THE CHOICE TO REFUSE OR WITHHOLD MEDICAL TREATMENT: THE EMERGING TECHNOLOGY AND MEDICAL-ETHICAL CONSENSUS

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INTRODUCTION

When a patient says "no" to recommended medical technology and treatment,1 he brings into conflict a confusing array of rights, interests and duties. The actors in these real-life dramas include the patient, the patient's family, the state, the hospital and its professional staff and finally the attending physicians.

The patient claims the right of self-determination. The state claims an interest in the sanctity of life and a duty to protect the interests of dependents. The physicians and hospital staff, trained in the application of their skills and mindful of their real or imagined legal exposure, argue for the integrity of the healing arts and set up the spector of involuntary exposure to suit. The family, frequently torn between respect for the patient's right to self-determination or religious ideology and the natural desire to see the patient survive through the application of relatively routine technology and skills, becomes a passive focus of the drama. When the patient's competency is in doubt and someone else says "no" on the patient's behalf, the controversy becomes more complicated, and resort to the courts becomes more certain. Further confusing the issue, the pace of events is frequently dictated by the biological deterioration of the patient's condition, accompanied in many cases by the certainty of the patient's death in the event treatment is withheld.

The actors in these dramas frequently play unaccustomed roles. Hospitals and physicians argue the case in favor of their

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1. The term "recommended" is chosen over "necessary" because the term and concept of necessary medical care are being redefined in light of advances in medical science and technology. The necessity of the recommended treatment is not an assumption in refusal cases. Rather, the necessity of the recommended treatment is a key issue to be resolved in each refusal case. See generally notes 189-94 and accompanying text infra.
own liability should they withhold treatment.\textsuperscript{2} Distant relatives and strangers to the family are asked to consent to medical and surgical treatment.\textsuperscript{3} Courts find themselves defining for physicians the scope of medical necessity and the limits of medicine.\textsuperscript{4}

Resolution of these cases need not be so difficult. There already exists a substantial body of traditional legal principals which define the various rights and duties and provide a solution in most cases. There also exist some major fictions and misconceptions which should be identified as such.

This article attempts to identify and analyze the various rights, interests and duties, and then to suggest the legal basis for sorting them out. The cases of the competent adult patient, the adult whose competency is in doubt, the incompetent patient, and the minor will be considered. Also examined is the impact of advances in medical science on the issue of whether the treatment is really necessary in the first place. Because the writer considers legislative intervention essentially undesirable\textsuperscript{5} and fears that further legislative intervention is a necessary corollary to the medical profession’s reluctance to act upon anything other than legal cer-

\textsuperscript{2} See, e.g., In re President and Directors of Georgetown College, Inc., 331 F.2d 1000, 1009 (D.C. Cir. 1964), reh en banc denied, 331 F.2d 1010 (D.C. Cir. 1964); United States v. George, 239 F. Supp. 752, 754 (D. Conn. 1965).

\textsuperscript{3} E.g., In re Long Island Jewish-Hillside Medical Center, 73 Misc. 2d 395, 342 N.Y.S.2d 356 (Sup. Ct. 1973) (based on the theory that someone must consent). The court by long-distance telephone appointed a niece of the patient special guardian. The niece consented and surgery was performed. Id. at —, 342 N.Y.S.2d at 361. In practice, in the absence of an available family unit, the consent of persons ranging from bank trust officers to long-time housekeepers is likely to be accepted by the hospital if the patient has expressed no actual objection such as where the patient is incompetent, senile, or unconscious.

\textsuperscript{4} See In re Quinlan, 70 N.J. 10, —, 355 A.2d 647, 671 (1976). Karen Quinlan, without warning, was discovered in a coma of unknown origin. She was described by her physicians as being in a persistent vegetative state from which there was no hope of recovery. Pulse and respiration were being artificially maintained. The physicians for Karen Quinlan asserted that to disconnect her from the respirator would conflict with their professional judgement. Finding that their professional judgment was heavily influenced by a perception of what the law required, rather than purely what the application of medical judgment would require, the court determined that the practice of medicine does not compel the use of all available techniques and technology in such cases. Id. at —, 355 A.2d at 667.

tainty, it is hoped that the existing rules of law and the suggested pattern for their application identified here will help remove some of the mystery and confusion surrounding refusal cases and thereby reinforce the existence of the traditional rules of law which assure reasonable certainty of result when consistently applied.

**WHAT ARE THE PATIENT'S RIGHTS?**

**COMPETENT ADULT PATIENT**

A competent adult patient is no more or less than a competent adult who happens to be in the hospital. He possesses four identifiable rights: these rights tend to merge into a summary right of self-determination or personal choice in all matters affecting his own body.

**Common-Law Right of Bodily Integrity**

The common law recognizes a fundamental right of personal liberty and choice in matters affecting one's person:

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 restraints or interference of others unless by clear and unquestionable authority of law. . . . "The right to one's person may be said to be the right of complete immunity: to be let alone."

This common-law right of self-determination, while sometimes severely tested, is universally recognized in the hospital setting. Justice Cardozo observed that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages."

The right of self-determination, even in matters of medical necessity, is safeguarded by the common-law remedy of tort such that nonconsensual surgery or treatment may result in liability to the treating physician and hospital, even though the treatment is medically necessary and the result is successful.

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9. See Church v. Adler, 350 Ill. App. 471, ---, 113 N.E.2d 327, 332-33 (1953); Gar-
In the hospital setting the patient's right is to give an "informed consent" before special procedures or treatment are undertaken. There are two theories under which liability may be imposed on the treating physician for failing to obtain his patient's informed consent. The first theory is under the tort of battery. The relationship between physician and patient is consensual. Treatment which exceeds the consent is by definition outside the relationship and unprotected by notions of duty. In the absence of any evidence of appropriate informed consent. The medical record shall contain evidence of the patient's informed consent for any procedure or treatment for which it is appropriate. This information should include the identity of the patient, the date, the procedure or treatment to be rendered (in layman terminology when possible), the name(s) of the individual(s) who will perform the procedure or administer the treatment, authorization for anesthesia if indicated, an indication that alternate means of therapy and the possibility of risks or complications have been explained to the patient, and authorization for disposition of any tissue or body parts as indicated. . . .
consent, the physician's actions become the intentional touching of another person without authorization. Such touching, or the performance of an unauthorized procedure, may support an action in battery.\textsuperscript{11}

In most situations some form of consent is given. In fact, the patient's presence in the hospital may be considered a form of implied consent to minimal care. Hence, the typical case litigating lack of informed consent involves the issue of negligence.\textsuperscript{12} The physician's duty to his patient extends beyond merely applying his skill in diagnosis and treatment in a professionally competent manner. The consensual nature of the relationship defines the physician's duty in terms of consent, so that his failure to obtain an informed consent may constitute a breach of duty, a deviation from the recognized standard of care. It was a recognition of the consensual nature of the relationship that led courts to shift from the old practice of vague and general consent to specific, and presumably informed, consent.\textsuperscript{13}

Lack of informed consent, whether sounding in the tort of battery or as a separate allegation of negligence, carries the ever present potential for litigation.\textsuperscript{14} The focus of the courts is not limited

\begin{footnotes}
\item[11] See, e.g., Pratt v. Davis, 224 Ill. 300, 307, 79 N.E. 562, 564 (1906); Schloendorff v. Society of New York Hosp., 211 N.Y. 125, —, 105 N.E. 92, 93-94 (1914). Battery is still a viable doctrine although it is generally reserved for those cases where no consent is asked or given, where no information of risk or consequences is provided or where the procedure performed violates express limitations in the consent or clearly exceeds the scope of consent given. See Cobbs v. Grant, 8 Cal. 3d 229, 240-41, 502 P.2d 1, 8, 104 Cal. Rptr. 505, 512 (1972). The Cobbs Court stated:

The battery theory should be reserved for those circumstances when a doctor performs an operation to which the patient has not consented. When the patient gives permission to perform one type of treatment and the doctor performs another, the requisite element of deliberate intent to deviate from the consent given is present. However, when the patient consents to certain treatment and the doctor performs that treatment but an undisclosed inherent complication with a low probability occurs, no intentional deviation from the consent given appears; rather, the doctor in obtaining consent may have failed to meet his due care duty to disclose pertinent information. In that situation the action should be pleaded in negligence.\textsuperscript{15}


\item[13] For the development of this liability, see Law, The Patient's Right to Refuse Treatment, 5 The Hospital Medical Staff 1 (1976).

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to whether or not the patient has given consent but includes considerations of whether or not the procedure performed is identical to that for which consent was obtained and whether or not the physician provided sufficient information concerning the risks, alternatives and nature of the procedure to permit the patient to make a truly informed decision. Many states now have legislation treating the subject of informed consent.

The doctrine of informed consent, obviously, has two elements. It must be informed, which carries the burden of adequate disclosure. It also encompasses the notion of consent, which recognizes a right of choice which, in turn, necessarily presupposes the right to refuse rather than consent. There is an important distinction between a right of choice and a right to consent which is often blurred or ignored. The typical substitute consent is premised upon a right (real or imagined) to consent, but frequently carries no right to choose the alternative to consent, i.e., refusal. That part of the doctrine which implies the right to choose imposes limits on what a physician may do as well as upon the scope of his duty to treat.

Constitutional Right of Liberty

While common-law rights protect the patient from private tortious action, constitutional rights protect the patient from the state. However, in most of the litigated cases where constit

A multi-year survey by St. Paul Fire and Marine Insurance Company, a major malpractice carrier, reports that only 2.5% of the malpractice claims against St. Paul between 1973 and 1978 were based on lack of informed consent. Curran, supra. Whether this represents increased awareness and compliance with the doctrine or overemphasis of the doctrine as a source of liability is not important for purposes of refusal cases since the doctrine is universally recognized and since it has the effect of placing limits on what hospitals and physicians may do and on what they may be held liable for not doing.

20. See notes 117-21 and accompanying text infra.
tional rights of liberty, privacy, or religion are raised, the state is not a party. Rather, the hospital or physicians are initiating suit to compel treatment. In these suits the entire array of states' rights may be raised to justify court ordered treatment. Hospitals and physicians may seek to stand in for the state or establish standing in their own right.

