Delivery Room Resuscitation of the High-Risk Infant: A Conflict of Rights

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The thirty-two year old woman delivered her two pound, twenty-five week baby at six a.m. The delivery room was quieter than usual. Only a nurse, obstetrician and pediatrician attended. The woman lay on the delivery table holding her husband’s hand. Her baby did not cry or move. The baby had died during the twelve-hour labor.

During the progress of the pregnancy, both parents had wanted this baby very much. They had visited the prenatal clinic regularly. At twenty-two weeks, the doctors noted that the mother’s uterus was growing at an abnormally slow rate. The mother underwent ultrasonography which revealed an abnormally small fetus. Because stunted fetal growth is often due to abnormal chromosomes, the doctors performed an amniocentesis. Two weeks later, this test disclosed that the fetus had a condi-
tion known as trisomy-18. After consultation with a genetic counselor, the parents decided to undergo an elective termination of the pregnancy.

The obstetrician induced labor with a prostaglandin suppository, inducing extreme uterine contractions. He sedated the mother with narcotics. The nurses notified the pediatrician of the impending delivery. They wanted a pediatrician present in case the baby was born alive; however, neither they nor the pediatrician knew what to do if this situation actually occurred.

These parents had chosen to abort their child, assuming that it would be born dead. Once delivery took place, did the pediatrician have either an obligation or a right to override the implicit wishes of the parents and resuscitate the infant?

INTRODUCTION

A. The Delivery Room: An Inappropriate Forum for Decision-Making

(1) Birth as an Emergency

Decisions affecting an individual's life should be made only after careful and considered deliberation. In the delivery room, this type of decision is often unanticipated. Most parents expect to deliver a healthy, full-term baby. This expectation may exist even if the parents are told that their child will be abnormal in some way. The fantasy of a normal pregnancy may persist even beyond the infant's birth.

Resuscitation decisions arise most commonly after delivery of extremely premature infants or of asphyxiated infants. In the case of premature delivery, a mother is often at the hospital alone, having recognized suddenly that there were complications with her pregnancy. Sometimes a premature delivery can be delayed with drugs. In these cases, some deliberation can occur. Often, however, delivery is imminent,

* Infants with trisomy-18 have a life expectancy measured in weeks or months. Occasionally such an infant will live through early childhood. All infants with this condition are also severely mentally retarded.
* Abortion, also defined as "[t]he knowing destruction of the life of an unborn child or the intentional expulsion or removal of an unborn child from the womb other than for the principle purpose of producing a live birth or removing a dead fetus." BLACK'S LAW DICTIONARY 7 (5th ed. 1979).
allowing several hours at the most for obtaining information about premature infants, discussing the implications of such information, and deciding how to handle the birth.

In the case of an asphyxiated infant, a fetus is determined to have a low or absent heart rate during labor or during prenatal testing. Generally, no discussion is possible as the mother is rushed to the delivery room for an emergency caesarean section to save the infant. Any attempt at obtaining "consent" to refrain from resuscitating a potentially brain-damaged infant would be futile: the consent would be both rushed and uninformed. In asphyxia at least, physicians assume that resuscitation will be performed.7

In all delivery room determinations, the emotional overlay to decision-making is high. When a mother delivers prematurely, or when a mother delivers an infant knowing the infant possesses a birth defect, the decision whether or not to resuscitate is made in the midst of the grieving process.8 In all abnormal pregnancies, parents mourn the loss of both a normal pregnancy and their "fantasy" child.9 A mourning time is a particularly inappropriate period in which to make such major decisions.

For the physician as well, the delivery of a high-risk infant is an emotional period. The obstetrician must contend with conflicting emotions over whether delivery is necessary or not; whether the mode of delivery chosen is the best for both mother and child; whether the physician waited too long before allowing delivery; and whether the physician was correct in assessing the gestational age of the fetus. All of these considerations will affect the outcome of the delivery and possibly the ultimate outcome of the infant's survival. The pediatrician must deal with conflicting emotions over whether he or she agrees with the obstetrical management decisions, whether resuscitation will be appropriate or even effective, and whether the pediatrician agrees morally with whatever decisions are made.

Inadequate time exists to collect information for the parents or for

8 See Sheagren, Grief Reaction to Sudden Unexpected Cardiorespiratory Arrest in a Normal Newborn Nursery, 26 CLIN. PEDIATRICS 369, 369-71 (1987) (after death of baby during perinatal period, parents may grieve anywhere from months to years); Watchko, Decision Making on Critically Ill Infants by Parents, 137 AM. J. DIS. CHILD. 795, 795-98 (1983) (reviewing forum-decision versus parent/physician-decision schools on decision-making relating to critically ill newborns).
9 See Fost, Counselling Families Who Have a Child with a Severe Congenital Anomaly, 67 PEDIATRICS 321, 321-24 (1981) (discussing parental reaction and decision-making in cases of birth of defective child). This reaction may occur in normal pregnancies and deliveries as well, partly explaining "post partum blues" syndrome.
the physician.\textsuperscript{10} For parents, the time shortage means having only the information supplied by those people present. Parents have no time to solicit second opinions or to investigate adequately the opinion given. For physicians the time deficit means having to operate only on information immediately available. The physicians have no time to review the medical literature for possible alternative plans of management or for statistics on infant outcome. They have no time to obtain another opinion from someone who might have more experience in a particular area. Neither parents nor physicians have time to weigh or to mull over possible alternative solutions to the problem.

The decision must be made without the benefit of contribution from the infant. Since resuscitation decisions must necessarily be made either before birth or immediately thereafter, there has been no time for the parents to "bond" with their infant. A parent might make a different decision once the baby is seen or held, or if the baby is vigorous and active and responds to therapy rather than being lethargic and unresponsive.

A physician as well may make a different decision once he sees the baby and how it responds to treatment. Different babies may have disparate reactions to the same stress and may respond very differently to treatment.\textsuperscript{11} Until resuscitation has been initiated, a child cannot demonstrate the ability to survive.\textsuperscript{12} The decision not to resuscitate a newborn must rest solely on statistical data of other infants' abilities to survive.

\textsuperscript{10} See Charney, supra note 6, at 64. Decisions that can be delayed with no adverse consequences to the baby, should be. Id. Doctors have studied situations where an emergency traditionally was felt to exist. See id. In some cases, notably those dealing with meningomyeloceles, it may make no difference in outcome whether correction is initiated immediately, or after several weeks. Id. at 63.


\textsuperscript{12} It has been suggested that resuscitation should be discontinued in the delivery room only if the infant is non-viable, based on weight and/or gestational age, and the infant fails to respond to resuscitative efforts. Martin & Fanaroff, Delivery Room Management of the Low Birth Weight Infant, 27 CLIN. OBSTET. & GYNECOL. 636, 636-46 (1984). Similar considerations arise in drowning accidents. Recommendations for resuscitation, even in the face of signs demonstrating a uniformly poor outcome, include attempts at full and aggressive resuscitation to be terminated only after "careful consideration of the particular circumstances in each individual case." Brooks, The Child Who Nearly Drowns, 135 AM. J. DIS. CHILD. 998, 998-99 (1981). In the nursery, some physicians advocate the use of an "individualized prognostic strategy" for decision-making which includes a consideration of the infant's response to treatment, in addition to relevant statistical information. See Fischer & Stevenson, The Consequences of Uncertainty: An Empirical Approach to Medical Decision Making in Neonatal Intensive Care, 256 J. A.M.A. 1929, 1930-31 (1987). See also infra notes 138-141 and accompanying text.
with similar abnormalities. Moreover, it must rest on current data based on current technology. Decisions rarely contemplate possible future technological advances. For example, a child born with no intestines will probably not be resuscitated even though the possibility exists of future intestinal transplants.

(2) Irrevocable Decisions

A decision not to resuscitate is irrevocable. However, the decision not to resuscitate does not necessarily mean the baby will die. Delivery room resuscitation is needed for stillborn infants, for depressed infants, or for active and otherwise healthy babies who, because of prematurity, have inadequate lung capacities. In all of these categories, infants can improve on their own. Even an occasional stillborn infant may start gasping and have a heartbeat when dried off and wrapped in a warm towel. If the infant lives in spite of initial non-resuscitation, his prognosis may be much worse. If resuscitation was initially withheld, brain damage from oxygen deprivation may be exacerbated. Lung collapse from prematurity may be worse, requiring more ventilatory support later on, along with its concomitant complications. Organ systems may be irreparably damaged from shock.

If the infant dies after resuscitation is withheld, the decision may be regretted later. Parents may later read of similar incidents where the infant survived through a happy childhood. They may feel differently after they have held their dead child. In the case presented above of the genetically defective infant aborted at twenty-five weeks, the parents had not realized that the physical appearance of their child would not be affected. Before the abortion, the genetic counselor and obstetrician had spoken to

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14 McLaughlin, supra note 13, at 907.

15 But see Rennie, Bubble Boy, 253 J. A.M.A. 78, 78-80 (1985) (infants born with no immune system raised in sterile plastic "bubbles" dramatic example of resuscitation in hope of future cure).

16 See Dawodu & Effiong, Neonatal Mortality: Effects of Selective Pediatric Interventions, 75 PEDIATRICS 51, 51-57 (1985) (even simple delivery room resuscitative measures without subsequent intensive care will result in decreased mortality).

17 See Martin & Fanaroff, supra note 12, at 637.
them about genetic "defects" and "abnormalities." The parents had pic-
tured a tragically deformed child who they believed would have a misera-
ble life. They had not understood the reality that their child's appearance
would not be unusual. They regretted their decision once they saw their
younger's lifeless body after the procedure had concluded. Thus, follow-
ing the tense environment of the delivery room and the hectic, emotion-
filled period of childbirth, calm deliberation may reveal a devastatingly
incorrect decision.

