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Someone Make Up My Mind: The Troubling Right to Die Issues Presented by Incompetent Patients with No Prior Expression of a Treatment Preference

The medical field has continually expanded its ability to sustain a patient in a condition that previously demarcated death.¹ Courts and legislatures have grappled with the medical, legal, and ethical aspects of when death occurs and what conditions justify the removal or withdrawal² of life-sustaining procedures. In an attempt to clarify these questions, the Ad Hoc Committee of the Harvard Medical School³ in 1968 provided criteria to determine brain death;⁴ this resulted in the adoption

1 The Ad Hoc Committee of the Harvard Medical School asserted:

From ancient times down to the recent past it was clear that, when the respiration and heart stopped, the brain would die in a few minutes; so that the obvious criterion of no heart beat as synonymous with death was sufficiently accurate. In those times the heart was considered the central organ of the body; it is not surprising that its failure marked the onset of death. This is no longer valid when modern resuscitative and supportive measures are used. These improved activities can now "restore" life as judged by the ancient standards of persistent respiration and continuing heart beat. This can be the case even where there is not the remotest possibility of an individual recovering consciousness following massive brain damage.

A Definition of Irreversible Coma, 205 J. A.M.A. 337, 339 (1968) [hereinafter AD HOC COMMITTEE].

See also PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE SUSTAINING TREATMENT: ETHICAL, MEDICAL AND LEGAL ISSUES IN TREATMENT DECISIONS I (U.S.G.P.O., March, 1983) [hereinafter PRESIDENT'S COMMISSION] ("Frequent dramatic breakthroughs—insulin, antibiotics, resuscitation, chemotherapy, kidney dialysis, and organ transplantation to name a few—have made it possible to retard and even reverse many conditions that were until recently regarded as fatal.").

2 In a right to die analysis, a distinction has arisen between euthanasia and antidythanasia. Euthanasia concerns "the act or practice of painlessly putting to death persons suffering from incurable conditions or diseases." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 786 (1986 unabridged). Antidythanasia relates to the lack of positive action to prolong the life of an incurable patient. Comment, *The Right to Die—A Current Look*, 30 LOY. L. REV. 139, 141 (1984). This distinction, while sometimes criticized as a slippery slope leading towards legalizing active euthanasia, establishes guidelines between permissible and impermissible actions. *Id.* See also *In re Colyer*, 99 Wash. 2d 114, 139, 660 P.2d 738, 757 (1983) (en banc); Comment, *The Right to Die*, 7 HOUS. L. REV. 654, 657-62 (1970) (A legal as well as psychological distinction exists between actively killing an individual and passively letting someone die.).

Modern medical practitioners do not differentiate between withdrawing medical treatment and prospectively withholding the treatment in the first instance. PRESIDENT'S COMMISSION, *supra* note 1, at 73-77. *Accord In re Conroy*, 98 N.J. 321, 369-70, 486 A.2d 1209, 1234 (1985); *In re Grant*, 109 Wash. 2d 545, 747 P.2d 445, 452 (1987) (en banc).

3 The Committee was comprised of ten physicians, a historian, a lawyer, and a theologian.

4 The brain is the human organ most sensitive to the absence of normal oxygenated blood flow. As a result, it cannot regenerate destroyed tissue. The brain dies rapidly in the absence of a normal heart beat and respiration. D. MEYERS, MEDICO-LEGAL IMPLICATIONS OF DEATH AND DYING 24 (1981).

The human brain serves two distinct functions, vegetative and sapient. Vegetative regulation controls body temperature, breathing, blood pressure to a considerable degree, and to some degree the heart rate, chewing, swallowing, sleeping, and walking. The sapient function, the more highly developed and uniquely human, controls our relations with the outside world. Both must die to constitute brain death. *In re Quinlan*, 70 N.J. 10, 24, 355 A.2d 647, 654-55 (citing expert testimony of Dr. Fred Plum), *cert. denied*, 429 U.S. 922 (1976). For a discussion of how the cortex, which controls the sapient functions, and the brain stem, which controls the vegetative functions, die, see D. MEYERS, *supra*, at 24-25.

The Ad Hoc Committee Report stated that the following four general conditions constituted brain death: (1) unresponsivity and unresponsivity to pain or other stimuli; (2) no spontaneous move-

of state statutes which used these criteria as a model.⁵ *In re Quinlan*⁶ and its progeny, however, have demonstrated that such definitions of brain death have failed to address the right to die issues presented by non-brain dead patients in a persistently vegetative coma⁷ or in a conscious state.⁸

Although many states have passed Living Will Acts, which honor an advance written declaration requesting the termination of life-sustaining

ments or breathing; (3) no reflexes; (4) two flat or isoelectric electroencephalograms (EEGs), measured twenty-four hours apart (demonstrating a nonfunctional higher and lower brain). *Ad Hoc COMMITTEE*, *supra* note 1, at 337-40. For a critique of the Harvard criteria, see D. MEYERS, *supra*, at 35-36.

5 The Uniform Determination of Death Act also recognizes the potential disparity between modern technology and the common law's reliance on the cessation of spontaneous respiratory and cardiac functions. It states that "[a]n individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem is dead. A determination of death must be made in accordance with accepted medical standards." UNIF. DETERMINATION OF DEATH ACT § 1, 12 U.L.A. 292-93 (Supp. 1988).

State brain death legislation may be classified into three categories. First, some states follow the Uniform Determination of Death Act and classify death as either the absence of respiratory and cardiac function or the absence of brain function. Second, others view brain death as a means of determining death when lack of respiration and circulation cannot be relied upon if maintained by artificial respiration and circulation. Third, some states simply accept a total irreversible cessation of brain functions alone to indicate death. See D. MEYERS, *supra* note 4, at 42-44; Comment, *The Right to Die—A Current Look*, *supra* note 2, at 144; Note, *Discontinuing Treatment of Comatose Patients Who Have Not Executed Living Wills*, 19 LOY. L.A.L. REV. 61, 62-63 (1985). See generally Abram, *The Need for Uniform Law on the Determination of Death*, 27 N.Y.L. SCH. L. REV. 1187 (1982).

The following state statutes attempt to demarcate the point when death occurs: ALA. CODE § 22-31-1 (1984); ALASKA STAT. § 20-17-101 (1987); CAL. HEALTH & SAFETY CODE § 7180 (West Supp. 1988); COLO. REV. STAT. § 12-36-136 (1985); CONN. GEN. STAT. ANN. § 19A-278(b) (West 1986); DEL. CODE ANN. tit. 24, § 1760 (1987); D.C. CODE ANN. § 6-2401 (Supp. 1988); FLA. STAT. ANN. § 382.085 (West 1986); GA. CODE ANN. § 31-10-16 (Supp. 1987); HAW. REV. STAT. § 327c-1(b) (1985); IDAHO CODE § 54-1819 (1987 Supp.); ILL. ANN. STAT. ch. 110-1/2, para. 1302 (Smith-Hurd 1978); IND. CODE ANN. § 1-1-4-3 (West Supp. 1987); KAN. STAT. ANN. §§ 77-204 to 77-206 (1984); LA. REV. STAT. ANN. § 9:111 (West Supp. 1988); ME. REV. STAT. ANN. tit. 22, §§ 2811 to 2813 (Supp. 1988); MD. HEALTH-GEN. CODE ANN. § 5-202 (1987); MICH. COMP. LAWS ANN. § 333.1021 (West 1980); MISS. CODE ANN. §§ 41-36-1, 42-36-3 (1981); MO. ANN. STAT. § 194.005 (Vernon 1983); MONT. CODE ANN. § 50-22-101 (1987); NEV. REV. STAT. ANN. § 451.007 (Michie 1986); N.H. REV. STAT. ANN. §§ 141-D:1 to -D:2 (Supp. 1988); N.M. STAT. ANN. § 12-2-4 (1978); N.C. GEN. STAT. § 90-323 (1985); OHIO REV. CODE ANN. § 2108 (Anderson 1987 Supp.); OKLA. STAT. ANN. tit. 63, §§ 3121 to 3123 (West Supp. 1988); OR. REV. STAT. § 146.001 (1984); PA. STAT. ANN. tit. 35, §§ 10201-10203 (Purdon Supp. 1987); R.I. GEN. LAWS § 23-4-16 (1985); S.C. CODE ANN. §§ 44-43-450, 44-43-460 (Law. Co-op. 1984); TENN. CODE ANN. § 68-3-501 (1987); TEX. REV. CIV. STAT. ANN. art. 4447t §§ 1 to 3 (Vernon 1987); VT. STAT. ANN. tit. 18, § 5218 (1987); VA. CODE ANN. § 54-325.7 (Supp. 1987); W. VA. CODE § 16-10-2 (1985); WIS. STAT. ANN. § 146.71 (West Supp. 1984); WYO. STAT. §§ 35-19-101 to -103 (Supp. 1987).

6 70 N.J. 10, 366 A.2d 647, *cert. denied*, 429 U.S. 922 (1976). For a discussion of *In re Quinlan*, see *infra* notes 63-70 and 169-73 and accompanying text. The New Jersey Supreme Court recognized that Karen Quinlan met none of the Harvard criteria. 70 N.J. at 27, 355 A.2d at 656. The testimony before the court characterized her as in a persistent vegetative state. *Id.* at 24, 355 A.2d at 654-55. For a discussion of such a condition, see *infra* note 7.

7 Vegetative state describes a body which is functioning entirely in terms of its internal controls. It maintains temperature. It maintains digestive activity. It maintains reflex activity of muscles and nerves for low level conditioned responses. But there is no behavioral evidence of either self awareness or awareness of the surroundings in a learned manner. *In re Jobs*, 108 N.J. 394, 403, 529 A.2d 434, 438 (quoting Dr. Fred Plum, creator of the term "persistent vegetative state") (citations omitted).

8 See, e.g., *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *In re Grant*, 109 Wash. 2d 545, 747 P.2d 445 (1987) (en banc).

care,⁹ most persons fail to provide such a statement of intention. This Note focuses upon the troubling questions presented by patients who have never indicated a preference for or against life-sustaining treatment, due to either life-long incompetence or oversight prior to becoming incompetent. An incompetent patient is unable to formulate and express a treatment choice;¹⁰ as a result, a surrogate decisionmaker will decide whether to terminate life-sustaining care.¹¹ Medical treatment, however, may not be withheld from an incompetent merely because a surrogate believes that death would be the best alternative for that patient. Courts have recognized that under certain factual circumstances, the withholding or withdrawal of medical treatment may be in the patient's best interests, even though the incompetent had never previously expressed his/her wishes about life-prolonging care. Decisions which grant such incompetents the right to die have vacillated on the answers

9 The National Conference of Commissioners of Uniform State Laws has submitted a proposed uniform act recognizing the enforceability of "living wills" under certain specified situations. UNIF. RIGHTS OF THE TERMINALLY ILL ACT, 9B U.L.A. 611 (1987).