The first of these constitutional rights is referred to as a right to liberty; to freedom of choice in matters affecting the body or bodily integrity. It finds expression in Mohr v. Williams as follows:

Under a free government, at least, the free citizen's first and greatest right, which underlines all others—the right to the inviolability of his person....is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon, however skillful or eminent, to violate, without permission the bodily integrity of his patient. ... This right to bodily integrity is a uniquely relevant vehicle for exercising the right of privacy or of religion in the hospital setting. Further, it underscores the concept of choice which colors the entire remaining discussion. The exercise of this right is the exercise of a choice personal to the patient. Rarely does a surrogate have standing to exercise this choice for the patient, although the court may accept testimony from others as evidence of a presently incompetent patient's prior choice.

This right of personal liberty is also the mirror image of the following a traffic accident. Someone obtained a court order authorizing treatment. On motion to dismiss a subsequent civil rights action the court ruled the plaintiff would be entitled to prove that there was no compelling state interest had been taken "under color of state law." Id. at 135-6.


23. But see In re President and Directors of Georgetown College, 331 F.2d 1010, 1016 (1964) (Burger, J., dissenting). Private litigants have no standing to raise rights which may be cognizable over the patient's fundamental right of choice. 331 F.2d at 1016.

24. 95 Minn. 261, 104 N.W. 12 (1905).

25. Id. at 268, 104 N.W. at 14.


27. In many cases the patient will be temporarily incompetent or unconscious and therefore unable to invoke this right by articulating his choice. However, a deeply held religious conviction, as in the case of a Jehovah's Witness objection to blood, may provide satisfactory evidence of the patient's choice to invoke this right on behalf of even an unconscious patient. Similarly, an unconscious patient may have previously exercised his choice while conscious and competent. Sullivan, The Dying Person—His Plight and His Right, 8 New Eng. L. Rev. 197, 198-200 (1973) [hereinafter cited as Dying Person].
common-law right of self-determination so that it evokes a body of case law giving it weight and definition. In its treatment by the courts, it is now nearly merged with and undistinguishable from its common-law counterpart.28

**Constitutional Right to Privacy**

The right of privacy has been advanced both to prevent the state from withholding treatment29 and to prevent the state from providing it.30 While it is probably no more than a further statement of the patient's right of self-determination, it is increasingly the vehicle by which patients can overcome assertions of countervailing rights and interests of others, such as the state's interest in the sanctity of life or the physician's interest in the integrity of the healing profession. Where a state's interests conflict with an individual's right of privacy a compelling state interest is clearly required for the state to prevail in the inevitable balancing process.31

In fact, however, the right of privacy has been advanced in relatively few cases, usually involving life-prolonging care,32 and then primarily as the vehicle by which the court may sanction a result which is contrary to the customary judicial role. The right of privacy has also been cited to permit elective surgery on minors and incompetents for the benefit of another when the traditional approach to such cases would not permit such a result.33

**Constitutional Right of Religious Freedom**

The constitutional right of religious freedom will support a decision to refuse medical treatment,34 but the doctrine has been severely tested in the hospital setting, particularly in the long line of cases involving Jehovah's Witnesses refusing the relatively safe, simple, and effective technique of blood transfusion.35 Clearly, it has not supported the refusal decision when invoked in those

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33. See notes 154 & 155 and accompanying text infra.
35. See, e.g., In re President and Directors of Georgetown College, Inc., 331 F.2d
cases in which recognized state interests are most strongly articulated and readily apparent.\(^3\) This is evidently due in part to the clear alternative between life and death which is presented in many of these cases at the cost of minimal physical discomfort and risk to the patient.\(^3\)

At least two courts have determined that the deep seated religious objection of Jehovah's Witnesses to blood extends primarily to consenting to its administration, and that if the patient is relieved of the decision by the court he can receive the blood in good conscience.\(^3\) A more likely basis for these holdings is the historical distinction between religious belief and religious practice coupled with the well-litigated basis for limiting the latter.\(^3\)

**The Summary Right of Self-Determination**

Taking the various patient rights and merging them together into a right of self-determination and bodily integrity yields a general rule applicable to this traditional analysis: "It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment."\(^4\) The rule presupposes a choice which may be exercised wisely or unwisely in favor of consent or refusal. In the absence of a compelling state interest subordinating the patient's right, the patient may refuse necessary, even life-saving medical treatment,\(^4\) may choose death


\(^{36}\) In many cases where religious objections have not been adequate to prevent the unwanted treatment, there have been complicating factors such as minor dependents. *In re* President and Directors of Georgetown College, 331 F.2d 1000, 1007-08 (D.C. Cir. 1964); John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, —, 279 A.2d 670, 672 (1971); Powell v. Columbian Presbyterian Medical Center, 49 Misc. 2d 215, —, 267 N.Y.S. 2d 450, 451 (1965).

\(^{37}\) Compare the transfusion cases, *supra* note 34, with those cases where the treatment is dangerous, painful, or risky, see notes 106 & 107 and accompanying text *infra*.

\(^{38}\) *In re* President and Directors of Georgetown College Inc., 331 F.2d 1000, 1009 (D.C. Cir.), *reh. en banc denied*, 331 F.2d 1010 (1964); Powell v. Columbian Presbyterian Medical Center, 49 Misc. 2d 215, —, 267 N.Y.S. 2d 450, 451 (1965).


\(^{41}\) See notes 93-114 and accompanying text *infra*.

\(^{42}\) In Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (1962) the court stated that "it is the individual who is the subject of a medical decision who has the final say and that this must necessarily be so in a system of government which gives the greatest possible protection to the individual in furtherance of his own desires." *Id.* at —, 252 N.Y.S.2d at 705.
over life or over continued pain and suffering, and may thereby impose absolute limits on what others may do to or for him.

The Emergency Exception

An important exception to the general rule that a patient's informed consent must precede treatment is the emergency doctrine. The doctrine presumes that, were the patient able to consider his condition, he would choose the medically indicated course of treatment. The doctrine usually comes into play when the patient is unable to give or withhold consent due to temporary or permanent lack of capacity coupled with a rapidly deteriorating medical condition, such that any further delay in rendering treatment would threaten death or serious impairment of health. It is invoked when no surrogate with standing to give substitute consent can be located. The law implies the patient's consent in such cases.

The doctrine of emergency is limited. Consent cannot be implied from the facts when there is a contrary indication from the patient. It is, after all, no more than a presumption of what the patient would do were he able. The doctrine avoids the need for substitute consent by a relative or other surrogate. Since consent, even substitute consent, rests first with the patient's right of choice, it should be necessary in the case of life-saving care or emergency care to find a relative with standing to refuse in order to give real weight to the decision to consent. Particularly in the case of these types of care, however, the law does not recognize the right of surrogates to refuse. Thus, the consent of the surrogate is of doubtful utility and emergency treatment may be rendered without it.

The point is aptly illustrated by the case of a man injured by gunshot wounds in New York City. While he lay critically wounded in desperate need of an operation, the hospital dealt with two women each claiming to be the patient's wife. One consented

43. The choice need not always be in terms of great physical pain as evidenced by In re Melideo, 88 Mass. 2d 974, 390 N.Y.S.2d 523 (Sup. Ct. 1976), in which a 23-year-old Jehovah's Witness without children refused blood necessary to save her life. The court found no compelling state interest and refused to intervene to permit the transfusion even though it meant certain death. Id. at —, 390 N.Y.S.2d at 524. See also In re Osborne, 294 A.2d 372 (D.C. Ct. App. 1972) (adult Jehovah's Witness who had made provision for his children); Case of Jackson, N.Y. Times, Nov. 14, 1968 at 23, col. 1, discussed in Byrn, Compulsory Lifesaving Treatment for the Competent Adult, 44 FORDHAM L. REV. 1, 11 (1975) [hereinafter cited as Lifesaving Treatment].

44. McGuire v. Rix, 118 Neb. 434, 440, 225 N.W. 120, 123 (1929).

to the operation and the other refused. The hospital was unwilling to proceed with the operation because of the controversy and the lack of unanimous consent. Only after the hospital filed a petition with the state supreme court did the consent become unanimous.\textsuperscript{46}

The doctrine of emergency does not require such temerity. Neither woman would have a right, personal to and enforceable by her, to refuse necessary life-saving treatment for the patient. Only in an unusual situation would a spouse be able to exercise the patient's personal rights in favor of a binding refusal.\textsuperscript{47}

There are other exceptions to the duty of prior disclosure and informed consent. One of these is known as the \textit{therapeutic privilege}, and it recognizes that in some cases a full disclosure to the patient of his condition, prognosis, or of attendant risk, might itself have the effect of worsening the patient's condition.\textsuperscript{48} This exception would appear to be completely inapplicable when a patient is refusing necessary life-saving care since the risks to be explained must include the probability of death or serious deterioration of health and since the patient's refusal must be predicated upon knowledge and acceptance of the risks.\textsuperscript{49}

A further exception to the general rule arises out of differing standards of materiality in risk disclosure.\textsuperscript{50} In a refusal case, however, the materiality of the risk is not an issue. The risk of certain or probable death or of grave impairment of health is always material and must be fully disclosed. This exception would therefore not appear to affect the duty to disclose in refusal cases.

\textbf{MINORS AND INCOMPETENTS}

"Minors" and "incompetents" are terms of broad meaning. On the one extreme they imply an absolute legal disability to act on one's own behalf. At the other extreme, they imply only slight doubt about the patient's capacity to participate in decisions regarding his own care. Most cases fall somewhere in the middle.

\textsuperscript{46} \textit{Lifesaving Treatment}, \textit{supra} note 43, at 14-15.
\textsuperscript{47} \textit{Id.} at 15. The patient's negative choice would have to be readily ascertainable. The hospital must distinguish between an exercise of purported spousal rights and the exercise or enunciation of the patient's choice by the spouse. In none of the literature or cases is it suggested that spousal rights include a personal right to withhold lifesaving care from the other spouse.
\textsuperscript{49} See notes 57-61 and accompanying text \textit{infra}. If a patient's capacity to refuse life saving care is premised upon his ability to acknowledge and accept the consequences of his refusal, then surely the consequences must be explained.
\textsuperscript{50} See note 16 \textit{supra}. 
The law recognizes three primary rights of such persons, together with certain specific and statutory rights. First, minors and incompetents are said to be possessed of all rights attributable to competent adults. Second, especially in the case of incompetents, the law requires that they be permitted to participate in decisions regarding their care and treatment to the extent possible. Third, the law recognizes that minors and incompetents have the right to have someone make decisions on their behalf and in their best interest.

