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Bartling v. Superior Court: The Final Transgression of a Patient's Right to Die

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Casenotes

BARTLING V. SUPERIOR COURT: THE FINAL TRANSGRESSION OF A PATIENT'S RIGHT TO DIE?

INTRODUCTION

In Bartling v. Superior Court (Glendale Adventist Medical Center), *a California appellate court reversed a lower court's refusal to permit a terminally ill patient to exercise his right to die. This Note traces the legal history of the right to die and discusses both decisions in* Bartling. *The author advocates a uniform standard to determine when a patient has the right to refuse necessary treatment.*

ADVANCES IN medical technology[1] have generated a variety of legal issues in health care.[2] For example, the health care system currently includes an unprecedented number of lifesaving and lifeprolonging mechanisms.[3] Because of these advances, the patient's right to refuse medical treatment has taken on new significance. Both the legal and medical professions are attempting to interpret the scope of this right, but their various analyses may ultimately conflict.[4]

The treatment of illness has traditionally been a medical con-

1. Advances in medical technology in the last decade alone include coronary bypasses, hip replacement surgery, kidney dialysis, magnetic resonance imaging, artificial hearts, organ transplants, and ultrasound. *See* Wells, *Medical Ultrasonics*, IEEE SPECTRUM, Dec. 1984, at 44. These developments are likely to continue.

2. Some of the areas in which law and medicine intersect are involuntary commitment hearings and medical malpractice cases.

3. The status of modern health care in the legal system may be shown by the dramatic increase in the number of medical malpractice suits, the size of jury awards, and the cost of malpractice insurance.

The results of a recent American Medical Association (AMA) study indicate that: (1) Americans currently are filing more than three times as many medical malpractice claims as they did in 1975; (2) several hundred of the malpractice awards in the last few years have exceeded $1 million; and (3) in the last 10 years, malpractice insurance premiums have risen by 400%-600% to cover the cost of these claims.

As the study notes, patients ultimately bear the cost. At present, the annual cost of the nation's health care bill has risen to $3.6 billion. At the current rate, the AMA projects that this figure could exceed $7 billion within three years. *See A.M.A. Study Finds Big Rise in Claims For Malpractice*, N.Y. Times, Jan. 17, 1985, at A1, col. 6; *An Epidemic of Malpractice Suits*, NEWSWEEK, Jan. 28, 1985, at 62.

4. The right to refuse treatment and the right to die are distinguishable. When a patient requests refusal of medical treatment he may do so knowing that he will die or knowing that there is only a chance that he may die. Though it is common to use these phrases

cern, but as technology develops, certain treatment options raise the legal implications of society's interest in the preservation of lives. An example of this impact on medical treatment on this interest arises when a competent adult patient[5] seeks to exercise his right to die.[6] The outcome in such cases has not been predictable.[7]

This Note sets forth and discusses the historical development of patient's right to die.[8] It then presents and analyzes the decision in *Bartling v. Superior Court (Glendale Adventist Medical Center)*,[9]

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interchangeably, such a distinction becomes important when attempting to discern the intent underlying a patient's request. *See infra* notes 213-17 and accompanying text.

5. "Right-to-die" cases are treated differently when the patient is competent than when he is incompetent. *See infra* notes 29-30 and accompanying text. The discussion in this Note is limited to the right of a competent, adult patient to refuse treatment and the establishment of a uniform standard for determining the parameters of such a right.

However, the competent-incompetent patient distinction may soon be eliminated in favor of a right-to-die standard for both categories of patients. This seems to be the intimation of the New Jersey Supreme Court in its most recent decision involving an incompetent patient's right to die. *See In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); *"Right to Die" In Terminal Cases Widened in Jersey*, N.Y. Times, Jan. 18, 1985, at A1, col. 1.

6. A competent patient's decision to exercise his right to die is typically the result of his reflection on the disease from which he is suffering, his poor medical prognosis, the hardships and sorrow felt by his family and friends, the unmanageable costs of his health care, and his own inability or unwillingness to endure. *See, e.g., infra* notes 43-64 and accompanying text.

Two recent surveys have shown that society now recognizes a terminal patient's right to die. From June 23-28, 1984, a New York Times-CBS News Poll randomly surveyed approximately 1,600 Americans, asking the question: "Medical technology now enables doctors to prolong the lives of many people who are terminally ill. Do you believe doctors should stop using these techniques if the patient asks, even if that means the patient will die?" Seventy-seven percent of the people interviewed fully agreed that patients should be allowed to refuse such treatment. Only 15% of those remaining said "no," and 8% were uncertain. For a detailed discussion of this survey, see *Playing God: Is Unplugging a Life-Sustaining Machine Murder, Or Is It Allowing Nature To Take Its Course?*, Cleveland Plain Dealer, Sept. 30, 1984, at 1-C, col. 1.

More recently, a Harris Survey was conducted by telephone between January 24-27, 1985, shortly after the New Jersey Supreme Court handed down an important right-to-die decision in *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985). Of the approximately 1,250 adults questioned in a nationwide cross-section, 85% believed that "a patient with a terminal disease ought to be able to tell his doctor to let him die rather than to extend his life when no cure is in sight," while 13% did not. In 1981, only 78% had believed so, while 19% did not. Further, 61% agreed that such a patient's wishes should be granted, while 36% disagreed. These statistics also represented a rise from the 1981 figures of 56% and 41%, respectively. *See Majority Favors Death For Terminally Ill Seeking It*, Cleveland Plain Dealer, Mar. 4, 1985, at 1A, col. 1.

7. *Compare* Bartling v. Superior Court (Glendale Adventist Medical Center), 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (Ct. App. 1984) (competent adult patients have the right to refuse medical treatment over the objections of their physicians and hospitals), *with* Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd* 379 So. 2d 359 (Fla. 1980) (competent adult patient's right to refuse artificially life-sustaining treatment qualified by consent of his family).

8. *See infra* notes 13-87 and accompanying text.

9. 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (Ct. App. 1984).

one of the most recent cases in this area of law.[10] Based on *Bartling* and its predecessors, this Note advocates adoption of a uniform standard for determining the scope of a patient's right to refuse medical treatment.[11] The Note concludes that when a competent adult patient requests the withholding of necessary medical treatment, that request should be honored, provided that certain findings and qualifications are met.[12]

I. HISTORICAL DEVELOPMENT OF THE RIGHT TO DIE

The legally recognized right to die is derived from three interrelated sources. The first is the United States Constitution. A right to die, though not expressly guaranteed, can be derived from the Constitution, based on the right to privacy. The second source is judicial process. Although courts have used differing interpretive schemes, their efforts have led to judicial recognition of a right to die. The third source is legislative action. As a result of the constitutional arguments supporting a right to die and the inconsistent judicial interpretations, a number of states have enacted natural death acts. The effect of this legislation is to provide certain patients with the right to die.[13]

A. *Constitutional Derivation*

The United States Constitution does not explicitly provide for a right to die, nor does it enunciate a right to privacy. However, the right to privacy has been established, in certain instances, as a protected legal right based on derivations from constitutional principles. It is this right which forms the foundation for the right to die argument.

Early judicial expression of a right to privacy arose from Justice Brandeis' dissenting opinion in *Olmstead v. United States*.[14] In *Olmstead*, Justice Brandeis stated that "the right to be let alone" was among the rights guaranteed by the United States Constitution.[15] Thirty-six years later, in 1964, this position was further advocated by Judge Burger[16] in *In re President and Directors of*

10. *See infra* notes 88-154 and accompanying text.

11. *See infra* notes 155-218 and accompanying text.

12. *See* part IV, *infra*.

13. *See infra* note 75 and accompanying text.

14. 277 U.S. 438 (1928).

15. *Id.* at 478 (Brandeis, J., dissenting).

16. Warren Burger, then a federal judge, and now Chief Justice of the United States Supreme Court.

Georgetown College, Inc.[17] Judge Burger dissented from the Court of Appeals' refusal to hear the case en banc and argued that the right to privacy justified the refusal of ordinary medical treatment that would otherwise save a patient's life.[18]

The major impact of the right to privacy arose after the Supreme Court acknowledged in *Griswold v. Connecticut*[19] that a constitutional right to privacy exists. In *Griswold*, the Supreme Court found that the right to privacy was included in the penumbra of rights granted by several constitutional amendments[20] and could be derived from a basic notion of personal intimacy.[21] The Court noted further that, as with all individual rights, the right to privacy was not absolute,[22] and in each situation, the individual right must be balanced against the asserted state interest.[23]

The Supreme Court extended the right to privacy in *Roe v. Wade*.[24] The Court stated that the "liberty" concept secured by the fourteenth amendment was the basis of this right.[25] It extended the right to privacy to encompass a woman's decision whether or not to have an abortion.[26] The *Roe* Court warned that the right to privacy

17. 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964). The *Georgetown* proceeding arose from an application for permission to administer blood transfusions to an emergency patient. The court reviewed the entry of an order authorizing a hospital to administer a blood transfusion to a patient who opposed the procedure on religious grounds, and whose husband was unwilling to authorize the transfusions. The court found the order proper because the transfusions were necessary to preserve her life and because the hospital had to administer the treatment or expose itself to the risk of civil and criminal liability. The patient was a 25-year-old Jehovah's Witness who was brought to the hospital by her husband for emergency care after having lost two-thirds of her body's blood supply due to a ruptured ulcer. She had no personal physician and relied solely on hospital staff. *Id.* at 1006.

18. *Id.* at 1017 (Burger, J., dissenting) (quoting Olmstead v. United States, 277 U.S. 438, 478 (1928)). Judge Burger noted that this right even applied to people with "foolish, unreasonable and even absurd ideas which do not conform, such as refusing medical treatment even at a great risk." *Id.* at 1016-17.