B. History of the Problem

The decision to resuscitate a newborn baby traditionally has rested
with the individual delivering the infant. Historically, a midwife made the
decision. A stillborn infant was a dead infant. Attempts at artificial respi-
ration or resuscitation by stimulation were more often futile than not. Premature infants determined their own fate after delivery by surviving
or dying after being warmed and dried.

With developing technology came a trend towards more vigorous re-
suscitative efforts in the delivery room. Stillbirths can now be distin-
guished from deadbirths and can often be revived with assisted ventila-
tion, infusion of intravenous or intracardiac drugs, and maintenance of
warmth. Premature infants with underdeveloped lungs can be resusci-
tated and maintained for long periods with artificial ventilation, extra ox-
ygen, intravenous fluids and other techniques developed within the past
fifteen years.18 Early resuscitation of premature infants decreases their
mortality rate.

Once deliveries shifted from the home to the hospital, physicians
made the decision whether a child should be resuscitated in the delivery
room. The decision was based on the individual physician's belief as to
the infant's potential for survival. An infant who was "too small" was not
resuscitated; the same was true for infants determined to be "too de-
formed" or "too sick."19 Infants with severe abnormalities were some-
times manipulated in the delivery room to ensure they would not survive.

With the advent of civil rights movements, increasing malpractice lit-
igation, and a trend toward "natural childbirth," as well as an increasing
social awareness, parents began to participate more actively in these de-

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18 See Gilstrap, Survival and Short-Term Morbidity of the Premature Neonate, 65 OBSTET.
& GYNECOL. 37, 37-41 (1985); Hershel, Survival of Infants Born at 24 to 28 Weeks Gestation,
60 OBSTET. & GYNECOL. 154, 154-58 (1982); Robson & Hay, Resuscitation of Preterm
Babies at Birth Reduces the Risk of Death From Hyaline Membrane Disease, 57 ARCH. Dis.
CHILD. 184, 184-86 (1982).

19 See Gilstrap, supra note 18, at 37 (as recently as 1985 some doctors still questioned bene-
fit of aggressive therapy for infants born at twenty-three to twenty-nine weeks gestational
age where morbidity could be high).
livery room decisions. A parent in premature labor or a parent who because of ultrasonography knew that the child was defective could opt not to have her baby resuscitated. Physicians almost invariably followed the parents' wishes.

Questions still remained. Infants delivered by caesarean section after fetal distress, infants delivered with unanticipated life-threatening conditions, and small premature were still delivered without any discussions with the parents as to whether or not to resuscitate. Even more disturbing than the question of whether or not to resuscitate these unanticipated high-risk infants without parental consent is the issue of whether parents even have the right to make such a decision. If they do not have the right—who does?

C. A Conflict of Rights

Traditionally, parents "owned" their children. Children had no individual rights of their own. Parents had ultimate control over all aspects of their children's lives. The paradigm of ultimate parental control is slowly eroding in favor of a new paradigm of individuality and a child's individual rights. The new standard examines children's and parents' rights in relation to one another and "balances" them to determine a

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80 Weil, Issues Associated With Treatment and Nontreatment Decisions, 138 Am. J. Dis. Child. 519, 519-22 (1984). Dr. Weil suggests that the shift from physician to patient decision-making is due to a recognition of "autonomy over one's own body." Id. at 519.

81 See Veatch, Medical Ethics, 252 J. A.M.A. 2296, 2296-2297 (1984) (suggesting that it may be that no individual has ultimate right to decide, and every decision may be subject to judicial review).

82 See Klaus, Commentary: Ethical Decision Making in Neonatal Intensive Care, 13 Birth 175, 175 (1986) (statement that "[t]he infant belongs to the parents" demonstrating how this traditional notion continues to pervade thinking among physicians). But see Leiken, Children's Hospital Ethics Committees: A First Estimate, 141 Am. J. Dis. Child. 141, 954-58 (1987) ("[c]hildren do not belong to their parents.").

83 Cf. KUHN, STRUCTURE OF SCIENTIFIC REVOLUTIONS 10-17, passim (2d ed. 1970) (developing concept of paradigms in evaluating scientific evolution).


85 See Bartholome, Decisions on Death and Dying, 68 Pediatrics 910, 910 (1981). Pediatricians, in particular, dislike the concept of children as chattel. See id. Bartholome strongly urges that children, "[i]f they 'belong' to anyone, they belong to themselves[,]" Id. A recent study of Massachusetts physicians demonstrates that today pediatricians as a group seem to support the interests of the infant more strongly that other specializations; previously, however, they were more willing to defer to parental decision-making. See Todres, Guillemin, Grodin & Batten, Life-Saving Therapy for Newborns: A Questionnaire Survey in the State of Massachusetts, 81 Pediatrics 845, 843-46 (1988).
course of conduct.\textsuperscript{26}

The Supreme Court has recognized a constitutional right of parents to oversee the rearing of their children.\textsuperscript{27} However, this is not an unconditional right.\textsuperscript{28} Parents waive this right when they demonstrate their parental unfitness by participating, for example, in child abuse.\textsuperscript{29} The discretion to remove the right of parenting rests with the courts. The parental right can be outweighed by the child's more pressing right to health and well-being.

The Supreme Court has also recognized a mother's constitutional right of privacy,\textsuperscript{30} allowing her to abort her fetus before it becomes viable.\textsuperscript{31} The Court implies a correlative fetal right to life after viability\textsuperscript{32} which outweighs the parental right to privacy.\textsuperscript{33} The mother's rights and the rights of the fetus are therefore in conflict once the fetus is viable.

This Article will examine the conflicting rights of the newborn infant and the infant's parents. In delineating the infant's rights, an attempt will be made to explore the development of those rights from the fetal stage,\textsuperscript{34} through the penumbral point of birth, to infancy. Does an infant

\textsuperscript{26} See Comment, Criminal Liability of a Prospective Mother for Prenatal Neglect of a Viable Fetus, 9 WHITTIER L. Rev. 363, 381 (1987) (commenting on Smith v. Brennan, 31 N.J. 353, 157 A.2d 497 (1960), and noting that "the courts view that a child had a right to begin life with a sound mind and body, appears to give the child somewhat of a preferred position over that of a parent's right to reproduce."). The balance of rights is applied not only to infant rights but also fetal rights. See generally Johnsen, The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy and Equal Protection, 95 YALE L.J. 599, 599-611 (1986) (reviewing development of fetal rights in relation to established maternal rights).


\textsuperscript{28} See Vitiello, Baby Jane Doe: Stating a Cause of Action Against the Officious Intermediary, 37 HASTINGS L.J. 863, 867 (1986).

\textsuperscript{29} See id. Some commentators do not view child abuse laws as protecting a child's rights over parental rights; rather, they see them as supporting a high state interest in protecting children which overcomes a weaker parental "autonomy" interest. Id.

\textsuperscript{30} See Johnsen, supra note 26, at 600.


\textsuperscript{32} See Field, Gates, Creasy, Jonsen & Laros, Maternal Brain Death During Pregnancy: Medical and Ethical Issues, 260 J.A.M.A. 816, 821 (1988) (hints of fetal rights after viability seen as early as 7th century B.C., when Roman laws required abdominal delivery of fetuses whose mothers had died). Current technology is being used to support mothers suffering brain death to assure the continued viability of a fetus being carried. Id.


\textsuperscript{34} See Note, State Prohibition of Fetal Experimentation and the Fundamental Right of Privacy, 88 COLUM. L. Rev. 1073, 1094 (1988) [hereinafter Fetal Experimentation] (noting "[w]hile Roe found that the fetus was not a person . . . it did not declare the fetus a 'legal nonentity.' "). Thus, fetal rights may vary, depending on the context in which they are ex-
have a right to “attempt life,” even where the potential for long-term survival of the infant is slight?

This Article will also seek to reveal the delivery room as an inappropriate place in which to make decisions that may violate an infant’s rights, reviewing the dangers inherent in having parents, physicians or committees substitute their judgment for the rights of the newborn. The standards of decision-making currently used in the delivery room and the hazards inherent in those standards will be reviewed. Finally, this Article will suggest that the delivery room should rarely, if ever, be the site for such decision-making: all babies should be resuscitated at birth, and determinations regarding continuing treatment of the high-risk infant should be deferred to a more appropriate time and place.

INCONSISTENT DECISIONS BASED ON UNDEFINED RIGHTS

A. A Parent’s Right to Decide

Allowing parents ultimate control over decision-making in the delivery room assumes a parental right to make decisions determining an infant’s life or death. Do the parents actually have this right, and if so, where does it come from? Many people immediately assert that parents should decide for their child in all circumstances. On an emotional level, and perhaps on an ethical one, this view is understandable. Who better than a child’s parents could make a decision for their child? However, on another level, when the interests of parent and infant conflict, the parents may be in the worst position to make such decisions because they may consider their own interests as superior, to their child’s detriment.

The law gives a mother rights over her pre-viable child’s life. The Supreme Court, in Roe v. Wade, recognized a maternal right of privacy that outweighs any fetal right to “potential life.” However, the Court shifted the balance to favor fetal life at the “compelling” point in pregnancy where the fetus is able to sustain its own life outside the womb. After viability, state law can prevent a mother from choosing to terminate her pregnancy. If the mother’s life or health is endangered, however, the

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*See Fetal Experimentation, supra note 34, at 1093.
*See Smith, supra note 33, at 769 (commenting on assumption that parents have final decision-making role for treatment of their children).
410 U.S. 113 (1973).
*Id. at 162-63. Once viability is reached, the mother “loses the liberty to act in ways that would adversely affect the fetus.” Robertson, Procreative Liberty and the Control of Conception, Pregnancy and Childbirth, 69 Va. L. Rev. 405, 437 (1983).
mother's right to life outweighs the fetus' right to potential life. Even if abortion is allowed to save the mother's life, a state, in protecting the fetus' interest, may still require that the fetus be resuscitated.

