On Letting Some Babies Die

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THE OCTOBER 25, 1973, issue of *The New England* Journal *of Medicine* contained two articles and one editorial dealing with the death of defective newborns. One author cited the following case:

> Baby B was referred to... [the MD] at the age of 36 hours with duodenal obstruction and signs of Down's syndrome. His young parents had a ten-year-old daughter, and be was the son they had been trying to have for ten years; yet, when they were approached with the operative consent, they hesitated. They wanted to know beyond any doubt whether the baby had Down's syndrome. If so, they wanted time to consider whether or not to permit the surgery to be done. Within 8 hours a geneticist was able to identify cells containing 47 chromosomes in a bone-marrow sample. Over the next three days the infant's gastrointestinal tract was decompressed with a Nasogastric tube, and he was supported with intravenous fluids while the parents consulted with their ministers, with family physicians in their home community, and with our geneticists. At the end of that time, the B's decided not to permit surgery. The infant died three days later after the withdrawal of supportive therapy.'

This tragic history reveals a set of difficulties faced by physicians, other members of the helping professions, parents, babies, and by our culture generally. I should like to comment in a rather rough and ready way about some of these problems .[2]

As I do this I shall make two assumptions, each of which is open to question. First, I shall assume that we are dealing with newborn human beings who are human persons. While I do not assume that each and every product of the human womb is such a person,[3] I do assume here that those scholars who suggest that a "self-concept" (presumably involving some level of self-consciousness) is a necessary ingredient of human personhood, are wrong. If I am incorrect in this assumption, of course, the problem is simplified and obligations to the newborn, although not eliminated, become indistinguishable from those to subhuman beings.

Second, I shall assume that we all accept, at least as a prima facie obligation, the prohibition on killing human beings. The problem, of course, is whether the prohibition applies in the newborn situation; I do not mean to settle that issue by definitional fiat. I do mean to note that no problem arises unless one starts out with a rejection of killing. A prohibition on killing might be justified in any one of a number of ways. My own theory would involve, in part, theological rationale beginning with the biblical poetry about human nature, about persons made in the image of God. But here I should like to move beyond that issue and consider a specific kind of case in which the limits of the prohibition on killing are tested.

I shall consider two issues in a little detail. These are: (1) procedural questions of who should make decisions of this kind and (2) substantive questions of what criteria should be used in making the decisions. In conclusion I *will* discuss one implication of my views, views which are rather conservative.

II

Professor Paul Ramsey argues that procedural questions, questions about who should make decisions, are not the only questions of importance in medical ethics. I grant that, but it does not follow that procedural questions are unimportant. I shall consider them before, but more briefly than, questions of substance.

When the family, described in the case with which I began, decided to refuse permission for an operation on their baby, they were, obviously, deciding to shorten his life. That is, they decided for euthanasia. This term (euthanasia) has been used in any number of ways, and it has been linked with various qualifiers (for example, passive vs. active, direct vs. indirect). I use it here in its most general and least technical sense, as meaning a decision for a comfortable death.

The reason that euthanasia on the newborn is an especially interesting case is that there is no possibility that the baby can consent to the procedure. This may be true of any proposed mercy killing of a child, although with older children the issue becomes less sharp. But it is clear that it is nonsense to speak of the consent of a thirty-six-hour-old baby. Thus euthanasia on the newborn would always be involuntary euthanasia. The decision about the shortening of his life must be made by others. While this makes the case hard on a human and personal level, it may simplify somewhat the theoretical problems involved.

It would be possible and plausible to move from this procedural point to a conclusion on the substance. That is, one could argue that given the impossibility of patient consent, all possible means to prolong life must be utilized. Since consent is impossible to obtain in this case, no limitation of treatment could be legitimate. If the patient's life is to be shortened, the logical thing to do is to nurture him until he can make that decision himself.

Such an argument is well intentioned, but stated this simply it is inconclusive because it rests on the assumption that prolongation of life is always in the interest of the child. The possibility that shortened life might be in the interest of the child is excluded without discussion. In other words, acceptance of this "procedural" argument as conclusive would involve a failure to see that what follows from the impossibility of consent is not an obligation to maximize length of life but an obligation to act in the best interest of the child. This may or may not involve the maximization of length of life.