Liberty, Privacy, and Religion

The United States Supreme Court has stated that: “Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights.”51 The same is true of incompetents.52 The problem is that minors and incompetents are presumptively unable to exercise their rights on their own behalf. A right of privacy which is vindicated by giving minors access to abortion is a much different right than one giving minors and incompetents an actual choice between consenting to or refusing life-saving medical care. The whole weight of the law favors doing what is in the best interest of minors and incompetents, usually rendering treatment and life-saving care.53

Therefore, while minors may and occasionally do consent to their own care and treatment, such as in those frequent cases when the parents or guardians cannot be located to give consent to emergency therapeutic care, their consent does not represent the exercise of a right to choose. They presumably cannot choose to refuse. Even the so-called mature minor, while he may consent to necessary care, may not independently consent to medical treatment not in his own best interest nor, presumably, refuse necessary life-saving care.54 Should they refuse life-saving or even emergency therapeutic care, their refusal would probably be ignored or the hospital and physicians would seek a judicial consent. The minor’s inability to refuse life-saving or emergency care

53. See note 70 and accompanying text infra.
54. At least one state has recognized the concept of “mature minor,” Younts v. St. Francis Hosp. and School of Nursing, Inc., 205 Kan. 292, —, 469 P.2d 330, 337 (1970), but only for the purpose of adding legitimacy to the minor’s consent to necessary care. See also Bonner v. Moran, 126 F.2d 121, 123 (D.C. Cir. 1941) (a minor could not consent to give skin grafts and blood to another patient).
stands in sharp contrast with their arsenal of rights to refuse other types of care. The rule holds for incompetents as well. Assuming that incompetency truly precludes participation in the treatment decision, there is no right of consent or refusal exercisable by the incompetent.

**Right to Participate**

The second right, particularly in the case of incompetents, is their right to participate, to the extent they are able, in treatment decisions. Courts do not require that patients be competent for all purposes before assigning them capacity to participate in the treatment decision. Even mentally ill patients "have the right to be informed of and participate in the decision-making aspects of their treatment." The key issue in many cases is not the choice of refusal or treatment but rather the capacity of the patient to exercise his choice.

The emerging test of capacity is perhaps best illustrated by four recent cases with nearly identical facts. Each case involved an elderly patient suffering from gangrene and requiring the amputation of feet or legs to preserve life. In all four cases the patients' competency was doubtful due to apparent senility, confusion, or just from the way in which they exercised their right of choice, i.e.—refusing the recommended care.

In two of the cases, *Lane v. Candura* and *In re Quackenbush* the courts refused to intervene upon a finding that the patient was competent to make the particular choice. In *State Dep't of Human Servs. v. Northern* and *In re Schiller,* the courts once competency was established, the patient's personal right of privacy, as discussed by the Massachusetts Supreme Court in Superintendent of Belchertown v. Saikewicz 370 N.E.2d 417, 435 (Mass. 1977) precluded the court from ordering the treatment.

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55. See Ruby v. Massey, 452 F. Supp. 361, 366 (D. Conn. 1978). Ruby indicates that a minor's right of privacy reserves to the minor the exclusive right to consent or refuse sterilization. In this case the minors were severely incompetent and would not exercise their right on their own behalf. See also North Carolina Ass'n for Retarded Children v. North Carolina, 420 F. Supp. 451 (M.D.N.C. 1976).


57. No. M78-417 (Mass Ct. of App., Middlesex County, May 22, 1978). Once competency was established, the patient's personal right of privacy, as discussed by the Massachusetts Supreme Court in Superintendent of Belchertown v. Saikewicz 370 N.E.2d 417, 435 (Mass. 1977) precluded the court from ordering the treatment.


59. 563 S.W.2d 197 (Ct. App. Tenn. 1978). The issue turned solely on competency to make the choice, the court stating: "If the patient would assume and exercise her rightful control over her own destiny by stating that she prefers death to the loss of her feet, her wish would be respected. . . . [T]his court here and now reiterates its commitment to this principal." *Id.* at 207.

60. 148 N.J. Super. 168, —, 372 A.2d 360, 386 (1977). Here the patient was found to be incompetent to make the decision prompting the court to invoke the rule that
found the patients incompetent to make the choice and intervened to order amputation. Read together the cases state a consistent rule for determining competency for the limited purpose of giving or withholding consent to lifesaving medical care. The test that emerges is the patient's ability to make the choice with recognition of the two alternatives, i.e., loss of limbs or death. The patient must be able to indicate knowledge and acceptance of the certainty of death before the court will recognize the refusal.61

This test coupled with the underlying right to participate really represent a more fundamental but unwritten right of the patient—the right to establish his competency to make his own choice. Whether the patient is in extremis due to the underlying injury or illness itself,62 unconscious,63 or simply incompetent for many other purposes,64 he has a right to be heard and to have doubts about his competency fairly resolved. Once resolved in favor of competency or capacity to exercise the choice, the incompetent patient has the right to be treated according to the scheme of rules and exceptions applicable to competent adults rather than as an incompetent patient.

Resolving the doubts about competency, rather than deciding whether care may be rendered or withheld, is the primary responsibility of courts and the judicial system. Any adult patient capable of expressing an objection and who actually does object would appear entitled to a judicial resolution of competency before the treatment is rendered if he appears to fall within the rule of competency articulated in Candura, Quackenbush, and Northern.

The Right to Have Someone Consent

Assuming a true lack of capacity—legal or mental—minors and incompetents are said to have the right to have someone represent

one who is incompetent has the right "to have some competent able person... make it in the best interest of the person." 61. See also In re Osborne, 294 A.2d 372, 375 (D.C. 1972) (holding that the primary issue on an adult refusal case is the patient's competency or capacity to make the choice).


63. Dying Person, supra note 27, at 198-200. To be heard while unconscious will obviously require that the patient has given prior instructions before lapsing into unconsciousness or that a surrogate presents strong evidence of the patient's choice.

their best interests and consent on their behalf. Someone with standing is usually sought out to give substitute consent. No one is ever sought out to refuse necessary life-saving medical treatment on an incompetent or minor patient's behalf. This is so because standing is a limited right or interest which diminishes in direct proportion to the clarity with which the patient's best interest may be defined and advanced by application of the disputed medical procedures or technology. In large measure, standing is merely a recognition that the person with standing occupies a special position with relation to the patient which best qualifies that person to determine and express the patient's best interest or personal choice. In the case of parents of a minor, the standing embodies a recognized duty to act in the minor's behalf as natural guardian. The duty is less clear in the case of adults.

The device of substitute consent has important practical ramifications. Except in clear cases of emergency, the prevailing belief is that someone must always consent before care is undertaken. Hence, institutional informed consent policies, which misapprehend the real meaning of substitute consent, can become a barrier to providing necessary care.

In fact, substitute consent is of two types. The first type is premised upon an underlying right of choice, as when the surrogate actually possesses a right of choice, personal to him. For example, when the treatment is life-prolonging, therapeutic, or elective (for the benefit of the patient), the best interest of the patient may not be so clear. These cases may present real opportunity and duty for surrogates with standing to the patient (surrogates such as spouses and parents) to define what is really in the patient's best interest and to choose between the alternatives. These cases may also present a situation where actual rights of the surrogate outweigh the countervailing interest of the state to compel treatment, such as where parents prohibit therapeutic care for their chil-

65. The most common surrogates are parents and spouses. Standing frequently presupposes a duty such as the parent's duty to look out for the welfare of the child.

66. Parents do have some constitutionally-based rights of their own. The courts recognize that parents are the natural guardians of their minor children but the relationship also implies duty. The duty colors the choice. See Custody of a Minor, 379 N.E.2d 1053, 1064 (Mass. 1978). This case involved natural parents of a child suffering from leukemia who refused recommended chemotherapy for the child which offered "substantial hope of life." Id. The court divested the parents of custody stating: "It is also well established, however, that the parental rights described above do not clothe parents with life and death authority over their children." Id. at 1063. See also note 70 infra.

67. See, e.g., note 3 supra.

68. See notes 70 & 71 and accompanying text infra.
However, the right of choice is not present in the case of life-saving care or most cases of emergency therapeutic care. The surrogate cannot refuse the care, he cannot choose between providing or withholding the needed treatment. This is the case because the patient's best interest is clear and because no rights personal to a surrogate outweigh the historic duty to act in the clear best interest of minors and incompetents. In these cases, the surrogate's right is limited to giving consent, not choosing between consent and refusal. Under these circumstances, the consent of a surrogate is not actually necessary.

Regardless of the actual relationship to the patient, physicians and hospitals may, and routinely do, act upon substitute consent to both life-saving and emergency therapeutic care without resort to the courts. The point is, however, that they could render the life-saving or emergency care without such consent because the situation implies no choice.


70. See, e.g., In re Ivey, 319 So. 2d 53, 57-58 (Fla. App. 1975); People ex rel Wallace v. Labrenz, 411 Ill. 618, —, 104 N.E.2d 769, 773, cert. denied, 344 U.S. 824 (1952); In re Brooklyn Hosp., 45 Misc. 2d 914, —, 258 N.Y.S.2d 621, 622 (1965); Santos v. Goldstein, 16 A.D.2d 755, —, 227 N.Y.S.2d 450, 450, appeal dismissed, 12 N.Y.2d 642, 232 N.Y.S.2d 1026, 1026 (1962); In re Clark, 21 Ohio App. 2d 86, —, 185 N.E.2d 128, 132 (1962). All of these cases involved parental religious objections to life-saving transfusions. In every case the court ordered treatment or sanctioned treatment which had already been given. No contrary rulings have been found, regardless of the objection or grounds selected by the parents in the case of lifesaving care.


73. No case has been located attaching liability for providing lifesaving or emergency care to minors or incompetents or, upon timely petition beforehand, withholding judicial consent for such procedures. But see cases cited in note 70 supra.
To the extent that the term "informed consent" has its foundation not only in a decision predicated upon sufficient information, but also upon the patient's personal right of choice, substitute consent is usually not informed consent. What, then, is the purpose of substitute consent in the case of minors and incompetents for other than life-saving of emergency therapeutic care?