A child's right to life has been the focal point of many so-called "wrongful life" cases, where courts have held that any life is better than no life at all. Although recent decisions have allowed recovery for the pecuniary costs of a handicap, they have specifically denied recovery for diminished capacity to enjoy life. Not only are such damages speculative, but as one New Jersey court noted, the infant's right to life itself is intangible.

While the Constitution gives the mother a right of privacy which overrides the rights of her non-viable fetus, it does not give the mother a right of parenting before birth. The woman's right to privacy is in her individual, not parental capacity. Since the abortion right is that of personal autonomy and not a right of parenting, a father has no constitutional right over his unborn, non-viable child. A father has no constitutional right of privacy in abortion since he cannot give birth. A woman may terminate her pregnancy prior to viability without consent of the father, and even in spite of the father's wishes to the contrary. The paternal role in pregnancy management after viability is unclear.

See, e.g., Planned Parenthood Assn. of Kansas City v. Ashcroft, 462 U.S. 476, 485-86 (1983) (upholding requirement of having a second physician present at an abortion performed in the third trimester to assist "in preserving the life and health of the child.").

See Vitiello, supra note 28, at 884.


See Vitiello, supra note 28, at 882-84. Courts have refused to decide that no life is better than life with handicaps, implying that any life is better than no life at all. See, e.g., Becker, 46 N.Y.2d at 412, 386 N.E.2d at 812, 413 N.Y.S.2d at 900 ("whether it is better never to have been born at all than to have been born with even gross deficiencies is a mystery . . .").


See Jonsen, Transition from Fetus to Infant: A Problem for Law and Ethics, 37 Hastings L.J. 697, 700 (1986) (paternal right over fetus may be seen historically in early Roman law).


See Planned Parenthood Assn. of Kansas City v. Ashcroft, 462 U.S. 476, 491 (1983); Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 492 (1983); Bellotti v. Baird, 443 U.S. 622, 650-51 (1979); Danforth, 428 U.S. at 74. The contrast between the right of privacy and the right of parenting is elucidated in this series of Supreme Court cases, which deal primarily with the requirement of parental consent for their minor child's abortion. The cases permit laws requiring parental consent for minors who are "immature" or not sufficiently emancipated. However, minors who are considered ineligible to make such decisions are permitted to prove to the court that their own decision is preferable to that of their parents. Moreover, courts must provide an opportunity for a minor to prove that she is in fact sufficiently mature and emancipated to make her own decision.
The Supreme Court established a constitutional right of parenting in *Pierce v. Society of Sisters.* The *Pierce* Court upheld the "liberty of parent and guardians to direct the upbringing and education of children under their control." The Court based the child-rearing right on parental autonomy. This parental autonomy, however, was held not to be absolute. In *Prince v. Massachusetts,* the Court refused to permit parents "to make martyrs of their children." Following this logic, other courts have almost uniformly mandated medical treatment for children in life-threatening situations whose parents objected to such treatment on religious grounds.

Courts have refused to extend the liberty of parenting to include the decision over life and death. Child-abuse statutes and common law authority removing children from parental care when the child's life or health is in danger demonstrate the vast distinction between right of upbringing and right over another's life. As one commentator noted, the right of parents in making a life-or-death decision for their child is merely the right to decide not to rear that child; it is not the right to allow the child to die.

### B. An Infant's Right to Life

Legislation generally has supported a child's right to life and health when that right conflicts with the parental right of child-rearing. Parents are subject to criminal sanctions when they negligently disregard their child's medical needs. Courts have required blood transfusions for...
Traditionally, disputes between a child's rights and parental rights arise well after the child's birth. Such issues were rarely phrased in terms of the minor's rights, but instead tended to focus on the state's interest in protecting the minor. Recent court decisions concentrate more on the individual child's rights. Tribunals may compel a pregnant woman to undergo a caesarean section to save the life of an unborn child. The trend is to deny mothers the right to make decisions that will result in their child's or viable fetus' death. Courts imply that the viable fetus itself has a right to life that outweighs all conflicting maternal rights save the right to life and health. Some courts have implicitly denied women the maternal right to prevent resuscitation of an aborted fetus that is born alive.

As technology improves, rights of the fetus may be triggered earlier and earlier in the pregnancy. As the Supreme Court noted in Roe, the stage of viability is usually twenty-eight weeks, but may be as early as the twenty-fifth. Current technology has saved even twenty-three week fetuses that were born alive. Fetuses can now be kept alive with routine techniques that only ten years ago were considered extraordinary. Some commentators attribute the decision-making dilemma to the advances in technology. Without these advances, small prematures could not be saved and the question of their rights would not arise.

Some infants saved with modern technology are defective, however. As one commentator stressed, "life-saving technology . . . is capable of prolonging infants at a near-vegetative level of existence." Along with
advanced technology comes added considerations in delivery room decisions. No longer is the conflict between the rights of two individuals in the conventional sense, but may be between a “normal” individual and a potentially severely handicapped one. Assessing the severity of possible handicaps and mediating conflicting rights requires more deliberation than can be done in the emotion-filled atmosphere of the delivery room. In the hospital setting, an attempt should be made to resuscitate all infants. If the infant’s right to life is to be denied, it should be denied later, when all aspects of a complex issue can be evaluated fully.

PROTECTING A NEWBORN’S RIGHT TO LIFE: WHO SHOULD DECIDE?

Even after a right to life has been recognized in a fetus and in an infant, a mechanism must be established to protect that right. Of course, as a legally incompetent individual, the infant cannot protect its own rights. Some states permit individuals to record their medical management decisions in so-called “living wills,” to be honored after the individual has become incompetent. This statutory option, obviously, is not available to an infant who never had the legal capacity to execute such a document.

Jon Watchko identifies two schools of thought regarding decision-makers. The first, propounded by Fost, would provide an ideal decision-maker. This individual would possess ideal decision-making qualities, including omniscience, omnipercipience, disinterest, dispassion and consistency. According to Fost, since no human exists with all these qualities, a committee or tribunal comes closest to fulfilling the ideal.

The second school, advocated by Duff, includes parental input as an integral part of decision-making. Families and patients should remain the core of medical resolution. The tenets of this school, like those of Fost, are unsuitable when applied to the delivery room.

A. Parents as Decision-Makers

Courts have permitted guardians to speak for incompetents in several situations. In a landmark case dealing with withdrawal of life support, Belchertown State School v. Saikewicz, the Supreme Judicial Court of Massachusetts allowed guardians of an incompetent individual to make a “substituted judgment” for him according to what he “probably” would

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*See Weil, supra note 20, at 521.*
*See Watchko, supra note 8, at 795 (quoting Fost, Ethical Issues in the Treatment of Critically Ill Newborns, 10 PEDIATRICS ANN. 16, 16-22 (1981)).*
*See id.*
*See id. at 796.*
*373 Mass. 728, 370 N.E.2d 417 (1977).*
have decided had he been competent at the time. Similarly, in *In re Quinlan,* the New Jersey Supreme Court allowed the parents of an irreversibly comatose woman to decide to withdraw their daughter's life support system. Notable in these cases and in those similar was the age of the incompetent patients. The patients had all been competent at one time, and thus the decision-makers could surmise in one way or another what the individual’s decision probably would have been.

Following *Quinlan,* courts have allowed parents to decide the medical management of irreversibly comatose children, including the removal of a child from life support. In those cases, courts have reasoned that continued medical support merely prolonged the act of dying. For those comatose children, the right of life became subordinate to the right to die. Whatever decision was made, the ultimate outcome for comatose children remained the same: they would die without ever regaining consciousness.

A similar rationale to that of withdrawal of life support in comatose individuals has been proposed to allow parents to refuse treatment for children with incurable diseases. For example, a child born with anencephaly (a total lack of brain development) cannot live indefinitely, even with maximal medical support. Whatever decision the parents make will not change the outcome.

However, failure to initiate support for an infant who will soon die with or without the support may not be the same as failure to initiate temporary support for an infant who might live indefinitely. A severely asphyxiated child, for example, may live indefinitely on assisted ventilation. The child may eventually recover if treated aggressively so that the medical support is not needed, eventually leaving the hospital and growing toward normal adulthood. If his parents decide against aggressive therapy, the child would probably die. The ultimate outcome for the asphyxiated child, therefore, depends on the decision for aggressive therapy. In the case of an anencephalic infant, physicians and parents know with certainty what the result will be. In the case of an asphyxiated infant, they can only guess at this, based on statistics of how other similarly situated infants have fared. When the outcome will be the same whatever decision is made, it does not really matter who makes the decision. Most delivery room decisions, unfortunately, do determine what the infant’s fate is likely to be.

Parents may be in a uniquely unsuitable position to make decisions for their infant in the delivery room, and perhaps even in the nursery. The emergency conditions under which these decisions are made under make them hasty ones, and, therefore, inherently unreliable. The ex-

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*See Smith, supra note 33, at 766 (during emotional crises, parental-decision-making may
treme emotional nature of these decisions add to their unreliability. The conflict between the parent’s rights and the infant’s may cause the infant’s rights to be compromised. The overlay of preconceived notions about a particular disease and the excessive influence that others may have over the parents in a time of stress may combine to produce a particularly unsatisfactory result.

In the delivery room, parents often concentrate on their own interests, rather than those of their child. A hurried decision in the delivery room or in the labor room may well determine the child’s future. If a parent decides to have a child resuscitated, will that decision mean that the parent will have to raise a disabled infant? If the decision is to forgo resuscitation, does that necessarily mean the child will die? Perhaps the child will be even more disabled than would otherwise have been if resuscitation had been instituted.

