYERS, MEDICO-LEGAL IMPLICATIONS OF DEATH AND DYING § 14:10 (Dec. Supp. 1986). In a suit brought by a right-to-life organization, the court ordered treatment of the newborn's neural tube defect. The court then withdrew its order upon the physician's finding that the infant's condition was hopeless but stayed the dissolution of the injunction until the plaintiff could oppose the attorney general's motion to dismiss because the organization did not represent the child. The infant's death mooted the case. See infra note 103 and accompanying text.

This is the well-known "Baby Doe" case. The parents of this infant, born with spina bifida and hydrocephalus, chose non-treatment among the options presented to them by the infant's physician. Another physician vehemently opposed the parents' decision and instigated the district attorney to bring suit on the matter. The trial court, through successive proceedings, upheld the parents' right to decide the course of their child's treatment. The intermediate appellate court and high state court refused to hear the case. While the district attorney was en route to argue for certiorari before the United States Supreme Court, the infant died.

In re Jeff & Scott Mueller, Nos. 81J300 & 81J301 (5th Jud. Cir. Ct. Vermilion Co., Ill. 1981) (unreported, noted in Ellis, Letting Defective Babies Die: Who Decides?, 7 AM. J. OF L. & MED. 393, 401 n.32 (1981); J. LYON, supra note 3, at 190-92; Robertson, Dilemma in Danville, 11 HASTINGS CENTER REPORT 5 (1981); Shatten & Chabon, Decision-Making and the Right to Refuse Lifesaving Treatment for Defective Newborns, 3 J. LEGAL MED. 59, 65 n.30 (1982) [hereinafter Shatten]; R. WEIR, SELECTIVE NON-TREATMENT OF HANDICAPPED NEWBORNS: MORAL DILEMMAS IN NEONATAL MEDICINE 97-99 (1984)). This case involved Siamese twins joined at the waist. The parents chose non-treatment, which included refusing to feed the newborns. The court removed the infants from the parents' custody, but found no neglect on their part, within the statutory meaning. Subsequently, when the infants' condition stabilized, the court ordered surgical separation.

In re Elin Daniels, No. 81-15577FJ01 (Dade Co. Cir. Ct., Fla., filed June 23, 1981) (unreported, noted in Portella, The Elin Daniels Case: An Examination of the Legal, Medical, and Ethical Considerations Posed when Persons and Doctors Disagree on Whether to Treat a Defective Newborn, 18 THE FORUM 709 (1982-83); Mnookin, Two Puzzles, 1984 ARIZ. ST. L.J. 667, 670 n.10; Shatten, supra, at 65 n.32; R. WEIR, supra, at 97-98.) The court ordered treatment for this infant born with spina bifida cystica and hydrocephalus.


A Detroit, Michigan juvenile court, relying on a Michigan child abuse statute, ordered surgery on a mongoloid newborn with duodenal atresia (unreported, noted in Brown & Truitt, Euthanasia and the Right to Die, 30 OHIO N.U.L. REV. 615, 632 nn.114-15 (1976)). The parents consented to treatment of the infant under a threat that the infant would be removed from their custody.

In re Teague, No. 104-212-81886 (Cir. Ct., Baltimore, Md., filed Dec. 4, 1974) (unreported, noted in Mnookin, supra, at 670 n.10.) The death of this infant, born with spina bifida, vacated the court proceedings.

Maine Medical Center v. Houle, No. 74-145 (Super. Ct. Cumberland Co., Me., filed Feb. 14, 1974) (unreported, reprinted in 1 ISSUES IN LAW & MED. 237 (1986); Mnookin, supra, at 670 n.10; R. WEIR, supra, at 93). This newborn suffered from a variety of maladies, the most crucial of which was a trachaelesophageal fistula. This condition causes two problems. First, it allows gastric juices to enter the lungs. Second, the esophagus is blocked, making eating impossible. The child died a day after court-ordered surgery took place. R. WEIR, supra, at 94.

This Note is specifically concerned with civil proceedings in which courts have determined whether parents may refuse consent for treatment of handicapped newborns, and, if not, whether the court will order such treatment. Whenever death is an issue, however, there are criminal concerns as well. Three cases, one in England and two in the United States, serve to illustrate that juries, judges and prosecutors shy away from criminal prosecutions and convictions of parents and physicians whose conduct results in the death of handicapped newborns. These cases are as follows:

People v. Mueller, No. 81-CF204 (5th Jud. Cir. Ct., Vermilion Co., Ill. 1981) (unreported, discussed in Robertson, supra, at 5; J. LYON, supra, note 3 at 190-92; R. WEIR, supra, at 95-97; Note, Withholding Treatment From Defective Infants: Infant Doe: Postmortem, 59 Notre Dame L. Rev. 224 (1983) [hereinafter Withholding Treatment From Infants]; Shatten, supra, at 65 n.30; Ellis, supra, at 401 n.32). Criminal charges were filed against the parents and attending physician for conspiracy to commit murder and endangering the life of the child. Robertson, supra, at 5; J. LYON, supra note 3, at 190. At a preliminary hearing the court ruled there was no probable cause and dismissed the charges. Robertson, supra, at 5; J. LYON, supra note 3, at 191. Later, the district attorney sought a grand jury indictment against the parents for attempted murder, conspiracy to commit murder, and solicitation to murder, and against the physician for conspiracy to commit murder. Withholding Treatment From Infants, supra, at 232. The grand jury did not indict. Id. The district attorney asserted afterwards that he was not interested in putting the Muellers in prison, but "only wanted to establish that they had done wrong." J. LYON, supra note 3, at 192.

In England, Regina v. Arthur involved the death of a Down's syndrome baby (Leicester Crown Ct. 1981) (unreported, discussed in Gunn & Smith, Arthur's Case and the Right to Life of a Down's Syndrome Child, 1985 CRIM. L. REV. 705; Editorial: Regina v. Dr. Leonard Arthur, 50 MEDICO-LEGAL J. 3 (1982); Gerber, Child Welfare—Infants Born as Mongols and with Other Defects—Liabilities of Parents and Medical Practitioners Involved—Criminal Implications, 56 AUSTL. L. J. 139 (1982); Gallagher, Parents' Rights in Respect of Their Children, 12 FAM. L. 168 (1982); J. LYON, supra note 3, at 193). After consulting with the parents, Dr. Arthur wrote an order stating that "[p]arents do not wish child to survive. Nursing care only." Gunn & Smith, supra, at 706. He further prescribed a narcotic to be administered to the infant "as required." Id. The infant was also to be fed "if it demanded it." Gallagher, supra, at 168. Attempted murder charges brought against the pediatrician (the initial charge was for murder) went to a jury trial. Gunn & Smith, supra, at 705. He was acquitted. The judge allowed the prosecution and defense to offer conflicting evidence as to whether Dr. Arthur administered the narcotic to quell the infant's hunger and thereby cause its death, or as a pain killer to reduce the infant's suffering. Gunn & Smith, supra, at 712 n.25. Subsequently, the judge grappled with the intent element of the charge and whether the physician's orders, a revocable act, constituted an omission for which he could be liable. Id. at 706-07. While the jury verdict provided a final disposition of the matter, it failed to tell whether a jury could grasp the legal nuances involved.

In Arizona, the parents of a child born with meningitis chose non-treatment, including the withholding of sustenance, among the options offered by the physician (unreported, noted in Robertson, Involuntary Euthanasia of Defective Newborns: A Legal Analysis, 27 STAN. L. REV. 213, 217 n.27 (1975) [hereinafter Involuntary Euthanasia]).
A. In Re B. (A Minor)

On July 28, 1981, "B." was born, afflicted with Down's syndrome, a fatally blocked intestine and possible heart trouble. Surgery could have remedied the fatal blockage, but, at the same time, might have exacerbated the heart trouble, resulting in an equally fatal condition. Either way, if she lived, severe mental retardation and physical handicaps were inevitable. With a successful operation, the Down's syndrome created a life expectancy of twenty to thirty years.

The parents made a decision to refuse consent for the operation because "nature had made its own arrangements to terminate a life that would not be fruitful and nature should not be interfered with." Doctors at the hospital reported the parents' decision to the local child care authority. The local authority made B. a ward of the court, petitioned for her care and control and asked for an order authorizing them to have the surgery performed. The trial court granted the petition, making B. a ward of the court until the age of majority (or until further order of the court) under the care and control of the local authority. The court empowered the local authority to consent to surgery, place B. for adoption and commence the adoption proceedings.

B. was moved to a different hospital where the operation was to be performed. When the surgeon spoke to B.'s parents, however, and learned of their objections, he declined to operate. The local authority brought the matter back to the trial court. The court's inquiry revealed that two other surgeons were in favor of the operation. At this point, however, the trial judge, influenced by the parents' argument, rescinded the part of the order authorizing the surgery.

That same afternoon, the local authority appealed to the Court of

The jury found that the underlying medical condition had caused the infant's death, not the parents' or physician's conduct. Thus, no criminal prosecution resulted. Id.

30. Id. at 1423.
31. Id.
32. Id.
33. Id. at 1423-24.
34. Id. at 1422.
35. Id.
36. Id.
37. Id.
38. Id. at 1422-23.
39. Id. at 1423.
40. Id.
41. Id.
42. Id. at 1422.
Appeal. The evidence that the court considered centered on the medical prognosis. Without the operation, B. would die in a matter of days. With the operation, the court considered the best and worst case scenarios. If the surgery exacerbated the heart trouble, B. might survive only two or three months. If it did not, B. could be expected to live the twenty or thirty years of an otherwise normal mongoloid.

The Court of Appeal reversed the lower court and ordered the surgery. The lower court was found to have erred because the trial judge based his decision upon the parental prerogative rather than the best interests of the child. The Court of Appeal asserted that the latter was the singularly correct issue upon which to decide the case. The parents argued that their decision not to treat was based upon the child’s best interests, for they wished to spare her from a life of perpetual medical difficulties, both mental and physical. The Court of Appeal concluded from the evidence, however, that, because the operation might be successful, and if so, B. might be no worse off than any other person afflicted with Down’s syndrome, surgery was in accordance with the newborn’s best interests.

B. Weber v. Stony Brook Hospital

The Weber case involved another little girl, protected in anonymity as Baby Jane Doe. She was born on October 11, 1983 with a combination of birth defects including spina bifida, microcephaly and hydrocephalus. At first, the parents decided to have their newborn treated surgically, and she was taken to the defendant hospital for that purpose. Subsequently, however, after consulting with medical personnel, clergy, a social worker and family members, the parents decided to forego surgery and opted instead for a medically conservative

43. Id.
44. Id. at 1423.
45. Id.
46. Id.
47. Id.
48. Id.
49. Id. at 1424.
50. Id.
51. Id. at 1423-24.
52. Id. at 1423.
53. Id. at 1424.
55. Id. at 588, 467 N.Y.S.2d at 686.
56. Id; see also J. LYON, supra note 3, at 46.
course of treatment. Rather than surgery, the plan was to treat the infant with antibiotics, a regimented diet and hygienic care. Someone on the hospital staff, however, disagreed with that decision and contacted a right-to-life attorney in Vermont by the name of A. Lawrence Washburn. Washburn filed suit in New York State Supreme Court, Suffolk County, petitioning the court for an order to compel the surgery.

