Infanticide, Physicians, and the Law: The “Baby Doe” Amendments to the Child Abuse Prevention and Treatment Act

Nelson Lund*

ABSTRACT

Infanticide, like most other species of homicide, is probably coeval with the human race itself. In modern Western civilization, what were formerly the most powerful incentives to infanticide have virtually disappeared. As with other social problems that affluence has seemed to solve, however, infanticide has reappeared in a new form that seems to have been made possible by affluence itself. This “new infanticide” occurs in a place whose very existence is the result of a tremendously wealthy society’s devotion to its most vulnerable and least “useful” members. The modern neonatal intensive care unit, which treats, and often saves, extremely ill newborn children, who during most of history would surely have died, has proven to be a setting where many of the age-old incentives for infanticide have begun to operate again. The “new infanticide” consists of withholding food or needed medical treatment from selected infants who suffer from one or more serious, though treatable, medical problems. The national government has now enacted legislation designed to curtail the practice of infanticide by the medical profession. This paper traces the genesis of that legislation, explores the problem to which it is addressed, and evaluates its prospects for success.

1. INTRODUCTION

Infanticide, like most other species of homicide, is probably coeval with the human race itself.1 Certainly, there is evidence that the practice has

---

* Ph.D. Harvard University (1981); J.D. University of Chicago (1985); Judicial Clerk, Hon. Patrick E. Higginbotham, United States Court of Appeals for the Fifth Circuit (1985-1986). The author would like to thank Leon Kass and Mara Solovy for helpful suggestions on an earlier draft of this Article.

1 I have chosen the term “infanticide” because this word (like “homicide”) connotes an act about which one ought to have serious reservations in almost all circumstances, but which may sometimes be considered justifiable.
been fairly common in a great variety of human cultures and at all epochs of human history. The causes of infanticide seem to fall into two main categories. First, and probably most common, are economic pressures. Particularly in primitive societies, the threat of starvation sometimes imposes on the group the harsh necessity of eliminating some of its least productive members (typically children) in order to increase the prospects for survival of those who remain. Second, some cultures have developed customs and superstitions that provide incentives for the destruction of certain children; common examples include bastards, the physically deformed (who have often been regarded not as human beings but as manifestations of evil spirits), and females.

In modern Western civilization, what were once the most powerful incentives to infanticide have virtually disappeared. Unprecedented affluence, together with the decline of superstition and the development of convenient means of birth control, has enabled our society not only to proclaim but also to practice an ethic based on the sanctity of innocent human life. Traditional forms of infanticide have been illegal for quite some time. More significantly, such infanticide is almost universally re-

---


Infanticide has not disappeared in all parts of the world. See, e.g., Chicago Sun-Times, Feb. 19, 1985 (5-star ed.), at 6 (reporting that female infanticide is widely practiced as a result of state population-control policies in Communist China).

3 Obviously, economic pressures can also lead to infanticide in less necessitous situations. For example, parents who calculate that preserving a handicapped child is not worthwhile (perhaps, because it will reduce the chance that the family will be able to send other children to college) are responding to economic pressures.

4 See R. Weir, supra note 2, at 18-20; Rosenblum & Buddle, supra note 2, at 1-3.

5 Many congenital defects can now be diagnosed in utero, and the birth of children suffering from these problems can be prevented by means of abortion. See Horan & Valentine, The Doctor's Dilemma: Euthanasia, Wrongful Life, and the Handicapped Newborn, in Infanticide, supra note 2, at 33. Whether this is properly characterized as a form of “birth control” and whether it is compatible with traditional medical ethics and general moral principles are debatable questions, but the law currently treats this practice as a legitimate one. See generally L. Kass, Perfect Babies: Prenatal Diagnosis and the Equal Right to Life in Toward a More Natural Science: Biology and Human Affairs 80 (1985).

6 Traditional forms of infanticide sometimes involved more or less active measures, for example, suffocation and strangulation. Often, however, people have sought to avoid such direct participation in the child’s death; this apparently accounts for the prevalence of more “passive” means of inducing death, such as, exposure to the elements, “accidental” suffocation that occurred when the child and parent shared a bed at night, and arrangements whereby third parties (often servants or midwives) tacitly agreed to dispose of the unwanted child. The distinctions between “active” and “passive” infanticide are not compelling, since the intent and the result are the same in both—indeed, the attempt to disguise the practice by using “passive” or “indirect” devices is itself probative evidence suggesting that it is regarded as morally wrong. For further criticism of the distinction between “active” and “passive” euthanasia, see Capron, Borrowed Lessons: The Role of Ethical Distinctions in Framing Law on Life-Sustaining
garded with horror and is in fact quite rare.\footnote{7}

Like other social problems that increased affluence seemingly has
resolved,\footnote{8} infanticide has reappeared in a form made possible by affluence
itself. This "new infanticide" occurs in the modern neonatal intensive care
unit, a setting whose very existence is the result of a tremendously wealthy
society's devotion to its most vulnerable and least "useful" members. This
hospital facility treats, and often saves, extremely ill newborn children who
during most of history would surely have died. It has proven to be a setting
where many of the age-old incentives have begun to operate again. The
"new infanticide" consists of withholding food or needed medical treat-
ment from selected infants who suffer from one or more serious, though
treatable, medical problems.

The national government enacted legislation in 1984, which took
effect in October 1985, that is designed to curtail the practice of infanticide
by the medical profession.\footnote{9} This Article explores the problem to which
the new law is addressed, traces the genesis of that legislation, and evaluates its
prospects for success.

Part II sketches the historical roots of the problem with which Con-
gress found itself confronted. Parts III and IV discuss the medical dilem-
mas that have led to the nontreatment of handicapped infants. Part V
examines the moral and political arguments that are used to justify and
criticize the "new infanticide." Part VI reviews the legislative history and
principal provisions of the new law. The Article concludes, in Part VII,
with an analysis of the strengths and weaknesses of the legislative approach
that Congress took.

II. HISTORICAL BACKGROUND OF THE INFANTICIDE
PROBLEM

The story behind the recent legislation begins in 1973 with four events
that, in retrospect, can be seen to have laid the foundation for con-
gressional action eleven years later. First, Congress held hearings on the
Med. 78 (1975). In this Article, I will assume that deliberately withholding the necessities of
life is fundamentally equivalent to more violent means of inducing death.
\footnote{7} It is estimated that in the United States, about 100 infants are killed each year. \textit{P. Hoffer & N. Hall, Murdering Mothers} 161 (1981). By comparison, there were over 22,000

\footnote{8} Poverty in the traditional sense, for example, has almost disappeared from the United
States, where the government provides food, shelter, and basic medical care to virtually
everyone who is willing to accept it. This, however, has raised to new prominence the
phenomenon of "relative poverty" (i.e. inequality in the possession of wealth), a condition that
many people seem to find more intolerable as they become objectively more wealthy.
codified at 42 U.S.C. §§ 5101-05).}
problem of child abuse, which until that time had apparently been considered a local problem not requiring the attention of the national legislature. Early the next year, Congress passed a law that authorized funds for studying the problem and for helping the states set up agencies to deal with it. This program, which Congress later modified in minor respects has received rather modest funding over the years and has been utterly uncontroversial. Everyone, it seems, is opposed to child abuse and is willing to let the government spend a little money to try to reduce its incidence. Last year's new legislation governing infanticide took the form of amendments to this law.

Second, Congress passed the Rehabilitation Act of 1973, which contains a provision (§ 504) that forbids providers of medical care from discriminating against the handicapped. Before the enactment of the 1984 infanticide legislation, the Reagan administration sought to characterize the withholding of medical treatment from selected children as a violation of section 504. This interpretation had a certain plausibility since virtually all the children selected for nontreatment are obviously and extremely handicapped. The administration's interpretation, however, has been rejected by at least one important court, on the ground that Congress had not meant to address this particular problem through the Rehabilitation Act.

Third, the Supreme Court decided the case of Roe v. Wade, which extended constitutional protection to persons wishing to terminate virtually any early-term fetus. It has been pointed out that many of the arguments used to justify abortion can easily be applied to postnatal children, thus

---

12 Appropriations have ranged from $4,500,000 to $22,928,000; authorizations have been considerably higher, as is typical with federal programs. See S. Rep. No. 246, 98th Cong., 1st Sess. 3 (Table 1) (1983).
14 § 504 (29 U.S.C. § 794 (1982)) provides:

No otherwise qualified handicapped individual in the United States ... shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.
15 United States v. University Hospital, 729 F.2d 144 (2d Cir. 1984).
17 Id. at 162-63.
making the distinction between fetuses and unwanted newborns difficult to maintain. And indeed, two arguments that have been prominent in the abortion debate (both of which appeared in the Supreme Court’s opinion) have resurfaced in the debates over terminating handicapped newborns. First, Roe v. Wade appeals to an asserted “right of privacy” for “medical” decisions. Although it is by no means clear that abortion on demand is truly a medical procedure, the privacy rationale has proven to be a durable rhetorical argument and is used today to criticize government “interference” with the decisions that doctors and parents make about the fate of very ill children. Second, abortion has been justified on the ground that it would be cruel to bring a child into a family that does not want it. The parallel argument that the decision to terminate a child’s life is justified by the prognosis of a poor quality of life, has been the most hotly debated issue in the controversy over the new infanticide.

The fourth significant event of 1973 was the publication in the prestigious New England Journal of Medicine of an article by two physicians from Yale University. This article, by Raymond S. Duff and A.C.M. Campbell, reported on the use of “death as a management option” in Yale’s special-care nursery and concluded that if infanticide violates the law, then “the law should be changed.” The article provoked a stormy debate in the medical profession—a debate that has continued to the present time.

