Cornell Law Review

Volume 75
Issue 1 *November 1989*

Article 7

Do Not Resuscitate: The Failure to Protect the Incompetent Patient's Right of Self-Determination

Elizabeth Shaver

DO NOT RESUSCITATE: THE FAILURE TO PROTECT THE INCOMPETENT PATIENT'S RIGHT OF SELF-DETERMINATION

INTRODUCTION

Traditionally, the physician has determined the time and manner of a terminally ill patient's death,[1] although the patient nominally maintained the right to control medical treatment through the exercise of informed consent.[2] Informed consent assumes that only the patient can truly weigh all the relevant factors involved in a personal treatment decision. In forgoing treatment, a terminally ill patient considers not only the medical factors involved, but also moral, ethical, religious, and familial values. The importance of these nonmedical considerations mandate patient participation in the treatment decision-making process.[3]

The right to determine treatment has evolved beyond the common law doctrine of informed consent to become a right of privacy protected by the federal Constitution. This "right of self-determination" allows competent patients to evaluate their medical condition, weigh other relevant factors, and then determine their treatment preference. Further, more than half of the states have enacted "Do Not Resuscitate" (DNR) statutes recognizing a terminally ill patient's right to refuse treatment and thereby determine the manner of their death.[4]

---

1 Note, *Medico-Legal Implications of Orders Not To Resuscitate*, 31 CATH. U.L. REV. 515 (1982) (authored by Nancy Tecklenburg).

2 *See infra* notes 12-19 and accompanying text.

3 *See* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE SUSTAINING TREATMENT 128 (1983) [bereinafter PRESIDENT'S COMMISSION].

4 Thirty-four states and the District of Columbia have enacted legislation providing for living wills and/or DNR orders: *see* ALA. CODE §§ 22-8-1 to -10 (1984); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1986); ARK. STAT. ANN. §§ 20-17-201 to -218 (Supp. 1989); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1989); COLO. REV. STAT. §§ 15-18-101 to -113 (1987 & Supp. 1989); CONN. GEN. STAT. §§ 19a-571 to -575 (1989); DEL. CODE ANN., tit. 16, §§ 2501-2509 (1983); D.C. CODE ANN. §§ 21-2202 to -2213 (1989); FLA. STAT. ANN. §§ 765.01 to .15 (West 1986); GA. CODE ANN. §§ 31-32-1 to -12 (1985 & Supp. 1989); IDAHO CODE §§ 39-4501 to -4509 (1985 & Supp. 1989); ILL. ANN. STAT. ch. 110½, ¶¶ 701-709 (Smith-Hurd Supp. 1989); IOWA CODE ANN. §§ 144A.1 to .11 (West 1989); KAN. STAT. ANN. §§ 65:28, 101-109 (1985); LA. REV. STAT. §§ 40:1299.58.1 to .10 (West Supp. 1989); ME. REV. STAT. ANN. tit. 22, § 2921-2931 (West Supp. 1989); MO. ANN. STAT. §§ 459.010 to .055 (Vernon Supp. 1989); MONT. CODE ANN. §§ 50-9-102 to -104 (1988); NEV. REV. STAT. ANN. §§ 449.540 to .730 (Michie 1986 & Supp. 1989); N.M. STAT. ANN. §§ 24-7-1 to -10 (1986); N.C. GEN. STAT. §§ 90-320 to -322 (1988); N.D. CENT. CODE §§ 23-06.4-01 to -14 (Supp. 1989); OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West Supp. 1990); OR. REV. STAT. §§ 97.050 to .090

Incompetent patients, however, raise special problems as to the right of self-determination because they lack the ability to appreciate medical and non-medical factors, and to formulate and communicate their treatment preferences.[5] Some courts have held that only competent patients have a right of self-determination and that such patients lose this right upon losing capacity.[6] Other courts have held that the right of self-determination extends to incompetent patients, through a surrogate, usually a family member, who exercises the right for the patient.[7] The patient's surrogate uses a "substituted judgment" test in which the surrogate "put[s] himself in the shoes of the incompetent patient and decide[s] as the patient would if competent."[8] The incompetent patient who has no surrogate further complicates the process, therefore, because there exists no person with sufficient knowledge of the patient to articulate the patient's treatment preferences.[9]

Although many states have enacted DNR statutes to protect the rights of terminally ill patients, only the New York General Assembly has addressed the problem of the incompetent patient without a surrogate.[10] Section 2966 of the statute allows a physician to issue a DNR order for an incompetent patient without a surrogate if two

---

(1983); S.C. CODE ANN. §§ 44-77-10 to -160 (Law. Co-op. Supp. 1988); TENN. CODE ANN. §§ 32-11-101 to -110 (Supp. 1989); TEX. HEALTH & SAFETY CODE §§ 672.001 to .021 (LEXIS 1989); UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1989); VT. STAT. ANN. tit. 18, §§ 5251-5262 (1987); VA. CODE ANN. § 54.1-2981 to -2992 (1988 & Supp. 1989); WASH. REV. CODE ANN. §§ 70.122.010 to .905 (Supp. 1989); W. VA. CODE §§ 16-30-1 to -10 (1985); WIS. STAT. ANN. §§ 154.01 to .15 (1989); WYO. STAT. §§ 33-22-101 to -109 (1988).

5 A surrogate is defined in one statute as a "person selected to make a decision regarding rescusitation on behalf of another person pursuant to section twenty-nine hundred sixty-five of this article." N.Y. PUB. HEALTH LAW § 2961(17) (McKinney Supp. 1990). Section 2965 lists the following persons in descending order: a spouse, son or daughter, parent, brother or sister, close friend. *Id.* § 2965(4)(a)(iii-vii) (McKinney Supp. 1990).

6 *See, e.g., 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). Under the common law doctrine, only the patient may decide to exercise the right of self-determination. The common law reflects the belief that only the patient may adequately weigh the probable consequences of treatment. Under the constitutional right of privacy, *see infra* notes 18-26 and accompanying text, the right of self-determination remains with the patient, whether or not conscious. Thus, the common law right and constitutional right create very different results for the incompetent patient.

7 *See, e.g., In re* Quinlan, 137 N.J. Super. 227, 348 A.2d 801 (Ch. Div. 1975), *modified and remanded*, 70 N.J. 10, 55, 355 A.2d 647, 664 (1976); *see infra* notes 27-42 and accompanying text.

8 Note, In re *Conroy: Forging a Path to Death with Dignity*, 67 B.U.L. REV. 365, 370 (1987) (footnote omitted) (authored by Andrew Agrawal); *see infra* notes 60-69 and accompanying text.

9 *See* PRESIDENT'S COMMISSION, *supra* note 3, at 126.

10 N.Y. PUB. HEALTH LAW §§ 2960-2978 (McKinney Supp. 1990).

physicians concur that "resuscitation would be medically futile."[11] This Note contends that section 2966 does not adequately protect the right of self-determination of the incompetent patient without a surrogate because the physician issuing the order cannot possibly evaluate the important, non-medical factors involved in making an irreversible treatment decision. This Note argues that, when no surrogate exists, a hospital ethics committee together with a guardian ad litem can better protect the incompetent patient's right by reviewing the case prior to the point at which a physician issues a DNR order.

I

THE ORIGINS OF THE RIGHT OF SELF-DETERMINATION

The doctrine of informed consent provides the basis for the patient's right of self-determination.[12] Under the doctrine, the physician must inform the patient as to the type of treatment and the risks involved, then the patient must consent to that particular treatment.[13] Informed consent thus recognizes the individual's interest in preserving the "inviolability of his person."[14] Self-determination as derived from informed consent gives each person the right to control his or her own body, "a basic societal concept long recognized in the common law."[15] Under self-determination, the individual weighs the costs and benefits of treatment according to his or her particular needs and exercises the right by giving or withholding consent.[16] Only a patient knows sufficiently the value preferences,

---

11 *Id.* § 2966.

12 3 FOWLER V. HARPER, FLEMING JAMES & OSCAR GRAY, THE LAW OF TORTS § 17.1 (1986).

13 *See* Logan v. Greenwich Hosp. Ass'n, 191 Conn. 282, 465 A.2d 294 (1983); *see also* Note, *Informed Consent and the Dying Patient*, 83 YALE L.J. 1632, 1635 (1974) (authored by Charles H. Montange) (informed consent does not give the physician an unqualified right to treat the patient in any manner; the patient must consent to any new treatment); RESTATEMENT (SECOND) OF TORTS § 892A comment e (1977) (consent is to substantially the same conduct as described and to any bodily invasion). *Cf.* W. PAGE KEETON & WILLIAM L. PROSSER, PROSSER & KEETON ON THE LAW OF TORTS 118 (W. Page Keeton 5th ed. 1984).

14 Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 739, 370 N.E.2d 417, 422 (1977) (citing Pratt v. Davis, 118 Ill. App. 161, 166 (1905), *aff'd*, 224 Ill. 300, 79 N.E. 562 (1906)).