Allow me to try to put the issue another way. The "procedural" argument is unassailable. if consent is a necessary condition for euthanasia, and if newborns arc persons. Given these premises, an absolute prohibition on euthanasia on the newborn will follow. I have conceded the premise about newborn personhood, but the premise about the necessity of consent as a prerequisite to euthanasia is not certain in circumstances where it would have been impossible to get consent. We must distinguish the more frequently discussed cases where the possibility of euthanasia could have been considered by the patient from cases in which it is obviously impossible for the patient to have made a decision on the matter. Conceding (for purposes of argument) that consent is a necessary condition for euthanasia on the adult, it does not follow from this that it is necessary in the case of the newborn. What we can say about the newborn is that in the absence of consent we may never define his interest in some idiosyncratic way. We must always act with an eye to his interest, plausibly construed. I shall return to this issue in part IV.

If decision-making power cannot rest with the patient, where should it reside? The two obvious possibilities are the family of the patient and the relevant physicians. How should power be balanced between these groups? Physicians have great power by virtue of their technical knowledge and social location, but it is not clear that they should exercise as much power as they sometimes do. One writer says that, when the question of who should decide is raised, the answer is:

> ... the child's doctor, for who else is in a similarly pivotal position to make sure that the proper medical consultation has been obtained in ascertaining the hopeless condition of the patient, that the parents receive sympathetic and thorough explanation, and that they are exposed to broadly based advice? Who else can lead all those involved to a decision, and who else is more responsible for consoling after decision has been reached? Society, ethics, institutional attitudes and committees can provide the broad guidelines, but the onus of decision making ultimately falls on the doctor in whose care the child has been put.

Another author has written that the role of the parent's input into such decisions "will be primarily emotional."

Against this tendency it is essential to assert the importance of family input. There are various reasons why this is true. For one thing the actual decision involved is not, in the narrow sense, a medical decision. The physician is an expert on diagnosis and therapy. His technical competence extends to both identification of pathology and decision about the relative merits of various ways of correcting the pathology. He can describe the likely course of life of patients with certain afflictions. This does not, however, make him an expert on such questions as whether a life lived with a serious handicap is "worth living." Answers to such questions involve decisions about values and their relative priorities. While I am far from thinking that such decisions are irrational, I see no reason to regard physicians as experts about them.

On the other hand, we must be on guard against suggesting that physician power is demonic. Many individuals and teams of physicians dealing with children born with birth defects go to great lengths to insure the meaningful involvement and input of the patient's family.[10] Professionals may also find it difficult to get families really to weigh options and take responsibility. While professionals may become jaded and block out certain considerations, they also may be able to compensate for this and present the forecast with clarity that only experience allows. Moreover, it is questionable-on general principles-to handle problems of power by pious exhortations to the powerful. Demands that physicians surrender power will be counterproductive, it they serve to shift attention away from the problem of how the physician should use the power which he or she inevitably will possess.

That said, it remains essential that a considerable amount of this particular power-over the life and death of an infant-be relinquished by physicians because the real issue involved is not a technical one over which physicians are professionally competent. It is rather a personal one concerning the family in and through which the child will live. I do not mean to suggest that the family should operate in a vacuum or unchecked. But I do mean that responsibility for this decision must be meaningfully shared and that the family (the group who *will* serve, enjoy, and in large part create the child) is the appropriate locus of primary decisional power.

At this point, however, we must turn to the substance of the issue. What decisions should be made about Baby B, and others more or less severely handicapped?

III

Many arguments are used to justify bringing a quick and painless end to the lives of defective infants. Such practices were well known in ancient times and received the approval of famous philosophers. The modern arguments tend to take two forms. Some argue that euthanasia on the defective child is justifiable for his own sake; others argue that it is justified for the sake of others: the family, community, or even the human race. I shall consider both these types of argument, beginning with the latter.

One argument for the quick and easy death of defective children assumes essentially the following form. The child represents a threat to the life or well-being of others. Therefore, he or she may be killed in order to *protect* these "others." This *type* of argument persuaded the early Christians to give up their pacifism and it has found recurrent form in various versions of the lust War theory. As presented there it has the following ingredients: although killing in self-defense is unjustified, people have obligations to protect others. This obliga*tion to protect* can override the prohibition on killing, if the person against whom action is taken is threatening the life of someone to whom one is obliged. Other and less serious ways of stopping the killer must have been attempted, if available. In the case of action by collectives, the justified killing must have been approved by the legitimate authority, i.e., the war must have been declared by the sovereign. Finally, for some versions of the theory, the justice of a particular cause had to be pronounced by an acknowledged and impartial arbiter."