---

19 Roe v. Wade, 410 U.S. at 152-54.
20 Traditionally, medicine has been devoted to the health of the patient and therefore to preventing and curing disease and injury. The use of medical tools to interfere with normal biological processes (whether overtly for the patient’s convenience, as when a woman has a normal breast removed because it interferes with her golf swing, or under a specious “mental health” rationale) requires considerable stretching of that traditional notion. For a thorough analysis of this problem, see Kass, Regarding the End of Medicine and the Pursuit of Health, 40 Pub. Interest 11 (1975) (Kass discusses the example of the golfer with the inconvenient breast at 13). See also Kass, Ethical Dilemmas in the Care of the Ill, 244 J. A.M.A. 1811, 1814-15 (1980).
21 During the 1984 presidential debates, for example, Walter Mondale used the phrase “the most personal decisions in American life,” apparently as a euphemism for “abortion.” N.Y. Times, Oct. 8, 1984, at B5 (transcript of televised presidential campaign debate of Oct. 7, 1984). See also id. (Mr. Mondale referring to abortion as something that concerns “the private lives of the American people,” referring to abortion regulations as “[g]overnment ... reaching into your living rooms,” and claiming that “[i]n America, on basic moral questions we have always let the people decide in their personal lives”).
22 Cf. infra notes 56-64 and accompanying text.
23 See, e.g., Roe v. Wade, 410 U.S. at 155 (discussing “the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it” (emphasis added)); id. at 163 (discussing the importance of a “meaningful life”). In Justice Blackmun’s opinion, as in the debates over the new infanticide, there is considerable ambiguity about whose welfare (the child’s or its parents’) is being considered.
24 This issue is discussed infra at notes 56-85 and accompanying text.
26 Id. at 892, 894.
27 Immediately after the article appeared, two other physicians from Duff and Campbell’s own newborn special care unit publicly dissociated themselves from the nontreatment policy,
Subsequent survey data suggest that the Duff and Campbell approach is not a fringe phenomenon and that it may indeed be the dominant approach in the profession.  

III. ROOTS OF THE LEGAL AND ETHICAL ISSUES

The infanticide problem is in one sense the direct result of technological progress. Until recently, virtually all the children who are now selected for non-treatment would have died simply because nothing could be done to save them. Even today, the infant mortality rates at hospitals lacking specialized intensive care units are much higher than the rates at institutions that have such facilities. Technological progress has led to ethical and legal questions about the propriety of withholding various forms of medical treatment—the Karen Quinlan and Joseph Saikewicz cases are which they characterized as a "therapy of nihilism." Venes & Huttenlocher, Letter to the Editor, 290 New Eng. J. Med. 518 (1974).

28 The literature on the subject is now enormous. For a brief summary of the principal contending positions, see R. Weir, supra note 2, at 60-90.

29 Several recent surveys indicate that a majority of pediatricians would withhold treatment in cases similar to the Bloomingdale "Baby Doe" case, discussed infra Part VI, that provoked widespread outrage in the public and Congress. See Child Abuse Prevention and Treatment and Adoption Reform Act Amendments of 1983: Hearings Before the Subcommittee on Family and Human Services of the Senate Committee on Labor and Human Resources, 98th Cong., 1st Sess. 6, 8 (1983) (testimony of the Surgeon General of the United States) [hereinafter cited as Senate Hearings]. Older survey data suggest that the practice of withholding treatment from handicapped newborns began long before it came to public attention. See Ellis, Letting Defective Babies Die: Who Decides?, 7 Am. L. & Med. 393, 399 & n.16-19 (1982).


31 Karen Quinlan was 22 years old when she became comatose and was being kept alive only (or so her doctors thought) with the help of a respirator. Her father, invoking several putative federal constitutional rights, asked the New Jersey courts to appoint her legal guardian with express authority to terminate use of the respirator; this request was opposed by Karen's doctors, the hospital, the county prosecutor, the State of New Jersey, and her guardian ad litem. The New Jersey Supreme Court ruled that Karen enjoyed a constitutional right to "privacy" that might permit termination of treatment. The court appointed her father her guardian, set up certain procedures to be followed by the physicians and hospital before the respirator could be disconnected, and immunized all participants from possible legal liability so long as the specified procedures were followed. The standard specified for determining the course of treatment was one of "substituted judgment," that is, an analysis of what Karen would probably have chosen had she been capable of making a decision. In re Quinlan, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976). When the doctors disconnected the respirator, Karen Quinlan failed to die as she had been expected to do. In fact, she lived until June 11, 1985. N.Y. Times, June 12, 1985, at 12.

32 Joseph Saikewicz was 67 years old and suffering from terminal cancer. Because he was extremely retarded (with a mental age of less than 3 years), he could not make an informed decision about whether to undergo painful chemotherapy treatments. The superintendent of the state institution that had custody of him petitioned the Massachusetts courts to appoint a guardian with authority to make the necessary decisions. The Supreme Judicial Court cited Quinlan for the proposition that a constitutional right to privacy could be asserted on behalf of

HeinOnline -- 11 Am. J.L. and Med. 6 1985
famous examples—and the infanticide issue can be viewed as a part of this more general problem.

At the same time, unlike other problems created by sophisticated medical technology, the new infanticide is closely linked with a moral and political issue that has arisen quite independently of advances in medical science: abortion. As noted in Part II, it has been frequently pointed out—by advocates as well as opponents of abortion and infanticide—that it is difficult, and perhaps impossible, to draw a principled distinction between feticide and infanticide. 33 Most of the arguments used to justify feticide can easily be extended to postnatal children, and there has appeared no scientific basis for a meaningful distinction between the two. 34

Furthermore, though less frequently noted, abortion violates an express provision of the Hippocratic Oath, 35 which has served for a very long time as the standard ethical guide for physicians. The Hippocratic Oath

an incompetent patient, but criticized the Quinlan court for leaving too much discretion to physicians. The court performed its own "substituted judgment" analysis and decided that the best interests of the patient required that chemotherapy treatment be withheld. Superintendent v. Saikewicz, 378 Mass. 728, 730 N.E.2d 417 (1977).


34 In Roe v. Wade, the Supreme Court seized upon the concept of fetal "viability" (i.e. ability to survive outside the mother's womb) in an effort to draw a principled line between constitutionally protected abortions and those that the states could regulate. 410 U.S. at 163. The Court failed to explain why this should be a legally meaningful distinction, except to note that the fetus is then "presumably" capable of "meaningful life" outside the mother's body. Id. Moreover, the Court seemed to assume that "viability" occurred around the beginning of the third trimester and that it could certainly never occur during the first trimester, id., an assumption that now seems quite unwarranted. See Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 457 (1989) (O'Connor, J. dissenting) ("Fetal viability in the first trimester of pregnancy may be possible in the not too distant future."). Thus, the Court's rule is inconsistent with the rationale that purports to underlie it. See id. at 457 (the Roe framework "is clearly on a collision course with itself"). Recent developments with in vitro fertilization and artificial placentas (i.e. "test-tube" babies) suggest that fetuses may eventually be "viable" in the Roe sense virtually from the moment of conception. See generally Annas & Elias, In Vitro Fertilization and Embryo Transfer: Medicolegal Aspects of New Techniques to Create a Family, 17 Fam. L.Q. 199, 203-06, 207-10 (1983); Grobstein, Flower & Mendeloff, External Human Fertilization: An Evaluation of Policy, 222 Science 127 (1983); Kass, "Making Babies" Revisited, 54 PUB. INTEREST 32, 55-40 (1979) (discussing the meaning of "viability" in relation to in vitro fertilization). Once this occurs, the entire Roe framework will completely disintegrate.

It is not surprising that modern science has failed to develop a meaningful distinction between fetuses and young children. While birth itself is a significant event in the life of the individual, it can occur at any time during a fairly extended period of continuous development. The particular stage of development at which birth typically occurs varies widely from species to species, and evolutionary biology suggests that the "embryonic" stage in humans properly extends through about the first year of postnatal life. See S. Gould, Human Babies as Embryos, in Euer Since Darwin 70 (1977).

35 The Oath provides in relevant part: "I will neither give a deadly drug to anybody if asked for it nor will I make a suggestion to this effect. Similarly, I will not give to a woman an abortive remedy."
embodies a coherent and comprehensive scheme of ethical principles which has proven highly durable despite the many impressive technological advances seen by the profession.\textsuperscript{36} The abortion policies of the last decade have led the profession to breach, on a mass scale, an integral part of that ethical scheme.\textsuperscript{37} It would be naive to assume that the remainder of the ethical guideposts in the Oath could remain unaffected by this phenomenon. As the new infanticide illustrates, another portion of the Hippocratic ethic has also become fairly widely discredited: the notion that a physician's duties run primarily to his patient.\textsuperscript{38} In order to see how this has happened, one must examine some of the details of the debate regarding the proper treatment of severely handicapped newborns.\textsuperscript{39} Before doing so, however, it will be useful to explore some of the medical phenomena that have provoked that debate.

IV. ETHICALLY PROBLEMATIC ILLNESSES IN NEWBORN CHILDREN

Doctors, hospitals, and parents are faced with a complex array of cases in which the question of whether to treat or not to treat an infant arises. Consider first the two polar extremes, about which there is little controversy. Some babies are born alive, but with such overwhelming medical problems that they are going to die very quickly no matter what anyone does. Nobody seems to advocate that these children be tormented with useless treatments; hence they ordinarily present few ethical or legal prob-

\textsuperscript{36} For a detailed explication of the coherence of the Oath and an explanation of why it has been so durable, see L. Kass, \textit{Is There a Medical Ethic?: The Hippocratic Oath and the Sources of Ethical Medicine}, in \textit{Toward a More Natural Science: Biology and Human Affairs} 224 (1985).