The idea that abandoning resuscitation, or other aggressive measures, will lead to exacerbation of a poor outcome is rarely discussed. For example, one mother decided to decline a caesarean section for her tiny twenty-five week premature who had evidence of oxygen deprivation during labor. The obstetrician had told the mother that the caesarean procedure would give the infant the best chance of survival. He had also told her that babies born at that stage had only a small chance for normal development, and had, based on this fact, actually recommended against caesarean delivery. The mother took the recommendation, believing it preferable that her baby die rather than face the obstacles of living with a severe handicap. She did not realize that the choice included a third outcome, that her infant might be born alive after a vaginal delivery with handicaps far more severe than they might have been otherwise.

In this case, the mother decided the fate of her child within hours of arriving at the hospital in premature labor. She did not fully understand the nature of her decision. Because it was a rapid decision made during a time of great emotional stress, it was a poor decision. The mother was in labor and in pain. Although she had been told that she was about to deliver, she did not really believe it. She still harbored a fantasy that her

“rest on factors irrelevant to the best interests of the child.”).

74 See id. at 775 (parent decision-makers exercise “substituted privacy” right for child).
76 See Post, supra note 9, at 322. Some observers suggest that parents act as proxies for their child. Id. However, a valid proxy assumes adequate parental information and that the parent will be holding the child’s interests as paramount in importance. Id.
78 How parents should consider their children is the subject of increasing debate. One method of consideration is the child’s “best interests” as the basis of decisions about life and death. The problem, however, is that a parent may not be able to put a child’s best interests before his or her own. Post, supra note 9, at 323; Weil, supra note 20, at 520-21 (“some mechanism needs to be involved to increase the likelihood that the individual’s best interests are actually the major determining factor in the decision-making process”).
child would not be born for another three months. Her husband was out of town; she had not yet started to buy clothes or diapers for the baby, and her first Lamaze class was still a month away. Although it was not yet time, the doctor was informing her that delivery was imminent, and the baby would probably die or be handicapped as a result. This particular mother remembered seeing tragically deformed, retarded individuals with cerebral palsy, and did not wish her child to suffer that misfortune.

The emotional overlay to decision-making at the time of birth decreases the chance of an informed decision. Since the decision must be made quickly, within hours or even minutes of birth, there usually is no time to call for a second opinion. Any second opinion available will likely be from another physician in the same hospital who presumably will have a similar viewpoint to that of the patient's own doctor. Any information gathered will necessarily be that given by the nurses or physicians present. The parent has no independent means of finding out whether different physicians or different institutions would handle the situation differently or might recommend a different course of action.

The rapidity with which the decision must be made also decreases the chance that it will be one with which the parent will later be comfortable. Important decisions are usually made after carefully weighing all alternatives and mulling over different possible outcomes for the various choices available. Parents who have never before thought of living with or raising a handicapped infant cannot be expected to decide whether or not they want to do so on the spur of the moment. An initial reaction that the parents could not cope with raising a handicapped child may turn into guilt over what is later seen as a selfish response. Likewise, a reaction such as “we will love our child no matter what” may change when the parents discover that they have neither the financial nor the emotional resources to deal with a multiply-handicapped youngster.

Having to make a decision without ever seeing the baby also decreases the chance that the parents will later be happy with their decision. During the pregnancy, almost all parents envision the birth of a “perfect” child. Parents who continue to believe that their child is perfect in spite of being told of the increasing risk of abnormalities, might well opt for aggressive management to preserve that conception. By opting to forego resuscitative efforts for their child, parents are acknowledging the loss of that perfect image. Most parents, it seems, are unwilling to give up their vision of a perfect baby. Many parents are unwilling to admit to the loss of a perfect child even after substantial periods of time. Rarely can a parent acknowledge the loss immediately after being told that their per-

77 See Fost, supra note 9, at 322 (decision to treat child should not be the same as decision to raise that child).
fect child probably does not exist. Even in the face of overwhelming odds, many parents believe that their child will be different, that their child will be the one who defies probability and fully recovers.

Other parents, when they are told that their child has an increased chance of abnormalities, will envision a pitifully deformed child with no capacity to enjoy life. In the actual case related in the Prologue, the parents were devastated after the birth of their child. When they first heard their child had “chromosomal abnormalities” and would be severely retarded, their mental image was of a physically deformed infant. When their daughter was born looking entirely normal, they were convinced that they had erred in opting for an abortion. They were sure that the doctors had been wrong.

Besides considering an imaginary child, parents are often influenced by preconceived notions of what the terms “handicapped” and “retarded” mean. If a physician mentions cerebral palsy, parents often think of a devastatingly handicapped individual with many socially unacceptable characteristics. They do not know of the thousands of individuals with cerebral palsy who have only minor physical or mental impairments. Those individuals do not “stand out” and therefore do not become part of the average person’s perception of what the condition can entail.

After creating an imaginary infant with possibly inaccurately envisioned handicaps, a parent then may consider what it would be like to raise such a child. Again, their contemplation may be totally erroneous. Parents may be considering a worst-case scenario that is unreasonably far from reality. They may also be considering a best-case scenario which is equally unrealistic. In either case, the decision that they make in the delivery room may depend on those inaccurate perceptions.

If a parent considers the worst case, a severely retarded child with multiple physical handicaps who cannot function independently, parents may consider whether they have the finances to support their family. They may also consider the effect that such a child might have on their other children, if any. They may doubt whether they have the emotional resources for the afflicted child’s needs. After considering the strain on their family, parents may decide not to resuscitate their baby. But this baby may not be the child they imagined. This child might turn out entirely normal, or have only minor muscle weaknesses or a minimally low-

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78 See id. at 321 (one stage of grieving is denial of reality that “perfect” child does not exist).
79 See id. at 322.
80 See Berseth & Ariagno, Ethical Dilemmas in Perinatal Medicine, 96 J. PEDiatrics 951, 951 (1980). The lay press has helped to bias parental views with articles on such topics as “the miracles of modern medicine” and case histories of perfect one-pound “miracle babies.” See Fost, supra note 9, at 322.
ered IQ. And, even if the child does conform to their worst fears, parents and family may respond with the same love, support and acceptance they would ordinarily demonstrate.  

A parent who considers only the best-case scenario may likewise be in a regrettable position. By failing to consider the possibility that their child might not be normal, parents may opt for extraordinary resuscitative measures to save an irreversibly handicapped infant. They may later lament this decision, believing that they, their family and the child would have been better off without the resuscitation. If only one parent had made the initial decision, family harmony may be irreparably disrupted.

Often, because of the stress of delivery, the atmosphere of emergency, or because the decision is necessarily based on inadequate information, parental decisions are actually those of their physician or of other family members. A parent often consciously defers to the physician's judgment, but even more often does so subconsciously. Physicians frequently have their own biases regarding whether or not to resuscitate, and their presentation of the facts to the parent may reflect those biases. A doctor who stresses the high percentage of retarded babies surviving prematurity with the minuscule chance of being normal may persuade a parent to forego resuscitation. A physician can present the same facts but engender a dissimilar decision by stressing that each child is different; that some children are totally normal after being born prematurely; that there is no way to determine whether this baby will be re-

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81 See Bartholome, supra note 25, at 910 ("acceptance" of handicapped infant may be very long process).
83 See Harrison, Neonatal Intensive Care: Parents' Role in Ethical Decision Making, 13 Birth 165, 165-74 (1986). Depending upon how the problem is presented to a parent, he or she may not even realize that the decision is indeed one of intricate ethical complication. Id. at 166. The parent may see the decision as a medical one, and thus defer to the physician's judgment.

A recent study revealed that parents whose child had been removed from life support believed that they themselves had made the decision. See Walwork & Ellison, Follow-Up of Families of Neonates in Whom Life Support was Withdrawn, 24 Clin. Pediatr. 14, 14-20 (1985). These parents admitted that the most helpful thing in making the decision was "the recommendation of the [medical] staff." Id. at 19. Generally, however, a single, unified "staff opinion" is rendered. Harrison, supra, at 166. The fiction of parental decision-making is highlighted by the response from the judiciary when parents themselves refuse treatment, almost uniformly ordering treatment if recommended by a treating physician. Id. at 168. Parents, therefore, "are essentially at the mercy of the philosophies and motives of their physicians." Id. at 169.

84 See Fost, supra note 9, at 323; Harrison, supra note 83, at 167. The latter states "I can persuade ninety-nine percent of parents to my way of thinking if I really work at it, even if I am one hundred percent wrong." Id. (quoting Scanlon, Barbarism, 9 Perinatal Press 103, 103-04 (1985)).
tarded; and that even if the child has problems later on, the problems are not necessarily going to be severe. The doctor may thus convince a parent that the right decision is to provide aggressive resuscitation. A second opinion might temper excessive physician influence over the parent, but in the delivery room, as observed previously, there usually is no time to obtain one.

Similar to physician bias, the preconceived notions of other family members may help to distort the parents’ decision-making process. For instance, a grandmother whose neighbor had a retarded child thirty years ago may convince a parent that resuscitating a child who might end up the same way is a huge error. A grandparent whose strong religious beliefs demand the preservation of life may persuade his children about to give birth that resuscitation is morally and ethically required. In neither situation are the parents actually making the decision themselves.

Parental decision-making even at its best often fails to consider the rights of the infant because of emotional circumstances and inadequate information. In the delivery room those failures are multiplied. Such decisions, therefore, should not be allowed to abridge infant rights in this setting. Neonates should almost always be resuscitated at birth. Therapy can always be discontinued later after considered deliberation when parental decisions may be more reasoned.

