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Correspondence — *continued from page 198*

accept responsibility for the care of an obstetrical patient of the nurse-midwife, in order to provide services which may not be rendered by the nurse-midwife, the payment question arises also. Much of the difficulty one may anticipate in the context of hospital nurse-midwifery practice may be obviated when nurse-midwives and obstetricians are joined in a group practice.

It could be asserted that the JCAH, in its provisions dealing with podiatric practice in the hospital, is too rigid, and that the requirements for physician responsibility are unnecessary in the interest of providing an adequate level of patient care. If that is the case, then its requirements, and those of state hospital regulatory agencies which often copy JCAH requirements, should be modified. On the other hand, if requirements for physician involvement and responsibility are sound, there can be a serious burden placed upon the medical staff, on behalf of the hospital, to establish procedures which have the net effect of forcing physicians on the medical staff to associate themselves with podiatrists in the care of their patients even though that may be contrary to their personal desires. Again, medical staff members are not compelled to attend every patient that an orthopedist admits for the same procedures, and therefore the reluctance to grant privileges to podiatrists is understandable.

The proponents of independent, entrepreneurial practice for limited practitioners in hospitals need to address realistically the issue of providing the necessary physician supervision and/or responsibility. It is simplistic to assert that the negative position of physicians is solely the result of anti-competitive motivation. Physicians have a legitimate argument against being compelled to become associated in the care of patients who have selected limited practitioners, and they may be even less motivated by economics than are the limited practitioners, who seek the opportunity to practice in hospitals to generate additional income for themselves. It is also possible that, if the physician who is to assume responsibilities to make practice by the podiatrist possible in the hospital is to be compensated along with the podiatrist, the net cost to the patient and/or third party payor may be greater than if the patient were to receive the entire service from an orthopedist.

Finally, I would like to suggest that there are questions involving informed consent and the patient's role in selecting the responsible physician, which also require examination in the context of hospital privileges for limited practitioners.

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2. *Id.* at 98.

Withholding Treatment

Dear Editors:

As author of the article, *Terminating Treatment for Newborns: A Theological Perspective*, which appeared in the June issue, I wish to comment upon the letters published in the Correspondence section in September.

RESPONSIBILITY FOR DEVALUED PERSONS: ETHICAL INTERACTIONS BETWEEN SOCIETY, THE FAMILY, AND THE RETARDED. Edited by Stanley Hauerwas, Ph.D. (Charles C Thomas, Pub., 2600 S. 1st St., Springfield, IL 62717) (1982) 112 pp., $14.75.

Health Care Delivery

Dolan AK, *The Law and the Maverick Health Practitioner*, SAINT LOUIS UNIVERSITY LAW JOURNAL 26(3): 627-78 (April 1982) [10-677].

Keyworth II, GA, *The Role of Science in a New Era of Competition*, SCIENCE 217: 606-09 (August 13, 1982) [10-711].

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DEATH OF THE CLINICIAN: REQUIEM OR REVEILLE? By Michael J. Lepore, M.D. (Charles C Thomas, Pub., 301-327 E. Lawrence Ave., Springfield, IL 62703) (1982) 359 pp., $27.50.

•HEALTH POLICY MAKING: FUNDAMENTAL ISSUES IN THE UNITED STATES, CANADA, GREAT BRITAIN AND AUSTRALIA. By Anne Crichton (Health Administration Press, University of Michigan, Ann Arbor, MI 48109) (1981) 416 pp., $40.00.

MEDICAL CHOICES, MEDICAL CHANCES: HOW PATIENTS, FAMILIES, AND PHYSICIANS CAN COPE WITH UNCERTAINTY. By Harold Bursztajn, M.D., Richard I. Feinbloom, M.D., Robert M. Hamm, Ph.D., and Archie Brodsky (Delacorte Press/Seymour Lawrence, 1 Dag Hammarskjold Plaza, New York, NY 10017) (1981) 558 pp., $14.95.

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Davis CK, *Effects of Medicare, Medicaid on Community Hospitals*, HEALTHCARE FINANCIAL MANAGEMENT 36(7): 34-38 (July 1982) [10-478].

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Medi-Cal to Use "Low-Bid" Health Providers, MEDICAL WORLD NEWS 23(16): 6-9 (August 2, 1982) [10-712].

DIAGNOSIS RELATED GROUPS: A PRACTITIONER'S GUIDE. By Paul L. Grimaldi, Ph.D., and Julie A. Micheletti, B.S., R.N. (Pluribus Press, 160 E. Illinois St., Chicago, IL 60611) (1982) 283 pp., $24.95 (paper).

The observations of Professor Henry Beyer on the theology of Jehovah's Witnesses is a common response of non-members of that sect: an attempt to impose one's own theological perspective on that sect's beliefs. It is not intent or volition but the ingestion of blood by mouth, regardless of motive, that results in separation from Jehovah.