\textsuperscript{37} Neither \textit{Roe v. Wade} nor any of its progeny compels any physician to perform an abortion. In this sense, there is no constitutional right to an abortion. \textit{See} Maher \textit{v. Roe}, 432 U.S. 464, 470-71 (1977). The Supreme Court's abortion decisions therefore do not compel the medical profession to abandon the Hippocratic Oath. In light of the internal problems in the Court's abortion jurisprudence, the persuasive value of these decisions is also quite limited. \textit{Cf.} Brief for the United States as Amicus Curiae, \textit{Thornburgh v. American College of Obstetricians and Gynecologists} (U.S. Nos. 84-495 and 84-1379); \textit{supra} note 34.

\textsuperscript{38} The Oath provides: "I will apply dietetic measures for the benefit of the sick according to my ability and judgment... into whatever houses I may enter, I will come for the benefit of the sick... ."

To claim that physicians have traditionally aspired to benefit their patients is not to imply that it has always been crystal clear what the patient's good entailed. As the \textit{Quinlan} and \textit{Saikewicz} cases, discussed \textit{supra} notes 31-32, so vividly remind us, the patient himself has almost always been permitted to choose to forego painful or "heroic" treatments.

A somewhat different problem arises when the physician is confronted with multiple patients whose interests conflict. This dilemma has produced the general and traditional rule permitting an abortion if medically necessary to save the life of the mother. It has also produced the triage system discussed \textit{infra} note 77.

\textsuperscript{39} \textit{See infra} notes 57-85 and accompanying text.
lems. At the other extreme are babies with very minor defects that could nonetheless cause the parents to prefer that their child die; examples of such defects might include the wrong eye or hair color, or (more likely) that the baby had the wrong father or was of the wrong sex. Almost everyone who speaks publicly appears to assume that these children should be kept alive.

Most cases, however, fall between these two extremes. The full range of medical phenomena encountered in neonatal intensive care units, which includes some very bizarre and rare diseases, is beyond the scope of this paper. I will briefly describe three of the most common areas in which the problem contemplated by this Article arises.

First, and perhaps most common, is the phenomenon of premature or "low weight" babies. The problem here is that there is a wide and continuous range of prematurity. Some children are born in such a hopelessly underdeveloped condition that today's medicine is powerless to help them. Other children, while technically premature, are strong enough that they can barely be distinguished from normal full-term babies. In between these

---

40 Physicians, especially at university hospitals, may sometimes be tempted to apply treatments that have an extremely small chance of success, in hopes of thereby increasing medical knowledge for the benefit of future patients (and perhaps also for the benefit of the physician's own prestige and professional advancement). See Goichman, A Critique of Louisiana's Approach to Withholding Medical Treatment from Defective Newborns, 9 S.U.L. REV. 157, 160 (1983). The problems associated with the use of subjects who have not consented to certain treatments in medical experiments present an interesting topic in their own right, but will not be pursued in this Article.

41 There may, however, be a hidden demand for the right to eliminate children who have these characteristics. In other times and places, infanticide of females and bastards has been especially common. See R. Weir, supra note 2, at 18-21. In our own culture, there is anecdotal evidence indicating that abortion is frequently used for just these reasons, though statistics would be extremely difficult to compile since women do not have to disclose their reasons for demanding the procedure. See L. Kass, supra note 5, at 95; see also Newsweek, Jan. 14, 1985 at 29 (reporting that women are said to have had abortions because their fetuses were of the wrong sex). We do know, however, that in 1979 approximately 30% of pregnant women chose abortion. Henshaw, Forrest, Sullian & Tietze, Abortion in the United States, 1978-1979, 13 FAMILY PLANNING PERSPECTIVES 6 Jan.-Feb. 1981. Thus, if infanticide were granted the same legal status as abortion, we might see it used—like abortion—as part of a kind of private eugenics programs.

It is extremely unlikely that the medical profession would resist such a development. One survey suggests that, even under the present laws, 8% of the surgeons sampled would acquiesce in a parent's decision to refuse an otherwise healthy child treatment for a simple intestinal blockage, though such operations are virtually always successful and the patient lives a completely normal life afterwards. Koop, Ethical and Surgical Considerations in the Care of the Newborn with Congenital Abnormalities, in INFANTICIDE AND THE HANDICAPPED NEWBORN 98 (D. Horan & M. Delahoyde eds. 1982).


43 Low weight at birth is in some ways generally a better predictor of medical problems than time spent in utero. The distinction is not important for my discussion except insofar as one recognizes that neither predictor is perfect. See infra notes 44-46 and accompanying text.
two extremes lies a vast middle range in which principled lines are difficult to draw and prognosis is a highly speculative endeavor.44

In cases involving premature babies, as perhaps nowhere else, the professional judgment of the attending physicians is inescapably disposi-
tive. Even if one believes that doctors are abusing their power and that the medical profession should be placed under strict new legal or bureaucratic supervision, it is extremely difficult to imagine what form that supervision could take. Premature infants do not fall into clearly demarcated categories that could be used to specify what treatment must be provided in each case. Rather, each case requires the exercise of individualized medical judgment, especially since "borderline" infants typically suffer multiple medical problems that require a carefully crafted and balanced treatment program. In such circumstances, any attempt to constrain physicians' judgment with specific legal rules would probably founder due to the complexity of the phenomena; indeed, its chief effect might be to encourage medically inap-
propriate decisions by doctors whose judgment is distorted by the spectre of legal liability.45

Down's Syndrome, another fairly common phenomenon, presents very different problems. This disease is a chromosomal disorder chiefly characterized by mental retardation, which can be quite mild in some cases but which is often so severe that the child will never be able to live a normal life. The degree of retardation, however, is impossible to predict at birth.46 Allowing the deaths of as many of these children as possible—a policy apparently favored by many physicians47—will inevitably destroy some who could have become productive members of society and who in some cases would have been almost normal. Yet, saving as many as possible will inevitably result in the preservation (often in institutions) of a considerable

---

44 For babies weighing 500-800 grams, for example, about 20% survive and 15% of the survivors suffer from major neurological handicaps. See Fitzhardinge & Bennet-Britton, Is Intensive Care Justified for Infants Less Than 800 Grams at Birth?, 14 Pediatrics Res. 590 (1980). Vigorous treatment, however, can affect the mortality rate considerably. See Strong, The Tiniest Newborns, Hastings Center Rep. Feb. 1983, at 14, 15-16 (citing study indicating that, for infants weighing 600-799 grams at birth, replacing "conservative" treatment with "aggressive" treatment raised survival rates from 5% to 52%). Costs of caring for these children can be as much as five times greater than for larger premature babies. See McCarthy, Koop, Honeyfield & Butterfield, Who Pays the Bill for Neonatal Intensive Care?, 95 J. Pediatrics 755, 758 (1979).

45 Cf. Meyer, Protecting the Best Interests of the Child: Is the State the Necessary Blunt Instrument?, 1984 Ariz. St. L.J. 627, 654 (suggesting that devices such as the "Baby Doe Hotline" "may be expected to result in defensive medical practice that may, however, unintended, prolong futile and painful treatments").

46 See R. Weir, supra note 2, at 44-45; Paris & McCormick, Saving Defective Infant's Options for Life and Death, 1983 Am. 313, 313; Senate Hearings, supra note 29, at 144.

47 See survey data cited supra note 29; Todres infra note 50. Note also that victims of Down's Syndrome are a principal target of prenatal diagnosis (mainly through amniocentesis) and abortion; cf. supra note 5.
number of extremely pathetic individuals, some of whom approach a vegetative state.

Down's Syndrome is frequently accompanied by other physical deformities such as gastro-intestinal blockages or malformations that can be fairly easily corrected but that lead to starvation if left untreated. These are the circumstances in which parents and physicians seem to exhibit the most startling behavior. Workers in the field report that parents are more intolerant of even minor mental retardation than they are of major physical handicaps, and they often want the infant to die even when there are offers of adoption. Many physicians, for their part, are quite willing to allow these children to die.

The phenomenon of Down's Syndrome children is made particularly poignant by the fact that these individuals, while often rather unattractive, are usually abnormally happy. This fact may throw some light on the true motives for the "quality of life" arguments advanced in support of the decision to permit them to die: the primary concern behind these arguments may be the quality of the parents' lives.

The third common "Baby Doe" condition is spina bifida cystica (meningomyelocele or myelomeningocele), a congenital neural tube defect involving a lesion in the back that exposes the spinal cord and often leaks spinal fluid. The mortality rate is high, and survivors suffer a range of disabilities of varying severity; these may include paralysis below the lesion, incontinence, neurological dysfunctions of various sorts, and hydrocephalus. A special problem with spina bifida is that the failure to treat the condition raises the mortality rate, but not to one hundred percent.

See, e.g., Hatcher, Economic Grounds No Criteria, 5 Brit. Med. J. 285, 285 (1973) ("I have always sensed that attempts to preserve life by surgery are more likely to be asked for [by parents] if the prospects for the child's intelligence are good.").

This was true in the Baby Doe case discussed infra notes 88-93 and accompanying text. There is presently a waiting list for the adoption of children with Down's Syndrome. Tedeschi, Infanticide and its Apologists, 1984 Commentary 31, 31.


See text accompanying notes 68-82 infra for a discussion of the theory characterized by the phrase "quality of life."


If all patients were treated vigorously, at least half would survive. See Lorber, Results of Treatment of Myelomeningocele, 13 Dev. Med. Child Neurology 279 (1971).

As in the case of Down's Syndrome, it is not possible to predict accurately at birth the degree of a specific patient's handicaps; nor is it possible to predict the extent to which medical treatment early in life will prevent later medical problems. See Soare & Raimondi, Quality of Survival in Treated Myelomeningocele Children, in Decision Making and the Defective Newborn 68 (C. Swinyard ed. 1978).