First, with respect to minors, it recognizes that certain rights accrue to the parents. They frequently are bona fide participants in the case of therapeutic treatment where the treatment is necessary but not life-saving. Even though their rights may not prevail over the clear best interests of the minor patient, their rights are so fundamental that the law may require that they be given the opportunity to present their case.

Second, in the case of adult patients who are permanently or temporarily incompetent, the requirement of consent may act to counterbalance an entirely medical resolution of the issue of medical necessity, especially in the case of life-prolonging care. The surrogate may not act out his assigned role. He may instead go to court in support of a refusal. He may interject a lay viewpoint about the limits of medical necessity and the distinction between what the physician is capable of doing with the tools and technology at his disposal versus what he ought to do in fact. Perhaps the law believes that even the act of explaining medical risks, alternatives, prognoses, and goals will narrow the gap between medical and lay viewpoints. Would Karen Quinlan still be on a respirator if medical ethics had not been tested against lay and legal opinions as to the parameters of medical necessity?

A third explanation for substitute consent may lie in the rule that incompetents are primarily the responsibility of the state. So long as someone else will exercise responsibility and act out the state's role, the state is spared the practical burden of doing so itself. For this purpose, the state may not care who is exercising responsibility or whether it is founded on duty. Hence, the rule that someone must consent translates into anyone must consent.

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74. See notes 79-89 and accompanying text infra.
75. See notes 58 & 60 and accompanying text supra. There are no reported cases in which parents have successfully objected to necessary lifesaving care.
76. See note 4 supra.
78. See note 3 supra. This is not to ignore the system of priority among potential surrogates usually founded first upon degree of kinship. For example, in the case of an adult patient, a spouse is more appropriate for substitute consent than an adult child; an adult child is more appropriate than a parent; a parent more appro-
WHAT ARE THE CONFLICTING RIGHTS AND INTERESTS OF OTHERS?

Like any rights, the constitutional and common-law rights of patients are not absolute. Rather, they are subject to a balancing test when they come in conflict with the rights of others or with a substantial state interest. Treated in this division are the rights and interests of parents (in minor refusal cases), physicians and hospitals, and finally the interests of the state.

RIGHTS OF PARENTS AND GUARDIANS

In the case of minor patients, parents have a number of rights of constitutional magnitude by which they may seek to exclude the state from decisions and actions affecting child rearing.

First, parents are free to raise their children according to the dictates of their faith with a minimum of interference from the state. 79 This is a right personal to the parents and is to be distinguished from a minor's constitutional and common-law right respecting choice or from what the parents' duty may entail. 80 The parents' religious beliefs may be distinguishable from what is in the best interest of the child 81 and may even constitute a conflict of interest in medical matters. 82 Thus, as it bears upon the parents' decision, based on religious grounds, to refuse or withhold recognized care or treatment, "Parents may be free to become martyrs themselves. But it does not follow that they are free, in identical circumstances, to make martyrs of their children . . . ." 83

The second constitutionally based interest of the parent is discretion and freedom to control the upbringing of their children. In Prince v. Massachusetts the court observed that: "[i]t is cardinal with us that the custody, care and nurture of the child reside first with the parents, whose primary function and freedom include preparation for obligations that the state can neither supply nor hinder." 84 This right of parental discretion and control, like the right of religious freedom, may clash with the child's best interests.

80. In In re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), the court refused to consider the father's religious rights as bearing upon the exercise of his daughter's choice.
84. Id. at 166. See also Meyer v. Nebraska, 262 U.S. 360 (1923).
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In the case of such conflicts, courts apply a balancing test and determine whether the conflicting interests of the child are sufficiently immediate and grave to either divest parents of this right or to subordinate the parent's right to the state's duty to do what is best for the child. Like religious freedom, the right of parental discretion will weigh most heavily when its exercise will not place the life of the minor in certain and immediate jeopardy or result in major impairment of the child's health.

A third parental right is the right of a parent, as natural guardian, to first priority in speaking out for the interest of the child. The parent is said to be in a favored position to express the child's wishes under the substituted judgment theory or to express the traditional notion of what is in the child's best interests. This right is more nearly a matter of priority in speaking out and is not, in and of itself, a separate parental right or a platform from which to advance some other parental interest.

In the face of a compelling state interest or a conflicting best interest of the minor, parental rights frequently yield. More importantly, these parental rights are distinguishable from the minors' rights.

INTERESTS OF THE STATE

The state possesses a number of important interests, some of which have been found sufficiently compelling to overcome a patient's refusal.

Public Health and Welfare Authority

States possess a broad public health and welfare power for the protection of their citizens generally. This interest has been held sufficiently compelling to uphold mandatory inoculation of minors over parental religious objections. It extends to the creation of special statutory rights of consent in minors to certain medical treatment at their sole request. This public health and welfare

85. See notes 58 & 60 supra. The state has a duty to protect the interests of minors when the natural parents do not do so.
91. Statutes in many states give minors the sole right to consent to diagnosis
authority is not limitless and may be balanced against the rights of those who might be affected by its exercise. The state's public health and welfare authority is generally seen as the authority for child abuse legislation and for neglect and custody statutes. The public health and welfare authority has not been cited in individual treatment decisions except to the extent that it does support such legislation.

State as Parens Patriae

A second fundamental interest of the state in the welfare of minors and incompetents is expressed in the state's right and duty to act in the capacity of parens patriae as “the general guardian of all infants, idiots and lunatics.”92 Exercising its authority as parens patriae the state can intervene to advance the best interests of minors vis-a-vis their parents, families, or others.93 Generally, the state must act where the manifest interest of the child is clear and is in conflict with the wishes and rights of the parents.94 The state also exercises its parens patriae authority on behalf of incompetents, either to advance their traditional best interests95 or to determine and give effect to their actual wishes and interests.96

The parens patriae role is important in refusal cases because it, together with the wide variety of child abuse and neglect statutes adopted under the public health and welfare authority of the state, forms the basis for judicial involvement.97 Therefore, should the hospital or physician determine to go to court to contest a refusal or even to seek consent, the logical vehicle would be a coupling of the statutory scheme with the common-law right. If the statutory scheme is too cumbersome because of time requirements or is otherwise ineffective, parens patriae, standing alone,
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should suffice to obtain immediate jurisdiction.98

State’s Interest in the Sanctity of Life

A third and important interest of the state is its interest in up-
holding and advancing the sanctity or preservation of life.99 The
common law regards life itself as sacred and unalienable and pro-
hibits anyone from committing suicide or licensing his own de-
struction.100 This was traditionally true both as to those “to whom
life has become a burden . . . those who are hopelessly ill or fatally
wounded” the same as for those “in the full tide of life’s enjoy-
ment.”101

While sanctity of life may remain a paramount interest of the
state, the rapid development of new medical technology coupled
with a growing emphasis on constitutional rights of privacy and
bodily integrity are forcing a reanalysis of the meaning of sanctity
of life in a hospital setting. As stated by the Massachusetts
Supreme Court:

The constitutional right of privacy, as we conceive it, is an
expression of the sanctity of individual free choice and
self-determination as fundamental constituents of life.
The value of life as so perceived is lessened not by a deci-
sion to refuse treatment, but by the failure to allow a com-
petent human being the right of choice.102

Several early cases characterized the patient’s refusal as
claiming a right to die and found it to be analogous to suicide. Bal-
cancing the state’s traditional interest in the sanctity of life against
the patient’s right to die yielded predictable results.103 Later cases
avoid this characterization although still recognizing the vitality of
the sanctity of life doctrine,104 while other cases seem to ignore the

98. See State v. Perricone, 37 N.J. 463, —, 181 A.2d 751, 758 (1962); In re Weber-
list, 79 Misc. 2d 753, —, 360 N.Y.S.2d 783, 785 (1976); In re Long Island Jewish-Hillside
the court remarked that, “[i]t is clear that the most significant of the asserted state
interest is that of the preservation of human life.” Id. at 425-26.
100. See generally Euthanasia: Criminal, Tort, Constitutional and Legislative
Considerations, 48 NOTRE DAME LAW., 1202 (1973).
101. Blackburn v. State, 23 Ohio St. 146, 163 (1872). See also Meyer v. Supreme
Lodge, K.P., 178 N.Y. 63, 70 N.E. 111 (1904).
1977).
103. See, e.g., In re President and Directors of Georgetown College, Inc., 331 F.2d
1000, 1009 (D.C. Cir. 1964), reh. en banc denied, 331 F.2d 1010 (D.C. Cir. 1964); John F.
Columbia Presbyterian Medical Center, 49 Misc. 2d 215, —, 267 N.Y.S.2d 450, 451
(1965).
104. See, e.g., Satz v. Perlmutter, 362 So. 2d 160, 162 (C.A. Fla. 1978); Superinten-
sanctity of life doctrine altogether.\textsuperscript{105}

Whether the patient's right to refuse treatment will overcome the state's interest in the sanctity of life is further clouded by cases suggesting that the balancing process is affected by the patient's condition (hopeless or curable)\textsuperscript{106} or the degree of bodily invasion and pain inherent in the procedure (amputation or transfusion).\textsuperscript{107} The result, usually respecting the patient's refusal, found in the majority of cases involving both excellent prognosis and minimal bodily invasion (e.g., the Jehovah's Witnesses cases) suggests that most courts will weight the decision in favor of the patient's fundamental right to chose, particularly where none of the other tradition-conflicting state interests is present.\textsuperscript{108}

**State's Interest in the Welfare of Minor Dependents**

Perhaps the most persuasive of the state's interests is its duty to represent the welfare of minor dependents who may be abandoned or harmed by the patient's unfettered refusal decision. The first case to advance this theory was *In re President and Directors of Georgetown College, Inc.*,\textsuperscript{109} where the court was confronted with an adult Jehovah's Witness who refused to consent to a blood transfusion necessary to save her life. The court characterized the patient's condition as *in extremis*. Noting that the patient was responsible for minor children, the court likened the consequences of her decision, i.e., death, to an abandonment of the children, and

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it intervened to order the transfusion.\textsuperscript{110}

Because the court in \textit{Georgetown} raised and considered practically every state and human interest available to support its ruling in favor of treatment, it is unclear what \textit{Georgetown} really stands for today.\textsuperscript{111}

\textit{Georgetown} has been cited numerous times, originally for its apparent holdings compelling treatment and as support for a like result\textsuperscript{112} but more recently as simply an enumeration of the countervailing rights and interests in cases reaching opposite results.\textsuperscript{113} To the extent that \textit{Georgetown} was once good authority for all that it said, its legacy appears to be dropping out of the law except possibly for its emphasis on the welfare of minor dependents. This is evident in decisions not to intervene as the courts frequently feel compelled to acknowledge the absence of minor dependents as a special consideration potentially affecting the patient’s exercise of his rights.\textsuperscript{114}

While the state’s interest in the welfare of minor dependents may affect the outcome of some cases, the doctrine is limited even where the facts apply. First, it will not even be raised in many cases since the typical plaintiffs, hospitals, and physicians have no duty to raise it.\textsuperscript{115} Second, it has been applied only in situations involving life versus death alternatives with patients who were not predisposed to violently or physically resist the treatment. To be consistently applied, the “welfare of minors” rule should be available to compel elective surgery on parents if it would improve their ability to provide support and maintenance for their children, although it has never been extended that far and such an extension seems unlikely.

