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Assuring "Detached But Passionate Investigation and Decision": The Role of Guardians Ad Litem in Saikewicz-type Cases

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Assuring "Detached but Passionate Investigation and Decision": The Role of Guardians Ad Litem in *Saikewicz*-type Cases

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ABSTRACT

The author focuses this Article upon the aspect of the *Saikewicz* decision which determines that the kind of "proxy consent" question involved in that case requires for its decision "the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created." This aspect of the decision has drawn much criticism from the medical community on the ground that it embroils what doctors believe to be a medical question in the adversarial processes of the court system. The author criticizes the decision from an entirely opposite perspective, arguing that the court's opinion fails in not laying down guidelines that would assure a truly adversary process in *Saikewicz*-type cases. He agrees with the *Saikewicz* court that our democratic institutional structure and societal commitment to individual liberty require that persons not competent to consent for themselves to acts of euthanasia be protected by a process of "detached but passionate investigation and decision." However, he points out that this ideal of the court system was not realized in *Saikewicz* itself and is not likely to be realized in other cases without reform of some of the procedures currently being employed by the courts in "proxy consent" cases. Drawing on previous articles that he has written in related areas, he then proposes a set of guidelines that he believes not only will remove existing procedural deficiencies, but also may reform some aspects of the existing system that have drawn criticism from the medical community.

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I. INTRODUCTION

> We do not view the judicial resolution of this most difficult and awesome question—whether potentially life-prolonging treatment should be withheld from a person incapable of making his own decision—as constituting a "gratuitous encroachment" on the domain of medical expertise. Rather, such questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is our responsibility and that of the lower court, and is not to be entrusted to any other group purporting to represent the "morality and conscience of our society," no matter how highly motivated or impressively constituted.[1]

With this language in its recent[2] opinion in *Superintendent of Belchertown State School v. Saikewicz*, the Supreme Judicial Court of Massachusetts unan-

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[1] Superintendent of Belchertown State School v. Saikewicz, 1977 Mass. Adv. Sh. 2461, 2501, 370 N.E.2d 417, 435 (1977).

[2] Although the case was argued July 2, 1976, and the Supreme Judicial Court issued its order affirming the decision of the Hampshire County Probate Court seven days later, the former court's opinion on the order and on related matters was not issued until November 28, 1977. The July 9 order merely answered in the affirmative the following questions that originally had been reported to the Appeals Court of Massachusetts:

> (1) Does the Probate Court under its general or any special jurisdiction have the authority to order, in circumstances it deems appropriate, the withholding of medical treatment from a person even though such withholding of treatment might contribute to a shortening of the life of such person?
> (2) On the facts reported in this case, is the Court correct in ordering that no treatment be administered to said JOSEPH SAIKEWICZ now or at any time for his condition of acute myeloblastic monocetic [sic] leukemia except by further order of the Court?

Order of the Honorable Harry Jekanowski, Judge of the Hampshire County, Mass., Probate Court, May 13, 1976.

On the same day that the July 9 order was issued, the Department of the Attorney General of Massachusetts requested permission to file a supplemental brief that would discuss procedural guidelines for the handling of such cases in the future. The Supreme Judicial Court granted such permission on July 15, and supplementary briefs dealing with procedural guidelines were filed by the Department of the Attorney General, the Civil Rights and Liberties Division of the Department of the Attorney General, the Legal Counsel to the Department of Mental Health, the Massachusetts Association for Retarded Citizens, Inc., and the Mental Health Legal Advisors Committee of Massachusetts. Suggested procedural guidelines were also the subject of several law review articles that appeared before the court's opinion was rendered. *See* Brant, *The Right to Die in Peace: Substituted Consent and the Mentally Incompetent*, 11 SUFFOLK U. L. REV. 959 (1977); Kindregan, *The Court as Forum for Life and Death Decisions: Reflections on Procedures for Substituted Consent*, *id.* at 919 (1977); Schultz, Swartz, & Appelbaum, *Deciding Right-to-Die Cases Involving Incompetent Patients: Jones v. Saikewicz*, *id.* at 936 (1977).

While the controversy surrounding his case was beginning to build, Joseph Saikewicz died at 7:25 p.m. on Saturday, September 4, 1976, of bronchial pneumonia brought on by his leukemic condition.

imously recognizes the proposition that our society has never conferred upon its medical community the power to decide which of society's members shall live and which shall die.[3] Earlier in the opinion, the court recognizes that this power over each individual life resides primarily in the individual involved and holds, for the first time in Massachusetts,[4] that, where certain specified state interests[5] do not outweigh the individual's right to privacy and right to be free from nonconsensual invasions of his bodily integrity,[6] the individual possesses a legally recognized right to choose death over life-prolonging medical treatment. However, Joseph Saikewicz clearly was not competent to make that decision[7] for himself since, although he was 67 years of age, he had an I.Q. of 10 and a mental age of approximately 2 years and 8 months. Under those circumstances, the court holds, first, that the right to choose death "must extend to the case of an incompetent, as well as a competent, patient because the value

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[3] In this respect, the decision is, as the court recognizes, directly contrary to the decision of the Supreme Court of New Jersey in *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), where the latter court stated:

> The nature, extent and duration of care by societal standards is the responsibility of a physician. The morality and conscience of our society places this responsibility in the hands of the physician. What justification is there to remove it from the control of the medical profession and place it in the hands of the courts?

Id. at 44, 355 A.2d at 665.

> [U]pon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital "Ethics Committee" or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital or others.

Id. at 55, 355 A.2d at 671 (footnote omitted).

The last-quoted sentence from the *Quinlan* opinion highlights what is desired from these cases by the medical community: legal insulation from civil and criminal liability for acts which will cause—indeed may be *intended* to cause—the death of a patient. What the *Quinlan* court has done is to grant such protection to all persons participating in such acts where there has been the sort of concurrence of opinion laid out by that court. (Note that the protection is granted only for *certain* acts, *e.g.*, turning off the "life-support apparatus." It is *not* granted for certain *other* acts, *e.g.*, injecting a dose of a painless but lethal drug. As a result of this distinction, Karen Quinlan continues to exist in a comatose state.) In contrast, it is clear that the *Saikewicz* court has refused to make such a blanket grant of protection. Such protection, the court is saying, can come only through a judgment rendered by a court of law on the basis of the fully developed facts of each case.

Beyond that, however, the *Saikewicz* opinion raises more questions than it answers. It is possible to read the court as saying nothing more than that only the courts have the power to grant what is in essence declaratory relief. What the participants in these cases want is assurance that the acts that they wish to perform will not subject them to liability. A traditional method for gaining such assurance is for the persons who are fearful of liability to bring a

of human dignity extends to both";[8] second, that in making that choice for an incompetent, a proxy decision maker must take into consideration only factors that go to the question of what the individual would have decided for himself[9] and may not consider, for example, such factors as the value of the particular life to society;[10] and, third, in the most widely noted part of its opinion, that the Probate Court of Massachusetts is "the proper tribunal to determine the best interests of"[11] a person incompetent to make such a decision for himself.

