WE ARE PLEASED TO ANNOUNCE
that on July 1, 1985, the Pope John Center will relocate its national headquarters offices from St. Louis to Boston.
We are equally pleased to announce that at the same time a new regional office will be opened in Houston, Texas.

Our July 1 new national office address will be:
The Pope John XXIII Medical-Moral Research and Education Center
186 Forbes Road,
Braintree, Massachusetts 02184

The Child Abuse Amendments of 1984

Defective newborn infants are the most defenseless of all handicapped individuals — and there are so many of them. In addition to approximately 130,000 infants born each year in the U.S.A. with readily-detectable congenital abnormalities, there are some 230,000 infants born each year which are categorized as low-birth-weight (usually premature). The enormity of the challenge is indicated by the fact that infants of the former group (congenitally defective) may be the victim of one or more of over 3000 conditions of abnormality.

It was especially the Baby Doe case which focused the attention of the nation on the plight of the defective newborns. This infant, born in Bloomington, Ind., in 1982, was a mongoloid baby (Down Syndrome). Although Down Syndrome is not a life-threatening condition, this infant did have a life-threatening condition in the form of an esophageal blockage which prevented the intake of food and water. A frequently-performed surgical procedure would have removed that threat to the baby’s life. The parents refused to consent to the surgery; their decision was upheld by a circuit court judge, and later also by the Indiana Supreme Court. This little baby girl was deprived of food and water and even of intravenous nourishment and hydration. She died within six days. The media abounded with stories and commentaries which raised the question of “how many more defenseless infants such as Baby Doe are denied the right to life through deliberate neglect in our American hospitals?”

Directives Regarding Child Abuse Followed by Legislation

It would take too long to trace the series of reactions to the Baby Doe case which led to U.S. governmental intervention. As of February, 1984, the Department of Health and Human Services had recommended that hospitals establish Infant Care Review Committees (ICRC’s). Such committees were directed to set guidelines for the care of handicapped infants, to review specific decisions to withdraw or withhold treatment of such infants, and to monitor periodically the hospital’s actual practices in the treatment of handicapped infants. Basically, these recommendations were in line with the current official policy of the American Academy of Pediatrics. After much heated controversy over other federal regulations which were viewed as governmental interference in hospital affairs (requirements of posted notices of federal rules, a “hot line” for reporting violations, etc.), President Reagan signed into law the Child Abuse Amendments of 1984 (also known as the “Baby Doe” law) on Oct. 9, 1984.

The most significant paragraph of this legislation reads as follows (indentations added so as to emphasize appropriate distinctions in the legislation):

“the term ‘withholding of medically indicated treatment’ means the failure to respond to the infant’s life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) which, in the treating physician’s or physicians’ reasonable medical judgment, will

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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; or (c) the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane “(Pub.L. No. 98-457, Oct. 9, 1984; Conference Report, Title I, Part B, Sec. 121, Section 3).

Three other features of this legislation merit special mention: it establishes a new requirement for state participation in federal child abuse grant programs (including mechanisms for responding to instances of medical neglect of disabled infants, programs for appropriate coordination of consultation, and authority to pursue legal remedies); it authorizes federal grants to states and to public or private non-profit groups for information clearing houses, social services, etc.; it requires the Secretary of Health and Human Services to issue regulations implementing all aspects of the law, including “model guidelines to encourage the establishment . . . of (hospital) committees” for educational, advisory, and counseling purposes on the subject of handicapped infants (Ibid., Sec. 122 (3), Sec., Sec. 123 (2) (A), Sec. 124 (b) (1)).

Interpretation of the “Child Abuse Amendments of 1984”

The legislation clearly extends “child abuse” to the withholding of “medically indicated treatment” from disabled infants with life-threatening conditions. The phrase “life-threatening” is not defined. The legislation would not apply, however, (as stipulated in provision (b), to infants who are dying (i), nor to some cases of infants who are victims of more than one life-threatening condition (see below) (ii), nor to situations where treatment would serve no useful purpose (iii). The “more than one life-threatening condition” is explained as follows: “Under the definition, if a disabled infant suffers from more than one life-threatening condition and, in the treating physician’s or physicians’ reasonable medical judgment, there is no effective treatment for one of those conditions, then that infant is not covered by the terms of the amendments (except with respect to appropriate nutrition, hydration, and medication) concerning the withholding of medically indicated treatment.” It is logical to assume that “life-threatening” means simply “in danger of death.” That it is NOT restricted to “imminent death” is indicated in the “Joint Explanatory Statement” that the amendments “may include older infants (than one year) who have been continuously hospitalized since birth who were born extremely prematurely or who have long term disabilities” (Appendix, Congressional Record, July 26, 1984, S9309-9310, p. 41). According to this legislation, “appropriate nutrition, hydration, and medication” may not be withheld even with regard to dying infants. Naturally this imperative is subject to the rule of “primum, non nocere” (“above all, cause no harm”) which would apply if efforts at any of the “comfort measures” (nutrition, hydration, medication) could not be tendered without adding to the suffering of the infant. The phrase “reasonable medical judgment” is explained as “a medical judgment that would be made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved.” The phrase “virtually futile” in Section (C) apparently means “worthless for all practical purposes” (as opposed to “absolutely futile”). The full sense of that Section (C), however, is stated as “virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane” (Ibid.) The inference seems to be: “It would be lacking in compassion if the treatment would lead to a mere tenuous survival.”

