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Choices for a Child: An Ethical and Legal Analysis of a Failed Surrogate Birth Contract

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And the king said, Divide the living child in two, and give half to one and half to the other.\(^1\)

This was King Solomon's advice to two women fighting over a child each contended was her own. The true mother was the one who was willing to give the baby to the imposter rather than see her child divided.

In today's world of increasingly sophisticated reproductive technologies which offer once infertile couples the chance to have their own child, one wonders what wisdom King Solomon would provide in a conflict involving a woman hired to bear another couple's child. This paper explores such a situation.

In our scenario, the husband and wife who hire the surrogate mother are both fertile, but because of her diabetes, the wife does not wish to endure the risks of pregnancy. They employ a second woman to carry the wife's egg, which is fertilized by the husband's sperm. The surrogate mother carries the baby to term. However, the baby is born with defects, and a conflict arises between the surrogate mother and the couple as to how much medical treatment the baby should receive.\(^2\) Part I of this paper will explore the medical complications of the couple, the terms of the surrogate contract, the procedure of in vitro fertilization involved, and the outlook for the child. The second part will discuss the ethical ramifications of the available choices and determine which choice is the "correct" choice, focusing on the question of who should decide for the infant. The third

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1. 1 Kings 3:25.
2. The medical portion of this problem is taken largely from the "Baby Doe" case which occurred in Bloomington, Indiana in 1982. For a very descriptive account of the story, see JEFF LYON, PLAYING GOD IN THE NURSERY (1985). The surrogacy arrangement is an added wrinkle designed to add another layer to the ethical and legal analyses.
part will determine how the law would handle this complex problem. Finally, the fourth part will explore whether the "ethical" or the "legal" answer is better.

I. THE PROBLEM

A. The Parents

Joe and Melissa have been married for ten years and have no children. They are both professionals, and they maintain a comfortable standard of living. They have chosen to avoid pregnancy for many reasons, including their desire to become professionally and financially established. However, the primary reason for delaying children has been Melissa's diabetes.

Diagnosed with type I diabetes\(^3\) at the age of fifteen, Melissa is aware of the risks a diabetic pregnancy brings. Diabetic women have greater chances for complications during pregnancy than women without diabetes, including an increased risk of "adverse birth outcomes."\(^4\) In the general population, approximately 250,000 children each year are born with birth defects in the United States.\(^5\) One in thirty-five children born in this country will be diagnosed as mentally retarded or as having some form of "significant neurological handicap."\(^6\) While great strides have been made in ensuring healthy and successful pregnancies to both diabetic mothers and their children, "[c]ongenital malformations still account for nearly fifty percent of the deaths among infants born to diabetic mothers today."\(^7\) The most serious defects are "three to four times more likely to occur among infants of diabetic women than among infants of

\(^3\) Type I diabetes results from decreased production of insulin, the hormone produced by the pancreas which processes glucose in the blood. Leo P. Krall & Richard S. Beaser, Joslin Diabetes Manual 2, 15 (12th ed. 1989). People who suffer from type I diabetes must take insulin injections for the rest of their lives. Id. at 15. This is in contrast to type II diabetes, wherein the body produces some insulin, but not enough to supply the body's needs. Id.


\(^6\) Id. at 28.

non-diabetics, and affect six percent to nine percent of all diabetic pregnancies.” These defects affect a variety of the baby’s organs, but “those affecting the heart and skeletal systems are the most frequent.” Nevertheless, with proper care the frequency of birth anomalies are not much more frequent for diabetic women than for the general population. After carefully weighing these facts, Joe and Melissa decided to avoid pregnancy and birth.

However, though they gained some comfort in their lives, they longed for the chance to share themselves with a child. Still very wary about the risks to both Melissa and their child should Melissa become pregnant, and after much thought, they decided to find someone who would carry their child for them.

B. The Surrogate Mother

Women have been serving as surrogate birth mothers for centuries. However, it was around 1976 that contract surrogacy emerged, and by 1986 about 500 children had been born as a result of such arrangements. Under a typical surrogate motherhood contract, the surrogate mother signs an agreement under which she consents to become pregnant for the contracting couple, gives birth to the baby, and thereafter terminates any and all parental rights she (and her husband, if there is one) may have regarding the child. The contracting couple agrees to pay the medical expenses of the pregnancy and delivery and perhaps even the surrogate mother’s living expenses during this time, in addition to a substantial fee. Generally, this latter fee is about $10,000.

8. Id.
10. Id. In addition, the pregnant diabetic woman herself is more likely to suffer from urinary tract infections, preeclampsia (characterized by elevated blood pressure, protein in the urine, and fluid retention), polyhydramnios (the accumulation of an excess amount of the amniotic fluid that normally surrounds the fetus), and stillbirth. Id. at 232-33.
11. See Genesis 16:1-15; 30:1-10 (when Sarah, Rachel, and Leah were infertile, they gave their handmaids to have babies for their husbands).
14. FIELD, supra note 12, at 5. Whether these contracts are enforceable, voidable,
Joe and Melissa conducted a private search for a suitable surrogate mother, and they decided that Lisa was the best candidate. She is twenty-eight, married with two children, and in good health. Lisa was interested because she knows how much joy and fulfillment her children have brought to her and thought it tragic that, for whatever reason, Joe and Melissa were a childless couple. She was also pleased with the opportunity to make $10,000. After extensive meetings and discussion, they agreed on the terms, signed the contract, and planned for a baby.