\textbf{INTERESTS OF THE PHYSICIAN AND HOSPITAL}

Several cases suggest that once an adult patient presents himself for care, the hospital and physicians are under a legal duty to

\begin{itemize}
\item \textsuperscript{110} \textit{Id.} at 1008-09.
\item \textsuperscript{111} In fact, upon rehearing en banc, five of the nine members hinted or stated that they would reach the opposite result, although for a combination of procedural and substantive reasons. \textit{In re President and Directors of Georgetown College, Inc.} 331 F.2d 1010, 1015 (D.C. Cir. 1964) (Burger J., dissenting).
\item \textsuperscript{113} See \textit{Winters v. Miller}, 446 F.2d 65, 70 (2d Cir. 1971); \textit{In re Melidio}, 88 Misc. 2d 974, —, 390 N.Y.S.2d 523, 524 (Sup. Ct. 1976); \textit{In re Long Island Jewish Hillside Medical Center}, 73 Misc. 2d 395, —, 342 N.Y.S.2d 356, 360 (Sup. Ct. 1973).
\item \textsuperscript{115} See note 117-21 and accompanying text \textit{infra}.
\end{itemize}
render proper care; that honoring the patient's refusal would amount to mistreatment of the patient and possibly malpractice; and that in balancing this ethical dilemma with the patient's right to freedom of choice, the physician's interest in treatment is superior to the patient's right to consent or refuse.\textsuperscript{116} It is usually the physicians or hospitals which raise this issue in order to overcome a patient's objections to treatment. The trend of the law, however, is to the contrary; the assertions of liability in such cases should not result in a self-fulfilling prophecy.

For liability to exist on the part of the physician and hospital, there must be a legally enforceable duty to render the care.\textsuperscript{117} The recognized duty does not extend to rendering care over the objections of one entitled to refuse. Once the physician-patient relationship is established, the physician "is under a duty to give his patient all necessary and continued attention so long as the case requires it. . . ."\textsuperscript{118} The physician is relieved of his duty only when medical attention is no longer needed, when he is discharged by the patient, or when he gives reasonable notice and ample opportunity to obtain another physician.\textsuperscript{119} However, the physician must obtain the patient's informed consent, in the absence of such consent the physician is under no duty to proceed.\textsuperscript{120} A patient's failure to take the physician's advice or to undergo the recommended procedure is a defense to malpractice growing out of omitting the treatment.\textsuperscript{121}

The state's interest in the rights and duties of the treating physician has been characterized as an interest in "maintaining the ethical integrity of the medical profession." It is an important con-

\textsuperscript{116} In United States v. George, 239 F. Supp. 752 (D. Conn. 1965) the court observed that "[s]imultaneously [the patient] sought to dictate a course of treatment amounting to medical malpractice. To require doctors to ignore the mandates of their own conscience, even in the name of free exercise, cannot be justified under the circumstances." Id. at 754. Similarly, in \textit{In re Long Island Jewish-Hillside Medical Center}, 73 Misc. 2d 395, 342 N.Y.S.2d 356 (Sup. Ct. 1973) the court phrased the dilemma:

The Court takes note that once [he] became a patient. . . it was the responsibility of the hospital and doctors to treat him. However, without obtaining a consent the hospital and doctors were faced with a dilemma of subjecting themselves to liability for damages if they proceeded with an unauthorized operation, or, to do nothing and let him die.

\textit{Id.} at —, 342 N.Y.S.2d at 358.

\textsuperscript{117} See People v. Beardlsey, 150 Mich. 206, —, 113 N.W. 1128, 1130-31 (1907).

\textsuperscript{118} Johnson v. Vaughn, 370 S.W.2d 591, 596 (Ky. 1963).


\textsuperscript{120} Natanson v. Kline, 186 Kan. 393, —, 350 P.2d 1093, 1107-08 (1960).

\textsuperscript{121} Roberts v. Woods, 206 F. Supp. 579, 583 (S.D. Ala. 1962); Peterson v. Branton, 137 Minn. 74, —, 162 N.W. 895, 898 (1917); Steele v. Woods, 327 S.W.2d 187, 196 (Mo. 1959).
sideration but it is not the same as a legal right. The physician's interest in rendering the treatment in a refusal case is more properly characterized as a moral obligation and hence may not be cognizable over the legal objections of the patient founded upon a recognized right.\textsuperscript{122}

It is not necessary to deny a right of self-determination to a patient in order to recognize the interest of doctors, hospitals, and medical personnel in attendance on the patient. Also, if the doctrine of informed consent and right of privacy have as their foundations the right of bodily integrity and control of one's own fate, then those rights are superior to the institutional considerations.\textsuperscript{123}

The physician's obligation does extend to making the types of disclosures required for informed consent because, after all, it is consent that was hoped for in the first place.\textsuperscript{124} The physician must advise the patient of the proposed procedure, why it should be undertaken and the probable consequences of its omission. It is recommended that this latter disclosure be made and documented in the most forceful and explicit terms available.

The hospital has no primary responsibility for informed consent in the first place. The doctrine is for the benefit of the patient and for the principal protection of the treating physicians.\textsuperscript{125} The hospital is obligated, however, to institute and enforce general policies designed to require that informed consent be routinely obtained in all cases.\textsuperscript{126} Similarly, the hospital is under no primary duty to chart a separate medical course for the patient's care and treatment. The hospital and its professional staff only carry out the directions of the attending physicians.\textsuperscript{127}

In summary, the physician's duty to treat is consensual and depends upon the patient's acquiescence; and the hospital's duty

\textsuperscript{122} In re President and Directors of Georgetown College, Inc., 331 F.2d 1000, 1017-18 (D.C. Cir. 1964) (Burger, J., dissenting).

\textsuperscript{123} Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417, 427 (Mass. 1977) (citing Union Pacific Ry. v. Botsford, 141 U.S. 250 (1891)).

\textsuperscript{124} The identical requirement for disclosures would appear to apply—with emphasis on the consequences of withholding the treatment.

\textsuperscript{125} The principal burden of informed consent falls on the physician. Since it is the physician who determines the course of treatment, it is he who risks liability for the failure to obtain the consent.

\textsuperscript{126} See Fiorentino v. Wenger, 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967) suggests that a hospital might be liable if it has actual or imputed knowledge of a physician undertaking treatment without informed consent. Id. at —, 280 N.Y.S.2d at 381. Hence, the institutionalization of informed consent through the policies and forms of the hospital. See also Blanton v. United States, 428 F. Supp. 360 (D.C. 1977).

is to follow the physician's directions. Therefore, assertions of liability for failure to render necessary medical care over the informed refusal of a patient with capacity to refuse is a false issue.

The hospital and physician do have two important duties in a refusal case. The first is to make certain that the patient's refusal is an informed refusal. The second duty is to resolve doubts about the patient's competency to receive and act upon the information provided by the physician. This duty extends to seeking judicial resolution of the issue of competency or capacity in appropriate cases.

BALANCING CONFLICTING RIGHTS AND INTERESTS

COMPETENT ADULTS

With respect to competent adults, the application of the rules and exceptions is perhaps best represented by Satz v. Perlmutter. Satz was recently decided by the Florida Appellate Court and builds upon a variety of contemporary cases. Abe Perlmutter was a 73-year-old patient suffering from Lou Gehrig's disease. His condition was hopeless and he had degenerated to the point where he required the use of a respirator and other life-support apparatus to maintain his bodily functions. He remained competent but was suffering great pain and would continue to do so until his death. Perlmutter had repeatedly requested that the life-support apparatus be removed with full knowledge of the consequences. Fearful of legal liability, his request had not been granted although his physicians and family concurred in his decision. Perlmutter brought suit against the state which responded by asserting the traditional state interests ranging from sanctity of life, the duty to prevent suicide and protection of medical ethics on the one hand, to an assertion that disconnecting the respirator would fall within the Florida murder statute on the other. The court disposed of all of these arguments with little difficulty, summarizing its balancing process as follows:

It is all very convenient to insist on continuing Mr. Perlmutter's life so that there can be no question of foul play, no resulting civil liability and no possible trespass on medical ethics. However, it is quite another matter to do so at the patient's sole expense and against his competent will, thus inflicting never-ending physical tortures on his body until the inevitable, but artificially suspended, moment of death. Such a course of conduct invades the patient's constitutional right of privacy, removes his freedom of choice

and invades his right to self-determine [sic].\textsuperscript{129}

Under the traditional analysis, the general rule remains that competent adult patients have the right, whether founded on the common-law right of bodily integrity or upon constitutional rights of liberty, privacy, and religion, to refuse care or treatment. Only two countervailing interests seem to have any vitality, and then only in the case of life-saving care. First, the patient's right may be tempered by the state's interest in the welfare of minor dependents\textsuperscript{130} unless the patient has made provision for their care and support.\textsuperscript{131} However, the hospital and physicians have no duty to raise this right on behalf of either the dependents or the state.\textsuperscript{132} Second, the patient's choice may conflict with the state's interest in the sanctity or preservation of life.\textsuperscript{133} It seems highly unlikely that sanctity of life standing alone and unsupported by the issue of minor dependents will constitute a compelling state interest in the face of an adult patient's refusal.\textsuperscript{134}

Of the various grounds advanced by patients in support of their refusal, religious freedom has presented the most difficult cases. Characteristically, these cases involve otherwise healthy adults who could be saved by blood transfusions. Courts have split on the outcome, primarily relying upon the state's interest in the welfare of minor dependents, but also citing the litany of state and private interests discussed in \textit{Georgetown}. It may also be that those courts which intervened to order or permit treatment were simply predisposed to so rule regardless of the right chosen in support of the refusal decision. Rather than any inherent weakness in religious belief as a basis for refusal, the particular facts in the cases decided adversely to the patient have mitigated against a finding that the patient's right of religious freedom outweighed the countervailing state interests. The transfusion of adult Jehovah's Witnesses over their objections has been ordered in at least six reported cases. In two of those cases pregnant women were ordered transfused ostensibly for the protection of the unborn in-

\textsuperscript{129} \textit{Id.} at 164. \textit{See also} Palm Springs General Hosp. v. Martinez, No. 71-12678 (Fla. Cir. Ct., July 2, 1971), \textit{discussed in The Living Will, supra} note 62, at 500. The court refused to order additional painful surgery on an elderly patient who pleaded with her family not to permit further surgery.