Thirty-eight states and the District of Columbia have enacted laws in this area. ALA. CODE §§ 22-8A-1 to -10 (1984); ALASKA STAT. §§ 18.12.010-.100 (1986); ARIZ. REV. STAT. ANN. §§ 36-320 to -3210 (1986); ARK. STAT. ANN. §§ 20-17-201 to -218 (Supp. 1987); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1988); COLO. REV. STAT. §§ 15-18-101 to -113 (1987); COLO. REV. STAT. § 12-36-117 (1985); CONN. GEN. STAT. ANN. §§ 19a-570 to -575 (West Supp. 1988); DEL. CODE ANN. tit. 16, §§ 2501-2509 (1983); D.C. CODE ANN. §§ 6-2421 to -2430 (Supp. 1987); FLA. STAT. ANN. §§ 765.01-.15 (1986); GA. CODE ANN. §§ 88-4101 to -4112 (Harrison 1985 and Supp. 1987); HAW. REV. STAT. §§ 327D-1 to D-27 (Supp. 1987); IDAHO CODE §§ 39-4501 to -4508 (1985 and Supp. 1987); ILL. ANN. STAT. ch. 110-1/2, paras. 701-710 (Smith-Hurd Supp. 1986); IND. CODE ANN. §§ 16-8-11-1 to -22 (West Supp. 1987); IOWA CODE §§ 144 A.1-A.11 (1985); KAN. STAT. ANN. §§ 65-28, 101-109 (1986); LA. REV. STAT. ANN. §§ 40:1299.58.1-.10 (West Supp. 1987); ME. REV. STAT. ANN. tit. 22, §§ 2921-2931 (Supp. 1987); MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (Supp. 1986); MISS. CODE ANN. §§ 41-41-101 to -121 (1984); MO. ANN. STAT. §§ 459.010-.055 (Vernon Supp. 1987); MONT. CODE ANN. §§ 50-9-101 to -104, 50-9-201-206 (1987); NEV. REV. STAT. §§ 449.540-.690 (1986); N.H. REV. STAT. ANN. §§ 137-H:1-16 (Supp. 1988); N.M. STAT. ANN. §§ 24-7-2 to -11 (1986); N.C. GEN. STAT. §§ 90-320 to -323 (1985); OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West Supp. 1987); OR. REV. STAT. §§ 97.050-.090 (1984); S.C. CODE ANN. § 44-77-10-160 (1986); TENN. CODE ANN. §§ 32-11-101 to -110 (Supp. 1988); TEX. REV. CIV. STAT. ANN. art. 4590 (Vernon Supp. 1986); UTAH CODE ANN. §§ 72-2-1101 to -1118 (Supp. 1986); VT. STAT. ANN. tit. 18, §§ 5251-5262 (1987); VA. CODE ANN. §§ 54.1-2981 to -2992 (1988); WASH. REV. CODE ANN. §§ 70.122.010-.905 (Supp. 1987); W. VA. CODE §§ 16-30-1 to -10 (1985); WIS. STAT. ANN. §§ 154.01-.015 (West Supp. 1986); WYO. STAT. §§ 33-26-144 to -152 (Supp. 1986).

10 PRESIDENT'S COMMISSION, *supra* note 1, at 121. The individual lacks the capacity to understand information relevant to the decision, to communicate with care givers about it, and to reason about relevant alternatives against a background of reasonably stable personal values and life goals.

Courts presume patients are competent to make their own medical decisions. See Note, *The Conflict Continues: Who Decides Treatment Questions For the Terminally-Ill Incompetent Patient?*, 23 SUFFOLK U.L. REV. 641, 644 (1984).

For a summary of the various approaches to evaluate competency, see Mooney, *Deciding Not to Resuscitate Hospital Patients: Medical and Legal Perspectives*, 1986 U. ILL. L. REV. 1025, 1079-80 n.341 (1986). Professor Mooney divides incompetency determinations into three categories. The first test is an outcome approach, which focuses upon evidence of incompetence when decisions do not adhere to community values. The second test, the status approach, evaluates a person's individual or mental status. Professor Mooney warns this standard is too broad. The third test bases its determination upon an individual's functional ability to make treatment choices. The President's Commission Report adopts this standard. See PRESIDENT'S COMMISSION, *supra* note 1, at 122.

11 When a patient lacks the capacity to make a decision, a surrogate decision maker should be designated. Ordinarily this will be the patient's next of kin, although it may be a close friend or another relative if the responsible health professional judges that this other person is in fact the best advocate for the patient's interests.

PRESIDENT'S COMMISSION, *supra* note 1, at 126-27. See also D. MEYERS, *supra* note 4, at 113.

to three essential questions: (1) what treatment should be withheld from the incompetent patient; (2) what is the appropriate standard which the surrogate decisionmaker should apply in assessing the treatment alternatives; and (3) who is the appropriate surrogate to make the treatment decision.

Part I of this Note traces the development of an incompetent patient's right to die based upon the common law right of bodily self determination and the constitutional right to privacy. Part II analyzes the types of treatment that may be withheld or withdrawn, noting the controversial questions concerning the removal of forced feeding devices. Part III argues that, in cases where the incompetent patient failed to indicate a treatment preference, it is impossible for the surrogate decisionmaker to substitute his or her judgment for what the incompetent would have desired in such a situation. Rather, the surrogate decisionmaker must evaluate whether it is in the best interests of the patient to terminate life-sustaining care. To the extent possible, this analysis must incorporate beliefs or traits of the particular patient as well as an evaluation of the medical prognosis, rather than simply relying upon a "reasonable person" standard. Part IV outlines the roles and responsibilities of the primary decisionmakers of an incompetent patient without a prior treatment preference—the family, the physicians, and the courts. It argues that the proper persons to whom the law should delegate the treatment decision are the patient's immediate family and attending physicians. The degree of judicial involvement in the decision should be a function of the patient's consciousness and prognosis. Part V concludes that by allocating the decisionmaking responsibilities in the above manner, the decision to terminate life-sustaining care will remain focused on the particular incompetent patient, rather than the preferences and needs of any surrogates.

I. Foundations of an Incompetent's Right to Refuse Medical Treatment

Courts have widely recognized that both competent¹² and incompetent patients have a right to terminate life-sustaining treatment. The right to die derives from the guarantees afforded by the common law right of bodily self determination¹³ and the constitutional right to pri-

12 The New Jersey Supreme Court in *In re Farrel*, 108 N.J. 335, 354 n.7, 529 A.2d 404, 413 n.7 (1987), stated that a competent patient possesses a "clear understanding of the nature of his or her illness and prognosis, and of the risks and benefits of the proposed treatment, and has the capacity to reason and make judgments about that information."

For cases upholding a competent patient's right to die, see *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); *Barling v. Superior Court*, 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); *In re Estate of Brooks*, 32 Ill. 2d 351, 205 N.E.2d 435 (1965); *Lane v. Candura*, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978), cited with approval in *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 497 N.E.2d 626 (1986); *In re Reguena*, 213 N.J. Super. 475, 517 A.2d 886, *aff'd*, 213 N.J. Super. 443, 517 A.2d 869 (1986). See also PRESIDENT'S COMMISSION, *supra* note 1, at 3 (recognizing the right of competent patient to forego life prolonging treatment).

13 See *infra* notes 16-21 and accompanying text.

vacy.¹⁴ A compelling state interest, however, may necessitate the initiation or continuation of life-sustaining care.¹⁵

A. *Common Law Right of Bodily Self Determination*

The common law respects the sanctity of life by allowing informed decisionmaking, not by requiring or prohibiting medical care per se. Nearly a century ago, in *Union Pacific Railway Co. v. Botsford*,¹⁶ the United States Supreme Court upheld an individual's right to prevent nonconsensual bodily invasions.¹⁷ In the context of medical treatment decisions, the doctrine of informed consent safeguards this right of self determination.¹⁸ The doctrine establishes the sovereignty of the patient in decisionmaking. A patient should receive all pertinent information concerning the risks and alternatives involved in the treatment.¹⁹ The doctor's consultation also must disclose the consequences of foregoing all care.²⁰ The patient's right to control bodily integrity pursuant to implied consent includes the right to make an informed refusal. Although an incompetent patient cannot evaluate treatment alternatives, the individual's surrogate decisionmaker must receive the same consultation as a competent patient would be afforded under such circumstances. In sum, an incompetent possesses the same right to informed consent as a competent patient, since any medical treatment will intrude upon the individual's bodily integrity.²¹

14 See *infra* notes 22-33 and accompanying text.

15 See *infra* notes 34-40 and accompanying text.

16 141 U.S. 250 (1891).

17 No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his person, free from all restraint or interference of others, unless by clear and unquestionable authority of law. As well said by Judge Cooley, "The right to one's person may be said to be a right of complete immunity: to be let alone."

Id. at 251 (citation omitted).

See also *Schleordorff v. Society of New York Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). Justice Cardozo stated that "[e]very human being of adult years and sound mind has the 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."

Some state courts have found that this common law right in and of itself may protect an individual's right to refuse medical treatment. See *In re Conroy*, 98 N.J. 321, 348, 486 A.2d 1209, 1223 (1985); *In re Storar*, 52 N.Y.2d 363, 376-77, 420 N.E.2d 64, 70, 438 N.Y.S.2d 266, 272-73, *cert. denied*, 454 U.S. 858 (1981).

18 A physician who acts without the patient's informed consent may face liability for battery or negligence. W. PROSSER & W. KEETON, *THE LAW OF TORTS* § 18 (5th ed. 1984). See also Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228 (1973); Clark, *The Choice to Refuse or Withhold Medical Treatment: The Emerging Technology and Medical-Ethical Consensus*, 13 CREIGHTON L. REV. 795 (1980); Plant, *An Analysis of "Informed Consent"*, 36 FORDHAM L. REV. 639 (1968); Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632 (1974).

19 See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Natanson v. Kline*, 186 Kan. 393, 406-7, 350 P.2d 1093, 1104, *reh'g denied*, 187 Kan. 186, 354 P.2d 670 (1960); *Harnish v. Children's Hosp. Medical Care*, 387 Mass. 152, 154, 439 N.E.2d 240, 242 (1982); *Wilkinson v. Versey*, 110 R.I. 606, 619, 295 A.2d 676, 685 (1972).

20 See, e.g., *Rasmussen v. Fleming*, 154 Ariz. 207, 216, 741 P.2d 674, 683 (Ariz. 1987) (en banc) ("The purpose underlying the doctrine of informed consent is defeated somewhat if, after receiving all information necessary to make an informed decision, the patient is forced to choose only from alternative methods of treatment and precluded from foregoing all treatment whatsoever.")

21 See *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977).

B. Constitutional Right to Privacy

The United States Supreme Court has not addressed whether the constitutional right to privacy, which flows from either the fourteenth amendment's due process clause or other constitutional penumbras, encompasses a person's right to refuse life-sustaining medical treatment.²² State law, however, has recognized the constitutional rights of a patient in authorizing the removal of life support systems.²³ In addition, the recent decision in *Gray v. Romeo*²⁴ involves the first federal case to find that the fourteenth amendment right to privacy is broad enough to include a person's right to refuse medical treatment, even if death results.

In *Gray*, the United States District Court of Rhode Island relied upon United States Supreme Court decisions that have repeatedly affirmed the principle of bodily self determination.²⁵ The court, for example, cited

The 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 To protect the incompetent person within its power, the State must recognize the dignity and worth of such a person and afford to that person the same panoply of rights and choices it recognizes in competent persons.

Id. at 745-46, 370 N.E.2d at 427-28.

See also Note, *Equality for the Elderly Incompetent: A Proposal for Dignified Death*, 39 STAN. L. REV. 689, 704-05 (1987).

22 The United States Supreme Court has twice refused to address the right to die question. *In re Storar*, 52 N.Y.2d 363, 422 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976). The Burger Court's decision not to resolve this issue may have resulted from the former Chief Justice's strong belief that such an issue involved a private matter, not cognizable by the courts. D. MEYERS, *supra* note 4, at 339 (citing Application of President and Directors of Georgetown College, Inc., 331 F.2d 1010, 1017 (D.C. Cir. 1964) (Burger, J., dissenting)).

23 *In re Quinlan*, 70 N.J. 10, 38-42, 355 A.2d 647, 662-64, cert. denied, 429 U.S. 922 (1976), involves the initial state court holding including the refusal of life-prolonging care under certain circumstances protected by the right of privacy. The Massachusetts Supreme Court, in Superintendent of Belcherton State School v. Saikewicz, 373 Mass. 728, 739-40, 370 N.E.2d 417, 424 (1977), shortly thereafter followed the *Quinlan* privacy analysis. See also Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987) (en banc); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 482 A.2d 713 (1984); *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334 (Del. 1980); *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 497 N.E.2d 626 (1986); *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980); *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (N.J. 1987); *In re Grant*, 109 Wash. 2d 545, 747 P.2d 445 (1987) (en banc); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983) (en banc). But see *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981). The New York Court of Appeals stated uncertainty existed over whether or not the constitutional right to privacy included the right to refuse life-sustaining care. The *Storar* court based its holding upon the patient's common law protections of bodily integrity. *Id.* at 376-77, 420 N.E.2d at 70, 438 N.Y.S.2d at 272-73. *Contra In re Beth Israel Medical Center*, 519 N.Y.S.2d 511, 513 (N.Y. App. Div. 1987) (Incompetent patients do not lose their constitutional right to privacy merely because of incompetency. Under certain circumstances a right to refuse life-prolonging or life-sustaining procedures may be exercised in their behalf as an aspect of such right to privacy.).

