The Case of Phillip Becker

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INCONSISTENCY IS THE MOST common element found in court decisions dealing with the issue of when parents must provide medical care for their children. The standards which guide court decisions are difficult enough to follow when a child is not mentally retarded,[1] but when the additional factor of mental retardation is present, courts are faced with even greater problems. The case of Phillip Becker, a 15-year-old child afflicted with Down's Syndrome, is a case in point. In *Re Phillip B.*,[2] the court's decision is a model of subjective decision making which stems largely from the court's inability to deal directly with difficult questions presented when anyone attempts to determine the quality of a mentally retarded child's life.

Very often, courts are able to avoid the issue by declaring that they will look only to the "best interests" of the child. In applying the "best interests" test in practice, however, the courts give great, if not complete, deference to the decisions of the parents. Courts are often hesitant to order medical care for a mentally retarded child, and, in the case of Phillip Becker, the California courts followed the general rule that deference should be given to parental choice. In doing so, however, they ignored the fact that, as a matter of policy, a point must exist when the child's right to life must override a determination by the parents that death is in the best interests of the child.[3]

At least one court has pointed out that the quality of life should not be considered in determining medical treatment and held that the only important consideration is the medical feasibility of treatment.[4] Judicial failure to deal openly with the question of whether or not a life afflicted by mental retardation is worth saving was clearly apparent in *Re Phillip B.*[5] It is the intent of this article to point out that generally applicable legal principles and a common sense approach to such questions are more than adequate in order

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to reach an equitable resolution to such a difficult problem and should have been applied to the *Becker* case.

I. FACTUAL BACKGROUND

At the time the litigation commenced, Phillip Becker was a twelve-year-old child afflicted with Down's Syndrome.[6] He has lived in private care homes from birth until the present time. He has never lived with his parents.[7] The cost of keeping Phillip institutionalized was initially borne by Phillip's parents, but now the cost is shared jointly by the State of California and the parents.

At the time of trial, his teacher, Mrs. Elizabeth Betten, stated that Phillip's motor sensory skills were very good and that his visual skills were exceptionally good. He was in the top level of his class and working at the top level for any retarded child. Mrs. Betten also indicated that for the next year she would recommend that Phillip be placed in a much higher class.

Mrs. Madeline Denman, a school psychologist for the Santa Clara Department of Special Education, concurred with Mrs. Betten's evaluation of Phillip as a high-functioning, retarded child. (She noted that Phillip has an I.Q. of near 60.) Eventually, she saw Phillip being placed in a sheltered workshop. Jean Haight, the program coordinator at Phillip's nursery, testified that Phillip was one of only two children at the nursery able to do chores. She stated that Phillip is responsible for his own area, makes his bed, dresses and feeds himself, helps clear the table, folds laundry, puts away groceries that are delivered, and feeds the cat. She also stated that Phillip's activity had diminished in the last few weeks before the trial and that he sometimes turned bluish around the eyes and the mouth after activity.

Sometime before 1973 it was discovered that Phillip had a cardiac problem. In early 1973 he was referred to Dr. Gary Gathman for diagnosis. Dr. Gathman made a clinical diagnosis of a ventricular septal defect[8] and elevated pulmonary artery pressure, a problem associated with a large defect. He also recommended cardiac catheterization, a simple, commonly-used and safe procedure, to discover more about the problem. Phillip's parents refused to allow it to be performed but gave no reason for the decision.

In 1977, Phillip was again referred to Dr. Gathman for evaluation. At that time he needed extensive dental work which was best performed under general anesthesia, and Phillip's dentist wanted to

know the degree of immediate risk for Phillip if general anesthesia were used. In order to calculate the risks, a cardiac catheterization was finally performed with the consent of Phillip's parents. Dr. Gathman reviewed his findings with Phillip's parents and recommended an operation to cure the defect. Mr. Becker's response was to request more psychological information about Phillip, and Mrs. Becker sought to be put in contact with a family who had a child afflicted with the same defect so that she might discuss the symptoms with them. Eventually, they refused to allow surgery.

At the trial, Dr. Gathman testified that a 3% to 5% mortality risk existed for Phillip, a percentage roughly the same for an adult patient during coronary bypass surgery. Dr. Gathman considered it to be low. Because of the low risk and Phillip's relatively high I.Q. for a Down's Syndrome child,[9] Dr. Gathman felt surgery should be performed. Without the surgery, Phillip would eventually lose interest in life because of a shortness of breath that would confine him to a bed to chair existence. With Phillip's additional pulmonary problem, Dr. Gathman felt surgery could not be delayed without significantly increasing the mortality risk.

Dr. James French, a pediatric cardiologist at Stanford University, corroborated much of Dr. Gathman's testimony but thought that the mortality risk would be slightly higher, 5% to 10%. Without the surgery, Dr. French said, research indicated that Phillip could survive for 20 more years, but that 20 years would be an optimistic prediction. He also testified that surgery could be expected to successfully lengthen Phillip's life. He agreed with Dr. Gathman's opinion that, because of Phillip's progressive pulmonary problem, delaying surgery could only increase the risks. Though he offered no opinion as to whether or not surgery should be performed, Dr. French felt the defect could be corrected with a reasonable risk. Thus, both doctors felt surgery was medically feasible and should proceed immediately.