C. The In Vitro Fertilization Process

Because both Joe and Melissa have the biological ability to create a child, they wanted their child to be the product of Joe's sperm and Melissa's egg. In vitro fertilization is the procedure they chose to guarantee the genetic connection. By this process, eggs are harvested from the mother's ovaries and joined in a petri dish with the father's fresh sperm.\(^5\) This harvesting involves cutting into the mother's abdomen, inserting a telescope (called a laparoscope) into the abdominal cavity to allow for inspection of the internal organs and collection of the eggs, puncturing follicles of one of the ovaries, and drawing follicular fluid containing one or more eggs through a needle inserted next to the laparoscope.\(^6\)

After successful fertilization, the fertilized egg is transferred to the surrogate mother. In this procedure, a catheter is filled with the embryo and culture fluid from the petri dish, inserted deep into the woman's uterus through the vagina, and emptied into the surrogate mother's womb.\(^7\) The rates of success of in vitro fertilization are very low, and even the most successful

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or void varies from state to state. See infra part III.


16. John F. Leeton et al., IVF and ET: What it is and How it Works, in TEST TUBE BABIES: A GUIDE TO MORAL QUESTIONS, PRESENT TECHNIQUES AND FUTURE POSSIBILITIES 2, 5-6 (William A. W. Walters & Peter Singer eds., 1982). An alternate method involves using ultrasound to locate ripe follicles so as to avoid both the general anesthesia and the incision into the abdomen. After viewing the ultrasound pictures on a television screen, the physician penetrates the vaginal wall with a needle that draws up the egg. FRANK & VOGEL, supra note 15, at 90.

17. FRANK & VOGEL, supra note 15, at 89.
programs only experience about a twenty percent chance of success. During the pre-fertilization counseling, Joe and Melissa were prepared not only for failure but also for the possibility of complications. Luckily enough, the procedure was successful. Lisa carried the baby for nine months, saw her doctor regularly, and took excellent care of herself. All the while, she was fully prepared to give the child to Joe and Melissa at birth and spoke freely to others about the arrangement and her willing and joyful participation.

D. The Baby is Born

When Lisa went into labor, Joe and Melissa rushed to the hospital. It was an uncomplicated labor and birth, and all three were elated when it was over. Their happiness, however, was soon overcome by disappointment. Their baby boy was born with the form of mental retardation commonly known as Down syndrome. He also had an additional serious complication called an esophageal atresia. This is a condition in which the esophagus fails to develop normally and ends in a "blind pouch" before connecting to the stomach, which prevents food from reaching the stomach. The esophageal obstruction could have been corrected by surgery, but the baby would die if left alone.

Down syndrome, on the other hand, is something that the child and the family would have to live with for the rest of the child's life.

Down syndrome can be diagnosed by a chromosomal analysis, but physical characteristics such as slanting eyes, white spots on the iris of the eye, tongue protrusion, a flat bridge of the nose, a short neck, and a gap between the first and second toes often draw a doctor to an initial diagnosis of Down syndrome. In addition to the developmental disabilities of Down syndrome children, there can be medical complications as

18. Id. at 82.
well. Some newborn infants with Down syndrome have jaundice. Some have blood abnormalities and heart problems that may or may not be detected in the newborn. These children also are very prone to ear infections that can cause hearing problems as they grow older. There is also the possibility of a dislocation of the first and second cervical vertebrae in the upper neck which could cause future neurological problems.

Thinking, perhaps overly optimistically, that there would be no problems, Joe and Melissa did not require Lisa to endure an amniocentesis procedure during the pregnancy. This test could have determined whether the baby was going to have any serious birth defects, including Down syndrome. Amniocentesis is urged for women who have previously given birth to a child with genetic birth defects, for women who come from families or ethnic groups with a history of genetic birth defects, or for women who have taken excessive drugs or alcohol or have been exposed to X-rays or German Measles since becoming pregnant. Mothers of Melissa's age have only between a one in four hundred and a one in nine hundred chance of having a child with Down syndrome, and neither Melissa nor Lisa fit any of the three criteria for recommending amniocentesis. Furthermore, the chance for infection, hemorrhage, and miscarriage from the amniocentesis procedure itself is between one in two hundred and one in five hundred. Finally, Lisa feared the discomfort associated with the insertion of a hypodermic needle into her abdomen and the removal of amniotic fluid from her womb. For these reasons, they decided that the risks involved with avoiding the procedure were slight. When the baby came, they regretted this decision.

22. Id. at 21.
23. Id.
24. Id.
25. Id.
26. Id.
28. Id. at 78.
29. Id. Since Down syndrome is caused by a genetic defect in the egg cell, I use the odds for Melissa's age as egg provider rather than Lisa's age as womb provider.
30. Id. at 20, 78.
Joe and Melissa were not sure they wanted to bring this baby into their world. They questioned whether they had the capacity to deal with the extra needs of a child with Down syndrome. They also did not want to subject their child to the intolerance that they felt he surely would encounter. It would be a different situation if Down syndrome were the only “defect”; they would view ending the life of an otherwise healthy Down syndrome child as murder and, therefore, not an option. However, this child also has a detached esophagus requiring serious surgery. While the surgery’s chance of success is good, it is not guaranteed to correct the problem. Since he would die without the operation, merely withholding treatment from this child seemed less “wrong,” because it would end the child's suffering.

Lisa, however, did not agree. Even though she was perfectly willing to give the child to Joe and Melissa, she was not willing to let them allow the child to waste away and eventually die. She thought that, since the chances were good that the esophagus could be repaired, the baby must be given a chance to survive. Lisa was of the opinion that Down syndrome children and adults, though challenged by their various handicaps, live happy lives. She was determined that the child she carried for nine months, though not the biological product of her DNA, must be given the chance to live and thrive.

When Joe and Melissa expressed their desire to the physician that he not perform the operation to repair the esophagus, Lisa protested, and demanded that the operation be performed. The remainder of this paper will attempt to determine how this conflict should be resolved.

II. The Ethics of Choosing

In exploring the ethical ramifications of this decision, we must approach it with two different questions in mind. First, who should decide whether to forego treatment? Second, what should that person or those people decide?
A. Who Should Decide?