The Child Abuse Amendments of 1984 and Catholic Moral Principles

Based on the modicum of official government interpretation of the Child Abuse Amendments of 1984 as available thus far, the purpose and provisions of this legislation would seem to be in harmony with Catholic moral teachings — provided that certain assumptions (to be made below) are valid. The legislation’s reference to treatment which is “futile in terms of the survival of the infant,” seems to say that “what kind of burden of survival” following treatment must be kept in mind as a humane consideration. It is valid to assume that this could not mean that a disabled infant’s “quality of life” handicap would constitute an impediment to appropriate treatment. The 1973 Federal Rehabilitation Act is very clear in prohibiting any discrimination against an individual on the basis of his or her handicap. If the legislation is saying that the full scope and extent of the burden associated with the treatment must be given due consideration in the name of human compassion, it is well in harmony with the Catholic teaching that there is a limit to what the patient and even family members can be expected to endure as burdens which are associated with the means proposed to preserve life: “. . . no one may be obliged to submit to a type of cure which, though already in use, is not without some risks or is excessively burdensome” (Declaration on Euthanasia, The Pope Speaks, 1980, p. 295).

Likewise, when the legislation speaks of not extending treatment to an infant with multiple life-threatening conditions “if there is no effective treatment for one of those conditions” (provision (b), (ii)), the provision would be acceptable morally only if intended in the sense that the legislation would still apply if one or more of the life-threatening conditions could be treated effectively at a later date. In many cases, effective treatment for such infants would be indicated only after the infant has reached a certain age, or after another life-threatening condition had been corrected or ameliorated.
In a subsequent article in this publication, an attempt will be made to illustrate the provisions of the Child Abuse Amendments of 1984 by applying the provisions to actual cases. For the present, there is reason for rejoicing that the law of the land has vindicated the right to life of every infant, regardless of “quality of life” considerations, and has taken steps to protect that inviolable right.

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Concurring In Part - Dissenting In Part

The New Jersey Supreme Court On Claire Conroy.

On January 17, 1985, five justices of the New Jersey Supreme Court issued a long awaited decision in the case of Claire Conroy. One other justice filed a separate opinion “concurring in part and dissenting in part”, and pleading for more openness than the majority opinion offered to what, in the judgment of the present writer, must be considered euthanasia at least of the “passive” type. One need not be open to the dissenting justice’s orientation in order in part to “concur with and in part dissent” from the majority opinion which now becomes, at least for the present, an effective element of our jurisprudence.

The Case.

Claire Conroy was an 84 year old nursing home resident who suffered serious and irreversible physical and mental impairment, to the point that she could not speak or swallow sufficient amounts of nutrients or water to sustain herself. Her intellectual capacity was about as limited as it could be, but, her physician said, “she responds somehow”. She was not in a vegetative or comatose state (p. 6 of the decision, hereafter Decision).

Nonetheless, her only surviving blood relative, a nephew, acting in his capacity as legitimate proxy, sought district court permission for the removal of the nasogastric tube which was supplying her food and fluids. The district court granted the permission, but, on appeal of a court-appointed guardian ad litem, the permission was withdrawn. Shortly after the nephew then appealed the case to the state supreme court, Claire Conroy died. That court agreed, nonetheless, to hear the case so as to establish legal guidelines for similar cases in the future.

One incident in the case history will be of particular concern to Catholics. At the district court level, where originally permission to remove the nasogastric tube was granted, a Catholic moralist testified that “acceptable Church teaching” would justify removing support from a life whose “value” was “outweighed” by its “burdens” (Decisions, p. 10). He concluded also that the “removal of the tube would be ethical and moral, even though the ensuing period of her death would be painful” (ibid., emphasis added).

The New Jersey Supreme Court Decision.

In effect, the court did not judge whether or not the nasogastric tube could have been withdrawn from Claire Conroy, but, that the evidence was not clear one way or the other in light of three norms which the supreme court set forth in its majority opinion:

The “subjective” standard: In an earlier, competent period, did the patient express clear and permanent misgivings about artificial life-support? The mind of the patient in his competent days, the supreme court insisted, overrides all other considerations.

The “limited-objective” standard: If the patient in his competent days expressed only vague or ambiguous misgivings about artificial life-support, is his present physical and mental condition nonetheless deplorable enough that it may do away with any uncertainties we may have about applying the “subjective” norm? Some “limited”, but “objective” and severe disabilities of the patient may combine with some past mere hints that “subjectively” he might reject artificial life-support, the court seems to say, to justify our removing such life-support.

The “pure-objective” standard: If, as a matter of fact, the