24 697 F. Supp. 580 (D. R.I. 1988). The United States District Court of Rhode Island ordered Rhode Island General Hospital to remove a feeding tube from Marcia Gray, comatose since January 1986, or transfer her to an institution that would carry out her family's wish that she be allowed to die.

25 *Thornburgh v. American College of Obstetricians*, 476 U.S. 747 (1986); *Akron Center for Reproductive Health, Inc. v. City of Akron*, 462 U.S. 416 (1983); *Roe v. Wade*, 410 U.S. 113 (1973) (abortion); *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (contraceptives); *Winston v. Lee*, 470 U.S. 753 (1985); *Union Pacific Co. v. Botsford*, 141 U.S. 250 (1891) (surgery choices).

*Roe v. Wade*²⁶ to affirm the principle "that a person has the right . . . to control fundamental decisions involving his or her own body."²⁷ *Gray* acknowledged the Supreme Court's caution in *Bowers v. Hardwick*²⁸ against an expansive interpretation of privacy rights.²⁹ The court recognized that the right to privacy should encompass personal decisions "implicit in our concept of ordered liberty"³⁰ or "those that are deeply rooted in this nation's history and tradition."³¹ As a result of our nation's respect for the right to be free from nonconsensual bodily invasions,³² *Gray* found an individual's right to refuse life-sustaining treatment to be consistent with the liberties protected by the fourteenth amendment's due process clause.³³

C. *Countervailing State Interests*

In making any decision to terminate treatment, a patient's constitutional right to privacy and common law guarantee against nonconsensual bodily invasion must be balanced against the state's interests.³⁴ Through the *parens patriae*³⁵ power, states have articulated four interests in favor of life-prolonging treatment: (1) the preservation of life;³⁶ (2) the ethical integrity of the medical profession;³⁷ (3) the prevention of suicide;³⁸ and

26 410 U.S. 113 (1973).

27 697 F. Supp. at 585 (citing *Roe v. Wade*, 410 U.S. 113 (1973)). See also P. RIGA, *RIGHT TO DIE OR LIVE?* 121 (1981). The author asserts that ending the fetus' life through an abortion is more difficult to justify than permitting the refusal of treatment.

28 478 U.S. 186, *reh'g denied*, 478 U.S. 1039 (1986).

29 The Court held that the right to privacy did not encompass consensual homosexual activity, stating that sodomy bore no resemblance to family, marriage or procreation rights. *Id.* at 190-91.

30 697 F. Supp. at 584 (quoting *Palko v. Connecticut*, 302 U.S. 319, 325 (1937)).

31 *Id.* (quoting *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977)).

32 See *supra* note 25.

33 697 F. Supp. at 586 (citing U.S. CONST. amend. XIV).

34 This balancing process has its historical roots in the "per legem terrae" clause of Magna Carta which states "[N]o freeman shall be seized, or imprisoned or disposed or outlawed or in any way destroyed, nor will we condemn him, nor will we commit him to prison, except by the legal judgment of his peers or by the laws of the land." Magna Carta, Art. XXXIX.

35 The President's Commission describes *parens patriae* in the context of an incompetent's right to die as including the following:

Civil courts . . . exercise the powers of *parens patriae* to protect individuals who cannot adequately defend their own interests. In this role, courts are the final authority as to who needs such protection, who should provide it (such as a guardian appointed for an incompetent patient), and what standards should be applied.

PRESIDENT'S COMMISSION, *supra* note 1, at 39. See also *In re Conroy*, 98 N.J. 321, 364-65, 486 A.2d 1209, 1231-32 (1985).

36 The State's interest in the preservation of life derives from "the broadest and most elemental state power, the police power." *Barsky v. Board of Regents*, 347 U.S. 442 (1954). This power is a "broad power, never precisely delimited, to take rational action for the protection of the public safety, health, morals, comfort and good order." *McMurdo v. Getter*, 298 Mass. 363, 10 N.E.2d 139 (1937). See also *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987) (en banc).

The State's interest in preserving life is most compelling when treatment offers a cure or another opportunity for normal, healthy, functionary life. See, e.g., *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 742, 370 N.E.2d 417, 425-26 (1977); *In re Dinnerstein*, 6 Mass. App. 466, 472-73, 380 N.E.2d 134, 137-38 (1978). In *Commissioner of Corrections v. Myers*, 379 Mass. 255, 259, 399 N.E.2d 452, 454 (1979), the Supreme Judicial Court of Massachusetts, however, held that the State's interest in preserving life did not outweigh the right to refuse treatment, although the dialysis treatment would have allowed the patient to lead a normal life.

37 In defining the integrity of the medical profession, a subtle distinction may be drawn between instances in which withholding life-sustaining measures allows the disease to take its natural course

(4) the protection of innocent third parties.³⁹ Courts, however, have seldom found the state interests sufficiently compelling to outweigh the patient's right to forego treatment.⁴⁰

II. What Treatment May Be Refused

A. *Interpretative Difficulties of the Ordinary/Extraordinary Distinction*

Courts initially characterized life-prolonging measures as either ordinary or extraordinary care.⁴¹ The distinction rested upon "the idea that ordinary care is simple and that extraordinary care is complex, elaborate, or artificial, or that it employs elaborate technology and/or great efforts or expense."⁴² If the treatment involved ordinary care, courts were re-

and those in which the actions themselves constitute the cause of death. *In re Dinnerstein*, 6 Mass. App. 466, 471-72 n.7, 380 N.E.2d 134, 137 n.7 (1978).

The institutional interest of the medical profession in a treatment case is inferior to the individual's right to privacy, and will rarely control by itself. *Saikewicz*, 373 Mass. at 737-40, 370 N.E.2d at 423-24. Nevertheless, that interest is entitled to some weight in considering such a case, since hospitals have a right to provide and offer optimal care to people under their control. *See also Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987) (en banc).

The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his family or legal representative if the patient is incompetent to act in his own behalf should prevail. In the absence of the patient's choice or an authorized proxy, the physician must act in the best interest of the patient *Even if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life prolonging medical treatment.*

Id. at 217, 741 P.2d at 684 (quoting Statement of American Medical Association Counsel of Ethical and Judicial Affairs, March 15, 1986) (emphasis in original).

38 The life of every human being is under the protection of the law, and cannot be lawfully taken by himself, or by another with his consent, except by legal authority. *Commonwealth v. Mink*, 123 Mass. 422, 425 (1877). Any patient refusing life-prolonging care can be attributed an "intent" to die. A patient making an informed choice to refuse life-sustaining treatment must realize that a hastening of death will result. In *Saikewicz*, the Supreme Judicial Court of Massachusetts distinguished the refusal of medical care from suicide, stating:

(1) [I]n refusing treatment the patient may not have the specific intent to die, and (2) even if he did, to the extent that the cause of the death was from natural causes the patient did not set the death producing agent in motion with the intent of causing his own death.

373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11.

Courts generally have agreed that refusing medical treatment does not constitute suicide. *See, e.g., Tune v. Walter Reed Army Medical Hosp.*, 602 F. Supp. 1452, 1455 n.8. (D. D.C. 1985); *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 137, 482 A.2d 713, 720 (1984); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11; *In re Conroy*, 98 N.J. 321, 351, 468 A.2d 1209, 1224 (1985). *But see Buchanan, The Limits of Proxy Decision Making for Incompetents*, 29 UCLA L. REV. 386, 405-06 (1981) (suggesting that courts' analysis in the suicide prevention interest has been incomplete and precarious).

39 *See Note, supra* note 10, at 651-52 ("The states' *parens patriae* interest diminishes in proportion to the decreasing dependency of the children.").

40 *See Rubin, Refusal of Life-Sustaining Treatment for Terminally Ill Incompetent Patients: Court Orders and an Alternative*, 19 COLUM. J.L. & SOC. PROBS. 19, 20-21 n.6 (1985) (stating that courts have rarely found the state interests to outweigh the dying patient's rights).

41 *In re Quinlan*, 70 N.J. 10, 48-49, 355 A.2d 647, 667-68, *cert. denied*, 429 U.S. 922 (1976); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 738; 370 N.E.2d 417, 424 (1977).

For a discussion of the distinction's significance in moral theology, see PRESIDENT'S COMMISSION, *supra* note 1, at 82 n.114.

42 PRESIDENT'S COMMISSION, *supra* note 1, at 84.

luctant to permit its termination.⁴³ Significant interpretive difficulties arose in classifying treatment, especially in cases involving intravenous feeding.⁴⁴ The President's Commission for the Study of Ethical Problems in Medicine and Biomedical Research advocated an analysis focusing upon the proportionate benefits and burdens of treatment as they pertain to a particular patient.⁴⁵

B. Barber v. Superior Court's Proportionate/Disproportionate Test

In *Barber v. Superior Court*,⁴⁶ the California Court of Appeals significantly modified the extraordinary/ordinary distinction of life support treatment alternatives, noting that the use of the distinction "begs the question."⁴⁷ Instead, the court focused upon the point at which medical technology ceased to perform its intended function.⁴⁸ Proceeding from the premise that a physician has no duty to continue ineffective treatment,⁴⁹ the *Barber* test determines "whether the proposed treatment is proportionate or disproportionate in terms of the benefits to be gained versus the burdens caused."⁵⁰

The *Barber* court rejected the idea that long-term use of artificial feeding is substantially different from long-term use of extraordinary devices, such as a respirator.⁵¹ Any attempt to distinguish long-term nutritional support resulted from what the court called the so-called "emotional symbolism" of food and water.⁵² *Barber* stressed that medical nutrition and hydration are closer to other medical procedures than to typical human ways of providing nutrition and hydration.⁵³ Therefore, their benefits and burdens ought to be evaluated in the same manner as

43 See *In re Storar*, 52 N.Y. 2d 363, 381, 420 N.E.2d 64, 73, 438 N.Y.S. 2d 266, 275 (blood transfusions, like food, must be supplied to a terminally ill patient), *cert. denied*, 454 U.S. 858 (1981); *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988); *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1, 13, 426 N.E.2d 809, 816 (1980) (holding that a terminally ill woman only had right to remove an intensive respirator).

44 PRESIDENT'S COMMISSION, *supra* note 1, at 83-84 (The treatment may be routine to the attending physician, but extraordinary to the patient, the lawyer, or presiding judge.).

45 *Id.* at 89.

46 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

47 *Id.* at 1018, 195 Cal. Rptr. at 491.

48 *Id.*

49 *Id.* at 1017-18, 195 Cal. Rptr. at 491. ("Although there may be a duty to provide life sustaining machinery in the immediate aftermath of a cardio-respiratory arrest, there is no duty to continue its use once it has become futile in the opinion of qualified medical personnel.").

50 *Id.* at 1018-19, 195 Cal. Rptr. at 491. The court stated:

Under this approach, proportionate treatment is that which, in view of the patient, has at least a reasonable chance of providing benefits to the patient, which benefits outweigh the burdens attendant to the treatment. Thus, even if a proposed course of treatment might be extremely painful or intensive, it would still be proportionate treatment if the prognosis was for a complete cure or a significant improvement in the patient's condition. On the other hand, a treatment course which is only minimally painful or intrusive may nonetheless be considered disproportionate to the potential benefits if the prognosis is virtually hopeless for any significant improvement in condition.

Id. at 1019, 195 Cal. Rptr. at 491.

51 *Id.* at 1016, 195 Cal. Rptr. at 490.

52 *Id.*

53 *Id.* at 1016-17, 195 Cal. Rptr. at 490.

any other medical procedure.⁵⁴ Courts have widely accepted the *Barber* analysis of the right to withhold artificial nutrition and hydration.⁵⁵

C. Brophy v. New England Sinai

In *Brophy v. New England Sinai*,⁵⁶ the Supreme Judicial Court of Massachusetts ruled that a gastrostomy tube could be removed from a patient who was not terminally ill.⁵⁷ The court noted that the extraordinary/ordinary distinction may constitute a factor in the consideration,⁵⁸ however, its use as the sole or major factor tends to create a meaningless distinction.⁵⁹ Finding the treatment intrusive and extraordinary, the court held that the individual's right to privacy outweighed the four state interests.⁶⁰ *Brophy* seems to indicate that an individual's right to privacy includes the ability to refuse any bodily intrusion, irrespective of imminent death.

