1982–1986: THE BABY DOE RULES (Case Study)

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 Date

Case study

In the 1980s, medical schools with bioethics courses emerged and the regulations Baby Doe (1982) and Baby Jane Doe (1983), Deciding to Forego Life-Sustaining Treatment (1984) were decreed in response to widespread problems in society North American. In modern democratic societies, morally secular and pluralistic, interest in practical philosophy in public affairs arises. These aspects are combined in medical practice where traditional, deontological, more or less codified and confessional ethics is reduced to “etiquette” in the face of the serious moral problems that arise from scientific progress and the institutional complexity of current medicine, where Moral dilemmas are frequent (for example, termination of treatments) and health policies (allocating resource nations, etc.).

Bioethics appears at the time of relativization of deontological principles, from criticism to rationalization. Thus, in 1966 Joseph F. Fletcher, in his book Situation Ethics, postulates the situationism and tries to apply a certain situation to the general norm. This situational moral theory arises from existentialist ethics. While Brody postulates the theory of rational decision, observes the consequences and values ​​(individual, community and legal), the bad consequences are those that do not respect the values. Look at what, who, under what circumstances and consequences, being a teleologic ethic. (Andre, 2002). The child's parents are the legal representatives of their child. The prerequisite for good and successful care is that the child can be cared for in agreement with his or her parents. However, parental rights have limits. If there is a clear conflict between the best interests of the child and the will of the parents - that is, parents wanting to prohibit medically justified treatment to counter the risk to the life

In order to address the ethical concerns of seriously ill newborns, the physician should consider the benefits and the avoidance of interventions and the rights and autonomy of the various parties involved like the case of Baby doe. Patient-focused research and treatment should be based on efficacy, available research data, and validated methods. The newborn must be treated with respect for his or her dignity. Unnecessary measures must be avoided. Respect for human dignity is also an end to ineffective recovery. (Cummings, Paris, Batten & Moreland, 2018).

In assessing the benefits and risks, it should be borne in mind that parents 'and health professionals' perceptions of good or acceptable quality of life and the best interests of the child may differ significantly. Religious and cultural differences should be taken into account to the extent that they are consistent with legislation and generally accepted ethical principles. Attitudes towards the importance of different levels of disability vary. Advances in medicine influence the setting of treatment boundaries as treatment opportunities increase.

If a fetus has been diagnosed with a severe disability that significantly reduces the quality of life and the survival of the fetus is unclear, parents have the right to opt for a passive fetal care option during pregnancy and childbirth. However, if the child's vital signs begin after birth, he or she is usually treated. The ethical reason tries to establish universal criteria, that is to say that they apply to all in the same circumstances, although they must be in continuous revision. However, we know that ethical views depend on each individual and opinions will therefore be different and diverse.

An important problem in the field of bioethics is precisely the moment of decision-making, whether in the field of relations between the health team and patients, as in the field of biomedical research or in the assignment of Resources in health policies.

Refraining from neonatal resuscitation or intensive care is considered in situations where premature death or prolonged suffering due to ineffective treatment is likely. A decision can be made if the diagnosis of a serious illness or structural abnormality in the newborn child is confirmed, for example, by imaging or fetal chromosome examination. If the prognosis is uncertain, the best option to avoid permanent harm is to treat the child as effectively as possible until the necessary examinations have been made to confirm the diagnosis. The parents' wishes regarding the child's care are taken into consideration as much as possible. For example, an 18-trisomy child may be admitted to the mother's care in a hospital wards or at home with the help of home health care. (Kopelman, 2005).

The prognosis of a very premature or very underweight child is rarely known with certainty. In these situations, refraining from resuscitation may result in an extremely ethical situation in the maternity ward if the child breathes and moves for an extended period of time. Therefore, active resuscitation and initial care are immediately recommended in order not to increase the risk of a potentially viable child being injured. Most often, within 1-2 days, it turns out that the child does not have the conditions for independent living or has already suffered serious damage. Then there are no longer grounds for continuing intensive care. (Kopelman, 2005).

If possible, the parents' views on the care activity should be clarified in advance if the child is born prematurely. Parents should be adequately informed about the prognosis of the survival and injury of an infant and what intensive care for an infant means in practice. If, after this discussion, parents do not want active intensive care for their very premature (less than 23 weeks) child, abstinence should be seriously considered.

References

Andre, J. (2002). Bioethics as practice. Univ of North Carolina Press.

Cummings, B. M., Paris, J. J., Batten, J. N., & Moreland, M. P. (2018). Dispute between

 physicians and family on surgical treatment for an infant with ultra-short gut syndrome: the

 perspective of an Ethics Committee. Journal of Perinatology, 38(7), 781.

Kopelman, L. M. (2005). Rejecting the Baby Doe rules and defending a “negative” analysis of

 the Best Interest Standards. Journal of Medicine and Philosophy, 30(4), 331-352.

Kopelman, L. M. (2005). Are the 21-year-old Baby Doe rules misunderstood or mistaken?

 Pediatrics, 115(3), 797-802.