

Note

Miller v. HCA, Inc.: Why the Emergent Circumstances Exception Is Threatening to the Best Interest of the Child Standard

By BRIENNE WESOLEK*

EVERY YEAR IN THE United States, over 450,000 babies are born prematurely.¹ Of those preterm births, 1.4%, or over 6500, are classified as very low birth weight, weighing less than 15,000 grams.² Over the last several decades, dramatic advancements in neonatal technology have improved the survival rate for infants born preterm, creating a shift in the philosophy of care from noninterventionist to aggressive treatment.³ Despite these medical improvements, decisions concerning the care of extremely premature infants are especially difficult because prognosis is nearly impossible to determine.⁴ The birth of an infant at or before twenty-five weeks of gestation or weighing less than 750 grams presents a gray area of uncertainty with regards to treat-

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1. See National Center for Health Statistics: Birthweight and Gestation, <http://www.cdc.gov/nchs/fastats/birthwt.htm> (last visited Jul. 11, 2005) [hereinafter National Center]. The length of a normal pregnancy or gestation is considered to be forty weeks (280 days) from the date of conception. Infants born before thirty-seven weeks gestation are considered premature. See Dr. Joseph F. Smith Medical Library: Prematurity, <http://www.chclibrary.org/micromed/00061790.html> (last visited Jun. 22, 2005).

2. The average birthweight in 2002 was 3332 grams. See National Center, *supra* note 1.

3. See Hastings Ctr. Special Project, *Imperiled Newborns*, 17 HASTINGS CTR. REP. 5, 7–8 (Arthur Caplan & Cynthia B. Cohen eds., 1987) [hereinafter *Imperiled Newborns*].

4. See *id.* at 6.

ment and prognosis⁵ because the expected outcomes for survivors span the entire range of severe handicap to normal.

The two dimensions concerning the treatment of premature infants are questions of substance and questions of procedure. Substantively, the question is whether all babies should be treated, and if not, which babies should be treated. Procedurally, the question is who should make the treatment decisions.⁶ Over the last three decades, a combination of litigation, legislation, and real life experience has created a consensus on this very sensitive, serious, and complicated ethical issue.⁷ In making treatment decisions regarding seriously ill newborns, the appropriate standard to use is the best interest of the child, as determined by the parents after informed discussion with their doctor.⁸

This Note analyzes the recent Texas Supreme Court decision, *Miller v. HCA, Inc.*,⁹ which failed to apply the best interest of the child standard in dealing with the treatment of a critically ill premature infant with an uncertain prognosis. *Miller* was wrongly decided and thus should not be used as a model for treatment decisions for preterm very low birth-weight infants. Making decisions in a child's best interest is the agreed upon standard by the medical community and the United States Supreme Court.¹⁰ Nevertheless, the *Miller* court's creation of the emergent circumstances exception to the need for informed consent threatens the best interest of the child standard. This Note further argues that the proper approach to making decisions in a child's best interest is an individualized approach. This gives the parents the primary decision-making authority after receiving compre-

5. See Amer. Acad. of Pediatrics Comm. on Fetus and Newborn & Amer. Coll. of Obstetricians and Gynecologists Comm. on Obstetric Practice, *Perinatal Care at the Threshold of Viability*, 96 PEDIATRICS 974, 974-75 (1995) [hereinafter *Perinatal Care*].

6. See *Imperiled Newborns*, *supra* note 3, at 8.

7. See John J. Paris, *Ethical and Legal Issues in Assisted Ventilation of Newborns*, in ASSISTED VENTILATION OF THE NEWBORN 81 (Jay Goldsmith ed., 4th ed., 2003) [hereinafter *Ethical and Legal Issues*].

8. See, e.g., President's Comm'n for the Study of Ethical Problems in Med. and Biomedical and Behavioral Research, *Deciding to Forego Life Sustaining Treatment: A Report on the Ethical, Medical and Legal Issues in Treatment Decisions*, 220 (United States Government Printing Office 1983) [hereinafter *President's Comm'n*]; Comm. on Bioethics, Amer. Acad. of Pediatrics, *Guidelines on Forgoing Life-Sustaining Medical Treatment*, 93 PEDIATRICS 532-36 (1994); John J. Paris & Michael D. Schreiber, *Parental Discretion in Refusal of Treatment for Newborns*, 23 CLINICS PERINATOLOGY 573 (1996) [hereinafter *Parental Discretion*].

9. 118 S.W.3d 758 (Tex. 2003).

10. See, e.g., *President's Comm'n*, *supra* note 8, at 220; Comm. on Bioethics, Amer. Acad. of Pediatrics, *supra* note 8, at 532-36.

hensive information, making it more likely that the best interest of the child will be considered.

Part I of this Note defines the best interest standard and the three categories in which to place infants regarding treatment decisions. Part II discusses the facts of *Miller* and the trial, appellate, and Supreme Court decisions. Part III analyzes and rejects the *Miller* decision because, in holding that emergent circumstances create an exception to the general rule of liability for a physician who treats a minor without parental consent, the best interest of the child was not the central consideration in whether or not to treat Baby Sidney.¹¹ Part IV presents decision-making guidelines and applies them to the *Miller* case, arguing that an individualized approach with decision-making based on a child's potential for relationship is the most appropriate approach to making decisions in the best interest of the child.¹²

I. Background

A. The Development of the Best Interest Standard

The best interest standard has traditionally been employed by courts in making child custody determinations or decisions involving placement of an infant or child.¹³ This standard, however, has not always been used for decision-making regarding treatment of critically ill infants, mainly because infants are unable to express their interests.¹⁴

Duff and Campbell's 1973 essay, "*Moral and Ethical Dilemmas in the Special Care Nursery*,"¹⁵ brought these issues to the public's eye for the first time. Duff and Campbell proposed that parents should be the

11. See John J. Paris, *The "Emergent Circumstances" Exception to the Need for Consent: The Texas Supreme Court Ruling in Miller v. HCA*, 24 J. PERINATOLOGY 337, 339 (2004) [hereinafter *Emergent Circumstances*].

12. This Note recognizes the sanctity of life, the dignity and worth of every human being, and is sensitive to the special vulnerability that the unborn and newborns are subjected to in society. Therefore, no arguments will be presented for the discontinuation of treatment based on the philosophy that seriously ill newborns are not deserving of the status of "personhood" in the ordinary or legal sense of the term and do not possess a right to care from others. See e.g., Michael Tooley, *Abortion and Infanticide*, 2 PHIL. & PUB. AFF. 37, 51 (1972) (arguing that infanticide is a morally acceptable practice because infants do not possess a right to life); James Bandler, *Furor Follows Princeton Philosopher*, BOSTON GLOBE, July 27, 1999, at A1 (describing Peter Singer's philosophy that animals have a greater right to life than infants because they are more self aware).

13. *Imperiled Newborns*, *supra* note 3, at 15.