That one might suffer or even be condemned to everlasting separation from God without sinning is not a theological oddity. Witness Yahweh's response to the challenge of Job that his suffering is not just: "Who is this that darkens counsel by words without knowledge? Where were you when I laid the foundation of earth? Tell me, if you have understanding." Yet stronger is the forceful comment of John Calvin: "To assume that human merit or guilt play a part in determining this salvation or damnation would be to think of God's absolute free decrees, which have been settled from eternity, as subject to change by human influence, an impossible contradiction."

In the *Georgetown* case,[1] Judge J. Skelly Wright introduced the notion that a court-ordered transfusion would absolve the individual of responsibility. An analysis of that proposition would soon reveal the "cheap grace" of such a standard. As soon as one needed a blood transfusion, the cry would go out to "call the judge." It must be remembered that no judge or state agent can supersede "the commands of the highest authority in the universe, the Creator of Life."

As for Judge Wright's purported reliance on Mrs. Jones' response to his question of whether she would oppose the transfusion if it were ordered by the court to justify his actions, it must be remembered that he had already declared her non compos mentis.

In a lengthy critique of the *Georgetown* opinion, I concluded: "In none of his analysis did Judge Wright consider the asserted claim of constitutional protection of religious freedom."[2] The same, I believe, is true of Judge Markowicz in *Powell v. Columbia Presbyterian Hospital*.[3] The Jehovah's Witnesses apparently concur in that view as they cite the article several times in support of their position in their official publication, *Jehovah's Witnesses and the Question of Blood*.

Professor Jonathan Brant's desire to have courts resolve termination of treatment cases is well-known. But to have him defend that position with references to *In re Storar*[4] is puzzling. George Annas aptly summarized the value of the *Storar* opinion when he stated: "What the court seems to ignore is that, by refusing to approve an alternative test, it effectively deprives incompetents of any 'right to refuse treatment' and 'forces' them to be treated under all circumstances."[5] If Annas was correct, and I believe that in this instance he was, then Les Rothenberg's conclusion, "God help us all," is very much on point.

As I had written earlier, the Court of Appeals "misunderstood Storar's medical condition and misapplied the traditional rulings on blood transfusions for non-terminally ill Jehovah's Witness children. . . ."[6] Brant ignores the fact that both the trial court and the intermediate appeals court had reviewed the case and agreed that Mr. Storar's right to refuse treatment could be exercised by his mother because she was in the best position to know what he would want. It was only because the Attorney General's office disagreed that the case went to the

FINANCING HEALTH CARE: COMPETITION VERSUS REGULATION: THE PAPERS AND PROCEEDINGS OF THE SIXTH PRIVATE SECTOR CONFERENCE, MARCH 23 AND 24, 1981. By Duncan Yaggy, Ph.D., and William G. Anlyan, M.D. (Ballinger Pub. Co., 54 Church St., Cambridge, MA 02140) (1982) 239 pp., $28.75.

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Health Maintenance Organizations

Benor D, *Procedural Requirements for Revocation of Federal Health Maintenance Organization Qualification*, SAINT LOUIS UNIVERSITY LAW JOURNAL 26(3): 679-709 (April 1982) [10-678].

Court of Appeals. By that time, however, the protection that Brant would have the unwary reader believe was provided to John Storar by court involvement was at best academic: he was long dead!

The issues raised by Professor Richard Sherlock are important. Yet, we must examine the alternative that would result from his rejection of the standard formulated in my address. This alternative is found in the indictment recently announced by the District Attorney of Los Angeles.[7] On August 18, 1982, two physicians who had in 1981, at the request of the family, turned off a respirator and removed the IVs from a 55 year old patient in an irreversible coma were indicted for murder. I trust that medical ethics, the law, and public policy can be more nuanced than that.

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Dear Editors:

In his letter in the September issue, Richard Sherlock listed three points which he considers to be decisive in the case against selective non-treatment of severely handicapped newborns: (1) there is no logical reason to limit such a policy to newborns; (2) no one has yet offered a persuasive definition of a life not worth living, which Sherlock says must be done in order to avoid the established legal prohibitions against child neglect or abuse; and (3) neither common law nor statutory law distinguishes between letting someone die by withholding necessary treatment and actively killing him, yet most writers who favor passive euthanasia are opposed to the active killing of handicapped newborns.

I will try to respond to each of these points in turn.

1) In fact, the law has already recognized both the morality and legality of withholding life-prolonging treatment from adults where the quality of that life had an extremely poor prognosis, and where the means required to prolong it were very difficult, expensive, painful, or fraught with side effects (for example, the well-known *Quinlan* and *Saikewicz* cases). The reason that so much discussion focuses on the handicapped newborn may be that recent advances in medical technology have made it possible to sustain the lives of extremely premature and extremely handicapped newborns, but only at great expense and often with poor prognoses. Thus, the birth of an extremely premature or severely handicapped child requires a prompt