B. Physicians as Decision-Makers

If parents are unsuited to make decisions about the life of their own infant at birth because of an inability to collect information and because of emotional conditions, perhaps the physician should be the person to safeguard the rights of the newborn. Ideally, the doctor should be experienced with similar cases and should not be swayed by emotional attachments to an unborn child which may be unrealistic. However, a physician may be torn between his commitment to save life and his commitment to alleviate suffering. The determination to save a life by resuscitating an infant may lead to long-term, high-technology intensive care with its attendant suffering. Moreover, the doctor may have biases and preconceived notions that may, consciously or not, slight the life interest of the child. These biases and notions may differ depending on whether the obstetrician or the pediatrician makes the decision.

See Smith, supra note 6, at 229 (physician is best protector of child’s interests).

See Stevenson, Ariagno, Kutner, Raffin & Young, supra note 13, at 1909. Infants in a neonatal intensive care unit are often attached to respirators with tubes in their lungs, tubes in their stomachs, and multiple intravenous lines, and typically require several needle punctures daily. Id. Even low-risk, relatively healthy premature infants usually require at least four such punctures a day; extremely sick prematures may need over thirty. Id.

See Gilstrap, supra note 18, at 49. Obstetricians have traditionally assumed the decision-
The obstetrician might be the most logical person to defend the infant's rights. If he is the mother's regular obstetrician, he knows the parents as individuals and has tracked the fetus' development through the entire pregnancy. The obstetrician should be able to consider both the infant's chances for survival and the parents' specific needs, and may be able to understand the effect on the family a defective child might have. Personal knowledge of the family's financial and emotional resources available to deal with an adverse outcome, including handicapping conditions and prolonged hospital stays, would probably be understood.

Unfortunately, many obstetricians have never seen their patients before delivery. Even if this were not so, the obstetrician may have severe biases that would lead to inadequate consideration of the infant's rights when deciding whether or not to resuscitate. Perhaps the strongest bias is a result of the current malpractice "crisis." Obstetricians who deliver damaged infants face lawsuits seeking enormous damages. Obstetricians who deliver dead infants, on the other hand, may face litigation, but for relatively insignificant awards. As most obstetricians know, a dead baby is just not worth very much in the eyes of the law. Therefore, in situations where a decision to resuscitate must be made, an obstetrician might lean toward not resuscitating, in hope of preventing resuscitation of a child with handicaps for which they later might be found liable. Some obstetricians, in fact, have been known to "run slowly" to do an emergency caesarean section for fetal distress, apparently hoping that the baby will die before delivery.

Obstetricians may also be biased because of faulty information. An obstetrician cannot be expected to remain current in pediatrics as well as obstetrics. He or she may not know what new therapies are available to help handicapped individuals or the latest statistics from the neonatal intensive care unit regarding the fate of babies which it has treated. For example, an obstetrician may think that a twenty-four week infant has virtually no chance of survival, when in fact that chance is over ten percent. Even if survival statistics relied upon are correct, the physician may

making and counseling roles in labor and delivery decisions. Id.

See Goldenberg, supra note 7, at 508 (statistics change rapidly as technology improves). A physician may not be able to keep up with ever-changing statistical patterns. See Goldenberg, The Variability of Viability: The Effect of Physicians' Perceptions of Viability on the Survival of Very Low Birth Weight Infants, 143 Am. J. Obstet. & Gynecol. 678, 678-84 (1982). In a survey, as many as forty-eight percent of doctors admitted either over- or underestimating the gestational age at which child would have fifty percent chance of survival given aggressive care. Id. at 680. Moreover, even if physicians are aware of the statistics, they may not know how to apply them. See Bergman & Pantell, The Impact of Reading a Clinical Study on Treatment Decisions of Physicians and Residents, 61 J. Med. Educ. 380, 380-81 (1986) (doctors may change clinical management on basis of incorrect interpretation of data).
underestimate the actual gestational age of a particular fetus. A decision against resuscitation may thus be made when resuscitation would in fact be appropriate. The survival of an infant may, therefore, directly depend on the obstetrician's factual information.

Obstetricians may also have personal biases that may lead to a paternalistic decision. For example, an obstetrician may feel that the burden of raising a child with spina bifida is too great for any parent, and the trauma of being a child with this condition is too great for any youngster. She or he may thus manipulate such an infant at delivery to decrease the newborn's chances for survival.

If the obstetrician is too misinformed and biased to make an acceptable decision, perhaps the pediatrician should decide. The pediatrician present at the delivery is likely a neonatologist specializing in newborn intensive care and disorders. Because the pediatrician's field is newborn intensive care, this doctor should be the most knowledgeable about the actual overall prognosis for a particular child. He or she should know if the child has any chance of survival at all, and if any therapy is available to increase such chances.

If survival alone were the issue, the pediatrician may be the best decision-maker. However, even experienced pediatricians have opted not to resuscitate a "non-viable" infant who later survives. In one instance, twins were delivered at twenty-five weeks by caesarean section. The neonatologist initially did not resuscitate the first twin because he thought it too immature to survive. He then decided the second twin was viable and did resuscitate it. Having resuscitated the second, the doctor realized his inconsistency and finally resuscitated the first as well.

When quality of life is permitted to influence the decision, the pedia-

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60 See Hershel, supra note 18, at 156.
61 See Goldberg, supra note 88, at 683. On the other hand, if the obstetrician incorrectly believes that an infant has a high chance of survival he or she may be overly aggressive in resuscitating a neonate who in fact has only a minimal chance of survival. Id.
62 See Goldberg, supra note 7, at 508.
63 See Johnson, "Baby Doe" Rules: There Are Alternatives, 138 Am. J. Dis. Child. 523, 525 (1984). With rapid improvements in medical technology, though, a single physician may be unable to prognosticate without consultation with other specialists. Id. at 524.
64 See Welch & Phillips, supra note 11, at 132.
65 A similar case was reported in 1981. Parents and physicians decided not to resuscitate cojoined ("Siamese") twins, believing them not to be viable. The twins survived without resuscitation and were later given resuscitative therapy. See Taub, Medical Decision-Making for Defective Infants by the Federal Government, 47 Conn. Med. 413, 413-16 (1983).

Other instances where a physician may err in her or his assessment of viability is where an infant has multiple deformities, which may appear to be lethal anomalies leading the physician not to resuscitate. See Setzer, Intrauterine Positional Deformations Masquerading as Multiple Congenital Malformations, 138 Am. J. Dis. Child. 642, 642-44 (1984).
trician may still be at a disadvantage. Unless a pediatrician participates in follow-up care of high-risk nursery "graduates" or unless extensive reading on follow-up is performed, the pediatrician may be subject to the same personal biases as are parents. The pediatrician's perception of long-term outcome of a child with spina bifida, for example, may be influenced by his or her own exposure to a small sample of infants with spina bifida, rather than by any objective assessment of infants with spina bifida in general. Some physicians, like a portion of the general public, believe that infants with this condition are better off dead. This belief is contrary to statistics that show most children with spina bifida have normal intelligence and are capable of independent life and meaningful human relations.

A pediatrician's personal experience may be useful in helping to consider how an infant's survival will affect the family, if this consideration is permissible. A pediatrician may have seen how similarly situated families react to and deal with handicapped infants. If a child is likely to have severe mental and motor deficiencies, a pediatrician may be able to predict whether or not a particular family is likely to be able to support the child either financially or emotionally, based upon what other similar families have been able to do.

In most instances, the pediatrician in the delivery room does not know the family. Since this doctor does not have a relationship with

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93 See Todres, supra note 25, at 646 (pediatricians today de-emphasize quality of life in decision-making, unlike doctors in the past). A recent survey revealed that physicians are more likely to intervene medically for infants in cases of extreme prematurity or serious anomalies than their counterparts in the Sixties and Seventies. Id.


95 See, e.g., Berseth, Longitudinal Development in Pediatric Residents of Attitudes Toward Neonatal Resuscitation, 140 AM. J. DIS. CHILD. 766, 768-69 (exposure may have been during residency training; may be an increasing reluctance to resuscitate high-risk infants in third year residents from first year interns). Many pediatric hospital admissions are for high-risk infants that have not done well. Id. These admissions may be the only exposure residents have to such children once they leave the hospital, coloring the residents' perception of how well high-risk infants do. Id.

96 See Wolraich, Pediatricians' Perceptions of Mentally Retarded Individuals, 80 PEDIATRICS 643, 649 (1987) (pediatricians seem to have lower expectation of performance for retarded individuals than other professionals who work extensively with handicapped).


100 In most cases, a neonatologist is called for specific problems occurring during labor, or at most a few days or weeks before delivery. Most neonatologists do not practice general pediatrics, and would only be familiar with families who have a known high-risk fetus. See Green, The Prenatal Visit (Report of Committee on Psychosocial Aspects of Child and Family Health), 73 PEDIATRICS 561, 561-62 (1984) (only twenty-two percent of expectant
the particular family, he or she cannot really know what their religious, 
moral and ethical convictions are, but can only guess how the family 
would deal with an abnormal infant based on whatever brief conversa-
tions take place.

By not knowing the parents well, however, a physician may be able to 
consider more objectively the infant's rights and interests. Since the doc-
tor can only guess as to the parents' ability to cope with their infant, 
perhaps the pediatrician can best support the infant's interests without 
considering those of the parents. The pediatrician may be able to concen-
trate on the child's chances for survival without considering its "quality 
of life," who will tend to the child, or who will be paying for its care.