Doubtless it seems a long way from the nice distinctions of philosophers and theologians to the intensive-care nursery of twentieth-century Western culture. But it may be that this paradigm of reasoning has some relevance to the issue at hand. These categories were not meant to be a way of outlawing all war; neither were they meant to be simply rationalizations which were compatible with any war which the sovereign might choose to declare. Rather, they represented a way of analyzing this most marginally moral of human activities, the taking of human life. This analysis schematized the questions which must be asked, and answered affirmatively, if a particular war were to be justified.

Let us try to see how these questions might apply to the case of the defective baby, such as Baby B. The maintenance of that baby obviously will drain the resources of his family and various health-care institutions and professionals. Resources of both family and community could be used for other purposes. Among these legitimate purposes is the protection and preservation of other people who now, or may in the future, live in his family or community. No amount of extra or palliative surgery will remove the child's mongolism and so this drain will continue no matter what is done. His death is the only alternative to living with the problem. This verdict may be well known to parents, the physician, and any relevant legal authorities. Thus the baby represents a serious threat to lives, a threat which cannot be removed in any other way. Once this verdict is impartially pronounced, an act destroying the child is justifiable infanticide rather than murder.

I do not think that this form of argument will fail in absolutely all cases, but there are serious problems with it. As stated above, it would prove far too much, for it would justify the killing of anyone, of any age, who in some way is a social liability. As a check against this abuse, the Just War theorists insisted that the only person who might be directly killed was the combatant, i.e., the person who was actually functioning as a killer. While they did not insist that the person to be killed must be at fault or guilty in some juridical sense, they did insist that this person's social function be that of an active threatener. His victims had to be identifiable and their prospective possible deaths had to be the results of something he brought about.

How could the defective newborn possibly fit these criteria? While it is obvious and very relevant to our overall understanding of the problem-that resources used to care for him could be used in other ways, it does not follow from this that he is personally threatening anyone. If one tries to make the most plausible possible case for threat, that is, that care for him will destroy the person (if not the life) of mother, siblings or father, one quickly runs up against the question of last resort. There are many ways in which the family can be saved, short of the death of the baby. The child can be institutionalized. One might argue of course that institutionalized life is not worth living, but then one has shifted the terms of the argument and is raising a question of the best interest of the child. Furthermore, the whole reason that this issue is a problem is that we lack a recognized sovereign who can adjudicate questions of this kind.

I am not prepared to say that there are no cases in which the argument could be made. I only say that one will have to show actual threat to very particular people (which means family members), absence of alternative possibilities for action, and a procedure which accords the infant some semblance of due process. In fact, in our society these conditions will preclude justifications of infanticide using this type of argument.

Moreover, I believe that we can draw another conclusion from the argument from protection and our procedural considerations. Sometimes it may be suggested that the defective newborn, whose parents are missing, is a more proper candidate for euthanasia than the baby whose parents accept responsibility for decision making. And it is suggested that the reason this is true is that this deserted baby not only will lack the advantages of a home; he will also represent an unusually serious drain on society's resources.

The striking thing however about such a deserted newborn is that there is no community of which he is a part. There is no family either to represent his interests or to be threatened by him. Thus it will be impossible to show his direct threat to specific other individuals or to accord him something like due process. Consequently, the deserted, defective newborn is precisely the child who may never be killed for the sake of others. This does not, of course, settle the question of what forms of care are appropriate for such a child. The absence of a family community means that society must be at special pains to act in the patient's interest. Interest and longevity are not identical, as we have suggested before. Thus it may be inappropriate to subject a deserted child to all possible treatment and he may, in consequence, live a shorter time than technology now makes possible. This sort of procedural consideration does not suggest the illegitimacy of such a course of events. But the baby with no advocate, and threatening no particular persons, cannot possibly be construed to be a legitimate victim of protective killing.

IV

Let us now shift to the second substantive argument under review. This is the notion that the death of the newborn is justified in his own interest. One decides for his death because, in his case, such a decision is better for him.

One interesting proposal for a way of arguing this case has been made by Professor Paul Ramsey. Ramsey claims that we are always obliged to care for sick persons, but that the requirements of care alter with the condition of the patient. Normally, caring for the patient requires attempts to cure his disease, but it sometimes happens that a patient begins to die. Once the dying process has begun the obligations of family and physicians shift. Specifically, the obligation to cure is gradually displaced by the obligation to provide "company," companionship, and human comfort to the dying person. Thus one should allow a dying patient to die.