19. 381 U.S. 479 (1965).

20. *Id.* at 482-85. According to the court, various specific guarantees in the Bill of Rights create zones of privacy, including the first, third, fourth, and ninth amendments. *Id.* at 484.

21. *Id.*

22. *See id.* at 484-86; Roe v. Wade, 410 U.S. 113, 154 (1972).

23. In *Griswold*, the state's interest in regulating the health and welfare of its citizens was found to be insufficient to overcome the individual right of a married couple to choose contraceptive methods without state interference. 381 U.S. at 485. State interests may occasionally be held to outweigh individual interests. *See infra* note 27 and accompanying text.

24. 410 U.S. 113 (1973). Roe was a pregnant, single woman who brought a class action suit challenging the constitutionality of the criminal abortion laws, which proscribed procuring or attempting an abortion except on medical advice for the purpose of saving the mother's life. *Id.*

25. *Id.* at 152-53.

26. *Id.*

was not absolute and could be curtailed by a demonstration of compelling state interest.[27]

While the Supreme Court has yet to determine whether an individual has a constitutional right to die, a number of state courts have found that such a right does exist. These decisions are based on the same constitutional principles which support the right to privacy.[28]

B. *Judicial Interpretation*

Cases concerning an adult patient's right to die generally have arisen in two distinct fact situations. In the first situation, the patient is incompetent and a third party either is seeking appointment as guardian, or already has been appointed and wants a court order that would enable him to make medical decisions for the patient.[29] In the second situation, the patient is competent to make his own decision.[30]

The current archetype for cases involving an incompetent patient's right to die is *In re Quinlan*.[31] Karen Ann Quinlan was a twenty-two-year-old woman who ingested drugs and alcohol, stopped breathing, and became comatose. After seeing his daughter in a vegetative state, supported by a respirator and nourished

27. *Id.* at 154-56. In noting the limitations of the pregnant mother's right to privacy, the Court observed that a state "may properly assert important interests in safeguarding health, in maintaining medical standards, and in protecting potential life. At some point in pregnancy, these interests become sufficiently compelling to sustain regulation of the factors that govern the abortion decision." *Id.* at 154. *See also*, Note, *Of Interests, Fundamental and Compelling: The Emerging Constitutional Balance*, 57 B.U.L. REV. 462 (1977).

28. *See infra* notes 29-68 and accompanying text.

29. *See, e.g.*, John F. Kennedy Mem. Hosp., Inc. v. Bludworth, 452 So. 2d 921 (Fla. 1984); *In re* Torres, 357 N.W.2d 332 (Minn. 1984); *In re* Conroy, 188 N.J. Super. 523, 457 A.2d 1232 (N.J. Super. Ct. Ch. Div.), *rev'd*, 190 N.J. Super. 453, 464 A.2d 303 (N.J. Super. Ct. App. Div. 1983), *rev'd*, 98 N.J. 321, 486 A.2d 1209 (1985); *In re* Coyler, 99 Wash. 2d 114, 660 P.2d 738 (1983); *In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984); Leach v. Akron Gen. Med. Center, 68 Ohio Misc. 1, 426 N.E.2d 809 (C.P. Summit County 1980); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1977); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Eichner, 73 A.D.2d 431, 426 N.Y.S.2d 517, *modified sub nom. In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981), *In re* Spring, 380 Mass. 629, 405 N.E.2d 115 (1980); *In re* Severns, 425 A.2d 156 (Del. Ch. 1980).

30. *See, e.g.*, Bartling v. Superior Court (Glendale Adventist Medical Center), 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984); Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); Lane v. Candura, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978); *In re* Quackenbush, 156 N.J. Super. 282, 383 A.2d 785 (Morris County Ct. 1978).

31. 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1977).

through a nasogastrointestinal tube, Mr. Quinlan petitioned the courts for appointment of guardianship for the purpose of removing the respirator.[32] Ultimately, the New Jersey Supreme Court held that Mr. Quinlan should be Karen's guardian and should be permitted to have her respirator removed, even though removal would likely result in her death.[33] In so deciding, the New Jersey Supreme Court recognized that there were certain areas of personal privacy under the Constitution,[34] and that Karen Quinlan's right to choose could not be disregarded simply because she was unable to decide for herself.[35] The court concluded that these interests in privacy and the freedom of choice outweighed both the state's interest in the preservation and the sanctity of human life[36] and the obligations of the physicians to administer medical treatment.[37]

A year later the Supreme Judicial Court of Massachusetts adopted a similar approach in *Superintendent of Belchertown State School v. Saikewicz*.[38] Mr. Saikewicz was a profoundly mentally re-

32. *See* 137 N.J. Super. 227, 348 A.2d 801 (N.J. Super. Ct. Ch. Div. 1975), *rev'd*, 70 N.J. 10, 355 A.2d 647 (1976). The lower court appointed neither Mr. nor Mrs. Quinlan as their daughter's guardian, because it believed their personal anguish would prevent them from effectively making day-to-day decisions on the future care and treatment of their daughter. 137 N.J. Super. at 270, 348 A.2d at 824.

33. 70 N.J. at 55, 355 A.2d at 671-72. Though the Superior Court reviewed the same factors as did the Chancery Court, it deemed Mr. Quinlan capable of full guardianship because "his strength of purpose and character" far outweighed his feelings of grief and sorrow, and thus qualified him eminently. The court noted, however, that the decision to discontinue life support would require the consensus of "the guardian and family of [the patient], the responsible attending physicians and the hospital's ethics committee." *Id.* at 53-55, 355 A.2d at 671-72.

Karen Ann Quinlan survived removal of the respirator, but remained in a coma. She died on June 11, 1985. *Karen Quinlan Dead, Prompted Right-to-Die Fight*, Cleveland Plain Dealer, June 12, 1985 at 1-A, col. 5.

34. 70 N.J. at 39, 355 A.2d at 663. The court stated that the right to privacy discussed in *Griswold* and *Roe* was "broad enough to encompass a patient's decision to decline medical treatment under certain circumstances in much the same way as it is broad enough to encompass a woman's right to terminate pregnancy under certain conditions." *Id.*

35. *Id.* at 41, 355 A.2d at 664.

36. *Id.* at 40, 355 A.2d at 663. The court found that the state interest in the preservation and sanctity of human life diminishes as the magnitude of the bodily invasion involved in the treatment increases, and the prognosis becomes worse. Finding Quinlan's prognosis extremely poor and the bodily invasion great, the court concluded that her right of independent choice must prevail over the state's interest in preserving life. *Id.* at 40-41, 355 A.2d at 663-64.

37. *Id.* at 45, 355 A.2d at 665. The physicians decided to terminate the use of the respirator. The court noted that in an action for declaratory relief it had the "nondelegable judicial responsibility" to review the doctors' decision to preserve underlying human values and rights. The court, in effect, found that the state interest in defending the physician's right was not sufficiently compelling to override the patient's right to privacy. *Id.* at 45-51, 355 A.2d at 665-69.

38. 373 Mass. 728, 370 N.E.2d 417 (1977).

tarded resident of a state mental health facility who suffered from acute myeloblastic monocytic leukemia.[39] The court held that all persons, whether competent or incompetent, have a right to refuse medical treatment in certain circumstances, and allowed Mr. Saikewicz's guardian ad litem to refuse chemotherapy on behalf of his ward.[40] The *Saikewicz* court's conclusion was based on its application of the *Quinlan* court's approach to the constitutional right to privacy.[41] Four factors were critical to the court's reasoning. It balanced the patient's interest in bodily integrity and privacy against the state's interests in the preservation of life, the protection of innocent third parties, the prevention of suicide, and the maintenance of the moral integrity of the medical profession.[42] Thus, like *Quinlan*, the *Saikewicz* court recognized the right to privacy and then balanced the competing interests in question.

In re Quackenbush[43] was one of the first cases in which a court applied the *Quinlan/Saikewicz* decisional framework to a competent patient's request to be permitted to die. Mr. Quackenbush was a divorced, seventy-two-year-old recluse who had no children and suffered from gangrene in both legs.[44] Doctors advised him that, unless his legs were amputated, he would die within three weeks. Mr. Quackenbush refused to consent to the operation.[45] The hospital petitioned the court for an appointment of guardianship for the purpose of authorizing surgery, alleging that the patient was incompetent to make an informed decision.[46]

The court found Mr. Quackenbush competent[47] and considered

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39. *Id.* at 731, 370 N.E.2d at 420.

40. *Id.* at 745, 754-55, 370 N.E.2d at 427, 432. The court stated further that "[t]he recognition of that right must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both." *Id.* at 745, 370 N.E.2d at 427.

41. *Id.* at 739-40, 370 N.E.2d at 424.

42. *Id.* at 741, 370 N.E.2d at 425. One of the first decisions to emphasize these interests was *In re* President and Directors of Georgetown College, 331 F.2d 1000 (D.C. Cir. 1964). *See supra* notes 16-18 and accompanying text.

43. 156 N.J. Super. 282, 383 A.2d 785 (Morris County Ct. 1978).

44. *Id.* at 284, 383 A.2d at 786-87.

45. *Id.* at 284, 383 A.2d at 786. When treatment was attempted, Quackenbush refused and became rambunctious and belligerent. The hospital tried to send him away because of his refusal of treatment, but ultimately admitted him when all agencies of transport refused to take him home. *Id.*

46. *Id.* at 283, 383 A.2d at 786.