15 *See* Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891) ("[N]o 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 own person . . ."); *see also* Pratt v. Davis, 118 Ill. App. 161, 166 (1905), *aff'd*, 224 Ill. 300, 79 N.E. 562 (1906); *In re* Farrell, 108 N.J. 335, 347, 529 A.2d 404, 410 (1987); Zimmerman v. New York City Health and Hosps., 91 A.D.2d 290, 458 N.Y.S.2d 552 (N.Y. App. Div. 1983); Schloendorff v. New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914); Note, *supra* note 13.

16 3 F. HARPER, F. JAMES & O. GRAY, *supra* note 12, at 563; *see also* PRESIDENT'S COMMISSION, *supra* note 3, at 136.

capacity for pain and suffering, and religious beliefs necessary to decide what treatment best serves his or her needs.[17] The right of self-determination thus preserves a patient's bodily autonomy.

The Supreme Court has not expressly recognized this right of self-determination as a federal Constitutional right of privacy.[18] However, the Court has expanded the right of privacy to include such personal and medical concerns as contraception,[19] procreation,[20] and family relationships.[21] For example, the Court has held that a woman may exercise the rights of privacy and self-determination to decide whether to bring her pregnancy to term.[22] Indeed, the Court has extended this right of self-determination to permit a woman to terminate her pregnancy without her husband's knowledge or input, despite the interest he may have in the medical decision.[23]

The Supreme Court decisions echo the common law notion that no right is more sacred than the right of every individual to

---

17 *See* 3 F. HARPER, F. JAMES & O. GRAY, *supra* note 12, at 563; Note, *supra* note 13, at 61.

18 *But see In re* Quinlan, 70 N.J. 10, 40, 355 A.2d 647, 663 (1975); Note, *supra* note 8, at 368-69 ("The most important aspect of the *Quinlan* decision was . . . that an incompetent person's right to refuse treatment flows from the federal constitutional right of privacy."); *see also* Griswold v. Connecticut, 381 U.S. 480, 484 (1965) ("The Bill of Rights have [sic] penumbras, formed by emanations from those [specific] guarantees that help give them life and substance.").

The right to refuse medical treatment does not extend to all forms of medical treatment. For example, some courts hold that a person may not refuse blood transfusions, on religious grounds, when refusal means a loss of life. *See, e.g., In re* President of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964); *see also* Note, *Appointing an Agent to Make Medical Treatment Choices*, 84 COLUM. L. REV. 985 (1984) (authored by Mark Fowler) [hereinafter Note, *Appointing an Agent*]; Note, *Equality for the Elderly Incompetent: A Proposal for Dignified Death*, 39 STAN. L. REV. 689, 700 (1987) (authored by Tracy L. Merritt) [hereinafter Note, *Dignified Death*]. *But see* Estate of Brooks, 32 Ill. 2d 361, 205 N.E.2d 435 (1965) (Jehovah's Witness has legal right to refuse medical treatment).

19 Eisenstadt v. Baird, 405 U.S. 438 (1972).

20 Skinner v. Oklahoma, 316 U.S. 535 (1942).

21 Moore v. East Cleveland, 431 U.S. 494 (1977).

22 Roe v. Wade, 410 U.S. 113 (1973). The right to decide whether or not to bring the pregnancy to term may be exercised only in the first trimester without any state interference. In the second trimester, the state may regulate the medical conditions of the abortion, following its interest in the mother's welfare. In the third trimester, the state's *parens patriae* interest in preserving life becomes compelling and the woman may no longer decide to terminate her preguancy. *Roe*, 410 U.S. at 164-65.

These circumstances differ from the incompetent patient because a treatment refusal case decision does not implicate another life, such as a fetus's life. Thus, the principle in *Roe*, that an individual has a constitutional right to determine private medical matters, becomes even more compelling in a treatment refusal case.

23 Planned Parenthood of Mo. v. Danforth, 428 U.S. 52 (1976) (the woman physically bears the child and is more affected by the pregnancy, so she may decide unilaterally).

possess and control himself free from restraint.[24] Although the Court recently limited the right to privacy in a case dealing with homosexual sodomy, it noted that privacy in matters dealing with family, marriage, or procreation still remained protected under the Constitution.[25] The Court has thus established two factors which it uses to determine the existence of a constitutional right of privacy: (1) whether the decision is personal, involving one's self or family, and (2) whether the decision greatly affects life and development. Because the decision to refuse life-sustaining treatment involves both of these issues, a constitutional right of self-determination has emerged.[26]

A. New Jersey and Massachusetts Establish a Right of Self-Determination

The celebrated case of Karen Ann Quinlan first established a constitutional right to refuse life-sustaining treatment. The New Jersey Supreme Court relied on the federal constitutional right of privacy cases to establish a right to refuse life-sustaining medical treatment.[27] In *Quinlan*, twenty-one year old Karen Ann Quinlan, for unknown reasons, had entered a chronic persistent vegetative state with no possible hope of recovery. The New Jersey Supreme

---

24 *See, e.g.*, Winston v. Lee, 470 U.S. 753, 759 (1985) ("A compelled surgical intrusion into an individual's body for evidence . . . implicates expectations of privacy and security of such magnitude that the intrusion may be 'unreasonable . . . .' "); Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 427 (1983) (citing *Roe*, 410 U.S. at 169 ("Central among these protected liberties is an individual's 'freedom of personal choice in matter of marriage and family life.")); Ingraham v. Wright, 430 U.S. 651, 673 (1977) ("Among the historic liberties . . . was a right to be free from, and to obtain judicial relief for, unjustified intrusion on personal security.") (footnote omitted); *see also* United States v. Charters, 829 F.2d 479, 491 (4th Cir. 1987) ("The right to be free of unwanted physical invasions has been recognized as an integral part of the individual's constitutional freedoms."); *In re* Colyer, 99 Wash. 2d 114, 120, 660 P.2d 738, 742 (1983) ("[A]n adult who is incurably and terminally ill has a constitutional right of privacy that encompasses the right to refuse treatment that serves only to prolong the dying process."); Note, *The Right to Die: An Extension of the Right of to Privacy*, 18 J. MARSHALL L. REV. 895, 906 (1985) (authored by Vincent T. Bust).

25 Bowers v. Hardwick, 478 U.S. 186 (1986), *reh'g denied*, 478 U.S. 1039 (1986). The *Bowers* Court upheld a Georgia state statute making sodomy a criminal offense and refused to find that homosexual sodomy was a constitutionally protected privacy right. As the Court stated: "No connection between family, marriage, or procreation on the one hand and homosexual activity on other has been demonstrated." *Id.* at 191; *see also* Whalen v. Roe, 429 U.S. 589, 599 (1977) ("The cases sometimes characterized as protecting 'privacy' have in fact involved at least two different kinds of interests. One is the individual interest in avoiding disclosure of personal matters, and another is the interest in independence in making certain kinds of important decisions.") (footnote omitted).

26 Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976). *Accord In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

27 *In re* Quinlan, 70 N.J. 10, 23, 355 A.2d 647, 654 (1976).

Court stated that "[United States] Supreme Court decisions have recognized that a right of personal privacy exists and that certain areas of privacy are gnaranteed under the Constitution."[28] The *Quinlan* court then held that this right of privacy encompassed a patient's decision to decline medical treatment under certain circumstances.[29] The New Jersey court thus guaranteed the terminally ill patient's right of self-determination to guide the course of his or her treatment.

In another seminal case, the Massachusetts Supreme Judicial Court also recognized a federal constitutional right of privacy which included the right of self-determination. In *Superintendent of Belchertown State School v. Saikewicz*,[30] Massachusetts mental health officials sought to refuse administering chemotherapy treatment to a sixty-seven year old mentally retarded man who had contracted leukemia. The Massachusetts Supreme Judicial Court held that the federal constitutional right of privacy included the patient's right to prevent "unwanted infringements of bodily integrity."[31] The court found that proper regard for human dignity and self-determination dictated that the terminally ill patient receive constitutional protection to refuse medical treatment.[32]

Although the *Quinlan* and *Saikewicz* courts determined that the right of self-determination included the right to refuse medical treatment, neither court found an absolute right to refuse life-sustaining treatment.[33] Both courts listed four countervailing state interests to balance against the individual's right of privacy: (1) the preservation of life, (2) the protection of innocent third parties, (3) the prevention of suicide, and (4) the maintenance of the medical profession's ethical integrity.[34] Treatment-refusal cases primarily

---

28 *Id.* at 40, 355 A.2d at 663; *see also Saikewicz*, 373 Mass. at 739, 370 N.E.2d at 424 (the constitutional guarantee of privacy "encompasses the right of a patient to preserve his or her right to privacy against unwanted infringements of bodily integrity in appropriate circumstances.").

29 *Quinlan*, 70 N.J. at 40, 355 A.2d at 663 (citing Roe v. Wade, 410 U.S. 113 (1973)). *Roe* held that a woman had a constitutional right to an abortion without any state constraints in the first trimester of her pregnancy. *See supra* note 22. Presumably these are the "certain circumstances" to which *Quinlan* refers.

30 373 Mass. 728, 370 N.E.2d 417.