In Ramsey's view allowing to die is appropriate; positive euthanasia is forbidden. This may appear to be a moralistic quibble; the impression is deepened by Ramsey's argument for his thesis which seems to make heavy use of a distinction between omission and commission. He seems to say that a person is more responsible for deaths following his commissions than for those following his omissions. In fact, however, Ramsey thinks that a decision to withhold or withdraw therapy should be described as "ceasing to do something that was begun in order to do something that is better because now more fitting."[13] A decision to cease curing is not an omission at all, but a decision about *which* kind of acts of care to commit. The trouble with positive euthanasia for Ramsey is that it represents an attempt to push the dying beyond reach of our care.

Ramsey concedes, however, that some individuals may slip beyond care either because they are permanently unconscious or because they are experiencing no relievable pain of a very intense sort. If such cases ever arise, Ramsey argues, the patient cannot receive our care and for that reason other norms become operative. He will allow positive euthanasia in such cases.

All this is tied into the newborn case by Ramsey's claim that the process of dying may begin at any age, indeed that one may be afflicted in utero by the malady from which he will die.

In order to assess this theory about the morality of euthanasia on the newborn, let us consider a real world case which seems to embody similar ideas. John Lorber, in Sheffield, England, is a physician with extensive responsibilities for a clinic specializing in the care of babies afflicted with spinal bifida. Spinal bifida is a birth defect of uncertain origin. The afflicted children have a split in the vertebrae and a portion of the spinal cord may be extruded, sometimes within a thick blister-like sack and sometimes outside such a sack which has been ruptured. The frequent consequences are paralysis, to some degree, of the lower extremities; bladder and bowel incontinence or malfunction, and, frequently, mental retardation. Death for such children used to be a virtual certainty because the exposed portion of the spinal cord would be very vulnerable to infection and the child would succumb to meningitis. Modern medical technology has made it possible to close the lesion, surgically attempt to straighten the back, drain the hydrocephalus which often develops, and treat, in various ways, both the infections and the frequently recurring renal problems. The result, of course, is to salvage many children who would formerly have died; yet a large percentage of these children are seriously handicapped; many are severely mentally retarded.

For the first twelve years of the Sheffield clinic's operation, a policy of maximal treatment was followed. Everything possible was done for all infants afflicted with spinal bifida. The battle against death and deformity was never given up. But accurate records were kept and in 1971 Lorber published an article in which he argued against the past policy of his own clinic and claimed that *selective* treatment should be the rule. As early as possible ore should decide which patients to treat and which to allow to die. Lorber writes that it is "easier not to draw a line" but that this would represent a failure to learn the lesson of the "massive therapeutic experiment" which happened at Sheffield. The good specialist can, he argues, accurately assess "the minimum degree of future handicap" even if it is impossible to "forecast the maximum degree of disability."" Essentially, the criteria Lorber proposed involve the degree of paralysis of the infant, head circumference (showing likelihood of hydrocephalus), presence or degree of curvature of the spine and "associated gross and congenital anomalies or major birth injuries."

While it is clear that Lorber bases part of his argument for this selection practice on social utility grounds, it is also obvious that he feels this kind of selection for treatment is in the interest of the patients from whom therapy is withheld. This might be because of anticipated serious physical or mental defect. An example of physical problems might be the following:

> One normally intelligent girl of 9 years of age has had 18 major operations so far, including 7 revisions of her shunt and two extensive spinal osteotomies in an attempt to correct her extreme kyphoscoliosis. She still has as gross scoliosis as ever. A long metal rod was passed through the bodies of her vertebrae along the length of her vertebral column: unfortunately, she has such a compensatory lordosis that this rod emerges from the thoracic vertebrae and through the skin to bridge the lumbar lordosis and enter the lowest lumbar vertebrae and sacrum.

Lorber does not explicitly tell the reader what the fate of this patient would have been if his proposed selection criteria had been in operation. On the other hand, most of those treated patients whom Lorber would now refuse treatment are, in fact, mentally retarded.

