CARDOZO
Benjamin N. Cardozo School of Law

Cardozo Law Review

Vol. 11
Iss. 3

Article 14

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Recommended Citation

Steven M. Weiner, *Privacy, Family, and Medicial Decision Making for Persistant Vegetative Patients*, 11 Cardozo L. Rev. 713 (1990).
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PRIVACY, FAMILY, AND MEDICAL DECISION MAKING FOR PERSISTENT VEGETATIVE PATIENTS

Since *In re Quinlan*[1] courts nationwide[2] have confronted the issue of whether to allow withdrawal of life-sustaining medical treatment from a patient in a persistent vegetative state,[3] enabling the patient to die. These patients neither meet the brain death criteria, nor are they able to determine their own fate. Three legal standards have been applied to resolve this question: the substituted judgment test,[4] the limited objective test,[5] and the pure objective test.[6] Because these tests apply different standards of evidence regarding the incompetent patient's prior wishes, if any, jurisdictions that have not yet decided the issue are guided by conflicting authority. Indeed, similar facts may lead to markedly dissimilar outcomes.[7]

Commentators point out that the rules currently applied by the courts are unrealistic and lead to conflicting legal results,[8] or are

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[1] 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976).

[2] Gray v. Romeo, 697 F. Supp. 580 (D.R.I. 1988); Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987); *In re* Drabick, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840, cert. denied, 109 S. Ct. 399 (1988); McConnell v. Beverly Enters.-Connecticut, Inc., 209 Conn. 692, 553 A.2d 596 (1989); Foody v. Manchester Memorial Hosp., 40 Conn. Supp. 127, 482 A.2d 713 (Super. Ct. 1984); Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334 (Del. 1980); John F. Kennedy Memorial Hosp., Inc. v. Bludworth, 452 So. 2d 921 (Fla. 1984); *In re* Barry, 445 So. 2d 365 (Fla. App. 1984); *In re* L.H.R., 253 Ga. 439, 321 S.E.2d 716 (1984); *In re* Gardner, 534 A.2d 947 (Me. 1987); Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 497 N.E.2d 626 (1986); *In re* Torres, 357 N.W.2d 332 (Minn. 1984); Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988), cert. granted sub nom. Cruzan v. Director, Missouri Dep't of Health, 109 S. Ct. 3240 (1989); *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987); *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); Delio v. Westchester County Medical Center, 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987); Leach v. Akron Gen. Medical Center, 68 Ohio Misc. 1, 426 N.E.2d 809 (Ct. C.P. 1980); *In re* Grant, 109 Wash. 2d 545, 747 P.2d 445 (1984); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983), overruled in part, *In re* Guardianship of Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

[3] "In this state the neocortex is largely and irreversibly destroyed, although some brainstem functions persist." Wanzer, Adelstein, Cranford, Federman, Hook, Moertel, Safar, Stone, Taussig & van Eys, The Physician's Responsibility Toward Hopelessly Ill Patients, 310 New Eng. J. Med. 955, 958 (1984) [hereinafter Wanzer].

[4] See infra text accompanying notes 72-82.

[5] See infra text accompanying notes 83-86.

[6] See infra text accompanying notes 87-91.

[7] Compare Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) (retarded adult did not have to undergo painful treatment under the best interest test) with *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981) (retarded adult did have to undergo painful medical treatment).

[8] Veatch, Limits of Guardian Treatment Refusal: A Reasonableness Standard, 9 Am. J.L.

based on faulty legal reasoning.[9] This same criticism can be directed to other areas of the law which, like this one, involve issues that are heavily value-laden, emotional, and challenge fundamental concepts of life and liberty. While this criticism is appropriate when similiar situations produce conflicting results, it is even more compelling when incompetent patients are placed into a medical and legal limbo.

Part I of this Note discusses brain death, distinguishing it from the condition of the patient in a persistent vegetative state, which is the focus of this Note. It traces what happens when the family seeks to discontinue life-support systems, identifies the potential decision makers, and demonstrates why some cases eventually end up in court. Part II examines the current state of the law, focusing on the inconsistent application of the three legal standards. Part III analyzes the doctrinal stumbling block that courts confront when deciding these cases and proposes that the privacy right be extended to encompass the family as a medical decision-making unit.

I. AUTONOMY AND MEDICAL CARE

Each of us wishes to be accorded respect and to be allowed to function autonomously—to engage in personal freedom of action.[10] Although autonomy, in and of itself, is not a legally protectible interest,[11] in the health care setting autonomy is viewed as the patient's right to make his own decisions.[12] Courts have recognized that individuals ought to be shielded from unwanted bodily intrusion and have protected this interest by relying on tort doctrine[13] and the right to privacy.[14] Because individuals are endowed with these protected interests, health care providers incur the correlative duty of respecting patient choice.[15]

& Med. 427, 428 (1984). Compare Cruzan v. Harmon 760 S.W.2d 408 (Mo. 1988), cert. granted sub nom. Cruzan v. Director, Missouri Dep't of Health, 109 S. Ct. 3240 (1989) (25-year-old persistent vegetative patient maintained on life support systems over parents' assertion that their daughter's will would be to die) with cases cited supra note 2 (persistent vegetative patients allowed to die).

9 Rhoden, Deciding About Treatment in the ICU, in Medicolegal Aspects of Critical Care 31, 43, 54 (K. Benesch, N. Abramson, A. Grenvik & A. Meisel eds. 1986); Rhoden, Litigating Life and Death [hereinafter Life and Death], 102 Harv. L. Rev. 375, 380 (1988).

10 P. Appelbaum, C. Lidz, & A. Meisel, Informed Consent: Legal Theory and Clinical Practice 21-26 (1987) [hereinafter Appelbaum].

11 Shulz, From Informed Consent to Patient Choice: A New Protected Interest, 95 Yale L.J. 219 (1985).

12 Appelbaum, supra note 10, at 23.

13 See infra text accompanying notes 16-22.

14 See infra text accompanying notes 23-33.

15 Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986) (physicians

A. *The Competent Individual*

Tort law protects patient choice through the doctrine of informed consent, which is an extension of the law of battery.[16] The right to be provided with sufficient information to make an informed choice is firmly established as a legally protectible interest.[17] A patient may seek redress for injury caused by a violation of that interest by bringing a negligent nondisclosure action.[18] The information that a doctor is required to provide a patient will vary. Some states rely on common law to shape the boundaries of informed consent,[19] while others rely on statute to determine appropriate disclosure.[20] If competent, the patient acts autonomously by deciding for himself the course of offered medical treatment,[21] and, under most circumstances, neither the medical profession nor the courts may veto the ultimate decision.[22]

Autonomy is also protected by the right to privacy.[23] The

must respect competent patient's refusal to submit to treatment); Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984) (same); Appelbaum, supra note 10, at 23.

16 Appelbaum, supra note 10, at 113-16. This Note would be incomplete without the following quote from Justice Cardozo: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault . . . ." Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914).

17 W. Keeton, D. Dobbs, R. Keeton & D. Owen, Prosser & Keeton on the Law of Torts § 32, at 189-93 (5th ed. 1984). For an overview of the consent to medical treatment doctrine, see generally F. Rokovsky, Consent to Treatment: A Practical Guide (1984 & Supp. 1988); Appelbaum, supra note 10.

18 See, e.g., Canterbury v. Spence, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972).

19 See, e.g., Sard v. Hardy, 281 Md. 432, 379 A.2d 1014 (1977); Troy v. Long Island Jewish-Hillside Medical Center, 86 A.D.2d 631, 446 N.Y.S.2d 347 (2d Dep't 1982); McPherson v. Ellis, 305 N.C. 266, 287 S.E.2d 892 (1982); Wilkinson v. Vesey, 110 R.I. 606, 295 A.2d 676 (1972); Cross v. Trapp, 294 S.E.2d 446 (W. Va. 1982).