See Discussion, 5 Brit. Med. J., 286, 286 (1973) mortality rate for untreated children with myelomeningocele is 50% at 6 months and 90% at 1 year). Physicians have since achieved higher mortality rates through more sophisticated selection techniques, but they still
some untreated patients survive, and they have far more serious medical problems than they would have had if treated promptly after birth. This special problem has caused spina bifida to be an especially exasperating problem for physicians who advocate selective nontreatment of defective newborns.

These three conditions—premature birth, Down's Syndrome, and spina bifida—account for many of the morally and legally troubling cases that neonatal specialists encounter. The preceding discussion indicates that each of the conditions presents physicians with very different dilemmas. There is room for reasonable disagreement among competent experts about the appropriate course of treatment for each disease considered in this part of the Article. These different medical opinions are generally taken into account by the doctors and parents who make the final decisions. It may be that these differences should also be reflected in any legal rules that affect those decisions, and it is certain that those who frame legal rules should at least be aware of the differences.\textsuperscript{56}

V. SACRIFICE OF LIFE VS. QUALITY OF LIFE

The central question underlying the whole Baby Doe controversy is not whether certain children will be selected for nontreatment. Some discrimination—if only between the hopelessly dying and the potentially salvageable—is inevitable. Nor is there any question about whether the law will impose constraints on those who make decisions in this area; the law has always taken a position, though one that now seems to have been somewhat imprecise and unfocused.\textsuperscript{57}

The real question is: who will decide which children are to be treated and what criteria is the decision maker to use? The two most obvious have not reached 100%. See Lorber, Selective Treatment of Myelomeningocele: To Treat or Not to Treat, 53 Pediatrics 307, 308 (1974).

\textsuperscript{56} The draftsman of the new law may have been aware of these differences, and may have consciously decided that the best way to take them into account was to use broad and vague language. In any event, they did erect a rather vague legal standard. See the analysis of the law, infra Part VII, and particularly the definition of "withholding of medically indicated treatment" quoted infra note 110, which at the crucial points uses the phrase "physician's and physicians' reasonable medical judgment."

For a critique of the new law, arguing that it is so vague that it may turn out to be unconstitutional as applied, see Vitiello, The Baby Jane Doe Litigation and Section 504: An Exercise in Raw Executive Power, 17 Conn. L. Rev. 95, 154-59 (1984).

\textsuperscript{57} The homicide laws, for example, pretty clearly prohibit the use of lethal drugs to hasten the death of children who have been selected for nontreatment. Even here, however, physicians seem to have found ways of evading legal proscriptions: there are hints in the literature of cases of overdoses of sedatives and analgesics and of stratagems such as heavy sedation accompanied by a policy of feeding only "on demand." See, e.g., Freeman, To Treat or Not to Treat: Ethical Dilemmas of Treating the Infant with a Myleomeningocele, 20 Clinical Neurosurgery 154, 141 (1972). Compare the discussion of prosecutorial discretion, infra note 114. See also infra note 78.
candidates are parents and physicians, for these are the persons to whom the decisions inevitably fall in the absence of legal regulations specifying some alternative decision maker. Neither parents nor physicians, however, are unproblematic candidates: both groups have incentives to act in ways that conflict with certain basic policies of the law.\textsuperscript{58}

This is easiest to see in the case of parents, who can sometimes have interests and passions that conflict with the interests of their children and who are perfectly capable of preferring their own interests to the lives of their offspring.\textsuperscript{59} This is hardly a new phenomenon, and the law has always found it necessary to make provisions for protecting children from the cruelty or indifference of their parents.\textsuperscript{60}

At first glance, physicians appear to be better suited to make final decisions in this area. Their self-interest is less clearly in potential conflict with the interests of the handicapped children who are entrusted to their care.\textsuperscript{61} Indeed, if there were a clear consensus among physicians about the appropriate way to handle these cases, it might be wise for the law to defer to the collective judgment of the profession.\textsuperscript{62}

\begin{footnotesize}
\textsuperscript{58} For further discussion of this point, see infra notes 59, 63-64.

\textsuperscript{59} Cf. Ellis, supra note 29, at 414 (in the perinatal period, "[p]arent-child bonding may not yet be complete, and the parental love assumed by society to exist in other contexts may not yet have developed").

\textsuperscript{60} The special child abuse laws of the present time merely supplement the common law doctrine that imposed a duty of care on the parents of minor children. Every state has statutes that specifically impose upon parents the duty to provide necessary medical care. See Robertson, Involuntary Euthanasia of Defective Newborns, 27 Stan. L. Rev. 213, 218 (1975).

\textsuperscript{61} Something akin to self-interest is perhaps involved. To the extent that physicians' training and professional outlook encourage them to pursue the health or biological fitness of their patients, the severely handicapped stymie and frustrate their professional goals. A kind of resentment towards this revelation of professional impotence may account in part for doctors' zeal in encouraging genetic screening and eugenic abortion, Cf. Horan & Valentine supra note 5; infra notes 62, 81-84 and accompanying text. On the other hand, the desire to exercise all possible professional skill to defeat the disease may also emerge.

\textsuperscript{62} Dr. Leon Kass has argued that there is a clear set of ethical principles flowing from the nature of medicine itself and has suggested that for a long time this offered an appropriate substitute for detailed legal regulation of physicians' conduct. See L. Kass, supra note 36; Kass, Professing Ethically, 249 J.A.M.A. 1305 (1983). Note, however, that Kass acknowledges that medicine, like all human pursuits, is and must be subject to the control of the political authorities. His principal concern seems to be with helping the profession provide itself with a set of principles that will minimize the need for direct government interference in the details of medical practice.

Some commentators have suggested relying on the decisions of hospital "ethics committees." See, e.g., Note, Withholding Treatment from Birth-Defective Newborns: The Search for an Elusive Standard, 31 Wayne St. L. Rev. 187 (1984). There is little reason, however, to suppose that such committees would have any special moral competence beyond that of the individual physicians who would compose them:

It would be inappropriate for a doctor or hospital to make [non]treatment judgments on identifiable patients without clear directions from the general society. It is beyond the doctor's competence and authority to decide, without clear directions from society, who should be treated based on their social worth. It would be analogous to
\end{footnotesize}
At the present time, however, the medical profession is bitterly divided on the ethical questions raised by the medical dilemmas discussed in Part IV. Given this division, it is hard to see how the law can avoid taking a position (if only by default) on the ethical questions—in contradistinction to the technical questions—that divide the profession and the community at large. Even if this controversy among physicians did not exist, it still might be appropriate for the law to intervene to control physicians' conduct. Physicians' technical knowledge, and even their presumed good intentions, do not guarantee that their decisions will be either correct or acceptable to the general public.

If the law must take a position, then, on what principles should that position be based? There are two main contending camps, each of which

---

Footnotes:

63 But see Angell, Handicapped Children: Baby Doe and Uncle Sam, 309 N. ENG. J. MED. 659, 660 (1983) (because any set of general rules would be “insensitive and vague when applied to a particular patient,” government interference with physicians' discretion is “both arrogant and foolish”). Dr. Angell is not the first to observe that general rules will not do justice in all the particular cases to which they apply. See, e.g., Aristotle, Nicomachean Ethics 1157 b 10-25. Aristotle, however, did not draw the conclusion that legal rules should be abolished.

One commentator has offered an even more radical assertion to justify government nonintervention in treatment decisions: “(H)ow can parents in such situations give the wrong answer since there is no way of knowing the right answer?” Goldstein, Medical Care for the Child at Risk: On State Supervision of Parental Autonomy, 86 YALE L.J. 645, 655 (1977). Taken seriously, this suggestion, like Dr. Angell's, would undermine the rule of law itself.

64 Physicians tend, naturally enough, to prefer self-regulation to government “interference” in their lives. So, probably, does everyone else, but that is not a sufficient reason for allowing self-regulation. Physicians have also worried, with some justification, that increased legal regulation will have bad side-effects, especially if courts and bureaucrats begin making medical decisions under the guise of enforcing the ethical principles of the law. This same concern, however, is also appropriate in many other fields in which the law seeks to curtail the misuse of power by experts who justifiably assume that courts and bureaucrats tend to have an insufficient appreciation of the nature of the day-to-day problems they face in their work. Conspicuous examples include policemen, prison wardens, and businessmen in their relations with their labor force. The natural clumsiness of the law is a factor that should be considered when deciding how to regulate and how much to regulate, but it is not by itself a reason to give unfettered discretion to the possessors of technical expertise.

65 It may not be superfluous to note that while the law has always taken a position and must take one today, it is also reasonable for the law to take a position. Among the strongest justifications for favoring republican government in general, and the American system of constitutional democracy in particular, is its ability to protect the rights of minorities (or the weak generally) against the contrary interests of the majority (or those who can manipulate and direct the majority) without thereby converting the protected minority itself into an oligarchy. See The Federalist No. 10 (J. Madison). This is what accounts for our remarkable panoply of protective civil rights and civil liberties laws; it would be strange to suggest that handicapped children are not the sort of weak and vulnerable minority that should be entitled to legal protection for their rights, however those rights might finally be defined.
has articulate and energetic spokesmen; for convenience, they may be grouped under the rubrics "sanctity of life" and "quality of life."

The "sanctity of life" approach is most commonly associated with Dr. Everett Koop, a prominent pediatrician now serving as Surgeon General of the United States. His approach is conceptually simple: wherever there is hope of life, a physician ought to try to save that life.66 While Koop and many other advocates of this approach seem to be motivated by religious beliefs, their conclusions are very close to the traditional, and until recently uncontroversial, consensus of the medical profession. It is not hard to see the attraction of this approach. The moral standard is clear, simple, and in most cases easy to apply. It avoids a lot of difficult and troubling line drawing and it could be enforced with manageable legal rules.