Phillip's parents, however, gave several reasons for not wanting Phillip to have surgery. To Vicki Hult, a deputy probation officer investigating Phillip's case, they expressed concern that Phillip would outlive them and become a burden to other members of the family. Also, they were not sure that he would be provided with adequate care in an institution. It should be noted that, prior to trial, their beliefs regarding institutional care were based on institutions they

had visited while living in Kansas; they had never visited the facilities in the California county in which they now live.

In his testimony at trial, Mr. Becker stated that he was concerned about Phillip being taken advantage of when he is older and "becomes less and less the lovable little boy that he is now." Given Phillip's condition, Mr. Becker unequivocally stated that, in his own mind, he felt Phillip would be better off dead than alive. The decision to let Phillip die prematurely because of the heart defect was based on what he felt was good for Phillip and the rest of the family. Specifically, Mr. Becker said "it would be best for everyone, including Phillip and the survivors."

The trial court denied the juvenile authorities' petition to obtain custody because it felt that the parents had thoughtfully reached their decision.[10] Feeling that a court should not second guess parents who are thoughtful, it held that the Beckers had fulfilled their legal and moral obligations to their child.

The Court of Appeals affirmed the order of the juvenile court.[11] Although it held that the possible risk of death was credible evidence supporting the decision of the juvenile court, its reliance on this fact is somewhat puzzling. The trial transcript clearly indicates that the medical feasibility of the surgery was something Mr. Becker never investigated, and both doctors considered the risk reasonable. In fact, it indicates that the *only* knowledge Mr. Becker had about the mortality risk involved in the surgery was received through the previous day's testimony at trial. Mr. Becker's admission makes it clear that the Court of Appeals upheld the juvenile court's order for a reason which the Beckers did not seriously consider when they decided not to permit the operation. Both the California Supreme Court and the United States Supreme Court refused to hear the case.[12]

II. LEGAL CONSIDERATIONS

Although the *Becker* case is one in which the facts strongly suggest the proper conclusion, the law of custody rights and the developing law in the area of mental health rights suggest even more strongly that the court's decision was faulty. The law in each of the areas described below is changing rapidly, yet its outlines are clear enough to form the basis of a reasoned decision which gives adequate weight to all competing interests.

A. Standards for Removal from Parental Custody

Parental "Fitness" or the Child's "Best Interests"? Cases dealing with custody rights often turn on questions of parental "fitness" or the "best interests" of the child. In general, two points of view can be found:

> The traditional view still followed by many states holds that a parent is prima facie entitled to the custody of the child unless shown to be unfit. Anyone who alleges the parent is unfit must establish the unsuitability of the parent. The remnants of the old concept of parent's property rights in his child are operative under this rule. Under the more contemporary view, the prevailing criteria revolve around the "best interests of the child." Under this rule the court will award custody to the person or agency that the court finds will best promote the child's welfare.[13]

California follows the contemporary view and uses the "best interests of the child" standard. In order to determine whether the parent-child relationship should be severed, the initial focus is whether allowing the child to continue in the parent's custody will endanger his or her permanent welfare. If so, the parent's rights must give way because their preservation is of less importance than the health, safety, morals, and welfare of the child.[14] While the court looks first to the welfare of the child, it is important to note that the court must find *both* that removal is in the best interests of the child and that a clear showing of harm is present.[15]

California follows the well-accepted general principle that parenting is a fundamental right which should only be disturbed in extreme circumstances.[16] But California courts also hold that parental rights are not absolute since the child is also a human being possessing rights subject to protection.[17] Thus, it is important to recognize at the outset that genuine love and concern for the child, coupled with a desire to help the child, does not defeat a clear showing of potential harm should the child remain in the parents' custody.[18] Courts will not, therefore, view parental behavior alone without considering its effect on the child.[19]

Several recent decisions from states other than California emphasize that parental behavior in custody cases must be considered in light of its effect on the child. In *Re Custody of a Minor*, [20] for example, the court considered the case of a twenty-month-old boy suffering from lymphocytic leukemia being treated through chemotherapy, the only known effective treatment. Though the doctors predicted a better than 50% chance for long-term survival with the

chemotherapy, the parents were concerned over the side effects (nausea and loss of hair) and wanted to remove the child from the chemotherapy and treat him through prayer and diet. The court refused to permit the change and held that, given the effect on the child, the parents' good motives and sincerely held beliefs were not of sufficient magnitude to out-weigh the risk to the child.