Were it not for the history of the development and growth in number of such life and death questions in a medical context in recent years, one might think the court's conclusion to be relatively uncontroversial. After all, doctors and hospital ethics committees[12] are not elected representatives of the people and hold no appointive commission to decide such weighty societal questions. Although doctors are licensed by the state to practice

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declaratory judgment action against the persons whom they fear as potential plaintiffs. If they obtain a declaratory judgment of nonliability, they may then perform the desired acts confident that they can raise an effective defense of res judicata in any later action brought by any of the parties to the action for declaratory relief. Under this reading, the court is not saying that failure to seek advance permission from a court makes the participants ipso facto liable for their acts of termination of care. It is not saying that advance court authorization is a *necessary* condition for avoiding liability, only that it is a *sufficient* condition.

However, another interpretation is possible. The *Saikewicz* court could be saying that, at least in some cases, terminating care for an incompetent without first getting court authorization in the form of "proxy consent" (the court or court-appointed guardian's "substituted judgment"), renders the participants liable ipso facto. Here the court would be saying that court authorization is a *necessary* condition for avoiding liability. Much of the case law regarding liability for decisions to *treat* incompetents rests on the theory that treatment without "proxy consent" is ipso facto a battery. *See* W. PROSSER, THE LAW OF TORTS 101-08 (4th ed. 1971). The *Saikewicz* case itself began as a routine request for "proxy consent" to treatment in order to avoid liability for battery. *See* notes 19-21 *infra* and accompanying text. And there are policy considerations that would favor this approach by the court in the area of decisions *not* to treat. Among them is the fact that there may be little motivation on the part of participants to go to court to obtain a declaratory judgment in a vast range of cases where there is no likely candidate to bring a subsequent suit for damages against the participants and where there is little likelihood of criminal prosecution. Hence, there would be no court supervision of the decision to terminate the life of the incompetent patient in some cases where that supervision might be thought crucial to proper protection of the interests of the patient.

It should be noted in passing that *Saikewicz* also does not deal with the question of whether there are classes of situations in which the courts should not allow participants to immunize themselves from liability in advance of action. Policies against allowing broad immunity to result from decisions that would have to be made without a full development of the facts, because of the emergency nature of the proceeding or for some other reason, might dictate against granting jurisdiction in some classes of cases. One author has suggested another reason for not allowing such jurisdiction in at least those cases that involve consent to causing the death of defective newborns:

> The true enormity of these actions to withhold life from newborns, viewed from our contemporary perspective, will remain in high visibility only if advance social authorization is withheld, and only if the parents and physicians who wish to take this action are willing to accept some significant risk that they will suffer by such action. Their suffering will come in increasing intensity if criminal prosecution is

medicine, such practice is defined in Massachusetts as conduct "the purpose or reasonably foreseeable effect of which is to encourage the reliance of another person upon an individual's knowledge or skill in the *maintenance of human health* by the prevention, alleviation, or cure of disease. . . ."[13] There is, of course, no mandate here to decide whether patients will live or die. But, because of the development in recent years of a sophisticated medical technology that provides possibilities for prolonging a merely vegetative existence indefinitely, doctors have found themselves forced by default to decide when life prolongation becomes, by their own individual standards of the moment,[14] senseless from a practical point of view. Although one would expect that many doctors would be happy to have this awesome responsibility taken from them, the more general, and understandable, reaction from the medical community to the *Saikewicz* decision has been resentment of what is seen as the Supreme Judicial Court's "total

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instituted, if a jury finds them guilty of unconscionable conduct and if a judge imposes sanctions on them accordingly. In deciding whether to withhold treatment from the newborn, the parents and physicians will be led to balance the suffering imposed on them by the continued life of the child against the suffering likely from their decision to end the child's life.

This gives no guarantee that every newborn will be kept alive, no matter what. But choosing this social mechanism for regulating the decision to withhold treatment does guarantee that the decision-makers will have powerful incentive to favor the child's continuing life, to uphold what one court has called our felt intuition . . . [that even a blind, deaf and dumb infant] would almost surely choose life with defects as against no life at all. Some current proposals for law change call for child advocacy by an attorney, for example, appointed to present the newborn's perspective to a judge empowered to authorize withholding treatment. But no imaginable formal mechanism for child advocacy could so starkly press home directly on the decision-maker, as possible criminal liability, the proposition that ending the child's life may inflict unjustifiable suffering on him.

Burt, *Authorizing Death for Anomalous Newborns*, in G. ANNAS & A. MILUNSKY, GENETICS & THE LAW 435, 444 (1975) (footnote omitted).

Because of uncertainty as to the scope of the *Saikewicz* holding, counsel representing medical facilities in Massachusetts have advised their clients that the *Saikewicz* decision should be assumed to require judicial review in order to avoid *liability* in a wide range of cases involving patients who are not competent to consent to termination of medical assistance of a variety of types. As a result, new kinds of cases are being brought to the courts, including actions for "proxy consent" to termination of life support services not only for defective newborns and terminally ill comatose adults, but also for persons who meet most, but not quite all, of the Harvard brain death criteria. *See* Annas, *After Saikewicz: No-Fault Death*, HASTINGS CENTER REP., June 1978, at 16. Moreover, the spirit of *Saikewicz* stalks more entrenched sorts of actions such as those brought to obtain "proxy consent" to chemotherapy where the parents of the patient refuse consent, or to removal of a gangrenous foot where an arguably incompetent patient refuses consent, or to use of an experimental drug to treat a cancer where the mentally retarded patient cannot give an effective consent. In every such case, the potential relevance of *Saikewicz* now becomes an issue raised by counsel or the court. Most recently, the *Saikewicz* opinion has brought to the courts the question of whether court authorization is in any sense rquired before a "no-code" order can be placed on the chart of a comatose patient.

Against this fluid background, it is impossible to give a generally accepted definition to the term "*Saikewicz*-type cases" that is used in this Article. However, for purposes of this

distrust of physicians' judgment in such matters,"[15] and fear that court involvement in this area will disrupt the work of doctors in ways that will affect deleteriously the treatment that can be given to patients generally. A recent editorial in *The New England Journal of Medicine* describes the position of the medical community:[16]

> Traditionally, doctors responsible for the care of "incompetent" patients have abided by the wishes of the next of kin, who are, of course, greatly influenced by the doctor's professional opinion. In the absence of relatives, physicians have customarily used their own best judgment, aided by the advice of colleagues and frequently the opinions of other health professionals, ministers and lawyers; sometimes, they are also advised by special hospital committees organized for this purpose. In the famous *Quinlan* case, the New Jersey Supreme Court acknowledged the

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Article, it will be used very broadly to refer to any case in which a court is asked to provide "proxy consent" for an alleged incompetent to some act, or omission to act, on the ground that the act, or omission to act, is in the "best interest" of the incompetent.