20 See, e.g., Alaska Stat. § 09.55.556 (1967); Del. Code Ann. tit. 18, § 6852 (1976); Fla. Stat. Ann. § 768.46 (West 1975); Idaho Code § 39-4304 (1975); Ky. Rev. Stat. Ann. § 304.40-320 (Michie 1988); Neb. Rev. Stat. § 44-2816 (1976); Pa. Stat. Ann. tit. 40, § 1301.103 (Purdon 1976); Utah Code Ann. § 78-14-5 (Supp. 1989); Vt. Stat. Ann. tit. 12, § 1909 (Supp. 1989).

21 Several commentators have criticized the autonomy-oriented informed consent theory. See Appelbaum, supra note 10, at 13-14 (the ethical and legal support for informed consent has been diluted by the duty the law actually imposes on physicians); Katz, Informed Consent—A Fairy Tale? Law's Vision, 39 U. Pitt. L. Rev. 137 (1977) (the law subordinates individual autonomy to the interests of the medical profession); Shulz, supra note 11, at 221 (recognition of patient autonomy may sometimes lead to controversy within the doctor-patient relationship).

22 See, e.g., Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1135, 225 Cal. Rptr. 297, 299 (1986). The state, however, can limit the patient's right to make an autonomous decision regarding treatment when that decision would compromise the state's compelling interests. See infra notes 30-33 and accompanying text.

23 See P. Riga, Right to Die or Right to Live?: Legal Aspects of Dying and Death 114 (1981) ("[T]he essence of privacy is that the individual is free to determine his or her destiny

United States Supreme Court has declared the right to privacy implied within the first, fourth, fifth, and ninth amendments, and within the liberty interest of the fourteenth amendment to the Constitution.[24] Nevertheless, the privacy right is not clearly defined[25] and has been associated not only with bodily autonomy, but with economic liberty[26] and other personal activities.[27]

The right to privacy has been extended to autonomous decisions, particularly where bodily integrity is at stake.[28] This protection has been cloaked in constitutional terms and is so far-reaching that it extends to decisions concerning one's body where that decision would mean death.[29] The claim to privacy, however, will not immunize a patient's treatment decision against governmental intrusion. The state's compelling interests in preserving life,[30] preventing suicide,[31]

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with little or no interference from others or from the state."); Gerety, Redefining Privacy, 12 Harv. C.R.-C.L. L. Rev. 233, 236 (1977) (defining privacy "as an autonomy or control over the intimacies of personal identity").

24 Roe v. Wade, 410 U.S. 113 (1973); Griswold v. Connecticut, 381 U.S. 479 (1965).

25 Henkin, Privacy and Autonomy, 74 Colum. L. Rev. 1410, 1423 (1974).

26 Meyer v. Nebraska, 262 U.S. 390, 399 (1923).

27 See, e.g., *Roe*, 410 U.S. 113 (right to decide to have abortion based on concept of liberty protected by due process clause); Loving v. Virginia, 388 U.S. 1 (1967) (right to privacy in marital decisions); Griswold v. Connecticut, 381 U.S. 479 (1965) (right to privacy in the penumbra of several guarantees of Bill of Rights protecting family planning decisions); Prince v. Massachussetts, 321 U.S. 158, 166 (1944) (liberty as a broad concept which applies to the integrity of the family as a unit, "respect[ing] the private realm of family life which the state cannot enter"); Skinner v. Oklahoma, 316 U.S. 535 (1942) (privacy in reproductive ability); Pierce v. Society of Sisters, 268 U.S. 510, 535 (1925) (privacy encompasses freedom of choice in child rearing).

28 See, e.g., Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1139, 225 Cal. Rptr. 297, 302 (1986) ("[i]t is a basic and constitutionally predicated right" to refuse medical treatment, and that right is a part of the right to privacy); Bartling v. Superior Court, 163 Cal. App. 3d 186, 195, 209 Cal. Rptr. 220, 225 (1984) (citing *Griswold*, 381 U.S. at 484); McConnell v. Beverly Enters.-Connecticut, Inc., 209 Conn. 692, 701, 553 A.2d 596, 601 (1989) ("The right to refuse medical treatment is a right rooted in this nation's fundamental legal tradition of self-determination."); Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 430, 497 N.E.2d 626, 633 (1986) (the right to refuse medical treatment arises from the common law and the penumbral constitutional right to privacy).

The right to make decisions concerning one's body is protected by the federal constitutional right to privacy, and that right is broad enough to encompass a patient's right to refuse life-saving treatment. *In re* Conroy, 98 N.J. 321, 348, 486 A.2d 1209, 1222 (1985) (citing *Roe*, 410 U.S. 113 and *Griswold*, 381 U.S. 479).

29 One federal district court has recently confronted this issue directly. Judge Francis J. Boyle held that the right to control fundamental medical decisions "whether described as the principle of personal autonomy, the right of self-determination, or the right of privacy, is properly grounded in the liberties protected by the Fourteenth Amendment's due process clause." Gray v. Romeo, 697 F. Supp. 580, 585 (D.R.I. 1988).

30 The state's interest in preserving life is greatly diminished when measured against the "life" of the persistent vegetative patient. McConnell v. Beverly Enters.-Connecticut, Inc., 209 Conn. 692, 716-17, 553 A.2d 596, 608-09 (1989). For such patients, life-sustaining technology cannot directly cure or palliate the pathologic condition, but can only maintain biological

preventing harm to innocent third parties,[32] and preserving the ethical integrity of the medical profession may override a patient's medical decisions.[33]

B. *Brain Death*

Prior to the development of the intensive care unit and its medical technology,[34] which have extended the lives of many, the courts echoed the common opinion of both the medical and lay communities regarding death. Death was a question of fact and could be determined through expert testimony, if necessary.[35] Since the technologi-

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functioning. Barber v. Superior Court, 147 Cal. App. 3d 1006, 1017, 195 Cal. Rptr. 484, 490 (1983). Therefore, the state's interest in preserving life will not outweigh the patient's interest in choosing his medical care. It is recognized that even when incompetent, the patient retains the right to have appropriate decisions made on his behalf. *In re* Drabick, 200 Cal. App. 3d 185, 205, 245 Cal. Rptr. 840, 852-53 (1988).

31 Suicide is distinguishable from the decision to refuse care. In the latter case, the event or illness that preceded the patient's decision was not self-inflicted. A competent patient may not so much desire death, but rather, may be suffering to such a degree that he no longer wishes to live in that condition. The same reasoning applies to those that are no longer competent. Ultimately, death is not set in motion by the refusal of care, but is due to the underlying disease or traumatic event. *McConnell*, 209 Conn. at 710, 553 A.2d at 605; *In re* Gardner, 534 A.2d 947, 955-56 (Me. 1987).

32 This state interest usually refers to the possible impact, emotional and financial, that the death of the patient may have on minor children. Foody v. Manchester Memorial Hosp., 40 Conn. Supp. 127, 137-38, 482 A.2d 713, 720 (Super. Ct. 1984). When considering the existence of persistent vegetative patients, this interest really has no application. However, when the patient is competent and has dependent children, "[t]he state, as *parens patriae*, will not allow a parent to abandon a child, and so it should not allow [the] most ultimate of voluntary abandonments." *In re* President and Directors of Georgetown College, Inc., 331 F.2d 1000, 1008 (D.C. Cir.) (ordering blood transfusion to adult Jehovah's Witness), cert. denied, 377 U.S. 978 (1964).

33 Brophy v. New England Sinai Hosp., 398 Mass. 417, 440 n.38, 497 N.E.2d 626, 638-39 n.38 (1986); *In re* Conroy, 98 N.J. 321, 351-53, 486 A.2d 1209, 1224-25 (1985); Delio v. Westchester County Medical Center, 129 A.D.2d 1, 25, 516 N.Y.S.2d 677 (2d Dep't 1987). This interest likely refers to one of the underlying premises of medical care: *primum, non nocere* (first, do no harm).

