the People's Doctor
A MEDICAL NEWSLETTER FOR CONSUMERS
by Robert S. Mendelsohn, MD

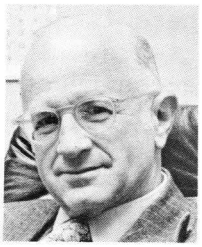
VOL.8, NO. 1

BULK RATE
U.S. POSTAGE
PAID
PERMIT NO. 9323
CHICAGO, IL

P.O. Box 982 Evanston, Illinois 60204

IN THIS ISSUE:

Baby Doe, Barney Clark and other questions of medical ethics



Dr. Robert Mendelsohn

As we enter 1984, a review of the most astounding decade in the history of medical ethics in our country seems in order. In 1973, the Roe vs. Wade decision (by removing previous barriers to abortion on demand) converted doctors into legal agents of death. In 1983, the "Baby Doe" legislation (by establishing barriers to withholding medical care from mentally-retarded babies) represents a major societal effort to reverse this dangerous trend and to restrict the "agent of death" role of doctors.

The bizarre history of modern medicine in dealing with ethical issues, especially involving death and sex, once again should remind all of us that medicine--especially medical ethics--is too important to be left to doctors.

Q What do you think of the Baby Doe cases, especially the New York baby with spina bifida, in which the federal government is pressing to review the medical records because the parents are refusing surgery? Can you help me reach a rational decision on this question?--J.C.

A *Baby Doe*

While I am disappointed with the discussion of the Baby Doe controversy in the public press, I am encouraged by the discussion of this issue among doctors whom I know.

The Baby Doe issue can be divided into two segments. The first raises the question of the State's responsibility for minor children. Practically every article I have seen has dealt with this issue which, of course, poses a serious problem for those who believe that parents are the ultimate judges of what is best for their children, as well as for those who believe that people in general should be free to "do their own thing."

My own ethical standards, based as they are on Old Testament teaching and commentaries, never have permitted parents to have absolute control over their children, so I have no problem with this part of the Baby Doe argument. Indeed, my ethical traditions, based on the concept that one's body (even as an adult) belongs to God, are at odds with some modern concepts that people are totally free to control their own bodies. For example, traditional religions prohibit suicide, i.e., the State has a right--indeed a responsibility--to intervene.

With regard to children, all of us accept limitations on the rights of parents. Parents are not free to leave their underage children uneducated, abandon them, physically abuse them, or sell them into servitude. Almost all Americans share these values.

Why then has the Baby Doe question become such a vexing issue in the last decade or so? We now face the second segment of the Baby Doe controversy--the entry of modern medicine into the parent-child-State equation.

A little more than 10 years ago, doctors at Johns Hopkins Hospital publicized their practice of going along with parents who didn't want surgery performed on newborn mongoloid babies who had intestinal blockage (atresia). Instead, these babies were allowed to die slowly within a few weeks. Because the doctors did not go to court to ask for a decision in these cases, the question of the State's right to intervene was evaded.

The medical consequences of failing to perform this operation in a Down's Syndrome (mongoloid) baby are clearcut. Without surgery, the death rate is 100 percent. With surgery, except for the mortality rate associated with any abdominal operation, the chances for survival into adult life and even old age are excellent. There is no difference of opinion among scientists with regard to these facts. Indeed, it doesn't take a doctor to understand the life-saving necessity of this kind of operation.

Pediatricians throughout the United States followed the Johns Hopkins example. So many mongoloid babies were left to die that a public outcry, particularly from outraged nurses, resulted in the Surgeon General of the United States, eminent pediatric surgeon C. Everett Koop, M.D., as well as President Reagan, calling for special Baby Doe legislation to protect babies from dying in this fashion. Among other measures, large signs were to be placed in pediatric nurseries giving the hotline number for reporting hospitals and doctors who withheld life-saving medical care.