47. *Id.* at 288, 383 A.2d at 788. *See also* Lane v. Candura, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978). In *Lane*, the patient refused to consent to surgical amputation of her right leg which was infected with gangrene. The *Lane* court held that the irrationality of the patient's decision did not justify a conclusion that her capacity was impaired to the point of legal incompetence to engage in decisionmaking. *Id.* at 383, 376 N.E.2d at 1235-36.

only whether there were any compelling state interests sufficient to override his right to die. The court held that the state's interest in preserving life was, in this instance, insufficient to compel the extensive invasion of privacy presented by a forced surgical procedure.[48] The court reached this conclusion despite doctors' testimony that the operation could have arrested the spread of gangrene.[49]

A similar conclusion was reached by the Florida Court of Appeals in *Satz v. Perlmutter*.[50] Mr. Perlmutter was a seventy-three-year-old man who suffered from amyotrophic lateral sclerosis, commonly called "Lou Gehrig's disease."[51] Mr. Perlmutter, competent and mentally alert, decided that he no longer wished to be attached to a respirator.[52] He was aware of the inevitable result of his decision and tried unsuccessfully to remove the respirator himself.[53] Despairing at his own prognosis, he exclaimed that removal of the respirator could not "be worse than what I'm going through now."[54] Relying on *Saikewicz*, the *Satz* court held that, based upon his constitutional right to privacy, Mr. Perlmutter had the right to discontinue use of the mechanical respirator.[55] The court analyzed the case in light of the four state interests enumerated in *Saikewicz*, but found none of them compelling.[56] The court limited its adoption of *Saikewicz*, however, to situations where the patient is capable of making his own decision, recognizing the complications inherent in cases where the patient is incompetent.[57]

The capacity for self-determination in medical treatment decisionmaking was a central issue for the Massachusetts Court of Appeals in *Lane v. Candura*.[58] Mrs. Candura, a seventy-seven-year-old widow who refused to consent to the surgical removal of her right foot, previously had consented to the amputation of other por-

48. 156 N.J. Super. at 290, 383 A.2d at 789 (citing *In re* Quinlan, 70 N.J. 10, 41, 355 A.2d 647, 664 (1976)); *see supra* note 36 and accompanying text.

49. 156 N.J. Super. at 286, 383 A.2d at 787.

50. 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd* 379 So. 2d 359 (Fla. 1980). In *Perlmutter*, the State appealed from a trial court order permitting the removal of the artificial life sustaining device. By the time the case reached the Florida Court of Appeals, the patient was virtually incapable of movement, unable to breathe without a respirator and certain to die in a very short time. 362 So. 2d at 160-61. The patient ultimately died before the Florida Supreme Court affirmed the Court of Appeals decision in toto. 379 So. 2d at 360.

51. 362 So. 2d at 161.

52. *Id.*

53. *Id.*

54. *Id.* This statement was conveyed to the trial judge at a bedside hearing. *Id.*

55. *Id.* at 162.

56. *Id. See supra* note 42 and accompanying text.

57. *Id.*

58. 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978).

tions of her foot in efforts to halt the spread of gangrene.[59] However, when informed that the disease had spread to her whole foot and would warrant its removal, she balked, consented twice to the operation, then later revoked her consent.[60] Ultimately, she concluded that she would welcome death before enduring what she felt would be an ineffective surgical procedure.[61]

Alleging that her mother was incompetent, Mrs. Candura's daughter petitioned for and received from the trial court an order appointing her temporary guardian with the power to consent to the surgery.[62] The court of appeals reversed the order, holding that the evidence presented did not justify a finding of legal incompetence.[63] It accepted testimony to the effect that Mrs. Candura's judgment was somewhat affected by her slight senility and occasional depression. Despite this evidence, the court of appeals asserted that incompetence could not be found absent evidence that the patient's "areas of forgetfulness and confusion cause, or relate in any way to impairment of her ability to understand that in rejecting the amputation she is, in effect, choosing death over life."[64]

These cases demonstrate the evolution of judicial evaluation in the treatment of right-to-die issues. They suggest that there are generally recognized circumstances in which courts will uphold the right to refuse medical treatment.[65] The decisions have been criticized, however, as inconsistent and arbitrary.[66] While some courts have set forth specific right-to-die guidelines, others simply have determined the existence of this right by implication.[67] Confronted with this inconsistency, a number of courts have spoken out for legislative assistance in this area.[68]

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59. *Id.* at 379, 376 N.E.2d at 1233-34.

60. *Id.*

61. *Id.*

62. *Id.* at 378, 376 N.E.2d at 1233.

63. *Id.* at 380, 376 N.E.2d at 1234. The court of appeals noted that the judgment of the trial court and that of the psychiatrist were based on the medical irrationality of Candura's decision, and that her competency had not been questioned until she refused the surgery. *Id.* at 383, 376 N.E.2d at 1235.

64. *Id.* at 384, 376 N.E.2d at 1236. The court of appeals went on to say that the decision, regardless of its wisdom, was "not the uninformed decision of a person incapable of appreciating the nature and consequences of her act." *Id.* The *Lane* decision makes it clear that special care must be taken in rejecting a patient's decision by a finding of incompetence.

65. *See supra* note 6.

66. Brown, *Therefore Choose Death*, HUM. RTS. Fall 1987, at 38, 44.

67. *Id.*

68. In fact, some courts have questioned whether they have the power to decide such issues. *See, e.g.*, Satz v. Perlmutter, 379 So. 2d 359, 360-61 (Fla. 1980).

C. *Legislative Response*

The legislative response to judicial treatment of right-to-die cases has varied from state to state.[69] Thirty-four states and the District of Columbia have enacted right-to-die statutes.[70] In 1984, forty-seven "right-to-die" bills were introduced in twenty-five legislatures.[71] The first such legislation was California's Natural Death Act.[72]

Enacted in 1976, the California Natural Death Act combined an individual's constitutionally protected right to privacy under California state law[73] with the legislature's belief that patients have the

69. Although such legislation was recently enacted in the United States, some sources have traced its roots to England in the 1930's. *See* Comment, *The Right to Die A Natural Death and the Living Will*, 13 TEX. TECH. L. REV. 99, 110-11 (1982) (citing Survey, *Euthanasia: Criminal, Tort, Constitutional and Legislative Considerations*, 48 NOTRE DAME LAW. 1202, 1252-53 (1973); Louisell, *Euthanasia and Biathanasia: On Dying and Killing*, 22 CATH. U.L. REV. 723, 725-26 (1973)).

70. Alabama Natural Death Act, §§ 22-8A-1 to -10 (1984); Arkansas Death with Dignity Act, ARK. STAT. ANN. §§ 82-3801 to -3804 (Supp. 1983); California Natural Death Act, CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1985); Delaware Death with Dignity Act, DEL. CODE ANN. tit. 16, §§ 2501-2509 (1983); District of Columbia Natural Death Act of 1981, D.C. CODE ANN. §§ 6-2421 to -2430 (Supp. 1984); Florida Life Prolonging Procedure Act, 1984 FLA. SESS. LAW SERV. 84-58 (West); Georgia Living Wills Act, GA. CODE ANN. §§ 31-32-1 to -12 (Supp. 1984); Idaho Natural Death Act, IDAHO CODE §§ 39-4501 to -4508 (Supp. 1984); Illinois Living Will Act, ILL. ANN. STAT. ch. 7, 110 §§ 701-710, (Smith-Hurd 1984); Kansas Natural Death Act, KAN. STAT. ANN. §§ 65-28, 101-109 (1979); Louisiana Life-Sustaining Procedures, LA. REV. STAT. ANN., 40:1299.58.1-.10 (West Supp. 1984); Mississippi Withdrawal of Life Saving Mechanisms, MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1984); Nevada Witholding or Withdrawal of Life-Sustaining Procedures, NEV. REV. STAT. §§ 449.540-.690 (1983); New Mexico Right to Die Act, N.M. STAT. ANN. §§ 24-7-1 to -11 (1978); North Carolina Right to Natural Death Act, N.C. GEN. STAT. §§ 90-320 to -323 (1979 & Supp. 1981); Oregon Rights with Respect to Terminal Illness, OR. REV. STAT. §§ 97.050-.090 (1983); Texas Natural Death Act, TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon Supp. 1984); Vermont Terminal Care Document, VT. STAT. ANN. tit. 18, §§ 5251-5262 (Supp. 1984); Virginia Natural Death Act, VA. CODE §§ 54-325.8:1-:12 (Supp. 1984); Washington Natural Death Act, WASH. REV. CODE ANN. §§ 70.122.010-.905 (Supp. 1985); West Virginia Natural Death Act, W. VA. CODE, §§ 16-30-1 to -10 (Supp. 1984); Wisconsin Natural Death Act, WISC. STAT. ANN. §§ 154.01-.15 (West Supp. 1984); Wyoming Act, WY. STAT. §§ 33-26-144 to -152 (1984).

Twelve states have passed legislation in 1985. Arizona, H.R. 2029 (1985); Colorado, H.R. 2027 (1985); Indiana, H.R. 1075 (1985); Iowa, S. 725 (1985); Maine, L. 1448 (1985); Maryland, H.R. 453 (1985); Missouri, S. 51 (1985); Montana, H.R. 228 (1985); New Hampshire, H.R. 47 (1985); Oklahoma, H.R. 765 (1985); Tennessee, H.R. 386 (1985); and Utah, S. 103 (1985).

A right-to-die bill, S. 67, has been passed by both houses in Connecticut, but has not yet been signed as of this writing.

71. 1984 Right to Die Bills, Newsletter From Society for the Right to Die, May 12, 1984 (On file with the *Case Western Reserve Law Review*).

72. CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1985).

73. "All people are by nature free and independent and have inalienable rights. Among these are enjoying and . . . pursuing and obtaining . . . privacy." CAL. CONST., art. 1, § 1.

"fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life saving procedures withheld or withdrawn in instances of a terminal condition."[74] The Act specifies a procedure whereby a qualified patient may direct his physician to withhold or withdraw life sustaining medical care in the event of a terminal condition.[75] This Act also prescribes the procedure by which the qualified adult may execute a written directive,[76] binding on the physician,[77] which provides that, in the event that death becomes "imminent," life sustaining procedures will be withheld or removed and the individual will be permitted to die naturally.[78]

The drafters of the Act anticipated difficulties in its interpretation, and with these difficulties in mind they included two very important provisions. The first provides that the directive executed by a competent adult will be considered "the final expression of [his] legal right to refuse medical or surgical treatment and [he will] accept the consequences of such a refusal."[79] The second is that the physician, health care facility, or licensed health professional, under the direction of a physician who participated in the withholding or withdrawing of life sustaining procedures in accordance with the Act, cannot be subject to civil action, criminal liability, or charges of unprofessional conduct.[80] The Natural Death Act also states that any action taken in accordance with its provisions is not considered suicide.[81] The Act provides that the procurement of life or health insurance may not be invalidated or impaired by the patient's signing a directive under the Act,[82] and that no health care provider or insurer may require a person to sign a directive as a condition for insurance or for receipt of health care services.[83] The Act concludes by stating that in no instance does it condone "mercy

74. CAL. HEALTH & SAFETY CODE § 7186 (West Supp. 1985).

75. *Id.* Section 7187 provides relevant definitions for this Act. The basis for the Act was the legislative finding that the artificial prolongation of life by modern medical technology may result in loss of patient dignity and produce unnecessary pain and suffering. *Id.* at § 7186.

76. *Id.* at § 7188.

77. *Id.* at § 7191(b).

78. *Id.* at § 7188.

79. *Id.*

80. *Id.* at § 7190. In fact, the physician would be liable for unprofessional conduct for failure to follow a binding directive. *Id.* at § 7191(b).

81. *Id.* at § 7192(a).

82. *Id.* at § 7192(b).

83. *Id.* at § 7192(c).

killings."[84]

The California Natural Death Act has provided the impetus for similar legislation in other states.[85] Though it has been criticized as constitutionally defective[86] and problematic,[87] it has not been amended since its passage.

II. THE *BARTLING* DECISION[88]

When William Bartling expressed his wish to refuse medical treatment, the California Natural Death Act was already in effect. When he first stated that he would prefer living without the life sustaining machines, the competent adult patient's right to die had been legally recognized and upheld by a number of other courts. Yet, his petition to the California Superior Court for permission to exercise his right to die was denied.[89]

A. *Background*

At the time of his death, Mr. Bartling was a seventy-year-old man who suffered from emphysema, chronic respiratory failure, arteriosclerosis, an abdominal aneurysm, and a malignant lung tumor.[90] He also had a history of depression and alcoholism.[91] On April 8, 1984, he entered Glendale Adventist Medical Center for treatment of his depression. During the course of a routine physical examination, the physicians discovered a tumor in his lung and they performed a biopsy which caused the lung to collapse.[92] The treating physicians were unable to reinflate his lung because of an em-

84. *Id.* at § 7195.

85. Several states' Natural Will Acts are similar to California's, including those in Alabama, Arkansas and New Mexico. *See supra* note 70.

86. *See* Comment, *Give Me Liberty and Give Me Death: The Right to the California Natural Death Act*, 20 SANTA CLARA L. REV. 971, 988-90 (1980) (suggesting that the Act is unconstitutional because it is underinclusive, vague and ambiguous, and because it subjects the right to die to unfettered physician discretion).

87. *See* Comment, *A Proposed Amendment to the California Natural Death Act to Assure the Statutory Right to Control Life Sustaining Treatment Decisions*, 17 U.S.F.L. REV. 579, 600-05 (1983) (indicating five separate situations where the Act makes it more difficult to die naturally).

88. Bartling v. Glendale Adventist Medical Center, No. C 500735 (Cal. Super. Ct. June 22, 1984) [hereinafter cited as *Bartling I*], *rev'd sub nom* Bartling v. Superior Court (Glendale Adventist Medical Center), 163 Cal. App. 3d __, 209 Cal. Rptr. 220 (Ct. App. 1984) [hereinafter cited as *Bartling II*].

89. *Bartling I*, No. C 500735 (Cal. Super. Ct. June 22, 1984).

90. *Bartling II*, 163 Cal. App. 3d __, 209 Cal. Rptr. 220, 221 (Ct. App. 1984).

91. *Id.*

92. *Id.*

physemic condition which hindered healing.[93] In addition to a prescribed regimen of antibiotics, a tracheotomy was performed, and Mr. Bartling was placed on a ventilator.[94] Mr. Bartling remained on the ventilator until his death; efforts to "wean" him from the machine were unsuccessful.[95]

After Mr. Bartling had attempted to remove his ventilator tubes several times, the physicians placed him in "soft restraints."[96] Despite requests from both Mr. Bartling and his wife, Glendale Adventist and the treating physicians refused to remove either the ventilator or the restraints.[97]

In June, the Bartlings filed suit, seeking damages[98] and an injunction restraining the hospital and its physicians, the real parties, from providing any medical care without Mr. Bartling's consent and from "forcing [him] to undergo mechanical breathing through the ventilator."[99] The Bartlings submitted a number of documents in support of their claim. Appended to the complaint were: (1) a "living will"[100] signed by Mr. Bartling and properly witnessed;[101] (2) a personal, present declaration from the patient requesting that the court grant the order;[102] and (3) a "Durable Power of Attorney

93. *Id.*

94. *Id.* A tracheotomy is a vertical incision made in the interior wall of the trachea to overcome obstructions. NEW AMERICAN POCKET MEDICAL DICTIONARY 298 (N. Roper ed. 1978). A ventilator, also known as a respirator, is a mechanical device which is used to assist patients whose lungs are too weak to breathe under their own power. Appellee's Brief at 21, Bartling v. Glendale Adventist Medical Center, No. C 500735 (Cal. Super. Ct. June 22, 1984), *rev'd sub nom.* Bartling v. Superior Court (Glendale Adventist Medical Center), 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (Ct. App. 1984) [hereinafter cited as Appellee's Brief].

95. *Bartling II,* 163 Cal. App. 3d at __, 209 Cal. Rptr. at 221. "Weaning" is the process by which the gradual removal of a patient from a ventilator is attempted. Appellee's Brief, *supra* note 94, at 22.

96. *Bartling II,* 163 Cal. App. 3d at __, 209 Cal. Rptr. at 221.

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.* A living will permits an individual to state in advance his wishes regarding the use of life-sustaining procedures. It also provides for the appointment of another person to make health care decisions if the individual is unable to do so. CONCERN FOR DYING, AN EDUCATIONAL CONCERN, CONCERN FOR DYING, QUESTIONS & ANSWERS ABOUT THE LIVING WILL (1984).

Mr. Bartling's "living will" stated in part that "at such time the situation should arise in which there is no reasonable expectation of my recovery from extreme physical or mental disability, I direct that I be allowed to die and not be kept alive by medications, artificial means or heroic measures." *Bartling II,* 163 Cal. App. 3d at __, 209 Cal. Rptr. at 222.

101. *Id.*

102. *Id.* Mr. Bartling's declaration stated, in relevant part:

> While I have no wish to die, I find intolerable the living conditions forced upon me by my deteriorating lungs, heart and blood vessel systems, and find intolerable my being continuously connected to this ventilator, which sustains my every breath and

for Health Care," appointing Mrs. Bartling as the attorney-in-fact.[103] The Bartling family also executed declarations in support of their contentions,[104] and documents which would release the hospital and its doctors from liability should they agree to honor Mr. Bartling's wishes.[105] The court also viewed the videotape of Mr. Bartling's deposition,[106] taken the day before the Superior Court hearing. In that deposition he indicated that he wished to live detached from the ventilator, and that he understood that he might die if it were removed.[107]

> my life for the past six and one-half weeks. Therefore, I wish this Court to order that the sustaining of my respiration by this mechanical device violates my constitutional right, is contrary to my every wish, and constitutes a battery upon my person. I fully understand that my request to have the ventilator removed and discontinued, which I frequently made to my wife and to my doctors, will very likely cause respiratory failure and ultimately lead to my death. I am willing to accept that risk rather than to continue the burden of this artificial existence which I find unbearable, degrading and dehumanizing. I also suffer a great deal of pain and discomfort because of being confined to this bed, being on this ventilator, and from other problems which are occurring.

Id.

103. *Id.* The Durable Power of Attorney for Health Care Act provides that a proxy can be designated as attorney-in-fact to make health care decisions in the event that the principal should become incompetent to make such decisions. CAL. CIV. CODE §§ 2430-2443 (West Supp. 1985). In the document he executed, Mr. Bartling expressed his desires concerning his future medical and supportive care.

> I am totally unable to care for myself, and believe that I am dependent on a mechanical ventilator to support and sustain my respirator and life. I continuously suffer agonizing discomfort, pain and the humiliating indignity of having to have my every bodily need and function tended to by others. I do not wish to continue to live under these conditions. It is therefore my intent to refuse to continue on ventilator support and thereby to permit the natural process of dying to occur—peacefully, privately and with dignity. I direct my attorney-in-fact to honor my desires in this regard, and to refuse ventilator support, at such time as I am unable to do so for myself. I am aware that impairment, incapacity and unconsciousness may occur as a result of my refusal of ventilation, but I desire that none of these be deemed to be a medical emergency.

Bartling II, 163 Cal. App. 3d at __, 209 Cal. Rptr. at 222.