Chemotherapy, though not life-threatening, was ordered continued because lack of treatment would certainly result in death, and the family relationship was intruded upon only to the extent necessary to insure that the child received needed treatment. These facts distinguish *Re Custody of a Minor* from cases where courts would not intervene when the treatment *was* life threatening.[21] The general rule is that the courts will require treatment even where an imminent risk of death exists.[22] In limited situations, however, courts have ordered surgery where the child's condition could not cause death, but permanent disfigurement was an almost certain result.[23]

The importance of medical opinion in cases where removal of custody is sought to insure medical treatment is illustrated by *In re Hofbauer*,[24] a New York Court of Appeals decision contemporaneous with the California Court of Appeals decision in *Re Phillip B.* In *Hofbauer,* the parents of a seven-year-old child suffering from Hodgkin's disease sought to remove their child from traditional radiation and chemotherapy treatments and put him under the care of a physician who advocated nutritional therapy including laetrile injections. The court permitted the change because the alternative was supported by the opinion of responsible physicians.[25]

Reliance on physicians for determinations of medical feasibility has been approved by the United States Supreme Court in numerous cases involving both minors and adults.[26] In *Parham* v. *J.R.*, for example, the Court held that it "[does] not accept the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using traditional tools of medical science to an untrained judge."[27] Yet this is precisely what was done in *Re Phillip B.* Both pediatric cardiologists who examined Phillip indicated that his heart condition, left uncorrected, would kill him.[28] In addition, both indicated that the operation could be performed at a reasonable medical risk,[29] yet the trial judge held that the surgery was elective, not life-saving. This contradiction of expert testimony was justified, in the judge's view, by a reference to the *Karen Quinlan* case[30] in which doctors' predictions of death when life-sustaining

machines were discontinued were proved to be wrong. "That kind of thing points to the fallibility of everybody, including the medical profession. So I am very skeptical . . . ," the judge in *Becker* asserted. But his logic and decision are unsupported by either common sense or case law.[31]

B. The Constitutional Right to Habilitation

Over the past few years, the law has begun to recognize that persons confined to mental institutions have a right to habilitation.[32] The cases make no distinction between the mentally ill and the mentally retarded.[33] Courts defining habilitation have held it to be "medical treatment, education, and care suited to residents' needs regardless of age, degree of retardation and handicapping condition."[34] The purpose of such a requirement is to allow the individual to lead a more useful and meaningful life and, if possible, return to society. The requirement of adequate and effective treatment has been imposed to prevent hospitals for the mentally handicapped from being transformed into penitentiaries where one can be held indefinitely without the benefit of a trial.[35] One court has summed up the right to habilitation as follows:

> The constitutional right to treatment is a right to a program of treatment that affords the individual a reasonable chance to acquire and maintain those life skills that enable him to cope as effectively as his own capacities permit with the demands of his own person and of his environment and to raise the level of his physical, mental, and social efficiency.[36]

Although the courts have begun to mark the boundaries of the right to habilitation, implementation of that right is not automatic, particularly in cases where other rights are involved as in *Re Phillip B.* Nevertheless, the decision of Judge Premo did not even consider the impact of these cases.

Phillip was placed in a private institution at birth. Seven years later, when his heart condition was discovered, his parents prevented evaluation and habilitation through a simple, safe heart catheterization. They were able to do this by exercising their custody rights to refuse treatment. The catheterization was finally agreed to as a prerequisite to dental surgery when Phillip was 12. It was discovered that the condition was operable at the time, but the operation was needed almost immediately to prevent progressive deterioration. When his parents' refusal to treat him was supported by the California courts,[37] their decision foreclosed Phillip's right to habilitation

by making further progress in a useful and fulfilling life medically impossible. He became, in effect, the pawn of a family which, the record shows, did not know him very well. Their decision condemned him to increasing confinement and death brought on by his condition. One commentator has noted:

> The greatest danger to the mentally retarded child lies in the institutional setting — in this case because it affords the parents the opportunity to "distance" themselves from the child and deal with the situation in an abstract manner, namely, in the doctor's office instead of at home where the cries of the child are a constant call to the normal parental instincts and an impetus to reconsider the decision not to operate.[38]

The problem which faces any court in a dispute over proper custodial care is determining when the right of the parent should be implemented over a conflicting right of the child. The California Supreme Court has defined custody as "the sum of parental rights with respect to the rearing of a child. It includes the right to the child's services and earnings, and the right to direct activities and make decisions regarding his care, control, education, health, and religion."[39] Obviously, when parents permanently institutionalize a child, they actually surrender a major portion of their custody rights. In a situation where the child is institutionalized, then, the first question that must be answered by the court is whether or not the parents are the parties whose determination should be given the greatest weight.

In *Quillon* v. *Walcott*,[40] the United States Supreme Court held that the state may recognize that the extent of parental commitment to the child may determine the extent of parental rights. In *Quillon*, a natural father was not permitted to interfere in the adoption of his child by another because his only commitment to the child was spotty financial support and an occasional visit. Thus, it is arguable from *Quillon* that courts may be justified in giving less weight to the medical decisions of parents who, like the Beckers, have surrendered actual custody and admit that their decision is heavily influenced by factors which do not center on the child. Since the first focus is always the child's welfare, a court should give greatest weight to the child's interests in habilitation. When the parents refuse to grant permission for life-saving or other necessary surgery on the basis of an arm's length determination of what is "best" for a child they know basically as an outsider to the family, the court ignores its

responsibility to the child as well as to those who see him as the unique individual that he is.