14. See John Paris & Eric Kodish, *Ethical Issues*, in NEONATOLOGY FOR THE CLINICIAN, 532 (Jeffery J. Pomerance & C. Joan Richardson eds., 1993) [hereinafter *Ethical Issues*].

15. See *id.*

only ones to decide whether or not to employ an aggressive level of treatment for their child because the consequences fall on the family.¹⁶ Their article was published just as the emerging discipline of bioethics began to question the ethics and legality of treatment practices.¹⁷ The article, however, was criticized by bioethicist John J. Paris, S.J. as "normless" because there were no guidelines, no standards, and no norms on which to base the decision.¹⁸ "It could equally be made on concern for siblings or 'family convenience' as on the best interest of the infant."¹⁹

A 1977 study by Shaw and colleagues found that an overwhelming majority of pediatricians and pediatric surgeons in the United States would omit surgery on a Down Syndrome infant having congenital heart disease, letting the infant die if the parent's so wished.²⁰ However, that consensus ended when the "Bloomington Baby Doe" controversy of 1982 received vast media attention.²¹ The parents and the attending obstetrician had agreed to forego surgical intervention for an infant with Down Syndrome and esophageal atresia, which could be corrected by a simple operation.²² Although the Shaw study indicated that this type of decision-making was standard during the late 1970s, when brought to the public's attention public outcry led to federal involvement through regulations.²³ Newborn nurseries and neonatal intensive care units receiving federal funds were required to post notice of a hotline number to report cases of discrimination in treatment based on handicap.²⁴ When reports came in, "Baby Doe squads" were dispatched to hospitals to determine whether treatment was

16. Raymond S. Duff & A.G.M. Campbell, *Moral and Ethical Dilemmas in the Special-Care Nursery*, 289 NEW ENG. J. MED. 890, 894 (1973).

17. See John A. Robertson, *Extreme Prematurity and Parental Rights After Baby Doe*, HASTINGS CTR. REP. 32, 32 (July-Aug. 2004) [hereinafter *Extreme Prematurity*].

18. See *Ethical and Legal Issues*, *supra* note 7, at 82.

19. *Id.*

20. See A. Shaw et al., *Ethical Issues in Pediatric Surgery: A National Survey of Pediatricians and Pediatric Surgeons*, 60 PEDIATRICS 588, 590 tbl.4 (1977) (stating that 85% of the pediatric surgeons and 65% of the pediatricians responding said they would follow the parents' wishes).

21. See *Ethical Issues*, *supra* note 14, at 532.

22. See *id.*

23. See Office of the Secretary, Department of Health and Human Services, *Nondiscrimination on the Basis of Handicap*, 48 Fed. Reg. 9630 (Mar. 7, 1983) (interim final rule modifying 45 C.F.R. § 84.61). See also Office for Civil Rights, Department of Health and Human Services, *Discrimination Against the Handicapped by Withholding Treatment or Nourishment; Notice to Health Care Providers*, 47 Fed. Reg. 26,027 (May 18, 1982) (applying 45 C.F.R. Part 84 to health services for handicapped children).

24. See *Extreme Prematurity*, *supra* note 17, at 33; *Ethical Issues*, *supra* note 14, at 532.

inappropriately denied.²⁵ The pediatric and hospital community successfully sued to invalidate the regulations on the grounds that they were beyond the federal regulatory authority.²⁶ Following this, Congress created the Federal Child Abuse Amendments of 1984.²⁷ States agreed to ensure that all newborn children were protected against discrimination on the basis of disability as a condition of receiving federal child abuse prevention funds to set up systems, including infant care review committees.²⁸

The Baby Doe controversy and following Amendments produced a pendulum effect in terms of moving the focus of decision-making in these cases from parents to the child.²⁹ The Baby Doe "treat at all costs approach" was one that demanded physicians to "do everything possible to save the life regardless of severity of disease, degree of suffering, or probability of success."³⁰ Although this approach guarantees that no infant will ever be under-treated, it also guarantees that some dying infants will suffer the abuse of over-treatment.³¹

This scenario is illustrated by the case of Baby Andrew.³² Andrew's parents, Robert and Peggy Stinson, wrote an article chronicling "what can happen when a baby becomes hopelessly entrapped in an intensive care unit where the machinery is more sophisticated than the code of law and ethics governing its use."³³ Doctors at the hospital treating Andrew refused to follow the parents' wishes to let their fifteen week premature son die a natural death, even though in the early 1980s infants in his category had less than a five percent chance of survival.³⁴ For six months, the Stinsons helplessly stood by and watched their son's prolonged suffering as the doctors treated Andrew for a brain hemorrhage, respiratory failure, necrosis of the right leg, gangrene, rickets, multiple bone fractures, retrolental fibroplais, blindness, and finally pulmonary hypertension.³⁵

The best interest standard is the result of changing public sentiment over providing treatment of doubtful value regardless of cost

25. See *Extreme Prematurity*, *supra* note 17, at 33.

26. See *Bowen v. Am. Hosp. Assoc.*, 476 U.S. 610 (1986).

27. See 42 U.S.C.A. § 5102 (West Supp. 2004) (repealed 1993).

28. See *Extreme Prematurity*, *supra* note 17, at 33.

29. See *Ethical Issues*, *supra* note 14, at 532.

30. *Id.*

31. *Id.*

32. See *id.*

33. Robert & Peggy Stinson, *On the Death of a Baby*, 7 J. OF MED. ETHICS 5, 5 (1981).

34. See *id.* at 7.

35. *Ethical and Legal Issues*, *supra* note 7, at 82.

since the Baby Doe Amendments.³⁶ As applied to infants, it can be defined as incorporating quality of life considerations and dictates that “infants should be treated with life-sustaining therapy, except when: (1) the infant is dying; (2) treatment is medically contraindicated; and (3) continued life would be worse for the infant than an early death.”³⁷ Implicit in the best interest standard is that parents do not have an absolute right to refuse or require medical treatment for their infants.³⁸ If the focus is on the patient as a person—one who can experience both pain and benefit—the standard for treatment should be what best serves his or her interest.³⁹

Treatment decisions fall into three categories: (1) the mandatory category; (2) the unwarranted category; and (3) the optional category. The best interest of the child standard is most easily applied to cases when an infant’s prognosis is certain, making treatment either mandatory or unwarranted.⁴⁰ Care falls into the unwarranted category when medical treatment would be futile because there is no chance of survival. Care falls into the mandatory category when the chances of survival are high. The optional category, however, where prognoses are unclear, as is the case with premature, very low birth weight infants, makes the best interest standard more difficult to apply.

B. Mandatory Category

Under the best interest standard, treatment is mandatory when there is a relatively low risk and a high likelihood that intervention would save the life of the child.⁴¹ In a case similar to the Baby Doe Bloomington case, a child commonly referred to as the John Hopkins Baby⁴² was born with Down Syndrome and duodenal atresia, a defect blocking the intestine, which could be corrected by a simple operation.⁴³ At the request of the parents, who were concerned about the “financial and emotional burden on the rest of the family,” the baby was left untreated and was allowed to starve to death over an eleven

36. See Robin W. Doroshow et al., *Treatment Decisions for Newborns at the Threshold of Viability*, 20 J. PERINATOLOGY 379, 380 (2000).