When the underlying event which renders the patient comatose in the right to die case is the result of other forces, the interest in preserving ethical integrity can hardly withstand scrutiny. Further support comes from the medical community that it is not unethical to discontinue "*all means* of life-prolonging medical treatment" from persistently vegetative patients. American Medical Association, Current Opinions of the Council on Ethical and Judicial Affairs § 2.18 (1986) (emphasis added). See also Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient, 39 Neurology 125 (1989).

Protection from abuse is another identifiable state interest that arises when incompetent patients need medical care. *In re* Gardner, 534 A.2d 947, 955 (Me. 1987); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

34 The medical technology that enables survival for persistent vegetative patients has developed during the past twenty-five years. Lave & Knaus, The Economics of Intensive Care Units, in Medicolegal Aspects of Critical Care, supra note 9, 87, at 90.

35 President's Commission for the Study of Ethical Problems in Medicine and Biomedical

cal explosion, medical decision making has necessarily expanded to include moral, ethical, and judicial concepts of life, death, and personal freedoms.

In 1968, an *ad hoc* committee of the Harvard Medical School published criteria, now known as the "Harvard Criteria," of irreversible coma or brain death.[36] When a person is declared brain dead, he is considered "legally" dead and therefore, artificial cardiorespiratory support may be terminated. Since the Harvard Criteria were announced, various states have enacted brain death legislation.[37] For patients who meet the brain death criteria, there is no choice to be made, no preference to be asserted on behalf of the dead individual. What legal doctrine should control the fate of the patient who is not brain dead, but no longer functions with a sense of personhood?[38] If decisions are to be made, who shall decide? Consider the following case.

C. *The Patient in a Persistent Vegetative State*

Mr. G.[39] was a 76-year-old man admitted directly to the neurosurgical intensive care unit as the result of massive bleeding in his brain, caused by a ruptured aneurysm. He was conscious for approximately twenty-four hours, during which time he was sedated with pain medications and constantly monitored by the nursing and medical staff. The patient also suffered from diabetes, high blood

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and Behavioral Research, Defining Death: A Report on the Medical, Legal and Ethical Issues in the Determination of Death 46 (1981) [hereinafter Defining Death]. See also Unif. Determination of Death Act (1989), reprinted in Defining Death, supra, at 119 (death determined according to accepted medical standards).

36 See Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, A Definition of Irreversible Coma, 205 J. A.M.A. 337 (1968). The lack of recovery potential from brain death is certain:

> [I]n the absence of CNS depressants or extreme hypothermia, a record which is "flat" (except for artifacts) all over the head is almost always a result of cerebral hypoxia, ischemia, or widespread cortical destruction. Such a patient, without EEG activity, reflexes, spontaneous respiration, or muscular activity of any kind for 6 h[ours] or more, is said to be in "irreversible coma." The brain of such patients is largely necrotic. There is no chance for neurologic recovery, and the patient may be considered dead, despite the preservation of vegetative (cardiovascular) functions supported by mechanical means, such as respirators. There has been no exception to this statement in more than 900 patients examined at the Massachusetts General Hospital in the past 18 years.

2 Harrison's Principles of Internal Medicine 1918 (11th ed. 1987).

37 See, e.g., Cal. Health & Safety Code §§ 7180-7182 (Deering Supp. 1980); Colo. Rev. Stat. § 12-36-136 (1985); Fla. Stat. § 382.085 (1985).

38 See Cranford & Smith, Consciousness: The Most Critical Moral (Constitutional) Standard For Human Personhood, 13 Am. J.L. & Med. 233 (1987) (the state of existence of a persistent vegetative patient is equivalent to a collection of organs).

39 Mr. G. was one of my patients.

pressure, congestive heart failure, and had suffered a heart attack one year earlier. His wife was deceased, but his family members appeared supportive and cohesive. After Mr. G's admission to the hospital, the oldest daughter expressed her concern that everything possible be done to make him comfortable.

The patient's condition rapidly deteriorated, and he required mechanical ventilation. Tube feedings were instituted to maintain nutritional support. Four months from the time of admission the patient's condition demonstrated no improvement. It was determined that the patient was in a deeply comatose, or perstistent vegetative, state. He could not breathe without intermittent mandatory ventilation. He could not eat without a feeding tube placed through the nose into the stomach. Every bodily function needed to be monitored and artificially controlled or regulated.

An electroencephalogram (EEG) revealed that the patient did not meet the criteria for brain death. Several emotionally painful conferences between the family and Mr. G.'s physicians took place, focusing on treatment and no treatment options. The family had never discussed the possibility of a family member being maintained in a persistent vegetative state. They appeared to be in agreement that their father would have preferred a natural and peaceful death rather than the artificial prolongation of a merely physical life.

This fairly typical situation can be resolved in several ways. When a patient is not competent to render a decision about his medical care, someone must do so on his behalf. Before deciding whether life-sustaining medical treatment should be discontinued, it is instructive to examine how routine medical decisions are made when the patient is unable to do so.

Typically, if family members are available, the physician will consult with them and obtain their consent. Such action is formally recognized by the substituted judgment doctrine.[40] In an emergency situation, the physician may proceed to render appropriate care without incurring liability under the emergency exception to the informed consent doctrine.[41] However, if the patient has been identified as in-

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[40] See infra text accompanying notes 72-82.

[41] F. Rokovsky, Consent to Treatment: A Practical Guide §§ 2.0-2.1.4, at 88-93 (1984 & Supp. 1988); Appelbaum, supra note 10, at 67-69. In some emergency settings, there may exist an affirmative duty on the part of the physician to initiate treatment. Indeed, emergency care physicians often do whatever is necessary to buy time. *In re* Drabick, 200 Cal. App. 3d 185, 195, 245 Cal. Rptr. 840, 846 (1988). Nonetheless, a physician has no duty to continue to provide life-sustaining machinery "once it has become futile in the opinion of qualified medical personnel." Barber v. Superior Court, 147 Cal. App. 3d 1006, 1018, 195 Cal. Rptr. 484, 491 (1983). See also Rahman, Why Pound Life Into the Dying?, N.Y. Times, Feb. 20, 1989, at

competent with no chance of improvement, a proxy decision maker must be identified. The proxy may be legally appointed or informally recognized, as where one family member communicates with the physician on behalf of the patient and other family members.[42] Either way, the recognition of the proxy, for purposes of medical decision making, is especially important if the issue of whether to terminate life-sustaining treatment is to be addressed.

D. *Proxy Decision Makers*

Four potential decision makers are readily identified—the patient, by way of a prior directive, the family, the doctor, and the judge.[43]

1. Patients with Prior Directives

As recognized by the principle of autonomy, the patient is the most appropriate one to make the decision concerning consent to medical treatment.[44] Even though a patient is incompetent, evidence of his desire regarding medical treatment may be documented in a "living will."[45] Thirty-nine states and the District of Columbia have enacted legislation recognizing the validity of such prior written directives.[46] Twelve states specifically authorize decision-making proce-

A19, col. 2 (advocating full discussion of treatment options well ahead of any potentially life-threatening event).

[42] See infra notes 43-66.

[43] Others too may be involved in the decision-making process. Ethics committees have been recommended. See Rubin, Refusal of Life-Sustaining Treatment for Terminally Ill Incompetent Patients: Court Orders and an Alternative, 19 Colum. J.L. & Soc. Probs. 19 (1985).

[44] See supra text accompanying notes 10-15.

[45] A living will is an advance written directive instructing physicians to withhold or withdraw life-sustaining procedures in the event of a terminal condition. D. Meyers, Medico-Legal Implications of Death and Dying 352-53 (1981).