The trial court heard evidence for two days, most of which concerned the infant’s prognosis. Two physicians, a pediatric neurologist and a neurosurgeon, testified in this regard. Without surgery, Baby Jane Doe would live less than two years. With surgery, she might live twenty years. Although there was some conflict between the physicians as to the minutiae of the prognosis with surgery, they agreed that severe mental and physical handicaps were certain. The neurosurgeon, who took a relatively optimistic prognostic view, testified as to whether the parents’ decision not to consent to surgery was “medically reasonable and acceptable.” He responded, “Yes sir, it is.”

The parents’ attorney asserted to the court that the parents’ decision was made with full concern for their newborn daughter’s welfare, and was based upon the “best medical advice available to them.” William E. Weber, the court-appointed guardian ad litem, made a closing argument of a single statement: “Judge, if you’re going to make a mistake in this case, make it on the side of life; that’s all I ask.” The trial judge ruled in favor of the surgery and authorized the guardian ad litem to consent thereto on behalf of the infant. The basis for his decision was that Baby Jane Doe was “in need of immediate surgical procedures to preserve her life.”

The parents entered an appeal with the Appellate Division of the

57. 95 A.D.2d at 588, 467 N.Y.S.2d at 686.
58. J. Lyon, supra note 3, at 46.
59. Id.
60. Weber v. Stony Brook Hosp., 95 A.D.2d 587, 588, 467 N.Y.S.2d 685, 686 (2d Dep’t), aff’d per curiam, 60 N.Y.2d 208, 452 N.E.2d 1186, 469 N.Y.S.2d 63 (1983); see also J. Lyon, supra note 3, at 46.
61. J. Lyon, supra note 3, at 47.
62. Id. at 47-48.
63. Id. at 47.
64. Id.
65. Id. at 47-48.
66. Id. at 48.
67. Id.
68. Id.
69. Id.
70. Id.
71. Id.
New York State Supreme Court, Second Department, that same day. Before midnight, the three-judge appellate panel stayed the trial judge's order. The next day, following a hearing, the Appellate Division reversed the lower court's decision and dismissed the petition. Upon review, the court found that the parents' decision was in the best interests of the child. Although the doctors testified that Baby Jane Doe would certainly die within two years without surgery, the court said "this is not a case where an infant is being deprived of medical treatment to achieve a quick and supposedly merciful death." The court deemed the parents' decision to be "informed, intelligent, and reasonable . . . based upon and supported by responsible medical authority." Putting it plainly, the court saw the situation as one "where the parents have chosen one course of appropriate medical treatment over another."

Now, it was the guardian ad litem's turn to appeal, this time to the highest court in the State of New York, the Court of Appeals. One week after the Appellate Division decision, the Court of Appeals affirmed the intermediate court's dismissal of the petition. The Court of Appeals did not, however, reach the merits of the case as the Appellate Division had done. Rather, the dismissal was upheld on procedural grounds, citing Washburn's failure to follow statutorily prescribed procedures which are necessary to petition the court for judicial authorization to override a parental decision.

The Court of Appeals firmly asserted that only legal means for intervention between parent and child was a "child neglect proceeding." Through the Family Court Act, specifically Article 10, the state legislature recognizes that the "primary responsibility . . . concerning the choice of medical care for [a] child" lies with the parents. There-
fore, the legislature created "explicit provision for those instances calling for governmental intervention." The statute itself states that the Act is expressly:

[D]esigned to establish procedures to help protect children from injury or mistreatment and to help safeguard their physical, mental, and emotional well-being. It is designed to provide a due process of law for determining when the state, through its family court, may intervene against the wishes of parent on behalf of a child so that his needs are properly met.

A child neglect proceeding may be originated only by a child protective agency or "a person on the court’s direction." A child protective agency "may file a petition whenever in [its] view court proceedings are warranted. All other persons and entities may only file a petition if directed to do so by the court."

The Court of Appeals steadfastly recognized and enforced the "[l]egislature’s concern that judicial proceedings touching the family relationship should not be casually initiated and impose upon the courts the obligation to exercise sound discretion before permitting such petitions to be filed."

The Court of Appeals opinion delivered scathing criticism towards Washburn for failing to contact the appropriate child protective agency. The court displayed great disdain towards the argument which would allow "any person . . . to institute judicial proceedings which would catapult him into the very heart of a family circle, there to challenge the most private and most precious responsibility vested in the parents for the care and nurture of their children . . . ."

The Court of Appeals was nearly as critical of the trial court for its failure in this regard as well:

We do not attempt to anticipate or set forth all the circumstances in which a court may be called upon to protect a child’s interests. Nor do we mean to define the extent of the court’s obligation to conduct an independent investigation or to consult with a child protective agency. There may be occasions when it is appropriate for the court to act without making fur-

84. Id. at 211, 456 N.E.2d at 1187, 469 N.Y.S.2d at 64.
85. Id. at 211-12, 456 N.E.2d at 1187, 469 N.Y.S.2d at 64 (quoting N.Y. Fam. Ct. Act § 1011 (McKinney 1983)).
86. 60 N.Y.2d at 212, 456 N.E.2d at 1187, 469 N.Y.S.2d at 64.
87. Id., 456 N.E.2d at 1187, 469 N.Y.S.2d at 64.
88. Id., 456 N.E.2d at 1187, 469 N.Y.S.2d at 64.
89. Id. at 212-13, 456 N.E.2d at 1188, 469 N.Y.S.2d at 64.
90. Id. at 213, 456 N.E.2d at 1188, 469 N.Y.S.2d at 64.
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ther inquiry of this nature. On this record, however, no such circumstances are evident.91

In closing its unanimous *per curiam* opinion, the Court of Appeals left no question as to its attitude towards the case:

There are overtones to this proceeding which we find distressing. Confronted with the anguish of the birth of a child with severe physical disorders, these parents, in consequence of judicial procedures for which there is no precedent or authority, have been subjected in the last two weeks to litigation through all three levels of our State's court system. We find no justification for resort to or entertainment of these proceedings.92

To best understand the significance of *Weber*, one should recognize that the Court of Appeals showed tacit approval of the Appellate Division's treatment of the substantive issues by affirming its decision without criticism.93 The United States District Court, Eastern District of New York, made that very point in its opinion for the federal case which arose from the *Weber* matter.94 The District Court opined that "[t]he Court of Appeals left undisturbed, and indeed apparently endorsed, the determination by the Appellate Division that the parents of Baby Jane Doe had acted reasonably and with the best interests of the child in mind."95

While the Appellate Division based its decision upon two express grounds—the parental presumption and the support of responsible medical authority,96 the Court of Appeals considered only the former in the context of the statutory protection of family privacy.97 Having reviewed the record of the case, however, the higher court did state that the circumstances did not warrant investigation by either the trial

91. *Id.*, 456 N.E.2d at 1188, 469 N.Y.S.2d at 64.
92. *Id.*, 456 N.E.2d at 1188, 469 N.Y.S.2d at 64.
94. 575 F. Supp. at 610.
95. *Id.* at 610-11 (footnote omitted) (emphasis added).
97. 60 N.Y.2d at 213, 456 N.E.2d at 1188, 469 N.Y.S.2d at 65.
court or the child protective agency to protect the child's interests. Furthermore, even though the Court of Appeals's opinion concurred that trial courts have the *parens patriae* authority to render a decision without making a further inquiry, the facts of this case did not call for an order to consent to surgery.

**C. Other Cases**

The universe of other cases involving challenges over consent for treatment of handicapped newborns totals eleven, all on the trial level of various state courts in the United States. Of these, eight resulted in orders to treat, one resulted in an order upholding the parents' decision not to treat, and two were mooted by the infants' deaths before the courts could render final decisions. One of the orders to treat was mooted by the infant's death before treatment began. The facts in some cases distinguish them from the topic cases. In *In re Cicero*, a New York State Supreme Court case, there was no conflict among the medical opinions. The doctors unanimously agreed that treatment was in order. The court agreed. The infant in the "Baby Ashley" case, heard in Idaho, was an abandoned newborn, so, obviously parents were not involved. A physician treating the infant petitioned for the removal of artificial life-support systems. Thus, there was no issue as to conflicts between the rights of parent and child. The court denied the petition.

98. *Id.* at 213, 456 N.E.2d at 1186, 469 N.Y.S.2d at 65.
99. *Id.* at 213, 456 N.E.2d at 1186, 469 N.Y.S.2d at 65.
100. See *supra* note 28 for a narrative description of these cases.
103. *In re Baby F, No. J928 (Cir. Ct., Coos County, Or., 1983); In re Teague, No. 104-212-81886 (Cir. Ct., Baltimore, Md., filed Dec. 4, 1974).
104. Maine Medical Center v. Houle.
107. *Id.*
110. *Id.*
111. *Id.*
Nevertheless, even without counting the distinguishable cases, England's Court of Appeal's B. decision, from a categorical perspective, represents the majority view, while the New York Court of Appeals's Weber decision represents the minority view.

III. The Issues

As usual with litigation where a minor's rights or welfare is involved, the B. and Weber cases turned on the determination of "the best interests of the child." \(^{112}\)

The best interests of the child doctrine requires that where a child's welfare is at stake, the court must resolve all conflicts solely on considerations of what will benefit the child. \(^{113}\) The doctrine originated in English common law, but its roots are historically vague. \(^{114}\) At early common law, parents had absolute rights of control over their chil-


113. *See, e.g.*, Finlay v Finlay, 240 N.Y. 429, 148 N.E. 624 (1925). When a non-resident of New York sued his estranged wife for custody of their children, and the custody suit was not incident to a suit for divorce or separation, Justice Cardozo wrote that the court, in equity, "does not concern itself with such disputes in their relation to the disputants." *Id.* at 433-34, 148 N.E. at 626. Instead, the court acts as parens patriae to do what is *best for the interest of the child.* [The judge] is to put himself in the position of a "wise, affectionate and careful parent," and make provision for the child accordingly. . . . He is not adjudicating a controversy between adversary parties [i.e., the parents], to compose their private differences. *Id.* at 433-34, 148 N.E. at 626 (quoting Queen v. Gyngall, [1983] 2 Q.B. 232, 238) (emphasis added); *see also* Annotation, *Action Between Parents for the Sole Purpose of Determining Custody of Child as a Proper Remedy*, 40 A.L.R. 940 (1926). *Parens patriae* is defined *infra* notes 322-24 and accompanying text.

114. R. Helfer, *supra* note 25, at 325-26; *accord, Re D. (A Minor),* [1988] 2 W.L.R. 398 (C.A.) (the English rule was evolved against a historical background of conflict between parents over the upbringing of their children).

Although the doctrine is universally accepted and employed in the Anglo-American system of jurisprudence, it has never been concretely defined, nor have guidelines as to what the child's best interests consist of ever been established. *Id.* Nevertheless, the doctrine is applied as the standard for legislative enactments and judicial resolution in matters involving child custody, abuse, neglect and generally, matters involving children's rights. For applications of the doctrine in divorce cases, see Banta, *Divorce—The Welfare and Best Interest of the Child*, 5 WILLIAMETTE L. J. 82 (1968). From a review of the applications of the doctrine, one may deduce that it behooves the court to offer a thorough and clear reasoning as to why the child's best interests are served by the decision of the court. Accordingly, some commentators assert that the court should not consider factors external to the individual child, such as those pertaining to parents, economic elements, or religion. Smith, *supra* note 14, at 1125.
With the advent of the doctrine of parens patriae, however, that right became limited by the state's role thereunder. The best interests of the child concept developed as the fulcrum upon which to balance the parental rights with the state's interests. English and American legislatures and courts have wholly embraced the doctrine.