C. The Quality of Life

In *Re Phillip B.*, the trial court considered evidence concerning "quality" of Phillip's life in reaching its decision. Phillip's father, as noted, expressly admitted to holding the belief that his son would be better off dead than alive.[41] Both doctors who testified stated that in certain cases of severe retardation they do not recommend surgery because they feel that little can be gained.[42] But the basic issue involved in "quality of life" cases is much broader than a simple risk-benefit analysis. The evidentiary question of whether such testimony is relevant at all, and if so, under what circumstances, is inextricably intertwined with the right of any one individual to determine whether another lives or dies.

In re Karen Quinlan[43] is perhaps the most celebrated case in which a court examined the issue. In *Quinlan* the New Jersey Supreme Court held that respirators could be discontinued because of the patient's very slim possibility of ever regaining cognitive life and her need to be under constant, expensive care. Although the court appointed the parents as guardians knowing that they would exercise their choice of care by refusing medical treatment for their daughter,[44] the Court apparently felt that their decision was reasonable and could not be said to have caused objective harm. The court's discussion of whether or not Miss Quinlan would return to a "cognitive, sapient" state was relevant only to the question of whether a particular form of treatment was legally required.

The decision is much more difficult in a case where a person may recover or where the treatment itself is unquestionably necessary to continue life (e.g., providing food or basic medical care to the comatose). Few courts have considered the issue,[45] although it is a major consideration for the parents of physically disabled or mentally retarded newborns.[46] In *Maine Medical Center* v. *Houle*, [47] the court, one of the few to consider the issue directly, held that quality of life should not be considered and that the only proper consideration is medical feasibility.

There are several significant reasons for not considering quality of life. If a court determines that it will consider "quality" to be a factor, it is put in the impossible position of determining that some point exists at which another's life is no longer worth living. If a

proxy is involved, as in *Quinlan* or *Becker* (the parents), ascertaining the patient's or subject's wishes and giving them sufficient weight may be impossible or tainted by the proxy's bias toward certain personal or culturally relative interests.[48] A person who values intelligence and success, for example, may find it more difficult to understand how a mentally retarded person's life can be "meaningful." As a result, the proxies may tend to project their cultural or personal desires into the mind of the person whose life or treatment is at issue.

Most legal commentators who have discussed the termination of life-sustaining treatment feel that it is not legal.[49] The basis for their judgments differ, but given the historical abuse that the concept "lives without value" has engendered,[50] courts are understandably hesitant to create precedent in this area. When one considers that denial of treatment because of a mental or physical defect violates the constitutional command of equal protection of the laws, the "quality" question is seen for what it is: a dangerously discriminatory device to enable the courts or others to eliminate, either actively or passively, those who do not fit a particular cultural, mental or physical norm.

Given what appears to be the general rule against using quality of life in making medical treatment determinations, making determinations on that basis, as well as receiving testimony on such an issue, should be considered an abuse of the court's discretion. A determination based even partially on the consideration should be summarily reversed.[51] Yet such testimony was considered in *Re Phillip B.* It clearly influenced the decision to permit refusal of the surgery, and the appeals court refused to find an abuse of discretion. By upholding the trial court's determination that to allow surgery would be risky,[52] the court avoided scrutiny of the true basis for the trial court's decision. The record was flimsy, and the facts simply did not support the decision. Even if, as the appellate court stated, "Legal judgments regarding the value of childrearing patterns should be kept to a minimum so long as the child is afforded the best available opportunity to fulfill his potential in society,"[53] it is difficult to reconcile that position with its decision to affirm a holding which left Phillip with no future.

D. The Conflict of Interest Problem

The potential conflict of interest between the parent's values and

what is best for the child has been recognized in cases involving parental decisions to institutionalize a child.[54] The nature of the conflict in the decision to institutionalize was summarized in the *amici* brief submitted in *Wyatt* v. *Stickney*:

> The parent may be motivated to ask for such institutionalization for a variety of reasons other than the best interests of the child himself, *i.e., the interests of other children in the family*, mental and physical frustration, economic stress, hostility toward the child stemming from the added pressures of caring for him, and perceived stigma of mental retardation. The retarded child's best interests may well be in living with his family and in the community, but theirs may not be in keeping him.[55]

When a child has been institutionalized, the parents may only deal with the child's concerns in the abstract, and they may not always be aware of the needs of such a child.[56] It may be much easier to deal with the fact that their child is *said* to have fainting spells than to see the child turn blue and pass out in front of them.

A close legal parallel exists between the position of mentally retarded children in need of physical care and the cases involving medical care for the children of Jehovah's Witnesses.[57] Courts have ordered blood transfusions for children over their parents' religiously-based objections because the child's best interests require it and harm would otherwise result.[58] In such cases the parents faced the conflicting demands of their faith and the needs of their child. Where treatment is suggested which violates their religious beliefs, it is the parents' religious responsibility to see that no member of the family receives treatments which are considered immoral. If a family member receives such treatments, the parents fear spiritual harm to the family member and themselves.[59]

"Parents have a duty of care, and if they grossly abuse it, religious objections stand as no excuse,"[60] though reasonable attempt must be made to accommodate the belief.[61] When a parent has a serious conflict of interest, the parent should not be the sole decision-maker regarding medical care for the child.[62] Courts have demonstrated an awareness of a conflict of interests in cases based on religious belief, and it is clear that a conflict can exist for other equally valid non-religious reasons which prevent the parents from acting solely on the basis of the best interests of the child.