37. *Id.*

38. See *Ethical and Legal Issues*, *supra* note 7, at 81.

39. See *Ethical Issues*, *supra* note 14, at 534.

40. See Leigh Hopper, *No Easy Calls When Baby Is Terminally Ill*, HOUSTON CHRON., Feb. 9, 2005, at A1, A6.

41. See *Ethical and Legal Issues*, *supra* note 7, at 81–82.

42. This child is referred to as the John Hopkins’ baby because he was born at the John Hopkins Hospital. See *id.*

43. See James M. Gustafson, *Mongolism, Parental Desires, and the Right to Life*, 16 PERSPECTIVES BIOLOGY & MED. 529, 529 (1973).

day period.⁴⁴ This tragic example clearly violated the best interest of the child standard, but was instrumental in shifting the prior consensus that parents had absolute discretion in decision-making to one that focuses on the infants and his or her interests.

C. Unwarranted Category

When there is little to no chance of survival compared to the large burden and pain that aggressive treatment will impose on an infant, there is no obligation to subject the infant to advanced medical procedures.⁴⁵ As evidenced by Baby Andrew, in many cases treatment is unwarranted because over-treating infants causes unnecessary suffering by postponing death or prolonging life with devastating disabilities.⁴⁶ An anencephalic baby provides an example of a situation where there is a clear prognosis and treatment is unwarranted. A statement by the Medical Task Force on Anencephaly generally described the condition as "a congenital absence of a major portion of the brain, skull, and scalp."⁴⁷ The Task Force reported that the medical consequences of anencephaly can be established with some certainty.⁴⁸ All anencephalics by definition are permanently unconscious because they lack the cerebral cortex necessary for conscious thought.⁴⁹ Therefore, it would be in the child's best interest to discontinue aggressive treatment and allow the child to die, as there is no hope for recovery.

D. Optional Category

The best interest standard is not as easily applied where prognoses are unclear. The prognosis for infants born prematurely and with very low birth weight commonly falls into a gray area of uncertainty because the expected outcomes for these infants span the entire range of severe handicap to normal.⁵⁰ In dealing with infants in this uncertain category, treatment should be optional with discretion given to parents, who are in the best position to decide what is in their child's best interest. The physician or neonatologists' role is to convey

44. See *id.*

45. See *Ethical and Legal Issues*, *supra* note 7, at 81.

46. Mia W. Doron et al., *Delivery Room Resuscitation Decisions for Extremely Premature Infants*, 102 *PEDIATRICS* 574, 574 (1998).

47. See The Med. Task Force on Anencephaly, *The Infant with Anencephaly*, 322 *NEW ENG. J. MED.* 669, 669 (1990).

48. See *id.* at 670.

49. In the Matter of Baby "K," 16 F.3d 590, 592 (4th Cir. 1994).

50. See Doroshow et al., *supra* note 36, at 380.

to parents their medical opinion of the child's prognosis so that parents can make informed decisions. Nevertheless, society has a duty to intervene when parents make decisions that no longer are in the child's best interest.⁵¹

Before *Miller*, the law was consistent with the optional category, as it expected parents to be their child's surrogate decision-makers and authorized them to make choices and grant consent for medical treatment.⁵² The United States Supreme Court recognized the pre-existing state-law framework governing the provision of medical care to handicapped infants, which vests primary decisional responsibility in the parents, subject to review by the state in exceptional cases.⁵³ Courts have consistently upheld parents' rights to serve as surrogate decision-makers for their children, stating that parents are better suited than health care professionals to act on behalf of their child's best interest.⁵⁴ "The expectation is that it is both legitimate and anticipated that parents, once informed of the risks of marked prematurity, are the ones to make the decision on whether or not to utilize aggressive interventions or to provide 'comfort care' for their child."⁵⁵ After the *Miller* court's holding that emergent circumstances is the exception to the general rule of liability for a physician who treats a minor without parental consent,⁵⁶ treatment decisions falling in the optional category become one for physicians and not parents. Decision-making without parental involvement runs the risk of decision-making that violates the best interest standard.

II. The Case—*Miller v. HCA, Inc.*

A. Baby Sidney's Story

Baby Sidney was born with an uncertain prognosis, and her parents were given no decision-making authority regarding her best inter-

51. See *Ethical Issues*, *supra* note 14, at 536.

52. Frank I. Clark, *Intensive Care Treatment Decisions: The Roots of Our Confusion*, 94 PEDIATRICS, July 1994, at 98, 100 (citing *Bowen v. Am. Hosp. Assoc.*, 476 U.S. 610 (1986)).

53. *Bowen v. Am. Hosp. Assoc.*, 476 U.S. 610, 627 (1986).

54. *Parham v. J.R.*, 442 U.S. 584, 602 (1979).

55. *Emergent Circumstances*, *supra* note 11, at 340. The 1995 joint report of the American Academy of Pediatrics Committee on Fetus and Newborns and the American College of Obstetrics and Gynecologists Committee on Obstetric Practice also supports parental decision-making. "Decisions regarding obstetric management must be made by the parents and their physicians if the neonate's prognosis is uncertain . . ." *Perinatal Care*, *supra* note 5, at 975.

56. *Miller v. HCA, Inc.*, 118 S.W.3d 758, 761 (Tex. 2003).

ests.⁵⁷ On August 17, 1990, Karla Miller was admitted to Woman's Hospital of Texas ("Hospital") with symptoms of premature labor, approximately four months before her due date.⁵⁸ After administering a drug to stop labor, Karla's physicians learned that she had a life-threatening infection that required them to induce labor.⁵⁹ According to an ultrasound, the baby girl was at an estimated gestational age of twenty-three weeks and weighed approximately 629 grams, or 1¹/₄ pounds.⁶⁰ Dr. Jacobs, the attending obstetrician, and Dr. Kelley, a neonatologist, warned that if the baby survived, she would suffer severe impairments, and that they had never seen such a premature infant live.⁶¹ The doctors told the Millers that anything they did to sustain the infant's life would be guesswork.⁶² Karla and her husband, Mark, orally asserted that they would like no heroic measures performed on their baby after she was born.⁶³ This request, however, prompted a series of meetings with hospital administrators and physicians.⁶⁴ The director of the Hospital and several physicians then met with Mark, and the administrators announced there would be a neonatologist present at the delivery to evaluate the baby before deciding whether to attempt resuscitation because denying treatment without an evaluation would be below the standard of care.⁶⁵ After the meeting, hospital administrators asked Mark to sign a consent form allowing resuscitation according to the hospital's plan, but he refused and asked how he could prevent resuscitation.⁶⁶ He was told by hospital administrators that the Millers could go to another hospital, but this was not a viable option given Karla and her unborn child's condition.⁶⁷

That night, Sidney Ainsley Miller was born alive and weighed over 500 grams. Sidney's actual gestational age was twenty-three and one-seventh weeks.⁶⁸ Dr. Otero performed life-sustaining procedures on Sidney⁶⁹ by immediately "bagging"⁷⁰ and "intubating"⁷¹ her and then

57. *Id.* at 758.