[46] See Natural Death Act, Ala. Code §§ 22-8A-1 to -10 (1984); Alaska Stat. §§ 18.12.010-.100 (1986); Medical Treatment Decision Act, Ariz. Rev. Stat. Ann. §§ 36-3201 to -3210 (1986); Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, Ark. Stat. Ann. 20-17-201 to -218 (Supp. 1989); Natural Death Act, Cal. Health & Safety Code §§ 7185-7195 (West Supp. 1989); Colorado Medical Treatment Decision Act, Colo. Rev. Stat. §§ 15-18-101 to -113 (1987); Conn. Gen. Stat. §§ 19a-570 to -575 (1987); Delaware Death with Dignity Act, Del. Code Ann. tit. 16, §§ 2501-2509 (1983); Natural Death Act of 1981, D.C. Code Ann. §§ 6-2421 to -2430 (1989); Life-Prolonging Procedure Act of Florida, Fla. Stat. §§ 765.01-.15 (1985); Living Wills Act, Ga. Code Ann. §§ 31-32-1 to -12 (1985 & Supp. 1989); Haw. Rev. Stat. §§ 327D-1 to -27 (Supp. 1989); Natural Death Act, Idaho Code §§ 39-4501 to -4509 (1985 & Supp. 1989); Living Will Act, Ill. Ann. Stat. ch. 110 1/2, paras. 701-710 (Smith-Hurd Supp. 1989); Living Wills and Life-Prolonging Procedures Act, Ind. Code Ann. §§ 16-8-11-1 to -22 (Burns Supp. 1989); Life-Sustaining Procedures Act, Iowa Code Ann. §§ 144A.1-11 (West 1989); Natural Death Act, Kan. Stat. Ann. §§ 65-28,101 to -28,109 (1985); La. Rev. Stat. Ann. §§ 40:1299.58.1 -.10 (West Supp. 1989); Me. Rev. Stat. Ann. tit. 22, §§ 2921-2931 (Supp. 1989); Md. Health-Gen. Code Ann. §§ 5-601 to -614 (Supp. 1989); Adult Health Care

dures for incompetent patients who have not provided living wills.[47]

2. The Doctor as Decision Maker

Notwithstanding criticism and dispute over the role of paternalism in medical care,[48] the doctor is still the most appropriate decision maker in some circumstances.[49] The doctor is in the best position to

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Decisions Act, Minn. Stat. Ann. §§ 145B.01-.17 (West Supp. 1990); Miss. Code Ann. §§ 41-41-101 to -121 (Supp. 1989); Mo. Rev. Stat. §§ 459.010-.055 (1986); Montana Living Will Act, Mont. Code Ann. §§ 50-9-101 to -104, -110 to -111, -201 to -206 (1989); Nev. Rev. Stat. §§ 449.540-.690 (1987); N.H. Rev. Stat. Ann. §§ 137-H:1 to -H:16 (Supp. 1988); Right to Die Act, N.M. Stat. Ann. §§ 24-7-1 to -11 (1986); N.C. Gen. Stat. §§ 90-320 to -322 (1989); Oklahoma Natural Death Act, Okla. Stat. tit. 63, §§ 3101-3111 (Supp. 1989); Or. Rev. Stat. §§ 97.050-.090 (1985); Death with Dignity Act, S.C. Code Ann. §§ 44-77-10 to -160 (Law. Co-op. Supp. 1988); Tenessee Right to Natural Death Act, Tenn. Code Ann. §§ 32-11-101 to -110 (Supp. 1989); Natural Death Act, Tex. Rev. Civ. Stat. Ann. art. 4590h (Vernon Supp. 1989); Personal Choice and Living Will Act, Utah Code Ann. §§ 75-2-1101 to -1118 (Supp. 1989); Vt. Stat. Ann. tit. 18, §§ 5251-5262 (1987 & Supp. 1989) & tit. 13, § 1801 (Supp. 1989); Natural Death Act of Virginia, Va. Code Ann. §§ 54.1-2981 to -2992 (1988 & Supp. 1989); Natural Death Act, Wash. Rev. Code Ann. §§ 70.122.010-.905 (Supp. 1989); West Virginia Natural Death Act, W. Va. Code §§ 16-30-1 to -10 (1985); Wis. Stat. §§ 154.01-.15 (1987); Wyo. Stat. §§ 35-22-101 to -109 (Supp. 1989). See also Unif. Rights of Terminally Ill Act §§ 1-18, 9A U.L.A. 456 (Supp. 1986) (draft legislation recommended for adoption in all states by the National Conference of Commissioners on Uniform State Laws).

[47] See Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, 1987 Ark. Stat. Ann. 20-17-201 to -218 (Supp. 1989); Conn. Gen. Stat. §§ 19a-570 to -575 (1987); Life-Prolonging Procedure Act of Florida, Fla. Stat. §§ 765.01-.15 (1985); Iowa Life-Sustaining Procedures Act, Iowa Code Ann. §§ 144A.1-.11 (West 1989); La. Rev. Stat. Ann. §§ 40:1299.58.1-.10 (West Supp. 1989); Right to Die Act, N.M. Stat. Ann. §§ 24-7-1 to -11 (1986); N.Y. Pub. Health Law §§ 2960-2978 (McKinney Supp. 1990); N.C. Gen. Stat. §§ 90-320 to -322 (1989); Or. Rev. Stat. §§ 97.050-.090 (1985); Tenessee Right to Natural Death Act, Tenn. Code Ann. §§ 32-11-101 to -110 (Supp. 1989); Personal Choice and Living Will Act, Utah Code Ann. §§ 75-2-1101 to -1118 (Supp. 1989); Natural Death Act of Virginia, Va. Code Ann. §§ 54.1-2981 to -2992 (1988 & Supp. 1989).

[48] Baron, Medical Paternalism and the Rule of Law: A Reply to Dr. Relman, 4 Am. J.L. & Med. 337 (1979); Baron, Assuring "Detached but Passionate Investigation and Decision": The Role of Guardians Ad Litem in *Saikewicz*-type Cases, 4 Am. J.L. & Med. 111 (1978); Buchanan, Medical Paternalism or Legal Imperialism: Not the Only Alternatives for Handling *Saikewicz*-type Cases, 5 Am. J.L. & Med. 97 (1979); Relman, The *Saikewicz* Decision: A Medical Viewpoint, 4 Am. J.L. & Med. 233 (1978) [hereinafter Relman, Viewpoint]; Relman, The *Saikewicz* Decision: Judges as Physicians, 298 New Eng. J. Med. 508 (1978) [hereinafter Relman, Physicians]; Veatch, Autonomy's Temporary Triumph, 14 The Hastings Center Rep. 38 (Oct. 1984).

[49] One commentator has expressed the following thoughts:

> I believe that families and those closest to the patient are usually the best decisionmakers. To decide effectively, they need good medical information and support from the physicians. Ideally, these decisions will be made jointly by physicians and family, although sometimes a family may elect to let the physician decide. If that is clearly their choice, I think it is a reasonable one. Many physicians are willing to take on this responsibility, particularly if it spares the family further anguish.

Bayley, Who Should Decide?, in Legal and Ethical Aspects of Treating Critically and Terminally Ill Patients 3, 9 (A. Doudera & J. Peters eds. 1982) [hereinafter Doudera & Peters].

make a decision when there is no family available, or when the patient has left no prior directive and the family prefers that the physician decide.[50] It should be assumed that, initially, medical decisions are based on the premise that everything can and should be done to preserve the life of the patient.[51] The treating physician is the most qualified individual to determine the diagnosis and the prognosis of the patient.[52]

3. The Judge as Decision Maker

The judge is the least appropriate decision maker in most cases.[53] One obvious barrier to effective judicial involvement in these cases is the time-consuming nature of the judicial process.[54] In reality, the overwhelming majority of decisions to withdraw life-sustaining treat-

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Judge Richard Byrne, after deciding *In re Benjamin C.*, No. J914419 (L.A. County Juv. Ct. Feb. 15, 1978) (allowing physicians to disconnect a ventilator from a comatose minor), expressed a similiar view: "If the patient is not competent, then the family and those closest to the patient, including his or her doctor, should decide according to criteria established by the courts." Byrne, Deciding for the Legally Incompetent: A View from the Bench, in Doudera & Peters, supra, at 25.