31 *Id.* at 739, 370 N.E.2d at 424. The court stated: "The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination . . . ." *Id.* at 742, 370 N.E.2d at 426.

32 *Id.* at 738, 370 N.E.2d at 423.

33 *Quinlan*, 70 N.J. at 40, 355 A.2d at 663; *Saikewicz*, 373 Mass. at 741, 370 N.E.2d at 425.

34 These factors follow the reasoning of Roe v. Wade, 410 U.S. 113, 155 (1973), which says that the right is subject to some compelling state interests. However, the courts in *Quinlan* and *Saikewicz* did not classify the state interest as compelling, but rather as "countervailing" or "significant." *See Saikewicz*, 373 Mass. at 742, 370 N.E.2d at 425. Neither the *Saikewicz* nor the *Quinlan* court required a compelling state interest as re-

implicate the state interest in the preservation of life and maintaining the ethical integrity of the medical profession.[35]

In both of these cases, the courts found that the individual's privacy interest outweighed the state's interest in preserving the sanctity of life.[36] Because terminally ill patients generally require highly intrusive measures which can only briefly and painfully maintain life,[37] "the state's interest . . . weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims."[38] Indeed, some cases have noted that the decision to refuse medical treatment does not desecrate the value of life; rather, the failure to allow a competent human being to choose desecrates the value of life.[39]

The courts have also held that the patient's right of privacy generally outweighs the interest in preserving the ethical integrity of the medical profession.[40] Physicians do not compromise their ethical integrity when acceding to patient's decisions because the function

---

quired in *Roe*, 410 U.S. at 155 ("Where certain 'fundamental rights' are involved, the Court has held that regulation limiting these rights may be justified only by a 'compelling state interest'. . . ."); *compare In re* Conroy, 98 N.J. 321, 348, 486 A.2d 1209, 1223 (1985) ("[The right to decline treatment] may yield to countervailing societal interests in sustaining the person's life"); *see also* PRESIDENT'S COMMISSION, *supra* note 3, at 31-32; Note, *Substituted Judgment in Medical Decisionmaking for Incompetent Persons:* In re *Storar*, 1982 WIS. L. REV. 1173, 1181-83 (authored by Suzanne E. Williams).

35 Note, *supra* note 34, at 1183.

36 *See Quinlan*, 70 N.J. at 41, 355 A.2d at 664 (individual right of privacy increases as bodily invasion increases, state's interests in preserving life concomitantly decreases); *Saikewicz*, 373 Mass. at 740, 370 N.E.2d at 424-25 ("In a number of cases, no applicable state interest, or combination of such interests, was found sufficient to outweigh the individual's interests"); *see also In re* Farrell, 108 N.J. 335, 348, 529 A.2d 404, 411 (1987); *In re* Conroy, 98 N.J. 321, 349, 486 A.2d 1209, 1223 (1985).

37 *Quinlan*, 70 N.J. at 41, 355 A.2d at 664 ("the bodily invasion is very great—she requires 24 hour intensive nursing care, antibiotics, the assistance of a respirator, a catheter and a feeding tube"); *In re* Dinnerstein, 6 Mass. App. Ct. 466, 468, 380 N.E.2d 134, 135 (1978) ("Various plastic tubes are usually inserted intravenously to supply medications . . . directly to the heart."); *Conroy*, 98 N.J. 321, 486 A.2d 1209 (insertion of a nasogastric tube extending from the patient's nose through her esophagus to her stomach). Note, *The Conflict Continues: Who Decides Treatment Questions for the Terminally-Ill Incompetent Patient?*, 18 SUFFOLK U.L. REV. 641, 649 (1984) (authored by Karen Michaud Moran).

38 *Quinlan*, 70 N.J. at 41, 355 A.2d at 664; *see also* Note, *Dignified Death*, *supra* note 18, at 721 ("[a patient's] right to refuse treatment outweighs the state's interest in prolonging . . . life") (footnote omitted).

39 *See, e.g.*, *Farrell*, 108 N.J. 335, 529 A.2d 404 (citing *Conroy*, 98 N.J. 321, 486 A.2d 1209).

40 *See Saikewicz*, 373 Mass. at 743, 370 N.E.2d at 426 (the prevailing ethical practice seems to be to recognize that the dying are more often in need of comfort than treatment); *Quinlan*, 70 N.J. at 43, 355 A.2d at 665 (we would see "a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support or radical surgery"); *Conroy*, 98 N.J. at 352-53, 486 A.2d at 1225 ("[I]f the patient's right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor . . . .").

of medicine, in addition to healing, is to comfort the dying.[41] Some medical professionals claim that the physician has never had "a categorical imperative to treat aggressively, or to attempt to prolong life, no matter what the circumstances."[42] The patient thus does not compromise medical ethics when exercising the right to refuse treatment.

B. New York Refuses to Recognize the Constitutional Right of Self-Determination

Contrary to the courts in New Jersey and Massachusetts, the New York Court of Appeals expressly declined to reach the question of a constitutional right of self-determination.[43] Although New York has long recognized the right of a competent adult to refuse treatment,[44] the Court of Appeals in *Storar* found that the common law basis for the informed consent doctrine adequately protected the patient's participation in making treatment decisions.[45] In *Storar*, the court decided two cases which had been consolidated. The first case involved an eighty-three-year old Catholic priest who, although incompetent at the time, "had made it known that under [certain] circumstances he would want a respirator removed."[46] The Court of Appeals held that "clear and convincing" evidence of Brother Fox's preference existed; therefore, the hospital could discontinue life-sustaining treatment.[47]

In the second case, the court held that it would not discontinue treatment for a fifty-two-year old mentally retarded man with cancer. The court stated that "John Storar was never competent at any time in his life. He was always totally incapable of understanding or making a reasoned decision about medical treatment."[48] Because the patient could not physically formulate and express his treatment preference, the court denied his right of self-determination. The New York court considered the common law principle to be as pro-

---

41 *Saikewicz*, 373 Mass. at 758-59, 370 N.E.2d at 426; PRESIDENT'S COMMISSION, *supra* note 3, at 3, 32, 79 ("[H]ealth care professionals serve patients best by maintaining a presumption in favor of sustaining life, while recognizing that . . . patients are entitled to forego any treatment . . . .").

42 Arnold S. Relman, *The* Saikewicz *Decision: A Medical Viewpoint*, 4 AM. J.L. & MED. 233, 236 (1978).

43 *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

44 Schoendorff v. Society of New York Hosp., 211 N.Y. 125, 129-30 105 N.E. 92, 93 (1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . . .").

45 *Storar*, 52 N.Y.2d at 376, 420 N.E.2d at 70, 438 N.Y.S.2d at 272 (the court noted that the legislature protected patients' rights because state public health laws require doctors to obtain informed consent).

46 *Storar*, 52 N.Y.2d at 371, 420 N.E.2d at 68, 438 N.Y.S.2d at 270.

47 *Id.* at 378-79, 420 N.E.2d at 72, 438 N.Y.S.2d at 274.

48 *Id.* at 380, 420 N.E.2d at 72, 438 N.Y.S.2d at 274-75.

tective as the constitutional right,[49] yet the case of John Storar demonstrates the failings of the common law doctrine. Under common law, the patient loses the right of self-determination if incompetent; it is a personal right that a surrogate cannot exercise on behalf of the patient without clear evidence of the patient's intent.[50] Thus, only a competent patient may exercise the common law right of self-determination, becuase the common law demands clear evidence of the patient's treatment preferences.

C. The Self-Determination Rights of Incompetent Persons

The *Storar* court relied solely on the common law in refusing to extend the right of self-determination to incompetent patients. Under traditional informed consent doctrine, however, the physician could not administer any treatment to an incompetent patient;[51] a surrogate exercised the incompetent patient's right to make treatment decisions, but only if the surrogate had clear evidence of the patient's preference.[52] The *Storar* holding thus vitally affected the traditional rights of incompetent patients by not allowing a surrogate to exercise the incompetent patient's right of self-determination.

Some courts and commentators have questioned whether incompetent patients lose their right of self-determination upon losing capacity because the principles of bodily autonomy dictate that the incompetent patient maintain a right to decide treatment. In addition, in treatment-refusal cases, the courts which have established a constitutional right of self-determination have also extended the right to incompetent persons.[53]

The *Quinlan* court granted the right to refuse life-sustaining treatment to incompetent persons because the decision was such "a valuable incident of her right of privacy, [that] it should not be dis-

---

49 *Id.* at 377, 420 N.E.2d at 73, 438 N.Y.S.2d at 270 ("Neither do we reach that question [of the right of privacy] in this case because the relief granted to the petitioner . . . is adequately supported by common-law principles.").

50 Note, In re *Storar: The Right to Die and Incompetent Patients*, 43 U. PITT. L. REV. 1087, 1097 (1982) (authored by Carol Ann Colabrese).

51 *Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266; *see also* Relman, *supra* note 42, at 236 ("[t]he traditional responsibilities of the physician demand that he make judgments to treat, or not to treat, which in effect will determine whether, and for how long, and in what condition, the patient is likely to live or die.").

52 *See In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987).