58. *Id.* at 761.

59. *Id.*

60. *Id.*

61. *Id.* at 761-62.

62. *Id.* at 762.

63. *Id.*

64. *Id.*

65. *Id.*

66. *Id.* at 763.

67. *Id.*

68. *Id.*

69. *Id.*

placing her on a ventilator.⁷² Within the first two days after birth, Sidney suffered a brain hemorrhage.⁷³ She survived and as predicted suffers from severe physical and mental impairments.⁷⁴ The trial record states that at the time of trial:

Sidney was seven years old and could not walk, talk, feed herself, or sit up on her own. The evidence demonstrated that Sidney was legally blind, suffered from severe mental retardation, cerebral palsy, seizures, and spastic quadriplegia in her limbs. She could not be toilet-trained and required a shunt in her brain to drain fluids that accumulate there and needed care twenty-four hours a day. The evidence further demonstrated that her circumstances will not change.⁷⁵

B. The Millers's Legal Battle

The Millers sued the hospital for treating Sidney without their consent under the common law doctrine of battery.⁷⁶ They also claimed that the hospital was negligent for having policies and taking action that allowed treatment of Sidney without consent.⁷⁷ The Millers's claims stemmed from their allegations that despite their instructions to the contrary, the hospital not only resuscitated Sidney but performed experimental procedures and administered experimental drugs without which, in all reasonable medical probability, Sidney would not have survived.⁷⁸ A jury found that the hospital was grossly negligent and acted with malice.⁷⁹ The jury awarded the Millers over \$60 million in actual and punitive damages.⁸⁰ The appellate court, however, reversed the trial court decision, reasoning that under the Natural Death Act,⁸¹ a parent has no right to refuse treatment unless

70. Bagging is defined as giving breaths using a hand held bag instead of a ventilator. See Calgary Health Region Neonatology Frequently Asked Questions, http://www.calgaryhealthregion.ca/neonatology/FAQ_comprob_glossary.htm (last visited Jun. 22, 2005).

71. To intubate is to pass a special tube into the nose or mouth into the windpipe (trachea), to help air and oxygen reach the lungs. See *id.*

72. *Miller*, 118 S.W.3d at 763.

73. *Id.*

74. *Id.* at 764.

75. *Id.*

76. *Id.* at 761. For a discussion of battery, see *infra* Part III.A.

77. *Id.*

78. *Id.* at 764.

79. *Id.*

80. *Id.*

81. TEX. HEALTH & SAFETY CODE ANN. §§ 166.031–051 (Vernon 2001). The Natural Death Act (now called the “Advance Directives Act”) allows parents to withhold medical treatment from a child whose medical condition is certifiably terminal. That right does not extend to children with non-terminal impairments, deformities, or disabilities, regardless of their severity. *Id.*

the patient is "certifiably terminal."⁸² The court held that Sidney was not, and the Millers received nothing.⁸³

The Supreme Court of Texas affirmed the court of appeal's decision in favor of the hospital.⁸⁴ Unlike the court of appeals, however, the Texas Supreme Court refused to apply the Natural Death Act because it "does not impair or supersede any legal right an individual may have to withhold or withdraw life-sustaining treatment in a lawful manner."⁸⁵ Instead, the Supreme Court held that a nonconsensual touching is not a battery when it falls under the emergent circumstances exception.⁸⁶ Emergency circumstances are present when death is likely to result immediately upon failure to treat.⁸⁷ The court reasoned that Sidney's birth presented the Hospital with an emergent circumstance because the parents withheld consent, and there was no time for the Hospital to consult further with the parents or seek a court order.⁸⁸ Therefore, under *Miller*, emergent circumstances provides an exception to the general rule that a nonconsensual touching is a battery, relieving hospitals of any and all liability for battery and negligence claims if they resuscitate premature infants even without parental consent.

III. Analysis

The holding in *Miller* poses a danger that physicians might read the decision as mandating the resuscitation of all newborns showing any signs of life regardless of probable outcome or parental input. This unlimited rule is problematic because a standard practice of this nature conflicts with the medically and legally accepted standard that treatment decisions should be made in the child's best interest.

A. The Emergent Circumstances Exception Is in Conflict with Legal Precedent

Miller has been called "a landmark ruling, one that marks a radical shift in the common law understanding of battery."⁸⁹ *Miller* expands the informed consent doctrine and disregards the parents'

82. *Miller*, 118 S.W.3d at 761.

83. *Id.*

84. *Id.*

85. *Id.* at 771.

86. *Id.* at 761.

87. *Id.*

88. *Id.*

89. *Emergent Circumstances*, *supra* note 11, at 339.

right to be the presumed decision-makers for their children. In doing so, the *Miller* court is in conflict with legal doctrine and United States Supreme Court precedent in holding that Sidney's resuscitation was an exception to the general rule that a physician commits a battery by providing medical treatment without consent.

Using the common law notion that a nonconsensual touching is a battery, Justice Benjamin Cardozo ruled in the 1914 New York case of *Schloendorff v. Society of New York Hospital*,⁹⁰ that physicians are required to obtain consent before "touching" a patient.⁹¹ The doctrine of informed consent, requiring that permission be obtained before providing medical treatment, is based on the patient's right to receive information adequate for her (or her surrogate) to exercise an informed decision to accept or refuse treatment.

Tandem with the right to give informed consent before a physician may treat is the opposite right to withhold consent, even if withholding consent would lead to their death.⁹² Since the patients' rights movement in the 1960s, the vast weight of federal and state law has supported patient autonomy in medical decision-making.⁹³ Although it is acceptable for people to refuse consent for treatment that ultimately brings about their own death, it is a different situation when others do it for them. Newborns, never having the capacity to give informed consent, present a new dilemma to the doctrine since the patient is not able to communicate her wishes.

The standard for informed consent is explained in *Canterbury v. Spence*.⁹⁴ In *Canterbury*, a patient submitted to an operation without being informed of the risks of paralysis and subsequently suffered paralysis.⁹⁵ The court explained that a physician's duty to impart information to a patient includes "generally informing the patient in non-technical terms as to what is at stake: the therapy alternatives open to him, the goals expectably to be achieved, and the risks that may ensue from particular treatment and no treatment."⁹⁶ The court in *Can-*

90. 105 N.E. 92 (N.Y. 1914).

91. See *id.* at 93.

92. See *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990) (holding a Missouri state law requiring clear and convincing evidence before withdrawing medical treatment from an incompetent patient constitutional). The opinion is presumed by many authorities to recognize a constitutionally protected liberty interest to refuse unwanted medical treatment. See generally BARRY R. FURROW ET AL., *BIOETHICS* (5th ed. 2004).