Now one way of interpreting Lorber's proposal is as an adaptation of Ramsey's criteria. We would then understand Lorber to be suggesting that some children are born so seriously defective that, although not dying, they should be allowed to die. Not all spinal bifida children fall into this group, only those most seriously affected. Rather than leave the judgment of *which* children to allow dying to the more or less amateur guesses of local physicians and family, Lorber has gone on to propose some well-tested rules of thumb to guide decision making. Lorber's rules apply only to the decision not to give treatment; he does not favor active euthanasia on the children from whom massive therapy is withheld, any more than Ramsey favors active euthanasia on the adult patient being allowed to die.[18]

I believe, however, that we can see some serious problems with this synthesis. One of these, concerns the adequacy of the criteria for selection which Lorber formulates. These have been called into question by other professionals in the field,[1]' who argue both that Lorber s prognosis for those babies whom he would allow to die is unjustifiably bleak and that some of those babies are worse off than they would have been if treated very early in life. They further point to the relative advantages of supportive services such as clinical and personal care over against orthopedic corrective surgery on the spine. In other words, there are possibilities of erroneous diagnosis and less than optimal therapy which make a decision to allow dying problematical. These objections are often raised against positive euthanasia, but they would seem to hold with equal force against Lorber's practice."

The problem of error is in no way unique to these medical decisions, however. If that were the only difficulty, allowing babies to die might be fitting. But there is a more serious problem. Let us assume that there are circumstances in which we might approve of allowing an adult to die. Our approval need not require the patient's consent, if such consent could not have been obtained. Yet our approval would involve a judgment that the patient had begun to die. How such a judgment might be made is a complicated problem. But one plausible ingredient will be a kind of comparison between the adult's past health and future prospects. We would consider past physical health and, to a limited point, his person, character and life-style. On the basis of some amalgam of these factors, we might infer that a particular patient had begun to die.

The striking thing about newborn persons, however, is precisely that they have no visible personal past. They have had no opportunity to develop a normality of their own functioning. No physical plateau, personality, character or style of life has had a chance to surface. The newborn presents himself as totally unexploited potential-if we were cynical we could say, as a field for potential exploitation. Thus, in the absence of a benchmark in past life for saying *this* particular person has started to die, I do not see how one committed to care (as Lorber surely is) could ever switch from cure to companionship. The yardsticks which would give such a division provisional legitimacy in the case of an adult (that is, consent and/or establishment of a norm of life) are absent in the case of the newborn. In their absence we should not disjoin care and cure.

Of course, the question of what is the fitting form of care-cure remains open. I have already claimed that maximal treatment and optimal treatment are not the same. Many religious moralists (including Professor Ramsey) express this point in very sophisticated form using a distinction between ordinary and extraordinary means. Patients are not required to use extraordinary (maximal) means, only the ordinary ones. Which means are extraordinary? One formulation is that those which harm the patient more than he will benefit from them.[21]

I do not want to argue for an obligation on physicians and families to use extraordinary means on all newborns. In the course of the care-cure of some babies it may become clear that additional therapy will cost that baby more than he can gain. But it is very unclear that most of the babies Dr. Lorber allows to die fall into this group; it is even less clear that baby B (Down's syndrome and duodenal obstruction), with whom we began, does. It is difficult to see how these decisions to withhold treatment could claim to be judgments made about optimal treatment for the particular babies at hand. Instead they are judgments comparing these babies and their limited prospects to "normal" babies and their different prospects. A judgment about these particular babies' interests would have a better basis later.

On the other hand, it may be that there are newborn human persons who are beyond the reach of our care. As Ramsey suggests, this might be because of their (inferred) unconsciousness or because they experience pain which cannot be relieved. No one, of course, really suggests that a Down's syndrome, or spina bifida, baby cannot receive love. They would not fall in this group. But if infants ever are in circumstances such that care-cure in the conventional sense cannot be received-or where it *is* received as torture, then the requirements of care would have to be rethought or obligations of other sorts might become more relevant.

V

In summary, I regard withholding treatment from defective newborns as wrong unless (1) it can be argued that the action is necessary to protect the personal life of at least one specifiable other person or (2) the infant cannot receive care in any other form. This amounts to a prohibition of active or passive infanticide on most newborns. I am uneasy with this conclusion, although I cannot see my way clear to any other. As a postscript I should like to make one additional point.