During the past 10 years, some doctors, emboldened by their success in defying societal norms with regard to mongoloid babies, extended their power to other medical areas. On the one hand, they began performing medical experiments on fetuses without societal consensus or court consent. On the other hand, they began to use the courts to force parents to accept medical care for their children in instances in which the effectiveness of treatment was far less than 100 percent. Such doctors went to the courts to force women to have Caesarean sections, to force children with cancer to have chemotherapy, and to force newborn babies to have silver nitrate poured into their eyes. They went to the legislatures to force parents to have their children vaccinated in order to attend school. Almost all these medical procedures are unproven, i.e., they have never been subjected to scientifically valid controlled studies.

Now, some doctors have gone to court in order to force an unproven and highly risky operation on a baby with spina bifida and hydrocephalus. Proponents of the surgery assure us that even though the child's quality of life may include mental retardation, severe hydrocephalus, and repeated surgeries, the years of life will be prolonged. No one knows whether that claim is true because no one ever has done a statistically valid controlled study in this area; that is, no one has ever alternated comparable cases, providing conservative management for the even-numbered cases and radical surgery for the odd-numbered ones. Therefore, in the absence of scientific data, all we have here is the quicksand of doctors' opinions. Not surprisingly, opinions supporting surgery emanate from

those surgeons who perform this surgery and who benefit financially and academically from such interventions. Conservative opinions come from non-operating doctors like me and my friends who have seen more than a few spina bifida patients survive without surgery for a long time and who also have watched the mortality and morbidity rates from repeated surgeries for this condition.

I previously noted my satisfaction with the doctors with whom I recently have discussed this spina bifida case. All of us have smiled at the empty boasts of the neuro-surgical enthusiasts, and we have been delighted that the courts ruled in favor of the parents' right to make a decision in a case in which no valid scientific evidence exists.

Regardless of the court decisions, you and everyone else can reach your own rational decision by asking doctors whom you know--both surgeons and otherwise--a few questions: 1) Do you know of any controlled studies showing the benefits and risks of spina bifida surgery? 2) Can you give me published studies which show the length of life among children whose parents have rejected the surgery? 3) If you have no such scientific studies, what is your opinion?

Barney Clark

During the past few weeks, probably many of you, like me, have watched on television Salt Lake City surgeons discussing the next candidate for their artificial heart. This time, in order to improve the surgical outcome, they are looking for a patient who is not as sick as Barney Clark was. Such a line of reasoning concerns me because, when carried to its ultimate absurdity, to insure the best surgical outcome, the artificial heart would have to be placed in a perfectly healthy patient.

I am not alone in my suspicions about the artificial heart; plenty of my colleagues have privately expressed their criticisms. One of the most eminent cardiologists in the U.S., Seattle's Thomas A. Preston, M.D., Chairman of the Department of Cardiology, University of Washington Medical School, now has publicly taken issue with the Barney Clark adventure. Therefore, I have pulled from my files an article written by Dr. Preston and published in The [Seattle] Weekly, March 1983. Let me share that article with you.

In reviewing the history of artificial hearts, Dr. Preston points out that, in contrast to the Utah physicians, research teams at the Cleveland Clinic and Pennsylvania State University at Hershey will not attempt to replace a human heart until they have completely implantable electrical devices that do not require lifelines running to external power sources. They estimate this technology will not be available for the next 10 years. Dr. Preston asks, "Why then did the Utah physicians move now?" His answer: "They were ready. They wanted to. The technology was available...They had FDA approval and the public [was] primed for the event...Technology has its own momentum--the need to utilize a new technology, regardless of purpose or even benefit... Entire careers were committed to that goal."

Dr. Preston reports the grave reservations shared by many other physicians, health planners, and government officials, but he points out that there was no mechanism for dissent or opposition. He describes the "element of adventurism" present with most innovations, especially those associated with high media visibility. He draws an analogy to Dr. Christian Barnard who, once having made up his mind to transplant a heart, "became

obsessed with finding a candidate and doing it... He hounded his cardiologist to find a patient, and became so anxious in the wait that he feared an incapacitating flare-up of his arthritis."