As previously mentioned, the topic cases did not include many issues usually raised in cases where there is a conflict over the refusal of medical treatment where death would result. The issues argued in these cases are: parental rights, particularly the presumption that parents act in their child's best interests; whether the support of responsible medical authority is sufficient grounds upon which the court will find that the parents so acted; and, whether quality-of-life considerations are valid criteria to include in the decision-making process. Other issues which the courts addressed, directly or indirectly, were the extent of the authority of the court in the exercise of its equitable powers of parens patriae and the attendant issue of custody when the court considers removal of the child from the parents.

A. Presumption That Parents Act in the Child's Best Interests

One of the most powerful notions in our modern jurisprudence is the autonomy of the family unit. Parents are presumed to act in their child's best interests. The presumption is grounded in long established principles of common law. The most authoritative legal commentators on both sides of the Atlantic have asserted that the natural bonds of affection lead parents to act in the best interests of their children. Accordingly, this notion has received legislative and judicial

116. Id.
117. Id.
119. See supra notes 8-23 and accompanying text.
120. See infra notes 124-200 and accompanying text.
121. See infra notes 201-91 and accompanying text.
122. See infra notes 292-319 and accompanying text.
123. See infra notes 320-29 and accompanying text.
125. Id. at 601.
126. Id. (quoting 1 W. Blackstone, Commentaries 447; 2 J. Kent, Commentaries on American Law 190).
support in both countries.

Statutory provisions in both England and New York, contained respectively in The Children and Young Persons Act (1969) and The Family Court Act, serve to protect the parent-child relationship from unwarranted intrusion. 127 Both statutes set forth clearly delineated rules for who may initiate proceedings, the grounds upon which they may be initiated and the specific roles of the child protective agencies and courts.128

In England, those authorized to initiate proceedings are the local child protection authority (local authority), constable, or other person authorized by an order of the Secretary of State.129 No other person may bring a proceeding unless he gives notice thereof to the local authority.130 The local authority must conduct inquiries unless it decides they are not necessary.131 If an inquiry is made, a proceeding must be brought.132 The court can summons the attendance of the infant and has discretion to give the parents an opportunity to be heard.133 The statute authorizes the court to act if it determines that the infant has suffered, inter alia, neglect of health or development.134 The remedies available to the court range from a complete severing of the parent-child relationship, which includes removing the child from the parents’ custody and making the child a ward of the court, to ordering supervision of the parents by the local authority when the child remains in the parents’ care.135

New York’s Family Court Act is nearly identical in substance.136 It is expressly “designed to provide a due process of law for determining when the state, through its family court, may intervene against the wishes of a parent on behalf of a child so that his needs are properly met.”137 Only the state may initiate proceedings, through the child protective agency or “a person on the court’s direction.”138 The agency

130. Id. §§ 2, 3.
131. Id. § 2(1).
132. Id. § 2(2).
133. Id. §§ 2(4),(5).
134. Id. § 1(2).
135. Id. § 1(3).
may file a petition for proceedings at its own complete discretion.\textsuperscript{139} For any other person or entity, a petition may be filed only if the court so directs.\textsuperscript{140} When a matter is presented to the court in the latter fashion, the court can order an agency investigation.\textsuperscript{141} Thereafter, the agency must report its findings to the court, which will then determine whether a proceeding is in order.\textsuperscript{142} Thus, although the court may entertain and decide proceedings without the agency's participation, the New York legislature clearly intended for the agency to play a "significant role" therein.\textsuperscript{143}

Judicial recognition of the parental presumption is reflected in a great many opinions from a wide variety of courts and cases in both England and the United States. For example, in a recent English case, \textit{Re K.D. (A Minor)},\textsuperscript{144} Lord Templeton of the House of Lords set forth the doctrine in a most concise manner.\textsuperscript{145} The case involved termination of access for an unwed mother who had virtually refused to raise her child, placing him in long-term foster care.\textsuperscript{146} After stating that "English common-law and statute require" that the child's welfare must be "the first and paramount consideration," the court asserted the general rule that "[t]he best person to bring up a child is the natural parent . . . . Public authorities cannot improve on nature."\textsuperscript{147}

The only limitation upon the parental presumption is when the court finds that the child is neglected or abused.\textsuperscript{148} The court also cited the European Convention for the Protection of Human Rights and Fundamental Freedoms.\textsuperscript{149} The Convention, to which the United Kingdom is a party, contains provisions which protect the family unit from governmental intervention.\textsuperscript{150} The court pointed out that the juxtaposition of the English common-law rule and the Convention rule supported the principle of the parental presumption.\textsuperscript{151}

While the House of Lords recognized the vast power that Parlia-
ment had given the local authorities over minors within their jurisdictions, it cautioned that the powers "should be exercised not only with responsibility but with . . . sensitivity." The court's caveat was prompted by the infrequency of judicial review of the local authorities' activities.

A case heard in the Family Division of England's High Court of Justice, Re D. (A Minor), resulted in an opinion which reflects adherence to the parental presumption in English law. The case involved a mother and daughter, where the daughter was eleven years old and severely retarded. The mother wished to have her daughter sterilized for two reasons. First, she feared that her daughter's retardation stemmed from genetic defects which could be passed along to subsequent generations. Second, she felt the young girl would never be capable of raising a child which might be conceived intentionally, accidentally or by force. She felt her daughter might someday marry, and if so, should not risk these consequences.

The D. court also wrestled with conflicting interests and rights of parent and child, as well as the state's parens patriae role. The court held that the sterilization procedure could not be performed. Nonetheless, the court recited great deference to the parental presumption as it stood challenged by the other interests. The court stated that "[t]hough in wardship proceedings parents' rights can be suspended, the court will not do so lightly, and only in pursuance of well-known principles laid down over the years." While clearly identifying the child's best interests as the controlling element of the case, the court asserted that parents are presumed to act in accordance therewith. As to its own role, the court deferred to the mother by stating that its "jurisdiction in wardship is very wide, but there are limitations . . . to be exercised carefully and within limits." Ultimately, the court concluded on the facts that "D." had, by age eleven, improved in her mental and social development enough so that the mother's fears

152. Id.
153. Id.
155. Id.
156. Id. at 326.
157. Id.
158. Id.
159. Id.
160. Id. at 335.
161. Id. at 333.
162. Id.
163. Id. at 332.
might prove groundless.\textsuperscript{164} Furthermore, in the case of accidental pregnancy or rape, the court's opinion was that abortion was preferable to sterilization, which would run counter to D.'s right to reproduce.\textsuperscript{165} Finally, the court felt that without medical evidence that D.'s retardation stemmed from genetic defects, that reason was insufficient to sterilize the young girl.\textsuperscript{166} Having determined that the mother had made a faulty decision based upon invalid premises, the court succinctly asserted that "the judge must act as a wise parent would act."\textsuperscript{167}

In the United States, the Supreme Court, setting forth a well-developed concept of the parental presumption in the case of \textit{Parham v. J.R.},\textsuperscript{168} stated that "[o]ur jurisprudence historically has reflected Western civilization concepts of the family as a unit with broad parental authority over minor children."\textsuperscript{169} The plaintiffs in this case, minor children, challenged the Georgia mental health laws which permitted parents or guardians to consent for children to be voluntarily admitted to a mental hospital.\textsuperscript{170} A three-judge panel for the United States District Court, Middle District of Georgia, had held the state statutes unconstitutional for violation of due process.\textsuperscript{171} Chief Justice Burger wrote the majority opinion reversing the lower court, holding that the statute was constitutional but qualified by the great risk inherent in potential erroneous parental decisions as to evaluations of the children's mental conditions.\textsuperscript{172} The Court directed the state to provide inquiries by a "neutral factfinder" (such as a staff physician)\textsuperscript{173} to decide if the statutory requirements for the child's admission have been met.\textsuperscript{174} Nonetheless, the Court refused to subordinate the "parents' traditional interests in and responsibility for the upbringing of their child" by requiring a formal adversarial hearing before admission.\textsuperscript{175} At this point, the opinion recited the litany of constitutional case precedents upholding the parental presumption, including \textit{Pierce v. Society of Sisters},\textsuperscript{176} \textit{Wisconsin v. Yoder},\textsuperscript{177} \textit{Prince v. Massachusetts},\textsuperscript{178} and

\begin{itemize}
\item \textsuperscript{164} Id. at 335.
\item \textsuperscript{165} Id.
\item \textsuperscript{166} Id.
\item \textsuperscript{167} Id. at 333.
\item \textsuperscript{168} 442 U.S. 584 (1979).
\item \textsuperscript{169} Id. at 602.
\item \textsuperscript{170} Id. at 588.
\item \textsuperscript{172} Parham v. J.R., 442 U.S. 384, 602 (1978).
\item \textsuperscript{173} Id. at 606-07.
\item \textsuperscript{174} Id. at 604.
\item \textsuperscript{175} Id. at 602.
\item \textsuperscript{176} 268 U.S. 510, 535 (1925).
\item \textsuperscript{177} 406 U.S. 205, 213-14 (1972).
\end{itemize}
Meyer v. Nebraska.179 Regarding medical care or treatment, the Parham Court stated that "parents can and must make [these] judgments."180 The court record revealed that of the class of plaintiffs suing, which numbered between 140 and 200 children being treated or diagnosed daily at Georgia facilities, "there is no finding . . . of even a single instance of bad faith by any parent of any member . . . ."181 The Court distinguished the case at bar from the aforementioned precedents only insofar as the statute required an independent evaluation of each voluntary admission by each hospital's superintendent.182

The rule of law regarding the respective rights and prerogatives of the children and parents in Parham was set forth as follows: "[W]e conclude that our precedents permit the parents to retain a substantial, if not the dominant, role in the decision, absent a finding of neglect or abuse, and that the traditional presumption that the parents act in the best interests of their child should apply,"183 albeit subject to the state's role as parens patriae. The results of the case turned on the goal of the Court to find a process to protect "adequately the child's constitutional rights by reducing risks of error without unduly trenching on traditional parental authority . . . ."184 By requiring state involvement to the extent of including a "neutral factfinder" in the decision-making process, the Court said "[w]e do no more than emphasize that the decision should represent an independent judgment of what the child requires and that all sources of information that are traditionally relied on by physicians and behavioral specialists should be consulted."185 In rejecting the plaintiffs' argument for formal pre-admission hearings, the Court emphasized "the danger it poses for significant intrusion into the parent-child relationship. Pitting the parents and child as adversaries often will be at odds with the presumption that parents act in the best interests of their child."186

The Court went so far as to assert the validity of parental care over that of the state as parens patriae.187 In discussing the legal presumptions that both the state and the parents will protect the child's welfare, the Court noted that while natural affections guide the par-

179. 262 U.S. 390 (1923).
181. Id.
182. Id. at 604.
183. Id.
184. Id. at 606.
185. Id. at 608.
186. Id. at 610.
187. Id. at 618.
ents, the state's presumption stems from a specific statute. Justice Stewart, in a concurring opinion, offered a constitutional basis for the parental presumption by stating: "For centuries it has been a canon of the common law that parents speak for their minor children. So deeply imbedded in our traditions is this principle of law that the Constitution itself may compel a state to respect it."  

The Parham case represents an ever more frequently occurring contest in the law - that which pits the rights of family autonomy and parental prerogative against those of the child as an individual. The Parham Court emphatically reinforced a fundamental notion upon which much law is made: that the parents are presumed to act in their child's best interests.