93. See Mia Wechsler Doron & Dana Wechsler Linden, *Eyes of Texas Fasten on Life, Death and the Premature Infant*, N.Y. TIMES, Apr. 30, 2002, at F5.

94. See 464 F.2d 772 (D.C. Cir. 1972).

95. *Id.* at 776.

96. *Id.* at 782 n.27.

terbury noted that there is an exception to this requirement of informed consent when individuals are unconscious or unable to express consent.⁹⁷

This exception is derived from *Moss v. Rishworth*,⁹⁸ in which a child was treated without the parent's consent. *Moss* held that emergent circumstances allow the physician to forgo consent to operate on a minor "when death is likely to result immediately upon failure to perform" treatment.⁹⁹ This exception—the emergent circumstances exception—was used by the Texas Supreme Court to justify Sidney's treatment over the objections of her parents. The court stated that in emergent circumstances, "the harm from failing to treat outweighs any harm threatened by the proposed treatment, because the harm from failing to provide life-sustaining treatment under emergent circumstances is death."¹⁰⁰ Applying this to Sidney, being a newborn incapable of consenting, the court pointed to evidence that Sidney would have died without treatment and therefore found the harm from a failure to treat was imminent and outweighed any harm threatened by the proposed treatment.¹⁰¹

The court, however, was very explicit that the physician's action was not based on the doctrine of "presumed consent" because there could not be a presumption that the patient (or parental proxy) would have consented when the Millers explicitly refused consent.¹⁰² The *Miller* court reasoned that if parents withhold consent, the exception can still arise in emergent circumstances when there is no time to consult the parents or seek court intervention.¹⁰³ *Miller* proposes, for the first time in American jurisprudence, a broadening of the emergent circumstances doctrine to the point of allowing a physician to treat a patient without consent, actual or presumed.¹⁰⁴

As the *Miller* court noted, the United States Supreme Court has held that the custody, care, and nurture of an infant resides with the parents and that parents are the presumed decision-makers for

97. *Id.* at 788–89.

98. *Moss v. Rishworth*, 222 S.W.2d 225, 226 (Tex. Comm'n App. 1920).

99. *Id.*

100. *Miller v. HCA, Inc.*, 118 S.W.3d 758, 768 (Tex. 2003).

101. *See id.* at 3 768–70 (citing *Gravis v. Physicians & Surgeons Hosp.*, 427 S.W.2d 310, 311 (Tex. 1968); *Moss*, 222 S.W.2d at 226–27).

102. *See Miller*, 118 S.W.3d at 768; *see also Emergent Circumstances*, *supra* note 11, at 338.

103. *See Miller*, 118 S.W.3d at 768.

104. *See Emergent Circumstances*, *supra* note 11, at 338.

newborns.¹⁰⁵ *Parham v. J.R.*¹⁰⁶ recalls the consistently followed historical jurisprudence of “broad parental authority over minor children,” recognizing that “natural bonds of affection lead parents to act in the best interests of their children.”¹⁰⁷ Nevertheless, parents’ constitutional rights are subject to limitations. In *Bowen v. American Hospital Association*,¹⁰⁸ the United States Supreme Court acknowledged parental decision-making authority and its limits. “[A]s long as parents choose from professionally accepted treatment options the choice is rarely reviewed in court and even less frequently supervened.”¹⁰⁹ State interference in such instances occurs only when parents “have made decisions that evidence substantial lack of concern for the child’s interests.”¹¹⁰ Children fall under the *parens patriae* power of the state, which allows states to “punish parents whose conduct has amounted to abuse or neglect of their children” and “may also supervise parental decisions before they become operative to ensure that the choices made are not so detrimental to a child’s interests as to amount to neglect and abuse.”¹¹¹

The newly expanded emergent circumstances exception articulated by the *Miller* court goes against United States Supreme Court precedent and common law notions of battery and informed consent. *Miller* removed parents, who are in the best position to decide what is in their child’s best interest, from the primary decision-making role in the treatment of seriously ill newborns in the optional category.

105. See *Miller*, 118 S.W.3d at 766 (citing *Parham v. J.R.*, 442 U.S. 584, 602 (1979)); see also *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944); *Troxel v. Granville* 530 U.S. 57, 65 (2000).

106. 442 U.S. 584, 602 (1979).

107. *Id.*

108. 476 U.S. 610 (1986).

109. See *id.* at 628 n.13.

110. See *id.* The Court notes that “[a]lthough societal involvement usually occurs under the auspices of governmental instrumentalities—such as child welfare agencies and courts—the American legal system ordinarily relies upon the private initiative of individuals, rather than continuing governmental supervision, to bring the matter to the attention of legal authorities.”

111. See *id.* at 628 n.13. The meaning of the term “abuse and neglect” has varied over time and has rarely been the subject of careful legislative definition. The difficulties stemming from two legal doctrines—respect for parental discretion and protection of children against harm—may partially account for the dispute over the meaning of the terms; See *President’s Comm’n*, *supra* note 8, at 213.

B. Expanding the Emergent Circumstances Exception to Avoid Tort Liability Does Not Serve the Child's Best Interest

In basing its decision on the emergent circumstances exception, the Texas Supreme Court relieved the Hospital from enormous liability—close to \$60 million—in a tort and negligence action. The court hastily used an exception to cast aside the necessary consent in order to avoid a precedent that would open hospitals up to this type of liability. Instead, the court should have ensured good policy for the complicated ethical issues surrounding the treatment of very low birth weight infants by evaluating the case using the best interest of the child standard. *Miller* should not be relied upon by courts or physicians for guidance in making treatment decisions for very low birth weight infants.

C. Alternatives to Emergent Circumstances Lead to Bad Policy

In criticizing the majority decision, the dissenting appellate judge in the *Miller* case argued that no emergency existed that would excuse the Hospital's treatment of Sidney without the parents' consent or a court order overriding their refusal to consent.¹¹² The dissenting judge further argued that there could be no court-based finding of emergent circumstances because there was sufficient time between the meeting at the hospital and Sydney's birth to inform the Millers of the alternatives of changing hospitals or seeking outside judicial review.¹¹³ The court found an exception based on circumstances that did not exist, attempting to circumvent the requirements of the emergent circumstances exception. This exception will lead to bad policy regarding treatment decisions of very low birth weight infants because it forces parents to choose between switching hospitals and seeking outside judicial review or staying at the present hospital.