Preston questions the validity of the surgeons' predictions that Barney Clark would have died within hours if he had not been operated on. "The fact is, we do not know whether Barney Clark would have died that night or the next night or on any particular day or night...However sick Barney Clark was on the eve of his operation, some patients just as sick or even sicker have survived weeks or months and, rarely, years after reaching a similar point...Like Christian Barnard, who became frenzied while waiting to make his leap, Chief Surgeon William DeVries and his team were primed for the operation days in advance and, above all, feared losing the opportunity to a premature death."

The remainder of Dr. Preston's seven-page article further explores the experimental nature and public relations aspects of the Salt Lake City adventure.

Journalists and others in positions of responsibility in the media have a special responsibility for reading Dr. Preston's analysis so that they will be prepared to ask the tough questions. If truth is to prevail, the crucial importance of objective reporting must not be swept away by the understandable sympathy and empathy that all human beings must have felt for Barney Clark.

I hope every radio/television interviewer and every print journalist, when interviewing the Utah surgeons who now want to put another patient on their artificial heart, will ask the questions raised by this eminent cardiologist, both in his above-mentioned article and in his two books, "Coronary Artery Surgery: A Critical Review" (Raven Press, 1977), and "The Clay Pedestal: A Re-examination of the Doctor-Patient Relationship" (Madrona Publishers, $12.95). If journalists are to inform the public, they first must become informed themselves.

A doctor who has been treating me for a lung disease has referred me to another doctor. This second doctor has followed through with x-rays and tests that may help me avoid an operation. I would like to switch to this doctor, but he won't take me as a patient because I am the patient of the referring doctor. What are the ethics of this situation? Why should any one doctor have such a hold on you? How do you free yourself from a doctor in whom you have no faith?--A.H.

"Contracting" with doctors

The field of medical ethics changes daily, and the changes run the gamut from A to Z. Concentrating only on the A's, let's look at two issues: abortion and advertising. When I was in medical school, abortion not only was medically unethical, it was also a criminal act. Today's medical student must make a special request if he wishes to be excused from participating in an abortion. Going on to advertising, that practice by physicians certainly no longer carries the same taboo it once did.

I know of no contract in which a patient signs himself over to the exclusive control of one physician; even the marital relationship can be dissolved by divorce!

Perhaps if one compares modern medicine to religion today, it becomes possible to answer your final question: You can free yourself of a doctor in whom you have no faith just as you change clergymen, churches or religion when, after serious consideration, you feel you have lost faith in them.

Animal experimentation

For all you anti-vivisectionists (and others who are interested in the issue of animal experimentation), journalist Hans Ruesch has reissued "Slaughter of the Innocent" (CIVITAS Publication, 60 East 42nd Street, Suite 411, New York, NY 10165, $3.95).

Ruesch's thorough documentation washes away the thin excuses medical experimenters use to justify animal testing. There is practically no relationship between toxic reactions in animals and toxic reactions in humans. Thus, Thalidomide was presumed safe after extensive animal tests, but it caused deformities in more than 10,000 children. On the other hand, a dose of opium that would kill a man is harmless to dogs and chickens. Similarly, doses of belladonna that are lethal for humans are harmless for rabbits and goats. Penicillin, a miracle for humans, kills guinea pigs. The use of digitalis was delayed for a long time because it first was tested on dogs, in which it dangerously raises blood pressure. And chloroform is so toxic for dogs that, for many years, this valuable anesthetic was not employed on patients.

"Since animals react differently from man," writes Ruesch, "any new product or method tried out on animals must be tried out again on man through careful clinical tests before it can be considered safe. ...Therefore, tests on animals are not only dangerous because they may lead to wrong conclusions but they also retard clinical investigation, which is the only valid kind."

If you are interested in the documented cruelty of some researchers to their experimental animals, I recommend you read one of the most comprehensive reports of the trial and conviction of Dr. Edward Taub, charged and convicted of cruelty toward laboratory animals, in The National Anti-Vivisection Bulletin, Number 3, Fall 1982 (100 East Ohio Street, Chicago, Illinois 60611).