Despite these powerful virtues, the Koop approach is not without its drawbacks. In some cases, an undiscriminating devotion to the preservation of life will lead to horrible suffering by the intended beneficiaries—suffering that many people would consider worse than death. Since newborn children obviously cannot choose for themselves whether to undergo medical treatment, it would seem extravagant for the law to compel medical treatment that can lead only to lives filled with little but pain and suffering. Nor would it be right simply to ignore the suffering visited upon the families of extremely defective children who are treated in the name of the "sanctity of life." While people may argue about the relevance and extent of this problem, and of the associated problem of the costs to society in general, it remains true that these children are sometimes extremely burdensome and that this is surely a cost of insisting strictly on the sanctity of life.67

These sorts of problems have led many physicians and other commentators to advocate some form of quality of life analysis,68 which involves an

---

66 For brief presentations of Koop's views, see Koop, Ethical and Surgical Considerations in the Care of the Newborn with Congenital Abnormalities, in INFANTICIDE AND THE HANDICAPPED NEWBORN 89 (D. Horan & M. Delahoyde eds. 1982); Senate Hearings, supra note 29, at 6-21 (statement of Everett Koop).
67 It should be noted, however, that it is easy to overstate the inevitability of the suffering that defective children impose upon their families. Adoption, as in the Bloomington case, is often available. Furthermore, most states have procedures by which parents can divest themselves of their legal obligations to their offspring, even when there are no offers of adoptions. See Robertson, Dilemma in Danville, 11 HASTINGS CENTER REP. 515 (1981).
68 There is now a large literature on this subject. Some of it consists of attempts to develop and refine criteria for deciding which children will be selected for nontreatment; this literature usually ignores the underlying questions about the propriety of developing such criteria and is mainly technical in nature. Another large portion of the literature is purely negative, and consists of attacks on the "sanctity of life" position (or some caricature thereof), usually by describing extremely pitiful patients in a way that implies that the infants are no good to themselves and a positive harm to others; the conclusion (either expressed or implied) is that some alternative must be found, but the exact nature of that alternative is often left extremely vague or uncertain.
estimation of the relative costs and benefits of providing medical treatment. The attraction of this approach is that it allows room for the decision makers to distinguish cases in an intelligent fashion, and thereby avoid the drawbacks of the sanctity of life approach.

It is very difficult to make plausible generalizations about the degree of intelligence and honesty that actually governs the individualized decisions that are made under the quality of life approach. The literature includes some very heart-rending accounts of the agony of parents who have been forced to decide whether their children should receive continued treatments or be allowed to die. In some cases, parents have complained that physicians mindlessly and mechanically (and thus cruelly) adhered to the traditional preservation of life ethic. In other cases, parents have resisted doctors' suggestions that treatment be discontinued. In many cases where doctors and parents have cooperated, the decisions were undoubtedly reached only after the most thorough and well-intentioned consideration

---

69 In this Article, I will focus on what seem to be the most moderate and well thought out versions of the quality of life analysis. It should be noted, however, that some prominent commentators are much more radical:

If we compare a severely defective human infant with a nonhuman animal, a dog or cat, for example, we will often find the nonhuman to have superior capacities, both actual and potential, for rationality, self-consciousness, communication, and anything else that can plausibly be considered morally significant. Only the fact that the defective infant is a member of the species Homo sapiens leads it to be treated differently from the dog or pig. Species membership alone, however, is not morally relevant. Humans who bestow superior value on the lives of all human beings, solely because they are members of our own species, are judging along lines strikingly similar to those used by white racists who bestow superior value on the lives of other whites, merely because they are members of their own race.

Singer, Sanctity of Life or Quality of Life, 72 PEDIATRICS 128, 129 (1983); see also The Hardest Question, Newsweek, Jan. 14, 1985, at 29 (reporting that Prof. Virginia Abernathy of Vanderbilt Medical School believes that until the age of three or four, infants are "nonpersons" whose interests are always subordinate to the rights of "persons").

Even more moderate advocates of the "quality of life" position seem to have trouble formulating reasonable general positions. John Lorber, for example, suggests that one precondition of a meaningful life is the ability to earn one's "own living in competitive employment and be self-supporting with a secure, independent place in society." Shaw, Spina Bifida Cystica: Results of Treatment of 270 Consecutive Cases with Criteria for Selection for the Future, 47 ARCHIVES OF DISEASE IN CHILDHOOD 854 (1972). If this criterion were applied to the adult population, it would seem to suggest the need for a large scale euthanasia program.

70 See, e.g., P. Stinson & R. Stinson, THE LONG DYING OF BABY ANDREW (1983); Lorber, Dilemmas of "Informed Consent" in Children, 289 NEW ENG. J. MED. 885, 887-88 (1973); Portela, The Elín Daniels Case: An Examination of the Legal, Medical, and Ethical Considerations Posed When Parents and Doctors Disagree on Whether to Treat a Defective Newborn, 18 FORUM 709 (1983) (describing a case in which medical treatment was performed, pursuant to court order, over parents' objections; it turned out that the child was not, as had been feared, mentally retarded).

71 See, e.g., Baer, Should Imperfect Infants Survive?, 35 NAT'L REV. 1069, 1092 (1983) ("One boy, for example, whose indigent parents refused Dr. Duff's [nontreatment] prescription when he was born is now an A student. Dr. Duff had said the child would be a 'vegetable.'").
of the welfare of the newborn child. In other cases, the adults involved
seemed to worry primarily about their own convenience or the effects that
the handicapped child might have on the rest of the family;\textsuperscript{72} in still other
cases, the adults hardly appear to have thought about the matter at all, and
have reacted with an almost visceral revulsion to the newborn baby.\textsuperscript{73}

Institutions, like individuals, appear to have varied widely in their
approaches to the problem. Some seem to pride themselves on their elabo-
rate procedures for ensuring that hasty or ill-informed decisions to termi-
nate treatment are not made. Others seem to have taken little interest in the
problem and have tolerated results that appear to some to be extraordinar-
ily barbarous.\textsuperscript{74}

Since most of these decisions are made in the relative privacy of
doctors' offices and neonatal intensive care units, it is impossible to know
how widespread one or another practice is. Still, it is reasonably clear that
there is considerable variation. Thus, while the flexibility in the quality of
life approach is its greatest strength, it is also its greatest weakness. A
cost/benefit analysis is potentially so flexible that it runs the risk of becom-
ing either completely unprincipled or, what may be worse, a device for
introducing inappropriate criteria into the decision making process.

These difficulties are illustrated by Dr. Anthony Shaw's "formula" for
measuring a child's expected "quality of life:"

\[
QL = (NE) (H + S)
\]

QL is "quality of life;"
NE is the child's "natural endowment;"
H and S are the resources (not limited to financial support but
including affection and training) that the family and society, re-
spectively, can be expected to devote to the child's welfare.\textsuperscript{75}

This formula is marked with a misleadingly scientific cachet, for even if one
agrees that it identifies the principal variables that affect a person's happy-
ness, it does not indicate how to measure the variables. Neither Shaw nor
anyone else has defined a meaningful unit that can measure any of the
independent variables, let alone a unit that would be commensurable with
all three.\textsuperscript{76} Thus, any attempt to use this formula to rank the relative

\textsuperscript{72} See, e.g., Freeman, supra note 57, at 143-44 ("[T]he family has rights, just as the affected
child has rights . . . the 'best' for everyone concerned may be the death of the child").

\textsuperscript{73} See, e.g., Senate Hearings, supra note 29, at 138 (testimony of Mrs. Karen Green-
McGowan, R.N.) ("The physician often comes in wanting to rescue the family, saying, if I were
in your place, gee, I wouldn't want a child like that.").

\textsuperscript{74} See, e.g., Fost and Cranford, Hospital Ethics Committees: Administrative Aspects, 255

\textsuperscript{75} Shaw, Defining the Quality of Life, HASTINGS CENTER REP., OCT. 1977, at 11.

\textsuperscript{76} Shaw himself disclaims any intent to use the formula to calculate "the numerical value
of human life." Indeed, he seems to recognize that there may be something problematic about
the formula when he points out that for a physically normal child born to an unwed drug
prospects for happiness of a group of children would in fact involve the kind of subjective guessing that should always be so troubling when one is called upon to make life and death decisions. Formulating these guesses in quantitative terms merely serves to conceal, not to diminish, their troublesome character.

The subjective nature of estimates about the child’s quality of life would thus be problematic even if they focused exclusively on the child’s prospective welfare. As Shaw’s formula suggests, however, these esti-

addict mother, “H” and “S” could both be zero, so that the baby’s “QL” would be the same as that of an extremely defective newborn, namely zero. Shaw, however, declines to draw any inference from this apparent parallel except to note that a person’s quality of life “may be determined to a significant degree by factors physicians frequently fail to consider.” Id.

Shaw’s formula should be contrasted with the use of the medical “triage system,” to which it has a certain misleading similarity. The triage system is used by doctors in emergency situations where there is a shortage of medical resources, for example in battle or after major natural disasters such as earthquakes. Under that system, patients are divided into three groups: those who will probably survive even without immediate attention, those who will probably not survive even with immediate attention, and those for whom immediate attention will probably make the difference between life and death. First priority is given to patients in the last group, as a combination of common sense and the principle of the sanctity of life quite clearly dictate. Even in this situation, where reasonably objective (though of course fallible) medical judgment is exercised, doctors have typically felt that they were being compelled only by necessity to make decisions that were in sharp tension with their moral and professional inclinations; they have been worried by the prospect of making errors in classifying the patients and have sought (for example, by demanding that additional medical resources be supplied as quickly as possible) to avoid being compelled to make such decisions.