53 *In re* Quinlan, 70 N.J. 10, 41, 355 A.2d 647, 664 (1976) ("[W]e have concluded that Karen's right of privacy may be asserted on her behalf . . . ."); *see also* Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 747, 370 N.E.2d 417, 428 (1977) ("The trend in the law has been to give incompetent persons the same rights as other individuals"); *In re* Dinnerstein, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978); *Jobes*, 108 N.J. 394, 529 A.2d 434; *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

carded solely on the basis that her condition prevents her conscious exercise of the choice."[54] The *Saikewicz* court also found that the right extended to the incompetent patient as well as the competent patient "because the value of human dignity extends to both."[55] Subsequent cases have routinely granted the right of self-determination to incompetent patients.[56] This right of self-determination for incompetent patients recognizes the individualistic ethos present in our history:

> The notion that a person is an autonomous being with inherent dignity and value and whose life and actions are—to the greatest extent compatible with the rights of others—to be controlled by his own choices, has been a dominant theme in the philosophy and politics of Western Civilization. . . .[57]

In declining to find a constitutional right of privacy, the *Storar* court expressly limited its holding to the facts of the case and noted that the legislature was better equipped to decide the relevant criteria for decisions to refuse treatment.[58] The New York General Assembly then extended the right to incompetent patients by adopting "Orders Not to Resuscitate."[59] The *Storar* holding remains important, however, because it means that incompetent patients are afforded no constitutional protection; their only source of right lies within the statutory provisions. If the statute does not permit adequate exercise of the right through substituted judgment, then incompetent patients have no recourse to constitutional law. Because of this lack of constitutional protection, incompetent patients, spe-

---

54 *Quinlan*, 70 N.J. at 41, 355 A.2d at 664.

55 *Saikewicz*, 373 Mass. at 745, 370 N.E.2d at 427 ("The recognition of that right must extend to the case of an incompetent, as well as a competent, patient."); *see also In re* Colyer, 99 Wash. 2d 114, 124, 660 P.2d 738, 744 (1983) ("An incompetent's right to refuse treatment should be equal to a competent's right to do so."); Note, *supra* note 37, at 652; Note, *supra* note 34, at 1187.

56 *See, e.g., In re* Spring, 380 Mass. 629, 634, 405 N.E.2d 115, 119 (1980) ("[T]he same right [of self-determination] is also extended to an incompetent person . . . ."); *Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978); *Peter*, 108 N.J. at 372, 529 A.2d at 423 ("all patients, competent or incompetent, with some limited cognitive ability or [terminally ill] . . . are entitled to choose whether or not they want life-sustaining medical treatment"); *Conroy*, 98 N.J. at 360, 486 A.2d at 1229 ("We hold that life-sustaining treatment may be withdrawn from an incompetent patient . . . .").

57 Note, *Decisionmaking for the Incompetent Terminally Ill Patient: A Compromise in a Solution Eliminates a Compromise of Patients' Rights*, 57 IND. L.J. 325, 333 (1987) (authored by Caroline Anne Knezevich).

58 *In re* Storar, 52 N.Y.2d 363, 378, 420 N.E.2d 64, 72, 438 N.Y.S.2d 266, 274 (1981).

59 *See* N.Y. PUB. HEALTH LAW §§ 2960-2978 (McKinney Supp. 1990); *infra* notes 138-49 and accompanying text. For commentary, see, *e.g.*, PETER I. RIGA, RIGHT TO DIE OR RIGHT TO LIVE: LEGAL ASPECTS OF DYING AND DEATH (1981); Note, *Dignified Death*, *supra*, note 18; Note, *supra* note 37; Note, *supra* note 50.

cifically those without a surrogate, need greater protection under this statute.

II
How to Exercise the Incompetent Patient's Right

The courts have developed two different methods by which a surrogate may exercise a patient's right of self-determination. Under the substituted judgment method, the surrogate draws from his or her personal knowledge of the patient's experiences or preferences to reach a decision that would most closely accord with the patient's wishes. Under the best interests method, the surrogate applies a more objective test to determine which treatment decision would be in the patient's best interests. Although each method has certain strengths and weaknesses, generally courts choose to apply the substituted judgment standard.

A. The Substituted Judgment Standard

The court in *Quinlan* was the first to allow a surrogate[60] to exercise the right of self-determination for an incompetent patient.[61] The New Jersey court noted that "[o]ur affirmation of Karen's independent right of choice . . . would ordinarily be based upon her competency to assert it. The sad truth, however, is that she is grossly incompetent and we cannot discern her supposed choice based on the testimony of her previous conversations with friends."[62]

To prevent destruction of Karen's fundamental right to refuse treatment, the court held that Karen's guardian and family would determine whether she would have chosen to refuse treatment given the circumstances.[63] The surrogate's decision then became Karen's course of treatment. This holding thus gave rise to the "substituted judgment standard," by which the patient's surrogate must "substi-

60 The surrogate is usually a family member. The President's Commission identified the family member as the preferable surrogate, because the family generally is most concerned about the patient, most knowledgeable about the patient's goals and preferences, and is generally recognized as an important social unit. *See* President's Commission, *supra* note 3, at 18, 128-29.

61 *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976); *see supra* notes 27-42 and accompanying text.

62 *Id.*

63 Evidence of the strong moral and religious character of Karen's father led the *Quinlan* court to determine that the family was the proper surrogate. *Quinlan*, 70 N.J. at 38, 355 A.2d at 662 ("Here a loving parent, qua parent . . . rais[es] the rights of his incompetent and profoundly damaged daughter. . . ."); *see also* Note, *supra* note 37, at 655 (treatment is painful and briefly extends life "through great sacrifice and bodily invasion").

tute its judgment as nearly as possible for [the patient's]."[64]

The court in *Superintendent of Belchertown State School v. Saikewicz* accepted the substituted judgment standard because of its straightforward respect for the integrity and autonomy of the individual.[65] The court stated that the primary goal in treating terminally ill, incompetent patients was to determine with as much accuracy as possible the individual's wants and needs.[66] From this principle, the court found that substituted judgment duplicated the patient's desires.

In contrast, the court in *Storar* rejected the substituted judgment standard as an unrealistic attempt to determine whether the terminally ill, incompetent patient would want to discontinue treatment.[67] The *Storar* court held that the mentally retarded Storar had never been competent and thus could not make a reasoned decision about treatment.[68] According to the *Storar* court, therefore, the patient alone could decide whether to refuse treatment, and once the patient became incompetent, the right to refuse treatment was lost.[69] The *Storar* decision thus denied the rights of any incompetent patient who did not have the forethought, or was unable, to make an explicit statement of his or her treatment preferences.

B. The Best Interests Standard

In *Conroy*, the New Jersey Supreme Court, faced with the case of an elderly patient who remained conscious yet lacked the mental and motor ability to let her wishes be known, attempted to articulate an alternative to the substituted judgment standard.[70] The *Conroy* court held first that Mrs. Conroy retained her right to refuse treatment although she was "incompetent." In a very detailed opinion, the court stated that, in applying substituted judgment, the patient's surrogate must "seek to respect simultaneously both aspects of the patient's right to self-determination—the right to live, and the right . . . to die . . . ."[71]

The *Conroy* court next stated that, "[i]n the absence of adequate

64 Note, *supra* note 34, at 1190.

65 Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 748, 370 N.E.2d 417, 428 (1977); *see id.* at 753, 370 N.E.2d at 428 ("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 that same panoply of rights and choices it recognizes in competent persons.").

66 *Id.* at 751, 370 N.E.2d at 428.

67 *In re* Storar, 52 N.Y.2d 363, 378, 420 N.E.2d 64, 72, 438 N.Y.S.2d 266, 274 (1981). *See supra* notes 43-59 and accompanying text.

68 *Id.* at 378, 420 N.E.2d at 72, 438 N.Y.S.2d at 274; *see* Note, *supra* note 34, at 1181.

69 *Id.* at 378, 420 N.E.2d at 72, 438 N.Y.S.2d at 274.

70 *In re* Conroy, 98 N.J. 321, 360-68, 486 A.2d 1209, 1229-33 (1985).

71 *Id.* at 356, 486 A.2d at 1227.

proof of the patient's wishes, it is naive to pretend that the right to self-determination serves as the basis for substituted decision-making."[72] The *Conroy* court then developed two standards for determining when to withdraw treatment in cases of inadequate proof. Under the "limited-objective" test, the surrogate weighs (1) any evidence of the patient's intent to refuse treatment and (2) whether the burdens of treatment outweigh its benefits.[73] In the absence of any proof of intent, the *Conroy* court developed the "pure-objective" test, in which the surrogate (1) weighs the benefits and burdens of treatment and (2) determines that treatment would cause the patient an inordinate amount of pain.[74] Although the court emphasized that the "primary focus [for making treatment decisions] should be the patient's desires,"[75] it nonetheless proposed objective tests based largely on the medical prognosis.