Several years ago, I read "Your Baby's Sex: Now You Can Choose" as well as another book on the same subject written by a doctor who claimed to have discovered the "male and female sperm." Strict regimens were given so that a man and woman might be able to conceive a baby of whichever sex they wanted. Are such systems accurate? If they were, wouldn't the practice be widespread? Would you please comment on research being done on this subject?--E.A.

Choosing baby's sex

In 1979, at Chicago's Michael Reese Hospital, a filtering process was used to get rid of the sperm responsible for female births, thus leading to a planned excess of males. In this particular study, which used artificial insemination, seven out of 11 births were male.

Two major areas of controversy over this procedure surfaced. Sociologists and others were concerned over a possible unbalancing of the total population. Clergymen and some physicians expressed concern about the moral implications. Even inside Michael Reese Hospital itself, different opinions were expressed by the physician conducting the research and a physician high in the administration who had "strong feelings about manipulating the elements of the birth process." He further stated, "I believe that the birth of a baby has a sacred quality, almost a spiritual quality that should not be tampered with."

I am certain that the "ethical issue" will be argued back and forth, and I am equally certain that little change will take place in the atti-

tude of those individuals and cultures that always have shown a bias in favor of male children. While this does not mean that the religious and ethical opinions surrounding this issue should be disregarded, it is vitally important that the ethical arguments do not obscure the possibly even more important (and easier to resolve) scientific questions.

Should you decide to explore these new scientific approaches to this age-old problem, you must try to find the answers to the following scientific questions:

1) What dangers are involved in the filtering process itself?

2) How carefully have the remaining "desirable" sperm been examined and biochemically tested to determine whether they are just as healthy and intact as sperm which have not been subjected to this process?

3) Have sufficient animal experiments been performed to determine whether this process may produce any genetic defects in successive generations?

These are the scientific issues which prospective parents have every right to raise and which scientists have every obligation to answer. As a matter of fact, the answers to these questions may well obviate any need for discussing the ethical issue.

Exterminative medicine

Allow me to call your attention to a book entitled, "Medical Holocausts: Exterminative Medicine in Nazi Germany and Contemporary America," by William Brennan, PhD (Nordland Publishing, 12160 Killbrock Drive, Florissant, Missouri 63033, $8.95).

Dr. Brennan, a historian and professor in the School of Social Services at St. Louis University, has written an important volume in which he compares the behavior of doctors who perform abortions in America today with the behavior of doctors in Germany during the pre-Nazi and Nazi eras. Dr. Brennan's extensively documented book reaches the following conclusion: "Responsibility for today's massive destruction of human lives, even more so than during the Nazi era, must be placed squarely on the shoulders of the medical profession." His thesis is that "The involvement of German doctors in promoting, planning and implementing the killing of unwanted and defective human beings before as well as after birth was so great as to constitute a medical holocaust."

Brennan quotes Andrew C. Ivy, M.D., the medical consultant at the Nuremburg Trials: "Had the [medical] profession taken a strong stand against the mass killing of sick Germans before the war, it is conceivable that the entire idea and technique of death factories for genocide would not have materialized....Far from opposing the Nazi state militantly, part of the German medical profession cooperated consciously and even willingly, while the remainder acquiesced in silence."

Brennan points out, "Before Hitler inaugurated the final solution to the Jewish question in 1941, doctors had already become the most experienced killers in Germany. From 1939 until 1945, physicians were almost exclusively responsible for putting to death around 275,000 German adults and children in mental hospitals and euthanasia institutions... Doctors first tested out the gas chambers and crematoriums on German patients in psychiatric hospitals before they were used on Jews and others in concentration camps."

Brennan argues that modern-day doctors began to perform illegal abortions on a large scale years before the 1973 Supreme Court decision and that the doctors' lobbying efforts were chiefly responsible for the liberalization of abortion laws. He states that even the language of modern doctors parallels that of the Nazis, pointing out that the Nazis

referred to the Jews as "parasites on modern society," just as today the fetus is referred to as a parasite on the mother's body.