[50] See *In re* Jones, 107 Misc. 2d 290, 433 N.Y.S.2d 984 (Sup. Ct. 1980); Kennedy v. Parrott, 243 N.C. 355, 363, 90 S.E.2d 754, 759 (1956). Others have suggested that allowing the doctor to make decisions is an invitation to roll back the doctrine of informed consent. See Rhoden, Litigating Life and Death, supra note 9, at 379.

[51] It is not easy for physicians and nurses to terminate treatment. A sense of personal failure and responsibility for the death may ensue. Thus, it is psychologically easier for a doctor to do everything technically possible for the care of the patient and it may be easier for a judge to allow this to happen. See Wallace-Barnhill, Human and Environmental Factors in Critical Care: Health Professionals, in Medicolegal Aspects of Critical Care, supra note 9, 147.

[52] See Relman, Viewpoint, supra note 48; see, e.g., Conn. Gen. Stat. § 19a-571(1) (Supp. 1989) ("The decision to remove such life support system [should be] based on the best medical judgment of the attending physician."); see also Wanzer, supra note 3, at 958 (concluding that it is morally justifiable for a doctor to withhold life-sustaining treatment from persistent vegetative patients).

It is estimated that there are five to ten thousand persistent vegetative patients in the United States. Abraham, Ethicists Try to Define Status of Vegetative Patients: Dead? Alive? Treatment Plans Hang on Decision, Am. Med. News, Feb. 24, 1989, at 3, col. 1. It is noteworthy that since *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976), there have only been about sixty judicial opinions involving incompetent patients' right to die, and approximately fifteen concerning persistent vegetative state patients. See, e.g., supra note 2. Doctors, hospitals, and families confront complicated treatment decisions every day. When medical care becomes complex and technical, requiring minute-to-minute titration, as it does in the intensive care unit, informed consent to a large degree remains a theory. It was my experience that with or without consent, there are numerous secondary treatment decisions that are necessarily made as a matter of hospital policy, standards of care, and individual nursing or physician preference.

[53] *In re* Drabick, 200 Cal. App. 3d 185, 196, 245 Cal. Rptr. 840, 846 (1988) (courts are not "constituted or especially well-qualified" to make treatment decisions involving personal and medical values).

[54] See *In re* President and Directors of Georgetown College, Inc., 331 F.2d 1000, 1009 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964) ("There was no time for research and reflec-

ment from comatose patients have been made without the involvement of lawyers and judges.[55] Many courts recognize the preference for allowing, perhaps even encouraging, decision making by the family and appear to be quite willing to allow extrajudicial decision making in the absence of conflict or dispute.[56] Some jurisdictions would require court intervention in every case where the refusal of medical care would allow the death of the incompetent patient.[57] Ample criticism of this view exists.[58]

4. The Family as Decison Maker

When the patient is incompetent, has left no prior directive, and is not expected to improve to a level of cognitive function, the family's choice, with few exceptions, should be respected.[59] There is generally no dispute that family members ought to be consulted and ultimately

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tion."); Dockery v. Dockery, 559 S.W.2d 952 (Tenn. Ct. App. 1977) (treating as moot the issue of patient's guardian appointment because patient died pending appeal).

[55] *In re* Conroy, 98 N.J. 321, 345, 486 A.2d 1209, 1221 (1985); *In re* Torres, 357 N.W.2d 332, 341 n.4 (Minn. 1984) (reporting that ten life-support systems are disconnected weekly in Minnesota); President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions 176-77 n.15 (1981).

[56] Rasmussen v. Fleming, 154 Ariz. 207, 219, 741 P.2d 674, 691 (1987); Barber v. Superior Court, 147 Cal. App. 3d 1006, 1021, 195 Cal. Rptr. 484, 492 (1983); *Torres*, 357 N.W.2d at 341 n.4; *In re* Peter, 108 N.J. 365, 384, 529 A.2d 419, 427 (1987); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987); *Conroy*, 98 N.J. at 384-85, 486 A.2d at 1242; *In re* Quinlan, 70 N.J. 10, 50-55, 355 A.2d 647, 669-72, cert. denied, 429 U.S. 922 (1977); *In re* Storar, 52 N.Y.2d 363, 383, 420 N.E.2d 64, 73-74, 438 N.Y.S.2d 266, 276, cert. denied, 454 U.S. 858 (1981); *In re* Grant, 109 Wash. 2d 545, 566-67, 747 P.2d 445, 456 (1987); *In re* Colyer, 99 Wash. 2d 114, 136-37, 660 P.2d 738, 750-51 (1983), overruled in part, *In re* Guardianship of Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

When courts resolve these life and death issues, they are actions in equity. Juries are not involved, and even though judges are human, they may not be as easily swayed by the emotional appeals of distraught family members seeking what they believe is in the best interests of their loved ones. A trial judge must confront the reality that an identified human life may pass on his decision. Although the judicial process must be "coldly objective and impersonal," separating the human from the legal elements of the case, B. Cardozo, *The Nature of the Judicial Process* 168 (1921), it must be acknowledged that "[j]udges, like doctors, are not machines and, although it may be true that 'laws and not men' rule, it must not be forgotten that in the last analysis men do rule, even when they rule within and through the framework of the law." P. Riga, supra note 23, at 12.

[57] See Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334 (Del. 1980); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); Leach v. Akron Gen. Medical Center, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980).

[58] Relman, Physicians, supra note 48; Annas, Reconciling *Quinlan* and *Saikewicz*: Decision Making for the Terminally Ill Incompetent, 4 Am. J.L. & Med. 367, 387-94 (1979).

[59] There is substantial support for the notion that the family or those closest to the patient should be the decision makers. See, E.g., Bayley, supra note 49; Byrne, supra note 49; Veatch, supra note 8.

decide treatment options.[60] In *In re Quinlan*,[61] the court held that such decisions "should be controlled primarily within the patient-doctor-family relationship."[62] When family members are available, they are often viewed by the medical establishment as the appropriate decision makers[63]—as indeed they should be.[64] Many courts[65] and commentators[66] have approved this view as well. Unfortunately, these endorsements are not enough, as an examination of the legal bases for resolving disputed treatment decisions demonstrates.

E. *How Some Cases Reach Court*

Medical decisions for incompetent patients are made in court due to physician fear of civil or criminal liability, or when a conflict exists between the desire of the patient—as articulated by a living will, the family, or a guardian—and the medical establishment. For example, in one case,[67] a hospitalized patient suffered a cardiopulmonary arrest and was rescusitated and placed on life-support machinery. After several days, the patient's physicians determined that he was in a deeply comatose state which was unlikely to improve. The treating physi-

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60 See Wanzer, supra note 3, at 956 (indicating that the treating physician should routinely consult with the patient's family and friends to assist in determining future treatment plans). Contra Relman, Viewpoint, supra note 48; Relman, Physicians, supra note 48.

61 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976).

62 Id. at 50, 355 A.2d at 669.

63 See, e.g., Kramer, Letter to the Editor: Decisions to Limit Care, 261 J. A.M.A. 696 (1989). "For a good many years, in a variety of locales, physicians in conjunction with families have withheld or withdrawn life-preserving measures from moribund patients. No pattern of abuse has surfaced." N. Cantor, Legal Frontiers of Death and Dying 108-09 (1987). Indeed, too much legal and judicial intervention may have negative consequences. "In our lawyer-dominated society, hospitals have been forced to devise bureaucratic rules that may not have the patients' welfare foremost in mind. Moreover, once a patient is on the life-support system, it is not easy to 'pull the plug.' Legal complexities will override ethical justifications." Rahman, supra note 41, at A19, col. 6.