In an ideal situation, a patient himself will decide the course of his treatment. Each of us is in control of his or her own destiny, and we must be given the opportunity to make the decisions which determine these destinies. This idea is reflected in the principle of biomedical ethics commonly referred to as respect for autonomy. Under this principle, we gain “personal rule of the self by adequate understanding while remaining free from controlling interferences by others and from personal limitations that prevent choice.”31 In this way, “[m]utual respect and fostering of autonomy guarantees on equal terms to each individual the opportunity to adopt, evaluate, and revise a point of view on how to live his life.”32 This view is often recognized as an important tenet of personal liberty under the law as well.33

When dealing with a person who is not competent to make the choice to proceed with or forego treatment, especially when the patient is an infant who was never competent, the principle of respect for autonomy is not very helpful to reaching a moral decision.34 When an incompetent patient must make a decision about medical treatment, a surrogate decisionmaker is required. In the case of an infant, the parents are by far the best surrogate decisionmakers.35 However, in this particular case, the baby arguably has three parents: the mother who provided the egg; her husband, the father, who provided the sperm; and the surrogate who provided the womb.

33. See, e.g., Rains v. Belshe, 38 Cal. Rptr. 2d 185, 192 (Ct. App. 1995); State v. Herbert, 568 So. 2d 4, 10 (Fla. 1990); In re Lawrence, 579 N.E.2d 32, 39 (Ind. 1991); In re Jobes, 529 A.2d 434, 454 (N.J. 1987) (Handler, J., concurring).
34. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 127 (1994).
35. “It is now widely agreed that the patient’s closest family member is the first choice as surrogate.” Id. at 244. When the patient is a newborn, “the parents generally should be the primary decisionmakers.” Id. at 245. Even though the idea of children as property over which parents have complete domain has changed dramatically, “parental autonomy has prevailed, protecting decisionmaking rights of parents in most circumstances.” Haddon, supra note 32, at 565-66.
It is clear that Joe and Melissa have a right to make the treatment decision as the baby's biological parents. The baby was given life because of their actions. Melissa went through the painful process of harvesting eggs from her ovaries. They waited anxiously to see if fertilization would occur. The baby has the combination of their genetic makeup.

However, Lisa's effort and connection to the situation cannot be denied. She carried the baby for nine months. Like most women, she grew very close to the fetus, this person, as it developed within her body. She arguably has the right to contribute to the decision, in spite of the fact that the agreement stipulated that she would forfeit all parental rights at birth. In fact, she is still willing to do so. She just cannot live with the thought that the child she bore will be allowed to die.

According to one proposed list of qualifications, a surrogate decisionmaker for incompetent patients should possess:

1) The ability to make reasoned judgments (competence);

2) Adequate knowledge and information;

3) Emotional stability; and

4) A commitment to the incompetent patient's interests that is free of conflicts of interest and free of controlling influence by those who might not act in the patient's best interests.

Let's assume that both Lisa and Joe/Melissa can act in accord with the first three qualifications. Whether there is a genuine conflict between the baby's interests and the biological parents' interests will likely be the deciding factor. The judgment of Joe and Melissa may be clouded by their unfulfilled hopes of having a perfect baby. There will be added expenses, both to save the baby and to adequately educate and maintain the health of the child. They also may have less invested in this new life than traditional parents because their roles were...


37. BEAUCHAMP & CHILDRESS, supra note 34, at 244.

38. That both can make reasoned judgments and possess adequate information is not problematic. As for emotional stability, there is no denying this is an emotional situation. However, I present a group of people experiencing a very emotional trauma who are nonetheless stable.
essentially completed nine months ago. While they monitored the pregnancy and interacted with Lisa on a regular basis during those nine months, this is not necessarily equivalent to the actual experience of a pregnant woman and her husband. To be sure, they have a great emotional stake in this child. They are greatly saddened by this tragic turn of events, and the decision to forego treatment for their child is undoubtedly the hardest decision they have ever made. If they cannot give the child as perfect a life as possible, they feel it is better for the child, for them, and for society to allow the baby to die.

It is questionable whether this analysis reveals a true conflict between the parents' interests and the baby's interests. One way to determine whether a conflict exists is to examine the impartiality of the decisionmakers:

[For surrogates of neonatal patients,] the requirement of impartiality means that such persons should determine, as objectively as possible, whether life-prolonging treatment would be in the best interests of the individual neonate in question. . . . [T]he persons making the treatment/nontreatment decision should be disinterested in the particular case at issue and dispassionate in weighing available alternatives. 39

If impartiality indicates a lack of conflict and partiality is equated with conflict, there most definitely exists a conflict between the parents' and the child's interests. However, accepting the fact that parents are generally the best surrogate decisionmakers, one might ask, "When are parents ever 'disinterested?'"

"Impartiality" should not require "neutrality." Parents will always have a vested interest in the decisions they make about their children, and in spite of this interest, they generally remain the best surrogate decisionmakers. However, when the decision takes into account monetary and other effects on the

39. ROBERT F. WEIR, SELECTIVE NONTREATMENT OF HANDICAPPED NEWBORNS: MORAL DILEMMAS IN NEONATAL MEDICINE 256 (1984). Weir actually uses impartiality as one criterion for determining who should make a surrogate decision for an infant. The other three (relevent knowledge and information, emotional stability, and consistency) are closely aligned with the four used by Beauchamp and Childress. Id. at 255-57.
parents, it is less likely that the decision is going to be impartial. The less impartial the decision will be, the less appropriate it is for them to be the decisionmakers.