III. Overview of the Decisionmaking Standards for Incompetent Patients

When the incompetent patient has failed to provide a prior expression of a treatment preference, it is necessary to devise a satisfactory decisional standard to guide the surrogate. The optimal standard would be one which focuses on the particular patient and remains free of the surrogate's biases. In practice, this has not been the case. Courts have used either the substituted judgment doctrine or best interests standard to evaluate the propriety of withholding care from the incompetent patient.

A. Substituted Judgment Doctrine

The substituted judgment doctrine, the majority decisional standard,⁶¹ requires the surrogate to make the same treatment choice that the incompetent would make if he or she were competent to do so.⁶² The typical substituted judgment case involves a situation in which a pre-

54 *Id.* at 1017, 195 Cal. Rptr. at 491.

55 Following *Barber*, courts have viewed artificial feeding as a form of life support. *See, e.g.*, *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1141, 225 Cal. Rptr. 297 (1986); *In re Severns*, 425 A.2d 156, 160 (Del. Ch. 1980); *Corbett v. D'Alessandro*, 487 So. 2d 368, 371-72 (Fla. Dist. Ct. App. 1986); *In re Heir*, 18 Mass. App. 200, 207-08, 464 N.E.2d 959, 964 (1984); *In re Conroy*, 98 N.J. 321, 374, 486 A.2d 1209, 1236-37 (1985); *Delio v. Westchester City Medical Center*, 516 N.Y.S.2d 677, 689 (N.Y. App. Div. 1987); *In re Grant*, 109 Wash. 2d 545, 747 P.2d 445, 454 (1987) (en banc).

56 398 Mass. 417, 497 N.E.2d 626 (1986).

57 *Id.* at 425, 497 N.E.2d at 630. It appeared that Brophy, despite being in a persistent vegetative state and suffering from brain damage, may have continued to live for several years.

58 *Id.* at 438, 497 N.E.2d at 637.

59 *Id.*

60 *Id.* at 439, 497 N.E.2d at 638. *But see id.* at 442, 497 N.E.2d at 640 (Nolan, J., dissenting) (arguing that withholding artificial nutrition and hydration constitutes death by starvation).

61 *See* Rubin, *supra* note 40, at 23.

62 PRESIDENT'S COMMISSION, *supra* note 1, at 132. The substituted judgment test originated in a nineteenth century English case, *Ex parte Whitbread in re Hinde*, a Lunatic, 35 Eng. Rep. 878 (1816), involving a petition to draw from an insane person's surplus estate and apply the funds to support his relatives. Lord Chancellor Eldon held the court must apply the property in such manner "as the Court thinks it would have been wise and prudent in the Lunatic himself to apply it, in case he had been capable." *Id.* at 879. The United States Supreme Court applied the substituted judgment standard in *City Bank Co. v. McGowan*, 323 U.S. 594 (1945):

viously competent patient may have provided some statements concerning medical care prior to becoming incompetent, but offered no explicit advance declaration against sustaining treatment.

1. *In re Quinlan*

In the *Quinlan* case,⁶³ the New Jersey Supreme Court lacked reliable evidence of Karen Quinlan's prior preferences,⁶⁴ but still granted her father's guardianship petition, which sought the right to discontinue the use of her respirator.⁶⁵ In purporting to implement the substituted judgment test,⁶⁶ the decision granted her father's petition on two grounds: (1) his close familial relationship with Karen allowed him to accurately determine what she would have chosen;⁶⁷ (2) most reasonable persons in her condition would not desire continued treatment.⁶⁸ A reasonable person standard, however, is fundamentally inconsistent with the substituted judgment doctrine.⁶⁹ Furthermore, the court failed to offer empirical evidence to indicate that most reasonable persons would have wished to have the respirator removed.⁷⁰

2. The Massachusetts Approach

The Supreme Judicial Court of Massachusetts, in *Superintendent of Belchertown State School v. Saikewicz*,⁷¹ was cognizant of *Quinlan*'s faulty substituted judgment analysis.⁷² Nevertheless, it proceeded to further mis-

We hold, therefore, that where, as in New York, the court is to substitute itself, as nearly as may be for the incompetent, and to act upon the same motives and considerations as would have moved her, the transfer is, in legal effect, her act and the motive is hers.

Id. at 599.

For an overview of the doctrine and its history, see Robertson, *Organ Donations by Incompetents and the Substituted Judgment Doctrine*, 76 COLUM. L. REV. 48 (1976); Weber, *Substituted Judgment Doctrine: A Critical Analysis*, 1 ISSUES IN LAW IN MEDICINE 131 (1985).

63 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

64 The New Jersey Supreme Court refused to admit evidence of Karen Quinlan's statements when competent expressing her distaste for continuance of life by extraordinary medical procedures. The court dismissed these remarks as "remote and impersonal, lack[ing] significant probative weight" *Id.* at 21, 355 A.2d at 653.

65 *Id.* at 53, 355 A.2d at 671. The trial court ruled that Mr. Quinlan's love for his daughter would distort his decisionmaking. The New Jersey Supreme Court disagreed and found his character to qualify him to act as guardian.

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

67 *Id.* at 53, 355 A.2d at 671.

68 *Id.* at 41-42, 355 A.2d at 664.

69 See *In re Conroy*, 98 N.J. 321, 360-61, 486 A.2d 1209, 1229 (1985) ("The question is not what a reasonable or average person would have chosen to do under the circumstances but what the particular patient would have done if able to choose for himself."); Weber, *supra* note 62, at 143 n.66 (The *Quinlan* majority-sentiment approach relies upon a statistical basis which does not justify a conclusion about an individual.).

70 See Buchanan, *supra* note 38, at 393.

71 373 Mass. 728, 370 N.E.2d 417 (1977).

72 *Id.* at 749-50, 370 N.E.2d at 429-30.

The *Saikewicz* court first attempted to explain *Quinlan*'s apparent abandonment of the substituted judgment standard and then proceeded to indulge in equally questionable reasoning when attempting to apply the standard to a more difficult set of facts. According to *Saikewicz*, the *Quinlan* court lacking adequate *direct* evidence, properly considered the preferences of most reasonable people as *indirect* evidence of what Karen Quinlan would have wanted. Thus, the *Saikewicz* court also failed to recognize that the genuine exercise of the right of self-determination must allow the possibility of choices which diverge from what most reasonable persons would prefer.

apply the standard to an incompetent patient who had never been competent. Joseph Saikewicz, a sixty-seven year old with an estimated I.Q. of ten and mental age below three years, suffered from terminal leukemia.⁷³ Saikewicz's guardian ad litem reported that the patient's condition was incurable and that chemotherapy would result in pain and adverse side effects.⁷⁴ In affirming the guardian's recommendation to terminate care, the court employed the substituted judgment standard,⁷⁵ even though there was no evidence of Saikewicz's preferences.⁷⁶ As a result, the *Saikewicz* court undertook a speculative analysis; it attempted to ascertain what an incompetent would prefer, "if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person."⁷⁷ The court attributed to an incompetent patient a brief moment of competence in which to analyze his medical well-being and evaluate future treatment alternatives.⁷⁸ It determined that Saikewicz's age lessened the chance of remission following chemotherapy and enhanced adverse side effects.⁷⁹ Therefore, he would have decided against the chemotherapy. The court maintained that it based its decision "on a regard for his actual interests and preferences and that the facts supported this decision."⁸⁰

Despite the questionable *Saikewicz* analysis, the Supreme Judicial Court of Massachusetts adhered to the substituted judgment doctrine in *In re Spring*.⁸¹ Earle N. Spring, seventy-three, suffered from senility and end stage kidney disease, requiring hemodialysis treatment (filtering of the blood) three days a week, five hours a day.⁸² Although both conditions were incurable, Mr. Spring's condition was not terminal.⁸³ While competent, Mr. Spring indicated no preference to have life-sustaining treatment removed or discontinued under such circumstances.⁸⁴ His wife and son, however, believed that if competent he would have wished the treatment discontinued.⁸⁵ The court noted that "[a]n expression of

Buchanan, *supra* note 38, at 393-94 (emphasis in original).

73 373 Mass. at 731, 370 N.E.2d at 420.

74 *Id.* at 729-30, 370 N.E.2d at 419.

75 *Id.* at 750-51, 370 N.W.2d at 430-31. *But see* Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 26 ARIZ. L. REV. 374, 377 n.17 (claiming that the court did not perform a substituted judgment analysis, but instead performed a patient-centered best interests analysis). For a discussion of the best interests standard, see *infra* notes 94-153 and accompanying text.

76 373 Mass. at 751, 370 N.E.2d at 430.

77 *Id.* at 752-53, 370 N.E.2d at 431.

78 *See* Weber, *supra* note 62, at 144 ("The image is that of an incompetent who becomes suddenly competent, but will shortly return to incompetency, and is aware of this.").

79 373 Mass. at 732-33, 370 N.E.2d at 420-21.

80 *Id.* at 754-55, 370 N.E.2d at 432.

81 380 Mass. 629, 405 N.E.2d 115 (1980).

82 *Id.* at 632, 405 N.E.2d at 118.

83 *Id.* The court noted that survival for five years would not be probable, but conceivable.

84 *Id.* at 632-33, 405 N.E.2d at 118. The court, however, noted that when Mr. Spring was competent, he acquiesced to the dialysis treatments. *Id.* at 636, 405 N.E.2d at 120. Additionally, the media reported that Spring had communicated to his nurses a desire to live. Dresser, *supra* note 75, at 377.

85 380 Mass. at 640, 405 N.E.2d at 122.

intent by the ward while competent was not essential."⁸⁶ Rather, the judge relied on the familiarity that Mrs. Spring and her son had with the patient, concluding they were looking out for his best interests and not motivated by financial considerations.⁸⁷ Such an analysis seems far removed from the substituted judgment doctrine, which requires a clear and convincing expression of the patient's wishes.⁸⁸

3. The Failure of the Substituted Judgment Doctrine

The substituted judgment doctrine supposedly preserves the incompetent's right to self determination through the surrogate's decision, given the reality that the patient cannot make a valid contemporaneous choice.⁸⁹ The substituted judgment doctrine often fails because a patient's incompetence negates his or her right to bodily self determination.⁹⁰

The substituted judgment doctrine is inappropriate under the following scenarios: (1) a patient who has been incompetent throughout his or her life and never possessed the ability to assert any matters relating to self determination;⁹¹ or (2) a patient who was previously competent, but never provided clear and convincing evidence about life-sustaining treatment preferences.⁹² Both scenarios allow the surrogate to infuse his or her personal biases into the decisionmaking process and lose sight of the patient's well-being.⁹³ In cases involving formerly competent patients,

⁸⁶ *Id.*

⁸⁷ *Id.* "[T]he wife and son had only the best interests of the ward at heart . . . [T]hey were best informed as to his likely attitude. There was no evidence that financial considerations were involved."). *But see* Buchanan, *supra* note 38, at 395 (citing amicus curiae brief for the American Society of Law & Medicine at 15) (The relevant evidence suggested only that Mr. Spring would be unable to live the active, vigorous life he previously enjoyed. In their brief, Professors George Annas and Leonard Glantz argued that a decline in activity as one ages does not indicate that a person wishes to die.).

⁸⁸ *See* Dresser, *supra* note 75, at 378.

⁸⁹ PRESIDENT'S COMMISSION, *supra* note 1, at 133.

⁹⁰ *See* Buchanan, *supra* note 38, at 1081; Weber, *supra* note 62, at 140-41.

⁹¹ *See* Mooney, *supra* note 10, at 1082 (It is illogical to talk of self determination for patients who, due to minority or disability, have never been competent.).