[4] Decisions from other jurisdictions recognizing a right to refuse life-prolonging or life-saving treatment include Montgomery v. Board of Retirement, 33 Cal. 3d 447, 109 Cal. Rptr. 181 (Ct. App. 1973) (dictum); *In re* Osborne, 294 A.2d 372 (D.C. 1972); *In re* Estate of Brooks, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976); Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962); *In re* Raasch, No. 455-996 (Prob. Div., Milwaukee County Ct. Jan. 21, 1972).

[5] These were recognized by the court to be "(1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) the maintenance of the ethical integrity of the medical profession." 1977 Mass. Adv. Sh. at 2477, 370 N.E.2d at 425. The court stated that the first of these interests was the most important, but that it was lessened in significance in a case, such as *Saikewicz*, where the most that could be hoped for through treatment was mere "prolongation" of life. "There is a substantial distinction," the court held, "in the State's insistence that human life be saved where the affliction is curable, as opposed to the State interest where, as here, the issue is not whether, but when, for how long, and at what cost to the individual that life may be briefly extended." *Id.* at 2478, 370 N.E.2d at 425-26. As to the second interest, the court found that, on the facts of the case, it was not an issue, since Mr. Saikewicz had no dependents. The fourth state interest was also found to be no bar since

> the prevailing ethical practice [in the medical profession] seems to be to recognize that the dying are more often in need of comfort than treatment. Recognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores; such a doctrine does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the State's interest in protecting the same.

Id. at 2480, 370 N.E.2d at 426-27. The third, and perhaps the most intriguing state interest, is consigned to a footnote:

> The interest in protecting against suicide seems to require little if any discussion. In the case of the competent adult's refusing medical treatment such an act does not necessarily constitute suicide since (1) in 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 death was from natural causes the patient did not set the death producing agent in motion with the intent of causing his own death. Furthermore, the underlying State

> appropriateness of such arrangements by delegating to the patient's father, her doctors and the hospital ethics committee the responsibility for deciding whether to withdraw the mechanical respiratory assistance that was believed to be sustaining her hopelessly comatose existence.
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> In Massachusetts the immediate disruptive consequences of the *Saikewicz* ruling have already appeared. In some cases physicians and next of kin will probably defer urgent medical decisions, both positive and negative, pending court approval. In other cases decisions that had formerly been made expeditiously, but only after full and explicit consultation, will now be made hastily and even furtively, thus returning "to the closet" questions that need open and thoughtful discussion. It will take time and many court decisions to sort out the problem, but in the meantime confusion

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> interest in this area lies in the prevention of irrational self-destruction. What we consider here is a competent, rational decision to refuse treatment when death is inevitable and the treatment offers no hope of cure or preservation of life. There is no connection between the conduct here in issue and any State concern to prevent suicide.

Id. at 2480, n.11, 370 N.E.2d at 426, n.11 (references omitted).

[6] The court bases its opinion in this regard upon "the unwritten constitutional right of privacy found in the penumbra of specific guarantees of the Bill of Rights," *id.* at 2474-75, 370 N.E.2d at 424, and upon "implicit recognition in the law of the Commonwealth, as elsewhere, that a person has a strong interest in being free from nonconsensual invasion of his bodily integrity." *Id.* at 2473, 370 N.E.2d at 424.

[7] Here the choice, as the Supreme Judical Court found it be on the basis of the record, was between refusing treatment for leukemia, which would mean a relatively comfortable death within a period that might range from a few weeks to several months, and consenting to chemotherapy, which might prolong life for as much as 13 months or longer, but might shorten it and would have side effects including anemia, bleeding, infections, "severe nausea, bladder irritation, numbness and tingling of the extremities, and loss of hair." *Id.* at 2466, 370 N.E.2d at 421. Despite the horrors thus painted of chemotherapy, however, "[i]t was the opinion of the guardian ad litem, as well as the doctors who testified before the probate judge, that most people elect to suffer the side effects of chemotherapy rather than allow their leukemia to run its natural course."
Id. at 2466-67, 370 N.E.2d at 421.

[8] *Id.* at 2482-83, 370 N.E.2d at 427.

[9] "[T]he primary test is subjective in nature—that is, the goal is to determine with as much accuracy as possible the wants and needs of the individual involved." *Id.* at 2489-90, 370 N.E.2d at 430 (footnote omitted). For a thoughtful discussion of this standard, see Robertson, *Organ Donations by Incompetents and the Substituted Judgment Doctrine*, 76 COLUM. L. REV. 48, 57-68 (1976).

It was in the subjective nature of the standard that the court found a basis for affirming the lower court's decision despite the lower court's fact finding that most people would elect chemotherapy in an objectively similar situation:

> Evidence that most people choose to accept the rigors of chemotherapy has no bearing on the likely choice that Joseph Saikewicz would have made. Unlike most people, Saikewicz had no capacity to understand his present situation or his prognosis. The guardian ad litem gave expression to this important distinction in coming

> reigns and much harm may be done. Attorneys I have spoken with do not believe the probate courts can possibly handle the number of cases that will be generated by the *Saikewicz* decision, nor do they believe that court action will be prompt enough in many cases to be helpful.

In the same edition of *The New England Journal of Medicine* cited above, a lawyer who is that journal's regular commentator on medicolegal problems also takes issue with the *Saikewicz* decision, expressing the wish that the Massachusetts Supreme Judicial Court had been more taken with the position of the New Jersey Supreme Court in *Quinlan*, and deploring the fact that under *Saikewicz* "each case is to be an adversary proceeding."[17]

It is ironic, given the latter statement, that under the procedures laid out in the *Saikewicz* opinion there is no guarantee that each case will be a true adversary proceeding. That fact, for which some doctors might be

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to grips with this "most troubling aspect" of withholding treatment from Saikewicz: "If he is treated with toxic drugs he will be involuntarily immersed in a state of painful suffering, the reason for which he will never understand. Patients who request treatment know the risk involved and can appreciate the painful side-effects when they arrive. They know the reason for the pain and their hope makes it tolerable." To make a worthwhile comparison, one would have to ask whether a majority of people would choose chemotherapy if they were told merely that something outside their previous experience was going to be done to them, that this something would cause them pain and discomfort, that they would be removed to strange surroundings and possibly restrained for extended periods of time, and that the advantages of this course of action were measured by concepts of time and mortality beyond their ability to comprehend.