104. *Bartling II*, 163 Cal. App. 3d at __, 209 Cal. Rptr. at 222-23.

105. *Id.*

106. *Id.* at __, 209 Cal. Rptr. at 223. Beyond its use for evidentiary purposes, Mr. Bartling's deposition was also videotaped for subsequent transmission on the CBS program "60 Minutes," Sept. 23, 1984. A transcript of this program segment is on file at the *Case Western Reserve Law Review* [hereinafter cited as Bartling Transcripts].

107. Bartling Transcripts, *supra* note 106, at 4-5.

In relevant part, Mr. Bartling's deposition provided the following communication:

> SCOTT (Bartling's Attorney): Mr. Bartling, we're now going to do this deposition which I explained to you this morning. Do you understand that you have an obligation to tell the truth? (Bartling nodding head) Is that a yes? Okay. You need to nod your head so this girl . . . can see you. Mr. Bartling, do you want to live? (Nodding head yes) Do you want to continue to live on that ventilator? (Nodding head no) Do you understand that if that ventilator is discontinued or taken away, that you might die? (Nodding head yes) All right. I have no further questions.
> GINSBURG (Defendant's Attorney): Mr. Bartling, are you satisfied with the care that the nurses have been giving you here at Glendale? (Nodding head yes) That's

Despite these strong and unequivocal statements, Mr. Bartling's treating physicians continued to refuse his request to remove either the ventilator or the restraints.[108] There were several factors upon which the physicians based their decision. It was their belief that Mr. Bartling's illness was not terminal and that he could live for at least a year if he were weaned from the ventilator.[109] They questioned his decisionmaking because his vacillation suggested an inability to make a meaningful decision.[110] They further believed that honoring Mr. Bartling's request would constitute insupportable, unethical conduct on their part,[111] and would raise the possibility of criminal and civil liability.[112]

The Bartlings' motion for a preliminary injunction was argued before the California Superior Court.[113] At the outset of this proceeding, the court established that the scope of discussion would be confined to four areas: statutory and "decisional" law, medical prognosis, competency, and the nature of relief requested.[114]

Addressing each of these issues in turn, the court first summarily dismissed the applicability of the California Natural Death Act.[115] It interpreted this Act to provide that before its terms could apply, the patient must be deemed terminally ill. Since Mr. Bartling's physicians had testified that they would be able to remove the ventilator, the court concluded that his condition was not terminal.[116] Similarly, it said that there was no case under United States law in which a person applying for injunctive relief was not in a comatose, vegetative, or brain dead state.[117] Accordingly, the court

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a yes . . . . And you're not in any pain, are you? (Nodding no) Okay. And—and you don't want to die, do you? (Nodding head no) And you—you do understand that if that ventilator is removed, that you might die? (Nodding yes) I have no further questions.

Bartling Transcripts, *supra* note 106, at 4-5.

108. *Bartling II*, 163 Cal. App. 3d at __, 209 Cal. Rptr. at 222.

109. *Id.* at __, 220 Cal. Rptr. at 223. Mr. Bartling's physicians did, however, concede that his treatment would not likely be successful. *Id.*

110. *Id.* This opinion was based on the declarations of several nurses who related instances in which the ventilator tube accidentally detached and Mr. Bartling "signalled frantically" for them to reconnect it. *Id.* According to staff testimony, Mr. Bartling also made several statements to the effect that he wanted to live, not to have the ventilator disconnected. *Id.*

111. *Id.* Glendale Adventist viewed itself as "a Christian hospital devoted to the preservation of life." *Id.*

112. *Id.*

113. *Bartling I* No. C 500735 (Cal. Super. Ct. June 22, 1984).

114. *Id.* at 5-7.

115. *Id.* at 5.

116. *Id.* at 6.

117. *Id.* at 5. The court viewed all the cases cited by counsel as requiring a poor progno-

reasoned that if the "medical community" determines that a patient is not terminally ill, and there is some potential for restoring that patient to a "cognitive and sapient life," then any petition for injunctive relief from the hospital's life sustaining procedures should be refused.[118] Based on these and other factual findings, the court asserted its belief that Mr. Bartling's prognosis was "guarded and cautious, but optimistic."[119] Further, from the evidence presented, it found Mr. Bartling legally competent.[120] Finally, interpreting the request for injunctive relief as one for a mandatory injunction, the court pointed out that the California courts disfavor such injunction requests and seldom grant them.[121] The court thus indicated that its tentative inclination would be to refuse the Bartlings' petition.[122]

The Bartlings argued four points in an attempt to dissuade the court from its stated inclination. First, California's Natural Death Act was relevant to the disposition of the present case because it evidenced the legislature's understanding that patients have the right to withdraw unwanted life sustaining medical care.[123] Although the Act provides that terminal illness is one basis for the exercise of that right, it explicitly states that this is not the exclusive criterion. Second, the court's summary of relevant precedent was overly broad and inaccurate.[124] Not every case cited involved chronic vegetative, comatose, or totally incompetent patients. Even so, all courts which have decided cases dealing with incompetent patients who were permanently comatose or in a persistent vegetative state have determined that the person's "substitute judgment-maker is permitted to make a decision because the patient, if com-

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sis and evidencing little chance for recovery for injunctive relief to be granted. Further, according to the court, the medical testimony in these cases stated unequivocally that "the petitioners had no possible hope for recovery, and that if not legally dead, they were medically dead in every sense of the word, and the court was asked to have the physicians or the hospital withdraw life-sustaining treatment so that the natural process of life and death would occur." *Id.*

118. *Id.* at 6-7.

119. *Id.* at 2.

120. *Id.*

121. *Id.* at 4. The court highlighted two other procedural matters relevant to the case. First, the plaintiff had asked for immediate and equitable relief well in advance of the trial date, and therefore assumed that additional discovery would be required. Second, the plaintiff's burden of proof in a preliminary injunction hearing, under state law, was irreparable injury, and that injunctive relief was designed to preserve the status quo in order that the parties might ultimately proceed to trial. *Id.* at 3-4.

122. *Id.* at 7.

123. *Id.* at 8.

124. *Id.* at 9.

petent, . . . could make that same decision."[125] Third, while the court interpreted the medical prognosis to be continuously or guardedly optimistic, the record depositions and declarations were "replete with hopelessness," since multiple prior attempts to wean Mr. Bartling from the ventilator had been unsuccessful and his prognosis was poor.[126] Finally, Mr. Bartling's counsel summarized his petition as one which requested that Mr. Bartling, as a competent individual, be placed back in the "position of power" and that he be given the "key of self-control," in accordance with California law.[127]

Notwithstanding these arguments, the court denied the petition.[128] In so ruling, however, it granted the Bartlings' request that the order from the preliminary injunction hearing be stipulated as a permanent injunction, thereby facilitating the expedition of the appellate process.[129]

B. *The California Court of Appeals Decision*

On November 6, 1984, two days after lapsing into a coma, William Bartling died of complications suffered due to kidney failure. At the time of his death, Mr. Bartling was still attached to a ventilator.[130] Twenty-three hours later, the California Court of Appeals determined that the potential for recurrence of the issues presented in this case was sufficient to warrant judicial review and the establishment of a workable standard to guide both the medical and legal professions when faced with similar situations in the future.[131]

Upon completion of its review of the record, the court concluded that the lower court erred when it held that the right to have life support equipment disconnected was limited to comatose, terminally ill patients, or representatives acting on their behalf.[132] Accordingly, the court stated that

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125. *Id.* It may be inferred that since Mrs. Bartling had a durable power of attorney for the health care of her husband, she should have been allowed to substitute her judgment for his. But if her judgment would have been the same as her husband's, then the court would still have been faced with the same problem.

126. *Id.* at 10.

127. *Id.* at 11-13. The petitioner cited two California cases in support of this argument, Cobbs v. Grant, 8 Cal. App. 3d 229, 104 Cal. Rptr. 505 (1972), and Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

128. *Bartling I*, No. C 500735 (Cal. Super. Ct. June 22, 1984), at 43.

129. *Id.* at 45.

130. *After Death—Court Will Hear Man's Right-to-Die Case*, Cleveland Plain Dealer, Nov. 9, 1984, at B-1, col. 1.

131. *Bartling II*, 163 Cal. App. 3d at __, 209 Cal. Rptr. at 221.

132. *Id.* at __, 209 Cal. Rptr. at 223. *See also Arguing the Right to Die*, Newsweek, Jan.

> [I]f the right of the patient to self-determinations as to his own medical treatment is . . . to have any meaning at all, it must be paramount to the interests of the patient's hospital and doctors. The right of a competent adult to refuse medical treatment is a constitutionally guaranteed right which must not be abridged.[133]

The court applied a two-part analysis in its assessment of the *Bartling* decisions. First, the court considered whether Mr. Bartling was legally competent to decide to remove the ventilator.[134] Based on its review of the facts, the court unequivocally established that Mr. Bartling was legally competent to make this determination. The declarations and executed statements which had been submitted to the trial court indicated that he knew he would die if the ventilator were disconnected. Nevertheless, he preferred death to a life sustained by mechanical means.[135] His periodic wavering from this position, whether the result of severe depression or any other factor, did not justify the real parties' conclusion that his capacity to make such a decision was impaired to the point of legal incompetency.[136] In reaching this conclusion, the court relied on *Lane v. Candura*,[137] a Massachusetts case involving a patient whose choice to forego amputation of her leg was tantamount to choosing death. In *Lane*, the court's determination of incompetency had not hinged on the rationality of her decision.[138] The court found that despite evidence of depression and senility, she fully appreciated the consequences of her ultimate choice, and her vacillation could be explained by the emotional nature of the decision, her choice not to communicate with certain doctors, and an occasional weakening of her resolve to give consent.[139]

In the second part of its analysis, the California appellate court applied a balancing test to determine whether Mr. Bartling's right to refuse unwanted treatment as a competent adult was outweighed by state, hospital, or physicians' interests.[140] The court focused on the patient's right to refuse medical treatment in light of case law,

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7, 1985, at 18 (discussing the *Bartling* case and the right to die); *Patient May Refuse Life-Support Care, Court on Coast Says*, N.Y. Times, Dec. 28, 1984, at A1, col. 1.