Lisa contends that she is thinking only of the child. She is not worrying about the future costs or the problems of having this child. She believes that because the operation would allow the baby to live and grow, Down syndrome is not enough to justify terminating his life. While these are noble thoughts, on what basis is Lisa claiming the authority to act? If she is asserting traditional parental rights by virtue of the fact that she gave birth to him, she may be in a good position to claim that she suffers from no conflict. As a "parent," she would be responsible both for the costs and burdens of seeing this child through life; unlike Joe and Melissa, Lisa may be disregarding these considerations. If she is willing to take on these responsibilities after knowing what lies ahead, she should be given the chance to do so. If, however, she is making this decision without taking responsibility for the upbringing of the child, why should she be allowed to decide the course of action and then abandon the child? It appears clear from our scenario, however, that Lisa is not ready to bear the burden of raising this child.

The question then becomes, "What is in the child's best interests?" Is Lisa, as decisionmaker but not as traditional parent, at odds with the child's best interest? Lisa would say that she has only the best interests of the child in mind and that Joe and Melissa are relying too heavily on the effects the child's life will have on them. She therefore has impartiality on her side. At least one ethicist would require parents and physicians in this situation to "distinguish between the question of ultimate custody of the child and the question of its immediate medical care and, if possible, let the decisions regarding medical care be made by a disinterested party." Lisa seems to be the amalgam of decisionmakers that is very rare in neonatal cases: the disinterested parent. She has the emotional attachment of a birth parent without the extraneous influences of a custodial parent. Given these conditions, she appears to be the best decisionmaker. The task now is to determine if her choice is the right one.

40. Id. at 150.
B. The Decision

In making this decision, two other principles of biomedical ethics are indicated: beneficence and nonmaleficence. In their simplest terms, the principle of beneficence refers to a "moral obligation to act for the benefit of others," while the principle of nonmaleficence is most closely associated with the medical maxim, "Above all do no harm." With a beneficence analysis, we determine what it is that we must do in order to be moral people. Concurrently, we must be aware that the principal of nonmaleficence is often violated by prolonging a suffering life with medical treatment. In trying to translate these two principles into general obligations, some philosophers have derived a list of four directives, listed in ascending order of the active participation required by the actor:

1) One ought not to inflict evil or harm.
2) One ought to prevent evil or harm.
3) One ought to remove evil or harm.
4) One ought to do or promote good.

The first is an obligation of nonmaleficence, and the others are obligations of beneficence. While we have obligations of nonmaleficence to all, and it would be immoral to act malefactorily toward any party, we are not required to act beneficently toward anyone with whom we do not have a special relationship, such as that between a parent and a child.

When asked, Joe and Melissa would say that their actions are both beneficent and nonmaleficient. They are merely preventing a procedure from being performed, so rather than actively killing the child, they would allow the baby to die as a result of the detached esophagus. Also, if Down syndrome were the only complication, they would not think of killing the baby. Since the baby also has a life-threatening defect, they are not

41. BEAUCHAMP & CHILDRESS, supra note 34, at 189, 260.
42. Id. at 189-90, 291.
43. Id. at 189.
44. Id. at 190 (citing WILLIAM FRANKENA, ETHICS 47 (2d ed. 1973)).
45. Id. at 262-63.
going to make their child endure the surgical procedure to prolong a life that Joe and Melissa see as having little value. Given the kind of life the child would have, in combination with the other considerations, they feel it would be better to forego the treatment. They are merely letting happen what would naturally happen, so they are being nonmaleficent. They are also acting beneficently by relieving the baby of any present or future suffering he may experience.

This analysis reveals moral flaws that, while common, may indicate that another decision should be reached. First, whether they are withdrawing a procedure or not starting a procedure is irrelevant. Even physicians attempt to make this distinction regularly: “[p]hysicians commonly feel more responsible for a patient’s death that results from stopping a respirator than from not starting one.” Many times, a physician will request a “Do Not Resuscitate” order for a patient pursuant to family wishes, guaranteeing death if the patient goes into cardiac arrest. Is there any moral reason for treating withdrawal of life-sustaining treatment as morally different and more serious than withholding the treatment in the first place? To borrow an example, suppose respirators turned themselves off every twenty four hours and had to be turned on again manually. Would failure to start these respirators be an omission while turning off an ordinary respirator an act? No real moral distinction can be drawn between the two. It is illogical to base moral distinctions on the dictates of technology. Given that Joe and Melissa have interpreted their choice as an allowable failure to act, their natural reaction may “lead them to act in ways that are not morally defensible and that conflict with their own considered moral judgements.”

The term “killing” has connotations of maleficence, while “letting die” conjures ideas of nonmaleficence. However, even though “killing” has come to mean “unjustified killing,” not

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46. See Beauchamp, supra note 31, at 340.
47. Id.
49. Beauchamp, supra note 31 at 341.
acting to save someone's life remains, strictly speaking, killing. One ends another person's life whether it is accomplished by unplugging a respirator or providing poison. It would be more useful to talk in terms of justified killing and unjustified killing. Joe and Melissa's refuge in the idea that they are merely letting their baby die is false, because refusing medical treatment in this case could be morally unjustified.

Another element of the decision which may be flawed is the distinction hinging upon the "extraordinary" procedure which is called for in order to save the baby. In common terms, physicians would not necessarily endorse extraordinary procedures to save a deformed baby. They would, however, encourage ordinary procedures to be performed. In one survey, when asked whether they considered repair of duodenal atresia an ordinary or extraordinary operation, one hundred percent of physician respondents in a survey said that it was ordinary; however, many physicians responded that performance of the same procedure on a baby with Down syndrome would be extraordinary.