Id. at 2488-89, 370 N.E.2d at 430.

[10] "The two factors considered by the probate judge to weigh in favor of administering chemotherapy were: (1) the fact that most people elect chemotherapy and (2) the chance of longer life. . . . With regard to the second factor, the chance of a longer life carries the same weight for Saikewicz as for any other person, the value of life under the law having no relation to intelligence or social position." *Id.* at 2492-93, 370 N.E.2d at 431.

> The sixth factor identified by the probate judge as weighing against chemotherapy was "the quality of life possible for him even if the treatment does bring about remission." To the extent that this formulation equates the value of life with any measure of the quality of life, we firmly reject it. A reading of the entire record clearly reveals, however, the judge's concern that special care be taken to respect the dignity and worth of Saikewicz's life precisely because of his vulnerable position. The judge, as well as all the parties, were keenly aware that the supposed ability of Saikewicz, by virtue of his mental retardation, to appreciate or experience life had no place in the decision before them. Rather than reading the judge's formulation in a manner that demeans the value of the life of one who is mentally retarded, the vague, and perhaps ill-chosen, term "quality of life" should be understood as a reference to the continuing state of pain and disorientation precipitated by the chemotherapy treatment. Viewing the term in this manner, together with the other factors properly considered by the judge, we are satisfied that the decision to withhold treatment from Saikewicz was based on a regard for his actual interests and preferences and that the facts supported this decision.

Id. at 2494-95, 370 N.E.2d at 432.

grateful, is nevertheless, in the present writer's opinion, the principal *defect* in the *Saikewicz* decision since it undermines the court's own goal of assuring for these life and death questions "the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created."[18] The present Article describes this flaw in *Saikewicz* more fully, and makes recommendations for correcting the flaw.

II. THE LACK OF ADVERSARY PROCESS IN THE *SAIKEWICZ* PRESCRIPTION

The *Saikewicz* case itself was not an adversary proceeding. On April 19, 1976, when Joseph Saikewicz was diagnosed as suffering from acute myeloblastic monocytic leukemia, he was a resident of the Belchertown State School, where he had lived for many years. Although the school

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[11] *Id.* at 2496, 370 N.E.2d at 433.

[12] These are also referred to as "optimum care committees," "ad hoc committees," and by other designations. (They also have been called "God-squads" due to the awesome nature of the issues with which they deal.) *See generally* Clinical Care Committee of the Massachusetts General Hospital, *Optimum Care for Hopelessly Ill Patients*, 295 NEW ENGLAND J. MED. 362 (1976); Rabkin, Gillerman, & Rice, *Orders Not To Resuscitate*, *id.* at 364 (1976); Teel, *The Physician's Dilemma, A Doctor's View: What the Law Should Be*, 27 BAYLOR L. REV. 6 (1975).

Such committees frequently comprise not only physicians but also social workers, attorneys, and theologians, among others. While the ethics committee concept is not new, such committees have been developed recently by an increasing number of hospitals as forums for principled consideration of moral, legal, and ethical problems of medical practice, which are now being discussed more openly than previously. *See generally* Annas, *In re Quinlan: Legal Comfort for Doctors*, HASTINGS CENTER REP., June 1976, at 29; Cantor, *Quinlan, Privacy, and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 243, 255 (1977); Collester, *Death, Dying and the Law: A Prosecutorial View of the Quinlan Case*, *id.* at 304, 319 (1977); Fried, *Terminating Life Support: Out of the Closet!* 295 NEW ENGLAND J. MED. 390 (1976); Hirsch & Donovan, *The Right to Die: Medico-Legal Implications of In re Quinlan*, 30 RUTGERS L. REV. 267, 273-86 (1977); Veatch, *Human Experimentation Committees: Professional or Representative?* HASTINGS CENTER REP., October 1975, at 31.

While the *Saikewicz* decision refuses to confer upon such committees the power to insulate the medical community from liability that was granted in *In re Quinlan*, *see* note 3, *supra*, the court does recognize that they might play a helpful role in the decision-making process.

> We note here that many health care institutions have developed medical ethics committees or panels to consider many of the issues touched on here. Consideration of the findings and advice of such groups as well as the testimony of the attending physicians and other medical experts ordinarily would be of great assistance to a probate judge faced with such a difficult decision. We believe it desirable for a judge to consider such views wherever available and useful to the court. We do not believe, however, that this option should be transformed by us into a required procedure. We take a dim view of any attempt to shift the ultimate decision-making responsibility away from the duly established courts of proper jurisdiction to any committee, panel or group, ad hoc or permanent.

Id. at 2499, 370 N.E.2d at 434.

[13] Mass. Regs. Governing Practice of Medicine, Section 1.4p (1977) (emphasis added).

regularly administers simple medical treatment to its residents under its general powers of guardianship, it will not administer elective medical treatment without court approval.[19] As a result, on April 26, it filed a petition in the Hampshire County Probate Court for the purpose of having the court appoint a guardian who would consent to a course of chemotherapy treatment for Mr. Saikewicz. Because the matter was thought urgent and existing law did not seem to provide for the appointment of a temporary guardian for mentally retarded persons,[20] the petitioners also requested that the court forthwith appoint a guardian ad litem in the hope that he would have the power to provide interim consent.[21]

By May 5, when the guardian ad litem was appointed, the doctors attending Mr. Saikewicz had changed their minds about whether it was in their patient's best interests to begin chemotherapy. They had come to the conclusion that he was probably better off being allowed to die from the leukemia. As a result, when the guardian ad litem filed a report with his recommendations on May 6, he concluded, on the basis of consultations with the attending physicians, "'that not treating Mr. Saikewicz would be in his best interests.'"[22] Hence, although the probate court held a hearing on the report of the guardian ad litem on May 13, it would be hard to argue that the hearing constituted an adversary proceeding. On one side were the petitioners, who had originally come to court seeking permission to begin chemotherapy but whose doctors gradually had come around to

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[14] The present writer's experience in working with medical personnel in various medical facilities over the past few years (which includes a two-week stint as a volunteer "medical-ethical consultant" at a chronic care hospital), confirms the fact that, until recently, such decisions were made by participants on the basis of standards that frequently were (1) not explicitly delineated or consistently worked out at any given time, (2) not consistently applied over time, (3) differed from participant to participant, and (4) took into consideration factors which the Supreme Judicial Court rejects as criteria in *Saikewicz*. Many of the doctors, nurses, and other medical personnel were well aware of these deficiencies in the decision-making system and have served as a motivating force in bringing the decision making "out of the closet" so that more consistent and just systems could be developed.

[15] Relman, *The Saikewicz Decision: Judges as Physicians*, 298 NEW ENGLAND J. MED. 508 (1978).