The Nazis' attitude toward the Jews as subhuman is mimicked by today's references to the fetus as "a blob of tissue." The word "evacuation" was euphemistically used by the Nazis to hide the reality of the concentration camps, just as the present language of "evacuating the uterus" is used to hide the reality of abortion.

For a new and authoritative insight into the leadership role of doctors in what Herbert Ratner, M.D., a decade ago referred to as "the specialty of exterminative medicine," I suggest you read Professor Brennan's book.

I am getting married in a few months. My fiance has children from a previous marriage, and he had a vasectomy about three years ago.

We really would like to have a child together, but we don't know how to go about it. Neither of us is sure that reverse vasectomies are possible, and I am very wary of artificial insemination. I don't like the idea of not knowing who the father of my baby is, what he looks like, etc. Can you offer us any help or information?--S.C.

Vasectomy reversal; artificial insemination

Even though urological surgeons around the country have widely publicized their success rates on vasectomy reversal, I share your concern. There are many scientific questions about these procedures, including the difficulty, perhaps impossibility, of determining the true paternity of children born to mothers whose husbands have had vasectomy reversals. Furthermore, I would feel much more reassurance if the measure of success of these operations were analyzed by someone other than the surgeon who is to perform the operation.

Nonetheless, since the desire for children is so deeply rooted in the human race, I advise that you don't give up. Rather, shop around with a suspicious eye. Don't hesitate to raise the above questions I have posed with each surgeon. If you can find a surgeon who will seriously address himself to these issues and who can give you persuasive answers, you will have come a long way in reaching a decision about vasectomy reversal.

I also can understand your concern about artificial insemination using donor semen. If you ask a doctor about the source of donor sperm, he may admit that one of the major sources of semen is medical students. You might ask how many women are inseminated with the same medical student's sperm, since it is not unusual for one specimen to be used on a dozen or so recipients. Most inseminations are done in the same city, often in the same neighborhood, and almost always in the same age group. Finally, find out whether your religion, like mine, contains any legal strictures against AID (artificial insemination--donor).

The reason I advocate such profound suspicion of physicians at this stage of the game is because a physician created your present problems by performing a vasectomy in the first place. Some of the doctors now establishing reputations for vasectomy reversal are the same individuals who were so prominent in performing approximately 20 million vasectomies in this country during the past 25 years.

Your letter, while reflecting a certain amount of sadness and desperation, is nevertheless realistic and thoughtful. You deserve no less from any surgeon whose advice you seek.

Test-tube babies

The recent birth of test-tube babies, like every such scientific breakthrough, answers some questions, but at the same time raises many questions.

The ethical issue, already being hotly debated, presents an excellent opportunity for in-depth discussions of the positions of different religious systems. To Jews, this specific case does not pose difficult ethical decisions, since the husband was the sperm donor and since Jewish law generally provides no objection to collection of the husband's semen for this purpose.

Obviously, other religions have different attitudes. Now is the time for full and open discussions that can provide guidelines for future cases which may not be as clearcut.

Transsexual surgery

In 1979, sex change operations were abandoned by Johns Hopkins Hospital, which in 1966 was the first U.S. hospital to officially support this operation. It took doctors at Johns Hopkins more than 10 years and 100 operations before they finally determined that there was no evidence of improvement in the lives of patients who underwent the surgery.

Dr. Jon K. Meyer, psychiatrist and director of the sexual behavior consultation unit, reports that "Surgical intervention has done nothing objective beyond what time and psychotherapy can do as far as the patient's home life, social life, jobs, and emotional stability are concerned." Not surprisingly, there is no mention of the mortality and morbidity which may have resulted from these 100 operations. Thus, while the doctors admit they did the patients no good, they do not reveal whether they caused any harm.