\textsuperscript{130} See notes 109-15, \textit{supra}.

\textsuperscript{131} \textit{In re} Osborne, 294 A.2d 372, 374 (D.C. 1972).

\textsuperscript{132} Their duty remains to treat the patient if the patient consents. No omission to go to court on behalf of dependents would support liability since it is not the omission of a duty. \textit{See In re President and Directors of Georgetown College, Inc.,} 331 F.2d 1010, 1016-17 (D.C. Cir. 1964) (Burger J., dissenting).

\textsuperscript{133} See note 104 and accompanying text \textit{supra}.

fants, while in the four other cases the death of the patient would have affected the welfare of minor dependents.

THE COMPETENCY ISSUE

In considering how much consent is required for the competent adult, temporarily rendered incompetent or unconscious by the injury or illness, the hospital's duty to the patient makes out a strong case for treatment when such treatment is life-saving or emergency therapeutic. Courts have created a presumption in favor of care absent a refusal from a surrogate with a recognized right to refuse or from the patient himself. The patient's refusal may, in an unusual case, be communicated through a surrogate, so long as those who must decide whether or not to act on the refusal are convinced that the surrogate is possessed of personal rights which support the refusal or is faithfully relating the patient's personal choice. In the case of life-saving care, there is no right personal to a surrogate to support a refusal.

In the case of incompetents, the first and foremost right is to have the issue of competency fairly resolved, even if this requires resort to the court. Those found competent for the limited purpose of giving or withholding informed consent must be treated as competent adults. Those found incompetent have the right to have someone else make decisions on their behalf and in their best interest.

The only time that hospitals and physicians have a duty to seek court intervention in the case of adults is to determine capacity when a patient of questionable capacity refuses treatment, and in the rare case where a surrogate seeks to dictate a course of care for an incompetent patient which is clearly not in the patient's

136. See note 34 supra.
137. See notes 57-61 and accompanying text supra.
138. The rules discussed in notes 79-86 and accompanying text supra would be applicable to incompetents except diluted somewhat by the fact that probably no constitutionally based rights would reside in the surrogate who is not speaking as the parent of a minor.
139. As in the case of a spouse giving evidence of the patient's own religious objection. See In re Jackson, discussed in Lifesaving Treatment, supra note 43, at 11.
140. See notes 70 & 71 and accompanying text supra.
141. See notes 62-65 and accompanying text supra.
143. See note 65 and accompanying text supra.
In the former case the patient's competency is the only *bona fide* issue that physicians and hospitals have standing to raise unless there is a finding of incompetency, in which case the court may be asked to acquiesce in a specific course of treatment. When a surrogate dictates a course of treatment which is not in the incompetent's best interest, the justiciable issue may either be custody of the incompetent premised upon a breach of duty by the surrogate where a relationship to the patient implies a duty, or the need for judicial exercise of the court's authority under the state's *parens patriae* authority or under abuse and neglect statutes by assuming the state's historic role toward incompetents. On all issues, other than that of establishing competency or capacity, the incompetent patient appears to be like the minor patient under an absolute legal disability to act.

**Minors and Incompetents**

How do courts choose between the alternatives of ordering or refusing treatment of minors and incompetents? Two approaches, consisting of the traditional best interests approach and the substitute judgment approach, are usually cited. The best interest approach involves doing what is in the traditional best interest of the minor or incompetent, such as ordering necessary life-saving treatment. The substitute judgment approach, on the other hand, involves deviating from the traditional notion of best interests or selecting an alternative where the patient's best interest is not so clear. The two approaches are not wholly at odds because they depend, at least in part, upon distinctions in the patient's underlying condition and prognosis.

The best interest approach involves doing that which is believed to advance the traditional best interests of the minor or incompetent. Taking this approach, courts usually order treatment or sanction treatment which has already been given. From the reported decisions thus far, the best interest approach will always be invoked to authorize or sanction treatment of minors and incompetents when such treatment is truly necessary. 

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145. See notes 85-90 and accompanying text *supra*.
146. See notes 93-95 and accompanying text *supra*.
147. See note 70 and accompanying text *supra*.
life-saving treatment.\textsuperscript{149} In the case of therapeutic treatment, application of the best interest approach, appears to turn upon first a balancing of competing parental rights in the case of minors and, second, upon some doubt or at least some conflict in the evidence concerning the utility of the procedure and the prognosis with and without it.\textsuperscript{150}

It is in the case of life-prolonging care that the best interest approach is being most severely tested. Although the court is reluctant to sanction the withdrawal of life-prolonging apparatus or the withholding of additional therapeutic and emergency care which amounts to no more than efforts to prolong the life of a terminally ill, noncognitive patient, no case has been located in which the best interest approach has been invoked to compel the provision of additional life-prolonging care. This is not to suggest that when confronted with the issue of life-prolonging care for the terminal, noncognitive patient, courts have simply switched to the substituted judgment approach. Rather, in this situation courts have held that the best interest of the patient does not require the provision of additional or extraordinary care.\textsuperscript{151}

The best interest approach draws upon the states' \textit{parens patriae} duty to minors and incompetents, its historic responsibility to see that their needs are met and therefore that they receive necessary medical care.\textsuperscript{152} It is not premised upon any fiction of rights of privacy, religion, or choice inuring to the patient. To the contrary, it realistically recognizes the absence of capacity to make personal choice and substitutes a traditional presumption in favor of life, health, and best interests of the patient.

The second judicial approach is titled the "substituted judgment" approach.\textsuperscript{153} It is supposedly premised upon a recognition that the minor or incompetent is possessed of the same rights of choice as those with capacity to make choices. It permits the court to reach results which are contrary to the traditional notion of what is in the minor or incompetent patient's best interest or in cases where the best interest is not clear.

The substituted judgment approach is reserved for two types

\begin{footnotes}
\item[149] See note 70 supra.
\item[150] Compare note 69 supra. See also Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417 (Mass. 1977); In re Nemser, 51 Misc. 2d 616, 273 N.Y.S.2d 624 (1966).
\item[152] See notes 91-98 and accompanying text supra.
\end{footnotes}
THE CHOICE

of cases. The first type is where there is some important interest alien to the well-being of the patient at stake. Using the substituted judgment approach courts have, in such cases, granted authority to remove a kidney from a healthy minor or incompetent for transplantation to a sick sibling, primarily on the theory that if the donor were not under legal or mental disability, he would consent himself.

In the second type of case, the substituted judgment approach permits the court to exercise the patient's right of privacy to refuse or withhold care. A close reading of these cases reveals the absence of clear medical necessity for the treatment in the first place. Query whether reliance upon the substituted judgment approach in such cases is any more than an exercise of the patient's best interest, but in a nontraditional manner, because the best interest is unclear.

In the case of necessary life-saving care, not a single case has been found where a minor or incompetent or anyone purporting to act on their behalf has successfully refused the treatment.

There are several cases which are sometimes considered exceptions to this rule but which are not. A comatose patient's right of privacy was cited by the court in In re Quinlan in its decision authorizing disconnection of the life-support system. Similarly, in Superintendent of Belchertown v. Saikewicz, the court invoked the patient's right of privacy to support its decision not to require painful and disorienting chemotherapy for a profoundly retarded sixty-seven year-old inmate at a state institution, even though it might produce brief remission of his cancer. What distinguishes these cases from the general rule is the absence of clear medical necessity for the treatment in the first case and the inability to save life (rather than prolong it) in the second. Because the law so strongly favors doing what is best for minors and incompetents, it is unlikely that personal constitutional rights will ever support the withholding of necessary life-saving treatment from

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157. This analysis excludes temporary or recent incompetency where the patient, otherwise competent, is now unconscious or has slipped into a coma but who previously expressed a treatment or refusal choice. See note 27 supra.
159. Id. at --, 355 A.2d at 663-64.
161. Id. at 424.
minors and incompetents.\textsuperscript{162}

The doctrine of substituted judgment has been seldom used and its vitality as support for the results thus far reached has been questioned.\textsuperscript{163} It is potentially important in the former class of cases as the only clear vehicle leading to the intended result. In the \textit{Quinlan} or \textit{Saikewicz} type of case, however, it would not appear to be necessary, and would clearly not be so if the disputed life-prolonging treatment is medically unnecessary.\textsuperscript{164}

Where the necessary care is therapeutic but not lifesaving, parental rights may support a refusal and care should not be rendered without judicial sanction.\textsuperscript{165} In these latter cases, which will generally not involve an emergency timetable, physicians and hospitals would be well advised to notify the appropriate civil authorities under child or incompetent abuse legislation or state custody and welfare programs rather than simply proceeding as plaintiffs themselves.\textsuperscript{166}