C. Rejection of the Best Interests Standard and a Return to the Substituted Judgment Standard

Despite commentators' approval, the courts have not adopted the objective "best interests" test.[76] Indeed, the New Jersey Supreme Court later questioned the validity of the *Conroy* test for making treatment decisions, noting that it is very difficult, if not impossible, to measure either the burdens of pain, rage, or frustration, or the benefits of joy or satisfaction that an incompetent patient may feel.[77] In *Peter*, the court found that medical choices are private and cannot be decided by societal standards of reasonableness or normalcy.[78] The court stated:

> While a benefits-burdens analysis is difficult with marginally cognitive patients like Claire Conroy, it is essentially impossible with patients in a persistent vegetative state. By definition such patients, like Ms. Peter, do not experience any of the benefits or burdens that the *Conroy* balancing tests are intended or able to appraise. Therefore, we hold that these tests should not be ap-

---

72 *Id.* at 364, 486 A.2d at 1231.

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

74 *Id.*, 486 A.2d at 1232.

75 *Id.* at 369, 486 A.2d at 1233.

76 *See* Note, *Natural Death: An Alternative in New Jersey*, 73 GEO. L.J. 1331, 1334 (1985) (authored by Suzanne Levant) ("[T]he *Conroy* pure objective test, modified so as not to consider pain the determinative factor, should be applied to all situations involving a decision to withhold or withdraw life-sustaining treatment . . . ."); *see also* Note, *supra* note 8, at 381 ("*Conroy*'s rejection of substituted judgment as the sole means for effectuating an incompetent's right to refuse medical treatment is appropriate . . . ."); Annas, *Reconciling* Quinlan *and* Saikewicz*: Decision Making for the Terminally Ill Incompetent*, 4 AM. J.L. & MED. 367 (1979).

77 *See In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987); *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987); *In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987).

78 *Peter*, 108 N.J. at 373, 529 A.2d at 423.

plied to patients in the persistent vegetative state.[79]

In *Jobes*, the court stated that when an incompetent's wishes are not clearly expressed, a surrogate decision maker must consider the patient's personal value system for guidance, looking to philosophical, theological and ethical values.[80] These cases demonstrate the New Jersey Supreme Court's rejection of the *Conroy* standards and its return to the substituted judgment standard for all terminally ill, incompetent patients.

The best interests method cannot reasonably serve to exercise the incompetent patient's right of self-determination. By relying on social norms, the best interests method fails to recognize "everyone's right to forego treatment or even cure if it entails what for [the patient] are intolerable consequences or risks, however warped or perverted his sense of values may be . . . ."[81] The substituted judgment standard, therefore, remains the viable standard.

Critics of the substituted judgment standard question whether one can feasibly decide to withdraw treatment simply on the basis of patient-centered substantive criteria.[82] They contend that no surrogate can properly ascertain what the patient would want, and that the fiction of substituted judgment serves only to confuse and not clarify the decisionmaking process.[83] These critics argue that, although the substituted judgment standard is on its face a subjective one, in reality the surrogate uses objective criteria to evaluate what would be in the patient's best interests.[84] They maintain that the objective standard is the only feasible one, that the courts should clearly articulate it, and that the medical profession should apply it.[85]

At least one commentator believes that only the physician can

---

79 *Id.* at 376-77, 529 A.2d at 425.

80 *Jobes*, 108 N.J. at 413-15, 529 A.2d at 444.

81 2 FOWLER V. HARPER & FLEMING JAMES, THE LAW OF TORTS 61 (1968 Supp.); *see also* Natanson v. Kline, 186 Kan. 393, 350 P.2d 1093 (each man is considered the master of his own body), *reh'g denied*, 187 Kan. 186, 354 P.2d 670 (1960).

82 *See, e.g.*, P. RIGA, *supra* note 59, at 171; Relman, *supra* note 42, at 237; Note, *Dignified Death*, *supra* note 18, at 714.

83 Note, *Dignified Death*, *supra* note 18, at 714 ("the decisionmaker is very seldom able to ascertain the incompetent's desires with any certainty"); PAUL S. APPELBAUM, CHARLES LIDZ & ALAN MEISEL, INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE 97 (1987) (the ideal of substituted judgment "is far more easily stated than achieved, if only because many people cannot say with much precision how they themselves would act in the future").

84 P. APPLEBAUM, C. LIDZ & A. MEISEL, *supra* note 83, at 97; *see also* J.P. Swazey, *Treatment and Nontreatment Decisions: In Whose Best Interests?*, in DILEMMAS OF DYING 96 (1981) ("In exercising substituted judgment, stewards by admittedly complex feats of mental gymnastics, try to reason what incompetent patients would deem to be in their own best interests.").

85 *See* Note, *Dignified Death*, *supra* note 18, at 714.

adequately protect the patient's rights because patients cannot comprehend fully the technical medical issues.[86] Thus, the physician carries the primary responsibility to decide treatment. Again, this critic argues that the courts should recognize the reality of how a DNR order comes about and abandon the farce of determining whether the patient would exercise the right to refuse treatment.

Despite these criticisms, many cases have adopted some form of the substituted judgment standard when issuing DNR orders for incompetent patients.[87] Substituted judgment, commentators contend, is the only method by which a surrogate can fully exercise the incompetent patient's right of self-determination.[88] Thus, any procedure for implementing a right of self-determination, like the New York statute, should fully and adequately uphold the substituted judgment standard.

III
SUBSTITUTED JUDGMENT FOR INCOMPETENT PATIENTS WITHOUT SURROGATES

A. Judicial Involvement in Substituted Judgment

Although cases such as *Quinlan* and *Superintendent of Belchertown State School v. Saikewicz* emphasized the importance of the substituted judgment standard, neither case specifically addressed the question of the incompetent patient who has no family or designated surrogate.[89] The Supreme Court of Washington, however, has expressly addressed the issue of the rights of an incompetent patient without a surrogate.[90] The Washington court has determined that the judiciary should intervene to protect the rights of the terminally ill, incompetent patient by applying the substituted judgment standard with the aid of a guardian ad litem.

---

86 *See, e.g.*, Relman, *supra* note 42, at 237.

87 *See, e.g.*, Barber v. Superior Court, 147 Cal. App. 3d 1006, 1021, 195 Cal. Rptr. 484, 493 (1983) (the court noted that any surrogate decisionmaker ought to be guided by his or her knowledge of the patient's personal feelings or desires); *In re* Spring, 380 Mass. 629, 405 N.E.2d 115 (1980); *In re* Dinnerstein, 6 Mass. App. Ct. 321, 380 N.E.2d 134 (1978); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985) (utilizes subjective, limited-objective and objective tests for substituted judgment); *In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

88 *See* Note, *A Structural Analysis of the Physician-Patient Relationship in No-Code Decision-making*, 93 YALE L.J. 362, 375 (1983) (authored by Dean M. Hashimoto) ("[g]eneralized, objective tests cannot satisfactorily approximate the subjective wishes of individual patients. . . ."); Note, *supra* note 37, at 674 ("[t]he patient's character and personality, prior statements, and general attitude towards medical treatment must be considered by the guardian when making the substituted judgment for the patient"); Note, *supra* note 34, at 1190.

89 *See supra* notes 60-66 and accompanying text.

90 *Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372; *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).

In *Colyer*, the court affirmed a constitutional right of self-determination for decisions to refuse life-sustaining treatment.[91] The *Colyer* court also affirmed the *Quinlan* holding that even an incompetent patient maintained the right of self-determination which a surrogate would exercise through the substituted judgment standard. Under Washington statutory law,[92] in cases involving incompetent patients, a court must appoint a guardian ad litem to serve as surrogate and "use his best judgment in deciding whether or not to assert the personal right of the incompetent to refuse life-sustaining treatment."[93]

The *Colyer* court determined that, in the case of an incompetent patient with a family member to serve as guardian, the court need not participate in the substantive decision to withhold treatment.[94] The court perceived the judicial process to be too cumbersome and unresponsive to adequately exercise a patient's right of self-determination.[95] In the case of an incompetent patient without a family member or designated surrogate, the *Colyer* court set up the following procedure:

> If a court determination is required, a guardian ad litem must be appointed to ascertain and protect the interests of the patient. At such a proceeding, the focus would be a determination of the rights and wishes of the incompetent. . . . On the basis of information presented to it, the court would determine, in its best judgment, whether the facts demonstrated that the incompetent would have chosen to exercise his or her right to refuse treatment, if he or she were able to do so.[96]

The court thus determined that the judiciary should apply the substituted judgment standard and make the substantive decision regarding treatment.

The Washington Supreme Court later recanted this analysis in a case involving an incompetent patient without a surrogate.[97] The court held that, since it would always participate in the appointment of the guardian, the court need not take part in the substantive decision to terminate treatment.[98] Although the court also emphasized "that these decisions must be made on a case-by-case basis with par-

---

91 *Colyer*, 99 Wash. 2d 114, 132, 660 P.2d 738, 747.

92 *See* WASH. REV. CODE 11.92.040(3) (1979).

93 *Colyer*, 99 Wash. 2d at 131, 660 P.2d at 747.

94 *Id.* at 127, 660 P.2d at 742.