One month after the Parham decision, the New York State Court of Appeals decided In re Joseph Hofbauer. Joseph was an eight year old suffering from Hodgkin's disease. His parents had him under the care of a physician who used metabolic therapy treatment for the disease. The Commissioner of Social Services of Saratoga County, where Joseph and his family resided, petitioned the Family Court, pursuant to Article 10 of the Family Court Act, alleging that Joseph's parents had neglected him in failing to follow the medical advice of one doctor rather than another. The other, more conventional treatment, included radiation and chemotherapy. The trial court, ruling in favor of the parents, "found that Joseph was not a neglected child within the meaning of section 1012 of the Family Court Act ...." Both the Appellate Division and the Court of Appeals affirmed unanimously.

In Hofbauer, the court clearly asserted the parental presumption by stating that "[i]t surely cannot be disputed that every parent has

188. Id.
189. Id. at 621 (footnote omitted) (Stewart, J., concurring). He further stated:
To be sure, the presumption that a parent is acting in the best interests of his child must be a rebuttable one, since certainly not all parents are actuated by the unselfish motive the law presumes. Some parents are simply unfit parents. But Georgia clearly provides that an unfit parent can be stripped of his parental authority under laws dealing with neglect and abuse of children.

Id. at 624 (footnote omitted).
191. 47 N.Y.2d at 652, 393 N.E.2d at 1011, 419 N.Y.S.2d at 938.
192. Id. at 652, 393 N.E.2d at 1011, 419 N.Y.S.2d at 938. The metabolic treatment included nutritional therapy and injections of laetrile. Id.
193. Id. at 652-53, 393 N.E.2d at 1012, 419 N.Y.S.2d at 938.
194. Id. at 653, 393 N.E.2d at 1012, 419 N.Y.S.2d at 939.
195. Id. at 654, 393 N.E.2d at 1012, 419 N.Y.S.2d at 939.
196. Id., 393 N.E.2d at 1012-13, 419 N.Y.S.2d at 939.
the fundamental right to rear its child."197 The predictable qualification followed, that when the parents fail in their duty towards their child the state will intervene.198 Nonetheless, and equally predictable, the court further qualified that "great deference must be accorded a parent's choice as to the mode of medical treatment to be undertaken and the physician selected to administer the same... "The filial bond is one of the strongest, yet most delicate, and most inviolable of all relationships.'"199 Since the record "disclose[d] that Joseph's mother and father were concerned and loving parents who sought qualified medical assistance for their child," the court upheld the parents' right to choose which medical treatment Joseph should receive.200

Thus, the paramount issue of contest in B. and Weber, i.e. the conflict between rights of parental authority and the child's rights as an individual, must be viewed from the perspective which accounts for the parental presumption. Both jurisdictions, England and New York, protect the family unit autonomy by clear directives which prevent officious intervention. The courts rigorously enforce the legislative directive and are prone to state their deference to the parental presumption. In the opinions reviewed supra, and many others, the courts recite the procedural steps which the parties must take to be in accordance with the presumption of parental authority. The general rule follows that only when the court can determine on the facts, almost invariably including an investigation by child protective authorities, that the child suffers from neglect as defined by statute and the parents are not acting in the child's best interests, will an order result to overrule the parents' decision. Otherwise, the proceedings are usually dismissed.

B. Support of Responsible Medical Authority

A second notion figuring prominently in cases litigating choices of medical treatment for handicapped newborns is the support of responsible medical authority.201 It has validity as a doctrine of presumption itself while also providing support to the parental presumption when medical treatment choices are at issue.

Traditionally, the law reposes substantial confidence in the physi-

197. Id. at 655, 393 N.E.2d at 1013, 419 N.Y.S.2d at 940 (citations omitted).
198. Id.
cian's role in the choice of treatment decision-making process. A wide variety of statutes in England and the United States require physicians' participation in the procedural aspects of laws which pertain to the health of citizens. Some English statutes which evince the presumption in favor of support of responsible medical authority are the Infant Life (Preservation) Act 1929 and the Abortion Act 1967. In the United States, examples of the same are the New York Mental Hygiene Law, the New York Public Health Law, the Mississippi Public Health Act, and the Rhode Island Mental Health Law.

Whenever the demands of the legal system include medical matters, the state calls upon the physicians it has duly licensed. The presumption in favor of the support of responsible medical authority may be said to derive from the state's authority to issue and regulate medical professional licensing. Once the state has determined that a medical professional is qualified, it presumes that his medical judgment may be relied upon.

The state uses medical professionals as well to assure that the state's parens patriae power operates in the child's best interests. In New York, there is a particularly striking example of the presumption in favor of the support of responsible medical authority in conjunction with the resolution of an infant's claim for personal injuries. Article 12 of the New York Civil Procedure Law and Rules (CPLR) dictates in section 1201, that, unless the court appoints a guardian ad litem, an infant's claim or action must be brought under the representation of the guardian of the infant's property, a parent having legal custody, or another person having legal custody, in that order. If none of the latter representatives are available, the court must appoint a guardian ad litem.

In order to settle the infant's claim or action, the statute requires

202. The Infant Life (Preservation) Act, 1929, 19 & 20 Geo. 5, ch. 34.
207. R.I. GEN. LAWS § 40.1-5-7 (1988).
210. Id.
211. Id.
that the court conduct an infant’s compromise hearing. The infant’s representative must bring a motion for settlement. If no action has been commenced, the representative may petition for a special proceeding in any court in which an action could have been commenced. An order issued by the court has the effect of a judgment.

CPLR Rule 1208 sets forth the settlement procedure. Subsection (c) requires that the infant’s attorney submit, inter alia, a medical or hospital report in the personal injury claim. The court will settle an infant’s claim when, under the circumstances, such settlement is in the infant’s best interests. A settlement is usually in order when there are questions as to the extent of the defendant’s liability or when the infant is not seriously injured. Accordingly, one of the court’s primary foci of the hearing is the extent of the infant’s injury and recovery therefrom.

The New York State Supreme Court has construed the requirement for a medical or hospital report in Rule 1208 to include an affirmation from a duly licensed physician as to the date of the child’s last physical examination and the extent to which the child has recovered from his injuries. This requirement results from the court’s concern that if the infant’s claim or action is settled, the infant’s right to sue the defendant is terminated. Thus, it is the responsibility of the in-

212. Id. 1207.
213. Id.
214. Id.
215. Id.
216. Id. 1208 (Sections and Rules carry equal weight of authority).
217. Id.
218. Id; see Naujokas v. H. Frank Carey High School, 57 Misc. 2d 175, 292 N.Y.S.2d 196 (Sup. Ct. 1968).
219. The author, while a legal assistant at the law offices of Richard J. Cardali, 233 Broadway, New York, New York, assisted in the preparation of papers for over fifty infant’s compromises during 1986-87, and attended several of the hearings. The New York State Supreme Courts in which the proceedings were brought included those in the counties of Bronx, New York, Kings, Nassau, Queens, Richmond, Rockland, Suffolk and Westchester. These courts construe the statutory sections pertaining to infant compromises very strictly, establishing a demanding standard that the infant’s attorney must meet in order to compromise the infant’s claim. The following discussion reflects experience acquired in dealing with the standards of exactitude that these courts demanded in these proceedings. See infra Appendix A: Rules Promulgated by the New York State Supreme Court, Queens County, Pertaining to Infant’s Compromises on file at N.Y.L. Sch. J. Int’l & Comp. L. [hereinafter Infant’s Compromise Rules].
220. See Physician’s Affirmation: Infant’s Compromise: Blank Court, (Form T 359) available from Julius Blumberg, Inc., Law Blank Publishers [hereinafter Physicians’ Affirmation Form]. Julius Blumberg, Inc. publishes a wide variety of blank legal forms used extensively throughout the State of New York by legal practitioners.
fant's attorney to demonstrate to the court that questions as to the defendant's liability or relative absence of seriousness as to extent of injury would result in a strong probability that the infant would receive a jury verdict equal to or less than the settlement offer.

The physician's affirmation provides the court with the basis upon which to make its finding of facts regarding the extent of and recovery from the injuries. The physician's affirmation gives rise to a rebuttable presumption that the infant has, indeed, recovered from the injuries. The judge will also visually examine the infant's injuries at the hearing, and question the infant and his representatives about injuries. If the judicial inquiries reveal information that contradicts the contents of the physician's affirmation, the presumption of the physician's medical authority is rebutted.

The court has the responsibility to order a settlement only when the appropriate circumstances exist. This occurs only when a settlement is in the child's best interests. The child's best interests are served when the offer for settlement represents the best damages recovery that the infant can reasonably expect to obtain. Thus, the court presumes that the support of responsible medical authority provides one of the bases upon which it may render a decision regarding the child's best interests.

In England, judicial attention to the presumption of support of responsible medical authority is taken in the case of *C v. S*, which was heard in the Queen's Bench Division. The case involved a contest between an unwed mother and father over an abortion. The case required the court to construe the effects of the Abortion Act 1967 (Act), and specifically, the necessity of obtaining medical certificates and the effect thereof.

Section 1 (I) of the Act requires the mother to obtain medical certification “that the continuance of her pregnancy would involve risk of injury to her physical or mental health greater than if the pregnancy

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222. *Id. See, e.g., Physicians' Affirmation Form, supra note 220.*
223. *See generally supra note 219 and accompanying text.*
224. *Id.*
226. *Id.; see supra note 219.*
228. *Id. See, e.g., Infant's Compromise Rules, supra note 219.*
231. *Id. at 1230.*
232. *Id. at 1233-34.*
were terminated. The statute requires that two physicians so certify. The presumption in favor of the support of responsible medical authority for the performance of a medical procedure is obvious here. If the termination of the pregnancy does not meet the statutory standard, the parties to the procedure have committed a penal offense under section 5 (2). The threshold qualification for contemplation of the procedure is the medical certification. The challenge in the case at bar, made by the father, was that since the child might be born alive via the abortion, the mother was in violation of the statute. A conflict of medical opinions existed because the father offered the testimony of another doctor that the procedure would violate the statute.

The court ruled in favor of the mother, dismissing the father's application and allowing the abortion. Based on the facts of the case, the court discounted the testimony of the physician brought in by the father. The court noted that physician's testimony was "unsupported by any other evidence or examination ... [and] not accepted by a wide body of eminent medical opinion and by many reputable doctors." Thus, the testimony of the father's physician failed to rebut the presumption of responsible medical authority of the mother's treating physician.

Some cases discussed in the previous section also exemplify judicial attention to the presumption. For example, the English Re D. opinion reflects both recognition of the presumption as well as the limitations thereon. The Family Division court accepted that the physician's recommended course of treatment was valid unless proven unwarranted by all the circumstances surrounding the case as regards the child's best interests. The court treated, as presumptively correct, the medical alternatives offered by the physician to the mother, plac-
ing the burden on the government to prove otherwise.\textsuperscript{245}

The government succeeded in doing so.\textsuperscript{246} Although this case represents the defeat of one doctor's opinion, and therefore, the limitations of the doctrine, it nevertheless also illustrates the doctrine's strength. The support of responsible medical authority required the government to mount not only a legal inquiry as to the child's best interests, but a medical one as well.\textsuperscript{247} The mother's parental prerogative could be defeated only if that support could be proven invalid.\textsuperscript{248} The only way the support could be proven invalid was to establish that the treatment was factually and medically unwarranted.\textsuperscript{249} The strength of the doctrine is seen, therefore, by the demanding burden put upon the challenger who seeks to dispute the physician's professional judgment.