In contrast to the ballyhoo, both to the profession and in the mass media, which heralded the inception of this surgery, the decision to stop the operation took effect quietly. Like many another surgery, it came in with a bang and went out with a whimper.

In February 1970, I wrote an article entitled "Surgical Sex Reassignment" for Medical World News at the invitation of its esteemed editor, Dr. Morris Fishbein. In that article, reviewing a book describing the Johns Hopkins experience ("Transsexualism and Sex Reassignment," by Drs. Richard Green and John Money), I wrote: "I progressed through its pages with a persistent, growing sense of uneasiness that culminated in a gut reaction bordering on revulsion." In the book, a male surgeon described his "mixed emotions while listening to the plea for surgery from a physically attractive young female and while examining the breasts for the specific purpose of amputation." My comment was, "But he does manage to go ahead with the surgery." Another surgeon writing the chapter entitled "Operative Treatment of the Male Transsexual," mentioned no such qualms as he removed perfectly normal penises. "But," I wrote then, "I experienced a jolt from the operative illustrations, showing--in 10 drawings--how to amputate a penis and construct a vagina." Interestingly enough, a survey described in this book showed that 94 per cent of the Johns Hopkins physicians were opposed to this surgical procedure, not only because of the risk of malpractice suits, but also on a moral and religious basis.

I ended my review, "The work of sex reassignment belongs to a large category of activities in our culture, which includes moon shots, lobotomy, and heart transplants. These achievements have two major characteristics: First, a high degree of technical capability--they can all be done and done well. But second, they are all subject to a gnawing question: Are they worth doing at all?"

"Love" surgery

I long have felt that much of modern medicine can be explained in terms of its sexual discrimination against women. According to Professor John McKnight of Northwestern University, the major transaction in modern medicine involves a male doctor dispensing a mood-modifying drug (Valium, etc.) to a female patient. This theory received substantial support in a book by sociologist Diana Scully entitled "Men Who Control Women's Health" (Houghton-Mifflin, $10.95). As enlightening as the text itself is, the footnotes strike me as even more dramatic. Let me share with you footnote 91 in the chapter entitled "Baby Catchers and Uterus Snatchers":

James C. Burt, a gynecologist in Dayton, Ohio, has designed a surgical procedure that he calls love surgery, one that, he alleges, increases women's orgasmic potential. As Burt sees it, women are prevented from being totally orgasmic because the anatomical design of the female vagina is faulty. He argues that the clitoris is not accessible enough to penile stimulation during intercourse, thus causing "structural coital inadequacy in the human female." To compensate for this, Burt has designed an operation that critics term "The Mark II Vagina." For about $1500, women can purchase the Mark II which consists of lengthening the existing vagina by severing the pubococcygeal muscle to create an alien set of female genitalia in which the vaginal opening, made smaller, has been moved closer to the clitoris.

Besides the obvious sexist implication of the surgery, the procedure is considered by critics to be hazardous. Dr. Diane S. Fordney, Associate Professor of Gynecology at the State University of New York at Stony Brook, calls the reconstruction "totally anatomically inappropriate," and points out that the pubococcygeal muscle gives partial support to the bladder. Its severing may result in a significant risk of urinary prolapse. Furthermore, the operation carries all the usual traumata of major surgery, including death by anesthesia. And because Burt's follow-up procedures appear to be unsystematic, there may be no real proof that the Mark II accomplishes its inventor's claim. Burt used to offer the reconstruction to women who were having other types of vaginal surgery, including episiotomy, at the time of delivery, but he now offers the Mark II as elective surgery. According to Burt, some 4,000 women have had the surgery. Burt says that many of these operations were done experimentally during other surgical procedures without the women's knowledge.

Love surgery has not been well received in medical circles, and Burt says that he has become an outcast. According to one report, he has no academic affiliation and is not board-certified. His papers are turned down by respectable medical journals, and he is denied the opportunity to speak at medical meetings. Such was the fate of other pelvic surgeons before their ideas caught on. But even if Burt continues to be boycotted by colleagues, it should be noted that this form of censure only serves to isolate him from medical colleagues and to make his actions less, not more, visible. It does not prevent him from performing the surgery. See James C. Burt and Joan Burt, "Surgery of Love" (Carlton Press, 1975).