Why does an ordinary procedure for one baby become extraordinary for another? For these doctors, the decision to treat seems related more to opinions about Down syndrome rather than opinions about the type of treatment involved. Also, what is extraordinary, as well as what is ordinary, can be a relative idea. For instance, to a physician who deals with respirators every day of his life, a decision to put someone on a respirator might not be truly "extraordinary." In both cases, arbitrary and morally inexplicable distinctions have the potential to serve as the basis for a morally indefensible choice to withhold medical treatment. Another illustration of this problem can be posed by this question: if a seven-year-old child with Down syndrome was in an accident and required a tracheotomy to

51. BEAUCHAMP & CHILDRESS, supra note 34, at 221-22.
52. See id.
55. Id.
56. Capron, supra note 48, at 653.
allow breathing, would parents be justified in forgoing this procedure simply because their child had Down syndrome? If not (and the answer must surely be “no”), why would the parents be justified in not allowing a life saving procedure at the beginning of the child’s life? Since the extraordinary/ordinary distinction is as unhelpful as the active/passive distinction, the most beneficial distinction might actually be a third, which measures the benefits of treatment versus the burdens of treatment.

A discussion of costs and benefits returns us somewhat to the concept of respect for autonomy and the decisionmaking method in the case of an incompetent patient. Because we are dealing with an infant, we have no way of knowing what he would have wanted. The standard used when we have no way of determining what the patient would have wanted is commonly referred to as the “best interests” standard.57 This type of critique involves a cost-benefit analysis which takes into account the physical suffering currently experienced by the infant, the suffering that any treatment would create or prolong, the quality of life that the infant can expect, and other tangible aspects directly affecting the infant.58 Ideally, this analysis should involve only the effect on the child. However, other factors, such as financial cost of care and the effect on other family members, often come into the analysis. Correctly conceived, the surrogate decisionmaker should focus only on “the value of the life for the person who must live it.”59

There are some other considerations which should be kept in mind under this analysis. First, the less likely it is that an act will help someone, the lower the obligation to act in order to be beneficent.60 Also, in the case of an infant, “one may wish to expend major resources in order to bring persons into existence, only if that existence will be of sufficient quality and quantity.”61 These quality and quantity judgments must be made by those associated with the infant.62

57. BEAUCHAMP & CHILDERESS, supra note 34, at 178.
58. Id. at 180.
59. Id.
61. Id.
62. Id.
In this situation, the most important consideration under the cost-benefit analysis is that the operation could, and probably would, save the child’s life. However, repair of his esophageal problem is a “rigorous procedure, generally accompanied by a significant amount of pain,” and additional surgery is often required over several years. Of course, if the child survived, he would live with Down syndrome for the rest of his life. The average life span of a person with Down syndrome is somewhere between forty and just over fifty years; however, twenty to forty percent of all Down syndrome babies die before age ten. There are, of course, countless Down syndrome children who live long, happy, and productive lives. On the other hand, there is no way of knowing what other additional physical complications may arise in the future.

If the child is allowed to die, the process by which death overtakes life will not be pleasant. As all intravenous feeding is removed, the child’s body weight will drop from lack of nourishment, he will cry from hunger, and his lips will become parched from dehydration. Because of the esophageal detachment, stomach acid will corrode the lungs, and once this occurs, the baby eventually hemorrhage blood from his nose and mouth. Finally, the baby will die, succumbing to chemical pneumonia, “due to regurgitation of his own stomach acid.”

Given the outlook under each of the two scenarios, the cost benefit analysis for this situation is replete with uncertainty. While we know the death from non-treatment will be painful, we are unsure whether any future medical condition will be more painful. While we know the child will not be like other children, he may lead a very happy life. Both sides can point to costs and benefits which weigh in their favor. Choices between life and death, when there are arguably valid arguments on both sides, should be made in favor of life. Lisa can make a good argument for providing the lifesaving treatment. The baby’s chances for a healthy life are no worse than his chances

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63. Lyon, supra note 2, at 26-27.
64. Id. at 26, 209.
65. Id. at 55-56.
66. Id. at 35.
67. Id. at 36-37.
68. Id. at 38. In the case of Baby Doe, the whole ordeal took six days. Id.
for a poor life. Death will surely be a painful exit. For these reasons, Lisa's decision to provide treatment should stand.

Once the decision to provide treatment is made, it is a secondary decision to decide what Joe and Melissa are going to do. They may not realize it now, but their lives would probably be enriched beyond their wildest dreams if they choose to keep their child. In the event that they choose to give up their son and since Lisa has neither wanted nor been willing to take custody, one possible option is to offer the baby for adoption. Of course, if no one were to adopt the child, he would become a ward of the state. Again, in a purely ethical framework, these are all extraneous factors which, while important, do not have much significance in determining whether non-treatment is beneficent and nonmaleficent. Given the close call on the costs and benefits and the fact that the parties involved cannot know with any degree of certainty what the future holds, the best decision would be to treat the esophageal abnormality as effectively as possible.

III. THE LEGAL ANSWER

For the legal analysis, it will be helpful to ask the same questions that we asked for the ethical analysis. Determining who the parents are may shed light on which decision would be upheld in a court of law.

A. Who Is the Real Mother?

Who the legal parents are will depend primarily on how the court interprets the arrangement between the parties. This will entail an analysis of the legal status of the surrogacy contract. Many states now have statutes which provide guidelines to determine the validity of such contracts. The groundbreaking

69. Indeed, there was at least one outside couple willing to take and even fight for custody of Baby Doe. Id. at 35.
70. Id. at 285. This would not be a solution without its costs to society; "If a Down's child is institutionalized starting today, the bill to the taxpayer will be $1.5 million over the course of his or her lifetime." Id.
71. Statutes which prohibit surrogacy contracts include: ARIZ. REV. STAT. ANN. § 25-218 (1991); IND. CODE ANN. § 31-8-2-1 (West Supp. 1993); KY. REV. STAT. ANN. §
case judicially interpreting the validity of surrogacy contracts came in New Jersey in 1988. In *In re Baby M.*, the Supreme Court of New Jersey was confronted with a man (Mr. Stern) whose wife had a mild case of multiple sclerosis and did not want to go through the possible complications of pregnancy. Mr. Stern made an agreement with another woman (Ms. Whitehead) to have his baby. The method of conception was artificial insemination, whereby Ms. Whitehead was impregnated with Mr. Stern's sperm. Unlike Joe and Melissa's case, this surrogate mother was both the birth mother and the biological mother, a key distinction.

