

The Messenger Case

Helen Harrison

Increasingly, parents are asking for the right to make resuscitation and treatment decisions for their newborn infants at high risk for mortality and morbidity. Failure of neonatologists to honor such parental wishes has led to criticism in the media and public disenchantment with neonatology. These issues were dramatized in a recent trial in which a father was charged with manslaughter after he removed his extremely premature son from life support to stop treatment administered against the family's wishes. Guidelines giving parents greater latitude in treatment decisions would help avoid similar tragic situations and would help restore public confidence in neonatology. (*J Perinatol* 1996;16:299-301)

As the author of *The Premature Baby Book*,¹ and as coordinator of the group that developed "The Principles for Family-Centered Neonatal Care,"² I have spent much of the last two decades interviewing neonatal caregivers and parents of high-risk infants.

In recent years I have encountered a large and growing number of parents, particularly well-educated parents—most particularly those with medical educations^{3,4}—who have come to recognize the short- and long-term suffering involved in the treatment of extremely premature infants and other marginally viable newborns. Many of these knowledgeable parents do not want this care for their babies. This has led to some dramatic conflicts between neonatal professionals and parents.

For example, in January 1995, Gregory Messenger, M.D., a dermatologist in East Lansing, Mich., went on trial for manslaughter for taking his newborn son—a severely asphyxiated 25-week-gestation, 780 gram infant—off life support after a physician's assistant intubated the baby against Dr. and Mrs. Messenger's expressed wishes.⁵

The Messengers' wishes were based on the poor prognosis for intact survival given by their neonatologist and by their previous experiences with neonatal intensive care. As a medical student in the late 1970s, Dr. Messenger had worked in a neonatal unit and assisted with the resuscitation and treatment of extremely pre-

mature infants. More recently, the Messengers had witnessed the suffering of marginally viable babies treated in the same NICU as their daughter Marissa, who was born in 1991 at 33 weeks' gestation and hospitalized for close to a month. Although the Messengers believed intensive treatment had been appropriate for their relatively mature daughter (who survived without sequelae), they felt that it was not in the best interest of their son, whose considerably more arduous treatment involved a greater than 50% chance of death or severe morbidity.⁶

Although Dr. Messenger received widespread community support and was easily acquitted on the first jury ballot,⁷ this is not the sort of ordeal any parent should have to face. Donna Clarke, the law student who served as jury foreman, stated that the disenfranchisement of parents in neonatology revealed during the course of the trial has left her frightened of having children.⁸

The prospect of having reasonable family wishes overruled by neonatal staff has terrified other parents as well, to the point that some couples say they would abort a troubled pregnancy, leave the country, or have their baby in the woods rather than give birth in a tertiary care center in the United States.^{9,10} Some of the parents I interview have taken these steps to avoid having their extremely premature infants subjected to intensive care.

Other parents whose critically ill newborns were treated over family objections or without adequate informed consent have given bitter accounts of their experiences with neonatology.¹⁰⁻¹⁸ Parents have also drawn public attention to the severe and prolonged pain involved in neonatal treatment, particularly in the care of extremely premature infants.¹⁸⁻²³ These accounts by parents, as well as recent pessimistic reports on outcomes of extremely low birth weight babies,²⁴⁻²⁶ even with the use of surfactant,^{27,28} has led to a growing public disenchantment with what was once a highly esteemed pediatric subspecialty.

Neonatologist Joyce Peabody addresses this disenchantment in a recent article in *Periscope*, a newsletter of the California Perinatal Association.²⁹ Referring to the Messenger verdict, she notes that "a pluralistic society, which has become more verbal, [is telling neonatologists] that our choices are not theirs."

"Ironically," she states, "the very advances that empowered neonatology, when taken to excess, may be the source of [its] disempowerment."

Peabody suggests that the purpose of neonatology be

Address correspondence and reprint requests to Helen Harrison, 1144 Sterling Avenue, Berkeley, CA 94708.

Copyright © 1996 by the National Perinatal Association and the California Perinatal Association.

0743-8346/96 \$5.00 + 0 38/1/74697

reexamined. "In my opinion," she writes, "we are not about forcing high-tech interventions on families when the risk-benefit analysis is questionable even in our own hearts and souls."

Peabody concludes that parents' wishes should determine resuscitation and treatment efforts for premature infants who weigh between 500 and 800 gm. Tyson³⁰ has also proposed that care be optional for babies below 800 gm who are appropriate for gestational age on the basis of data from the Neonatal Research Network and the Vermont-Oxford Trials Network showing mortality and severe morbidity for this group to be above 50%. Similarly, the neonatal committee of GUIDe, a program to develop intensive care guidelines for the city of Denver, has recommended that parents be allowed to decline intensive care for infants below 26 weeks' gestation or 750 gm birth weight.³¹ If guidelines such as these had been in place and honored by staff, the events that led to the Messenger prosecution would never have transpired.