[16] *Id.*

[17] Curran, *Law-Medicine Notes: The Saikewicz Decision*, 298 NEW ENGLAND J. MED. 499 (1978).

[18] 1977 Mass. Adv. Sh. at 2501, 370 N.E.2d at 435.

[19] Conversation with Paul R. Rogers, Esq., Staff Attorney, Belchertown State School, March 7, 1978.

[20] At the time of filing, the statute authorizing the appointment of temporary guardians, MASS. GEN. LAWS ANN. ch. 201, § 14 (1958), seemed to omit authorization of the appointment of a temporary guardian for a mentally retarded person. The statute was amended to remedy that deficiency on August 9, 1976, when Chapter 277 of the Acts of 1976 was signed into law. MASS. GEN. LAWS ANN. ch. 201, § 14 (Supp. 1978).

[21] 1977 Mass. Adv. Sh. at 2461-62, 370 N.E.2d at 419.

[22] 1977 Mass. Adv. Sh. at 2462, 370 N.E.2d at 419.

a position generally opposed to it. On the other side was an incompetent defendant, represented by a guardian ad litem who was also opposed.

The transcript of the May 13 probate court hearing makes the lack of adversary process patent. Although the petition in the case called for the appointment of a guardian who would consent to treatment, counsel for the petitioner put on evidence that essentially proved the case against treatment. Three doctors were put on the stand by the petitioner for the purpose of testifying to some of the surrounding facts and, in the case of two of them, of expressing opinions that Mr. Saikewicz should *not* be given chemotherapy.[23] When one of the doctors was unclear about that opinion, counsel for the petitioner led the witness with this question: "You feel that the treatment should be withheld since his condition is stable?"[24] When the same doctor seemed to be muddying the evidence for denying chemotherapy by saying, "If we give him chemotherapy, he will become very sick and if we treat him intensively, then he might live indefinitely and recover," counsel for the petitioner provoked the following clarifying exchange:[25]

Q. You say that he might live indefinitely?
A. I am saying for a year or so.
[Q.] You can be seated. Thank you Dr. Ross.

Through all of this there were no objections by the guardian ad litem, although there was one question asked by way of cross-examination.[26] At the conclusion of the case, the guardian ad litem expressed a relatively equivocal opinion that was taken to be the same as that expressed in his earlier report.[27] The only person in the room who seemed interested in considering arguments in favor of chemotherapy was Judge Jekanowski. At one point, he said: "I feel that if I had a serious disease and with treatment I could live another five or eight years or ten years, whatever, I'd rather take the treatment than just take the chance of dying tomorrow or next week."[28] At another point he recalled:[29]

> I had a patient, a patient at the State Hospital who didn't want water, and didn't want food. So the doctors were frightened for without water and without food he would die. They had a hearing such as this and they were asking the Court his permission to

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[23] *In re* Joseph Saikewicz, No. 45596, transcript of proceedings of May 13, 1976 (Mass. Probate Court, Hampshire County, May 13, 1976).

[24] *Id.* at 20.

[25] *Id.* at 22.

[26] *Id.* at 21.

[27] *Id.* at 28-29, 32-33.

[28] *Id.* at 28.

[29] *Id.* at 29.

> allow them to force feed this patient. This must have been two years ago and the patient is living because they did force feed and gave him water and food by force and he is still alive and happy. In effect, they saved his life or that saved his life. This is a similar type of case, in a way.

But the judge found no support for his position from anyone else in the courtroom, and, although he at one point said, "I am inclined to give treatment,"[30] he ultimately was argued around to the opposite position, after which counsel for petitioner offered to draft the written order authorizing the withholding of chemotherapy.[31]

In an effort to avoid this sort of procedural confusion in the future, the Supreme Judicial Court in *Saikewicz* devotes an unusual amount of attention to the matter of laying down guidelines for future handling of such cases. "The first step," reads the opinion, "is to petition the court for the appointment of a guardian or a temporary guardian."[32] At the hearing that is to be provided upon such petitions, the questions to be addressed are (1) whether the person involved is incompetent,[33] and (2) if the person is incompetent, who shall be appointed guardian. The court goes on to recognize important functions for the guardian ad litem:[34]

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[30] *Id.* at 31.

[31] *Id.* at 33. Apparently on the basis of concern that court action would not give full immunity to the petitioners until the appeal period had expired unless quick appellate review were obtained within that period, counsel for petitioner requested that the case be reported to the appropriate appellate court. *Id.* at 29. Immediately upon issuing its order, the probate court did, in fact, report to the Massachusetts Appeals Court the two questions that appear in note 2, *supra*. Shortly thereafter, counsel for petitioner filed an application for direct appellate review by the Supreme Judicial Court, which was granted on June 14, 1976. At that point, the case took on an adversarial quality for the first time. The Department of the Attorney General filed with counsel for petitioner a brief that aggressively pressed the case for reversing the lower court and for giving chemotherapy to Mr. Saikewicz. Among other things, the brief attempted to introduce published reports of empirical studies that cast doubt on the probate court's finding that patients over 60 are less successfully treated by chemotherapy. The court rejected the invitation to consider the studies. "None of these authorities was brought to the consideration of the probate judge. We accept the judge's conclusion, based on the expert testimony before him and in accordance with substantial medical evidence, that the patient's age weighed against the successful administration of chemotherapy." 1977 Mass. Adv. Sh. at 2466 n.4, 370 N.E.2d at 421 n.4. On behalf of appellee, a brief was filed by the guardian ad litem and an amicus curiae brief was filed by the Civil Rights and Liberties Division of the Department of the Attorney General. Other amicus curiae briefs were filed by the Mental Health Legal Advisors Committee, the Massachusetts Association for Retarded Citizens, Inc., and the Developmental Disabilities Law Project of the University of Maryland Law School.

[32] *Id.* at 2497, 370 N.E.2d at 433 (statutory references omitted).

[33] *Id.* The opinion actually uses the term "mentally retarded" rather than "incompetent." However, read in the context of the paragraph in which it appears and the full opinion, the court cannot reasonably be taken to be suggesting that the question is merely one of mental retardation.

[34] *Id.* at 2497-98, 370 N.E.2d at 433-34.

> As an aid to the judge in reaching these two decisions, it will often be desirable to appoint a guardian ad litem, sua sponte or on motion, to represent the interests of the person. Moreover, we think it appropriate, and highly desirable, in cases such as the one before us to charge the guardian ad litem with an additional responsibility to be discharged if there is a finding of incompetency. This will be the responsibility of presenting to the judge, after as thorough an investigation as time will permit, all reasonable arguments in favor of administering treatment to prolong the life of the individual involved. This will ensure that all viewpoints and alternatives will be aggressively pursued and examined at the subsequent hearing where it will be determined whether treatment should or should not be allowed.