When Ms. Whitehead refused to give up the child shortly after birth, the Sterns sued. The court had to decide who the legal parents were. In a careful decision, the New Jersey Supreme Court found the contract invalid. Not only did the contract conflict with statutory provisions "prohibiting the use of money in connection with adoptions... laws requiring proof of parental unfitness or abandonment before termination of parental rights... and... laws that make surrender of custody and consent to adoption reversible in private placement adoptions," the contract also, by determining in advance of birth which natural parent is to have custody, conflicted with the public policy of the state that the child's best interests shall determine the custody of the child. In the end, Ms. Whitehead and Mr. Stern were found to be the parents, despite the contract under which Ms. Whitehead promised to give up all parental rights.

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72. 537 A.2d 1227 (N.J. 1988).
73. Id. at 1235.
74. Id.
75. Id. at 1237.
76. Id. at 1240.
77. Id.
78. Id. at 1246.
79. Id. at 1246-50.
While this case presents a popular view rejecting the validity of surrogate contracts in general, it did not involve a situation in which the birth mother and the biological mother are two different people. California, however, was recently confronted with just such a situation. In *Johnson v. Calvert*, Mr. and Mrs. Calvert entered into a surrogacy contract with Ms. Johnson, whereby Ms. Johnson was implanted with an egg from Mrs. Calvert, fertilized by Mr. Calvert. Ms. Johnson agreed to give up the baby and all parental rights at birth. Unfortunately, the relationship between the couple and the surrogate soured, and both the Calverts and Ms. Johnson sued for custody.

In deciding who the "real" mother was, the court noted that there was undisputed evidence showing that Mrs. Calvert was genetically related to the child and that Ms. Johnson gave birth to the child. While both women thus provided evidence of a mother-child relationship as contemplated by the California Uniform Parentage Act, the law could only recognize one natural mother. Because of this dilemma, the court resorted to an analysis of the intent of the parties and concluded that, under California law, when genetic parentage and birth parentage do not coincide in one person, "she who intended to bring about the birth of a child that she intended to raise as her own... is the natural mother." By validating the intent of the surrogacy contract, the court did not find the agreement to be inconsistent with public policy.

In a strong dissent, one justice argued that the "best interests" standard should be used rather than the "intent" test. "This 'best interests' standard serves to assure that in the judicial resolution of disputes affecting a child's well-being, protection of the minor child is the foremost consideration." The

80. 851 P.2d 776 (Cal. 1993).
81. Id. at 778. Mrs. Calvert had previously undergone a hysterectomy, thereby rendering her unable to carry a child. Id.
82. Id.
83. Id. at 781.
84. Id. Amicus briefs submitted by the American Civil Liberties Union encouraged the court to find that the child had two mothers. The court declined to do so. Id.
85. Id. at 782.
86. Id. at 783.
87. Id. at 789 (Kennard, J., dissenting).
88. Id. at 799 (Kennard, J., dissenting).
factors which should be considered under this analysis are the abilities to nurture the child physically and psychologically, to provide ethical and intellectual guidance, and to provide stability and continuity. The intent of the genetic mother is relevant in this analysis, but not dispositive.

While the dissenting opinion in *Johnson* is persuasive, the law of California would call Joe and Melissa the parents and would give them full decisionmaking authority. Two other states have examined California's reasoning. New York found it persuasive, while Ohio did not. In jurisdictions which have not addressed this question, especially those jurisdictions which have invalidated surrogacy contracts, it would be difficult to guess how courts would interpret the rights of a woman who gave birth to a baby who was not her genetic child. Under the rational of the *Baby M.* decision, Lisa would have a good argument that the contract is void and that she should be allowed to exercise her rights as a parent. She was the one who gave birth to the child, and Melissa should be treated as nothing more than an egg donor. As such, Lisa should be able to help make the decision. If Lisa and Joe are to be treated as the baby's parents, the issue then becomes how the court should resolve the conflict between the two parents. The court would probably have to act as final arbiter and look to the best interests of the child, as it must in any event when looking to see which decision is correct. It is important to point out that Lisa would also be required to live up to the responsibilities of a parent if she were claiming her parental rights. A court would probably not allow her to make an important decision regarding treatment for the baby if she were not willing to help with the parenting.

Given that Joe and Melissa would be found to be the parents in at least two of the three jurisdictions which have answered this question, we now turn to the type of decision they may be able to make.

89. *Id.* at 800 (Kennard, J., dissenting).
90. *Id.*
93. See *infra* part III.B.1.
B. The Decision to Terminate Life

1. State Court Interpretations

Courts have continually affirmed the idea that an autonomous person has the right to refuse medical treatment. In addition, "virtually every state court has extended the right to refuse medical treatment to include nonautonomous patients." A number of courts have specifically looked at this issue and have used a number of different standards to determine what decision is warranted.

In Superintendent of Belchertown State School v. Saikewicz, the Massachusetts Supreme Judicial Court was faced with the issue of whether to allow a severely retarded sixty-seven year old man with a mental age of two to forego painful chemotherapy treatment for a fatal case of leukemia. Mr. Saikewicz had a court-appointed guardian as his surrogate advocating that he be spared the chemotherapy treatment which would have made him feel sicker and might not have affected the cancer. Treatment was rejected in favor of the relatively painless and natural death that would have resulted in a few weeks or months if no course of treatment were pursued. The trial court found six factors about Mr. Saikewicz's situation which supported the decision to forego treatment, and only two factors which supported forcing the chemotherapy. Consequently, he was not forced to receive the treatment.