In the absence of guidelines parents are largely at the mercy of an ever-expanding life-support technology and the individual neonatologist's philosophy and motives concerning its use. A recent Canadian survey of intensive care physicians reveals that decisions on the use of life support vary widely and depend, for the most part, on each caregiver's personal values.³² Surveys in the United States also indicate significant variability in resuscitation and treatment philosophies among neonatal units,³³ and among individual neonatologists.^{34,35} In the past 2 years, I have spoken with a neonatologist who feels that parents should be allowed to make decisions in births below 28 weeks' gestation. I was also told by the director of a neonatal unit that there is no birth weight or gestational age below which he would honor parental wishes for non-treatment. On a recent hospital tour, I was taken to the bedside of a severely brain-damaged infant. "The only reason this baby is alive," a neonatologist told me, "is that I wasn't on call the night he was born." Unfortunately, most parents are unable to know in advance about the treatment practices in a given NICU or of the philosophy of the neonatologist who happens to be on call.

Guidelines that create areas of optional neonatal care would create a more consistent situation for parents and would allow the philosophies of individual families to predominate over the philosophies of individual caregivers when the burdens of treatment (mortality, serious morbidity, pain of treatment) arguably outweigh the benefits. Used in conjunction with prenatal counseling and advance directives, guidelines would give parents a framework in which to discuss what they want done, or not done, in the event of the birth of a marginally viable baby. These discussions would encourage parents to examine their own values and to locate caregivers and institutions with compatible philosophies. Guidelines

would also help define and discourage treatment that is inappropriate regardless of parental wishes (e.g., ventilators for anencephalic babies.)

Programs to develop guidelines for the use of intensive care—adult, pediatric, and neonatal—are currently underway throughout the country with community support and input.³⁶ Guidelines to create areas of parental discretion have been endorsed by the NICU parents who drafted "The Principles for Family-Centered Neonatal Care."² Opinion polls also reveal overwhelming public support for the concept of parental discretion in areas of high mortality and morbidity.^{37,38}

During their legal ordeal, the Messengers received more than 1000 letters of support from around the world, many from other parents of prematurely-born children. These letters (and supportive statements in the media) came even from conservative Republican politicians and from members of right-to-life groups.³⁹ Right-To-Life of Michigan, which closely followed the trial, declined to criticize the verdict.⁴⁰ All of this indicates to me that as a society we may be ready to replace the cruel rigidities of the technological imperative and "Baby Doe"-type legislation and replace them with more family-centered, rational, and compassionate approaches to the care.

Guidelines that offer increased latitude for parental decision making will not end all tragic outcomes or resolve all conflicts in the NICU, but they will help to reduce the suffering of many babies and families. In doing so, they may also help restore parental and public confidence in neonatology.

If guidelines for increased parental decision making are encouraged by the outcome of the *Messenger* trial, the verdict will be a victory not for just one family, but for every set of prospective parents in this country. It will also be a victory for neonatal caregivers who wish to be more responsive to the values of the families they serve.

References

1. Harrison H, Kositsky A. The premature baby book. New York: St. Martin's Press, 1983.
2. Harrison H. The principles for family-centered neonatal care. *Pediatrics* 1993;92:643-50.
3. Klass P. Survival odds. *The New York Times Magazine* Oct 23, 1988;56-7.
4. Rutenberg MB. Unchained egos. [letter to the editor]. *The New York Times* Oct 18, 1991:A30.
5. *The People v Gregory Glenn Messenger*. Ingham County (Michigan) Circuit Court, Judge Harrison, File no. 94-67694-FH, 1995.
6. Messenger GG, Messenger T, personal communications, September 1994-September 1995.
7. Miner BJ. Messengers receive flood of support. *Lansing State Journal* Feb 5, 1995:A1, A4.
8. Donna Clarke, personal communication, September 1995.
9. Quindlen A. The littlest patients. *The New York Times* Jan 29, 1992:A21.
10. Kolata G. Parents of tiny infants find care choices are not theirs. *The New York Times* Sept 30, 1991:A1, A12.