95 *Id.* at 130-31, 660 P.2d at 746 (the court noted that the patients often died long before the case came before the court); *see In re* Spring, 380 Mass. 629, 405 N.E.2d 115 (1980); *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

96 *Colyer*, 99 Wash. 2d at 136-37, 660 P.2d at 750-51.

97 *In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

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

ticularized consideration of the best interests and rights of the specific individual,"[99] the court feared that burdensome judicial intervention could thwart the exercise of the incompetent patient's right of self-determination.

B. A Procedural Method to Exercise Substituted Judgment

Three different methods have been proposed and implemented in an attempt to fully and adequately exercise the incompetent patient's self-determination right in the absence of a surrogate. The *Quinlan* court proposed the first method, by which a hospital's medical staff, through a hospital ethics committee, could properly organize the decisionmaking process.[100] The *Saikewicz* court, on the other hand, chose to require judicial intervention in which a substantive decision to withhold treatment is made.[101] Commentators have suggested a third method which simply leaves the decision to the physician, since the physician presumably understands most fully the patient's medical situation.[102]

Because no third party exists to protect the patient's rights, the incompetent patient's right of self-determination depends on the method chosen to implement the right. If the physician alone decides, the chances increase greatly that the patient's treatment will follow the medical prognosis regardless of the patient's personal considerations. If a guardian ad litem or other party represents solely the patient's non-medical interests, then the decision will more closely follow the substituted judgment standard.[103]

---

99 *Id.* at 815, 689 P.2d at 1375. Under WASH. REV. CODE § 11.92.010 (1986), the guardian has the duty to act in the best interests of the ward and to assert the ward's rights. This duty itself provides a safeguard for the rights of incompetent patients. In addition, under WASH. REV. CODE § 70.122 (1979), the attending physician must consult with a prognosis committee before issuing a DNR order, ensuring complete review of the medical diagnosis. On the basis of these procedural safeguards, *Hamlin* permitted life-sustaining treatment to be withdrawn from an incompetent patient without a surrogate. *Hamlin*, 102 Wash. 2d at 822-23, 689 P.2d at 1379.

100 *In re* Quinlan, 70 N.J. 10, 49, 355 A.2d 647, 668 (1976) ("[I]t would be more appropriate to provide a regular forum for more input and dialogue in individual situations . . . .").

101 Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 759, 370 N.E.2d 417, 434-35 (1977) ("[S]uch questions of life and death seem to us to require the process of detached but passionate investigation . . . on which the judicial branch was created.").

102 *See* Relman, *supra* note 42, at 237 ("The essence of the relation between doctor and patient is *trust*. The patient *trusts* that his physician will do the best thing possible for him under the circumstances, using a reasonable degree of professional skill . . . .") (emphasis in original).

103 Most courts have recognized that the patient without a surrogate deserves special attention. *See, e.g.*, *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987); *In re* Peter, 109 N.J. 365, 529 A.2d 419 (1987); *In re* Farrell, 108 N.J. 355, 529 A.2d 404 (1987); *In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).

1. *The Hospital Ethics Committee*

The *Quinlan* court found that, in regular treatment situations, a hospital ethics committee composed of physicians, lawyers, theologians and/or other non-medical professionals could aid in making treatment decisions.[104] Because the patient in that case had a surrogate, the court directed the hospital ethics committee to only review the possibility of "Karen's ever emerging to a coguitive, sapient state."[105] The actual decision to terminate treatment was given to the surrogate. As an underlying principle, however, the court stated that decisions to refuse life-sustaining treatment must "be responsive not only to the concepts of medicine but also the common moral judgment of the community at large."[106] The court suggested that the medical prognosis alone cannot bring all important factors under consideration. Although the court did not address the problem of an incompetent patient without a surrogate, presumably it would follow the ethics committee procedure.

Other courts have criticized the *Quinlan* procedure of establishing an innerhospital committee to deal with such cases. The *Colyer* court, for example, found the committee to be ineffectual "for its amorphous character, for its use of nonmedical personnel to reach a medical decision, and for its bureaucratic intermeddling."[107] One commentator suggested that the hospital ethics committee is actually nothing more than a prognosis committee because that is the only issue on which it renders an opinion.[108] Despite these criticisms, the committee remains a valuable method for implementing a patient's rights.

2. *Judicial Involvement*

Contrary to the *Quinlan* court, *Saikewicz* required that the judiciary review all decisions regarding the substituted judgment standard for incompetent patients.[109] The *Saikewicz* court reasoned that choices of a personal nature for incompetent persons involve irreversible medical decisions and, as such, warrant close scrutiny by

---

104 *Quinlan*, 70 N.J. at 49, 355 A.2d at 668 ("Ethics Committee[s] . . . serve[ ] to review the individual circumstances of ethical dilemma . . . .") (citing Karen Teel, *The Physician's Dilemma—A Doctor's View: What the Law Should Be*, 27 BAYLOR L. REV. 6, 8-9 (1975)).

105 *Quinlan*, 70 N.J. at 55, 355 A.2d at 671-72.

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

107 *Colyer*, 99 Wash. 2d at 132, 660 P.2d at 749; *see also* P. RIGA, *supra* note 59, at 172-73.

108 *See* Annas, *supra* note 76, at 379.

109 Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 755-59, 370 N.E.2d 417, 432-35 (1977).

society, its legislature and its courts.[110] The court required the guardian ad litem to present to the judge all reasonable arguments to "ensure that all viewpoints and alternatives [for the patient] will be aggressively pursued and examined at the subsequent hearing where it will be determined whether or not treatment should or should not be allowed."[111] Thus, the *Saikewicz* court envisioned a much more active role for the judiciary.

In subsequent cases, courts have struggled with the *Saikewicz* court's effort to increase the measure of court involvement in the treatment decision making process.[112] The Massachusetts Supreme Court in *Spring* later explained that actions taken without judicial approval were not *per se* illegal or subject to legal consequences,[113] yet also stated that "when a court is properly presented with the legal question, whether treatment may be withheld, it must decide that question . . . ."[114] Thus, the *Spring* court gave no guidance as to exactly when the court should be involved.

Commentators have sharply criticized the *Saikewicz* procedure of judicial involvement both for "the problems that result from court intervention such as the extra emotional and financial burden" on the family[115] and "the large potential case load, which leads to delay."[116] For these reasons, other courts have shied away from excessive judicial involvement by entrusting the decisionmaking to a qualified, court-appointed guardian ad litem.[117]

C. The Physician as Sole Decisionmaker

Ideally, the physician and the patient together would evaluate both the medical and the personal concerns of the patient and decide whether to terminate the patient's life-sustaining treatment.[118] Some commentators urge that, if the patient lacks the capacity to decide, the physician should make treatment decisions because the physician alone can assess the patient's medical situation.[119]

---

110 *See* Note, *supra* note 34, at 1190.

111 *Saikewicz*, 373 Mass. at 756, 370 N.E.2d at 433.

112 *See In re* Spring, 380 Mass. 629, 405 N.E.2d 115 (1980); *In re* Dinnerstein, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978); *In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

113 *Spring*, 380 Mass. at 634, 405 N.E.2d at 119.

114 *Id.*, 405 N.E.2d at 119. The court noted that no binding precedent existed on the question of the incompetent patient without a surrogate.

115 Note, *supra* note 50, at 1092.

116 Note, *supra* note 57, at 343.

117 *See, e.g., In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

118 *See* P. RIGA, *supra* note 59, at 103.

119 *See, e.g.*, Relman, *supra* note 42, at 236-37, 241-42; *cf.* John F. Kennedy Memorial Hosp., Inc. v. Bludworth, 452 So. 2d 921, 926 (Fla. 1984) (stating that "[d]octors, in consultation with close family members are in the best position to make these deci-

The medical profession contends that judicial encroachment on the physician's traditional role hinders the physician's ability to perform his duties.[120] They aver that, as trained professionals, they have the background, experience and psyche to make difficult medical decisions.[121] These commentators recognize that the desires of the patient must be respected, but they believe that only the physician can realistically interpret a patient's desires in light of the medical prognosis. These commentators further urge that the physician should determine a patient's status without the constraints of judicial intervention or committee review.

The physician alone, however, cannot exercise the right of self-determination. As medical technology allows physicians to delay death, profound questions about values arise that are not answerable on the basis of professional expertise alone.[122] The physician cannot adequately protect the patient's rights, because each patient attaches a different value to the possible benefits and costs involved in the medical decision.[123] As one commentator noted:

> [T]he doctor's lack of impartiality may rise to the level of conscious consideration of criteria which he believes should be relevant even though society might not be willing to tolerate their use as criteria—for example, the patient's intelligence, personality, or social or economic status, *or the expense of maintaining the patient*.[124]

If the physician alone determines a patient's status, the physician may thus impose his or her own values in a manner "both inconsistent with patient preferences and unjustified by technical expertise."[125]

Indeed, physicians can pose a significant threat to patient self-determination because the physician may rely on his or her traditional expertise and preempt patient authority.[126] The possibility of medical malpractice litigation or even criminal sanctions could greatly affect a physician's judgment in a treatment situation.[127]

---

sions," rejecting the *Quinlan* ethics committee and the judicial appointment of a guardian ad litem, and noting that physicians should be held only to a good faith standard).