⁹² The President's Commission Report warns that the substituted judgment standard should apply "only if the patient was once capable of developing views relevant to the matter at hand; further there must be reliable evidence of these views." *See* PRESIDENT'S COMMISSION, *supra* note 1, at 133.

In re Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981), illustrates the application of the substituted judgment standard when such clear and compelling evidence exists. Brother Fox, an eighty-four-year-old member of a Catholic religious order, underwent a hernia operation which prompted a cardiac arrest and severe brain damage. As a result, he remained in a vegetative state and required a respirator for life support. *Id.* at 370-71, 420 N.E.2d at 67, 438 N.Y.S. 2d at 269. Father Eichner, the guardian requesting removal of the respirator, conveyed Brother Fox's prior statements about the moral implications of the *Quinlan* case and extraordinary care. At that time, Brother Fox expressed that he would not want any extraordinary care. *Id.* at 371-72, 420 N.E.2d at 68, 438 N.Y.S.2d at 270. Shortly before his hospitalization, Brother Fox reiterated these feelings to Father Eichner. *Id.* at 372, 420 N.E.2d at 68, 438 N.Y.S.2d at 270. In permitting the removal of the respirator, the *Storar* court found Father Eicher's only motive involved respecting Brother Fox's wishes. *Id.* at 379-80, 420 N.E.2d at 72, 438 N.Y.S.2d at 274. *See* Weber, *supra* note 62, at 145 ("The *Eicher* case, with its uncontested testimony on precisely the question investigated by the court, presented an ideal of practical simplicity. Any deviation from the *Eicher* fact pattern, however, presents the court with difficulties.").

⁹³ *See In re Conroy*, 98 N.J. 321, 364, 486 A.2d 1209, 1231 (1985) (citations omitted) ("[I]n the absence of adequate proof of the patient's wishes, it would be naive to pretend that the right to self-

the substituted judgment doctrine often relies upon attenuated or remote past statements, which are then improperly interpreted as what presently constitutes the incompetent's personal treatment preference. When the patient is a life-long incompetent, the decision may almost exclusively derive from the whim and caprice of the surrogate decisionmaker.

B. *Best Interests Standard*

In decisions involving life-long incompetents or previously competent patients that offered no advance treatment directive, courts have increasingly recognized the shortcomings of the substituted judgment doctrine and instead adopted a best interests analysis. This standard focuses upon which alternative will provide the optimal net benefits to the incompetent.⁹⁴ Application of the best interests test, however, has been far from uniform. Some courts have considered the best interests of a reasonable patient with a similar medical prognosis. Others examine the best interests of the particular incompetent.⁹⁵ In either case, courts have recognized that the surrogate decisionmaker's evaluation may include the right to refuse an incompetent patient's medical treatment.⁹⁶

1. The Objective Best Interests Approach

In 1983, a Report of the President's Commission on the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research advocated an objective best interests analysis for an incompetent lacking evidence of a prior treatment preference.⁹⁷ Under this approach, the surrogate evaluates the patient's best interests based upon objective so-

determination serves as the basis for substituted decision making."); Buchanan, *supra* note 38, at 407.

People seldom hold universal views concerning handicaps and illnesses. Additionally, life and death decisions often require instantaneous choice, further inducing an individual to rely on personal preference. See Annas, *Quality of Life in the Courts: Earle Spring in Fantasyland*, HASTINGS CENTER REP., Aug. 1980, at 9; Dresser, *supra* note 75, at 382 ("The current law's failure to examine and weigh openly these considerations exposes it to charges of according insufficient protection to defenseless incompetent patients, covertly assigning priority to economic and other third-party interests. . . ."); Note, *supra* note 21, at 714 (1987); Note, *Live or Let Die: Who Decides An Incompetent's Fate?* In re *Storar* and In re *Eichner*, 1982 B.Y.U. L. REV. 387, 393. But see In re *Boyd*, 403 A.2d 744, 751 (D.C. 1979) (The District of Columbia Court of Appeals realized that "any imputation of a preference to an incompetent person will, to some extent, be fictional." Nevertheless, the court accepted the substituted judgment standard.)

⁹⁴ See Dresser, *supra* note 75, at 383.

⁹⁵ See *id.*

⁹⁶ See, e.g., *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987) (en banc). The court stated that the refusal to include death in a best interests evaluation may ignore reality. *Id.* at 220-21 741 P.2d at 687-88. The court cited as support In re *Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984) and In re *Torres*, 357 N.W.2d 332 (Minn. 1984). Both of these cases held that a patient's best interests could include receiving no care. *Hamlin*, 102 Wash. 2d at 815, 689 P.2d at 1375; *Torres*, 357 N.W.2d at 337. For a discussion of *Rasmussen*, see *infra* notes 103-09 and accompanying text. See also Mooney, *supra* note 10, at 1083 (Even in its most objective form, the best interests standard does not require treatment if a reasonable patient would refuse it.)

⁹⁷ PRESIDENT'S COMMISSION, *supra* note 1, at 134. The Commission advocates the objective best interests analysis in cases involving (1) a patient that has not given thought to treatment preferences or failed to communicate any thoughts; (2) life-long incompetents, whose subjective intent, if any, cannot be ascertained with any certainty. *Id.*

cially shared criteria.⁹⁸ The Report stated that such an analysis derives not from the patient's right to self determination, but solely as an effort to protect the patient's welfare.⁹⁹ The surrogate should weigh factors such as relief from suffering, the preservation or restoration of functioning, and the quality and extent of life sustained.¹⁰⁰ These guidelines focus on the contemporaneous interests of the patient and potential for future satisfaction, but do not seek to reconstruct any prior preference.¹⁰¹ Additionally, the impact of any decision upon the incompetent patient's family may be included in the best interests analysis.¹⁰²

Rasmussen v. Fleming,¹⁰³ for example, rejected the substituted judgment standard in favor of such an objective best interests standard.¹⁰⁴ The Arizona Supreme Court upheld "Do Not Resuscitate" ("DNR") and "Do Not Hospitalize" ("DNH") orders for a sixty-four year old nursing home patient who remained persistently vegetative due to a degenerative neural muscular disease and an organic brain syndrome.¹⁰⁵ Ms. Rasmussen offered no expression of her medical preference prior to becoming incompetent.¹⁰⁶ Also, no family member attempted to exercise her medical decisions.¹⁰⁷ The court stated that a public fiduciary, appointed as a decisionmaker, must adhere to the objective best interests approach promulgated by the President's Commission Report.¹⁰⁸ Because Ms. Rasmussen would likely never have returned to a cognitive state, the objective best interests analysis would have concluded that any further medical treatment in the absence of the DNR and DNH orders would

98 *Id.* at 135.

99 *Id.*

100 The Commission also recognizes the varying definitions of the quality of life. It intends the analysis to determine the value that the continuation of life has for that patient, focusing upon actual and potential life expectancy. *Id.* at n.43.

101 *Id.* at 135 ("An accurate assessment will encompass consideration of the satisfaction of present desires, the opportunities for future satisfactions, and the possibility of developing or regaining the capacity for self-determination.").

102 To avoid abuse . . . especially stringent standards of evidence should be required to support a claim that the average, reasonable person in the patient's position would disregard personal interests (for example, in prolonging life or avoiding suffering) in order to avoid creating emotional or financial burdens for their family or other people to whom they were close."

Id. at 136.

103 154 Ariz. 207, 741 P.2d 674 (1987) (en banc).

104 *Id.* at 222, 741 P.2d at 689 ("Where no reliable evidence of patient's intent exists, as here, the substituted judgment standard provides little, if any, guidance to the surrogate decision maker and should be abandoned in favor of 'the best interests' standard.").

105 *Id.* at 212, 741 P.2d at 679. Dr. Stephen Cox testified that Ms. Rasmussen existed in a chronic vegetative state with no possibility of returning to higher functioning. *Id.* at 212-13, 741 P.2d at 679-80. Dr. William Masland, a court appointed neurologist, diagnosed her as being in a profound vegetative state from which she would never recover. *Id.* at 213, 741 P.2d at 680. Ms. Rasmussen died before the case was resolved; however, the Arizona Supreme Court proceeded to review the case, due to the public importance of the issue. *Id.*

106 *Id.* at 213, 741 P.2d at 680.

107 *Id.* at 220, 741 P.2d at 687. Due to the lack of family members, the court limited its determination only to whether the public fiduciary as guardian could vicariously exercise Ms. Rasmussen's right to refuse medical treatment.

108 *Id.* at 222, 741 P.2d at 689. For a discussion of the President's Commission Report's criteria, see *supra* notes 97-102 and accompanying text.

have offered minimal, if any, benefits and would have postponed Ms. Rasmussen's death.¹⁰⁹

Such an objective approach, like the substituted judgment doctrine, inherently contains the possibility that the decisionmaker may rely on personal values rather than the patient's best interests. In applying a reasonable person best interests analysis, courts have failed to clearly articulate what values should influence the treatment decision.¹¹⁰ *Rasmussen*, for example, advocates the President's Commission Report's view that the objective test should consider both the satisfaction of present desires and any opportunities to regain or attain a right to self determination.¹¹¹ The court, however, failed to offer any precise guidelines.

2. *In re Conroy*

Recognizing the conflicting interpretations of the substituted judgment and best interests standards, the New Jersey Supreme Court in *In re Conroy*¹¹² attempted to outline the factual scenarios under which these standards should apply. Claire Conroy, an eighty-four-year-old nursing home patient, suffered from numerous mental and physical impairments, but still remained somewhat conscious of her surroundings.¹¹³ Conroy's nephew, as guardian, sought to have her nasogastric feeding tubes removed.¹¹⁴ The trial court permitted removal of the tubes, viewing Conroy's condition as burdensome to her.¹¹⁵ The appellate court reversed on two alternative grounds.¹¹⁶ First, the court limited a guardian's right to refuse treatment only to "patients who are brain dead, irreversibly comatose, or vegetative, and who would gain no medical benefit from continued treatment."¹¹⁷ Second, the court refused to allow the withdrawal

109 *Id.*

110 Those who argue in favor of incorporating reasonable person values in treatment decisions must first define these values. For instance, they might be values held by the incompetent patient's family or guardian, clinicians who routinely care for such patients, general or specific patient populations, institutional ethics committees, or customary interpreters of the law's reasonable person standard, the judge and jury. Dignity and personal privacy might have highly disparate meanings for members of these groups.

See Dresser, *supra* note 75, at 387.

111 154 Ariz. at 222, 741 P.2d at 689.

112 98 N.J. 321, 486 A.2d 1209 (1985). For an analysis of *Conroy*, see Note, *In re Quinlan: One Step Further*, 24 Hous. L. Rev. 383 (1987).

113 At the commencement of trial, Ms. Conroy remained in a semi-fetal position. Her ailments included arteriosclerotic heart disease, hypertension, diabetes mellitus, bed sores, an eye problem requiring irrigation, inability to control her bowels, inability to speak, and limited swallowing ability. Nevertheless, she had some capacity to interact in her environment, through small movements, moans, and facial expressions. *Id.* at 337, 486 A.2d at 1217. Conroy's doctors diagnosed her life expectancy as a few months and lacked treatment which could offer her a cure or remission. *Id.* at 338-39, 486 A.2d at 1217-18.

114 *Id.* at 335, 486 A.2d at 1216.

115 *Id.* at 340-41, 486 A.2d at 1218-19.

116 While the appeal was pending, Ms. Conroy died with her nasogastric tube intact. The Appellate Division found the issue of sufficient public importance to merit its consideration. *Id.* at 341, 486 A.2d at 1219. Several other cases have applied the "public interest" rationale to consider the removal of life support systems where the person has died. See, e.g., *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987) (en banc); *Barling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984); *Corbett v. D'Alessandro*, 487 So. 2d 368 (Fla. Dist. Ct. App. 1986); *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

117 98 N.J. at 341, 486 A.2d at 1219.

of a nourishment device.¹¹⁸ Upon review, the New Jersey Supreme Court offered three alternative tests to guide a guardian's decision to refuse care for the patient.