\textbf{SHORTCOMINGS OF TRADITIONAL ANALYSIS}

The traditional analysis does not work satisfactorily in two instances. The first is the case where a court seeks to invoke the patients' right of privacy to refuse unnecessary or questionable medical care. Invoking the right of privacy of a vegetative or incompetent patient in such cases is an unnecessary fiction.\textsuperscript{167} The better approach would be to recognize the distinction between medically necessary and unnecessary care and to apply the distinction where appropriate.\textsuperscript{168} This would yield the same results

\begin{footnotes}
\item[162] See notes 70 \& 71 and accompanying text \textit{supra}. See also notes 57-61 and accompanying text \textit{supra} (distinguishing between incompetency for purposes of consenting to or refusing medical care).
\item[163] The doctrine has been carefully examined and expressly rejected in one recent case. See \textit{In re Guardianship of Pescinski}, 67 Wis. 2d 4, —, 226 N.W.2d 180, 181-82 (1975). See also \textit{In re Richardson}, 284 So. 2d 185, 187 (La. Ct. App. 1973), cert. denied, 284 So. 2d 338 (Sup. Ct. 1973).
\item[164] See notes 193 \& 194 and accompanying text \textit{infra}.
\item[165] See note 69 and accompanying text \textit{supra}.
\item[166] They may even have a duty to do so under many existing child abuse or incompetent abuse statutes.
\item[167] See also the English case of Dr. John Bodkins-Adams, \textit{reported in} Gurney, \textit{Is There a Right to Die?—A Study of the Law of Euthanasia}, 3 \textit{Cumberland-Samford L. Rev.} 235, 241 (1972). Dr. Bodkins-Adams was caring for a terminal patient in great pain. He gradually increased the dosage of medication to relieve her until the drugs killed her. Justice Devlin of Central Criminal Court instructed the jury: "[i]f it is no longer possible to restore the patient to health, the doctor may do what he can to alleviate pain and suffering." \textit{Id}. It was determined that the disease caused the death and the painkilling drugs only determined the moment of death.
\item[168] See generally \textit{In re Quinlan}, 70 N.J. 10, 355 A.2d 647 (1976); \textit{Superintendent of Belchertown v. Saikewicz}, 370 N.E.2d 417 (Mass. 1977). If courts and legal commentators sometimes feel the medical profession is out of touch and requires the
\end{footnotes}
as presently obtained in these cases without encouraging the further fiction that unnecessary care may be compelled or may even be obligatory absent court intervention. Where the distinction between necessary and unnecessary care does not resolve the issue of granting or withholding questionable medical care, the courts remain the proper forum for making the choice, although they should rely heavily on medical opinion.

The second instance in which the traditional analysis has not worked satisfactorily is in its apparent insistence that someone must consent in all cases, absent emergency. The law does not require this at all. Moreover, the law does not sanction substitute refusal as a permissible alternative in all cases where substitute consent has traditionally been accepted. Two factors, not clearly articulated in any of the reported cases, intervene in the substitute consent—substitute refusal dilemma to provide for beginnings of a practical solution.

First, the practical results in the decided cases strongly suggest that there is an unwritten presumption in the law to the effect that necessary treatment is always favored. This presumption is drawn from many separate parts and forms a general rule of its own. One not unrealistic approach is to consider this presumption the general rule and the patients' rights of personal choice the principal exception. The presumption has many sources.

There is the traditional parens patriae role of the state toward minors and incompetents, coupled with the vast array of statutory schemes permitting jurisdiction and action where a minor's or incompetent's life or health is in danger. Second, there is the doctrine of emergency which has its origin in the assumption that the patient would consent were he able. Third is the legal and practical acquiescence in the use of distant or unrelated surrogates, the rule that anyone may consent. Fourth is the hospital industry's practical acquiescence in the mature minor theory coupled with

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testing of medical principles against a legal or lay background, see notes 4 & 77 and accompanying text supra, consider the legal profession's similar exposure in this case. Try to explain to a layman how the right of privacy of a negative patient is determined and exercised in cases such as Quinlan.

170. See note 194 and accompanying text infra. There will always be cases of the Saikewicz variety offering real treatment alternatives. Courts remain an appropriate forum for these cases, but not the only forum. These cases do present an opportunity for families or others with a duty to the patient to chart a course of selecting what really constitutes the patient's best interest under the circumstances.
171. See notes 80-89 and accompanying text supra.
172. See McGuire v. Rix, 118 Neb. 434, 440, 225 N.W. 120, 123 (1929).
173. See note 3 supra.
judicial recognition of the doctrine and the absence of litigated cases challenging treatment rendered in such situations.\textsuperscript{174} Fifth is the unanimous result reached in all cases involving minors in need of emergency, life-saving care.\textsuperscript{175} Finally, there is the judicial reluctance to accept a refusal where recognized, viable exceptions to the patient’s rights are found to exist.\textsuperscript{176}

All of these separate parts merge into a viable presumption favoring treatment and attempting to prevent the withholding of treatment by mistake, i.e., unless there is a clear absence of medical necessity or a clear exercise of patients rights. The rule that someone must consent is not, therefore, a necessary part of the traditional analysis.

The second factor intervening to test the maxim that someone must always consent relates back to the underlying purpose of the maxim. A proper surrogate with sufficient standing to the patient is potentially the best person to weigh the information and chart a course of treatment which will advance the patient’s best interest.\textsuperscript{177} Part of this process involves finding where the patient’s best interest lies. The clearer the best interest and the necessity of the recommended treatment to advance it, the less room for decision is permitted the surrogate. The more clouded the picture, the more opportunity there is for the surrogate to discharge his historic role. Hence, the real value of substitute consent lies in treatment decisions affected with shades of gray such as in some types of therapeutic,\textsuperscript{178} life-prolonging,\textsuperscript{179} and elective care.\textsuperscript{180}

Further, the role and therefore the choice of the surrogate seems to increase in importance in relation to the degree of stand-
ing and duty which the surrogate has to the patient. Parents, for example, have a greater role to play in consenting to or refusing therapeutic care for their children because of their duty and their own array of constitutionally based rights, than have nieces and cousins in the case of adults. Spouses, while possessing no life and death authority over the patient by which they may order care withheld based on rights personal to themselves, are in the best position to give evidence of the patient's personal choice, such as religious objection to a procedure. Nieces, bank trust officers, and others would appear correspondingly ill-suited to discharging this function.

In the hospital setting the two factors just discussed should lead to a practice which diminishes the role of substitute consent as a barrier to necessary care. Certainly, this is so where the case is life-saving or emergency therapeutic care. Even in the case of life-prolonging and therapeutic care, reliance upon substitute consent or refusal should diminish as (a) the degree of standing, kinship, and duty of the surrogate diminishes, and (b) the necessity of the medical procedure to advance the patient's best interest becomes more clear.

Who is to consent if nieces and bank trust officers are not? Probably no one need consent where no surrogate would have authority to bind the hospital and physicians with a refusal. In many other cases where, de facto, there is no close family, perhaps no one need consent or anyone may consent. A hospital official or physician would appear as capable of making the right choice based on the medical facts as anyone else.

Only in those cases of therapeutic or life-prolonging care involving an absence of close family coupled with doubts about what the patient's best interest requires would it appear necessary to seek judicial appointment of a guardian. Even then, the application would not be coupled with a request to authorize specific

181. See note 72 supra.
182. See notes 79-84 and accompanying text supra.
183. See Dying Person, supra note 27, at 198-200.
185. This is not to suggest that families, even though they frequently cannot order treatment withheld, should not be involved in the treatment decision. Involving families is good practice. It builds their confidence in the treating physician, permits families to contribute to the treatment and recovery of the patient, and may lessen the devastating impact of otherwise unexpected results such as death. The situation described in the text, however, presupposes that there is no available family, as in the fairly typical case of elderly senile patients admitted from nursing homes. Even if there were an available family, however, they could not compel unnecessary care or withhold care clearly necessary for the patient.
treatment since, if the need for the treatment is so clear, then so is
the patient's best interest and the need for a guardian becomes
less apparent.

All of this is not to ignore the practical problem of proceeding
in the face of a refusal. It is to suggest, however, that substitute
refusals will always be ineffective to bind the hospital and physi-
cians in two situations: Substitute refusal is ineffective when the
treatment is life-saving or emergency therapeutic and the refusal
is not predicated upon the patient's own wishes, even if expressed
through a surrogate. Substitute refusal is also unavailing when
the treatment is therapeutic or life-prolonging but the patient's
best interest is clearly served by providing it and the surrogate has
no separate rights through which he may prevent it or he is unable
to express the patient's known wishes against it.

NONTRADITIONAL CONSIDERATIONS

The foregoing analysis is in traditional form with perhaps a
few nontraditional observations. The analysis holds for most of
the cases and fact situations discussed. Because it overlooks the
impact of new medical technology and evolving concepts of death,
dying, and medical necessity, this classical equation of conflicting
rights and interests fails to explain several of the cases. These are
the cases where court reliance upon asserted rights of privacy of
comatose—even vegetative—patients and where legislative interven-
tion to codify medical necessity constitutes at best a fiction and at
worst an invitation to ignore the evolutionary nature of medicine,
law, and ethics.

EVOLVING NATURE OF MEDICAL STANDARDS

What do Shirley Dinnerstein and Karen Quinlan have in com-
mon? Shirley Dinnerstein was a 67-year-old patient suffering
through the terminal stages of Alzheimer's disease with a life ex-
pectancy of a year or less. Alzheimer's disease is a degenerative
disease of the brain which leads ultimately to the loss of all brain
function and death. Shirley Dinnerstein had entered the final
stages of the disease. She was comatose and described by her phy-

186. Here the duty would be to treat, unless the surrogate expressed strong evi-
dence of the adult patient's objections to the treatment.
187. Particularly in the case of minors needing therapeutic or elective care over
the objections of their parents, hospitals and physicians should not treat and proba-
ably should not seek to compel treatment through the courts. Instead officials
charged with administering child and neglected person abuse legislation should be
involved and should carry the load.
sician as vegetative, although she retained some brain function. Her condition was complicated by a stroke which occurred subsequent to the onset of the disease, by high blood pressure, and by a life-threatening coronary artery disease.\textsuperscript{189} Her physician recommended that if cardiac or respiratory arrest should occur, no efforts at cardio-pulmonary resuscitation should be made. This recommendation, if implemented in the form of a "no code" order, could result in her death prior to her estimated life expectancy.\textsuperscript{190} Fearful of liability should they act on their opinion, the physicians and hospital brought an action seeking judicial approval of the recommendation.