The option to change hospitals can be a serious health issue for mothers in Karla's position. For instance, at the time Karla learned that the Hospital was not going to honor her refusal to consent to Sidney's treatment, she was hospitalized and had a life-threatening infection.¹¹⁴ Thus, the option to seek care in another hospital was not one realistically available to her. Encouraging this type of policy is not in the best interest of the child because it is dangerous to both the health of the mother and the unborn child that she is carrying. Medi-

112. See *HCA, Inc. v. Miller*, 36 S.W.3d 187, 197–98 (Tex. App. 2000) (Amidei, J., dissenting).

113. See *id.*

114. See *Miller*, 118 S.W.3d at 761.

cal attention and care must be the priority during a high risk labor situation. Having an emergent circumstances standard that could impose unwanted treatment, which could only be avoided by seeking care in another facility, is "an abandonment of both the mother and the child to the ravages of an untended to birth."¹¹⁵

Furthermore, judicial review of treatment decisions for newborns, such as those the Millers faced, where treatment should be optional, does not comport with the best interests of the child. Both the American Academy of Pediatrics and the President's Commission for the Study of Bioethical Problems in Medicine recommend that institutional hospital ethics committees review borderline decisions,¹¹⁶ particularly when there is disagreement or uncertainty about whether the child's interest requires treatment.¹¹⁷ Parents' decisions in difficult cases are best reviewed by an in-house, broadly based, multidisciplinary hospital ethics committee because that committee is familiar with community standards, as opposed to courts, which are removed from clinical situation and are less familiar with those community standards.¹¹⁸

Judicial review of this nature should be used only as a last resort, when the parent or physician is blatantly acting out of line with the child's best interest—for example where parents demand or refuse treatment for a child in the mandatory or unwarranted categories—and when hospital ethics committees are unable to resolve the issue. At this point, the child can be referred to the court for the appointment of a legal guardian who would be empowered to evaluate options and make decisions in the best interest of the child.¹¹⁹ The policy put forth in the *Miller* case and the other cases presented in this Note, make clear that judicial interventions provide no guarantee of consistency among the courts, or practical policy guidelines to see that the best interest of the child standard is followed. Court proceedings are long, invasive, expensive, and insensitive to the agonizing and intimate experience of medical decision-making—especially as applied to

115. John J. Paris & Frank Reardon, *Bad Cases Make Bad Law: HCA v. Miller Is Not a Guide for Resuscitation of Extremely Premature Newborns*, 21 J. OF PERINATOLOGY 541, 543 (2001) (discussing the mother in the case *Jefferson v. Griffin Spaulding Mem'l Hosp.*, 247 S.E.2d 457 (Ga. 1981), who fled the hospital to avoid an unwanted court authorized caesarian section).

116. For example, where parents demand or refuse treatment for a child in the mandatory or unwarranted categories.

117. *Extreme Prematurity*, *supra* note 17, at 37; *Perinatal Care*, *supra* note 5, at 975.

118. *See Ethical Issues*, *supra* note 14, at 536.

119. *See id.*

the case of seriously ill newborns. Moreover, “[s]ome maintain that judges have no special competence to exercise judgment about complex matters in which difficult moral issues are intertwined with complicated medical considerations.”¹²⁰ Therefore, parents should be afforded primary decision-making authority and when parents exercise that prerogative in a way that may not be in the infant’s best interest, society should intervene in order to serve the best interest of the child.

D. There Is a Particular Need for Consent When Embarking on Experimental Medical Procedures

The need for parental consent before treating Baby Sidney is even more compelling given that the proposed treatment was experimental in nature. Although the survival rate for very low birth weight infants has been improving, there is insufficient data regarding the cost of initial and ongoing care of these infants and the long-term outcome of survivors.¹²¹ Treatment decisions of very low birth weight babies, such as Sidney, have been called “so new . . . and so unproven that it is an ‘innovative’ or ‘experimental’ procedure.”¹²² The facts of the *Miller* case show that the physicians had never seen such a premature infant live and told the parents that anything they did to sustain the infant’s life would be “guesswork.”¹²³ The Millers’s claim stemmed from their allegations that the Hospital performed experimental procedures and administered experimental drugs.¹²⁴

International regulation of research involving human subjects through the Nuremberg Code and the Declaration of Helsinki necessarily conditions patient—in this case parental—consent before embarking on experimental, investigational, or research based treatment.¹²⁵ A 1988 study (two years prior to Sidney’s birth) by John Lantos and his colleagues at the University of Chicago found that not one of thirty-eight very low birth weight infants who received CPR in the first seventy-two hours of life survived.¹²⁶ Four of the eleven very low birth weight infants who received CPR after the first seventy-two

120. *Imperiled Newborns*, *supra* note 3, at 19.

121. *See Perinatal Care*, *supra* note 5, at 976.

122. John D. Lantos et al., *Survival After Cardiopulmonary Resuscitation in Babies of Very Low Birth Weight*, 318 NEW ENG. J. MED. 91–95 (1988).

123. *See Miller*, 118 S.W.3d at 761–62.

124. *Id.* at 764.

125. *See FURROW ET AL.*, *supra* note 92, at 408, 447.

126. *See Lantos et al.*, *supra* note 121, at 93–94 (evaluating outcome in terms of survival until hospital discharge or death).

hours survived, but three of the four had residual neurological deficits.¹²⁷ The researchers concluded that since the survival rates are so low, CPR should not be considered a validated treatment in this population and should only be administered upon advanced informed consent to experimental treatment.¹²⁸ Although Sidney did not receive CPR, the treatment she did receive was an experimental procedure that was embarked upon by her doctors before her parents gave the appropriate medical consent. Medical professionals have ethical obligations to protect vulnerable patients from clinical trials.¹²⁹ For experimental procedures on neonates to be in the best interest of the patient, consent must be obtained only after discussion with the parents about the outcome data and futility of aggressive intervention.¹³⁰

IV. Decision-Making Guidelines

To prevent another outcome as in *Miller*, universal guidelines should be adopted in practice by physicians and followed by courts to address problems with medical decision-making for seriously ill newborns with an uncertain prognosis. If these guidelines are used properly and applied consistent with the child's best interest, fewer cases will end up requiring judicial review. If cases do end up in the courts, the guidelines would help allow for more consistency to emerge in the courts. The special *Hastings Center* project on neonatal ethics outlines three approaches to responding to uncertainty in neonatal medicine: (1) the statistical approach; (2) the wait until certainty approach; and (3) the individualized approach.¹³¹ Instead of following the *Miller* court's reliance on the emergent circumstances exception, which utilizes the wait until certainty approach, hospitals should adopt the individualized approach because it is most in line with the best interests of the child.¹³²

127. *See id.*

128. *See id.* at 94–95.

129. *See id.* at 95.

130. *See id.*

131. *See Imperiled Newborns, supra* note 3, at 11.

132. The Hastings Center Project endorses the individualized approach. *See Imperiled Newborns, supra* note 3, at 13.

A. Approaches for Responding to Uncertainty in Neonatal Medicine

1. Statistical Approach

The first approach is a purely statistical one, allowing physicians to make an “across-the-board determination that infants in a particular statistical profile are unlikely to benefit from treatment and that it should therefore not be initiated for them.”¹³³ The problem with this approach is that it allows some babies to die who could have thrived and reduces these difficult decisions with far reaching implications to decisions about infants in general and not on the individual infant’s prognoses.¹³⁴ Therefore, this approach is not in line with the best interest of the child standard. For instance, in Sidney’s case, just the fact that she was at twenty-three weeks gestation would be enough to put her in the unwarranted category without any inquiry into her prognosis, assessment after birth, or discussion among the doctors and parents regarding her specific best interests.