133. *Bartling II*, 163 Cal. App. 3d at __, 209 Cal. Rptr. at 225.

134. *Id.* at __, 209 Cal. Rptr. at 223.

135. *See supra* notes 100-03 and accompanying text.

136. *Bartling II*, 163 Cal. App. 3d at __, 209 Cal. Rptr. at 223-24 (citing Lane v. Candura, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978)).

137. *Lane*, 6 Mass. App. Ct. 377, 376 N.E.2d 1232. *See supra* notes 58-61 and accompanying text.

138. *Id.* at 383, 376 N.E.2d at 1235-36.

139. *Id.* at 382, 376 N.E.2d at 1235.

140. *Bartling II*, 163 Cal. App. 3d at __, 209 Cal. Rptr. at 225.

statutory provisions, and the state and federal constitutions. The court asserted that the right of a competent adult patient to self-determination in the context of medical treatment was first judicially recognized in 1972,[141] and recently reaffirmed by the California courts.[142] Legislative recognition of this right for qualified adults began with the enactment of the California Natural Death Act in 1976[143] and had been supplemented by legislation specifically concerning patients' rights.[144] The court pointed out that the right of a competent adult to refuse medical treatment is specifically guaranteed by the California Constitution[145] and has been judicially derived from the United States Constitution.[146] Thus, the court concluded that an individual's constitutionally guaranteed right to privacy provides a competent adult patient with the freedom to reject or refuse consent to medical treatment.[147]

The free exercise of Mr. Bartling's rights were balanced against the interests asserted by Glendale Adventist Medical Center and its physicians. These interests included the preservation of life, the prevention of suicide, and the maintenance of the ethical integrity of

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141. *Id.* at __, 209 Cal. Rptr. at 224.

142. *Id.* at __, 209 Cal. Rptr. at 224 (citing Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983)). In *Barber*, the court held that two physicians who were prosecuted for the alleged murder of an incurably ill patient under their care were not criminally liable for the patient's demise. The *Barber* court pointed out that while the California Natural Death Act was specifically addressed to a limited number of individuals, the legislature recognized a general right of self-determination in medical treatment. *Barber*, 147 Cal. App. 3d at 1015, 195 Cal. Rptr. at 489. The court in *Bartling II* agreed that the Act applies to a limited number of individuals, that is, to terminally ill patients. This class of individuals is further limited by the specific requirements of the statute.

Mr. Bartling did not meet all of these requirements. In the declaration attached to his amended complaint, he stated:

> My attorney has explained the provisions of the 'California Natural Death Act'; I understand that I am not a 'qualified patient' under those provisions in that I have not had a written diagnosis of 'terminal illness' submitted to me two weeks ago, or at any time. I do not wish to wait two weeks to become a 'qualified patient' before proceeding with my earnest desire to have the ventilator disconnected.

Bartling II, 163 Cal. App. 3d at __, 209 Cal. Rptr. at 224. Whether or not Mr. Bartling met the statutory requirements, the Act was relevant to the analysis of the case because it demonstrates the legislature's belief that a competent adult does have the right to refuse medical treatment.

143. *Bartling II*, 163 Cal. App. 3d at __, 209 Cal. Rptr. at 224; *see supra* notes 72-84 and accompanying text.

144. *Bartling II*, 163 Cal. App. 3d at __, 209 Cal. Rptr. at 225.

145. *Id.*

146. *Id.* (quoting Griswold v. Connecticut, 381 U.S. 479, 484 (1985)); *see supra* notes 19-23 and accompanying text.

147. *Bartling II*, 163 Cal. App. 3d at __, 209 Cal. Rptr. at 225 (citing Superintendent of Belchertown School v. Saikewicz, 373 Mass. 728, 739, 370 N.E.2d 417, 424 (1977)); *see supra* notes 38-41 and accompanying text.

the medical profession.[148] Though it acknowledged that preservation of life was the primary concern of the hospital, the physicians, and the profession, the court determined that this interest was superseded by Mr. Bartling's interest in self-determination.[149] Further, the court declined recognition of the real parties' asserted interest in preventing suicide as the disconnecting of Mr. Bartling's ventilator would simply hasten his inevitable death by natural causes.[150] The court established that because death by natural causes was imminent, disconnection of the ventilator would not hinder the state's interest in preventing suicide.[151] Finally, the court determined that the real parties' fear of criminal or civil liability for complying with Mr. Bartling's request was unfounded. It was satisfied that the case law concerning this issue clearly indicated that, had Mr. Bartling lived, the real parties would not have been held criminally or civilly liable for carrying out his instructions.[152]

The court urged that, in the future, parties facing similar problems should be free to act according to a patient's instruction without fear of liability and without advance court approval.[153] In closing, the court quoted *Quinlan* and stated that:

> [T]here must be a way to free physicians, in pursuit of their vocation, from all possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their dying patients. We would hope that this opinion might be servicable to some degree in ameliorating the professional problems under discussion.[154]

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148. *Bartling II*, 163 Cal. App. 3d at __, 209 Cal. Rptr. at 225.

149. *Id.*

150. *Id.* at __, 209 Cal. Rptr. at 226. The court cited *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1977), in support of this distinction. In *In re* Quinlan, the New Jersey court observed "a real distinction between the self-infliction of deadly harm and a self-determination against artificial life-support or radical surgery, for instance, in the face of irreversible, painful and certain imminent death." 70 N.J. at 43, 355 A.2d at 665.

151. *Bartling II*, 163 Cal. App. 3d at __, 209 Cal. Rptr. at 226.

152. *Id.*

153. *Id.* at __ & n.8, 209 Cal. Rptr. at 226 & n.8. The court noted that had Mr. Bartling lived past the date of its decision, it would have issued a mandatory injunction permitting Mr. Bartling to remove the ventilator and leave the hospital without interference from the staff. *Id.* at __ n.8, 209 Cal. Rptr. at 226 n.8. The court also stated its belief that prior judicial approval would not be needed in future cases. *Id.* at __, 209 Cal. Rptr. at 226.

154. *Id.* at __, 209 Cal. Rptr. at 227 (quoting *In re* Quinlan, 70 N.J. at 49, 355 A.2d at 668 (1976)).

The Glendale Adventist Medical Center has recently returned to the California appellate court. This time it is requesting that a directive be issued which would allow private hospitals to transfer "ambivalent" terminally ill patients who request to exercise their right to die to state institutions. It had asserted in *Bartling* that even if the court ordered the removal of the respirator, as a state agency it could not compel a private institution to comply. It main-

III. AVOIDING FUTURE INTERFERENCE — A CALL FOR A UNIFORM STANDARD OF REVIEW

Prior to *Bartling*, few courts were able to articulate an acceptable method of determining whether any adult patient should be permitted to exercise his right to die.[155] Consequently, when faced with similar factual situations, courts questioned their own capacity to adjudicate such issues.[156] The *Bartling* decision helped to resolve this dilemma, since courts can now rely on its two-part analysis for guidance in deciding cases where competent adult patients assert their right to die.[157]

A. *The Determination of Competency*

The first part under the *Bartling* analysis requires a determination of whether an individual is competent to exercise his right to self-determination. Competency is traditionally defined as the capacity to understand and appreciate the nature and consequences of one's actions.[158] The law presumes that every adult is capable of making decisions for himself unless adjudged incompetent. In the medical context, the law looks to the effectiveness of patient participation in health care decisionmaking[159] and requires legally effective informed consent. There are three traditional elements of informed consent: the patient's capacity to make particular decisions, the voluntariness of his decisionmaking, and the physician's

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tained that the court's discretion in this matter was limited to ordering that the patient be transferred to a state-run institution where the court-ordered removal could be carried out. *See Hospital Bids For Approval To Transfer Terminally Ill*, Am. Med. News, Feb. 1, 1985, at 11, col. 1.

155. *See supra* notes 31-64 and accompanying text.

156. *See supra* note 68.

157. The two-part *Bartling* standard will have the greatest practical application if it reflects the perspectives of the individuals most likely to use it: doctors and lawyers. For a discussion combining legal guidelines and insights of medical practitioners, see volumes I and III of PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS (1982) [hereinafter cited as MAKING HEALTH CARE DECISIONS], and DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT (1983).

158. *See* Annas & Densberger, *Competence to Refuse Medical Treatment: Autonomy vs. Paternalism*, 15 U. TOL. L. REV. 561, 561-62 (1984). The law presumes that every competent adult is capable of making decisions for himself unless adjudged otherwise. *Id.* at 565; *see also* 1 MAKING HEALTH CARE DECISIONS, *supra* note 157, at 56.