The role the court suggests for the guardian ad litem in the quoted passage is much like that proposed by the present writer in a 1975 article that explored problems of nonadversariness in organ and tissue transplant proceedings brought in the state courts for the purpose of securing proxy consent from minor donors.[35] That article, which is discussed in two of the supplementary briefs filed in *Saikewicz* for the purpose of proposing procedures for future handling of *Saikewicz*-type cases,[36] deplored the lack of procedural fairness afforded minor donors that had resulted from confusion regarding the role of the guardian ad litem. Such confusion was natural. The traditional role of a guardian ad litem is to represent in any proceeding the best interests of his ward.[37] However, in those minor donor proceedings, where the parents and hospital were seeking to have the donor child consent to a transplant that might save the life of a sibling, the very question that was to be decided by the court was which result was in harmony with the best interests of the *donor* child: saving the life of his sibling, or refusing to submit to the risks of donation. As a result, a practice had arisen under which the guardians ad litem forsook their traditional advocacy role.[38] They would determine for themselves and report to the court their conclusions regarding the question that was to be decided by

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[35] Baron, Botsford, & Cole, *Live Organ and Tissue Transplants from Minor Donors in Massachusetts*, 55 B.U.L. REV. 159 (1975) [hereinafter cited as Baron, Botsford, & Cole]. *See also* Baron, *Voluntary Sterilization of the Mentally Retarded*, in G. ANNAS & A. MILUNSKY, GENETICS & THE LAW 267 (1975).

[36] The briefs filed by the Department of the Attorney General and by the Civil Rights and Liberties Division of the Department of the Attorney General cite the article on the role of the guardian ad litem in assuring a true adversary process. However, the article is cited in the *Saikewicz* opinion for a different purpose only. 1977 Mass. Adv. Sh. at 2492, 370 N.E.2d at 431.

[37] *See* Kingsbury v. Buckner, 134 U.S. 650 (1889); Rankin v. Schofield, 71 Ark. 168, 66 S.W. 197 (1902); Tyson v. Richardson, 103 Wis. 397, 79 N.W. 439 (1899).

[38] Baron, Botsford, & Cole, *supra* note 35, at 182-86.

the court: whether donation was in fact in the best interests of their wards. This nonadvocacy function, the article argued, undermined what the *Saikewicz* opinion has since then felicitously called "the process of detached but passionate investigation and decision . . . ." The essence of that process comprises a division of role between, on the one hand, advocates who have the primary responsibility for passionate investigation and argument on behalf of their opposed positions and, on the other hand, judges who have the primary responsibility for detached and objective decision making rendered upon a record made full by the advocacy of counsel. "Failure generally attends the attempt to dispense with the distinct roles traditionally implied in adjudication," warns a 1958 report of a committee of distinguished legal scholars and practitioners. "What generally occurs in practice [where those roles break down] is that at some early point a familiar pattern will seem to emerge from the evidence; an accustomed label is waiting for the case and, without awaiting further proofs, this label is promptly assigned to it."[39]

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[39] *Report of the Joint Conference On Professional Responsibility of the Joint Conference of the American Bar Association and the Association of American Law Schools*, 44 A.B.A.J. 1159, 1160 (1958).

For a later empirical study that supports the Joint Conference Report, *see* J. THIBAUT & L. WALKER, PROCEDURAL JUSTICE: A PSYCHOLOGICAL ANALYSIS (1975). The authors' conclusion is remarkably unequivocal:

> It is perhaps the main finding of the body of our research, therefore, that for litigation the class of procedures commonly called "adversary" is clearly superior.
>
> Our suggestion that the adversary procedure is superior to other classes of procedure rests both on its operating capabilities and on subjective and normative appraisals of its performance. In Chapter 5 [of *Procedural Justice*] the adversary procedure exhibits a capacity to protect against erroneous decisions based on chance distributions of the immediately discovered facts. Advocates who encounter facts unfavorable to their side of the case are instigated to search diligently and persistently for more favorable evidence. In Chapter 6 the procedure has been shown effective in moderating preexisting bias among decision makers. The results reported there do indeed appear to support Fuller's (1961) claim that the adversary mode serves to combat a "tendency to judge too swiftly in terms of the familiar that which is not yet fully known." In Chapter 7 the procedure is found able to correct potential distortions of judgment deriving from the temporal presentation of evidence. We conclude from this research that the adversary trial is remarkably well arranged to neutralize the ultimate effects of order and to insulate the decision-making process from this source of irrelevant influence. Indeed, paradoxical as it may seem, the very contentiousness of the adversary proceeding may exert a beneficial moderating influence on litigation.
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> With respect to appraisals of justice, the adversary procedure again appears to be superior. In the research reported in Chapter 8 the procedure has been judged fairest and most trustworthy both by persons subject to litigation and by those observing the proceedings. Moreover, the adversary procedure produces greater satisfaction with the judgment, regardless of the outcome of the case and regardless of the parties' beliefs in their own guilt or innocence. In Chapter 9 a further assessment of some elements of adversary procedure has shown that each of the elements—separation of presentations, alignment of attorneys, and free choice of attorneys—contributes significantly and about equally to heightened satisfaction and

Such was the result in most of the minor donor cases. The guardian ad litem would reach his own conclusion (concerning the best interests of his ward) as a detached decision maker without the benefit of any advocate's passionate investigation and development of the record upon which to make his decision. He would then go into court with his mind virtually made up, thus denying to the court in turn the value of passionate investigation and advocacy in developing a record upon which the court could base its detached decision. Furthermore, the 1975 article observed, "[t]he hospital and the parents assuredly are not engaged in a dispassionate search for truth. They want the transplant to occur, and they go into court with the intention of proving that the participation of the prospective donor is consistent with whatever standard the court decides to apply."[40] Because, in almost every such case, the guardian had already determined that donation was in the best interests of his ward, there was no advocate present to argue the case against donation, and it became[41]

> too easy for the judge to gloss over the evidence and issues in an effort to reach quickly and efficiently what seems to be the right result. Of course, such action need not reach the level of a conscious effort to take the path of least resistance. It may operate merely through the unconscious development of a mental set as to the merits of the case, blinding the judge to the lines of opposing argument and evidence that could have been developed.

In order to obviate this problem, the article proposed:[42]

> Courts should be required to appoint guardians ad litem to represent prospective minor donors in all transplant proceedings. The guardian's role should be defined as that of an advocate of the child's interest in not acting as a donor; the guardian should be instructed to present all the evidence and arguments against his ward's donation and to oppose the positions taken by the hospital and family, regardless of the guardian's personal perception of the child's actual interests.