64 Families should be allowed an expanded role in questions concerning the appropriate level of patient care. Physicians should not feel threatened when patients or families assume a greater role in decision making regarding medical treatment. They should recognize that in a moral, ethical, and legal sense, families should be and are empowered to participate in this decision making. Although there will certainly continue to be situations that can be resolved only through legal processes, it is quite possible that many such problems can be resolved through more understanding by the physicians and nurses involved.

Wallace-Barnhill, Human and Environmental Factors in Critical Care: Patients and Their Families, in Medicolegal Aspects of Critical Care, supra note 9, 133, at 139.

65 E.g., John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921 (Fla. 1984) (reducing the procedural requirements of the family prior to exercising the incompetent's right to terminate treatment); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983), overruled in part, *In re* Guardianship of Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

66 E.g., Litigating Life and Death, supra note 9; Veatch, supra note 8.

67 Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

cians informed the patient's family of the situation. After discussion, the family presented a written statement to hospital personnel requesting that all artificial support systems be discontinued. The physicians complied with the family's request. After the patient died, the state charged the physicians with murder. Though the court eventually dismissed the murder indictment,[68] the possibility of facing criminal charges remains a strong disincentive to open communication and consultation with the family regarding possible treatment options for the incompetent patient.[69]

Another reason for court intervention is the refusal of the treating physician to respect the family's choice. In another matter,[70] the wife-guardian and family of a patient in a persistent vegetative state sought to have a feeding tube removed so that he could die. This request was opposed by the treating physician, who was then supported by the medical and nursing staff at the hospital.[71]

Potentially, the duties, rights, and interests of the doctor, patient, family, and state may conflict. The disputed treatment option must then be decided in court.

II. THE VARIOUS JUDICIAL APPROACHES TO TERMINATION OF TREATMENT

The three legal rules that have been prescribed by the courts to enable decision making for incompetent patients are: 1) the substituted judgment test; and two types of best interest tests, 2) the limited objective test, and 3) the pure objective test. Although every court that has decided a termination of treatment case has purported to apply one of these tests, there are examples where the test applied does not really conform to its underlying rationale. Some courts have adopted one or another of these tests, but apply them in such a way as to disallow the outcome apparently dictated by its application. Outcome-oriented opinions may be favored by some judges or panels of judges, but consistency and predictability are lost in the process.

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68 The court held that, since the physicians had not unlawfully failed to perform a legal duty, their behavior did not constitute murder. Id. at 1012-13, 195 Cal. Rptr. at 487.

69 In dismissing the murder complaint, the court noted that the patient's physicians would have provided continued treatment if requested to do so by the family. Id. at 1020, 195 Cal. Rptr. at 492. The court further noted that "a murder prosecution is a poor way to design an ethical and moral code for doctors who are faced" with such life and death decisions. Id. at 1011, 195 Cal. Rptr. at 486.

70 Brophy v. New England Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986).

71 Id. at 429, 497 N.E.2d at 632.

A. *Substituted Judgment Test*

Some courts apply this test in an attempt to determine what the incompetent patient would choose if able to do so.[72] Other courts allow the guardian to apply his own best judgment in his capacity to exercise the ward's right to refuse treatment.[73]

The substituted judgment test is founded on the law of guardianship.[74] The guardian is appointed to manage the affairs of the patient. One of these affairs involves the consent or refusal to submit to medical care. The substituted judgment test requires the guardian to exercise the ward's rights, protecting his interests, as though having stepped into the ward's shoes.[75] The guardian's judgment would more nearly approximate that of the ward's if a bonded relationship[76] previously existed between them.[77] When the guardian is a family member (spouse, parent, child) or close friend, he will assert, in an attempt to meet the evidentiary standard of the substituted judgment test, that the ward had expressed the desire not to be maintained in the state in which he now exists. The guardian must present evidence of this preference regarding medical care.

The evidentiary standard of the incompetent patient's desire or intent that must be met is one of clear and convincing evidence.[78] This heightened scrutiny is based on common-law doctrine[79] and requires a higher degree of proof than most civil actions, which require a preponderance of the evidence, but lower than the criminal standard, which requires evidence beyond a reasonable doubt. While some commentators suggest that a reasonableness standard be employed,[80] the argument for a heightened evidentiary burden is justified

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72 *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 972 (1976).

73 *In re* Colyer, 99 Wash. 2d 114, 128, 660 P.2d 738, 746 (1983), overruled in part, *In re* Guardianship of Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

74 The doctrine of substituted judgment requires that the guardian "don the mental mantle of the incompetent." Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 752, 370 N.E.2d 417, 431 (quoting *In re* Carson, 39 Misc. 2d 544, 545, 241 N.Y.S.2d 288, 289 (Sup. Ct. 1962).

75 Id.

76 A bonded guardian is usually a close relative, but may be a close friend. Veatch, supra note 8, at 441.

77 This is also supported by a clinical study which found that a family's preference to submit a family member to intensive care was similar to the preference of the surviving patient. Danis, Patrick, Southerland & Green, Patients' and Families' Preferences for Medical Intensive Care, 260 J. A.M.A. 797, 799 (1988).

78 *In re* Westchester County Medical Center, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988); *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).

79 See McCormick on Evidence § 340, at 959 (3d ed. 1984).

80 The burden of proof rests on the guardian seeking to discontinue treatment. This aspect of the rule's application requires close evaluation. A problem arises when the decision made

by the potential result of the decision—the death of the patient.

Once the question of whether to discontinue care has been reached and the court is preparing to apply the substituted judgment test, the guardian must offer sufficient evidence to prove that the ward would not have consented to the existing medical care. The guardian is in a position to supply such evidence by virtue of his relationship to the patient. If and when this burden is met, the burden shifts to those opposing the refusal of care.[81] At the same time, an investigation should be undertaken to ensure that no conflicts of interest exist between guardian and ward sufficient to compel the continuation of care.[82]

B. *Limited Objective Test*

The limited objective test[83] adopted by some courts allows the discontinuation of care when there is not enough evidence to survive the substituted judgment test. This test allows the withdrawal of life-sustaining medical treatment where there is "some trustworthy evidence that the patient would have refused the treatment, and the decision-maker is satisfied that it is clear that the burdens of the patient's continued life with the treatment outweigh the benefits of that life for him."[84] This two-prong test represents a relaxation of the stringent clear and convincing evidentiary standard that must be met under the substituted judgment test. Specifically:

> Evidence that, taken as a whole, would be too vague, casual, or remote to constitute the clear proof of the patient's subjective intent that is necessary to satisfy the subjective test—for example, informally expressed reactions to other people's medical conditions

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by one individual conflicts with the decision of most other people, some other people, or even the "reasonable" person. Rhoden, Litigating Life and Death, supra note 9; Veatch, supra note 8, at 433. When a doctor presents a treatment option to a patient who does not consent to a low risk/high benefit procedure, the doctor will probably conclude the patient is incompetent to make a decision. Tepper & Elwork, Competence to Consent to Treatment As a Psycholegal Construct, 8 Law & Hum. Behav. 205, 208-10 (1984).

[81] Litigating Life and Death, supra note 9.

[82] In *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983), overruled in part, *In re* Guardianship of Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984), the court proposed a four-step process for the determination of whether to withhold life-sustaining treatment: (1) concurrence by a prognosis committee composed of physicians; (2) court appointment of a guardian and a guardian *ad litem*, not necessarily to act in an adverserial manner, but to represent the best interests of the ward during the guardianship procedure; (3) exercise by the guardian of the patient's rights based on the guardian's best judgment of the patient's preferences; (4) and only if required, a court determination of the rights and wishes of the incompetent. Id. at 128-37, 660 P.2d at 746-51.