The use of Shaw’s formula, or “quality of life” criteria in general, is very different from the triage system. It requires the use of far less objective criteria, which is troubling enough in itself. More important, however, it is not imposed on doctors as the least bad alternative in the face of a scarcity of resources. Rather, it requires that they embrace the opportunity to allow some individuals to die according to criteria selected by the physician (or by whomever is charged with calculating the patient’s expected “quality of life”).

The New Jersey Supreme Court, which decided the Quinlan case, see supra note 31, recently adopted a test that seems to incorporate a “quality of life” criterion in this sense. At least for elderly patients with severe mental and physical disabilities, life-prolonging treatment may be withheld, even without evidence that the patient himself would have refused the treatment, if “the net burdens of the patient’s life with the treatment [wo]uld clearly and markedly outweigh the benefits that the patient derives from life.” Matter of Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

It should be noted that if one believes that it is sometimes in the patient’s interest to be allowed to die because his life will be filled with more pain than he would wish to endure, one should find it hard to resist the conclusion that the process of dying should be made as swift and painless as possible. The law, however, clearly prohibits active euthanasia (e.g. by lethal injection); hence, a commitment to this position should require one to favor changes in the legal status quo. Cf. Harris, Ethical Problems in the Management of Some Severely Handicapped Children, 7 J. Med. Ethics 117 (1981) (suggesting that active euthanasia is preferable to selective nontreatment); Freeman, supra note 57, at 144 (“[U]ntil active euthanasia, with whatever appropriate safeguards, becomes acceptable to society.”); Parness & Stevenson, Let Live and Let Die: Disabled Newborns and Contemporary Law, 37 U. Miami L. Rev. 43, 54-60 (1982) (suggesting that a constitutional “right to die” be established on the basis of the Supreme Court’s privacy decisions); Smith, Life and Death Decisions in the Nursery: Standards and Procedures for Withholding Life-sustaining Treatment from Infants, 27 N.Y.U. L. Rev. 1125, 1166-68 (1982) (advocating active euthanasia in some circumstances).
mates can be (and indeed the literature indicates, usually are) a device for taking into account other people's happiness. In Shaw's formula, “H” and “S” are not truly independent variables, but are factors that will almost inevitably be affected by, *inter alia*, perceptions of the child's “NE.” Shaw seems to recognize this when he distinguishes contributions to the individual by the home and society from contributions to the home and society by the individual. Indeed, one of Shaw's main points seems to be to discourage confusion between the “QL” of the individual and the “QL” of his family and society. Shaw is utterly ambiguous, however, on the question of whether it is proper for a physician to consider the quality of life of persons other than his patient, and he certainly does not propose a means by which decision makers could in practice convert “H” and “S” into truly independent variables. Shaw, *supra*, note 75.

For physicians to base decisions about the treatment of their patients on the interests of third parties conflicts with the most fundamental premise of the Hippocratic Oath and perhaps of medicine itself. When one adds to this radical departure from traditional canons of medical ethics the fact that parents are ordinarily quite deferential to physicians' recommendations, it can appear that physicians' enthusiasm for using “quality of life” criteria is, at least in part, an attempt to arrogate to themselves a striking new power to manage a program of eugenics. One can debate the propriety of engaging in eugenics programs, but one can hardly argue

---

79 Shaw seems to recognize this when he distinguishes contributions to the individual by the home and society from contributions to the home and society by the individual. Indeed, one of Shaw's main points seems to be to discourage confusion between the “QL” of the individual and the “QL” of his family and society. Shaw is utterly ambiguous, however, on the question of whether it is proper for a physician to consider the quality of life of persons other than his patient, and he certainly does not propose a means by which decision makers could in practice convert “H” and “S” into truly independent variables. Shaw, *supra*, note 75.

80 See *supra* notes 58-59 and accompanying text.

81 See *supra* notes 35-39 and accompanying text.

82 See, e.g., Eckstein, *The Problems of Selection*, 5 Brit. Med. J., 284, 284 (1973) (“The parents' opinion should be considered, but in practice very few parents express a strong opinion which is different from those of the medical attendants.”); Rickham, *The Ethics of Surgery on Newborn Infants*, 8 Clinical Pediatrics 251, 252 (1969) (“At the end it is usually the doctor who has to decide the issue.”).

83 Eugenics programs can be divided into several types, but they all share the goal of improving the biological fitness of a population. Some are “positive” (programs to promote reproduction by individuals with superior genes) while others are “negative” (programs to prevent reproduction by individuals having inferior or defective genes). Some programs focus on eliminating certain genotypes (e.g. by genetic screening of prospective parents) while others require direct destruction of the unwanted phenotypes (e.g. the Nazis’ extermination programs at German mental hospitals).

The new infanticide is somewhat unusual in that most of its promoters are primarily and consciously concerned only with the improvement of very small populations (individual families) rather than with society at large. The aggregate effect, however, is the same as it would be if the specific intent to improve the overall gene pool were present. In any case, the crucial moral distinction among eugenics programs is between those that aim only to eliminate certain undesirable biological traits (e.g. congenital diseases) and those that destroy undesired individuals (e.g. those who suffer from congenital diseases). The new infanticide is in the latter category.

84 Sterilization programs have been carried on at various times in this country and have received the outspoken support of at least one highly respected American jurist. See Buck v. Bell, 274 U.S. 200, 207 (1927) (Holmes, J.) (“It is better for all the world, if instead of waiting
that such a program should be a matter of political indifference, to be left to the discretion of unaccountable private persons. Thus, in seeking to curtail the practice of infanticide by physicians, the government is entering a province to which its own duties and judgment quite properly extend. It is physicians, not government officials, who have begun “interfering” in matters that are not their proper business.

If one is attracted by the flexibility of the “quality of life” approach, one can argue that the legislature ought to establish or endorse a program of selective nontreatment of handicapped children. The danger in doing this, a danger that will probably prevent the national legislature from ever seriously considering it, is that any such program is an obvious and extremely slippery slope. At the bottom of this slope lies a Nazi-type conception of the legitimacy of eliminating all kinds of “social expendables,” a conception that in fact did begin to take root in Germany with programs for exterminating handicapped children.85 While the argumentum ad hitlerem86 is itself a slippery instrument that can easily be abused, the spectre
to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. . . . Three generations of imbeciles are enough.”). Sterilization, however, is significantly less drastic than the destruction of unwanted individuals.


86 In its simplest version, the argumentum ad hitlerem takes the following form: Policy X was adopted by the Nazi regime; the Nazi regime was evil incarnate; we should therefore not adopt Policy X. The fallacy in this argument is obvious enough that it should not require explication. The argument sometimes takes a more sophisticated form: Policy X was adopted by the Nazis and we should reject the policy in order to avoid taking what could be the first step toward Nazism. In this form, the argumentum ad hitlerem is dangerous, but not completely invalid: it is always prudent to be wary of taking steps that could lead to undesirable unintended consequences, though one should also be wary of overestimating such dangers and of losing sight of the more immediate virtues of the proposed policy.

A sober version of the slippery slope argument was used by Abraham Lincoln to demonstrate the untenability of the proslavery position:

If A. can prove, however conclusively, that he may, of right, enslave B.—why may not B. snatch the same argument, and prove equally, that he may enslave A?—

You say A. is white, and B. is black. It is color, then; the lighter having the right to enslave the darker? Take care. By this rule, you are to be slave to the first man you meet, with a fairer skin than your own.

You do not mean color exactly?—You mean the whites are intellectually the superiors of the blacks, and, therefore have the right to enslave them? Take care again. By this rule, you are to be slave to the first man you meet, with an intellect superior to your own.

But, say you, it is a question of interest; and, if you can make it your interest, you have the right to enslave another. Very well. And if he can make it his interest, he has the right to enslave you.

II Collected Works of Abraham Lincoln 222 (R. Basler ed. 1953) (emphasis in original). Lincoln’s argument applies, mutatis mutandis, with equal force to the claim that supposedly defective or inferior people should be killed.
of the slippery slope is not a mere illusion. Once one begins to make explicit decisions to terminate the lives of certain people because their medical problems seem to make them not "worth" preserving, there will certainly be pressures to make more such decisions. These pressures are likely to appear sooner rather than later in a society where old people are becoming increasingly numerous and increasingly burdensome consumers of medical care that is provided largely at government expense. As the technology of organ transplants becomes more sophisticated, there may also be increased temptations to hasten the deaths of some people in order to obtain their organs for others who for one reason or another are deemed more worthy of continued life. Whether legalized infanticide would lead to other forms of euthanasia is impossible to know, but the principle used to justify it would also justify them. The possibility of these other forms being practiced is real enough that it constitutes an important drawback of the quality of life approach to the selective nontreatment of handicapped newborns.

VI. THE NEW FEDERAL LAW

Neither the analogy between abortion and infanticide nor the academic controversy over the principles of the "sanctity" and "quality" of life would have been enough to excite Congress into enacting new legislation. That required a much more visible public event, which finally occurred in 1982.

On 6 April 1982, "Baby Doe" was born in Bloomington, Indiana. He suffered from two congenital defects: trisomy-21 (Down's Syndrome), an illness whose principal symptom is mental retardation, and a malformed esophagus, which needed to be surgically connected to the stomach in order for him to eat normally. This esophageal disorder is fairly common in the victims of Down's Syndrome, but it can also afflict otherwise normal children; it is routinely corrected with a surgical procedure that succeeds about 90% of the time. Baby Doe's parents (apparently supported by

---

87 The advocates of the quality of life argument for infanticide have themselves felt the need to worry about the possibility of Nazi-type consequences. See, e.g., Duff & Campbell, supra note 25, at 892 (mentioning Nazi Germany); id. at 894 (mentioning the need to avoid the "extreme excesses of 'Hegelian rational utility' under dictatorships").