2. Wait Until Certainty Approach

The second approach, wait until certainty, is generally employed by physicians and hospitals in the United States.¹³⁵ Under this approach, treatment is initiated for every infant that is even potentially viable, and treatment is continued until it is certain that the either the child will die, or that the parents could legitimately opt for termination of treatment.¹³⁶ This approach’s most positive feature is that it ensures every infant who could survive is treated.¹³⁷

However, the wait until certainty approach is also flawed because it may not take the best interest of the child into account. Waiting for certainty in an area pervasive with uncertainty “may result in mandatory treatment of infants who end up with an extremely painful or minimal existence.”¹³⁸ Very low birth weight survivors often have significant physical and mental handicaps, including blindness, hydrocephalus, cerebral palsy, limited use of language, and learning disabilities.¹³⁹ Others, such as Baby Andrew, suffer a prolonged and

133. *Id.* at 11.

134. *See id.* at 12–13.

135. *See id.* at 11. *See also* Nancy K. Rhoden, *Treating Baby Doe: The Ethics of Uncertainty*, HASTINGS CTR. REP., Aug. 1996, at 34, 35.

136. *Imperiled Newborns*, *supra* note 3, at 11.

137. *Id.* at 12.

138. *Id.*

139. *See Extreme Prematurity*, *supra* note 17, at 34.

painful dying process.¹⁴⁰ “Waiting for near certainty ignores information, abuses basic principles of probability, and denies the ethical complexity of these decisions.”¹⁴¹

Another danger in this approach is that as long as there is uncertainty, decisions regarding treatment are considered medical rather than ethical. Medical decisions are completely left up to the physician, reducing the role of the parents, the legally presumed decision-makers for their children, to that of onlookers.¹⁴²

The *Miller* court followed a wait until certainty approach. The court based its holding on the reasoning that premature infants could not be fully evaluated for medical treatment until birth, and any parental decision prior to birth would be based on “speculation” and would not be “fully informed.”¹⁴³ The court found a medical emergency even though both parents were in the delivery room and had expressed wishes to withhold treatment prior to delivery. However, the court assumed there was—and always is—no time in the post-delivery decision-making moment for parental input on whether or not to resuscitate, and the only factor in the decision is the physician’s judgment on the potential viability of the infant.¹⁴⁴

It appears the court embraces the wait until birth approach so that the baby can be “properly evaluated,” in order to give certainty to the prognosis in cases of early gestational age infants.¹⁴⁵ Only after an evaluation that uncovers absolute certainty in prognosis will the court legitimize any decision to withhold treatment. However, the studies on extremely premature and low birth weight infants show that their prognoses are inherently uncertain and all decision-making regarding treatment, even after birth, is based on speculation.¹⁴⁶

Agreeing with the *Miller* court’s rationale that assessment of the child cannot be possible until birth, ethicist John A. Robertson writes that “[d]octors and hospitals should be legally free to have neonatologists resuscitate and treat for a limited period after birth to assess the child’s capacity regardless of parental consent or orders not to resuscitate.”¹⁴⁷ This approach fails because it leaves no room to make a judgment based on the child’s best interest and prognosis, no matter how

140. See Stinson, *supra* note 33, at 5.

141. *Ethical Issues*, *supra* note 14, at 533.

142. See *id.*

143. See *Miller v. HCA, Inc.*, 118 S.W.3d 758, 769 (Tex. 2003).

144. See *Emergent Circumstances*, *supra* note 11, at 341.

145. See *Miller*, 118 S.W.3d at 769.

146. See *Emergent Circumstances*, *supra* note 11, at 341.

147. *Extreme Prematurity*, *supra* note 17, at 32, 38.

uncertain. Instead, it endorses “[t]rying to resuscitate all potentially salvageable newborns indifferent to the known data on mortality and morbidity.”¹⁴⁸ Robertson’s article has been criticized as requiring resuscitation of all infants without regard to pre-delivery assessment of gestational age and weight.¹⁴⁹

In Sidney’s case, for example, the Millers were told that “the infant had little chance of being born alive,” that “they had never had such a premature infant live,” and that if she were born alive she “would most probably suffer severe impairments.”¹⁵⁰ Sidney had an uncertain, very poor prognosis, yet she was aggressively treated despite the Miller’s request that no heroic measures be performed. Sidney, as a very low birth weight infant, was in the optional category of treatment. The wait until certainty approach is faulty because it forces physician initiated treatment until decision-making is clear cut. Since the Millers only had a probable outcome for Sidney’s prognosis and not certainty, the wait until certainty approach prevented them from making the decision to end treatment, the decision they believed was in the best interest of their child.

3. Individualized Approach

The third approach, the individualized approach, is the superior method for decision-making that is in the best interest of the child. The individualized approach is an intermediate approach that, similar to the wait until certainty approach, begins treatment for every infant, “but [also] allow[s] parents the option of termination of treatment before it is absolutely certain that a particular infant will . . . die.”¹⁵¹ The approach depends on probabilities rather than “wait[ing] for near-certainty in an area characterized by pervasive uncertainty.”¹⁵² Doctors try to obtain as much information as possible about a particular infant’s probable prognosis by taking into account factors or other indicators of probable neurological impairment.¹⁵³

This approach involves parents in the decision-making process, respecting their rights and acknowledging the presumption that the decisions that the parents make will be in their child’s best interest. The individualized approach encourages discussion among parents

148. *Emergent Circumstances*, *supra* note 11, at 342.

149. *Id.*

150. *Miller*, 118 S.W.3d at 762.

151. *Imperiled Newborns*, *supra* note 3, at 11. See also *Emergent Circumstances*, *supra* note 11, at 341–42.

152. See *Imperiled Newborns*, *supra* note 3, at 13.

153. See *id.* at 11–12.

and physicians and informed decision-making prior to birth based on pre-delivery assessment of gestational age and weight. Then, after the birth of the infant, the parents and physicians jointly reevaluate the infant's prognosis as compared to the predicted one so that parents can make an informed decision based on their child's best interest.