94. Robert F. Weir & Larry Gostin, Decisions to Abate Life-Sustaining Treatment for Nonautonomous Patients, 264 JAMA 1846, 1848 (1990). The U.S. Supreme Court, while endorsing the right of autonomous people to refuse medical treatment, has said that individual states may require a high standard of evidence that an incompetent patient had expressed wishes prior to incompetence that he not be allowed to live if he were forced to use a feeding tube. Id. at 1847.

95. Id. at 1848.


97. Id. at 420.

98. The only member of his family who could be located were two sisters who wanted nothing to do with the situation. Id.

99. Id. at 421.

100. Id. at 420-21.

101. Id. at 422.
In reviewing the trial court's decision, the supreme judicial court noted:

[T]he substantive rights of the competent and the incompetent person are the same in regard to the right to decline potentially life-prolonging treatment. The factors which distinguish the two types of persons are found only in the area of how the State should approach the preservation and implementation of an incompetent person's wishes and in the procedures necessary to that process of preservation and implementation.102

After recognizing the longstanding right of privacy that guarantees each person freedom from bodily invasion,103 the court proceeded to weigh the interests the state has in keeping people alive. The court identified four compelling state interests: 1) the preservation of life; 2) the protection of the interests of innocent third parties; 3) the prevention of suicide; and 4) maintaining the ethical integrity of the medical profession.104 The court then balanced the "interest of the State in prolonging a life . . . with the interest of an individual to reject the traumatic cost of that prolongation."105 The court could not say that the lower court's balancing was incorrect, so they extended the analysis to determine what legal standard should be used in determining whether to administer life-prolonging treatment to an incompetent.106 The court found that Mr. Saikewicz's guardian had satisfied the requirements of the best interests standard and, in a sort of hybrid of the best interests and substituted judgment tests, determined that the guardian was fighting for the same outcome that the incompetent would have fought for if he could.107

102. Id. at 423.
103. The Massachusetts court extrapolated from the "unwritten Constitutional right of privacy found in the penumbra of specific guarantees of the Bill of Rights" the right of a patient to be free from unwanted bodily invasions. Id. at 424. However, the United States Supreme Court later rejected extending this "penumbra" of rights to the right to refuse life-prolonging forced feeding, and instead found the right in the concept of liberty guaranteed by the Constitution. Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261 (1990).
104. Saikewicz, 370 N.E.2d at 425.
105. Id.
106. Id. at 427.
107. Id. at 427-31.
In a similar case, the New Jersey Supreme Court used two different best interests tests. In *In re Conroy*, an incompetent eighty-four-year-old woman with a litany of ailments was being kept alive by a nasogastric feeding tube.\(^{108}\) Her only blood relative was a nephew acting as her guardian, and he was asking that she be allowed to die.\(^{109}\) The New Jersey court declared that life-sustaining treatment may be withheld when it is clear that the patient would have refused the treatment under the particular circumstances.\(^{110}\) To determine what an incompetent person would have wanted, the court decided to use either a "limited objective" best interests test or a "pure objective" best interests test.\(^{111}\) The limited objective test requires some trustworthy evidence that the patient would have refused treatment,\(^{112}\) which renders this test useless in the case of the never-competent, since there will never be evidence of how that patient would have acted. Under the pure objective test, the "net burdens of the patient's life with the treatment should clearly and markedly outweigh the benefits that the patient derives from life" in order for life-sustaining treatment to be withheld.\(^{113}\) In spite of this balancing, the court expressly rejected the use of such factors as assessments of personal worth or social utility of a patient's life or of the value of the patient's life to others.\(^{114}\) Given the inherent uncertainty of such a test, the court said it could not justify terminating life-sustaining treatment if the evidence was insufficient to satisfy either standard; furthermore, whenever "evidence of a person's wishes or physical or mental condition is equivocal, it is best to err, if at all, in favor of preserving life."\(^{115}\)

These two cases provide a helpful framework for analysis. Parental decisions, especially those relating to young children, have generally been allowed to stand. Even though the doctrine of *parens patriae* allows the state to come in and protect the interest of any of its citizens, "its invocation has been tempered

\(^{108}\) 486 A.2d 1209 (N.J. 1985).
\(^{109}\) Id. at 1215-17.
\(^{110}\) Id. at 1229.
\(^{111}\) Id. at 1231-32.
\(^{112}\) Id.
\(^{113}\) Id. at 1232.
\(^{114}\) Id. at 1293.
\(^{115}\) Id.
by the long standing preference for decentralized decision-making in matters concerning the family.\textsuperscript{116} This is supported by the idea that it is the parent who is in the best position to make decisions that are in the best interest of the child.\textsuperscript{117} While there are instances when the state will intervene to protect children,\textsuperscript{118} "the number of these instances are small because a policy of minimal interference serves the state's own interests. The nurtured family is a source of productive citizens."\textsuperscript{119} In these situations, the parental interests override the four state interests pointed out by the court in \textit{Saikewicz}. Nevertheless, \textit{Conroy} suggests that some courts are unwilling to gamble when there is no clear evidence that terminating the patient's life is in the patient's best interest. In balancing these interests, when the incompetent is a child and the parents are the ones making the choice, the proof required in \textit{Conroy} may be relaxed in order to respect the rights of the parents.

In the end, Joe and Melissa would probably be allowed to make the decision. Further, since their decision to allow their child to die is supported by some evidence that it is in the child's best interest and is the result of careful deliberation, it would likely be approved by a court.