Though such a conflict of interests was explicit in *Re Phillip B.*, the court was unconcerned.[63] Since those whose lives touched Phillip's on a day-to-day basis felt that Phillip needed the operation and

brought suit to seek custody, the court *should* have considered the parental conflict of interest as a significant factor, and ruled against them. But the court failed even to consider it. As a result, it never confronted one of the most important issues in the case. Although the appeals court correctly recognized that the state "has a serious burden of justification before abridging parental authority . . .,"[64] evidence that there is a conflict of interest such as the one apparent in the record of Phillip's case should go a long way toward meeting that burden.

III. A SUGGESTED APPROACH

From an examination of the trial court record and the opinion of the juvenile court judge, it seems apparent that the judge did not wish to interfere with the decision of two parents who, he felt, were reasonable. However, the *Becker* case did *not* present a parental rights issue of the type that is involved in more traditional cases such as *Wisconsin* v. *Yoder*;[65] it presented an issue dealing with the child's unquestioned medical needs. The judge's focus on the parental rights issue to the exclusion of all else reflects both a fundamental lack of understanding of the issues before him and the degree to which judicial perceptions regarding non-legal issues affect decision-making.

Judge Premo's choice of the *Quinlan* case as a factual and legal model for his decision is significant, both because of its quality-of-life orientation and its irrelevance to the parental rights issue he held to be controlling. As in *Quinlan*, the proper focus of decision in *Phillip B.* was the welfare of the child.[66] The judge's decision, however, focuses almost exclusively on the behavior of the parents. No longer accepted by California, this outmoded legal approach mandates a finding of parental neglect as a prerequisite for judicial intervention. In *Becker*, Judge Premo held that he could not "second-guess the decision away from the parents *in the absence of neglect on their part*,"[67] but he ignored the contemporary view that the court must consider the *effect* of the parental decision on the child.

In Phillip's case, the impact of the parental refusal to permit medical treatment was clear, but the court refused to interfere because it apparently felt that the parents were acting in Phillip's "best interests" even if the result of their act was certain death. The inherent problem in the application of the "best interests" standard in cases involving quality of life along with medical, legal, and moral factors is that courts often approach the decision backwards. In

such a procedure the initial determination of what is in the child's best interests is made in the abstract with only a cursory review of the facts. The result of such a haphazard procedure is the inconsistency that exists in case law.

The correct standard, followed by many states including California, is first to consider whether or not a demonstrable showing of objective harm exists.[68] This forces the court to deal with the facts in a thorough, detailed manner to determine if there is actual harm existing or certain to occur. Only after this determination is made can the court determine what in actuality is in the best interests of the child.

The most common forums in which this incorrect procedure has been applied are the treatment of the mentally and physically handicapped, [69] birth control and abortion,[70] and child custody cases where the parents' life-style or social status do not fit society's norm.[71] In each area, the courts have been asked to deal with facts of the situation presented but invariably seem to prefer to judge the *value* to be placed on the parental judgment, life-style, practice, or treatment.

In *Becker*, the decision of the juvenile court reflected a value judgement about the propriety of surgery which would extend the life of a retarded child. *Becker* did not focus on the objective harm to the child because the court was overly concerned with what was subjectively in the "best interests" of all those involved. The Supreme Court has recognized that parents should not be permitted to exercise arbitrary veto power over decisions which will affect the future of their children. The difficulty is finding the point at which a line can be drawn which recognizes both the rights of the child and interests of the parents without undue interference in matters properly left to the family.

In the case of Phillip Becker, the judge drew a line which was inconsistent with California law, the facts of the case, and sound public policy in his zeal to do what he thought was "best" for Phillip and his parents. The Supreme Court has drawn a line which is intended to eliminate arbitrary parental vetos of the type Judge Premo affirmed.[72] But, unfortunately, even this has been interpreted as being designed to eliminate input from parents, all in an attempt to do what is "best."[73] The problem common to all these cases is that the courts are failing to focus on the nature of the alleged harm in an

attempt to reconcile what may appear at first to be an irreconcilable conflict of interests.

From the perspective of those who place ultimate value on the preservation of individual human life and eschew determinations which seek to place an objective measure of value on the life of another, the interests in Phillip's case can safely be characterized as irreconcilable. Obviously, the court must choose, and the law is clear that it must consider the child's interests to be paramount. In the case of a pregnant adolescent, as in *Bellotti v. Baird*,[74] or the child whose parents wish to seek permission for the use of an experimental drug as in *In re Green*,[75] the interests may or may not be irreconcilable, depending in large part on the values shared by the participants in the decision-making process. In any case a determination of what is "best" for the minor involved or whether a parental decision is "harmful" will turn on which value judgments are made, and by whom.