As applied to *Miller*, Sidney was at twenty-three weeks of gestation, and the Millers were informed that Sidney had "little chance of being born alive," and that if she were born alive she would most probably "suffer severe impairments."¹⁵⁴ At the time of the birth, even the most sophisticated NICUs did not have protocols for the care of infants at Sidney's level of prematurity.¹⁵⁵ The "now classic"¹⁵⁶ study of twenty-two to twenty-five week gestation deliveries from May 1988 to September 1991, represents the standard of care in place at the time of Sidney's birth.¹⁵⁷ It found that none of the infants born at twenty-two weeks survived, 15% of those born at twenty-three weeks survived, 56% of those born at twenty-four weeks survived, and 79% of those born at twenty-five weeks survived.¹⁵⁸ Of the 15% of infants that survived at Sidney's gestational age, twenty-three weeks, only 2% did so "without severe abnormalities on cranial ultrasound."¹⁵⁹ Sidney's prognosis was uncertain, placing her in the optional category, within which parents should be given discretion as to whether or not to treat their infant, even though there is a slight possibility, 15%, that the child will survive.¹⁶⁰

When dealing with probabilities, there is always the chance that the wrong decision will be made in an individual case. However, in the cases of extremely premature infants whose prognoses are inherently uncertain, probabilities are the only tools the decision-makers have to work with. In making the treatment decision, it is recommended that physicians gather as much data as possible on the outcome probabilities of similar infants and discuss resuscitation with the parents before

154. See *Miller*, 118 S.W.3d at 761-62.

155. See *Emergent Circumstances*, *supra* note 11, at 341-42.

156. See *id.* at 340 (citing Marilee C. Allen et al., *The Limits of Viability—Neonatal Outcomes of Infants Born at 22 to 25 Weeks' Gestation*, 329 NEW ENG. J. MED. 1597-601 (1993)).

157. See *id.* at 340.

158. The survival rate in this study was defined as the number of infants born at a given gestational age who survived six months from birth, divided by the number of infants born at that gestational age, including stillborn infants. See Marilee C. Allen et al., *The Limits of Viability—Neonatal Outcomes of Infants Born at 22 to 25 Weeks' Gestation*, 329 NEW ENG. J. MED. 1597, 1598 (1993).

159. See *id.* at 1599.

160. See *Emergent Circumstances*, *supra* note 11, at 341. See also Hopper, *supra* note 40, at A1, A6.

delivery. The decision should be altered if necessary after initial treatment and evaluation at birth, taking into account the possibility of inaccuracy of predicting gestational age and weight.¹⁶¹ In its endorsement of the individualized approach, the special Hastings Center project on neonatal ethics said:

[A]n individualized approach that seeks a high degree of moral probability rather than certainty can be embraced with some confidence. As time goes on, physicians do gain more information about the probable outcome for very premature babies, though of course in an individual case they can be wrong. The possibility of error should, we believe, be reason for caution, not an excuse for mandating aggressive treatment until the bitter end.¹⁶²

B. The Potential for Relationship Standard

After determining that the individualized approach is the best suited approach for the best interest of the child, the parents need criteria for making decisions regarding the treatment of their child. For instance, Baby Sidney was among the 15% of babies at her gestational age and weight to survive because of treatment, but not one of the 2% to survive without severe abnormality on cranial ultrasound. Even though there is a likelihood of survival, is the fact that it will be with severe disability enough to justify a parent's cessation of treatment? Richard McCormick, S.J., a Catholic bioethicist, suggests making this determination by using a quality of life judgment based on the potential for human relationship.¹⁶³ McCormick, the leading authority on the potential for relationship standard, frames his guidelines in the Christian tradition, but also provides secular guidelines for decision-making in the cases of newborns like Sidney. "Translated into the language of 'best interests,' an individual who lacks any present capacity or future potential for human relationships can be said to have no interests at all, except perhaps to be free from pain and discomfort."¹⁶⁴ He frames the best interest of the child with the proposition that "life is a value to be preserved only insofar as it contains some potentiality for human relationships."¹⁶⁵

Therefore, if an individualized approach using a potential for relationship standard was used during the case of the John Hopkins

161. Doroshov et al., *supra* note 36, at 380–81.

162. *Imperiled Newborns*, *supra* note 3, at 13.

163. Richard A. McCormick, *To Save or Let Die: The Dilemma of Modern Medicine*, 229 JAMA, 172, 172–76 (1974).

164. *Imperiled Newborns*, *supra* note 3, at 15.

165. McCormick, *supra* note 163, at 175.

baby,¹⁶⁶ cessation of treatment would never be in that child's best interest because of the potential for relationship that people with Down Syndrome have. On the other hand, an anencephalic baby has no potential for relationship and therefore should never be aggressively treated at birth.

As evidenced by Baby Sidney's condition today, the argument could be made that she has no potential for relationship. Therefore, had the Millers been able to withhold treatment using the individualized approach, their decision would have been justifiable. On the other hand, there is evidence in the *Miller* case that Sidney smiled and responded favorably to physical contact.¹⁶⁷ With that evidence, one could argue that Sidney has some potential for relationship. Sidney's case demonstrates the lack of absolute certainty in these cases and highlights the difficulty of these life and death decisions.

It is important to remember, when applying the best interest of the child standard, that an impaired child does not have the luxury of comparing his life to a "normal" one, and we should not compare their life's worth to a healthy child.¹⁶⁸ Therefore, the decision should be made as objectively as possible and not by the perspective of what one would consider "normal." In fact, the *Miller* court avoided this issue and found a court order unnecessary to override the Miller's refusal to consent to Sidney's treatment because "a court cannot decide between impaired life versus no life at all."¹⁶⁹ The court's reluctance to address this issue shows the need for more comprehensive ethical methodology discussion and awareness of the ethical questions posed in the NICUs in our nation's hospitals. McCormick addresses this concern:

This risk of error should not lead to abandonment of decisions; for that is to walk away from the human scene. Risk of error means only that we must proceed with great humility, caution, and tentativeness. Concretely, it means that if err we must at times, it is better to err on the side of life—and therefore to tilt in that direction.¹⁷⁰

166. The John Hopkins Baby was a baby born with Down Syndrome and duodenal atresia, a defect blocking the intestine, which could be corrected by a simple operation. Upon request of the parents, the baby was left untreated and allowed to starve to death over an eleven day period. See Gustafson, *supra* note 43, at 529.

167. See *Extreme Prematurity*, *supra* note 17, at 37.

168. See *Imperiled Newborns*, *supra* note 3, at 15.

169. *Miller v. HCA*, 118 S.W.3d 758, 765 (Tex. 2003).

170. McCormick, *supra* note 163, at 176.

Conclusion

Miller was wrongly decided and should not be used by parents, physicians, or other courts as a model for making treatment decisions for preterm, very low birth weight infants. Making decisions in a child's best interest is the agreed upon standard by the medical community and the United States Supreme Court. The emergent circumstances exception to the need for informed consent, which was the doctrine on which the *Miller* decision based its holding, is threatening the best interest of the child standard. The proper approach to making decisions in a child's best interest is an individualized approach. This gives the parents the decision-making authority after conversations with their physicians, before and after birth, about the probabilities that their child will survive with the potential for human relationship. The physician, and finally the court, should only intervene in this decision-making if there is strong disagreement as to the proper course of treatment, and even then, only to ensure that life or death decisions are ultimately made in the child's best interest.