One of the aspects of this conclusion that troubles us is that it leads to the salvaging of a very large number of seriously defective children; thus Lorber and others who practice selection point with pride to the "high quality" of the children now under their care. Of course, we should be doubly shocked if selection did not have this result, but the problems of the hardships and sufferings of others cannot be denied. This is especially troubling for someone who argues against quality control, for life with defect means sacrifice and hardship for the child, siblings, and parents. It seems the moralistic conclusion of the abstract theorist.

Against this I would note that neither family disaster nor a great increase in the number of living defective children is inevitable given my conclusions. The reason these consequences do not *necessarily* follow is that we can allocate resources so as, at least, to minimize them. In other words, we can see this as a problem of resource allocation. As such it would have two distinct levels.

The first of these is the level of deciding which babies to treat and how to treat them. Given finite resources to spend on newborns, the issue is unavoidable. I have already argued that the only fair criterion for deciding appropriate treatment for a given baby is that baby's own welfare and ability to receive love. This precludes selection on some qualitative basis and, in effect, forces a surgical team to a random or, its nearest social equivalent, a first-come, first-served "system" of selection.

What then of the related question of how to treat? This cannot be separated from the question of selection since, presumably, some kinds of care are more likely to exhaust our financial and personal resources than others. And, at least to the amateur eye, there seem to be real differences among, e.g., spina bifida centers, over such questions as the relative emphasis on shunting and counseling, orthopedic surgery and physical therapy. It is not obvious that maximal use of technology leads to optimal care.

In fact, a method of treatment in which family support is not central seems to border on blackmail. As things stand, the family can often only make the "right" decision at incredible cost. No parents can be sure how they would face such a crisis. But if mistakes are made, we may be able to say that responsibility ultimately lies not with the parents but with a medical system which offered them only unacceptable ways of handling the problem: too much massive intervention, on the one hand, and insufficient help in caring for the afflicted baby, on the other. There seems to be a rough analogy with a weapons technology which produces only megaton weapons, leaving nothing appropriate for fighting conventional skirmishes. Why do we have refined surgical techniques but inadequate institutional supports for handicapped persons and their families?

In any case, given their finite resources, health-care professionals will have to find a workable balance between offering maximal treatment to a very few infants and offering minimal care to all. Limitations of resources *will* mean that we can offer less than ideal treatment for those afflicted babies who are treated. This *will* lead to some infant deaths and misery as will the more or less random selection process. While these are sad facts, they are inevitable.

The error we want to avoid is the notion that we should solve our limited resource problem simply by assessing the "quality" of the output. Such an approach leads one to think that the ideal result is either a "perfect" baby or a dead baby.” And the root problems of this way of looking at the issue are that both the human rights of defectives and the imperfections of all babies are glossed over. We would be horrified to learn that an obese, myopic professor was refused treatment on the grounds that he would always be a decrepit physical specimen. Why do we tolerate the same *kind* of reasoning when applied to newborns?

Beyond this, of course, lies the problem of the second level of resource allocation. How much of our medical budget should be spent on newborn care, and how much of our GNP should be allocated to medicine? In my view, such decisions should be based on fairness considerations and should in some way reflect the deepest value commitments of our culture. Full discussion is obviously impossible here. But it is not obvious that, within health care, the salvaging of defective newborns should be our highest priority. Extending basic services to more people may be much more important. Further, it may be that we spend too much on health and too little on education and the arts.

Briefly put, we can attack the problem of defective newborns by putting much greater stress on support for the family and by realizing that other obligations force us to restrict the numbers of such children whom we reach. Whether we should develop resources is an open question, as is the question of their ideal form. But once we have decided to develop resources there are moral constraints on the way we may use them. One of those constraints, in a just society, is that we will not refuse treatment to babies whom it is in our power to help.

'Anthony Shaw, M.D., "Dilemmas of Informed Consent in Children," *The New England Journal* of *Medicine* 289 (October 25, 1973), p. 886. This sensitive article is invaluable for study of the problems discussed in this paper.

An earlier version of this paper was read at a colloquium sponsored by the Committee on the Humanities at Indiana University. I am very grateful to the Committee, and its chairman, Professor Robert Byrnes, for the invitation. Since then, helpful suggestions have been made by Andre Hellegers, Richard McCormick, S.J., David C. McCullough, and LeRoy Walters. Of course, none of these persons is to be held responsible for the views I express.

As an example of a problematical case, I would cite the anencephalic child.

A brilliant and well-qualified statement of an alternative view is Michael Tooley, "Abortion and Infanticide," *Philosophy and Public Affairs* 2 (Fall, 1972), pp. 37-65.