In a long series of cases, the Supreme Court has held that value judgments are to be made first by the parents,[76] and only when there is a showing of harm may the state intervene to "protect" the child from the parent.[77] The trend, unfortunately, is for the courts to become involved in judging the reasonability of the first level of decision-making rather than focusing on the decison made and its potential for creating objective harm. If, as in *Hofbauer*, the decision made, in light of the harm alleged, is reasonable, the parental decision should be left undisturbed. In all cases, care must be taken by the court to identify all relevant factors: the *exact* nature of the harm alleged, its degree, and the rationale of the decision. If the difference between the parties is merely one of form (e.g., the manner of treatment or its morality where medical opinions differ), the decision should be left to the parents if the child cannot decide. If the determination of either the existence of "harm" or the "best interests" of the child turns on subjective value judgments by the court, the parents or medical witnesses, the court must scrutinize all the factors noted above. To proceed on a lesser basis would run the danger of the court serving merely as a rubber stamp for parental or medical judgment or imposing its own value judgments in an area heavily protected by the Constitution

IV. CONCLUSION

A case such as *In Re Phillip B.* is disturbing because it points to

the general inconclusiveness of the law in dealing with the medical rights of mentally retarded children. Courts indicate that an institutionalized child has a right to habilitation, but statutes and court decisions allow the right to be circumvented. *In Re Phillip B.* presents a difficult problem for any court. Legally, the parent is the person who is vested with nearly complete authority over the medical care of the child. Clear and convincing evidence is needed to remove the child from the custody of his parents and override their decision. When the parents have institutionalized the child from birth and visit him for several hours on the average of once every two months, however, it is difficult to justify allowing the parents to retain the same dominant power over health care decisions as they would have if the child were living at home under their care. Realistically speaking, they are not in as knowledgeable a position to judge the best interests of the child as those who have become what Goldstein, Freud and Solnit describe as the "psychological parents"[78] who make day-to-day custodial decisions for the child. Legally the biological parents retain the power to make custodial decisions, and should make medical decisions whenever they are qualified to do so. Generally, those decisions should be given great deference, but when their commitment to the child has been less than that of a custodial parent, their rights and the weight accorded to their opinions should be reduced accordingly.[79]

The case of Phillip Becker is symptomatic of a judicial failure to recognize that courts exist to arbitrate disputes. The need for consistent and clear legal standards which guide judicial behavior in an area of the law receiving increasing attention by policy makers, litigators, and scholars is readily apparent, but the courts have yet to respond with anything more than decisions which simply affirm or reject specific parental choices on the basis of unarticulated judicial preferences. When the courts fail to exercise their proper function, injustice is the result. In Phillip's case, the result of this *ad hoc* approach to the law promises to be a disaster for the only person who really had anything to lose: Phillip himself.

NOTES

1. See, e.g., Destro, "Social Values of the Federal Judiciary: The 'Least Dangerous Branch' Unleashed" *The Human Life Review*. Vol. VI, No. 2, Spring, 1980, p. 37.

2. *In the Matter of Phillip B.*, A Minor, No. 66103 (Superior Ct., Santa Clara County, CA, April 27, 1978).

3. *Jehovah's Witnesses in the State of Wisconsin* v. *King's County Hospital Unit No. 1*, 278 F. Supp. 488 (E. D. Wash, 1967).

4. *Maine Medical Center* v. *Houle*, Civil No. 74-145 (Superior Ct., Cumberland City, Maine, Feb. 14, 1972).

5. *In The Matter of Phillip B.*, A Minor, No. 66103 (Superior Ct., Santa Clara County, CA., April 27, 1978), recorder's transcript p. 22 (hereinafter referred to as *Becker*).

6. Down's Syndrome is also referred to as mongolism.

7. *Becker, supra* note 5, recorder's transcript p. 87-8; throughout the "Factual Background" discussion, the statements and quotations are taken from this transcript.

8. This is a hole between the two main pumping chambers of the heart. Forty percent of Down's Syndrome infants have such a defect.

9. Id. at 21. It should be noted that a severely retarded Down's Syndrome child will have an I.Q. of around 30. Phillip's near-sixty I.Q. ranks him in the top five percent of Down's Syndrome children.

10. *In the Matter of Phillip B.*, *supra* note 2.

11. *In re Phillip B*, 92 Cal. App. 3d 796, 156 Cal. Rptr. 48 (1979).

12. *Bothman* v. *Warren B.*, 48 U.S.L.W. 3623 (1980).

13. Thomas, "Child Abuse and Neglect, Pt. I: Historical Overview, Legal Matrix and Social Perspectives," 50 N.C.L. Rev. 293, 340 (1972).

14. *In re Imperatricis Guardianship*, 182 Cal. 355, 358, 188 P. 48, 50 (1920).

15. *In re B.G.*, 11 Cal. 3d 679, 699, 523 P. 2d 244, 255, 114 Cal. Rptr. 623 (1978).

16. *In re Carmeleta B.*, 21 Cal. 3d 482, 579 P. 2d 514, 146 Cal. Rptr. 623 (1978).

17. *Campbell* v. *Wright*, 130 Cal. 380, 62 P. 614 (1900).

18. *In re Randy B.*, 62 Cal. App. 3d 89, 132 Cal. Rptr. 720 (1976). Other courts also have supported this view. See generally *Prince* v. *Massachusetts*, 321 U.S. 158 (1944). (Neither the rights of parenthood nor religion are beyond limitation. The state's authority is not nullified because the parents ground their claim to control the child's course of conduct in religion); *State* v. *Perricone*, a 37 N.J. 462, 181 A. 2d 751 (1962) (the sincere affection and concern of Jehovah's Witnesses parents for their child were not controlling in finding neglect of the child for the purpose of obtaining a guardian).