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judged fairness of the procedure. Chapters 8 and 9 have dealt with the impact of structural variations in procedure on rated satisfaction. In Chapter 10 structure has been held constant and the stylistic performance of roles has varied. The results in Chapter 10 have led us to conclude that as compared to structural variations stylistic differences are less potent determinants of satisfaction with procedures. Likewise, in Chapter 11 the adversary procedure fares well when tested by a normative standard of justice. Participants behind a "veil of ignorance" concerning their advantage or disadvantage in a subsequent trial express a conception of procedural fairness that is recognized uniquely in an adversary system.

Id. at 118.

[40] Baron, Botsford, & Cole, *supra* note 35, at 183.

[41] *Id.*

[42] *Id.* at 186.

The system proposed in the 1975 article is now being employed by some of the courts and guardians ad litem handling cases involving organ and tissue transplants from minor donors.[43] On the one hand, such advocacy has not produced thus far any case in Massachusetts in which a court has refused to authorize proxy consent for donation of bone marrow or a kidney to a sibling.[44] This is not, of course, surprising, in light of the fact that these cases normally involve offering great benefit to the recipient at the price of what seems relatively slight risk to the donor.[45] On the other hand, there have been benefits to the donors and to the system. The earliest cases in which guardians played full advocacy roles[46] produced a court-developed scheme for insurance devised to compensate a donor who might be disabled by the donation. One attorney who has handled a number of such appointments on a pro bono basis believes that his strong advocate's position[47] has been responsible for reducing the extent and number of operative procedures upon his wards in some cases and has assured concern for the special risks of anesthesia for one ward who had asthma. He has also found that his commitment to his role as an advocate stimulates a continuing desire to learn more about the details of the transplant procedures so that he can more effectively cross-examine witnesses and develop the evidence for his side. These efforts at education have been assisted by doctors in the field and have included observing a two-and-one-half-hour bone marrow transplant operation on one of his wards.

This attitude of "passionate investigation" is even more important in cases of the *Saikewicz* type, where it is more likely to make a difference in the ultimate outcome. In *Saikewicz*, the Supreme Judicial Court states very clearly that the only substantive standard which the courts are to employ (assuming there are no pro-life state interests to the contrary) is that of taking that action for the ward that he would have taken for himself if he were competent. But without adequate safeguards, other criteria are likely to intrude. Indeed, as the Supreme Judicial Court points out, the probate court in *Saikewicz* could be read to have improperly considered, in reaching its decision against chemotherapy, the fact that Mr. Saikewicz was profoundly retarded and the effect that this had upon "'the quality of life possible for him even if the treatment does bring about remission.'"[48] As

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[43] One judge of the Suffolk County Probate Court regularly appoints two guardians ad litem in cases where the donee, as well as the donor, is a minor.

[44] For a case outside Massachusetts in which advocacy by a guardian ad litem developed a record upon which a court felt compelled to refuse to sanction donation of a kidney by a mentally retarded sibling, see *In re* Pescinski, 67 Wis. 2d 4, 226 N.W.2d 180 (1975).

[45] Baron, Botsford, & Cole, *supra* note 35, at 163 nn.19 & 20.

[46] Nathan v. Farinelli, Suffolk Eq. 74-87 and Nathan v. Flanagan, Suffolk Civil No. J 74-109.

[47] Interview with James R. DeGiacomo, Jr., Esq., in Boston, March 17, 1978.

[48] 1977 Mass. Adv. Sh. 2494, 370 N.E.2d 432. *See* note 10 *supra*.

a result of the disapproval voiced by the Supreme Judicial Court, this criterion is unlikely to surface explicitly in the future. But without aggressive advocacy, including assiduous cross-examination of witnesses, it still may function as a factor implicitly biasing the testimony of witnesses—as may other forbidden factors such as the potential costs to family, medical facilities, and society of prolonging the life in question.[49]

In light of the crucial importance of the role of the guardian ad litem in assuring objectivity and fairness in the judicial administration of these cases, the fault in the *Saikewicz* opinion is that it does not go far enough in laying guidelines for the development of a full and fair record through zealous representation of all positions.

First, the court neither requires that a guardian ad litem be appointed in every case, nor lays down specific guidelines for when such appointment is necessary or desirable. The opinion says only that "it will often be desirable to appoint a guardian ad litem, sua sponte or on motion, to represent the interests of the person,"[50] that "the Probate Court may appoint a guardian ad litem whenever the court believes it necessary to protect the interests of a person in a proceeding before it,"[51] and that "[t]his power is inherent in the court even apart from statutory authorization, and its exercise at times becomes necessary for the proper function of the court."[52] The cases cited by the court for this last proposition[53] approve it at best only in passing and without themselves giving any criteria for deciding when such appointment might be necessary. That a clear mandate from the court on this subject is needed is evidenced by the fact that many of the kidney transplant decisions in the Commonwealth have authorized the taking of a kidney from a child on the basis of proceedings in which no guardian ad litem was ever appointed to represent the interests of the child.[54]

Second, the court imposes a responsibility upon the guardian ad litem to make "all reasonable arguments in favor of administering treatment to prolong the life of the individual involved,"[55] but it does not say whether this is to be in addition to making arguments as well against treatment. At least one attorney who has served as a guardian ad litem in a post-*Saikewicz*

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[49] That none of these factors are to be permitted as criteria is a necessary implication of the court's commitment to the "substituted judgment" test. Such factors clearly would not justify termination of life-prolonging treatment for a patient who was competent and refused to consent to termination. They cannot, therefore, justify termination where an incompetent's "substituted judgment" comes out opposed to termination.

[50] 1977 Mass. Adv. Sh. 2497-98, 370 N.E.2d 433 (case reference omitted).

[51] *Id.* at 2495-96, 370 N.E.2d 433 (statutory reference omitted).

[52] *Id.* at 2496, 370 N.E.2d 433.

[53] Lynde v. Vose, 326 Mass. 621, 96 N.E.2d 172 (1951); Buckingham v. Alden, 315 Mass. 383, 53 N.E.2d 101 (1944).

[54] Baron, Botsford, & Cole, *supra* note 35, at 181.