Unfortunately, like obstetricians, pediatricians also have emotional 
and intellectual biases and prejudices. Neonatologists in particular often 
believe strongly in life and in their own abilities to sustain it in marginal 
cases.101 Without this type of conviction, physicians might never have al-
lowed medical technology to advance to the point of being able to save 
one-pound infants, or to transplant hearts into malformed newborns.102 
However, this "Superman syndrome"103 leads many neonatologist to favor 
aggressive therapy which laymen might consider excessively "heroic."104

Where to draw the line between extraordinary and routine therapy 
may differ both between different physicians and laypersons.105 The 
boundary may also change through time. For example, the use of artificial 
ventilation was at one time considered an extraordinary procedure, used 
only on rare occasions in an academic setting. Today, assisted ventilation 
is standard therapy, used for any type of infant who cannot breath effec-
tively. The question of assisted ventilation now is whether this therapy is 
justified for certain categories of infants—prematures, newborns with 
otherwise lethal anomalies, and the like. The answer in any particular 
instance will usually depend on the personal bias of the physician.

The spectre of medical malpractice liability also haunts pediatri-
couples had seen pediatrician prior to delivery; figure probably lower in clinic population). 
101 See Berseth & Ariagno, Ethical Dilemmas in Perinatal Medicine, 96 J. PEDIATRICS 951, 
951 (1980) (in Housestaff in particular, "death is seen as personal physician failure."). 
102 See Harrison, supra note 83, at 167 (citing Dr. Phibb's belief that one justification for 
this type of extraordinary effort is to improve "knowledge and skills" of physicians).
103 See Whitfield, The Application of Hospice Concepts to Neonatal Care, 136 AM. J. DIS. 
CHLD. 421, 421-24 (1982) (physicians and other neonatal intensive care unit ["NICU"] staff 
often feel great sense of failure when unable to save life).
104 See Lumley, Does This Work?, 79 PEDIATRICS 1040, 1040-44 (1987) (noting that physi-
cians often "feel better" if "heroic" therapy was tried before infant died).
105 Pope Pius XII defined "heroic" care as that "which cannot be obtained by or used with-
out excessive expense, pain, or other inconvenience, or where, if used, would not offer a 
reasonable hope of benefit." See Taub, supra note 94, at 414 (quoting Papal Allocution to a 
Congress of Anesthetists, Nov. 24, 1957, ACTA APOSTOLICA SEDIS 1027 (1957)).
The concern over suits for damaged as opposed to dead children is not as acute as it is for obstetricians, however. An infant requiring vigorous delivery room resuscitation is more likely to be the product of obstetrical mismanagement than pediatric. Pediatricians, nonetheless, may question the validity of consent obtained during an emotional period. Consent for treatment or for withholding resuscitation may not be considered “informed” if the parents are distraught, the mother is in pain or sedated, or the consent is obtained hastily. A pediatrician may worry that a suit will later be filed no matter what she or he does. If the infant is resuscitated and problems later develop, the parents may claim that they did not understand the full extent of the problem when they agreed to the procedure. If resuscitation is withheld, parents may later assert that they did not realize the possibility that their infant might survive anyhow, in an even worse condition. If their infant dies because resuscitation is withheld, the parents may claim that they did not realize that the infant could have been normal.

Bias, either obstetrical or pediatric, makes physician delivery room resuscitation decisions suspect. Hasty decisions may be particularly affected by unconscious motives. Physicians should therefore resuscitate almost all infants in the delivery room. Later, after considered deliberation, their biases may be less evident and decisions to withdraw therapy from a child may be more satisfactory.

C. Decision-Making in Concert

Since decision-making by parents alone often leads to unsatisfactory results, and decision-making by doctors usually leads to biased conclusions, perhaps a better outcome would be obtained by parents and physicians acting together as a group. Research on group decision-making supports the belief that group decisions are often better accepted and based on more information than are individual decisions. The method probably most used in practice is some variant of group interactive decision-making.

As stated previously, parents often consider their own interests above those of their infant. The physician, if a pediatrician, is more likely to consider the infant’s interests before those of the parents. A joint parent-physician decision, it would appear, would balance the competing forces. However, even if a decision is personally acceptable to the decision-mak-

108 See Harrison, supra note 83, at 167 (“defensive medicine” may require aggressive therapy in all cases); Fost, supra note 9, at 323 (health care professionals involved in decision making “are at risk for civil and criminal liability”).

ers, it may not be a legally acceptable one. Moreover, severe conflict may arise if parents and physicians disagree, or if nurses disagree with the decision made without nursing input. For example, in the case related in the Prologue, the nurses felt very uncomfortable with the final decision. It was the nurses who cared for the mother and who attended to the infant after delivery, but they were denied the opportunity to participate in the decision-making process. Some of the nurses had disagreed with the decision to abort, while others were uncomfortable with the implied agreement that no resuscitation would be performed if the baby were born alive.

Where conflict develops, the solution may end up being one that leaves everyone unsatisfied. The relationship between the doctor and the parents will be disturbed, as well as those between the nurses, parents, and doctor. The outcome will be that care to either the infant or the mother will suffer.

In an attempt to solve some of the problems of group conflict or of bias of the group participants, ethics committees have been developed. These committees that have a wide range of participants including medical professionals, lay persons, handicapped individuals, religious counselors and legal advisors, can consider parental and infant interests and doctor's opinions more objectively. In 1984, the American Academy of Pediatrics promulgated the Guidelines for Infant Bioethics Committees. The committees were envisioned to provide educational resources, institutional guidelines and consultation for individual cases. Under these recommendations, the ultimate objective of the committees was to "facilitate consensus about the interests of the infant."111

The theoretical value of an ethics committee may be overestimated. The medical information about a particular case will be derived from the doctors involved. Most ethics committees do not research a case independently. Therefore, the information presented to them will necessarily be biased according to the inclinations of the presenter. The committee, hearing that a child "might turn out entirely normal," may feel differently about resuscitating that child than if the committee hears that the

108 See Rosner, Hospital Medical Ethics Committees: A Review of Their Development, 253 J. A.M.A. 2693, 2693-97 (1985). One of the earliest attempts at forming ethics committees was in 1971, in Catholic hospitals. Id. at 2693. These committees blossomed after the Karen Quinlan case and the "Baby Doe" regulations in the 1970's. Id. at 2694.
110 See id. at 307.
111 Id. at 309.
112 See Johnson, The "Baby Doe" Rule: Is It All Bad?, 73 PEDIATRICS 729, 729-30 (1984) (if all decisions made by committee, only way physician can remain infant's advocate may be through input into committee).
child "has almost no chance of survival." Both statements may be saying the same thing, but the reaction to the facts may be entirely different.

Similarly, if the parents participate in the ethics committee discussion, the committee may become biased in favor of their interests. Parents who are thoughtful, caring and concerned about the type of life their child will lead may engender a different response from the ethics committee than would a young professional couple who demonstrates a lack of available time to care properly for an infant with serious medical complications. Therefore, depending on the parent, children with the same physiological problems may receive different treatment because the ethics committee favored one set of parents.

Inherent bias may exist in individual members of ethics committees, just as it exists in parents or physicians. Prior exposure to handicapped individuals and their families, or relevant hospital procedures may influence an individual committee members' reaction. An individual with a strong influence on the committee or with unusual powers of persuasion may sway the committee to his or her point of view.

Bias of the committee may be controlled, however, if the group is given the opportunity to address the bias issue. With larger groups, the bias of an individual may be recognized and become less influential. Since ethics committees are typically made up of five or more members, they may be less influenced by the bias of individual members than is the small group of just parent and physician.

Even though bias may be limited, the value of an ethics committee in the delivery room may be impaired by the timing involved. Most delivery room resuscitation decisions are made within hours or even minutes. To expect a committee to convene on such short notice is unrealistic. Therefore, in most high-risk situations, use of an ethics committee is impractical.

An ethics committee may, however, be useful in determining the standards to be used in making delivery room decisions. Such a committee could develop general guidelines that could be followed in individual circumstances. For instance, the committee could develop procedures to be followed when a genetic amniocentesis reveals that a fetus exhibits trisomy-18 and the parents request abortion. The committee recommendations might include consultation with a pediatrician to discuss the par-

118 See Weil, supra note 20, at 521.
114 But see Fetal Experimentation, supra note 34, at 1094 (little uniformity in composition, authority, or effectiveness of these committees).
118 See Weil, supra note 20, at 522 (four functions of ethics committees are establishment of general policies, procedures and tentative guidelines; provision of general education programs; reviewing physician-parent performance; and emergency consultation). But see Veatch, supra note 21, at 2258 (suggesting exact role of ethics committees is unclear).
ents' feelings concerning resuscitation if the infant is born alive, a mini-
mal infant weight below which resuscitation should not be undertaken, or
a minimum level of resuscitation that should be applied generically. The
recommendations might include a flexible standard where the committee
would review the parents' financial condition, the length of anticipated
hospital care for the infant, and the extent of the child's probable defects.
In this scenario, a doctor and parent would have a blueprint of the type
of factors they should consider and the weight to be given to each. The
recommendations might be based on a "typical" situation. For example,
such guidelines might outline procedures for management of a child with
Down's Syndrome, or one for management of a premature infant deliv-
ered after elective abortion, or one for an infant whose heart rate had
been low before delivery.

The problem with the ethics committee process is that the recom-
mendations promulgated are not individual-specific. If the recommenda-
tion is based on a "typical" case, it may simply be inadequate. A particu-
lar baby with Down's Syndrome may have only minimal deficiencies. This
premature may have a normal development. A decision based on statistics
of what a "typical" infant is expected to do may be unfair to the individ-
ual child. Just as statistics are of limited use in the courtroom to prove
the guilt of a particular individual, their role in the delivery room in
predicting the development of a particular child should likewise be se-
verely restricted.