Robert Vetch, Willard Gaylin and Councilman Morgan (eds.), "The Nature of Medical Ethics" in *The Teaching of Medical Ethics* (Hastings-on-Hudson, N.Y.: Institute of Society, Ethics and the Life Sciences, 1973), pp. 18-19.

This point is very well made in LeRoy Walters, "Ethical Concepts and Attitudes Toward Passive Euthanasia" (unpublished manuscript). My great debt to Professor Walters is here, in a token way, acknowledged.

F. J. Ingelfinger, M.D., "Bedside Ethics for the Hopeless Case," *The New England Journal of Medicine* 289 (October 25, 1973), p. 914. Why do the parents require "advice" if "the onus of decision-making" rests with the physicians?

John M. Freeman, M.D., "To Treat or Not to Treat: Ethical Dilemmas of Treating the Infant with a Myelomeningocele," *Clinical Neurosurgery* 20 (1973), p. 141.

Robert M. Vetch has discussed this issue in many places. See especially "Generalization of Expertise," *The Hastings Center Studies 1* 121 (1973), pp. 29-40.

Cf. Dr. Shaw's article, previously cited as well as Raymond S. Duff, M.D., and A. G. M. Campbell, M.D., "Moral and Ethical Dilemmas in the Special-Care Nursery," *The New England Journal of Medicine* 289 (October 25, 1973), pp. 890-94; also, Mary D. Ames, M.D. and Luis Shut, M.D., "Results of Treatment of 171 Consecutive Myelomeningoceles-1962-1968," *Pediatrics 50* (September, 1972), pp. 466-70.

My formulation of this is dependent on Paul Ramsey, *War and the Christian Conscience* (Durham, N.C.: Duke University Press, 1961) and Paul Ramsey, *The Just War* (New York: Charles Scribner, 1968).

Cf. the works of Ramsey previously cited and Baruch Brody, "Thomson on Abortion," *Philosophy and Public Affairs 1* (Spring, 1972), pp. 335-40.

Paul Ramsey, *The Patient as Person* (New Haven: Yale University Press, 1970), p. 151; cf. pp. 144-53, 132-36. Emphasis added.

Paul Ramsey, "Reference Points in Deciding About Abortion" in *The .Morality of Abortion, ed. by* John T. Noonan, Jr. (Cambridge: Harvard University Press, 1970), pp. 91-10C Ramsey, *The Patient as Person, pp.* 161-64.

John Lorber, M.D., "Results of Treatment of Myelomeningocele," *Developmental Medicine and Child Neurology* 13 (1971), p. 300.

lbid., pp. 290-91.
1bid., pp. 284-85.
For Lorber, see his "Early Results of Selective Treatment of Spinal Bifida Cystica," *British Medical Journal* (October 27, 1973), p. 204.

See Freeman, and Ames and Shut cited in notes 8 and 10.

The problems for exponents of positive euthanasia are clearly presented by Yale Kamisar, "Euthanasia Legislation: Some Non-Religious Objections" in *Euthanasia and the Right to die. ed* .A. B. Downing (Los Angela: Nash, 1969), pp. 85-86.

A full discussion of the complex distinction between ordinary and extraordinary means lies outside our scope. These terms have not always and to everyone meant the same thing. qty formulation is very freely adapted from Thomas J. O'Donnell. S. I.. *Morals in 'Medicine* iWcstminster, .v1d.: Newman Press. 1960). p. 72.

The serious difficulties with this claim have been pointed out by Richard NIcCormick. S.J., in "Notes on `coral Theology," *Theological Studies* 34 (March, 1973), pp. 67-69.

It is, of course, possible that patients from whom treatment would be withheld at one clinic are intentionally referred to another with a less selective policy. Cf. James Lister's letter in the *British Medical Journal* 4 (November 10, 1973), *p. 355.*

An excellent statement of the arguments for randomization is James F. Childress, "Who Shall Live When Not All Can Live?" *Soundings* 43 (Winter, 1970), pp. 339-55. I do not assume that 'first-come, first-served" is identical with random selection.

I have in mind the differences in emphasis that emerge from reading the account of the practice at Sheffield as compared with that of Ames and Shut in Philadelphia.

While he can in no way be held responsible for the use to which I have put it, I owe this phrase to LeRoy Walters.