The *Conroy* court first recognized the need to respect a patient's prior expressed preference not to undergo such treatment.¹¹⁹ It listed sufficient evidence of such an intent to include a living will, an oral directive given to a close relative, a durable power of attorney, any reactions the patient may have expressed to medical treatment, the patient's religious beliefs, or the patient's pattern of behavior prior to medical care.¹²⁰ The relevance of such evidence, however, varied with remoteness, consistency, thoughtfulness, or maturity.¹²¹ If the evidence meets these threshold requirements, the applicable standard is the substituted judgment test.¹²²

The New Jersey Supreme Court also realized that many patients fail to offer advance declarations. Therefore, in such instances, the second and third tests promulgated by the court involved variations of the best interests standard: a limited objective and a pure objective test.¹²³ In instances where some facts indicate that the incompetent patient would reject treatment, but the evidence is not sufficiently compelling to provoke reliance, the limited objective standard applies.¹²⁴ In order for care to be withheld or withdrawn, the surrogate must prove that the net burden to the patient of continued life "markedly outweighs" any "physical pleasure, emotional enjoyment or intellectual satisfaction" that continued life offers a patient.¹²⁵ Where the patient has provided no evidence at all of a treatment preference, the pure objective standard applies.¹²⁶ Under such circumstances, the court imposed the following requirements: (1) the burdens that the treatment inflicts upon the patient must "clearly and markedly" outweigh the benefits to prolonging life; and (2) severe, recurring, unavoidable pain would make the patient's life inhumane.¹²⁷ In either of the two best interests tests, the *Conroy* court explicitly denied the surrogate's right to refuse care based upon a "quality of

118 *Id.*

119 The standard we are enunciating is a subjective one, consistent with the notion that the right that we are seeking to effectuate is a very personal right to control one's own life. The question is not what a reasonable or average person would have chosen to do under the circumstances but what a particular patient would have done if able to choose for himself.

Id. at 360-61, 486 A.2d at 1229.

120 *Id.* at 361-62, 486 A.2d at 1229-30. The court stated that it previously erred in *Quinlan* when it disregarded evidence of statements made by Ms. Quinlan concerning life support treatment. *Id.* at 362, 486 A.2d at 1230. See *supra* note 64.

121 *Id.* at 362, 486 A.2d at 1230.

122 *Id.* at 360-61, 486 A.2d at 1229.

123 *Id.* at 364-65, 486 A.2d at 1231-32.

124 *Id.* at 366, 486 A.2d at 1232. The court noted that evidence which might be too vague or remote to satisfy the subjective substituted judgment test (i.e., informal reactions to others' medical conditions and treatment) may satisfy the limited-objective test. *Id.*

125 *Id.* at 365-66, 486 A.2d at 1232. The medical evidence should relate to life expectancy, duration and consistency of pain with or without treatment, and possibility of relieving the pain through measures short of terminating life support. *Id.*

126 *Id.* at 366, 486 A.2d at 1232.

127 *Id.*

life" determination.¹²⁸ Rather, the two tests must focus upon the patient in terms of pain, suffering, and possible enjoyment.¹²⁹

The *Conroy* court limited its three alternative standards to an individual who fit Claire Conroy's characteristics—an elderly incompetent nursing-home patient with severe mental and physical impairments and a life expectancy of less than a year.¹³⁰ Since Ms. Conroy met none of the requirements of the subjective or objective standards, the court refused to allow the termination of her care.¹³¹

In his partial dissent in *Conroy*, Justice Handler warned that the majority too narrowly confined its best interests alternatives by limiting the analysis to the physical pain which the patient was suffering.¹³² Given the increases in medical technology and pain relieving medication, he warned that in many cases these standards may promote future administration of life-sustaining care and prevent a natural death.¹³³ Justice Handler advocated an analysis which incorporates the particular needs and characteristics of the patient in question, including dependency on others, personal privacy, dignity, and the ideal of bodily integrity.¹³⁴ Justice Handler, like the majority, fails to articulate the content and relative importance of such values.¹³⁵

3. Focusing on the Particular Patient's Best Interests

Under facts similar to *Conroy*, *In re Beth Israel Medical Center*¹³⁶ recognized the utility of incorporating the incompetent's personal values or traits, if any, when applying the best interests standard.¹³⁷ Beth Israel

128 *Id.* at 367, 486 A.2d at 1232-33. ("We do not believe that it would be appropriate for a court to designate a person with the authority to determine that someone else's life is not worth living simply because, to that person, the patient's 'quality of life' or value to society seems negligible."). This limitation differs from the President's Commission's recommendation that the best interests standard include a "quality of life" assessment. See *supra* note 100.

129 *Id.*

130 *Id.* at 363, 486 A.2d at 1231.

131 *Id.* at 385-87, 486 A.2d at 1242-43. The evidence that Ms. Conroy would have refused treatment did not meet the clear showing of intent required under the subjective substituted judgment test. Additionally, there was insufficient information relating to the benefits and burdens of her life to meet either best interests standard.

132 98 N.J. 321, 394, 486 A.2d 1209, 1247 (Handler, J., concurring in part and dissenting in part). Justice Handler warns that pain eclipses many other human values "that have a proper place in the subtle weighing that will ultimately determine how life should end." *Id.* He notes that the President's Commission rejected pain as the sole criterion in a best interests analysis. *Id.* at 396-97, 486 A.2d at 1248-49.

133 *Id.* at 394, 486 A.2d at 1247.

134 *Id.* at 395-96, 486 A.2d at 1248. Justice Handler notes that the person should be terminally ill and face imminent death. Additionally, he states that at least one major organ of the patient should have failed. Justice Handler recognized that the level of pain must be incorporated into the surrogate's analysis. *Id.* at 398, 486 A.2d at 1249 (citations omitted). See also Cantor, *Best Interests, and the Handling of Dying Patients*, 37 RUTGERS L. REV. 543, 565 (1985) ("It is unclear whether the *Conroy* majority really intended to make physical pain a sine qua non in this context.") (emphasis in original).

135 See Dresser, *supra* note 75, at 387.

136 519 N.Y.S.2d 511 (N.Y. App. Div. 1987) (ex parte part).

137 Neither the courts nor the legislature of New York had ever directly addressed the issue of when, if ever, a life-prolonging treatment may be withheld when the incompetent has expressed no prior wishes. *Id.* at 515. The court noted that previously *In re Storar*, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64, cert. denied, 454 U.S. 858 (1981), had disallowed a mother's request to have transfusions withheld from her life-long retarded son. 519 N.Y.S.2d at 515. The *Beth Israel* court noted that this decision should not foreclose withholding of treatment where it would be humane to

Hospital sought authorization to perform an emergency amputation on Sally Weinstein, a seventy-four-year-old semi-conscious nursing home patient who was brought to Beth Israel following a stroke.¹³⁸ Ms. Weinstein was aphasic, which prevented her from communicating and understanding or decoding speech.¹³⁹ Ms. Weinstein's only prior expressions involved scant statements made to her sister that remaining in a wheelchair "was no way to live."¹⁴⁰ The New York Supreme Court held that the "focus must always be on attempting to ascertain what is or what would be the particular patient's choice in the matter, rather than on any broader societal or ethical interests which may be implicated."¹⁴¹ Additionally, the court adopted *Conroy's* criteria that burdens of sustaining life "markedly outweigh" the benefits.¹⁴² The court proceeded to list twelve factors which integrated aspects of the patient's physical status, her ethical beliefs and societal concerns.¹⁴³ The list was not intended to be dispositive of the proper focus of a best interests analysis.¹⁴⁴ The court applied these factors and concluded that continued care of Ms. Weinstein would be "simply cruel."¹⁴⁵

do so. The right to die did not belong simply to those who executed living wills or with friends or relatives to provide a clear statement of the patient's previous desires. *Id.*

138 *Id.* at 512. Following her admission, Ms. Weinstein suffered from an occlusion or clot of the left iliac artery and vein, which resulted in a gangrenous spreading through her left leg. If an amputation did not occur immediately, she would likely die in a few weeks. *Id.*

139 *Id.* The court noted that she had little cognitive function; if Ms. Weinstein felt pain, she didn't realize it. *Id.*

140 *Id.* at 513. Her sister vigorously opposed the amputation, fearing that the 'shock would kill her.' *Id.* All the doctors, including Ms. Weinstein's internist, agreed that a patient in her paralyzed and physically debilitated condition has only a poor chance to survive amputation surgery. *Id.*

141 *Id.* at 517. The court further required that a patient be suffering from severe and permanent mental and physical debilitation and have a limited life expectancy. *Id.* Although Ms. Weinstein was not comatose, the court found she did have the requisite degree of mental and physical debilitation. *Id.* at 518.

142 *Id.* at 516. In such a best interests analysis, a clear and convincing proof standard is more appropriate than a preponderance of the evidence standard. *Id.* at 516-17.

143 The court listed the following twelve factors:

1. the age of the patient
2. the life expectancy with or without the procedure contemplated
3. the degree of present and future pain or suffering with or without the procedure
4. the extent of the patient's physical and mental disability and degree of helplessness
5. statements, if any, made by the patient which directly or impliedly manifest his views on life prolonging measures,
6. the quality of the patient's life with or without the procedure, i.e., the extent, if any, of pleasure emotional enjoyment or intellectual satisfaction that the patient will obtain from prolonged life
7. the risks to life from the procedure contemplated as well as its adverse side effects and degree of invasiveness
8. religious or ethical beliefs of the patient
9. views of those close to him
10. views of the physician
11. the type of care which will be required if life is prolonged as contrasted with what will actually be available to him
12. whether there are any overriding state *parens patriae* interests in sustaining life (e.g. preventing suicide, integrity of the medical profession or protection of innocent third parties, such as children.).

Id. at 517.

144 *Id.*

145 *Id.* at 517-18.

Similarly, cases involving minors have applied a best interests analysis which stresses family values, rather than a totally objective test.¹⁴⁶ *In re L.M.R.*,¹⁴⁷ involving a persistently vegetative girl who suffered a "medical catastrophe" fifteen days after birth,¹⁴⁸ noted that the patient could not have formulated a treatment preference.¹⁴⁹ The court recognized that "[t]he right of the parent to speak for the minor child is so imbedded in our tradition and common law that it has been suggested that the constitution requires that the state respect the parent's decision in some areas."¹⁵⁰ The court began with the presumption that the parent has the child's best interests at heart,¹⁵¹ although it was not necessary for the parents to chose the single best interest.¹⁵² The court limited this holding only to those patients diagnosed with no hope of recovery and existing in a chronic vegetative state.¹⁵³

In sum, when a patient was never competent or failed to offer an advance treatment directive sufficient to meet the "clear and convincing" evidentiary requirement for a substituted judgment analysis, a best interests standard should not focus upon "reasonable person" values. Any best interests analysis applied to an incompetent should diligently focus upon the particular patient and devise guidelines outlining when and how subjective factors may be incorporated into the analysis.

IV. The Surrogate Decisionmakers for an Incompetent Without an Advanced Directive

A. Overview

Aside from the questions of the types of treatment which may be refused and the appropriate decisionmaking standard, right to die cases involving incompetents without an advance treatment directive have also fluctuated as to who makes the choice to initiate or continue life-sustaining care. The United States Supreme Court has recognized third party standing to assert the constitutional rights of others in instances when: (1) a substantial relationship exists between the claimant and third party; (2) the claimant is unable to assert constitutional rights; or (3) the

146 See Mooney, *supra* note 10, at 1085.

147 253 Ga. 439, 321 S.E.2d 716 (1984).

148 *Id.*, 321 S.E.2d at 718. Eighty-five to ninety percent of her brain tissue had been destroyed. The neurologist, her parents, and the guardian ad litem agreed life support should be removed. An ad hoc Infant Care Review Committee concurred. The DeKalb Superior Court enjoined the hospital and physicians from interfering with the wishes of the child's parents and guardians to have life support removed. Upon removal of the life support, the child died within thirty minutes. *Id.* An appeal was heard for outlining guidelines as to such treatment decisions. *Id.* at 439-40, 321 S.E.2d at 718.

149 *Id.* at 445, 321 S.E.2d at 722. See also Mooney, *supra* note 10, at 1086.