[55] 1977 Mass. Adv. Sh. 2498, 370 N.E.2d at 433.

case has interpreted this language as a mandate to the guardian ad litem to remember to raise all such arguments as part of an effort to present relatively evenhandedly arguments both for and against prolongation of life.[56] However, others have interpreted the language to mean that the guardian ad litem is to devote himself primarily to the case for prolongation, leaving to opposing counsel the job of developing the case against.[57] Experience with the latter, more traditional, advocacy role indicates that it is much more conducive to the sort of "passionate investigation" that the court seems interested in promoting.[58]

Third, there is no guarantee that in the *Saikewicz*-type cases even requiring that a guardian ad litem be appointed and that he argue the case in favor of treatment "will ensure that all viewpoints and alternatives will be aggressively pursued and examined at the . . . hearing where it will be determined whether treatment should or should not be allowed."[59] In a case where the only other party is a petitioner who is also arguing for treatment, having the guardian ad litem argue for treatment will mean that the viewpoint against treatment will not be "aggressively pursued and examined." Technically this was the situation in *Saikewicz*. The Belchertown State School had petitioned, as it frequently does, for permission to begin treatment. In that case, as we have seen, it did not really press that position. But there may be other cases where a state institution will come to court prepared to vigorously assert that position. Under those circumstances, the need is to have someone, presumably the guardian ad litem, aggressively pursue the case against treatment. After all, the Supreme Judicial Court has recognized that the right to choose death with dignity "must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both."[60] It would seem, then, important to make sure that in every case the position against treatment is as adequately represented as the position for treatment.

Furthermore, even in many cases where the petitioner takes the position against treatment, there may be no meaningful representation of that position. Typically, the real moving party in these cases is the medical care facility that wants to be insulated from liability by a court order before it terminates supportive care or services—even though it may have the consent of the patient's family. Even if the principals of the facility and the doctors involved truly believe that care should be terminated, they do not want to be placed in the position of pressing the case for death. Moreover, in many cases, the principals and doctors are not sure what position they should take and are really seeking the court's guidance. As

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[56] Interview with Paul Resnick, Esq., March 10, 1978.

[57] Interview with James R. DeGiacomo, Jr., Esq., March 17, 1978.

[58] *Id.* and Interview with Beverly W. Boorstein, Esq., May 2, 1978.

[59] 1977 Mass. Adv. Sh. 2498, 370 N.E.2d at 433-34.

[60] *Id.* at 2482-83, 370 N.E.2d at 427.

a result, the medical personnel will suggest to the relatives that they petition for an order authorizing termination of care. But the relatives are frequently no more ready than the medical personnel to aggressively press the court for termination of care. They are likely to be very embarrassed about aggressively urging such a position, less able than the medical personnel to find and afford able counsel to represent them in such a specialized proceeding, and just as likely to be really interested in seeking the court's detached and wise guidance.[61] As a result, the position in favor of the patient's right to die with dignity is in danger of lacking adequate representation.

Hence, there may well be as much need for a court-appointed advocate for death with dignity as there is for a guardian ad litem who will make "all reasonable arguments in favor of administering treatment to prolong the life of the individual involved."[62]

III. RECOMMENDATIONS FOR PROCEDURES FOSTERING AN ADVERSARY PROCESS

For the purpose of attempting to assure an adversary process in *Saikewicz*-type cases, the present writer recommends the following procedural guidelines:

1. In every *Saikewicz*-type case, a guardian ad litem is to be appointed to represent the positions opposed to those taken in the petition.

2. That guardian ad litem is to see his role solely as that of an advocate for the positions opposed to the petition. He is to investigate, develop, and present evidence for his side, cross-examine opposing witnesses, and make arguments just as he would if he had a competent client who had retained him to oppose the position.

3. At any point in the proceedings, the guardian ad litem, any other party, or the judge, may suggest the appointment of a second guardian ad litem whose role will be to represent the position in favor of granting the petition in the same way that the first guardian ad litem is representing the position opposed to it.

At first blush, this proposal might seem to complicate further a system that already has drawn criticism from the medical community for being so cumbersome that it will imperil the proper exercise of medical discretion. In fact, if properly structured, it may make the system more workable from the point of view of both the legal and the medical communities. The Massachusetts Probate Court already has begun discussion of the possibility of establishing a corps of guardians ad litem who have volunteered for pro bono service in the cases that will follow in the wake of *Saikewicz*.[63]

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[61] Interview with Ronald Schramm, Esq., and Daniel Roble, Esq., March 24, 1978.

[62] 1977 Mass. Adv. Sh. 2498, 370 N.E.2d at 433.

[63] The establishment of such a corps of guardians ad litem was discussed at a statewide

With such a corps of experienced guardians ad litem intact, a given probate court could, upon the filing of a petition, immediately appoint one of its members to each side of the case with the expectation that they could prepare the case and argue it in a very short period of time. Preparation for the first *Saikewicz*-type case tends to be preparation in many respects for those that follow. Moreover, the Massachusetts Probate Court plan calls for constant communication between the volunteer guardians ad litem involved, and for efforts at interdisciplinary communication and cooperation with the health professionals in the fields affected. Among the many benefits that might come from such a system, therefore, are continuing proposals for improved procedures, suggestions that certain patterns of cases need no longer be brought to court in order to insulate the medical community from liability,[64] and improved understanding between the legal and medical communities.

These benefits are, of course, laudable but quite speculative. What seems certain is that, without a system, such as that proposed, that assures appropriate advocacy in each case of the interests of the patient both for and against treatment, the ideal of "passionate but detached investigation and decision" is likely to be served no better in the courtroom than it is in the intensive care unit.

Judicial Conference of Massachusetts Probate Court Judges held at Framingham, Massachusetts, on March 31, 1978. The principal topic of the Conference was the *Saikewicz* decision and the challenges it presented to the probate court. The idea of establishing a specialized panel of guardians ad litem to assist the court in handling *Saikewicz*-type cases was well received by the judges present. It was well received also by members of the medical community who attended the Conference.

Since the Conference, Chief Judge Podolski has encouraged the development of a list of attorneys who are willing and able to serve in such a capacity, which he will distribute to the probate court judges.

[64] In those cases where suit need not be brought to avoid liability but only to obtain declaratory relief, *see* note 3, *supra*, it may become clear that certain fact patterns no longer raise the risk of a successful suit on the merits, thus eliminating the motive for bringing those cases to court for what is essentially a declaratory judgment. The "brain death" cases provide a good example of candidates for this sort of treatment. On August 26, 1977, the Supreme Judicial Court adopted a version of the Harvard "brain death" criteria for purposes of establishing the death of a victim in a criminal case. Commonwealth v. Golston, 1977 Mass. Adv. Sh. 1778, 366 N.E.2d 744. Because *Golston* was a criminal case, some medical personnel and their counsel have been concerned about potential civil liability in situations where they terminate life support treatment for patients who are dead by the Harvard criteria but not by more traditional criteria. There is even more widespread concern about terminating such support where most, but not all, of the technical "brain death" criteria have been met. As a result of these uncertainties, medical personnel and relatives who would be participants in terminating supportive services for "brain dead" patients have brought petitions to probate court seeking court authorization for termination. Since these suits result from uncertainty regarding the precise limits of the law, there is likely to be no need to bring them as it becomes clear that certain fact patterns fall within or without them. Where it is clear in advance that certain acts do not give rise to liability, it would be a waste of court time and taxpayers' money to go through the ritual of obtaining a court declaration of nonliability.