88 It should also be noted that the danger of a slippery slope is taken very seriously by some thinkers who are very far removed from the religious and politically conservative influences that manifestly affect many opponents of infanticide. Prominent libertarian Nat Hentoff, for example, has asked: "If fetuses have no rights, handicapped infants have no rights, can the aged and infirm be far behind?" The Hardest Question, Newsweek, Jan. 14, 1985, at 29.

89 The case described below was not the first to become publicly known; there was a small flurry of publicity about similar cases in the early 1970's. See Ellis, supra note 29, at 399-401.

90 Paris & McCormick, supra note 46, at 313.
their obstetrician) refused to authorize either the esophageal surgery or intravenous feeding. Perhaps fearing legal liability, hospital administrators notified the district attorney, who sought an emergency hearing in state court. Though there were many offers to adopt Baby Doe, all three levels of the Indiana courts upheld the parents’ decision.91 Lawyers were en route to Washington to seek review by the United States Supreme Court when the baby died; the Supreme Court refused to hear the case in 1983.92 This incident received heavy play in the media, and it is not hard to see why it would attract public attention.93 The Baby Doe incident was a disturbingly clear case in which a baby who almost surely could have been saved and who might have lived a relatively normal life94 was starved to death, under color of law, though many people had volunteered to adopt and care for him. This case has come to symbolize the new infanticide problem, and it certainly served as the paradigm for the legislators who drafted the new child abuse legislation.95 It is suggested in Part VII that this is a somewhat misleading paradigm and that it may have led Congress to underestimate the difficulty of solving the underlying problem. First, it will be useful to review the history of the new law.

Three weeks after Baby Doe died, President Reagan instructed the Secretary of the Department of Health and Human Services (HHS) to ensure that the nation’s hospitals complied with section 504 of the Rehabilitation Act of 1973. HHS eventually adopted a rule requiring all federally funded infant care facilities to post notices warning against discrimination


Ironically, Indiana was the only state in the Union at the time that had a statute specifically providing for criminal and civil liability where newborn children have been denied needed medical treatment. Ind. Code Ann. § 35-1-58.5-7 (West Supp. 1984-85). At least three other states have now responded to the problem with new legislation. See Kuzman, The Legislative Response to Infant Doe, 59 Ind. L.J. 366, 400-05 (1984).


94 Although the “Baby Doe” problem has received considerable attention in the media, there is some evidence that the coverage has been inaccurate, euphemistic, and generally biased in favor of parents and physicians who withhold food or medical treatment from handicapped children. See Tedeschi, supra note 49. Despite whatever suppression of the truth has occurred, enough emerged to provoke both the President and the Congress to act.

95 Victims of Down Syndrome suffer mental retardation that can be quite severe but is often rather mild. The degree of retardation cannot be predicted at birth. Paris & McCormick, supra note 46, at §15.

96 The legislative history of the new law focuses heavily on the Bloomington case, which was clearly the catalyst for congressional action. See, e.g., Senate Hearings, supra note 29, at 1-2 (statement of Sen. Denton); S. Rep. No. 246, 98th Cong., 1st Sess. 5-6 (1983).
towards handicapped patients and providing a toll-free phone number for reporting suspected violations to the federal government. Judge Gerhard Gesell of the District Court for the District of Columbia struck down the rule as "arbitrary and capricious" under the Administrative Procedure Act. The administration next sought to use an existing disclosure regulation under section 504 to obtain access to the medical records of another suspected victim of medical neglect. The United States Court of Appeals, Second Circuit, relying extensively on strongly worded dicta in Judge Gesell's opinion, ruled that section 504 did not apply to situations of this kind. Meanwhile bills aimed at dealing with the problem were introduced in both houses of the 98th Congress, and committee hearings were held in each chamber.

The House bill consisted of a series of amendments to the Child Abuse Prevention and Treatment Act, which coincidentally was due to expire in late 1983. Most of the amendments were minor, technical changes intended to make the law operate more effectively. The only significant and potentially controversial provisions were those requiring the states, as a condition of receiving federal funds under the child abuse prevention program, to set up procedures for preventing facilities from denying nutrition or medically indicated treatment to children with life-threatening

---

99 United States v. University Hospital, 729 F.2d 144 (2nd Cir. 1984). The Court quoted Gesell as follows: "The legislative history . . . [on this subject] focuses on discrimination against adults and other children and denial of access to federal programs. As far as can be determined, no congressional committee or member of the House or Senate ever even suggested that Section 504 would be used to monitor medical treatment of defective newborn infants or establish standards for preserving a particular quality of life." Id. at 158 (quoting American Academy, 561 F. Supp. at 401). The majority opinion is somewhat ambiguous about exactly what kinds of situations are not covered by § 504. A strong dissent suggested that the majority's opinion employed such a tendentious reading of the legislative history that it constituted an "outright disagreement with Congress' judgment and an unconstitutional act in itself." Id. at 163 (Winter J., dissenting). The Supreme Court will take up the issue presented in this case during the next term. See Heckler v. American Hospital Association, No. 84-1529 cert. granted, 105 S. Ct. 3475 (1985).

For a detailed history of the administration's attempt to address the Baby Doe problem through the regulatory process, see Note, The HHS' Final Rule on Health Care for Handicapped Infants: Equal Protection Not Guaranteed, 11 J. Legis. 269 (1984).

congenital impairments. The House seems to have regarded these provisions as unproblematic additions to a popular, if limited, child-abuse program. The “Baby Doe” amendments were hardly mentioned in the hearings, the committee reported the bill out with a perfunctory and unanimous report, and the bill passed the House by an overwhelming vote.

The Senate bill included provisions similar to those in the House bill, but went further in two significant respects. First, it required HHS to undertake a major study of the problem and report back to Congress within one year. More important, the bill authorized HHS to issue regulations that would directly govern hospitals receiving federal funds. This provision would have placed responsibility directly on the federal government (rather than the states) for preventing the kind of infanticide represented by the Bloomington Baby Doe case; it therefore suggests that the draftsmen of the Senate bill regarded the Baby Doe problem as one that might be more intractable than the House believed.

The validity of the suggestion that the Senate viewed infanticide as more of a problem than did the House is strengthened by the contrast between the Senate and the House hearings. Whereas the House subcommittee passed very lightly over the Baby Doe provisions, Senator Jeremiah Denton’s Subcommittee on Family and Human Services devoted a full day of hearings to the subject. But if the Senate subcommittee took the problem

---

102 The crucial provision of the Child Abuse Amendments of 1984, Pub. L. No. 98-457, 98 Stat. 1749 (1984), as finally enacted, is § 122, which adds a clause ((4)(b)(2)(k)) to the existing Act. It requires that states receiving funds under the federal child abuse program:

within one year after the date of the enactment of the Child Abuse Amendments of 1984, have in place for the purpose of responding to the reporting of medical neglect (including instances of withholding of medically indicated treatment from disabled infants with life-threatening conditions), procedures or programs, or both (within the State child protective services system), to provide for (i) coordination and consultation with individuals designated by and within appropriate health-care facilities, (ii) prompt notification by individuals designated by and within appropriate health-care facilities of cases of suspected medical neglect (including instances of withholding of medically indicated treatment from disabled infants with life-threatening conditions), and (iii) authority, under State law, for the State child protective services system to pursue any legal proceedings in a court of competent jurisdiction, as may be necessary to prevent the withholding of medically indicated treatment from disabled infants with life-threatening conditions.


106 This provision was apparently intended to give HHS the authority that the Reagan administration had attempted to exercise under § 504 of the Rehabilitation Act. Though this did not survive to become part of the bill as enacted, the new law contains a “savings” clause (§ 127 (a)) that provides: No provision of this Act or any amendment made by this Act is intended to affect any right or protection under section 504 of the Rehabilitation Act of 1973.
seriously, it also sought out a rather unbalanced panel of witnesses. Out of

ten witnesses, only one represented the organized medical lobby, and only

he stressed the difficulty of framing legal rules to govern the exercise of

medical judgment.\(^{108}\)

The Senate bill was reported out of committee by a unanimous vote, but it stalled on the Senate floor for over a year, apparently because of

opposition from organized medical groups. Late in 1984 a compromise was

reached, and the Senate passed the House version of the bill\(^ {109}\) after

modifying some of the language to ensure that doctors would not be

required to provide useless treatment to hopelessly ill patients.\(^ {110}\) Most of

the medical groups accepted this compromise; the American Medical As-

sociation, however, continued to insist that the law should allow physicians
to base their decisions in part on the prospective "quality of life" of the

patient. The compromise bill passed both houses easily, and was signed by

the President.\(^ {111}\)

The new legislation is a compromise, with which most of the interested

parties seem to think they will be able to live. That may be a sign that the

law is a good one. Compromise and moderation, after all, have long been

regarded as a special genius of the American political system and a principal

source of the country's stability and prosperity.\(^ {112}\) Certainly the implicit

\(^{108}\) See Senate Hearings, supra note 29, at 47-60, 111-17.

\(^{109}\) The crucial provision (§ 122) of the bill as finally enacted is quoted supra note 102.