150 253 Ga. at 445, 321 S.E.2d at 722. The attending physician must diagnose no reasonable possibility of attaining cognitive function. Two physicians with no interest in the case must concur. Although prior judicial approval is not required, it is available in the event of disagreement and abuse. *Id.* at 446, 321 S.E.2d at 723.

151 *Id.* at 446, 321 S.E.2d at 723.

152 *Id.*

153 *Id.* The court found no legal difference between situations involving an infant and the incompetent adult who has made no living will. It extended its holding to such an incompetent adult patient.

third party protects against dilution of the claimant's constitutional rights.¹⁵⁴ In deciding the incompetent's fate, the decisionmaking process may involve three parties—the family, the doctors, and the courts.¹⁵⁵

As mentioned, the best interests standard which focuses upon the particular incompetent patient offers the optimal analysis in a refusal of life-sustaining treatment.¹⁵⁶ The decisionmaking process, therefore, should rely upon those surrogates most capable of making such an analysis: the family and physicians. Judicial review of cases involving the withholding of medical treatment has proven to be an expensive, time consuming and indeterminate process.¹⁵⁷ In fact, many of the patients often have died before the final adjudication of the case.¹⁵⁸ Courts have themselves recognized the problems created by their active role and have called upon the legislature to devise right to die procedures.¹⁵⁹

Family members allowed to participate in the refusal of life support should include only the immediate family or next of kin;¹⁶⁰ a concise limitation would eliminate the need for judicial guardianship procedures. The family, unlike the judiciary, has suffered throughout the entire ordeal.¹⁶¹ Judicial involvement may suppress familial evaluation of the patient's needs, as it tends to suggest that the family has no control over the loved one's destiny.¹⁶²

154 See *Eisenstadt v. Baird*, 405 U.S. 438, 443-46 (1972) (Baird, who had adequate incentive to assert the rights of unmarried persons denied access to contraceptives, had standing to do so.); *Griswold v. Connecticut*, 381 U.S. 479, 481 (1965) (A married couple's rights may be negated unless considered in a suit by someone with such a confidential relationship to them.); *NAACP v. Alabama*, 357 U.S. 449, 458-59 (1958) (The Association had standing because it and its members were practically identical.).

155 See Mooney, *supra* note 10, at 1087. See generally Note, *Decisionmaking for the Incompetent Terminally Ill Patient: A Compromise in a Solution Eliminates a Compromise of Patient's Rights*, 57 IND. L.J. 325 (1982).

156 See *supra* notes 136-53 and accompanying text.

157 For an evaluation of the positive and negative aspects of active judicial review, see PRESIDENT'S COMMISSION, *supra* note 1, at 159. The Report found beneficial aspects of such decisionmaking to include (1) the process is a public one; (2) judicial decisionmaking is principled; (3) the judicial process seeks impartiality; and (4) the adversarial process seeks to encourage proponents of opposing positions to participate. Negative features included (1) the process is lengthy and costly; (2) it can create unnecessary strife in the relationship between surrogate decisionmakers and others; and (3) it exposes ordinarily private matters to publicity.

158 See *supra* note 116.

159 See, e.g., *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674, 692 (1987) (en banc); *In re Conroy*, 98 N.J. 321, 343-46, 486 A.2d 1209, 1220-21 (1985); *In re Hamlin*, 102 Wash. 2d 810, 822, 689 P.2d 1372, 1379 (1984) (en banc).

160 See Comment, *Withholding Life-Sustaining Treatment from the Incompetent Patient: The Need for Statutory Guidelines*, 17 LOY. U. CHI. L.J. 427, 445 (1986).

The President's Commission states that "[o]rordinarily this will be the patient's next of kin, although it may be a close friend or another relative if the responsible health care professional judges that this other person is in fact the best advocate for the patient's interests." PRESIDENT'S COMMISSION, *supra* note 1, at 126-27.

See, e.g., N.C. GEN. STAT. § 90-322(b) (1985) (The statute designates the following family members to refuse life-sustaining care for the incompetent: (i) the person's spouse; (ii) the guardian of the person; or (iii) a majority of relatives in the first degree in that order. If none of the above is available, then the choice to withhold or discontinue extraordinary care is made at the discretion of the attending physician.).

161 See Mooney, *supra* note 10, at 1104. ("To the extent that anyone can perceive whether another person is experiencing growth and fulfillment, those who spend the most time with the patient are most able to sense whether the business of living is drawing to a close.")

162 *Id.* at 1107.

The treating physician, like the family, maintains a special relationship to the patient. The doctor possesses the professional expertise to determine the available alternatives and their potential consequences to the particular incompetent.¹⁶³ While the family and physician should have the prominent role when an incompetent has offered no preference, their responsibilities and the degree of judicial involvement should not be uniform in all instances. In order to truly protect the patient's best interests, the decisionmakers' guidelines must vary with the differing prognoses and interests presented by incompetents existing in a persistently vegetative or conscious state.

B. *Deciding for a Permanently Unconscious Incompetent*

Permanently unconscious patients lack all possible components of mental life—all the thought, feeling, sensation, desire, emotion, and awareness of self or environment.¹⁶⁴ Physicians will diagnose a patient as permanently unconscious only after vigorous medical evaluation.¹⁶⁵ When such a diagnosis becomes clear, the best interests of the patient do not include continued treatment.¹⁶⁶ Aside from the miniscule chance of a medical recovery,¹⁶⁷ continued medical treatments to incompetents in such a condition also involve two substantial, adverse side effects: (1) the severe disabilities evidenced in the few patients who have actually

163 See *id.*; Note, *supra* note 155, at 335. (A physician has the obligation to treat the patient's interests as paramount. Additionally, medical questions of highly technical nature may arise which cannot be fully appreciated or understood by lay persons.)

164 PRESIDENT'S COMMISSION, *supra* note 1, at 174-75. In such a condition, only the patient's vegetative functions and reflexes persist. *Id.* The Report, however, warns of three variables which affect any determination that the unconsciousness is in fact permanent. First, the prognosis may be falsified by future medical advancements; as a result, it is always a matter of degree based upon the quantity and quality of available evidence. Second, the evidence regarding such a determination is still quite limited and often specific to the particular patient. Third, a prediction of permanent unconsciousness assumes that a future medical breakthrough would not permit a return to consciousness. *Id.* at 176-77.

The Report also outlines five categories of permanently unconscious patients. In the first group are patients in a persistent vegetative state ("PVS"), which often derives from head injuries or intracranial hypoxia from cardiac arrest or asphyxiation. Although recovery is highly unlikely, PVS patients may stay alive for an indefinite period and die of other illnesses contracted while incompetent. The second group contains those who do not respond following a brain injury or hypoxia; such patients usually die within a few weeks of the brain damage. The third group consists of end stage victims of degenerative neurological conditions such as Jacob-Creutzfeldt disease and severe Alzheimer's disease. These patients have a life span ranging from a few weeks to months. Fourth are comatose patients with intracranial mass lesions from neoplasms or vascular masses. Patients in this group only survive a few days or weeks. The final group consists of patients with congenital hypoplasia of the central nervous system (anencephaly). This condition afflicts one in every 850 births. *Id.* at 177-81.

165 *Id.* at 181. (When improvement is believed possible, therapies will be intensive and aggressive, seeking to reverse the unconsciousness and overcome any other existing problems.)

166 The primary basis for medical treatment of patients is the prospect that each individual's interests (specifically, the interest in well-being) will be promoted. Thus, treatment ordinarily aims to benefit a patient through preserving life, relieving pain and suffering, protecting against disability, and returning maximally effective functioning. If prognosis of permanent unconsciousness is correct, however, continued treatment cannot confer such benefits. Pain and suffering are absent as are joy, satisfaction, and pleasure. Disability is total and no return to even minimal level of social or human functioning is possible.

Id. at 181-82.

167 Continued care would seem to derive from a small possibility that the diagnosis was incorrect. *Id.* at 182.

regained consciousness; and (2) the severe financial and emotional impact the lengthy process has upon the patient's loved ones.¹⁶⁸

1. *In re Quinlan*

The *Quinlan* court articulated a decisionmaking scheme for permanently unconscious patients which stressed judicial restraint. The New Jersey Supreme Court noted that to require prior judicial authorization would vastly intrude upon the medical profession and prove too cumbersome.¹⁶⁹ Rather, health care decisionmaking should occur within the patient-doctor-family relationship.¹⁷⁰ While the court recognized Mr. Quinlan's right, as guardian, to assert the cessation of his daughter's life support, it set forth the following procedural safeguards: (1) the attending physician must diagnose "no reasonable possibility" of the patient's returning to a sapient state; (2) a concurrence by the family and guardian to disconnect; and (3) an overview and concurrence of the diagnosis by a hospital ethics review committee.¹⁷¹ This ethics committee would include physicians, social workers, attorneys, and theologians.¹⁷² The court compared the committee to a "multi-judge court," protecting the hospital and doctors by screening out improper motivations by the family or physician.¹⁷³

2. Washington's Judicial Restraint

Most courts have recognized that the best interests of a permanently unconscious patient who failed to offer an advance treatment directive do not necessitate prior judicial approval of a treatment refusal.¹⁷⁴ The Washington Supreme Court, for example, mandated judicial restraint in

168 *Id.* at 182-83.

169 70 N.J. 10, 50, 355 A.2d 647, 669 (1976) ("This is not to say that in the case of an otherwise justiciable controversy access to the courts would be foreclosed; we speak rather of a general practice and procedure.")

170 *Id.*

171 *Id.* at 54, 355 A.2d at 671.

172 *Id.* at 49-50, 355 A.2d at 668-69 (quoting Teel, *The Physician's Dilemma: A Doctor's View: What The Law Should Be*, 27 BAYLOR L. REV. 6, 8-9 (1975)).

173 *Id.* at 50, 355 A.2d at 669.

174 *Rasmussen v. Fleming*, 154 Ariz. 207, 224, 741 P.2d 674, 691 (1987) (en banc); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1022, 195 Cal. Rptr. 484, 493 (1983) (citations omitted) ("Although there is not complete agreement among the courts that have addressed the issue in the civil context, we agree with those which have held that requiring judicial intervention in all cases is unnecessary and may be unwise."); *In re Storar*, 52 N.Y.2d 363, 382-83, 420 N.E.2d 64, 74, 438 N.Y.S.2d 266, 276, cert. denied, 454 U.S. 858 (1981); *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984) (en banc); *In re Colyer*, 99 Wash. 2d 114, 127-28, 660 P.2d 738, 745-46 (1983) (en banc). For a discussion of the two Washington cases, see *infra* notes 175-85 and accompanying text. *Cf. In re Torres*, 357 N.W.2d 332 (Minn. 1984). Torres' lack of family and his potential negligence cause of action necessitated a court order. But the court noted in a footnote:

At oral argument it was disclosed that on an average about 10 life support systems are disconnected weekly in Minnesota. This follows consultation between the attending doctor and family with the approval of the hospital ethics committee. It is not intended by this opinion that a court order is required in such situations.

Id. at 341 n.4.

See also Mooney, *supra* note 10, at 1088-89 (discussing that the permanently unconscious patient does not have to be terminally ill to permit refusal of life support).

*In re Colyer*¹⁷⁵ and *In re Hamlin*.¹⁷⁶ *Colyer* involved a sixty-nine-year-old permanently unconscious woman sustained by a respirator with a prognosis of no meaningful existence.¹⁷⁷ In response to her husband's request to remove the respirator, *Colyer* affirmed the trial court's order to do so.¹⁷⁸ Analyzing cases involving formerly competent patients, the court stated that judicial approval was not a prerequisite for the treatment removal.¹⁷⁹ Judicial intervention would be mandated when: (1) the family members disagree as to the incompetent's wishes; (2) the physicians disagree over the prognosis; (3) the patient is a life-long incompetent; (4) evidence of wrongful motive or malpractice exist; or (5) the patient lacks a family member to act as a guardian.¹⁸⁰

In *In re Hamlin*,¹⁸¹ the Washington Supreme Court extended its judicial restraint to cases involving life-long incompetents. Forty-two-year-old Joseph Hamlin, blind and severely retarded since birth, persisted in a vegetative state with the assistance of a respirator.¹⁸² Since Mr. Hamlin had no family, he needed a court appointed guardian to protect his best interests.¹⁸³ When the physicians, the prognosis committee, and the guardian agreed that termination of life support would serve the patient's best interests, absent a legislative directive to the contrary, *Hamlin* concluded that the judiciary need not participate in the actual substantive

175 99 Wash. 2d 114, 660 P.2d 738 (1983) (en banc). The court limited its holding to antidysphasia, removal of life-sustaining system from an incurable patient. See *supra* note 2.

