

## *From the Editors*

The centerpiece of this issue is the problem of treating very vulnerable newborns. In the United States, the debate centered around "Baby Doe," a child with Down's syndrome and an esophageal atresia whose parents refused, on the advice of their obstetrician, to allow surgical repair of the atresia so that he could be fed. This 1982 case in Indiana led to proposals for federal and state legislation that would protect the vulnerable newborn. These proposals were eventually issued in guidelines that are called the "Baby Doe Regulations." The Indiana case actually echoed earlier ones at Johns Hopkins University in which Down's syndrome infants were allowed to starve to death rather than be treated for their disabilities. In one 1971 case there, doctors went along with the family's wishes but refused to give the baby a lethal injection on ethical grounds, instead letting the baby starve to death over the next 11 days. Subsequently, the case of Baby Jane Doe, a child with spina bifida, born in the suburbs of New York City whose parent also refused surgery, amplified concerns that handicapped infants would suffer negatively from quality-of-life judgments made either by parents or caregivers or both. A later review by Health and Human Services Inspector General Richard Kusscrow noted that the state Baby Doe programs were working smoothly.

Uneasiness about the issue nonetheless continues. Advocates for handi-

capped newborns insist that physicians give up too easily on such babies, mostly for economic reasons. Daily we hear heartrending tales from these spokespersons of survival and excellent quality of life against all odds. However, some individuals paint a more realistic picture of hardship, not only for the children who are rescued this way but also for the parents and families who must care for such children for many years. Are these potential burdens worth it to save the life of the child?

For the most part, however, ethicists and neonatologists think that America has solved the problem. Enter the Dutch. Quite possibly as a natural outgrowth of the euthanasia movement there, concerns about incompetent patients qualifying for the "kindness" of euthanasia have led to reports of active involuntary euthanasia, not only of adults but of handicapped newborns. Dutch pediatricians are debating proposed guidelines written by a committee of the Dutch Pediatric Association aimed at immunizing them from prosecution for actively terminating the life of a disabled newborn. Recently, the courts in The Netherlands have dismissed charges against a physician (the Molenaar case) who advised against treating a Down's syndrome child for esophageal atresia. The infant was allowed to die at the request of the parents but against the wishes of their own general practitioner, who went to the prosecutor to bring charges. All of these complex is-

sues are aired by Dutch healthcare professionals in the Special Section: Ethics at the Beginning of Life.

As a result of the Dutch debate presented in this issue, Americans may find it useful to reexamine their own resolution of this issue, particularly in light of a principle proposed by Earl Shelp, Executive Director of the Foundation for Interfaith Research and Ministry in Houston, that "those who are most responsible for the longer term care should make those decisions." We include a powerful piece by Dr. Cor Spreeuwenberg who describes a decision to actively terminate the life of his own son in the early 1970s, in this case opting for more immediate and kinder death than starvation for many days.

New in this issue is the "Philosopher's Corner," for papers that are more theoretical than those found in other sections of the journal. Our first paper in this new section is by board member Helga Kuhse, who objects to Michael Tooley's position on the difficult question of terminating the lives of potential persons such as fetuses. In her view, Tooley failed to show that abortion and infanticide, as well as other reproductive choices involving the existence of people likely to live satisfying lives, is a morally neutral matter. Tooley claimed that there is a *prima facie* responsibility

to refrain from bringing wretched people into the world. A response from Tooley, in turn, will answer her objections. This debate is but one philosophical undercurrent to the issue of withdrawing treatment or actively terminating the lives of newborns, especially with respect to determining what is a satisfying life.

Another new feature is "Teamwork," a section edited by Roberta Springer Loewy that will provide an interdisciplinary forum for all the health professionals who are involved in healthcare delivery and healthcare ethics committees. We are also proud to announce that Nancy Jecker has assumed the duties of Book Review Editor.

Finally, we call your attention to two pieces that will have echoes in subsequent issues of *CQ*. Sissela Bok's article, "Impaired Physicians: What Should Patients Know?" initiates an examination of the inextricable complexities that exist in the relationships between patients and health professionals. In our regular feature, "Ethics Committees at Work," Alexander Ivanjushkin of the Russian Medical Academy of Science comments on the case of "The Outpatient Management of a Brain Dead Child." Look forward to more case discussions from an international perspective.