\(^{110}\) The bill as finally enacted defined the prohibited "withholding of medically indicated

treatment" as follows:

the term 'withholding of medically indicated treatment' means the failure to respond

to the infant's life-threatening conditions by providing treatment (including appro-

priate nutrition, hydration, and medication) which, in the treating physician's or

physicians' reasonable medical judgment, will be most likely to be effective in

ameliorating or correcting all such conditions, except that the term does not include

the failure to provide treatment (other than appropriate nutrition, hydration, or

medication) to an infant when, in the treating physician's or physicians' reasonable

medical judgment, (A) the infant is chronically and irreversibly comatose; (B) the

provision of such treatment would (i) merely prolong dying, (ii) not be effective in

ameliorating or correcting all of the infant's life-threatening conditions, or (iii)

otherwise be futile in terms of the survival of the infant and the treatment itself

under such circumstances would be inhumane.

§ 121(3) (adding § 3(3) to the Act).

\(^{111}\) Implementation of the new Act's crucial provision (quoted supra note 102) may be

made easier than it would otherwise be by the availability of a model state statute developed by the

ABA's Developmental Disabilities State Legislative Project. The model law provides that

physicians who deny "necessary medical care and treatment" would be subject to loss of their

medical licenses (§ 11) and that physicians would be immune for good faith provision of care

without parental consent (§ 5(2)), if delay in providing the care would jeopardize the infant's

life (§ 5(1)). Unlike the new federal law, the model statute defines the protected group of

children (those born alive and less than two years old) (§ 3(1)). See B. Sales, D. Powell & R.


\(^{112}\) For a detailed analysis, see R. Dahl, Pluralist Democracy in the United States

(1967).
premise of the new law is that the Baby Doe provisions should be politically unproblematic. This is indicated by the fact that Congress chose to leave enforcement of the rights of handicapped children to state agencies, which are presumed to be no more likely to be deterred by local political forces in this area than in connection with the other problems, such as child beating, incest, and child pornography, addressed in the Child Abuse Prevention and Treatment Act. 113 This premise of public consensus contrasts with the many federal laws that offer direct protection to groups of people who are believed to be vulnerable or disadvantaged in local political processes. Racial minorities, women, and handicapped adults, for example, are all protected by laws that provide for direct federal enforcement. As demonstrated in Part VII, extremely ill newborn children have more in common with these latter groups than with the victims of child beating, incest, and "kiddie porn," who are the primary concern of the Act. The problem of protecting these children, however, is complex enough that it may be extraordinarily difficult to solve it through direct legal regulation.

VII. CONCLUSION—THE NEW LAW’S PROSPECTS FOR SUCCESS

The new legislation that Congress designed to protect Baby Does appears to rely on a fairly simple model of the problem, a model based on the Bloomington incident. Under this model a handicapped child is denied necessary, yet routine medical treatment that would certainly be given to an otherwise normal child. Providing the treatment would improve the child’s chance to survive, although without removing the handicap, whereas withholding the treatment would lead to the child’s death. Denying treatment in such cases fits easily within the concept of “discrimination against the handicapped,” and indeed it is hard to distinguish from outright murder. 114 Stories of such incidents understandably incense many people,


114 There have apparently not been any successful murder prosecutions in this area. See Ellis, supra note 29, at 401 & n.32. In one case, parents and physicians were charged with conspiring to commit murder when food was withheld from newborn Siamese twins, but the charges were dismissed for lack of evidence. See Robertson, supra, note 67, at 5. Prosecutors and juries, however, often consider factors that are foreign to the applicable legal concepts—lynch mobs, for example, were immune from liability for murder in certain sections of the country until fairly recently. Factors that may discourage prosecution in Baby Doe cases include sympathy with the “afflicted” parents, deference to the judgment of physicians (who are rightly assumed not to be acting out of vicious motives), and a natural tendency not to regard extremely defective infants as fully human.

especially when the law affirmatively sanctions the infanticide, as it did in the Bloomington case.\textsuperscript{115}

As indicated in Part III of this Article, many cases that will be affected by the new law will present problems that are far more ethically and medically complex than those in the Bloomington example. Paradoxically, perhaps this complexity suggests that it is especially important that parents and physicians be provided with clear and administrable legal guidelines. For that reason, and because of the "slippery slope" problem discussed in Part V of this Article, the "sanctity of life" approach to medical treatment decisions is probably preferable to the "quality of life" approach, even apart from religious or other suprapolitical doctrines that may be decisive for some of its champions. Even if one disagrees with this conclusion, the discussion in Parts IV and V above should suffice to show that Congress was at least acting defensively in seeking to curtail the new infanticide. One question, however, remains unanswered: how well can the new law be expected to accomplish Congress's goal?

Recall that the new legislation is in the form of amendments to a perfectly noncontroversial child abuse prevention program. That program relies on the states to establish effective mechanisms for carrying out Congress's desire to protect the interests of endangered children. For most forms of child abuse, there is no organized constituency with an interest in promoting the proscribed practices. The child abuse program is essentially an exercise in revenue-sharing, and it appears to be well-suited to that approach.

By sharp contrast, "Baby Does" are threatened by a very well-organized and well-financed interest group, the medical profession, that can be expected to promote its own agenda in an effective and persistent manner.\textsuperscript{116} Given this fact, a dispersal of enforcement responsibilities to the several states rather than to an agency of the federal government can be expected to strengthen the hand of the pro-infanticide forces in relation to their opponents. In the smaller forums, where financial resources and media scrutiny are in shorter supply, special interest groups are likely to be especially effective. This general tendency is liable to be particularly pronounced in the present context because the new legislation defines the prohibited practices as deviations from "reasonable medical judgment."\textsuperscript{117}

\textsuperscript{115} It is by no means true that all observers are disturbed by cases like the Bloomington incident. Cf. Sorensen, \textit{The Rationalizing of Reproduction and Parenthood: Some Societal Developments}, in \textit{Decision Making and the Defective Newborn} 261, 275-76 (C. Swinyard ed. 1978) (discussing survey data suggesting significant levels of approval for euthanasia among the general population).

\textsuperscript{116} The AMA presented its own scheme for dealing with the issue, which was defeated in Congress. Cong. Q. Weekly, Feb. 2, 1984.

\textsuperscript{117} See supra note 108. Note also that the new law contains a provision (Section 127(b)) that indicates an intent to retain the traditional deference towards physicians.
Physicians are the recognized experts in medicine, and as we have seen, the ethical questions in this area are in practice closely intertwined with technical medical considerations. All of this, combined with an apparent lack of sustained public interest in the problem,\(^\text{118}\) makes it quite unlikely that state agencies will begin aggressively trying to reform what has now become an almost routine professional practice.

This is not to say that the new law is sure to be completely useless, nor to imply that those supporting the “sanctity of life” position (including many physicians) are utterly powerless in state politics and administration. It is suggested, however, that handicapped newborns are so situated that their interests are generally favored by moral principle but opposed by powerful private interests and prejudices. In similar circumstances, Congress has often found it advisable to establish programs that provide for direct federal enforcement of the civil rights of the vulnerable constituency. Conspicuous examples include racial and ethnic minorities, women, and handicapped adults, all of whom can vote and none of whom seem in any obvious way more likely than handicapped children to be ignored in the ordinary political processes.

This analogy suggests that the Senate bill, which would have authorized HHS to enforce its anti-infanticide provisions,\(^\text{119}\) might have been a considerably stronger and more beneficial alternative. One might even go further and contemplate the possibility of devising strong federal sanctions, perhaps including criminal penalties, to deter physicians from the practice of infanticide. Certainly, if Congress truly regarded infanticide as the ultimate form of child abuse and if Congress recognized that there are powerful forces committed to promoting such abuse, one would expect the full force of federal law and law enforcement capabilities to be devoted to the protection of the endangered children.

As soon as one begins to consider these possibilities, however, one realizes why Congress would wish to avoid truly vigorous and potentially effective action. Despite the sharp interest of a few members of Congress and despite the lack of any significant congressional opposition to the rather mild new law, Congress is undoubtedly aware that there is no real national consensus on the underlying moral questions. Infanticide, like

\(^{\text{118}}\) No provision of the Act or any amendment made by this Act may be so construed as to authorize the Secretary [of HHS] or any other governmental entity to establish standards prescribing specific medical treatments for specific conditions, except to the extent that such standards are authorized by other laws.


\(^{\text{119}}\) For a suggestion that the lack of public interest is in part caused by a lack of public understanding, which in turn has been caused by a campaign of distorted and tendentious journalism, see Tedeschi, supra note 49, at 31.

\(^{\text{119}}\) See supra note 106 and accompanying text.
abortion, is a practice that many people are likely to oppose as a matter of "personal morality," especially when they are in circumstances that do not make the practice a convenient temptation. It appears however that not enough people, especially among the leaders of national opinion, are yet willing to take steps that would actually stop this practice.

Furthermore, because the Baby Doe problem is so entwined with technical matters of medical judgment, it would probably be very difficult to devise and then impose truly strict legal rules on a recalcitrant medical profession. This suggests that we might be grateful that Congress expressed its sense of what is proper by enacting anti-infanticide legislation, but that it refrained from what might have been a failed effort to actually enforce its general principles. This suggestion, however, does not take account of the extreme passion that animates the most vocal and active opponents of infanticide. They are generally the same people who have forced the nation to give the abortion issue serious political attention for years after the Supreme Court attempted to lay it to rest. It seems likely that the new infanticide, no less than abortion on demand, will continue to command their attention and that they will refuse to allow the rest of us to enjoy the pleasant slumber of the complacent. On both of these issues involving the rights and status of the weakest and most unwanted among us, the most imprudent course of all might be to suppose that they can conveniently be swept out of sight. On such basic questions as the sanctity of innocent human life, it may pay to remember that a house divided against itself cannot stand.

120 For a discussion of the argument that "we should muddle though and live with a striking dichotomy between the law on the books and the law in action rather than developing more precise standards or adopting new procedures," see Mnookin, Two Puzzles, 1984 Ariz. Sr. L. J. 667, 683.