176 102 Wash. 2d 810, 689 P.2d 1372 (1984) (en banc).

177 99 Wash. 2d at 116, 660 P.2d at 740.

178 *Id.* The Washington Natural Death Act did not articulate guidelines to discontinue an incompetent's life support in the absence of a living will. *Id.* at 118-19, 660 P.2d at 741 (interpreting WASH. REV. CODE ANN. §§ 70.122.010-.060 (Cum. Supp. 1984)).

179 In order to prevent judicial intervention, the court stated that all physicians must agree with the prognosis and a close family member must use his or her best judgment to exercise the rights of the incompetent. 99 Wash. 2d at 127-28, 660 P.2d at 746. "While we do not accept the *Quinlan* court's view that judicial intervention is an encroachment upon the medical profession, we do perceive the judicial process as an unresponsive and cumbersome mechanism for decisions of this nature." *Id.* at 127, 660 P.2d at 746. (citations omitted).

Colyer listed the procedures to be followed:

(1) A unanimous concurrence by a prognosis board, made up of the attending physician and no fewer than two other disinterested physicians with relevant qualifications, that the patient's condition is incurable and there is no reasonable medical probability of returning to a cognitive, sapient state, or in the event of disagreement on the prognosis board, a court decision making such findings by clear and convincing evidence.

(2) Court appointment of a guardian for the incompetent person [pursuant to statutory procedure], including the appointment of a guardian ad litem to represent the best interests of the incompetent in that proceeding.

(3) Exercise of the patient's right to privacy and freedom from bodily invasion by the guardian, if it is the guardian's best judgment that the patient, if competent to make the decision, would choose to have life sustaining treatment removed.

(4) If required, a court determination of the rights and wishes of the incompetent, with a guardian ad litem appointed to represent the incompetent patient and to present all relevant facts to the court.

Id. at 137, 660 P.2d at 751.

180 *Id.* at 136, 660 P.2d at 750.

181 102 Wash. 2d 810, 689 P.2d 1372 (1984) (en banc). In *Colyer*, the Washington Supreme Court noted in dicta that there are instances when judicial approval would be required in the decision to withhold treatment. These scenarios included (1) life-long incompetents; (2) evidence of wrongful motives or malpractice; or (3) the absence of a family member to act as guardian. 99 Wash. 2d at 136, 660 P.2d at 750.

182 *Id.* at 812, 699 P.2d at 1374.

183 *Id.* at 820, 689 P.2d at 1378.

decision.¹⁸⁴ If necessary, the court would resolve any conflict existing among the decisionmakers.¹⁸⁵

3. Alternatives to Judicial Review

If the permanently unconscious incompetent has failed to provide clear and compelling evidence of a preference, a medical ethics committee provides an effective alternative to court review in order to protect the patient's best interests.¹⁸⁶ In all instances, the committee should begin with the presumption in favor of administering life support. The committee's membership should integrate a variety of medical, legal and societal perspectives into a review of the particular patient's best interests.

If the permanently unconscious incompetent has no family, a court should appoint a guardian ad litem to safeguard the patient's best interests.¹⁸⁷ Given the substantially deteriorated well-being of permanently unconscious individuals, judicial review of the guardian ad litem's choice—if in concurrence with the physician's opinion of the treatment's futility—would only waste judicial resources.¹⁸⁸

C. Decisionmaking for a Conscious Incompetent

When the patient retains cognitive functioning, the question of who should apply the best interests standard to a conscious incompetent becomes more difficult. The presence of some mental capability by the incompetent enhances the state's interest in preserving life. The degree of judicial authorization of any withdrawal or withholding of medical treat-

184 102 Wash. 2d at 820, 689 P.2d at 1378. *Hamlin* rejected *Colyer's* requirement of a judicially appointed guardian for a patient with an immediate family. *Id.* at 819, 689 P.2d at 1378.

185 *Id.* at 821, 680 P.2d at 1378-79.

186 Ethics committees enhance the protection of the patient's best interests through the following:

- (1) They can review the case to confirm the responsible physician's diagnosis and prognosis of a patient's medical condition.
- (2) They can provide a forum for discussing broader societal and ethical concerns raised by a particular case; such bodies may also have an educational role, especially by teaching all professional staff how to identify, frame and resolve ethical problems.
- (3) They can be a means for formulating policy and guidelines regarding such decisions.
- (4) Finally, they can review decisions made by others (such as physicians and surrogates) about the treatment of specific patients or make such decisions themselves.

PRESIDENT'S COMMISSION, *supra* note 1, at 160-61.

The Commission also surveyed hospitals and found that less than one percent have such committees. *Id.* at 161.

187 The guardian ad litem's duty involves discovery of all pertinent facts concerning the treatment. The report should include the following evaluations:

- (a) facts about the incompetent: *i.e.*, age, case of incompetency, relationship with family members and other close friends, attitude and prior statements concerning life-sustaining treatment; (b) medical facts: *i.e.*, prognosis for recovery, intrusiveness of treatment, medical history; (c) facts concerning the state's interest in preserving life: *i.e.*, the existence of dependents, other third party interests; and (d) facts about the guardian, the family, other people close to the incompetent, and the petitioner: *i.e.*, their familiarity with the incompetent, their perceptions of the incompetent's wishes, any potential for ill motives.

Rasmussen v. Fleming, 154 Ariz. 207, 223, 741 P.2d 674, 690 (1987) (quoting *In re Colyer*, 99 Wash. 2d 114, 133, 660 P.2d 738, 748-49 (1983)).

188 See *Mooney*, *supra* note 10, at 1117. (Given the endemic physical condition of permanently unconscious patients, prior court approval of a guardian's choice is unnecessary.)

ment from a conscious incompetent should depend upon whether the patient's prognosis is terminal.

1. Terminally Ill Conscious Patients

In re Grant,¹⁸⁹ for example, permitted the cessation of mechanical and artificial life-sustaining measures from a conscious twenty-two-year-old woman suffering from Batten's disease with a minimal life expectancy.¹⁹⁰ In doing so, the Washington Supreme Court enumerated four circumstances which are necessary to negate the need for judicial authorization.¹⁹¹ First, the patient's attending physician, in conjunction with two other physicians, must determine with reasonable medical judgment that the patient suffers from an advanced stage of terminal and incurable illness with permanent mental and physical deterioration.¹⁹² Second, the legal guardian, if any, implements either (a) the incompetent's preference while competent; or (b) if unable to make such a determination, the best interests of the patient.¹⁹³ Third, members of the incompetent's legal family as designated by statute agree to withhold treatment.¹⁹⁴ Fourth, neither the patient's physicians nor the health care facility object to withholding such treatment.¹⁹⁵

A best interests analysis for the terminal conscious incompetent, like the permanently unconscious incompetent, should determine whether life-prolonging measures will enhance significant physical improvement or merely prolong the dying process.¹⁹⁶ In such cases, an optimal best interests analysis requires implementation by the family with the concurrence of the physicians and a hospital ethics committee. These parties are more apt to focus upon the particular patient rather than rely solely upon a vague "reasonable person" standard. If the parties disagree, judicial involvement then becomes essential to protect and implement the patient's best interests.

2. Non-Terminal Conscious Incompetents

More troubling questions arise in decisions involving a conscious incompetent in a non-terminal condition, for a best interests analysis would seem to favor life-prolonging procedures in such instances. *In re Spring*,¹⁹⁷ for example, applied a substituted judgment analysis¹⁹⁸ and allowed a request by Mr. Spring's wife and son to discontinue hemodialysis

189 109 Wash. 2d 545, 747 P.2d 445 (Wash. 1987) (en banc).

190 *Id.* at 547-49, 747 P.2d at 446-47. Barbara Grant had a mental age of between two weeks and one and a half months. Her limited capacities allowed her to respond to sound, smile or laugh at inappropriate times, react to touch, and occasionally differentiate between people. *Id.* at 549, 747 P.2d at 447.

191 The court held that in the absence of countervailing state interests, a person has the right to have life-sustaining treatment withheld in cases involving (1) an advanced stage of terminal illness; (2) severe and permanent mental and physical deterioration. *Id.* at 556, 747 P.2d at 451.

192 *Id.* at 566, 747 P.2d at 456.

193 *Id.* at 566-67, 747 P.2d at 456.

194 *Id.* at 567, 747 P.2d at 456.

195 *Id.*

196 See Mooney, *supra* note 10, at 1097.

197 380 Mass. 629, 405 N.E.2d 115 (1980).

198 For an evaluation of *Spring's* substituted judgment analysis, see *supra* notes 81-88.

treatment for the patient's end-run kidney disease.¹⁹⁹ Although Mr. Spring suffered from senility, the dialysis would have allowed him to live a few months or potentially as many as five years.²⁰⁰ In holding that it should maintain ultimate decisionmaking responsibility for Mr. Spring, the court enumerated a list of factors which guide an evaluation of the necessity for a court order concerning the incompetent's treatment:

the extent of impairment of the patient's mental faculties, whether the patient is in the custody of a State institution, the prognosis without the proposed treatment, the complexity, risk and novelty of the proposed treatment, its possible side effects, the patient's level of understanding and probable reaction, the urgency of the decision, the consent of the patient, spouse or guardian, the good faith of those who participate in the decision, the clarity of professional opinion as to what is good medical practice, the interests of third persons and the administrative requirements of any institution involved.²⁰¹

The court, however, refused to decide what combination of circumstances would require prior judicial approval.²⁰² *Spring* noted that any private medical decisions must be made in accordance with good faith and good medical practice, subject to judicial scrutiny if good faith or due care is brought into question in subsequent litigation.²⁰³ The court stated that the concurrence of qualified hospital consultants concerning the treatment would be persuasive on issues of good faith and good medical practice.²⁰⁴

Absent an evidence of the patient's wishes, society should favor administration of life-prolonging procedures to the conscious non-terminal incompetent. Termination of care should occur only upon a clear and compelling showing that the treatment is contrary to the patient's best interests. Given the increased state interests for such a patient's well-being, judicial authorization should be a prerequisite. The evidence before the court must clearly prove that the life-prolonging treatment will only induce further suffering without providing the patient any significant benefits.

V. Conclusion

Life-sustaining treatment necessitates deciding whether to undergo continued medical care. The law delegates the decision to the affected individual, regardless of competence. The authority it grants, however, is not absolute; the decision must be consistent with certain state interests.

199 380 Mass. at 631-32, 405 N.E.2d at 117-18.

200 *Id.* at 632, 405 N.E.2d at 118.

201 *Id.* at 637, 405 N.E.2d at 121.

202 *Id.* The court refused to critique these factors even under the facts before it. Additionally, the court noted that changing medical technology may make the factors inapplicable. *Id.*

203 *Id.* at 639, 405 N.E.2d at 122.

204 *Id.* The court stated that subsidiary questions regarding the implementation of the decision must almost inevitably be left to private decisions, but without immunity for actions taken in bad faith which are previously unreasonable. *Id.*

Although the law shows no concern for whether the individual is competent, the law does assume that the individual has made or can make some expression from which the individual's decision can be inferred. In cases involving patients that have never indicated a preference for or against medical treatment, due to either incompetence or oversight, that assumption proves false. The law must delegate the treatment decision to someone else, and the surrogate must evaluate the decision not only in light of the state's interests and societal values, but also the individual's best interests.

The proper persons to whom the law should delegate the treatment decision are the patient's immediate family and attending physicians. The proper degree of judicial involvement in the decisionmaking is a function of the patient's consciousness and prognosis. In many cases, courts should become involved only as a last resort when the decision-makers disagree.

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