Moreover, although the committee's recommendation is not legally
binding, it may give a physician a false sense of security. If the recom-
mendation is procedural, the parents and the physician may get an incor-
correct sense that what they decide is legally and morally appropriate. If the
law requires only careful consideration of infant and parental interests
before making a decision, reliance on ethics committee guidelines may in
fact be protective. However, if the law actually requires that the rights
of the different parties both must be preserved, following guidelines may
be no defense if an infant's rights have been denied by failing to resusci-
tate. Moreover, the moral decision is by nature not one that can be dele-
gated to a committee. A decision does not take on the trappings of moral-
ity merely because a committee condones the activity considered. It only

(testimony that statistical probability of accidental match between defendant's blood type
and sample found on victim was 1 in 500 improperly admitted).

117 See Leiken, supra note 22, at 957 (ethics committee determinations should be admissible
as evidence in court); Michels & Oliver, Human Rights Consultation: A 12-Year Experience
of a Pediatric Bioethics Committee, 78 Pediatrics 566, 570-72 (1986) (noting one case
where consultation was requested to protect against legal proceedings). See also Johnson,
supra note 92, at 526 (ethics committees may just "rubber stamp" decisions already made in
routine fashion).
becomes morally correct when it conforms to the beliefs of the individuals involved, and with societal norms. A committee of individuals in one hospital cannot be expected to define what those norms are.

Decision-making in concert, it seems, is ineffective in the delivery room setting. Conflicts between physician, nurse and parents should not be resolved hastily, and ethics committees cannot function under emergency conditions. General guidelines developed by ethics committees can only be applied if a situation has been evaluated sufficiently to assure that it falls within the committees' parameters. Thus, decisions to withhold therapy from a newborn should not be made in the delivery room, even under the auspices of group assent. Almost every infant should be resuscitated initially; treatment may later be withdrawn once all considerations can be fully evaluated.

D. Decision-Making by the Legal System

Because decisions made by individuals suffer from bias and misinformation, and since decisions made or assisted by groups suffer from possible bias, misinformation, and ultimate illegality and immorality, perhaps decisions should be made by the legal system. Legislative or judicial solutions would at least have the benefit of legality, and doctors could be more comfortable with the decision in terms of liability. Both legislative and judicial intervention in newborn resuscitation have been attempted.

Legislative intervention was first positively applied to the area of infant care in the 1980's in the case of a child born with with Down's Syndrome and esophageal atresia. The infant's parents and physician opted to forego surgical correction for this child who would ultimately be retarded to an unknown degree. A complaint filed by an attending nurse

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118 See Neuspiel & David, supra note 64, at 759. Early, subtle changes in individual and societal attitudes may be worrisome. Using the Nazi brutalities as a model, Alexander noted:

The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in the category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans.

Id.

119 See Fetal Experimentation, supra note 34, at 1073-80.


Esophageal atresia is a birth defect in which the main passage from the mouth to the stomach is undeveloped. Secretions from the mouth have nowhere to go and often overflow into the lungs, causing pneumonia. Without surgery, a child with this condition cannot eat and will slowly starve to death.
resulted in a judicial opinion, In re Infant Doe,141 which reasoned that it was not the province of the court to interfere in these decisions. Baby Doe later starved to death.

After an enormous public outcry, Congress enacted the “Baby Doe Regulation” ["the Act"] of the Rehabilitation Act of 1973. This regulation forbade withholding treatment from individuals solely because of their handicaps if treatment was “otherwise appropriate.” To assure compliance with the Act, health care facilities were required to post notices detailing the Act’s requirements, with a “hotline” number to be called by anyone with knowledge of infringements.

While on its face a giant step forward in support of infant’s rights, the Act was in fact intrusive, unclear, and ultimately unworkable.142 What exactly did “handicapped” mean? When the medical condition was ultimately tied to the handicap, was treatment still required? For example, if Baby Doe had not had Down’s Syndrome, she most likely would not have had a surgically correctable lesion either. Did the Act require treatment only if a medically correctable lesion was something separate from the handicap? What if the “handicap” was a lethal anomaly?143 Did associated medical difficulties still need correction? For example, a child with a malformed heart might also have pneumonia, or an intestinal blockage. If the child would die within days anyway, did the Act require treating the pneumonia or the intestinal problem?

In Bowen v. University Hospital Assn.,144 the Supreme Court held that the Baby Doe regulations were partly unconstitutional. In Bowen, parents of an infant with a congenital defect decided against surgical correction.145 The Department of Health and Human Services sought to intervene on behalf of the infant, citing the Baby Doe regulation. The

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143 Physicians generally disliked the initial regulation. Frequently cited were concerns for the disruption of the doctor-patient relationship, disruption of the family unit and the “placement of ethical decision-[making in the hands of one or several minor bureaucrats.” Berseth, A Neonatologist Looks at the Baby Doe Rule: Ethical Decisions by Edict, 72 PEDIATRICS 428, 428 (1983).
144 See Taub, supra note 94, at 415 (according to Surgeon General, regulation not intended to apply to terminally ill).
146 Id. at 621.
Court held that since no parental consent had been given for the surgery, the infant was not in fact "otherwise qualified" for the procedure.\textsuperscript{126} It was not the handicap of the infant that precluded surgery, but the lack of parental consent itself, and the regulation was held not to apply. Justice Stevens, writing for a plurality, concluded that the regulations were not authorized by section 504 of the Rehabilitation Act. First, the regulations required state agencies to demonstrate that they were in compliance with the regulations,\textsuperscript{127} but impermissibly required state agencies to enforce compliance by other recipients of federal aid.\textsuperscript{128} Secondly, the regulation authorized investigations when no evidence of discrimination on the basis of handicap was evident. In \textit{Bowen}, no evidence existed that the hospital refused to treat the infant because of the infant's handicap; rather, they refused treatment for lack of consent only. Under the Baby Doe rules as promulgated, handicapped individuals had an "absolute right" to be treated in a hospital receiving federal funds.\textsuperscript{129} If hospitals did not vigorously pursue treatment, they could be denied federal funding. The legislation was intended to protect equal rights, not to develop new ones.\textsuperscript{130}

Congress subsequently amended the Baby Doe rules. The new regulations provided guidelines for decision-making and suggested the format and role of infant care review boards. In effect, the regulations provided directions for decision-making in the manner in which it had traditionally been done in the nursery. The physician was permitted to make the assessment of the effect of treatment, and the parents and physician, often in consultation with a committee, could make the ultimate decision as to what therapy, if any, would be given. The new regulations permitted withholding treatment for "irreversibly comatose" infants, for infants who would die no matter what therapy was given, for infants for whom therapy would be "futile," and for infants for whom therapy would be "virtually futile" because the therapy itself would be inhumane.

Since the legislative model of decision-making is the codification of what has already been done in practice, it cannot be applied satisfactorily to the delivery room. In emergency situations, these decision-making methods have already proven themselves inadequate.

Judicial intervention on a case-by-case basis would likewise be inadequate. Although a court would be able to address each case individually, considering both the rights of the child and the parents, a judicial decision suffers from the same defects as other decisions made by individuals. A judges' own bias would interfere, the medical facts and prognosis avail-

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\textsuperscript{126} \textit{Id.} at 631.
\textsuperscript{127} \textit{Id.} at 639.
\textsuperscript{128} \textit{Id.} at 642.
\textsuperscript{129} \textit{Id.} at 641.
\textsuperscript{130} \textit{Id.}
\end{flushleft}
able would be those of a biased physician, and the social or family situation would appear only as presented by the parents or a third party. Moreover, in a delivery room atmosphere, there would be no time to call a judge and have a decision rendered before the child would in fact need to be resuscitated. Judicial intervention in the delivery room has been attempted in cases of fetal distress, where courts have ordered caesarean sections against the parent's wishes. The results have been disappointing. In cases where it has been applied, by the time delivery could have been effectuated, the infant was already damaged, vaginal delivery had already occurred resulting in a healthy infant, or both the infant and the mother died. Even if judicial intervention is the option most likely to result in an acceptable decision, it usually is too little and too late. In order to be effective, there would have to be a judge in every delivery room standing by to make timely decisions.

Since judges are not available for every delivery, almost all infants should be resuscitated in the delivery room. If judicial intervention is needed, it can be obtained later in order to evaluate withdrawal of the infant from therapy. Once resuscitation is complete, the decision to withdraw therapy is usually non-emergent. All aspects of the infant's prognosis and care can be considered at length.

E. The Infant as Decision-Maker

Parents, physicians, committees, and legal mechanisms have been proven to be inadequate to make life-and-death decisions in the delivery room. The only decision-maker left is the person who has perhaps the most interest in the outcome: the infant. The infant is the one whose rights will be lost forever if a decision is made to forego that infant's resuscitation in the delivery room.

The infant may be allowed, after a fashion, to be his own decision-maker. The infant's interest in survival may be inferred from his reaction to treatment. An infant in the nursery who is not responding to or who is deteriorating despite aggressive treatment may be said to be demonstrating an interest in "refusing" further treatment.

In the delivery room, the infant may respond readily to resuscitation or may fail to respond at all. If the infant responds, the other decision-makers will then have time to consider more carefully the ultimate decision of whether care should be continued. If the infant fails to respond to resuscitation, the caretakers have not denied the child his right to life. By initiating therapy and allowing the infant a chance to respond, the caretakers are giving the infant the opportunity to exercise that right. Therefore, almost all infants should be resuscitated in the delivery room. The

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181 See R. Cooper, supra note 107 (describing infant as part of decision-making group).
infants who survive can later be evaluated in the nursery. An infant may later be withdrawn from therapy after careful deliberation of all factors including that infant’s response to various treatment programs.