[83] Foody v. Manchester Memorial Hosp., 40 Conn. Supp. 127, 482 A.2d 713 (Super. Ct. 1984); *In re* Torres, 537 N.W.2d 332 (Minn. 1984).

[84] *In re* Conroy, 98 N.J. 321, 365, 486 A.2d 1209, 1232 (1985).

and treatment—might be sufficient to satisfy this prong of the limited-objective test.[85]

This test may be viewed as a device employed by outcome-oriented jurists who recognize that doctors and hospitals traditionally seek guidance in decision making from the incompetent patient's family. Assuming that the family has the welfare of the patient at heart and probably knows the patient's preferences, it allows the "right" outcome by acknowledging that the family is the best decision maker.[86]

C. *Pure Objective Test*

The pure objective test[87] is a balancing test that weighs the benefits and burdens encountered by the incompetent patient, thereby allowing the judge to order a discontinuation of care. This test is applied when the prognosis of continued incompetence is certain, and the patient never indicated any preference whether to be maintained in such a condition.

The outcome hinges on who does the balancing. The family may assert the right of the incompetent family member to "die with dignity,"[88] yet courts may favor the continuation of care. If, for exam-

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[85] Id. at 366, 486 A.2d at 1232.

[86] In *In re Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988), four brothers and a long-time companion of a persistent vegetative patient sought to have artificial feeding discontinued. This request was based on the best interests of the patient and the belief that the patient would not want to be maintained in his current state. Id. at 190-92, 245 Cal. Rptr. at 842-43. The trial court, although empathizing with the family, determined that it was in the patient's best interest to be artificially maintained in an irreversibly comatose condition. Id. at 193, 245 Cal. Rptr. at 844. This illustrates the difficulty of judicial intervention at all in such cases, where conflicting and complicated issues of morality and ethics will unavoidably play a role in judicial determination. Generally, these issues may not be "well-suited for resolution in an adversary judicial proceeding." Satz v. Perlmutter, 379 So. 2d 359, 360 (Fla. 1980).

[87] *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987); *Conroy*, 98 N.J. 321, 486 A.2d 1209.

[88] *Conroy*, 98 N.J. at 343, 486 A.2d at 1220. The question becomes: death with dignity for whom? Is it the comatose patient or the family members who are unable to grieve properly for their loved one and must also endure the daily turmoil of the family member's condition?

If the now comatose patient had expressed a prior wish not to be maintained in such a state and the family has become the decision maker, then the interest of the family in asserting the patient's right must be protected. See *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983), overruled in part, *In re* Guardianship of Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

> At some point, such a course of treatment upon the insensate patient is bound to touch the sensibilities of even the most detached observer. Eventually, pervasive bodily intrusions, even for the best motives, will arouse feelings akin to humiliation and mortification for the helpless patient. When cherished values of human dignity and personal privacy, which belong to every person living or dying, are sufficiently transgressed by what is being done to the individual, we should be ready to say: enough.

Conroy, 98 N.J. at 399, 486 A.2d at 1250 (Handler, J., concurring in part and dissenting in part).

ple, a panel of vitalists preside, then certainly the balance will rest on the side of continued life for life's sake.[89] The courts that apply this test recognize the difficulty of the decision and the anguish that the family must endure.[90] After all, the patient is a loved family member that no longer participates within the family as he once did. Family dynamics are disturbed by the needless prolongation of the dying process, and the family becomes suspended in a condition of mourning that cannot conclude until their family member is buried.[91]

For most people that have encountered the reality of the intensive care unit, the prospect of continued artificial, life-sustaining treatment after the prognosis is irreversible is not a favorable one. What benefits are there? If no cognitive function is possible, the simplistic balancing of painful sensation against pleasure is irrelevant. This state of "life" is one that is difficult to imagine. If there is no awareness or volitional interaction with one's environment, then what is there? Even dreams are dependent on cognitive functioning and can only be "experienced" by remembering when one is awake. The pure objective test is a utilitarian doctrine that allows the family of the incompetent patient to exercise a paternalistic, beneficent decision to refuse the application of technology to the body of their loved family member.

III. WHAT RIGHT IS IT AND TO WHOM DOES IT BELONG?

Even though the conceptual analysis for invoking a right to privacy for "comatose and unconsenting persons is difficult . . . the right is so fundamental that a way must be found to invoke it for every

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[89] For example, if Justice Nolan (dissenting in Brophy v. New England Sinai Hosp., 398 Mass. 417, 432, 497 N.E.2d 626, 640 (1986)) were to decide all of these cases, then no patient would ever be allowed to die.

> I can think of nothing more degrading to the human person than the balance which the court struck today in favor of death and against life. It is but another triumph for the forces of secular humanism (modern paganism) which have now succeeded in imposing their anti-life principles at both ends of life's spectrum. Pro dolor.

Id. at 443, 497 N.E.2d at 640.

[90] *Peter*, 108 N.J. at 387, 529 A.2d at 430 (O'Hern, J., dissenting) ("None of us would want to experience the anguish of choice that families in this situation must suffer.").

[91] Joe Cruzan, discussing the plight of his daughter, Nancy (Cruzan v. Harmon, 760 S.W.2d 408, cert. granted sub nom. Cruzan v. Director, Missouri Dep't of Health, 109 S. Ct. 3240 (1989) (the court denied the family's request to withdraw nutritional support from a patient in a six-year persistent vegetative state)) stated: "It just consumes me trying to figure out what to do. I feel as Nancy's father, I've let her down . . . . It's like having a death in the family, and the state says 'I'm sorry, but you can't bury that person.' " Abraham, supra note 52, at 32, col. 3.

adult."[92]

Courts that have faced the question of whether to allow a proxy decision maker to refuse life-sustaining medical care on behalf of an incompetent person have analyzed the issue in terms of personal privacy. This judicial willingness to extend the concept of privacy to an incompetent, as asserted by a guardian, gives rise to questions such as: What exactly are the parameters of this right? How and by whom may the right be asserted?

A. *Privacy*

In 1890, Samuel Warren and Louis Brandeis published their essay, *The Right to Privacy*.[93] For Warren and Brandeis, the privacy right was meant to protect the personality as an inviolate entity.[94] The need to protect the personality grew out of a concern surrounding the protection of citizens from new information-gathering technology and newspaper gossip columnists.[95] After the Warren-Brandeis article appeared, new legal arguments were developed that were predicated on an unconsenting individual's right to protect his "thoughts, statements, or emotions"[96] from public dissemination. Although, subsequently, several definitions of the privacy right have been proposed,[97] none captures the essence of the Warren-Brandeis concept of the "right to one's personality."[98] Moreover, regardless of these proposed definitions, the courts determine the parameters and status of the right to privacy.[99]

In one of the first Supreme Court opinions to address the right to privacy, the Court stated: "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all

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92 P. Riga, supra note 23, at 120.

93 Warren & Brandeis, The Right to Privacy, 4 Harv. L. Rev. 193 (1890).

94 R. Hixson, Privacy in a Public Society: Human Rights in Conflict 29 (1987).

95 *Id.* at 31-32; Warren & Brandeis, supra note 93, at 195-96.

96 R. Hixson, supra note 94, at 29.

97 See, e.g., 3 Privacy Law and Practice 23.01[1], at 23-24 (1988) (defining "true privacy" as a right to confidentiality or autonomy); Parent, A New Definition of Privacy for the Law, 2 Law & Phil. 305, 306 (1983) (defining privacy as "the condition of not having undocumented personal information about oneself known by others").

98 See R. Hixson, supra note 94, at 33.

99 A. Breckinridge, The Right to Privacy 3 (1970). Much criticism has been generated by the Supreme Court's reluctance or inability to expressly define privacy.