120 Note, *supra* note 1, at 516 n.4 & 518.

121 *See* Roe, *Treatment Decisions and Triage: The Physician's Burden*, in DILEMMAS OF DYING 91 (C. WONG & J. SWAZEY ed. 1981); Note, *supra* note 50, at 1105 ("Physicians make life and death decisions as a part of their everyday job and it is their duty to keep the best interests of the patient at heart.").

122 *See generally* PRESIDENT'S COMMISSION, *supra* note 3, at 15-41.

123 *See* Marjorie Maguire Shultz, *From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 220, 292-93 (1985); *see also* Note, *supra* note 88, at 379.

124 Baron, *Medical Paternalism and the Rule of Law: A Reply to Dr. Relman*, 4 AM. J.L. MED. 340, 350 (1979) (emphasis added).

125 Note, *supra* note 88, at 369.

126 *See* Shultz, *supra* note 123, at 272 ("[T]here is a siguificant danger that decisions will reflect the doctor's attitudes and values rather than the patient's.").

127 *In re* Quinlan, 70 N.J. 10, 46, 355 A.2d 647, 666 (1976).

Some studies reveal that physicians listed poor prognosis, not patient or family wishes, as the reason for issuing an order not to resuscitate.[128] In some instances, physicians did not even consult with competent patients, but unilaterally issued treatment orders,[129] thus contravening the goal of patient self-determination.[130]

The leading cases on life-sustaining treatment agree that the physician should not be the sole decisionmaker.[131] The *Quinlan* court stated that it would hesitate greatly to immunize physicians from liability when physicians unilaterally make treatment decisions.[132] The *Quinlan* ethics committee divided the responsibility for the decision, noting that "[m]any physicians, in many circumstances, would welcome this sharing of responsibility."[133] The court in *Saikewicz* also expressed grave doubts as to the ability of physicians to make such decisions:[134] "[S]uch 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."[135] None of these decisions held that the physician alone should make the decision to refuse treatment. In light of some medical professional reluctance to discuss life-sustaining treatment with patients and the intensely personal nature of the privacy right involved,[136] the state should use all means necessary to emphasize and protect patient self-determination. Because the physician alone cannot fully protect the patient's rights, the patient or the surrogate should make the ultimate decision.[137]

---

128 Susanna E. Bedell, Denise Pelle, Patricia L. Maher & Paul D. Cleary, *Do-Not-Resuscitate Orders for Critically Ill Patients in the Hospital*, 256 J. A.M.A., July 11, 1986, at 233; Andrew L. Evans & Baruch A. Brody, *The Do-Not-Resuscitate Order in Teaching Hospitals*, 253 J. A.M.A., Apr. 19, 1985, at 2236.

129 Evans & Brody, *supra* note 128, at 2237.

130 *See id.*

131 *See* 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); *Quinlan*, 70 N.J. 10, 355 A.2d 647; *In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

132 *Quinlan*, 70 N.J. at 48, 355 A.2d at 668 ("We would hesitate, in this imperfect world, to propose as to physicians that type of immunity which from the early common law has surrounded judges. . .").

133 *Id.* at 49, 355 A.2d at 669.

134 *Saikewicz*, 373 Mass. at 758, 370 N.E.2d at 434.

135 *Id.* at 759, 370 N.E.2d at 435.

136 *See* Note, *supra* note 88, at 379-82.

137 *See id.* at 371-72.

IV
NEW YORK'S "DO NOT RESUSCITATE" STATUTE

A. Introduction

On August 7, 1987, New York enacted a statute entitled "Orders Not To Resuscitate."[138] The statutory goal is to allow physicians to withhold cardiopulmonary resuscitation in certain treatment situations "where appropriate consent has been obtained."[139] Section 2960 of the statute states that the legislative intent was "to clarify and establish the rights and obligations of patients, their families, and health care providers" regarding orders not to resuscitate.[140]

The New York State Task Force on Life and Law drafted the Do Not Resuscitate statute substantially adopted by the legislature.[141] The General Assembly incorporated the substituted judgment standard in the statute,[142] noting that the surrogate must rely on the "patient's values and interests" when making treatment decisions.[143] The statute further states that the surrogate should decide for or against resuscitation based on the patient's wishes, "including a consideration of the patient's religious and moral beliefs."[144] This goal of self-determination accords fully with prior New York statutory law,[145] as well as with New York decisional law on informed consent.[146] Thus, before anyone could make a treatment-refusal decision under the New York statute, he or she must consider the patient's personal wishes, regardless of whether the patient is incompetent.

The statute expressly adopts the substituted judgment standard for surrogates, yet it blatantly abandons this substituted judgment standard when dealing with incompetent patients without a surrogate. Under the statute, the physician, and only the physician, has the authority to control these patients' treatment. *Section 2966 discusses decision making for incompetent patients without a surrogate:*

---

138 N.Y. PUB. HEALTH LAW § 2960-2978 (McKinney Supp. 1990).

139 *Id.* § 2960.

140 *Id.*

141 *See* NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, DO NOT RESUSCITATE ORDERS: THE PROPOSED LEGISLATION AND REPORT OF THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW (1986) [hereinafter TASK FORCE].

142 N.Y. PUB. HEALTH LAW § 2965(5)(a) (McKinney Supp. 1990).

143 TASK FORCE, *supra* note 141, at 36.

144 N.Y. PUB. HEALTH LAW § 2965(5)(a) (McKinney Supp. 1990).

145 *Id.* §§ 2504, 2805-d (McKinney 1985).

146 *See, e.g., In re* Storar, 52 N.Y.2d 363, 378, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 274 (1981) (state law supports the right of the competent adult to make his own decision); Zimmerman v. New York City Health and Hosps. Corp., 91 A.D.2d 290, 458 N.Y.S.2d 552 (New York App. Div. 1983); Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914).

> 1. If no surrogate is reasonably available, willing to make a decision regarding issuance of an order not to resuscitate, and competent to make a decision regarding issuance of an order not to resuscitate on behalf of an adult patient who lacks capacity and who had not previously expressed a decision regarding cardiopulmonary resuscitation, an attending physician (a) may issue an order not to resuscitate the patient, provided that the attending physician determines, in writing, that, to a reasonable degree of medical certainty, resuscitation would be medically futile, and another physician . . . concurs in writing with such determination . . . .[147]

In effect, a physician may unilaterally issue an order not to treat an incompetent patient during cardiac arrest. The statute outlines the possible situations in which a physician may issue a DNR order for an incompetent patient. The patient need not be unconscious; if the physician determines that the patient may not understand the consequences of the order, then the physician may designate the patient as incompetent.[148] More importantly, the physician is placed under no duty to attempt to ascertain the patient's wishes. The physician need only determine to a reasonable degree of medical certainty that resuscitation is medically futile before issuing an order that meets the statute's provisions.[149]

B. The Statute Fails to Promote Either Self-Determination or Substituted Judgment

The goal of the statute was to enact a procedure for issuing DNR orders that was consistent with the principle of patient self-determination.[150] Section 2966, however, contravenes this policy. The statute provides few procedural safeguards for protecting the rights of an incompetent patient without a surrogate. It protects the incompetent patient without a surrogate only to the extent that another physician must concur in the medical prognosis. The physician need not take any affirmative steps beyond a purely medical

---

147 N.Y. PUB. HEALTH LAW § 2966 (McKinney Supp. 1990).

148 The statute defines cardiopulmonary resuscitation as any means necessary to restore cardiac function or to support ventilation should cardiac arrest occur. *Id.* § 2961(4). " 'Capacity' means the ability to understand and appreciate the nature and consequences of [the order] and to reach an informed decision," *id.* § 2961(3), and, although the physician may determine that the patient lacks capacity to decide to issue a DNR order, the physician may still consider the patient competent to make other decisions. "Medically futile" means that the patient is likely to have more cardiac arrests and will die in a short period of time or it means that the patient will die despite the attempted cardiopulmonary resuscitation. *Id.* § 2961(9).

149 *Id.* § 2966(1)(a). A reasonable degree of medical certainty most likely follows the traditional requirement that a physician employ the skill and knowledge of the profession as a whole. KEETON & PROSSER, *supra* note 13, at 185.

150 TASK FORCE, *supra* note 141, at 7-8.

diagnosis, and need not consider any important non-medical concerns. Section 2966 thus entirely fails to promote either statutory goal: self-determination or the substituted judgment standard.

The New York statute further fails to promote the substituted judgment standard because it does not designate a surrogate for the incompetent patient who lacks one.[151] As such, section 2966 fails to follow the standards of substituted judgment adopted elsewhere in the statute.[152] No one has responsibility for protecting the incompetent patient's rights. Although courts have required judicial appointment of a guardian for every incompetent patient without a surrogate,[153] the New York statute fails to use the guardian ad litem or any other safeguard to protect the incompetent patient's right of self-determination. Furthermore, the physician cannot be held responsible for protecting the patient's rights or liable for a breach of those rights, because he or she is responsible solely for the medical prognosis.