19. California statutory law also emphasizes that the first consideration must be the child's welfare. The Civil Code provides for removal of custody upon finding "that an award of custody to a parent would be detrimental to the child, and an award to a non-parent will be in the best interests of the child." Cal. Civ. Code Sec. 4600(c) (West 1980).

20. 4 Fam. L. Rep. 2432 (BNA 1978).

21. Id. at 2435. See generally *In re Chad Green*, 448 Pa. 338, 292 A. 2d 387 (1972); *In re Seiferth*, 309 N.Y. 80, 127 N.E. 2d 820 (1955); *In re Hudson*, 13 Wash. 2d 673, 126 P. 2d 765 (1942).

22. See *State* v. *Perricone*, 37 N. J. 463, 181 A. 2d 751 (1962); *People* v. *Lalrenz*, 41 Ill. 618, 104 N.E. 2d 769 (1952), *cert. denied*, 344 U. S. 824 (1952).

23. *In re Sampson*, 29 N.Y. 2d 900, 328 N.Y.S. 2d 686 (1972), *In re Rotkowitz*, 175 Misc. 948, 25 N.Y. S. 2d 624 (9141).

24. 47 N.Y. 2d 648, 419 N.Y.S. 2d 936 (1979).

25. Specifically, the court held:

> The court's inquiry should be whether the parents once having sought accredited medical assistance and having been made aware of the seriousness of the child's affliction and the possibility of a cure if a certain mode of treatment is undertaken, have provided for their child a treatment which is recommended by their physician and which has not been totally rejected by all possible medical authority.

419 N.Y.S. 2d at 940-41.

26. See, e.g., *Doe* v. *Bolton*, 410 U. S. 179 (1973); *Jacobson* v. *Massachusetts*, 197 U. S. 14 (1905); *Planned Parenthood of Central Missouri* v. *Danforth*, U. S. 52 (1976).

27. *Parham* v. *J.L. and J.R.*, 442 U.S. 584, 609 (1979).

28. See *Becker, supra* note 5, recorder's transcript at p. 18, in which Dr. Gathman discusses the final stages in their various forms. On pages 40 and 41 of the recorder's transcript, Dr. French describes the inevitable terminal stages of Phillip's illness.

29. See *Becker, supra* note 5, recorder's transcript at p. 22 where Dr. Gathman states the risk in Phillip's case would be low. On page 53 Dr. French states the operation could be performed at a reasonable risk.

30. *In re Karen Quinlan*, 70 N.Y. 10, 355 A. 2d 647, *cert. denied*, 429 U.S. 922 (1976).