"MalePractice: How Doctors Manipulate Women," Dr. Mendelsohn's latest book, is now available in paperback from Contemporary Books ($6.95).

"Confessions of a Medical Heretic" is available from WarnerBooks ($3.25).

The People's Doctor Newsletter
P.O. Box 982
Evanston, Illinois 60204

Published monthly. Subscription rate: $24.00 annually.
Robert S. Mendelsohn, MD, Editor
Vera Chatz, Managing Editor

Another View

by Marian Tompson
Executive Director,
Alternative Birth Crisis Coalition

I think you'll agree that the case of Baby Jane Doe is far too important to be left to physicians and lawyers. As we soon realized during the long weeks of media attention, the heart-rending decision of one New York couple also was testing our own beliefs about families, the value of life, the omniscience of doctors and the rights of parents to make decisions for their children. So one November afternoon, Herbert Ratner, M.D., editor of Child and Family, Robert Mendelsohn, and I got together to discuss some of these issues, for as syndicated columnist George Will has noted, "Cases like this shape society's mind of which law is a distillate."

Dr. Ratner began the discussion: "Doctors have so little understanding of life and are in general bad, especially when giving judgments about values, that it's unfortunate physicians are the patient's chief source of direction on what to do. We should not be so quick to accept the projection of a healthy person on what it's like to live as an impaired person. After all, if you look at the statistics, it's the healthy people who are committing suicide, not the handicapped. And no one can predict at birth how a child is going to progress."

Dr. Mendelsohn responded: "I'll tell you where I draw the line at letting parents decide. I draw the line between operations and treatments which, if not done immediately, will result in the death of the child. The prototype case is Down's Syndrome with atresia. There, we know the child is going to be dead in two weeks if he doesn't get the operation, and we know the operation carries a mortality of 1 or 2 per cent, and we know that with the operation the child can live 100 years. So I put those cases on one side because there is no difference of opinion. And then on the other side of that line, I put everything else which is questionable. Whether it's blood transfusions for Jehovah's Witnesses, spina bifida, or congenital heart, in my opinion all of these fall into the controversial because none of them has been subjected to scientific study because nobody has ever done a controlled study."

Ratner: But that's not the issue. The issue is who decides in advance that these spina bifidas are so bad that the only thing is not to do anything and to let them die as quickly as possible.

Mendelsohn: Oh well, I would regard that as untenable.

Ratner: The principle is that every child with a handicap deserves whatever medical science can do to improve the quality of that child's life, and that principle we won't argue with. So then our difference of opinion is if what they do is really helping out.

Mendelsohn: Well, if the problem is Down's Syndrome with atresia, the answer is obvious to any layman. But if the problem is spina bifida, for example, then I would like to put the case before a judge or jury. And then I would have two sets of doctors testify. The ones who are enthusiastic about surgery would present their data. Then I would present the data which includes lots of cases of children with hydrocephalus who for no apparent reason became arrested without a shunt.

Ratner: You want to turn it into a big scientific debate.

Mendelsohn: That's right. Then the next step, once it becomes a debatable issue, is that it has to be regarded as an experimental treatment. And if I were a judge, right now, listening to the divergent opinions on treatment, I don't think I could make a judgment.

Tompson: Then who would make the decision?

Mendelsohn: Then I would say, "Back to the parents."

Tompson: So in the Baby Jane Doe case, what you are saying is that given the controversial nature of the proposed treatment, the parents had the right to make the decision, even though their decision apparently was based on what could be a mistaken assumption that the child doesn't have a chance for a 'quality' life.

Mendelsohn: Right.

Ratner: But in all these kinds of situations, it would seem that society in general and the government in particular has an obligation to let everybody know that we respect human life.

Mendelsohn: That's the bottom line.