\textit{Parham v. J.R.} shows acceptance of the presumption in United States case law.\textsuperscript{250} The United States Supreme Court upheld as constitutional a Georgia statute allowing voluntary admission of minors to state mental hospitals when the child's natural parents request their admission.\textsuperscript{251} The linchpin of the Court's reasoning was based upon the presumption of support of responsible medical authority for the admission. First, the statute gave responsibility for temporarily admitting minors upon parental request to the hospital supervisors.\textsuperscript{252} For final admission, however, further medical authority was required since the supervisors were not always physicians. The Court concluded that adding a requirement that a staff physician determine whether the statutory standard for admission was met, was a sufficient basis upon which to hold the statute constitutional in the face of the risk of parental error in deciding to request the admission.\textsuperscript{253} That risk jeopardized the constitutionality of the statute because the child's rights required protection.\textsuperscript{254} Other concerns of the Court were to avoid infringement upon the parental authority, promote the interests of both the state and patients that benefit from voluntary admissions, and assure that the law was in accordance with the demands of due process.\textsuperscript{255} The Court relied upon its confidence in licensed physicians to keep the con-

\textsuperscript{245} Id.
\textsuperscript{246} Id.
\textsuperscript{247} Id. at 1239.
\textsuperscript{248} Id. at 1240.
\textsuperscript{249} Id. at 1241.
\textsuperscript{251} Id. at 616.
\textsuperscript{252} Id. at 591.
\textsuperscript{253} Id. at 607.
\textsuperscript{254} Id.
\textsuperscript{255} Id.
stitutionality of the statute intact.\textsuperscript{256} The Court directed that an inquiry process by a "neutral factfinder" should include an inquiry into the child's background, an interview with the child, authority to refuse admission and periodic review of the child's continuing need for commitment.\textsuperscript{257}

As to who the neutral factfinder should be, the Court stated that "[t]he mode and procedure of medical diagnostic procedures is not the business of judges. What is best for a child is an individual medical decision that must be left to the judgment of physicians in each case."\textsuperscript{258} The Court asserted that although the judgment of medical professionals is not inviolate and unreviewable, the presumption is nevertheless strong.\textsuperscript{259} Furthermore, while the Court conceded that medical diagnosis is fallible and by no means error free, it found no solution in "shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing."\textsuperscript{260} Rather, the Court adhered to the presumption by stating that "[i]n general, we are satisfied that an independent medical decision making process . . . will protect [the] children . . . ."\textsuperscript{261} Linking together this presumption with the best interests of the child doctrine, the Court noted that, in medical situations, the judgment of physicians is best for the children.\textsuperscript{262} Even the powerful force of constitutional due process "cannot be divorced from the nature of the ultimate decision that is being made."\textsuperscript{263} When the questions are essentially medical in character, the Court deferred to the traditional reliance upon medical professionals rather than the "procedural tools of judicial or administrative decision-making."\textsuperscript{264} The Court realized that trained medical professionals will surely have more skill in evaluating medical situations than a layman or legally trained factfinder.\textsuperscript{265} The rare exception of risk of error was not found to contravene procedural due process rules when applied to the generality of cases.\textsuperscript{266} Due process does not require that the neutral factfinder be a judge or administrative officer.\textsuperscript{267} The Court implied

\begin{itemize}
\item \textsuperscript{256} Id. at 607-08.
\item \textsuperscript{257} Id. at 606-07.
\item \textsuperscript{258} Id. at 607-08.
\item \textsuperscript{259} Id. at 609.
\item \textsuperscript{260} Id.
\item \textsuperscript{261} Id. at 613.
\item \textsuperscript{262} Id. at 608.
\item \textsuperscript{263} Id.
\item \textsuperscript{264} Id. at 611-12.
\item \textsuperscript{265} Id. at 612.
\item \textsuperscript{266} Id. at 615 (citing Mathews v. Eldridge, 424 U.S. 319, 344 (1976)).
\item \textsuperscript{267} Parham v. J.R., 442 U.S. 584, 618 (1978).
\end{itemize}
that unless the medical professional is deemed incompetent or oblivious or indifferent to the child's welfare, his opinion is to be presumed valid.\textsuperscript{268} For the case at bar, the Court recognized that commitment.\textsuperscript{269}

The \textit{Parham} Court noted that state statutes set the standard under which the determinations are made as to whether a child is abused or neglected.\textsuperscript{270} In the analysis of the relationship between medical professionals and the legal system, \textit{Parham} states that a trial court, rather than the physician, determines whether the facts of a given case meet the statutory standard.\textsuperscript{271} It is the physician, however, upon whom the court should appropriately rely to establish the medical facts.\textsuperscript{272} This reliance gives rise to the presumption that a court acts appropriately when it makes its decision based upon responsible medical authority. Furthermore, this support acts as a back-up to the parental authority by providing a juxtaposition of medical analysis with the parental decision.\textsuperscript{273} The physician is seen as a buffer in a potential conflict between the rights of parent and child.\textsuperscript{274} The Court also stated that the state is correct to rely upon the physician's evaluation in order to pursue its interests.\textsuperscript{275} Finally, the presumption that the physician will act in the child's best medical interests is inherent in the patient-physician relationship.\textsuperscript{276}

In \textit{Hofbauer}, the effect of support of responsible medical authority was a prominent issue.\textsuperscript{277} The trial court had to decide whether one physician's unconventional treatment of Hodgkin's disease was as valid as the conventional course of treatment.\textsuperscript{278} It determined that the alternative form of treatment was valid because it was viable, and therefore the child was not neglected within the statutory meaning.\textsuperscript{279} The New York Court of Appeals narrowed its inquiry to the legal issues, having found that the evidence presented in trial court supported that court's findings of fact.\textsuperscript{280} The issue addressed was whether the parents had neglected their child because they had placed him under the care

\begin{itemize}
\item \textsuperscript{268} \textit{Id.} at 604.
\item \textsuperscript{269} \textit{Id.} at 618.
\item \textsuperscript{270} \textit{Id.} at 604.
\item \textsuperscript{271} \textit{Id.} at 618.
\item \textsuperscript{272} \textit{Id.}
\item \textsuperscript{273} \textit{Id.} at 607.
\item \textsuperscript{274} \textit{Id.} at 610.
\item \textsuperscript{275} \textit{Id.} at 618.
\item \textsuperscript{276} \textit{Id.} at 609.
\item \textsuperscript{277} \textit{In re Hofbauer}, 47 N.Y.2d 648, 652, 393 N.E.2d 1009, 1011, 419 N.Y.S.2d 936, 938 (1979), aff'g 65 A.D.2d 108, 411 N.Y.S.2d 416 (3d Dep't 1978).
\item \textsuperscript{278} \textit{Id.} at 553, 393 N.E.2d at 1012, 419 N.Y.S.2d at 939.
\item \textsuperscript{279} \textit{Id.} at 654, 393 N.E.2d at 1012, 419 N.Y.S.2d at 939.
\item \textsuperscript{280} \textit{Id.}, 393 N.E.2d at 1013, 419 N.Y.S.2d at 939.
\end{itemize}
of a physician who practiced metabolic therapy, especially after having received the advice of physicians who advocated conventional treatment.  

The parents’ decision was challenged by the child care agency as inadequate and ineffective. The Court of Appeals affirmed the dismissal of the challenge based upon the findings of the court below that the physician was performing responsibly. The Court of Appeals was “unable to conclude, as a matter of law, that Joseph’s parents [had] not undertaken reasonable efforts to ensure that acceptable medical treatment [was] being provided [to] their child.”

Most often, in cases of this nature, courts will be called upon to resolve a “conflict in medical opinion.” When two or more qualified physicians advocate different courses of treatment, both enjoy the presumption of responsible medical authority. Absent a showing that the prescribed course of treatment is wholly unacceptable to the medical profession, the courts usually defer to the physician’s expertise.

The courts will often inquire as to whether there is any measure of acceptance within the medical profession as a whole regarding a given course of treatment. Mere unorthodoxy or lack of convention does not render a specific treatment invalid. When the measure of acceptance is demonstrated, the only remaining inquiry is whether it is warranted for the patient’s condition.
sue of whether quality-of-life is an appropriate criterion for decision-making.\footnote{291}{See infra notes 292-319 and accompanying text.}

C. Quality-of-Life Considerations

Perhaps the most controversial aspect of the decision-making process is whether to consider the infant’s projected quality-of-life. Modern medical technology throws the timeless value of the sanctity of life and the attendant goals to relieve human suffering in conflict with life-prolongation which may now entail considerable suffering.\footnote{292}{D. Crane, \textit{The Sanctity of Social Life: Physicians’ Treatment of Critically Ill Patient} 7 (1975).}


One commentator’s “principle of sanctity of life” argument advocates treatment despite the extent of deformity.\footnote{295}{Shils, \textit{supra} note 294, at 30.}

Another commentator’s argument is based upon “salvageability,” that any reasonable hope of saving life demands treatment, without regard to whether it can prolong life or not, nor whether it ultimately benefits the patient’s medical condition.\footnote{296}{Ethics, \textit{supra} note 294, at 203.}

The same commentator later wrote that the risk of erroneous diagnosis as to the newborn’s potential development obviates the use of quality-of-life in the decision-making process.\footnote{297}{Involuntary Euthanasia, \textit{supra} note 28, at 254-55.}

A third commentator’s argument is that determinations based on quality-of-life considerations are subjective in nature and create a “slippery slope” dilemma.\footnote{298}{See \textit{Ethics}, \textit{supra} note 294, at 254-55. The “slippery slope” dilemma envisioned by these commentators is that subjective quality-of-life considerations could lead to decisions not to treat handicapped newborns who have such relatively trivial birth defects as missing fingers or slight mental retardation. Furthermore, they would not rely upon any given set of parents’ or physicians’ decisions whether to treat, but rather prefer legally mandated guidelines. \textit{Id.}}
or cultural factors would dictate treatment decision-making. The arguments opposed to the use of quality-of-life considerations share as common ground that life should be preserved without regard for the constitution of that life, and that there should be universal mandatory treatment.

Other United States courts, however, relied on quality-of-life criteria to decide whether to order treatment for handicapped newborns. In In re Cicero, the New York State Supreme Court, Bronx County, looked to whether the "child has a reasonable chance to live a useful, fulfilled life." Likewise, the Indiana Circuit Court, Monroe County, found that "the value of parental autonomy outweighed the infant's right to life where minimally adequate quality-of-life was non-existent." Even the United States Supreme Court made such an indication in its opinion in the landmark case of Roe v. Wade. Justice Blackmun refers to a fetus's capability for "meaningful life" outside the mother's womb.