PROTECTING INFANT RIGHTS: HOW TO MAKE THE DECISION

A. The Basis of the Decision: Resolving Who Will Be Decision-Maker

Perhaps a decision-maker could more easily be identified if the bases of the decision were clearly identified. What needs to be considered in making the decision? If it is purely the chance of survival of the infant, then it is the pediatrician who has all the information that is needed. If it is purely the wishes of the parents, then the parents alone can make the decision. In China, for example, where parental rights are considered paramount, a parent can decide not to have a child resuscitated or treated for any reason whatsoever, with no questions asked. If it is a societal/economic cost-benefit analysis, conceivably Congress or state legislatures could best set the standards for resuscitation. If it is the “best interests” of the child, then the choice of decision-maker is more difficult, because personal biases start to enter the picture. Likewise, decisions based on family interests, the quality of the infant’s life or the inferred wishes of the child require difficult choices as to who will act as decision-maker.

Current laws do not adequately provide standards for decision-making even outside the delivery room. Courts have looked at the criteria for decision-making under two circumstances similar to the delivery room. First, the Supreme Court implied standards for resuscitation in decisions relating to abortion. In Planned Parenthood Assn. of Kansas City v. Ashcroft, the Court found constitutional a state law requiring a second physician to be present at all post-viability abortions. So, if a state can require a physician to resuscitate an infant in furtherance of its “compelling interest in protecting the lives of viable fetuses,” presumably the requirement for resuscitation is viability alone.

The second instance in which courts have looked at standards for life

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138 See Faix, Triploidy: Case Report of a Live-Born Male and an Ethical Dilemma, 74 Pediatrics 296, 297-300 (1984). Three historical guidelines for decision-making have been noted by some commentators: “(1) save or preserve life at all costs, (2) relieve suffering, and (3) do no harm.” Id. at 298.

139 See Neuspiel & David, supra note 64, at 757. The authors caution that “‘death with dignity’ and ‘quality of life’ concepts have been introduced as thinly veiled justifications for plans that are at root economically motivated.” Id. Although couched in terms of patient interest, the decision in fact reflects no “concern for the victims of these policies.” Id.

140 See id. at 758.


142 Id. at 486.

143 See id. at 485.
support is in cases of the withdrawal of such support. In *In re Quinlan*,\(^{138}\) the New Jersey Supreme Court allowed the substituted judgment of a comatose woman's parents to authorize removal of life support equipment. In *In re Conroy*,\(^{139}\) the same court added an objective test to be used when it was unclear what such an individual would decide. In the objective test, the decision-maker had to weigh the net benefit of life against the net burden of treatment.\(^{140}\) Similarly, in *Belchertown State School v. Saikewicz*,\(^{141}\) the Supreme Judicial Court of Massachusetts allowed a third party to postulate what a retarded individual would have decided if he had been competent to do so.

The third circumstance in which courts have examined related decision-making issues is in the nursery for non-treatment decisions.\(^{142}\) In those cases, notably those involving Indiana's "Baby Doe"\(^{143}\) and New York's "Baby Jane Doe,"\(^{144}\) the courts declined to discuss the logic behind the decisions and focused entirely on their procedural aspects.

**B. Viability Standard: Is Quality of Life Included?**

In *Roe v. Wade*,\(^{145}\) the Supreme Court adopted the standard of viability for determining when a state's interest in protecting life outweighed the mother's interest in privacy. In his opinion, Justice Blackmun defined "viability" as the stage at which the fetus had the "capability of meaningful life outside the mother's womb."\(^{146}\) The time in gestation when a fetus became viable could vary as technology varied.

Today, as physicians are more able to rescue smaller babies and treat them through to maturity, the point of viability is getting earlier and earlier in the pregnancy. The *Roe* Court left the definition of "meaningful" unclear. Many physicians have interpreted "meaningful" to include a quality of life determination. Thus, if the fetus had a genetic defect that would result in severe mental retardation, physicians often considered


\(^{139}\) 98 N.J. 321, 486 A.2d 1209 (1985).

\(^{140}\) See Coulter, *supra* note 120, at 45.


\(^{143}\) 410 U.S. 113 (1973).

\(^{144}\) Id. at 163.
that fetus "non-viable." By this definition, the life of a retarded infant is not "meaningful".

The Court had not intended this result, however. In Colautti v. Franklin, Justice Blackmun wrote for the majority in clarifying this aspect of Roe. The potentiality of "meaningful" life meant "not merely momentary survival." Thus, only length and not "quality" of survival should be considered. Viability under Roe included only chance of survival, determined by a physician. Once the child is born, no one needs to decide if the child can survive. The child demonstrates its ability to survive by its continued existence. The question then becomes, should the infant be allowed to try?

Although the Supreme Court has excluded quality of life as a criterion in abortion decisions, it has permitted it in the withdrawal-of-support context. In cases of older children and adults, decisions might consider the individual's life prior to the need for any decision. Thus, in the Quinlan case, the comatose woman's parents were allowed to factor in her former lifestyle in making their surrogate decision. In Conroy, the decision-maker was permitted to balance the benefit the retarded individual derived from life against the burden of a life undergoing constant treatment. These methods obviously suffer from the possibility of a wrong assumption about the quality of the patient's life. In the case of a newborn in the delivery room, there is no way to know what the infant's life will be like. Decision-makers can only guess as to the quality of life the neonate will enjoy. They must assume that this baby will be like most other infants similarly afflicted. Because of the inherent difficulties in prognostication, this assumption is dangerous.

Since neither an objective test nor a substituted-judgment test function in the delivery room, perhaps a more practical test should be applied. The "Baby Doe" regulations propose to remove from the decision of whether the baby should live the consideration of a child's potential handicap. One author has labelled this the "non-discrimination" approach. Under this paradigm, a decision-maker must determine what would be appropriate for the child if he did not have the handicapping condition.

148 See id. at 397.
150 See Smith, supra note 33, at 774-75.
151 See id. at 782.
152 See id.
153 See Coulter, supra note 120, at 44.
The non-discrimination approach, unfortunately, is also unworkable in the delivery room. Most resuscitation decisions arise because of the handicapping condition. Most premature infants, for example, need to be resuscitated because they have immature lungs which cannot function independently. Under the “Baby Doe” approach, decision-makers would have to resuscitate all premature infants simply because they would have to resuscitate a full-term baby whose lungs could not function independently. But this approach breaks down if the infant, actually a fetus, has only reached a gestational age of twenty-two weeks. At this stage, the infant cannot breathe on its own. Generally speaking, that is the only reason a twenty-two week neonate would need to be resuscitated in the delivery room. But such a child has absolutely no chance of survival, because its lungs are undeveloped and incapable of sustaining life even with support. The child’s “handicapping condition,” therefore, is intimately bound up with his or her need for resuscitation. Denying resuscitation in this context would not be discriminating against the handicapped; it would merely consist of recognizing futility.

The Child Abuse Amendment of 1984 focused on remedying the problems inherent in this approach. The Amendment’s approach allowed specific exceptions to the otherwise mandatory provision of medical care. The exceptions include situations where the treatment would be virtually futile and inhumane. Thus, in the case of the twenty-two week fetus, resuscitation would not be mandated. But what about an asphyxiated newborn where the outcome is uncertain? Since most severely asphyxiated infants do not survive, treatment could be considered “virtually futile.” However, some do survive, with abnormalities absent or minimal. Is it inhumane to provide treatment in an attempt to give a baby an opportunity for survival? The standard proposed is unclear, and thus unreliable.

The President’s Commission attempted to clarify the concept of “humane” in its reliance on a “best interests of the child” standard. Under this standard, a competent decision-maker could consider the “net benefit” to the child in deciding whether to forego medical treatment. This benefit had to be examined from the child’s perspective, excluding considerations of the family’s emotional and financial burdens and the so-called “burden on society.” Unfortunately, this standard suffers even more from ambiguity than any of the others preceding. It depends on who the decision-maker is and what that particular person or persons consider a “net benefit.” This term is left undefined; so, in fact, is the term “competent decision-maker.” Similarly situated infants in different hospitals could be treated differently under the same standard of decision-making.

Comparable unequal decision-making would occur under the tests us-

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184 See id.
ing financial, social, or emotional considerations. In each test, the decision might be clear in an individual case, but children with similar afflictions would end up being treated differently depending on the circumstances of their birth. A child with wealthy parents who were anxious to raise their child no matter what his or her handicap might be resuscitated, while a child of a single parent with no resources might be left to die.

CONCLUSION

None of the proposed tests for withdrawal of therapy from incompetents or for the initiation of treatment in disabled infants can be easily applied when it comes to the delivery room. All use “quality of life” as a factor to some degree. Even the non-discrimination approach, purporting to exclude disabilities in decision-making, in fact allows quality of life to be considered. In the delivery room, as elsewhere, the ability to predict what life will hold for a particular infant is limited. A child who appears to have chromosomal defects may merely have positional deformations. A fetus that appears from its size to be in its twenty-third week may in fact be in its twenty-sixth.

Allowing quality of life to enter into decision-making complicates the choice of who will act as decision-maker. Any of the candidates except the child may suffer from bias and misinformation if allowed to consider quality of life; the infant as decision-maker will suffer from incompetence.

In the delivery room, decisions to resuscitate do not lend themselves to deliberation or discussion. There is usually no time for cool contemplation. Any child with a chance of survival, therefore, should be resuscitated unless the doctor knows for certain that treatment would be futile. Instances of non-resuscitation should be rare, reserved for infants with conditions, such as anencephaly, known to be lethal. Even infants with anomalies suspected to be lethal should be resuscitated. Treatment may later be withdrawn if, after considered deliberation, decision-makers agree that continued treatment would be hopeless. The greatest danger in resuscitating a non-viable infant is that the infant might die anyway or may later need to be removed from life support. The greatest danger in failing to resuscitate a viable infant in disregard of the child’s rights is that a life will be forever lost. High-risk should not mean insurmountable risk. No person, through a denial of resuscitation procedures or otherwise, should be denied an opportunity to live.