The term "false privacy" has been applied to the situation where the refusal of medical treatment will result in death. 3 Privacy Law and Practice, supra note 97, at 24. There is also a confusion between "privacy" and "liberty." Liberty is defined as the value that citizens "ought not to be subject to unwarranted government coercion in matters which fundamentally affect their lives." Parent, supra note 97, at 317.

restraint or interference of others, unless by clear and unquestionable authority of law."[100] Later, the Court speaks of privacy as a "[f]undamental personal right, emanating 'from the totality of the constitutional scheme under which we live.' "[101] The assertion of this fundamental right is not limited to the individual to whom it applies—for example, there is a privacy right within "the marital relation and the marital home."[102] Thus, the right of privacy has become associated with the right of individuals and married couples to make important and fundamental decisions.[103]

The right to die cases have created a doctrinal stumbling block for courts, requiring them to seek out and protect rights in patients who lack thought, expression, and consciousness—who some may not even consider to be alive.[104] Nevertheless, the Supreme Court noted that "[t]hose who are irreversibly ill with loss of brain function . . . retain 'rights,' to be sure, but often such rights are only meaningful as they are exercised by agents acting with the best interests of their principals in mind."[105] Therefore, by relying on the substituted judgment doctrine, courts allow the vicarious assertion of fundamental rights by a guardian on behalf of his ward.[106] But not all rights can be asserted by the guardian, and certain rights do not exist if they are not exercised by the individual.[107]

Persistent vegetative patients cannot speak for themselves, yet the courts are striving to protect their rights as individuals. The Supreme Court has recognized that "[t]he law must often adjust the manner in which it affords rights to those whose status renders them unable to exercise choice freely."[108] The "desires" of the persistent vegetative patient become known only through the actions of others.

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[100] Union Pac. Ry. v. Botsford, 141 U.S. 250, 251 (1891).

[101] Griswold v. Connecticut, 381 U.S. 479, 494 (1965) (Goldberg, J., concurring) (quoting Poe v. Ullman, 367 U.S. 497, 521 (1961) (Douglas, J., dissenting)).

[102] *Griswold*, 381 U.S. at 495 (Goldberg, J., concurring); accord Eisenstadt v. Baird, 405 U.S. 438 (1972).

[103] See Parent, supra note 97, at 315.

[104] Cranford & Smith, supra note 38, at 236 (asserting that permanently unconscious patients form a "medically, morally, and legally distinguishable class" and, therefore, may not have any constitutional rights). The courts must analyze and identify each party's protectible interests. One of the problems in the right to die cases involves the protection of patient autonomy through the privacy right. Autonomy presupposes the existence of a person capable of acting.

[105] Thompson v. Oklahoma, 108 S. Ct. 2687, 2693 n.23 (1988).

[106] See supra notes 72-82 and accompanying text.

[107] The guardian may not vote on behalf of his ward.

[108] *Thompson*, 108 S. Ct. at 2693 n.23.

The patient only continues to exist through the actions of others.[109] Therefore, rights that were never intended to be asserted by an incompetent person are nevertheless extended to fit the situation.[110]

B. *Who Should Decide*

Since it is recognized that the traditional family relationship is "as old and as fundamental as our entire civilization,"[111] a reconsideration of perspective is necessary. Courts have viewed the problem as a balancing between the rights of the incompetent and the interests of the state. Theoretically, the right to privacy that resides with the patient must be transferred to the family. Some courts have hinted at a shift in decision-making power.[112] Courts should view the decision-making process through the eyes of the decision makers, most often the family, and balance this right of the family against identified and compelling state interests. A court may do this by recognizing that family cohesion and autonomy form the conceptual basis for a family privacy right.

There are several advantages to simply recognizing and protecting the family's decision. One advantage is practicality. The single most advantageous result of recognizing the family's right to decide is

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109 Indeed, there may not even exist an affirmative duty to maintain the persistent vegetative patient. See supra note 41 and accompanying text.

110 Cranford & Smith, supra note 38.

For example, if a court were to confront a right to die case as one of first impression, there are three tiers of decision-making guidelines. If the facts clearly and convincingly demonstrate that the incompetent patient would decide to forgo life-support measures, then the substituted judgment test would be satisfied. If there was no evidence regarding the patient's choice, the same result—termination of treatment—could still be dictated by the pure objective test. Despite this seemingly wide doctrinal gap, the justification for deciding to withhold life-sustaining medical treatment, in both cases, is predicated on the individual right to privacy.

111 Griswold v. Connecticut, 381 U.S. 479, 496 (1965) (Goldberg, J., concurring).

112 In *In re Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988), the court noted that most judicial decisons concerning vegetative patients recognize "that a patient's 'right to choose' or 'right to refuse' medical treatment survives incompetence." Id. at 206, 245 Cal. Rptr. at 852. The court then touched on an objective decision-making standard when it stated that "[i]t would be more accurate to say that incompetent patients retain the right to have appropriate medical decisions made on their behalf." Id. But the court then held that an appropriate medical decision is one that is made solely in the patient's best interest without regard to anyone else. Id.

The Court in *Roe v. Wade*, 410 U.S. 113 (1973), when determining the limits to be placed on a woman's right to decide to seek an abortion, discussed the state's compelling interest in protecting a fetus at the point of viability and used the phrase "meaningful life" rather than "potential life." Id. at 163. "With respect to the State's important and legitimate interest in potential life, the 'compelling' point is at viability. This is so because the fetus then presumably has the capability of meaningful life outside the womb." Id. Professor Tribe asserts that the *Roe v. Wade* Court was choosing to allocate decision-making authority. That authority was to be given to the woman and her physician or agencies of government. Tribe, Foreword: Toward a Model of Roles in the Due Process of Life and Law, 87 Harv. L. Rev. 1, 11 (1973).

that a decision will be made. Currently, if the patient has spoken of his desire or has left a living will, there is a basis for making a decision. In the absence of the patient's views on the subject, a decisional vacuum results. Since the family usually makes medical decisions for the incompetent patient, doctors would know with whom to discuss all treatment decisions. They would then be able to render appropriate life-prolonging care until such time as the family decides otherwise. Therefore, private medical decisions are kept out of the public arena.

Another advantage lies in the fact that the family must live with the medical care decisions that are made. This approach would work in cases where the family is estranged. The family may still exercise the preference of the patient. If the family is unavailable or incapable of exercising the patient's choice, a bonded guardian, in the form of a close friend, may be appointed. To protect against clear conflicts of interest, formal judicial oversight may be instituted. Those who most bear the consequences ought to also bear the responsibilty for making such decisions.

Indeed, a court may sometime soon write an opinion holding that the family's choice is to be respected and accorded legal status. The family's right, as medical decision maker, may then be recognized by other courts, even the legislature, and be labelled a "legally protectible interest." Thus, courts need to shift the locus of decision-making authority, by relying on the familial privacy right, and to articulate a protected interest in the family as decision maker.

CONCLUSION

In the absence of legislation, the courts have been called upon to announce doctrinal guidelines for difficult decisions. Confronted with dramatically new and difficult fact situations, the courts understandably rely on analogous doctrines—guardianship, substituted judgment, battery, informed consent—when formulating opinions around the new situation. In the realm of medicine and scientific advancement, the ability of the law to keep abreast is limited by the slower pace of legal decision making and change.

The right to die cases present a particularly ripe opportunity to adapt long-standing, time-tested judicial doctrine to new and as yet unresolved legal challenges. When the right to die case reaches the courtroom, the first question that should be addressed is who may exercise an incompetent's right to refuse life-sustaining treatment if no directive or evidence of the incompetent's desire exists. If the patient's family is available, capable, and willing to do so, it should be

granted the legal status of ultimate decision maker. Courts may protect this decision-making power in a fashion similar to the way marital privacy is protected by recognizing the importance and fundamental sanctity of the family and expressly extending the right of privacy to the family. This would resolve the problem of protecting and asserting rights in patients who cannot and will never be able to do so.

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