This position finds support among commentators as well. One commentator considers the infant's quality-of-life as it will affect both the infant and the infant's family. When faced with "an existence of misery and suffering both for [the infants] and for their families . . . we are not justified in prolonging the lives of these infants." The same commentator also considers the amount of additional life which the treatment will provide. The thrust of that argument is that the parents' hopes will be raised for a short while (one year to eighteen months) only to be dashed again. This commentator's concern is that the child and its parents will face the agonies of loss during the original decision-making period and then again when the child's health fails later on. He asks if "anything [has] been gained by subjecting

299. Id.
300. See sources cited supra note 294.
301. See, e.g., In re Infant Doe, No. GU8204-004 A (Monroe Co. Cir. Ct., filed Apr. 12, 1982); see also In re Cicero, 101 Misc. 2d 699, 421 N.Y.S.2d 965 (Bx. Co. Sup. Ct. 1979).
302. 101 Misc. 2d at 699, 421 N.Y.S.2d at 965.
303. Id. at 702, 421 N.Y.S.2d at 968.
304. Letter from Judge John Baker of Monroe Co. Cir. Ct. to anonymous person (June 8, 1983) (discussing In re Infant Doe), quoted in Withholding Treatment from Infants, supra note 28, at 235-36.
305. 410 U.S. 113 (1973).
306. Id. at 163.
307. Bucy, 8 CLINICAL NEUROSURGERY 64 (1960).
308. Id. at 65.
309. Id. at 67-68.
310. Id. at 68.
311. Id.
these parents to the same dreaded fire twice?"  

A pediatric neurosurgeon, commenting on quality-of-life considerations in an interview, stated that he would respect parents' wishes not to treat complicated cardiac and intestinal problems with surgery in cases of infants with Down's syndrome. He bases this decision upon the absence of a likelihood that the child will achieve sufficient participation in the life of his family. Another commentator likewise has argued that infants' awareness or consciousness of life are factors to be considered in decision-making. Other commentators advocating the use of quality-of-life considerations in treatment decision-making base their arguments on cultural and legal norms and values.

A very subtle point pertaining to quality-of-life considerations which distinguishes the cases of newborns from those of older children is the availability of a reliable prognosis. Medical prognosis is less reliable the earlier in life it is made. This exacerbates the problem of whether quality-of-life considerations should enter the decision-making process. When older children are victims of life-threatening maladies, prognoses may be developed more completely. This can be attributed to such factors as the relatively greater medical stability of the older person, more time in which to arrive at the prognosis, the exis-

312. Id.
314. Id.
317. For examples of cases involving older children, see In re L.H.R., 253 Ga. 439, 321 S.E.2d 716 (1984); In re P.V.W., 424 So. 2d 1015 (La. 1982); In re Hofbauer, 47 N.Y.2d 648, 393 N.E.2d 1009, 419 N.Y.S.2d 936 (1979), aff'd 65 A.D.2d 108, 411 N.Y.S.2d 416 (3d Dep't 1978); In re Guardianship of Barry, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984). Although jurisdictions differ in their decisions in cases of older infants as well, a reading and comparison of those cases with newborn cases reveals the difference that a more reliable prognosis makes. One may query whether, as between older infants on the one hand, and fetuses on the other hand, which may be terminated at the mother's unilateral prerogative during the first two trimesters, newborns are treated as a special class to whom unique legal reasonings are applied.

318. J. Lyon, supra note 3, at 111.
319. Id.
tence of a verbally responsive patient, the capability of the patient to withstand more extensive diagnostic procedures and the corresponding ability of medical professionals to apply such procedures. Furthermore, newborns' birth defects often present more challenging and complex prognostic difficulties than the relatively more familiar medical problems encountered by older children.

Even if one accepts the use of quality-of-life considerations, the call is usually for unequivocal prognoses that will make the use of quality-of-life considerations determinative as to treatment decisions. Relatively reliable prognoses are not often available. Although paralysis, retardation or other disabling conditions may be clearly indicated, the extent of their harm or how far they may progress is often not.

D. Parens Patriae Authority

Common law provides the basis of parens patriae authority in the Anglo-American system of jurisprudence. Innumerable cases and statutes have relied upon and reinforced that authority to the point where it provides a main root to the power of government in western society.

Parens patriae, literally "parent of the country," originally applied to the prerogative of the King of England as sovereign. In the United States, the prerogatives devolve to the states, and are attributes contributing to the notion of internal sovereignty enjoyed by the states. The most literal dimension of parens patriae power is seen when the state assumes parental authority and duty towards a minor deprived of natural or legal parental care. Furthermore, under the
doctrine, the state has a duty to ensure "that every child within its borders receives proper care and treatment." Thus, the state's authority over children exceeds its corresponding authority over adults.

The doctrine inheres enormous power in the state, which has an obligation to exercise this power cautiously, reasonably and only with just cause. Constitutionally based parental rights act as a check on the state's parens patriae power. Yet, because the function of the state as parens patriae is so important, constitutional limitations should be construed so as not to interfere with the legitimate exercise thereof.

IV. Analysis of the Topic Cases

A. Presumption that Parents Act in Their Child's Best Interests and Parens Patriae

1. In Re B.

The Court of Appeal, in B., acknowledged the parental presumption by stating that "great weight ought to be given to the views of the parents," and, "due weight must be given to the decision of the parents which everybody accepts was an entirely responsible one, doing what they considered best . . . ." Yet, the B. court rebutted that presumption without further investigation, without invalidating the responsible medical authority supporting the parents' decision, and against the findings of fact of the lower court. The Court of Appeal reversed the lower court, holding the trial judge in error for respecting the wishes of the parents and allowing their wishes to affect his reasoning. The Court of Appeal also held that the trial judge erred by failing in his duty to reach his decision based upon the best interests of the child.

The record showed, however, that the parents' decision was so

326. Id.
327. Id.
328. Id.
329. Id.
331. Id. at 1424 (Dunn, J.).
332. Id. at 1422-24.
333. Id. at 1424 (Dunn, J.).
334. Id.
founded, that "they genuinely believed that it was in the best interests of their child." The parents asserted that the child's interests motivated their decision, and not the difficulties that raising the child presented to them. The Court of Appeal's opinion characterizes the parents as "caring . . . [and] entirely responsible."

The trial court had followed the statutory procedure for removal of B. from her parents' custody. While the trial judge revoked the portion of his order authorizing the surgery, his order giving care and control of the child to the local authority and authorization for the local authority to place the child for adoption and begin the adoption proceedings remained intact. The Court of Appeal reinstated the revoked portion of the order. The severing of the parent-child relationship and overriding of the parents' decision as to the medical treatment was complete.

Apparently, the Court of Appeal's only basis for rebutting the parents' decision was that they could not make a responsible decision due to the great shock of giving birth to a mongoloid child. At first, the court, indicating the sincerity of the parents' decision, characterized it as "agonizing" and made "with great sorrow." The court then cites that same emotional trauma as the basis on which to override their decision. The court reasoned that the parents' decision was faulty because their anguish invalidated their decision-making capabilities. In arriving at its own decision, the Court of Appeal found the case "difficult" and "very poignantly sad." Nevertheless, the court took away the most cherished of parental responsibilities, the care and custody of their child. The Court of Appeal's opinion reflects neither a thorough investigation nor a clearly reasoned foundation upon which to justify a usurpation of the parents' prerogative.

The Court of Appeal expressed no basis upon which to negate the trial court's finding of fact that the parents had made the decision in the child's best interests. The local authority conceded that same

335. Id. at 1422.
336. Id. at 1423.
337. Id. at 1422-24.
338. Id. at 1422.
339. Id.
340. Id. at 1424.
341. Id. at 1422.
342. Id. at 1424 (Dunn, J.).
343. Id. at 1422.
344. Id.
345. Id.
346. Id. at 1424.
347. Id. at 1422.
The Court of Appeal cited none of the "well-known principles" necessary to suspend the parental right to decide medical treatment for their child. The court dismissed the oft-cited parental presumption, which has been characterized as the best natural protection for children, reinforced by statute and judicial precedent, on no more a sound basis than that the parents were upset over their dilemma.

The Court of Appeal's decision represents less than a careful exercise of its wide parens patriae power against parental autonomy and a disregard for the presumption that parents act in their child's best interests. By failing to develop a sound reasoning for overriding the parental presumption, the Court of Appeal is open to the same criticism it made of the parents; namely, that the difficulty of the situation, the sadness and anguish involved, and the personal preferences of the justices influenced the court's decision.

2. Weber

In the Weber case, the Court of Appeals rendered its decision entirely upon the statutory reflection of a parental presumption which was under attack by a stranger to the family. The court did, however, note the effects of the record below. In the trial court, the controversy centered on the infant's prognosis, disregarding both the parental presumption and the responsible medical authority supporting the parents' decision.

The Appellate Division felt the need to justify the parents' choice between treatment options, and thus concentrated on the support of responsible medical authority. The intermediate court also cited constitutional precedent, statutory authority, and the equitable parens patriae power of the court. That court did not emphasize the parental presumption, but noted in its conclusion that the parents were "concerned and loving" and acted in the "best interest of the infant."

348. Id. at 1423.
349. The "well-known principles" are those referred to in Re D. (A Minor), [1976] 1 All E.R. 326 (Fam. 1975).
351. Id. at 213, 456 N.E.2d at 1188, 469 N.Y.S.2d at 65.
352. Id. at 211, 456 N.E.2d at 1187, 469 N.Y.S.2d at 64.
354. Id. at 588, 467 N.Y.S.2d at 686.
355. Id. at 589, 467 N.Y.S.2d at 687.
The New York Court of Appeals was utterly emphatic regarding the parental presumption. Indeed, that court's entire opinion rested upon the failure of the trial court to follow the statutorily prescribed provisions for governmental intervention into such cases:

The requirement for court approval or authorization for proceedings prompted by those other than child protective agencies indicates the Legislature's concern that judicial proceedings touching the family relationship should not be casually initiated and imposes upon the courts the obligation to exercise sound discretion before permitting such petitions to be filed."

Because the petitioner had failed "to follow the statutory scheme contemplated ... for the protection of children" the court would not permit him to "catapult ... into the very heart of a family circle, there to challenge the most private and precious responsibility vested in the parents for the care and nurture of their children." The court showed distinct disdain for the "unusual, and sometimes offensive, activities and proceedings ... sought ... to displace parental responsibility for and management of [Baby Jane Doe's] medical care." The fundamental legislative principles of the statutory scheme were sufficient grounds to uphold the Appellate Division's dismissal of the case.

The Court of Appeals was so offended by the unwarranted, blatant intrusion into the family's privacy that it did not even entertain the medical merits of the case. The court ruled that no private person could challenge the parental presumption. Only through the statutory scheme could the parents and physicians be called upon "to appear in court and justify their actions." Its opinion stands as a tribute to the notion of parental presumption and the standard that proceedings of this type must be handled by the child protective agencies.

The Court of Appeals rejected consideration of every other element of the case except the legislatively recognized parental presumption. Most appropriately, the Court of Appeals placed the state's re-

357. Id. at 213, 456 N.E.2d at 1188, 469 N.Y.S.2d at 65.
358. Id. at 211, 456 N.E.2d at 1187, 469 N.Y.S.2d at 64.
359. Id. at 211-13, 456 N.E.2d at 1187-88, 469 N.Y.S.2d at 64-65.
360. Id. at 213, 456 N.E.2d at 1188, 469 N.Y.S.2d at 65.
361. Id. at 211-12, 456 N.E.2d at 1187, 469 N.Y.S.2d at 64; see also J. Lyon, supra note 3, at 50-51.
sponsibility to intervene between parent and child squarely upon only those who have the expertise to deal with such matters; namely, the child protective agencies. The Court of Appeals did not even scratch the surface of the case beyond that consideration.