11. Aleccion DG. Lost lullaby. Berkeley (CA): University of California Press, 1995.
12. Barthel J. Jimmy: Should he have been allowed to live? *McCalls* Nov 1985;109-11, 156-61.
13. Eikner S. Dealing with long-term problems: a parent's perspective. *Neonatal Network* 1986;5:4-9.
14. Halpern S. Miracle baby. *Ms* Sep 1989:56-94.
15. Mehren E. Born too soon. New York: Doubleday, 1991.
16. Roan S. Heroics and heartbreak. *The Los Angeles Times* Dec 26, 1993:E1, E6.
17. Stein S. The cruelest choice. *The Chicago Tribune Magazine* Dec 11, 1994:16-22.
18. Stinson S, Stinson P. The long dying of baby Andrew. Boston: Atlantic-Little, Brown, 1991.
19. Lawson J. The politics of newborn pain. *Mothering* Fall 1990:41-6.
20. Londner R. Ailing "Baby Doe" a cruel statistic—but not Michael. *Miami Herald* Feb 15, 1992:27A.
21. Cunningham N. Moral and ethical issues in clinical practice. In: Anand KJS, McGrath PJ, editors. *Pain in neonates*. New York: Elsevier, 1993:255-73.
22. Roark A. Treating the pain of children. *The Los Angeles Times* Oct 28, 1991:A1,A22-3.
23. Rovner S. Surgery without anesthesia: Can preemies feel pain? *Washington Post, Health Talk*. Aug 13, 1986:7-8.
24. Hack M, Taylor HG, Klein N, Eiben R, Schatschneider C, Mercuri-Minich N. School-age outcomes in children with birth weights under 750 g. *N Engl J Med* 1994;331:753-9.
25. Whyte HE, Fitzhardinge PM, Shennan AT, Lennox K, Smith L, Lacy J. Extreme immaturity: outcome of 568 pregnancies of 23-26 weeks' gestation. *Obstet Gynecol* 1993;82:1-7.
26. Johnson A, Townshend P, Yudkin P, Bull D, Wilkinsin AR. Functional abilities at age 4 years of children born before 29 weeks of gestation. *Br Med J* 1993;306:1715-8.
27. Walther FJ, Mullett M, Schumacher R, Sundell H, Easa D, Long W, and the American Exosurf Neonatal Study Group. One-year follow-up of 66 premature infants weighing 500 to 699 grams treated with a single dose of synthetic surfactant or air placebo at birth: results of a double-blind trial. *J Pediatr* 1995;126:S13-9.
28. Casiro O, Bingham W, MacMurray B, Whitfield M, Saigal S, Vincer M, Long W, the Canadian Exosurf Neonatal Study Group and the Canadian Exosurf Neonatal Follow-up Study Group. One-year follow-up of 89 infants with birth weights of 500 to 749 grams and respiratory distress syndrome randomized to two rescue doses of synthetic surfactant or air placebo. *J Pediatr* 1995;126:S53-60.
29. Peabody JL. Who controls the plug? *Periscope* Spring 1995;6:3-6.
30. Tyson J. Evidence-based ethics and the care of premature infants. In: Berhman RE, editor. *Low birth weight. The Future of Children* Spring 1995;5:197-213.
31. Neonatal Intensive Care Subcommittee. *GUIDe* 1994;1:1,6. (Guidelines for the Use of Intensive Care in Denver, 1801 High Street, Denver, CO 80218.)
32. Cook DJ, Gordon GH, Jaeschke R, Reeve J, Spanier A, King D, Molloy DW, Willan A, Striener DL, the Canadian Critical Care Trials Group. Determinants in Canadian health care workers of the decision to withdraw life support from the critically ill. *JAMA* 1995;273:703-8.
33. Hack M, Horbar JD, Malloy MH, Tyson JE, Wright E, Wright L. Very low birth weight outcomes of the National Institute of Child Health and Human Development Network. *Pediatrics* 1991;87:587-97.
34. Kopelman LM, Irons TG, Kopelman AE. Neonatologists judge the "Baby Doe" regulations. *N Engl J Med* 1988;318:677-83.
35. Carter BS. Neonatologists and bioethics after Baby Doe. *J Perinatol* 1993;13:144-50.
36. Gianelli DM. Getting a better fix on futility. *American Medical News* December 5, 1994;37:3,14-6.
37. Taylor H (Louis Harris and Associates, Inc.). Withholding and withdrawal of life support from the critically ill. *N Engl J Med* 1990;322:1891-92.
38. Abrams FR, Cargo RA, Foss LL, Mashaw R. Colorado Speaks Out On Health, Campus Box 133, 1200 Larimer Street, Denver, CO 80204: Colorado Speaks Out on Health 1988:7-9.
39. Schultz S. Messengers victims of legal system. *Town Courier* (East Lansing, Michigan) Feb 5, 1995:4.
40. Interview with Ed Rivet, legislative director of Right-to-Life of Michigan. *Evening News*, 6 PM, WILX TV 10, Lansing, Michigan, Feb 3, 1995.