31. See generally, *Parham* v. *J.L., 442 U.S. 584 (1979).*

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

33. *In the Matter of Phillip B., supra* note 2.
34. 442 U.S. 584.
35. See, 92 Cal. App. 3d at 802, 156 Cal. Rptr. at 51.
36. *Gary W.* v. *State of Louisiana*, 437 Supp. 1209, 1219 (E.D. La. 1976).
37. *Bothman* v. *Warren B.*, 92 Cal. App. 3d at 802, 156 Cal. Rptr. at 48. Paradoxically, the Appeals Court also stated the surgery was too risky since children with Down's Syndrome have more problems in the postoperative period. In other words, Phillip was institutionalized because he was retarded, but surgery, a recognized habilitation right, was now denied to Phillip since his parents had not permitted it when it would have been safer.
38. Murdock, "Civil Rights of the Mentally Retarded: Some Critical Issues," 48 Notre Dame L. Rev. 133, 142 (1972) (hereinafter cited as Murdock).
39. *Burge* v. *City and County of San Francisco*, 262 P. 2d 6, 12 (1953).
40. 434 U.S. 246, 256 (1978).
41. *Becker, supra* note 5, recorder's transcript at 111.
42. Id. at 34 where Dr. Gathman testified little can be gained from surgery if the child's I.Q. is under 30. Phillip's is about 60. Also, see Dr. French's testimony on page 30 where he testifies that if Phillip were a normal child he would recommend surgery.
43. 70 N. J. 10, 355 A. 2d 647 (1976) *cert. denied*, 429 U.S. 922 (1976).
44. Id. 355 A. 2d at 664.
45. See "Birth-Defective Infants: A Standard for Nontreatment Decisions," 30 Stan. L. Rev. 599, 601 N. 12 (1977).
46. See Robertson, "Involuntary Euthanasia of Defective Newborns: A Legal Analysis," 27 Stan L. Rev. 213 (1975) (hereinafter cited as "Involuntary Euthanasia").
47. Civil No. 74-145 (Superior Ct., Cumberland City, Maine, Feb. 14, 1972).
48. "Involuntary Euthanasia," *supra* note 46, at 255.
49. See, e.g., Horan, "Euthanasia, Medical Treatment and the Mongoloid Child: Death as a Treatment of Choice?" 27 Baylor L. Rev. 76 (1975); Nolan-Haley, "Defective Children, Their Parents, and the Death Decision," J. Legal Med. Jan. 1976, at 9: Robertson, "Involuntary Euthanasia of Defective Newborns: A Legal Analysis," 27 Stan. L. Rev. 213 (1975).
50. See generally, *United States* v. *Griefelt* Nuremburg Military Tribunals, Trials of War Criminals Before the Nuremberg Military Tribunals Under Control. Council Law No. 10. 599 (1950).
51. Cf., e.g. *Spevak* v. *Klein*, 385 U.S. 511 (1967); *Wong Sun* v. *United States*, 371 U.S. 471 (1963). In each of the foregoing cases improper procedure was held to taint the proceeding at issue.
52. 92 Cal. App. 3d at 802, 158 Cal. Rptr. at 51.
53. Id. at 801, 156 Cal. Rptr. at 51.
54. See Murdock, *supra* note 38, at 139.
55. Id. at 139 (emphasis added).
56. Id. at 142.
57. Id. at 142.
58. See e.g., Jehovah's Witnesses in *Wash.* v. *King County Hospital Unit No. 1* (Harborview), 278 F. Supp. 488 (D. Wash. 1967), aff'd *per curiam*, 390 U.S. 598 (1968); *State* v. *Perricone*, 37 N. J. 463, 181 A. 2d 751 (1962), *cert. denied*, 371 U.S. 890 (1962); *Hoerner* v. *Bertinato*, 67 N. J. Super. 517, 171 A. 2d 140 (1961).
59. Jehovah's Witnesses in *Washington* v. *King County Hospital Unit 1* (Harborview), 278 F. Supp. at 502.
60. Bennett, "Allocation of Child Medical Care Decisionmaking Authority: A suggested Interest Analysis," 62 VA. L. Rev. 285, 324 (1976) (hereinafter cited as Bennett).
61. *Sherbert* v. *Verner*, 374 U.S. 398 (1963).
62. Bennett, *supra* note 60, at 324.
63. The trial transcript *In re Phillip B.* indicates that the Beckers institutionalized Phillip because, ironically, they felt he would get better health care, and also because they were worried about how his presence in the home could affect their other children. In stating that Phillip would be better off dead, Mr. Becker said he based this belief on what he thought was best for Phillip and for the rest of the family. Also, Mr. Becker expressed concern that if Phillip outlived him and his wife, he would become a burden on his brothers. While a parent must be concerned about the welfare of his entire family, if he is to make decisions on the basis of the "best interests of the child" test, he must be able to put aside other competing interests. This illustrates the conflict about which Murdock was concerned.
64. Cal. App. 3d 802, 156 Cal. Rptr. at 51.
65. 406 U.S. 205 (1972).

66. See *In re Karen Quinlan, supra* note 43.

67. *Becker; supra* note 5, recorder's transcript at p. 150.

68. See, e.g., *In re B.G. supra* note 15; *Guardianship of a Minor,* Mass. App. Ct. 392, 298 N.C. 2d 890 (1973).

69. *In the Matter of Phillip B., supra* note 2; *In re Chad Green, supra* note 21.

70. *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52 (1976); *Bellotti* v. *Baird,* 428 U.S. 132 (1976).

71. E.g., *Smith* v. *Organization of Foster Families,* 431 U.S. 816 (1977); *New Hampshire* v. *Robert H.,* 393 A. 2d 1397 (N.H. 1978).

72. See *Bellotti* v. *Baird* (II), ____U.S.____, 99 S. Ct. 3035 (1979).

73. See, e.g. *Akron Center for Reproduction Health* v. *Akron,* 479 F. Supp 1172 (N.D. Ohio 1979): *Doe* v. *Irwin,* 428 F. Supp. 1198 (W.D. Mich. 1977) *vacated and remanded,* 559 F. 2d 1219 (6th Cir. 1977), *aff'd on remand,* 441 F. Supp. 1247 (W.D. Mich. 1977) *rev'd* No. 79-1056 (6th Cir. Feb. 26, 1980) compare, *New Hampshire* v. *Robert H., supra* note 71; *contra,* H.L. Matheson, No. 16 249 (S. Ct. Utah 1979) *cert. granted*____U.S.____

74. 99 S. Ct. 3035.

75. 448 Pa. 338.

76. *Wisconsin* v. *Yoder,* 406 U.S. 205 (1972); *Griswold* v. *Connecticut,* 381 U.S. 479 (1965); *Skinner* v. *Oklahoma,* 316 U.S. 489 (1960); *Pierce* v. *Society of Sisters,* 268 U.S. 519 (1925).

77. *Prince* v. *Massachusetts,* 321 U.S. 158 (1944); *New Hampshire* v. *Robert H., supra* note 71; *Smith* v. *Organization of Foster Families, supra* note 71; *Alsoger* v. *District Court,* 406 F. Supp. 10 (S.D. Iowa 1975), *aff'd,* 545, F 2d 1137 (8th Cir. 1976); *Doe* v. *Irwin, supra* note 73; *Wisconsin* v. *Yoder, supra* note 74.

78. See J. Goldstein, A. Freud, and A. Solnit, "Beyond the Best Interests of the Child," 17-21 (1973).

79. *Quilloin* v. *Walcott,* 434 U.S. 246 (1978).