Furthermore, it is important to note that the court did not remand the case for such an investigation. Presumably, by the time the case reached that level, the appropriate agencies were aware of the case and could act accordingly. There is no indication, on or off the record, that an investigation was deemed necessary by those agencies. Since the entire record was before the court, one must presume that the Court of Appeals made its decision based upon the best interests of the child. If the court had felt that the treatment decision was wrong, or that further investigation was necessary, it surely would have ruled differently. Thus, the approval of the Appellate Division's ruling on the merits, as well as the parent's decision not to consent to surgery, is found in the Court of Appeals's decision not to rule on these issues.

B. Support of Responsible Medical Authority

1. In Re B.

It is difficult to understand how a court would supplant the medical authority of a responsible physician without relying on conclusive medical evidence to the contrary, but the Court of Appeal did so. The court merely identified a "difference of medical opinion ..." The doctor who refused to perform the surgery, testified: "I decided therefore to respect the wishes of the parents and not perform the operation, a decision which would, I believe (after about 20 years in the medical profession), be taken by the great majority of surgeons faced with a similar situation." Two other surgeons "advised that the operation should be carried out." The trial court had ruled in favor of the parents based on the support of responsible medical authority.

The Court of Appeal, in reversing the lower court, rejected the widely recognized parental presumption with the unsupported statement that "the decision no longer lies with the parents or the doctors, but lies with the court." In its reasoning, the discretion of the par-

363. Id. at 212, 456 N.E.2d at 1187, 469 N.Y.S.2d at 65.
364. Id.
365. Id. at 213, 456 N.E.2d at 1188, 469 N.Y.S.2d at 65.
366. Id.
368. Id.
369. Id.
370. Id. at 1424.
ents and supporting physician were considered merely as "evidence and views," then summarily rejected. The trial court's reliance upon the professional opinion of the surgeon respecting the parents' decision was held as error.

This is not to say that parents' decisions are inviolable. For example, there have been cases, such as *In re Cicero*, where the parents' decision was entirely opposite to all medical authority, and was, therefore, overruled. The *Cicero* court stated that "[p]arental rights . . . are not absolute," and aptly concluded that "[c]ertainly every physician who prefers a course of treatment rejected by a parent is not privileged to have the court decide upon the treatment under its *parens patriae* powers." A conflict existed between the parents and the baby's best interests based on the physician's prognosis. In the *Cicero* case, the medical opinions were unanimous that surgery was the most desirable course of treatment.

What is disturbing in the English court's decision is that the fate of the child and her family was decided upon an academic application of lofty moralistic notions, rather than the realistic human concerns of those involved. The presumption that physicians make their recommendations responsibly is valid. Without reference to any competent review of the medical opinions, the court turned away from the well-established precepts of parental and medical authority.

The *B.* court's ruling on the best interests of the child contravened the stated position of a responsible medical authority. The court itself termed the result as "brutal."

The court found that the parents' decision was "entirely responsible" but stated that it could not "hide behind the decision of the parent or the decision of the doctors." Even though the "court's first and paramount consideration is the welfare of this unhappy little baby," the court made its decision against the parental presumption, against the support thereof of responsible medical authority, and against the ruling of the lower court, ostensibly the most competent finder of fact.

371. Id.
372. Id.
374. Id. at 702, 421 N.Y.S.2d at 968 (citations omitted).
375. Rosenzweig Interview, supra note 28.
376. Id.
378. Id. at 1424 (Dunn, J.).
379. Id.
2. Weber

Although the New York Court of Appeals affirmed the Appellate Division decision on procedural, rather than substantive grounds, it tacitly approved the Appellate Division’s reasoning and disposition of the case on its merits. Since the Appellate Division was the only court in Weber to directly address this issue, and since its opinion received tacit approval from the Court of Appeals, this portion of the analysis will concentrate on the intermediate court’s decision.

The decision of the Appellate Division to uphold the parents’ right to decide stands on two grounds. The first is a genuine concern for the child’s best interests based on quality-of-life projections that the child could be spared from an existence of almost certain endless medical complications. The second is that the parents had made a reasonable choice among possible medical treatments based on responsible medical authority.

Two physicians, a pediatric neurologist and a neurosurgeon, testified that the parents’ choice of a conservative antibiotic regimen, rather than surgery, was “well within acceptable medical standards.” The pediatric neurologist testified that the course of treatment would certainly result in the death of the infant within two years. While surgery might prolong the child’s life for twenty years or more, “her existence would be a grim one.” Thus, despite a reliance on quality-of-life considerations, the court accepted the conservative course of treatment which would result in a markedly shorter life span for the infant.

The importance of this point is that the court deferred to the medical professionals regarding the choice of appropriate treatment. This position has valid legal precedent because, traditionally, the law reposes substantial confidence in the medical decision-making process. The physician may appropriately consider more than just the

380. See supra notes 93-95 and accompanying text.
382. Id. at 589, 467 N.Y.S.2d at 686-87.
383. Id.
384. J. Lyon, supra note 3, at 47.
385. Id.
386. Id.
387. Id.
389. See Parham v. J.R., 442 U.S. 584 (1978), which involved a decision of whether to admit a child for psychiatric treatment. The Court’s opinion, however, addressed the general doctrines pertaining to medical treatment decision-making for minors. The
effectiveness of treatment. The Appellate Division recognized that the risks and ramifications of treatment, as well as the patient's prognosis, must be included.\textsuperscript{380} The court implicitly indicated that it did not endorse newborn euthanasia.\textsuperscript{391} Nevertheless, the final decision must be a product of responsible medical opinion as it affects the situation as a whole, rather than the medical evaluation exclusively.\textsuperscript{392} The court concluded that the parents were best able to decide, among the valid treatment options presented by the physicians, what is best for their child.\textsuperscript{393}

According to Parham, the appropriate review of the parents' choices regarding medical decisions involving children should be whether the child is abused or neglected.\textsuperscript{394} State statutes set that standard.\textsuperscript{395} In Weber, the New York Court of Appeals stated that the trial court "abused its discretion as a matter of law by permitting this proceeding to go forward . . . in the absence of any further investigation pursuant to section 1034 of the Family Court Act."\textsuperscript{396} This failure was fatal to the petitioner's case.\textsuperscript{397}

C. Quality-of-life Considerations

1. \textit{In Re B.}

The B. court rejected quality-of-life as a criteria for deciding whether to treat. The evidence showed that, untreated, the intestinal blockage would promptly and inevitably cause the infant's death.\textsuperscript{398} Though the infant also might die from heart trouble even if treated for the intestinal problem, surgery was the only chance for her to live.\textsuperscript{399} Thus, the court saw the choice presented as simply one between life and death.\textsuperscript{400}

The parents argued that if the operation was a success, and their daughter lived the "normal span" of a person afflicted with Down's
syndrome, she would suffer extreme mental and physical handicaps.\(^{401}\) Still, the court saw a nontreatment decision as a condemnation to death.\(^{402}\) Since the infant’s quality-of-life could not be concretely established, quality-of-life considerations were rejected as decision-making criteria.\(^{403}\) The court concluded that because the infant’s potential quality-of-life was uncertain, and a possibility of “normal mongoloid life” existed, life saving surgery must be performed.\(^{404}\) The parents’ opinion that any such possibility was too remote, and that they wished to spare their daughter the more likely consequence of a life of prolonged suffering, was rejected.\(^{405}\)

A reading of the opinion, however, reveals quality-of-life considerations made by the court which are difficult to square with the court’s conclusory statements. “On one hand the probability is that she will not be a cabbage . . . . On the other hand it is certain that she will be very severely mentally and physically handicapped.”\(^{406}\) Yet, the court found “no evidence that [the] . . . child’s short life is likely to be an intolerable one [and] . . . no evidence at all as to the quality of life which the child may expect.”\(^{407}\)

The court acknowledged the possibility of quality-of-life considerations in other cases by stating: “There may be cases, I know not, of severe proven damage where the future is so certain and where the life of the child is so bound to be full of pain and suffering that the court might be driven to a different conclusion . . . .”\(^{408}\) Yet, in resolving the case at bar the court stated that:

The evidence in this case only goes to show that if the operation takes place and is successful, then the child may live the normal span of a mongoloid child with the handicaps and defects and life of a mongoloid child, and it is not for this court to say that life of that description ought to be extinguished.\(^{409}\)

Apparently, because the court could not concretely establish the infant’s quality-of-life prospects, it rejected that criteria in determining whether the surgery was in the child’s best interests.

The parents were satisfied that the medical outlook for their
daughter warranted a decision not to treat. "[T]he parents . . . took the view that it would be unkind to operate on her . . . ."410 No untoward motives were ascribed. The court emphatically sympathized with the parents' agony and genuine concern for their infant's welfare.411 The court acknowledged the presumption of the parents' rights by noting that "great weight ought to be given to the views of the parents . . . ."412 Ultimately, however, the court usurped the parents' prerogative to decide, even though no proof was presented to show that the parents' decision was faulty.413 The court seems to have agreed with the commentators who believe that error in such decisions must be made in favor of life, without regard for what that life may hold.414

2. Weber

In contrast, the Appellate Division did not reject quality-of-life considerations.415 Rather, it deferred to the parents' evaluation of the infant's projected quality-of-life. It recognized as valid a parental decision which was based on an evaluation of quality-of-life possibilities. Though surgery meant a considerable prolongation of the infant's life, it would not cure her anticipated paralysis and retardation.416 Alternatively, though death was not imminent, without surgery the infant would certainly die within two years.417 Further characterization of the infant's prognosis included a life of nasogastric feeding,418 incontinence with constant bladder and kidney infections, extreme physical discomfort, absence of meaningful interaction with her environment, no capability of interpersonal relationships and no likelihood of any cognitive skills development.419

A. Lawrence Washburn, a Vermont right-to-life attorney, who was a complete stranger to the infant and her family, had filed suit to compel the surgery.420 Espousing the anti-quality-of-life view, Washburn

410. Id. at 1422.
411. Id. at 1422-24.
412. Id. at 1422.
413. Id. at 1424.
414. See supra notes 294-300 and accompanying text.
415. Discussion of the merits of the Weber case relies on the Appellate Division decision. See supra notes 93-96 and accompanying text.
416. J. Lyon, supra note 3, at 46.
417. Id. at 47.
418. Nasogastric feeding is facilitated by a plastic tube inserted through the nose and leading to the stomach. This is used for patients who cannot swallow. Taber's Cyclopedic Medical Dictionary 529 (14th ed. 1981).
419. J. Lyon, supra note 3, at 47.
stated: "No matter what the child's condition is, she still has the same right to life that you and I have." 421

The Appellate Division saw the case in a different light. The court weighed the medical outlooks, with and without surgery:

The record confirms that the failure to perform the surgery will not place the infant in imminent danger of death, although surgery might significantly reduce the risk of infection. On the other hand, successful results could also be achieved with antibiotic therapy. Further, while the mortality rate is higher where conservative medical treatment is used, in this particular case the surgical procedures also involved a great risk of depriving the infant of what little function remains in her legs, and would also result in recurring urinary tract and possibly kidney infections, skin infections and edemas of the limbs. 422

Furthermore, a decision not to operate would leave the infant with a worsening hydrocephalic condition, 423 progressively impairing any intellectual functions. 424

Thus, rather than try to make the quality-of-life decision itself at the sake of the parents' right to decide for their child, the court recognized that the parents' decision, made in good faith, truly represented the best interests of the child. 425 The New York Court of Appeals upheld the dismissal of the petition. While focusing on the rejection of Washburn's invasion of the family privacy, the court also noted that "it does not appear that the petitioner had any direct or personal knowledge of the facts relating to the child's condition, the treatment she is presently receiving or the factors which prompted her parents to adopt the course they have." 426 The New York court allowed the parents to evaluate the quality-of-life meaning for their child and decide accordingly.