2. Other Possible Responses

a. Child Abuse Legislation

In Virginia, as with all other states, it is a crime to abuse or neglect a child. Under the Virginia statute, "Any parent . . . who by willful act or omission or refusal to provide any necessary care for the child's health causes or permits serious injury to the life or health of such child shall be guilty of a Class 4 felony."\textsuperscript{120} In order to prosecute a parent for killing a newborn baby, it must be proven that 1) the child was born alive, 2) the child had reached an independent and separate existence apart

\textsuperscript{116} Haddon, \textit{supra} note 32, at 567-68.
\textsuperscript{117} Id.
\textsuperscript{118} For instance, the state will intervene to protect children in areas of education, vaccination, inoculation, and abortion decisions.
\textsuperscript{119} Haddon, \textit{supra} note 32, at 567-68.
\textsuperscript{120} VA. \textit{CODE ANN.} § 18.2-371.1 (Michie Supp. 1995).
from its mother, and 3) the accused was the criminal agent causing the infant's death.\textsuperscript{121} It is this third element which would be difficult, if not impossible, to prove in a situation such as ours. Given the broad autonomy granted to parents in medical treatment decisions, it is difficult to imagine that Joe and Melissa would be convicted of child abuse.

Federal statutory protection is another possibility. After the 1982 Baby Doe case in Bloomington, Indiana,\textsuperscript{122} Congress passed the Child Abuse Amendments of 1984.\textsuperscript{123} Congress attempted to protect disabled infants from medical neglect, defined as “instances of withholding of medically indicated treatment from disabled infants with life threatening conditions.”\textsuperscript{124} The amendments make an exception to the mandate for medical treatment. Under the statute:

[Withholding medically indicated treatment] does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when, in the treating physician’s . . . reasonable medical judgement—

(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.\textsuperscript{125}

While this may appear to allow for termination of neonates'...
medical treatment, a close reading of the statute indicates a number of scenarios in which continued treatment would be required. Inhumanity of treatment alone is not enough to allow a baby to die, since exception (C) also requires that the treatment be futile. In addition, the statute calls for “reasonable medical judgement,” but does not indicate that ethical considerations or even parents’ wishes should be considered. Indeed, in theory, “[t]he extent to which treatment is made compulsory by the federal rule is astonishing.”

However, this harshness exists solely in theory. The requirements are only binding on the states if they accept money from a “minor federal grant program” that provides limited funds for state child abuse and neglect agencies. In addition, enforcement of these provisions is relegated to state child protective service agencies. The amendments “have faced no judicial challenges and have generated little litigation.” The lack of cases likely has much to do with the scarcity of resources in state agencies in spite of federal support, and a reluctance to rechannel funds “away from growing problems of physical and sexual abuse and drug-exposed infants to Baby Doe enforcement activity.”

The attempts of the federal government to address this problem through legislation demonstrate the difficulty of statutorily mandating what is largely an ethical and moral decision. No bright lines can be drawn between those cases like ours in which different outcomes can be supported as ethical and those cases which involve true abuse, neglect, and criminal negligence. Perhaps this is one issue which does not warrant government involvement.

127. Id. at 4-5.
128. Id. at 4.
129. Id. at 2.
131. Id. at 1615.
132. Id. at 1616.
b. The Americans with Disabilities Act

In 1990, Congress passed the Americans with Disabilities Act (ADA).\(^{133}\) The purpose of the ADA is to recognize and correct the way that "society has tended to isolate and segregate individuals with disabilities."\(^{134}\) The ADA also specifically recognizes that this discrimination has historically extended to the area of health services.\(^{135}\)

The ADA generally prohibits discrimination on the basis of handicap. Perhaps the ADA could be used to strike at those decisions which mandate that a Down syndrome baby not receive an operation to correct a defect that an otherwise healthy baby in the next bed would receive. While this has not yet been tested in a situation similar to that of Joe and Melissa, it would seem that "in most cases an infant's parents make decisions regarding their baby's medical treatment, and . . . the ADA [does not] extend to such quintessential private, parental decisionmaking."\(^{136}\)

IV. WHICH IS RIGHT?

Both parties make persuasive cases. Under the ethical framework, Lisa is a valid surrogate decisionmaker. Her decision to treat the esophageal atresia and allow the baby to live is both beneficent and nonmaleficent. Legally, however, Joe and Melissa would likely have the upper hand. As the biological parents who intend to care for the child, they would be the best decisionmakers. Because Joe and Melissa could effectively argue that the child's best interests were being provided for, their decision to withhold treatment would stand in a court of law.

Though it is an extremely close case, the ethical analysis provides the better answer. Many unknowable variables must be evaluated and quantified. The baby could live a wonderful

\(^{135}\) Id. § 12101(a)(3).
\(^{136}\) Crossley, supra note 124, at 1643.
life, or he could live a horrible life. He could have other complications in childhood, adolescence, or adulthood or he could live a long healthy life. The procedure to correct the esophageal blockage may cause more suffering. Doing nothing would certainly bring about a painful end. To take language from the New Jersey Supreme Court, when evidence of the likely effects of medical treatment on a person's life is uncertain, "it is best to err, if at all, in favor of preserving life."\footnote{137}

Of course, the ethical solution is not perfect. While it is easy in a theoretical exercise to say that financial and other considerations must not enter into the decisionmaking process, the reality is that extravagant costs of caring for sick children can have "ruinous effects on families, depriving parents and existing children of their economic security."\footnote{138} While there is no telling what the added costs will be in the future, it is clear that the chance for survival is good, and as that chance increases, the consideration of cost as a factor should decrease.\footnote{139} In addition, one may be tempted to require Lisa to share some of the responsibilities if her wishes are allowed to control. The mechanism with which this would be accomplished is hard to imagine. One possibility is for a court to require her as a "birth parent" to share at least partially in the added costs of raising this child.

In a sense, neither decision is "right." One decision is an ethical decision and one is a legal decision. Each has been developed using two separate systems of values and priorities. Perhaps the "right" decision will be the one produced when the two systems working in harmony, with the strengths of one system complementing the weaknesses of the other. Maybe Solomon would have a better answer. For the sake of the Baby Does of this country, the "right" decision cannot come soon enough.

Adam Marshall

\footnote{137. In re Conroy, 486 A.2d 1209, 1233 (N.J. 1985).} \footnote{138. Newman, supra note 126, at 52.} \footnote{139. Id.}