159. *See* 1 MAKING HEALTH CARE DECISIONS, *supra* note 157, at 55. In its discussions, the Commission employed the phrase "decisionmaking capacity" to avoid the confusing implications of the terms competence and incompetence. *Id.* at 56 n.5. For the purposes of this Note, the terms "decisionmaking capacity" and "competence" are used interchangeably.

disclosure of information.[160]

To participate effectively in making health care decisions, the patient must possess the proper mental, emotional, and legal capacity.[161] Decisionmaking capacity is a factual determination, based upon findings that the patient: (1) possesses a "set of values and goals;" (2) has the ability to "communicate and understand information;" and (3) has the ability to reason and deliberate about his choices.[162] Each of these factors has an important purpose. Values and goals help the patient weigh his decision within the proper framework.[163] The ability to communicate and understand the relevant facts and alternatives is essential to a productive physician-patient discourse regarding treatment.[164] Finally, the ability to reason and deliberate shows that the patient is able to foresee the potential impact of the selected treatment.[165] In essence, the ultimate determination is whether the patient can "give reasons for the decision, in light of the facts, the alternatives, and the impact of the decision on the patient's own goals and values."[166]

The physician's assessment of a patient's decisionmaking capacity is a difficult one to make, but may be eased by the rebuttable legal presumption that every adult is competent, thus leaving it to the challenger to demonstrate incompetency.[167] Even where a patient's treatment decision differs from his treating physician's, the presumption of competency continues.[168] At most, this difference of opinion may indicate that the physician needs to scrutinize more closely the implications of a patient's decision.[169] But when such an

160. *Id.* at 55. The doctrine of informed consent is rooted in the fundamental recognition that adults have a right to self-determination. The concept was formulated as legal doctrine in Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914). Justice Cardozo stated that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." *Id.* at 129-30, 105 N.E. at 93. For additional background on the historical development of informed consent as a legal doctrine, see 1 MAKING HEALTH CARE DECISIONS, *supra* note 157, at 15-39; 3 MAKING HEALTH CARE DECISIONS, *supra* note 157, at 1-35, 193-204.

161. 1 MAKING HEALTH CARE DECISIONS, *supra* note 157, at 55.

162. *Id.* at 57. These "elements of decisionmaking capacity" are not intended to be rigidly applied, and application should allow for individual idiosyncracies. However, when these idiosyncracies are so distinct that they raise significant capacity questions in the professional's mind, the possibility of incompetence must be considered. *Id.* at n.6.

163. *Id.* at 57-58.

164. *Id.* at 58-59.

165. *Id.* at 59-60.

166. *Id.* at 60.

167. *See supra* note 158 and accompanying text.

168. *See* 1 MAKING HEALTH CARE DECISIONS, *supra* note 157, at 62.

169. *Id.*

evaluation "indicates that the patient understands the situation and is capable of reasoning soundly about it, the patient's choice should be accepted."[170]

The second element of informed consent requires that a patient's health care deliberations and decisions be voluntary.[171] The law will regard consent obtained by any other means as invalid.[172] In a health care setting, involuntary consent may result from three different actions taken by a physician: forced treatment, coerced treatment, or manipulation. Although an uncommon occurrence in mainstream health care, forced treatment is usually the result of an assumption on the part of physicians that patients submit to treatment upon admittance.[173] Although situations involving coerced treatment also occur infrequently, they are most likely to arise when there is a significant disparity between the positions of the patient and the health care professional. The most common method by which a physician might wrongly elicit a desired response is by manipulating the facts so that the patient believes he has no other choice. If a health care professional desires, he can control the patient by withholding, distorting, or overly emphasizing certain information. The potential for abuse is limited only by a physician's sense of integrity. Because coercion and manipulation vitiate voluntariness, health care professionals are bound to a fundamental ethical obligation not to use these techniques.[174]

The third element of informed consent is disclosure of informa-

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> When the consequences for well-being are substantial, there is a greater need to be certain that the patient possesses the necessary level of capacity. When little turns on the decision, the level of decisionmaking capacity required may appropriately be reduced (even though the constituent elements remain the same) and less scrutiny may be required . . . . Thus a particular patient may be capable of deciding about a relatively inconsequential medication, but not about the amputation of a gangrenous limb.

Id. at 60.

170. *Id.* at 62. Conversely, when a physician determines that the patient may lack the requisite decisionmaking capacity, he must take appropriate steps to insure that the patient's interests are properly protected. *Id.* at 177-88.

171. Canterbury v. Spence, 464 F.2d 772, 783 (D.C. Cir. 1972) ("[T]he consent, to be efficacious, must be free from imposition upon the patient.").

172. *See* RESTATEMENT (SECOND) OF TORTS §§ 55-58, 892B (1979).

173. 1 MAKING HEALTH CARE DECISIONS, *supra* note 157, at 63-64. Generally speaking, forced medical intervention is not consensual. In certain instances, however, society legitimates such intervention. Societal sanction of forced medical intervention is justified by pursuit of important social goals such as the promotion of public health (forced vaccinations) and law enforcement (removing bullets needed as evidence). *Id.*

174. The extent of coercion exerted frequently depends on "the nature of a patient's illnesses, the institutional setting, the personalities of the individuals involved, and several other factors." The family is one other such factor which may coercively influence a patient's decisionmaking. *Id.* at 66.

tion. Disclosure is defined as "the actual communication between patient and physician of the facts, values, doubts and alternatives in which decisions must ultimately be based."[175] Communication is intended to promote the twin objectives of all health care: improved well-being and self-determination.[176] As the party with the greater command of the information relevant to a patient's condition, the physician has a duty that includes disclosure of information in an understandable manner.[177] The test is "not what the physician in his exercise of his medical judgment thinks a patient should know before acquiescing in a proposed course of treatment; rather the focus is on what data the patient requires in order to make an intelligent decision."[178] The professional and patient should discuss three issues:

> (1) the patient's current medical status, including its likely course if no treatment is pursued; (2) the intervention(s) that might improve the prognosis, including a description of the procedure(s) involved, a characterization of the likelihood and effect of associated risks and benefits, and the likely course(s) with and without therapy; and (3) a professional opinion, usually, as to the best alternative. Furthermore, each of these elements must be discussed in light of the associated uncertainties.[179]

Through a discussion of these issues, the physician not only meets a current perspective favoring complete disclosure and open discussion about a patient's diagnosis and prognosis, but he also provides the patient with the opportunity to discuss alternative courses of treatment for his condition.[180] In this context, it is important to note that while it is a physician's obligation to mention all approved medical treatment alternatives available,[181] he need only discuss them in a "fairly general way" until a more detailed evaluation of the treatment options is warranted.[182]

In disseminating information to patients during the decision-making process, physicians must also consider the role of uncertainty in treatment[183] and possible qualifications to full

175. *Id.* at 69.

176. *Id.*

177. *Id.* at 70.

178. Sard v. Hardy, 281 Md. 432, 442, 379 A.2d 1014, 1021 (1977).

179. 1 MAKING HEALTH CARE DECISIONS, *supra* note 157, at 74.

180. *Id.* at 76. A statistical study conducted during the course of the Commission's hearings indicates that 94% of the patients polled reported that they wanted complete disclosure in medical treatment. *Id.* at 75.

181. *Id.* at 75.

182. *Id.* at 77. When a physician openly discusses treatment options with the patient, he also learns the patient's preferences and can better prescribe the measures to be taken. *Id.*

183. *Id.* at 86-87. The Commission identified five sources of uncertainty in medical deci-

disclosure.[184] Uncertainty in treatment is rarely communicated openly, as both physicians and patients tend to refrain from a full examination of this aspect of health care.[185] Yet, because it may assist patients in making health care decisions, it is an integral facet of informed consent. Therefore, it is incumbent upon the physician to make the patient aware of any uncertainties involved in a particular treatment decision.[186]

Arguably, there are five qualifications to the fundamental requirement of full disclosure which serve as prerequisites to informed consent.[187] Of these qualifications, or "exceptions to informed consent," only that of waiver is directly applicable to the health care decisionmaking process of competent patients.[188] The courts have yet to consider whether an individual may waive his right to informed consent and, in effect, instruct his physician that "I will consent to this form of treatment but I do not want to know anything about it."[189] Courts may eventually recognize a patient's waiver of disclosure of certain aspects of medical treatment, but it is unlikely that they will grant individuals an unqualified right to waive disclosure, yet still deem them capable of effectively participating in health care decisionmaking.[190] Thus, when confronted with such a situation, a health care professional may be justifiably reluctant to proceed further in the discussion of treatment with the

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sionmaking: (1) limitations in current medical knowledge; (2) reliability of empirical information; (3) likelihood of success in treatment; (4) limitations in the knowledge of the particular health care provider; and (5) limitations inherent in an individual's ability to forecast future impact of present-day treatment. *Id.*

184. *Id.* at 93.

185. *Id.* at 87-89.

186. *Id.*

187. *Id.* at 93. The five exceptions to informed consent are: (1) legal requirements; (2) emergencies; (3) incompetency; (4) waiver; and (5) therapeutic privilege. *Id.*

188. *Id.* at 94-95. The remaining qualifications are inapplicable to the present discussion because each situation obviates the need for informed consent and thus for determination of a patient's competency. Where medical intervention is authorized by law, informed consent is not required. In an emergency situation it is frequently impossible to obtain consent at all. Even to the extent that it may be possible, the law overrides the requirement of consent prior to treatment on the basis of exigent circumstances.

The ramifications of obtaining informed consent from an incompetent patient's surrogate is not within the scope of this Note. Therapeutic privilege is so rarely considered a justifiable basis for qualification of informed consent that its application should be precluded. *Id.* at 93-96.

189. *Id.* at 94 (quoting Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413, 459).