V. COMPARATIVE ANALYSIS

The best interests of the child doctrine serves the broad purpose of application in cases of custody, divorce, adoption, neglect, abuse and nearly every civil legal proceeding involving a child. Unfortunately,
there are no concrete rules or even guidelines to aid the courts in determining the constitution of that doctrine. At best, the doctrine requires the courts to show sound reasoning as to why its conclusion is in the best interests of the child.

It is here that the Weber courts produced a logical, legally valid reasoning to serve that doctrine. First, the legislative scheme recognizes the presumption that the parents will act in the child’s best interests. That presumption prompts the law to forbid any untoward interference with the parent-child relationship. Only the expertise of the child protective agencies can authorize such an interference. Even the courts are precluded from unilateral interference, but can merely direct an agency to investigate and report on whether a proceeding should be initiated. Second, the court recognizes and defers to responsible medical authority. Third, when appropriate, quality-of-life considerations may be taken into account. Again, only the properly equipped agency has the power of review. Finally, after the first two tests are met, the decision as to treatment can be overruled only when it is proven that the best interests of the child are not served. Therefore, the burden of proof will fall on the challenger, and will require the concurrence of the child protective agency.

Except for the parental prerogative and the best interests of the child concept, the Court of Appeal’s B. opinion is starkly devoid of any reference to precedent, statutory law or legal doctrine. Although there are scant implications to other legal concepts—such as support of responsible medical authority, right to life and death, and parens patriae—they are not raised, addressed or utilized by the Court of Appeal in arriving at its decision. Rather, they are summarily discounted by a notion which the court left equally undeveloped; namely, that any treatment decision must be made in favor of life without regard for what the nature of that life might be.

The B. court’s approach proves to be haphazard, failing in both logic and reasoning. The parental presumption is discounted because of the emotional trauma the parents experienced from the birth of a

427. Id. at 211-12, 456 N.E.2d at 1187, 469 N.Y.S.2d at 64.
428. Id. at 212, 456 N.E.2d at 1187, 469 N.Y.S.2d at 64.
429. Id.
431. Id.
432. Id.
433. See id.
435. Id. at 1421.
436. Id. at 1422-24.
handicapped child.\textsuperscript{437} Although the "great majority of surgeons" would respect the parents’ wishes, despite the trauma,\textsuperscript{438} the court does not agree with the judgment of medical professionals about a medical issue. The court alternately identifies quality-of-life considerations, then denies that they exist. When the parents make a good faith decision, taking quality-of-life into account, the court rejects the acceptance of support of responsible medical authority for that decision.\textsuperscript{439}

The court replaces its own medically untrained and uneducated discretion for that of the treating physician when a difference in medical opinions arises. Finally, the court indicates that, if necessary, the child can be treated and removed from the parents’ custody permanently, and can be placed for adoption.\textsuperscript{440} The court acknowledges that the parents’ decision was made in the child’s best interests, rather then with a view towards the difficulties presented to them.\textsuperscript{441} The court’s remedy of adoption is unsupported by any reasoning at all, other than convenience to arrive at the drastic and harsh measure of invading the privacy of the family unit.

Though the crux of the issue in these cases is certainly the best interests of the child, as it should be, there is also a strong secondary element of the autonomy and stability of the family unit. The absolutist position that \textit{all} life must be preserved at \textit{all} costs is flawed.\textsuperscript{442} The difficulties of such decision-making dilemmas are obvious. Commentators have stated that ultimately, the courts are no better equipped to make these decisions than family members or physicians.\textsuperscript{443} The effects on the family as a whole must be considered. The professional and ethical integrity of the health care professionals come into play. The costs, benefits and burdens to society must be considered.

The Weber courts’ approach represents a far more equitable solution than the English court. Therein, the rights of all parties are given due weight.\textsuperscript{444} The difficulty of decision-making is inescapable. Only with the logical application of sound legal doctrines do the courts serve the ends of justice. The B. court, in arbitrarily blocking out the valid legal rights and concerns of the parents and physicians, does not serve

\textsuperscript{437} Id. at 1422, 1424; see supra notes 341-45 and accompanying text.
\textsuperscript{438} Id. at 1423.
\textsuperscript{439} Id. at 1424; see supra notes 367-79 and accompanying text.
\textsuperscript{440} Id. at 1422-24.
\textsuperscript{441} Id.
\textsuperscript{443} Id.; see also Longino, \textit{Withholding Treatment from Defective Newborns: Who Decides and on What Criteria?}, 31 U. Kan. L. Rev. 377 (1983); Riga, supra note 9, at 109.
\textsuperscript{444} See supra notes 54-99, 350-66, 380-97, 415-26 and accompanying text.
the best interests of the child. The court cannot be more concerned for the infant's rights than are the "caring, responsible"445 parents. The court is not as well-equipped as the treating physician or a child protective agency to weigh the medical options. Unilateral, emotional decisions dictated by the personal preferences of the justices cannot be the rule of law.

In England, the rule of law now stands, as a result of the B. case, that virtually any chance for life must be pursued absolutely.446 The Court of Appeal's opinion does not give the judicial system clear guidelines by which to decide future cases. In the case of handicapped newborns, prognoses are often unavailable or unreliable immediately after birth. In such cases, the English court's rule is to order treatment without regard for the plethora of attendant circumstances surrounding the case and affecting the lives of those concerned.

The New York court presents a much more applicable rule. Statutory child abuse and neglect schemes, which are present in every state of the United States and England, serve as appropriate foundations for dealing with these cases. The parental presumption must maintain high recognition, particularly when supported by responsible medical authority. The New York court sets forth a rule whereby parental decisions can be overturned only by those with the expertise to make an informed, intelligent review.447 Treatment decisions often present no preferable options. They are virtually always emotionally wrenching and scarring. Only through deference to the emotional and personal sensibilities of the parties involved can the courts achieve results that truly serve the best interests of the child.

VI. CONCLUSION

There is, perhaps, no other type of case entertained by the Anglo-American system of jurisprudence that moves the court processes more rapidly than a case which concerns the immediate health of a child. The sleeping giant of justice wakes and moves with almost unbelievable speed when the pained cry of an infant calls upon the law for resolution of its dilemma. The largest financial dealings, the most important of treaties between nations, and even the heavy hand of criminal justice are all subject to the politics, delaying tactics and vagaries that may influence judicial systems. Not so when the awesome authority of parens patriae comes to the rescue of a child.

The English Court of Appeal heard the B. case the same day as

446. Id. at 1421-24; see supra notes 402-14 and accompanying text.
447. See supra notes 82-99, 350-66 and accompanying text.
the trial court decision was rendered. The "Baby Jane Doe" case sped through the three levels of the New York State court system in two weeks. The prosecutor in the Bloomington, Indiana "Baby Doe" case believed that the United States Supreme Court would hear an emergency appeal upon which a child's health or life depended within twenty-four hours of petition.

When a child's welfare is immediately at stake all the usual facades and frustrations incumbent upon the judicial system fall away. When the court steps into a role of responsibility for the welfare of its children, it is perhaps the singular instance when the parties actually receive all the effort at which courts otherwise merely make a pretense. Parens patriae is one of the most powerful and deeply rooted doctrines in the legal system of western societies. There is no question that power will be exercised on behalf of children's welfare. Its foundation lies in common law, constitutional law, statutory authority, and general powers of law and equity courts.

For cases of this sort, adjudicatory forums are the preferable resolution device, rather than legislative or administrative remedies. In the vast majority of cases, parents and physicians decide most effectively how the best interests of the child will be served. The courts need only hear those cases where a dispute arises between the family and the health care providers. Natural parental concern, widely recognized as a presumption, provides an adequate check on irresponsible decision-making. Professional ethics and hospital administrative oversight effectively temper a physician's discretion. When parents and physician disagree, then the courts are available.

As adjudicatory forums and finders of fact, the courts are well-equipped to marshall the appropriate evidence and balance the competing interests. Court-appointed guardians will protect the infant's interests and provide the information required by the court. The courts may demand whatever additional expert testimony is needed. Temporary court directives can prevent deterioration of tenuous medical and custody situations while proceedings are pending. Furthermore, courts can maintain jurisdiction as long as is necessary to insure proper resolution of all the issues involved. The courts also provide appeal

450. J. Lyon, supra note 3, at 44, 57.
451. For example, the "Baby Jane Doe" trial court was still resolving matters connected with the case as recently as 1988. See Baby Doe Guardian Gets Attorney's Fee, N.Y.L.J., Sept. 14, 1988, at 1, col. 3. Judge Tannenbaum limited the compensation of Baby Jane Doe's guardian ad litem, William E. Weber, to "fees incurred by representing
mechanisms. No other formal body has the experience and necessary authority to adequately resolve the issues of such enormous complexity and weight.

For the courts to administer justice in such cases, however, it is, of course, essential that clear rules of law be established by sound legal reasoning. When complex, intimate, familial interests are at stake, precedents created must have the flexibility to take into account the situations of the individuals involved. Family autonomy and privacy cannot be compromised without compelling justification.

The courts must clarify which factors will be considered in balancing the competing rights of the child and parents, or indeed whether any competition exists at all. The best interests of the child doctrine does not provide a concrete standard. The absolutist position of mandatory treatment does not work because it fails to take into account all the circumstances surrounding the case. Repeated invasion by surgical medical procedures may not decrease, but rather increase the infant's suffering. This may occur at the added sacrifice of severe emotional and financial strain on the family unit.

The decision in the United States case reflects the aforementioned positive elements. When the choice is left to the parents, the fact that...
there is a choice remains. Those faced with the dilemma of decision-making have the choice to reject a non-treatment option if it is offensive. If personal preferences are to be involved, they should surely be those of the parents, who must live with the consequences thereof. If the court deems to overrule the parents, it must provide clear, compelling justification therefor. When the decision is left to personal preferences, those of the justices are no more valid than the parents and physicians involved.

The courts must set forth clear legal rules because these events are so emotionally traumatic and potentially devastating. Parents and physicians should have notice as to the legality of the available treatment options. They should not face the added burden of litigation of the issues while the infant lies suffering.

The rule of the United States court is superior because it provides clear guidelines as to how the best interests of the child are served, while intruding minimally on family autonomy and privacy. It recognizes the parental and medical authority presumptions, the proper role of the appropriate state agencies, and consideration of familial as well as individual interests.

The English court establishes only one clear rule: if a definite prognosis cannot be made, then the infant must be treated. Given the practical impossibility of achieving a reliable prognosis for handicapped newborns at birth, the B. case stands as a virtual edict for universal mandatory treatment. The Court of Appeal failed in its opportunity to set the law on a clear course in a newly emerging area of legal contention.

Advances in medical technology create legal dilemmas that are on the cutting edge of the law for family and individual rights, health care providers and professionals, and governmental responsibilities and powers of intervention. Just as the technological developments transcend national and jurisdictional boundaries, so must the resolutions of the dilemmas. It is incumbent upon the law to achieve adequate resolutions which will simultaneously preserve the values of societies, families, individuals and professionals. The issues involved are the very roots of civilized society: life, death and family. Therefore, the ques-
tions must be pondered with reliance upon all the sophistication and insight that the community of nations can provide. Only with such concurrence will the solutions we find be valid.

William L. Bouregy