This departure from the substituted judgment standard for the incompetent patient without a surrogate has no support from commentators or existing case law. As many courts have noted,[154] decisionmakers for incompetent patients should concern themselves primarily with protecting the patient's right of self-determination. These courts have enacted procedural safeguards to protect the incompetent patient's rights. In *Quinlan*, the court recommended the use of hospital ethics committees "to provide a regular forum for more input and dialogue in individual situations."[155] The ethics committee serves to address the individual's non-medical concerns or preferences, thus protecting patients' rights. The holdings in *Farrell*, *Peter*, and *Jobes* demonstrate the New Jersey Supreme Court's conviction that a non-medical committee or group must review the decision to ensure full protection of the patient's rights.

The *Saikewicz* court required judicial intervention whenever a physician desired to withdraw treatment from an incompetent patient. The Massachusetts court further clarified its holding in *Spring*,[156] stating that the judiciary protected the patient's rights by

---

151 *See* N.Y. PUB. HEALTH LAW § 2966 (McKinney Supp. 1990).

152 *See id.* § 2965(5)(a).

153 *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).

154 *See 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* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976); *In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *Colyer*, 99 Wash. 2d 114, 660 P.2d 738.

155 *Quinlan*, 70 N.J. at 49, 355 A.2d at 668.

156 *In re* Spring, 380 Mass. 629, 405 N.E.2d 115 (1980).

appointing a guardian ad litem to represent the patient's wishes.[157] The Washington court in *Hamlin*[158] and *Colyer*[159] followed this reasoning in holding that the judiciary must appoint a guardian ad litem. The court stated that, since "the court will always be involved in the appointment of the guardian,"[160] the patient's rights would be adequately protected.

Safeguards to protect patients' rights become even more important when a statute allows physicians to issue a DNR order for cardiac arrest. Cardiopulmonary resuscitation, unlike life support systems for vegetative patients, represents life-sustaining treatment which can restore the patient to a functional, cognitive state.[161] One study notes that patients who survive cardiopulmonary resuscitation tend to have only one major residual disability—confinement in the home.[162] The study stated, however, that these patients were limited mainly by fear rather than by a change in physical capabilities.[163] An improper decision to issue a DNR order for cardiac arrest is even more egregious than in the case of the vegetative individual, becuase it could deprive a patient of a "normal life."

The statistics about cardiopulmonary resuscitation show that physicians cannot easily determine whether cardiopulmonary resuscitation will be unsuccessful.[164] The Task Force found that from three to thirty percent of resuscitated patients survive and are eventually discharged from the hospital.[165] The survival rate of cardiopulmonary resuscitation changes greatly depending on the personal characteristics of the patient.[166] Although doctors attempt "to present a face of decisiveness to patients, they are often only sure about their own uncertainty."[167] Physicians may be unwilling to discuss a patient's status if they feel unable to predict accurately the extent of the patient's illness and chances for survival.[168] In some cases, physicians have issued orders not to resuscitate for some patients that

---

157 *Id.* at 638, 405 N.E.2d at 121 ("There is responsible opinion . . . that a duly appointed guardian of the person may give effective consent for the ward.").

158 *In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

159 *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).

160 *Hamlin*, 102 Wash. 2d at 820, 689 P.2d at 1378.

161 Susanna E. Bedell, Thomas L. Delbanco, E. Francis Cook & Franklin H. Epstein, *Survival After Cardiopulmonary Resuscitation in the Hospital*, 309 NEW ENG. J. MED. 569 (Sept. 8, 1983).

162 *See id.* at 575.

163 *Id.*

164 *See* Bedell, Pelle, Maher & Cleary, *supra* note 128.

165 TASK FORCE, *supra* note 141, at 4.

166 *Id.*; *see also* Bedell, Delbanco, Cook & Epstein, *supra* note 161, at 574-75.

167 Shultz, *supra* note 123, at 270.

168 *See* Brennan, *Do-Not-Resuscitate Orders for the Incompetent Patient in the Absence of Family Consent*, 14 LAW MED. & HEALTH CARE 13, 16 (1986).

did not need such designation;[169] these physicians evidently determined that "resuscitation [would] serve no useful purpose" and issued an order on that basis.[170]

This attitude contravenes both the New York statute's intent and social policy, since the physician totally abrogates the patient's right to self-determination. A patient may be deprived of bodily integrity if a physician makes a purely medical, non-reviewable and possibly incorrect decision. Thus, the patient's right of self-determination should be adequately protected under state statutory law, yet the New York statute fails to do so.

V

A Better Method to Protect the Incompetent Patient's Rights

Several commentators have suggested other methods by which the state and the medical profession can protect the incompetent patient's right of self-determination. One suggestion is to have the patient execute a living will in which the patient states that he or she does not want to have life unnecessarily prolonged.[171] The living will has major drawbacks, however, because it cannot react to changing medical situations, and not every patient has the foresight to execute a living will.[172] Alternatively, one commentator suggests that the patient appoint an agent to serve as a surrogate.[173] The agent can protect the patient's right of self-determination, and give the physician legally binding consent before the physician issues an order not to resuscitate.[174] The agency theory, however, fails to address the unique and important situation of the incompetent patient who has not designated a surrogate before losing consciousness. Therefore, neither approach solves the problem at hand.

For the incompetent patient without a surrogate, states should combine the *Quinlan* hospital ethics committee and the *Hamlin* judicial appointment of a guardian ad litem. Under this procedural framework, the judicially appointed guardian represents the patient to the hospital committee, and together they review the patient's

169 *See* Bedell, Pelle, Maher & Cleary, *supra* note 128, at 234. The study found that "239 patients designated DNR patients . . . survived to the time of discharge from the hospital. Thus, 38% of patients designated DNR did not have a cardiac arrest and left the hospital alive." *See also* Robert M. Veatch, *Deciding Against Resuscitation: Encouraging Signs and Potential Dangers*, 253 J. A.M.A., Jan. 4, 1985, at 77 (another study found that "only 39% of the patients who would not be resuscitated would be considered terminal, based on the criterion of having less than a 10% chance of surviving hospitalization").

170 *See* Veatch, *supra* note 169, at 77.

171 Note, *supra* note 88, at 378.

172 *Id.*

173 *See* Note, *Appointing an Agent*, *supra* note 18.

174 *Id.* at 1001.

known medical and personal history. This method would accord with the substituted judgment standard much more than the method embodied in the statute.

The New York statute already provides for a dispute mediation system which each hospital must establish.[175] Each hospital may establish any system it wishes to resolve disputes over orders not to resuscitate, for example, if two physicians could not concur in a medical prognosis. Since the statute already requires a specifically structured dispute mediation committee, the same committee could aid in the decisionmaking process for incompetent patients without a surrogate.

The dispute mediation committee, like the *Quinlan* ethics committee, could consist of non-physicians, who would seek to ensure individualized review weighing important non-medical factors relevant to a DNR decision. Under the current statute, the dispute mediation system has seventy-two hours in which to decide a particular case, a time period which is reasonably efficient, yet allows for a thorough review.[176] The committee together with the physician and a judicially-appointed guardian ad litem could review an incompetent patient's case within this time period. This proposal refers to only the incompetent patient without a surrogate, not to every DNR decision. The proposal would not be burdensome because only rarely does an incompetent patient lack a surrogate.

This inner-hospital committee would function better than judicial resolution, because the judicial system is often slow and costly. In many of the treatment-refusal cases, the patient died before the court reviewed the case.[177] The judiciary can appoint a guardian ad litem relatively easily,[178] and the guardian ad litem can then represent the incompetent patient's non-medical wishes. The court appointment thus provides another procedural safeguard for the incompetent patient's right of self-determination.

These two less-costly, time-saving safeguards would adequately ensure that the statute protects the incompetent patient's right of self-determination. Both safeguards demand that someone other than the physician attempt to determine what the patient would

---

175 N.Y. PUB. HEALTH LAW § 2972 (McKinney Supp. 1990).

176 *Id.* § 2972(3).

177 *See* Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (Cal. Ct. App. 1984); *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* Farrell, 108 N.J. 335, 529 A.2d 404 (1987); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981); *In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

178 The appointment of a guardian ad litem does not require a great deal of the court's time and can be accomplished fairly quickly. *Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372; *see also* Note, *supra* note 37, at 674.

want to do. The physician provides the medical prognosis for the patient and the mediation committee issues the order not to resuscitate. The system thus guards against any conflicts of interest due to the cost of resuscitating and maintaining the patient.[179] In this manner, the incompetent patient's right of self-determination is not lost; to the greatest degree possible, the patient without a surrogate receives a complete review of his or her case.

CONCLUSION

Self-determination is the right to exercise control over one's own body. The right is so basic to each individual that the patient does not lose such a right although he or she may have lost the capacity to exercise it. The incompetent patient without a surrogate thus retains the same rights as the incompetent patient with a surrogate. The right of self-determination includes not only the right to refuse treatment, but also the right to expect treatment. Given an incompetent patient without a surrogate, the decision must be made carefully and only after all relevant information has been considered.

Elizabeth Shaver

179 *See supra* note 124 and accompanying text.