190. *Id.* at 94-95.

patient.[191]

The question of competency remains unwieldly in the abstract, in part due to the different factual determinations that are necessarily presented by each case. In *Bartling*, for example, the court determined that the patient was competent to decide whether he wanted to have the ventilator disconnected.[192] The court based its conclusion on evidence that Mr. Bartling executed a living will, a durable power of attorney for health care, and a release of liability for the hospital and its physicians, and that he was able to manifest clearly and physically that he had an understanding that he needed the ventilator to continue breathing.[193] There was no issue whether the real parties provided Mr. Bartling with the proper information on which to base his consensual decision. All recognized that Mr. Bartling was completely dependent upon the mechanical ventilator to sustain his life and that he had clearly indicated his opposition to such measures. Mr. Bartling competently and capably withdrew his consent to treatment.[194] The decision was complete, and the real parties were to comply with his wishes. The court of appeals properly determined that William Bartling should be disconnected from the ventilator.

B. *Balancing Competing Interests*

Upon determining that a patient is capable of participating effectively in health care decisionmaking, a court should apply the second part of the *Bartling* analysis to evaluate the competing interests. The interest of a competent adult patient to self-determination in medical treatment[195] must be balanced against the state interest to preserve life.[196]

The right of a competent adult patient to refuse medical treatment[197] should be honored for two reasons. First, recognition of

191. At this point, a physician would be confronted with three options. First, he may proceed despite the waiver and risk eventually facing charges of assault. Second, he may refuse to continue in this relationship, absent the patient's willingness to hear at least the most fundamental aspects of the considered treatment. Third, in the best possible situation, the physician will attempt to elicit why the patient refuses to be informed of a particular medical procedure's guidelines and work with the patient to the point where that patient has a sufficient understanding of the treatment contemplated, yet not so much that it would violate the patient's initial request to be spared such disclosures.

192. 163 Cal. App. 3d at __, 209 Cal. Rptr. at 222-23.

193. *Id.*

194. *Id.* at __, 209 Cal. Rptr. at 223.

195. *See infra* notes 198-99 and accompanying text.

196. *See infra* notes 200-02 and accompanying text.

197. *See* DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 157, at 44

the patient's right to self-determination acknowledges that the patient is best suited to determine which course of action will best promote his well-being.[198] Second, respect for the patient's right to self-determination promotes maintenance of his "freedom from interference" as well as his "creative self-agency."[199] The right to self-determination, however, is not unqualified.

An individual's right to refuse medical treatment may be tempered by the state's interest in requiring treatment. A state may assert four interests in advocating a patient's continued treatment: preservation of life, protection of innocent third parties, prevention of suicide, and preservation of the ethical integrity of the medical profession.[200] The most significant of these state interests is preservation of life. This consideration is strongest when a particular case involves a patient who, despite the potential for a return to a normal life with life saving treatment, refuses such treatment.[201] Further, since the preservation of life is a fundamental tenet of the Hippocratic Oath, the physician's code of ethics, the disconnection of life support systems is considered inconsistent with medicine's purposes.[202]

There are several countervailing considerations regarding the utility of arguments based on the interest of preserving life. First, and foremost, the right of a competent adult patient to self-determination is paramount to the interests of the hospital and doctors.[203] Second, when the patient is dying, "the state's interest in the prolonging of life must be reconciled with the patient's interest in re-

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n.4; Cantor, *A Patient's Decision To Refuse Life-Saving Medical Treatment: Bodily Integrity versus the Preservation of Life*, 26 RUTGERS L. REV. 228 (1973); Annas & Densberger, *supra* note 158, at 561-66.

198. *See supra* note 178 and accompanying text.

199. *See* 1 MAKING HEALTH CARE DECISIONS, *supra* note 157, at 45-47. A patient's "freedom from interference," and his "creative self-agency" are often considered components to the definition of a patient's "autonomy." *See, e.g.*, Dworkin, *Autonomy and Informed Consent* in 3 MAKING HEALTH CARE DECISIONS, *supra* note 157, at 70-72.

200. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 741, 370 N.E.2d 417, 425 (1977); *accord* Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978).

201. *Cf. In re* President and Directors of Georgetown College, Inc., 331 F.2d 1000, 1009-10 (D.C. Cir.) (patient refused necessary blood transfusion on religious grounds; court noted that because death was the result of a religious choice, the state's interest would prevail over patient whose "life hung in the balance"), *rehearing en banc denied*, 331 F.2d 1010, *cert. denied*, 377 U.S. 978 (1964).

202. The Hippocratic Oath provides in relevant part: "I will prescribe regiment for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 680 (24th ed. 1965).

203. *See supra* note 133 and accompanying text.

jecting the traumatic cost of that prolongation."[204] Third, health care professionals are now beginning to realize that with each advance in medical technology, man is capable of being maintained "in life" for greater and greater lengths of time.[205] Certainly at the point where the maintenance of life by invasive, mechanical means subsumes all quality of life, then the individual's right overcomes the state interest.[206] Fourth, the scarcity and ever-increasing cost of the medical instruments required for life sustaining treatment will inevitably lead to difficult decisions of resource allocation. Society's interest in the preservation of life may soon be outweighed by the economic necessity that it allocate its resources only to those patients with a reasonable potential for survival.

The second asserted state interest lies in the protection of innocent third-party interests. Traditionally, an individual's right to refuse medical treatment has been subordinated to the state's interest in requiring treatment where exercise of the right to refuse treatment may adversely affect his children.[207] Where continued treatment fails to alter a patient's prognosis, however, the state's interest in protection of innocent third parties is no longer predominant. Rather, the individual's right is more important when the continued treatment of a dying patient would only serve to impact adversely on the surviving members of his family.[208]

The third asserted state interest, the prevention of suicide, is a corollary to the interest in the preservation of life. Health care professionals placed in the position of complying with a patient's request to terminate life support systems have frequently refused to honor this request, arguing that to do so would be tantamount to aiding and abetting in a patient's suicide.[209] However, no modern court considering a patient's right to refuse life sustaining treatment has ever held that such a decision constituted suicide.[210] In fact,

204. *Saikewicz*, 373 Mass. at 742, 370 N.E.2d at 425.

205. *See* DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 157, at 1.

206. *In re* Quinlan, 70 N.J. at 41, 355 A.2d at 664; *see In re* Spring, 380 Mass. 629, 634, 405 N.E.2d 115, 119 (1980).

207. The leading case in this area is *In re* President and Directors of Georgetown College, 331 F.2d 1000 (D.C. Cir. 1964).

208. *Saikewicz*, 373 Mass. at 737-38, 370 N.E.2d at 423.

209. *See supra* note 201 and accompanying text; *see generally* W. LAFAVE & A. SCOTT, JR., HANDBOOK ON CRIMINAL LAW § 74 at 570-71 (1972) (discussing criminality of aiding suicide).

210. *In re* Quinlan is the seminal case on this point. The *Quinlan* court distinguished between "the self-infliction of deadly harm and a self-determination against artificial life-support or radical surgery . . . in the face of irreversible, painful and certain imminent death." 70 N.J. at 43, 355 A.2d at 665.

several courts have expressly or implicitly rejected arguments which likened the refusal of life sustaining medical treatment to suicide.[211] There are two prerequisites to a finding of suicide—specific intent and causation.[212] According to the courts, an incurably ill patient who refuses medical treatment usually lacks the specific intent to die.[213] Even assuming he had the intent, these courts say, the patient did not set into motion the natural processes that ultimately cause death.[214]

The fourth state interest concerns preservation of the ethical integrity of medical practice. A traditional goal of medicine is to prolong life.[215] Advances in medical technology have created situations which were never thought possible, and which will require careful reformulation of the goals of health care decisions in the context of terminally ill patients,[216] with some provision for the recognition that "the dying are more often in need of comfort than treatment."[217] The laws of many states currently preclude criminal or civil liability for the termination of life sustaining treatment of incurably ill patients,[218] and indeed, a physician or other health care professional may be held liable for failing to honor a patient's request to terminate treatment.[219] As medical advances have thrust practitioners into the twenty-first century, so must the medical-ethical framework prescribe conduct that is appropriate to these advances.

IV. CONCLUSION

Today it is clear that a competent adult patient has the right to refuse necessary medical treatment. Yet the cases dealing with this issue reveal pervasive inconsistency in interpretation and confusion in application of the relevant principles. A uniform standard of

211. *See, e.g., Saikewicz*, 373 Mass. at 741-43 & n.11, 370 N.E.2d at 425-26 & n.11; *Satz*, 362 So. 2d at 162-63.

212. *See Saikewicz*, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11; *Satz*, 362 So. 2d at 162-63; *see generally* W. LAFAVE & A. SCOTT, JR., *supra* note 209, at § 74 (discussing elements and criminality of suicide).

213. *See, e.g., Saikewicz*, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11; *Satz*, 362 So. 2d at 162-63.

214. *See, e.g., Saikewicz*, 373 Mass. at 743 n.11, 370 N.E. 2d at 426 n.11; *Satz*, 362 So. 2d at 162-63.

215. *See supra* note 202 and accompanying text.

216. *See* DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, *supra* note 157, at 1.

217. *Id.* at 11-12.

218. Such provisions are especially evident in states which already have right-to-die statutes. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 7190 (West Supp. 1985).

219. Estate of Leach v. Shapiro, 13 Ohio App. 3d 393, 469 N.E.2d 1047 (1984).

analysis would ideally integrate the rights of competent adult patients in health care decisionmaking with current medical and ethical perspectives which take into account future advances in health care.

The approach taken by the appellate court in *Bartling* is a useful model for future cases involving the right to refuse medical treatment. The *Bartling* analysis should be applied in any case where an adult patient expresses his desire to refuse medical treatment. The threshold inquiry entails evaluation of the individual's capacity to refuse treatment. Upon a finding of competency, the patient's interests in self-determination must be balanced against the contrary state interests asserted. Absent evidence of significant countervailing considerations, the patient must be granted the freedom to exercise his right. This approach is the most responsible means of reconciling the powerful conflicting interests in these cases.

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