In \textit{Quinlan} the patient was a young girl suffering from an unknown disease. Her condition was described as vegetative, characterized by an absence of measurable brain activity. She was maintained on a life-support apparatus which mechanically continued her circulatory and respiratory functions. Her physicians believed that her life expectancy would be brief if the apparatus were disconnected. Following what they referred to as their professional judgment, her physicians recommended against disconnection from the respirator.\textsuperscript{191} Her father brought an action seeking to have himself appointed guardian with authority to order her disconnected from the life-support apparatus.

The two courts reached the same result via differing routes. The \textit{Quinlan} court found that the patient had a right of privacy, determined that she would exercise her right against continued care, and thereupon exercised it for her, authorizing the father, as guardian, to consent to removal of the respirator.\textsuperscript{192} The \textit{Dinnerstein} court never concerned itself with a right of privacy. It authorized a no code order withholding resuscitation efforts because such care was without medical justification. More important, the \textit{Dinnerstein} court recognized that the decision was peculiarly a medical decision.

This case does not offer a life-saving or life-prolonging treatment alternative within the meaning of the \textit{Saikewicz} case. It presents a question peculiarly within the competence of the medical profession of what measures are ap-

\textsuperscript{189} Id. at 135.
\textsuperscript{190} Ordinarily, when a hospital patient goes into respiratory or cardiac arrest, an emergency page is broadcast throughout the hospital to summon medical assistance to resuscitate the patient. The page is frequently designated as a "Dr. Blue" or "Code Blue." When the attending physician directs that the emergency page not be broadcast such that the patient will not be resuscitated, it is commonly known as a "no code" order.
\textsuperscript{191} \textit{In re Quinlan}, 70 N.J. 10, —, 355 A.2d 647, 657 (1976).
\textsuperscript{192} Id. at 671-72.
propriate to ease the imminent passing of an irreversibly, terminally ill patient in light of the patient's history and condition and the wishes of her family. That question is not one for judicial decision, but one for the attending physician, in keeping with the highest traditions of his profession and subject to court review only to the extent that it may be contended that he has failed to exercise 'the degree of care and skill of the average qualified practitioner. . . .'

Implicit in the Quinlan court's reliance upon the right of privacy is the assumption that it could have been exercised the other way—in favor of indefinite use of a respirator. Implicit in the Dinnerstein court's decision is the assumption that there comes a time in the dying process of some patients when rights of personal choice by patients (or families) must yield to medical standards defining the outer limits of medical necessity. Beyond this limit, families and even courts exercising the patient's supposed rights of privacy may not compel further or unnecessary care. The Dinnerstein family and court could not, for example, compel the physicians to perform surgery to alleviate the coronary artery disease over the physician's objections that such surgery was medically contraindicated, any more than the family of a fracture victim could compel his physicians to remove his healthy appendix.

The rationale in the two cases is not so different when one recalls that in Quinlan the attending physician's professional judgment weighed against disconnecting the patient from the life-support system. As much as any other single factor, the decision in Dinnerstein seems to have been affected by the passage of time and a hardening of medical opinion around notions of appropriate medical care for the dying.

193. In re Dinnerstein, 380 N.E.2d 134, 139 (Mass. App. 1978) (citations omitted). The Dinnerstein Court said:

   The purpose of cardiopulmonary resuscitation is the prevention of sudden, unexpected death. Cardiopulmonary resuscitation is not indicated in certain situations, such as in cases of terminal irreversible illness where death is not unexpected or where prolonged cardiac arrest dictates the futility of resuscitation efforts. Resuscitation in these circumstances may represent a positive violation of an individual's right to die with dignity. When CPR is considered to be contraindicated for hospital patients, it is appropriate to indicate this in the patient's progress notes.

   Id. at 139 n.10 (quoting National Conference on Standards for Cardiopulmonary Resuscitation and Emergency Cardiac Care, Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC), 227 J.A.M.A. 837, 864 (1974)).

194. In re Dinnerstein, 380 N.E.2d 134, 139 (Mass. App. 1978). The court did not consider the issue of whether CPR would be required if the family wanted it.

195. See note 4 supra.

196. Another important intervening factor was the case of Superintendent of
Is there a standard of medical care independent from perceived legal duty? Put another way, do medical standards such as appropriate care for the hopelessly ill evolve around legal principles or vice versa? The writer believes that the contemporary sequence finds medical technology outpacing solutions to the ethical dilemmas which it creates; that once lay ethics find some consensus for dealing with the new problems spawned by technology, medical practice, and public medical ethics gravitate increasingly toward implementing the ethical solution; and that finally, law sanctions the medical practice when called upon to do so.  This sequence is illustrated by the adoption of the concept of brain death and by the evolving standard of care for the hopelessly ill patient. As one commentator has stated, what constitutes “good” or “acceptable” or “ordinary” medicine “is a function of time and culture.”

**BRAIN DEATH: AN ANALOGY**

The traditional common-law notion of death is that it is defined by a cessation of heart beat, the stoppage of circulation, and the cessation of animal and vital functions. Early cases seeking to recognize brain death as an alternate definition of death were rejected. Commentators of this period, recognizing the emergence of new technology and capability, wrestled with distinctions such as act and omission or active and passive, to justify changing medi-

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Belchertown v. Saikewicz, 370 N.E.2d 417 (Mass. 1977) where the court exercised the right of privacy of a hopeless mental defective to refuse potentially life-prolonging cancer therapy. Id. at 435. As the Dinnerstein court notes, Saikewicz presented some real alternatives not present in the Dinnerstein case such as a real possibility of temporary remission of the disease. In re Dinnerstein, 380 N.E.2d 134, 137-38 (Mass. App. 1978).

197. For example the practice of writing no code orders or of giving them verbally has existed for years. In re Dinnerstein, 380 N.E.2d 134, 139 (Mass. App. 1978). The practice carries no malevolent overtones. It is a matter of professional judgment of those giving the order that further efforts at CPR will serve no medical purpose. The practice represents an abandonment of the medical ethic that life must be sustained, even artificially, at whatever cost, forever. But the abandonment has been forced on the medical profession by the emerging technology which creates the capacity to do just that, i.e.—to artificially maintain pulse and respiration indefinitely.


199. Smith v. Smith, 229 Ark. 579, —, 317 S.W.2d 275, 279 (1958); Sauer v. Stolz, 121 Colo. 456, —, 218 P.2d 741, 742 (1950); United Trust Co. v. Pyke, 199 Kan. 1, —, 427 P.2d 67, 73 (1967); Gray v. Sawyer, 247 S.W.2d 496, 497 (Ky. App. 19752) (a simultaneous death case in which continued life was established by evidence of blood spurring from a decapitated accident victim); W. Dorland, *Dorland's Illustrated Medical Dictionary* 387 (29th ed. 1965). Death as “the apparent extinction of life as evidenced by absence of heart beat and respiration...” Id.

While the debate went on in abstract terms, technological capabilities overcame the debaters and rendered many of the issues moot. Machines were developed capable of artificially maintaining the traditional vital signs intact indefinitely, while the capability of transplanting organs emerged on a parallel track. Gradually, medical opinion and practice hardened; a general medical consensus, supporting a concept of death in terms of a permanently nonfunctioning brain was reached, and the consensus in medicine brought about a change in the law. Technology and new medical capability forced the change; the medical consensus gave it direction. The need for healthy organs for transplant and the capability of maintaining the vital functions of victims of crime forced the courts to distinguish between normal vital functions and those which were artificially sustained.

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201. See generally Comment: Legal Aspects of Euthanasia, 36 Alb. L. Rev. 674 (1972); The Living Will, supra note 62, Note: The Right to Die, 7 Hous. L. Rev. 654 (1970); Comment: Euthanasia—Criminal, Tort, Constitutional and Legislative Considerations, 48 Notre Dame Law. 1292 (1973).


204. At the Twenty-Second World Medical Assembly in Sydney, Australia, in 1968, the so-called “Declaration of Sydney” recognizing that the primary concern of the medical profession should be the care of human beings and not the “preservation of isolated cells.” See Hyland & Baime, In re Quinlan: A Synthesis of Law and Medical Technology, 18 Jurimetrics J. 107, 115 (1977). See also Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, 205 J.A.M.A. 337 (1968), reprinted in 5 U.S.F.L. Rev. 283 (1971).


206. See Tucker’s Administrator v. Lower, No. 2831 (Ct. Law & Equity, Richmond, Va., May 25, 1972). In this case a surgeon was absolved in wrongful death action brought by brother of a patient whose beating heart was removed for transplantation. The Judge instructed the jury it could use a brain death criteria in addition to traditional criteria and could consider whether the traditional criteria of pulse and respiration were naturally or artificially sustained. Id. at —, discussed in Death in Vital Organ Transplants, supra note 205, at 220.

207. In re New York Health and Hosp. v. Sulsona, 81 Misc. 2d 1002, 367 N.Y.S.2d 686 (Sup. Ct. 1975). An assault victim with gunshot wounds to the head was maintained on life support apparatus until declared neurologically dead, then was disconnected, and his eyes and kidneys were removed for transplant. Id. at 688-89. The brain/death definition has been put to the practice most frequently in criminal prosecutions in which defendants have argued in favor of the old definition of circulation and respiration by which the victims would not be dead.

As early as 1963, the British Courts held an assault victim maintained on a respirator could be pronounced dead while his circulation and respiration were artificially maintained See In re Potter, an unreported decision discussed in Death in Vital Organ Transplants, supra note 205, at 232.

208. Commonwealth v. Golston, 366 N.E.2d 44 (Mass. 1977) is the most complete judicial treatment of brain death. An assailant appealed his murder convic-
The concept of brain death is now the general rule. The emerging issue now is what concept of brain death to use—total brain death, cerebral death, or some other test—and what criteria will be used in determining whether death has occurred.\textsuperscript{209} The test is important. Equally important, the test is still evolving. It is hard to predict how legislation defining death will assist this evolutionary process.\textsuperscript{210} How will a codification of medical principles spawned by the scientific and technological state of the art in the mid-1970's fit the technology of the 1980's and beyond? Probably not very well as early advocates of Natural Death Legislation are learning.\textsuperscript{211} What is important for this discussion is the fact that the recognition of new definitions or criteria of death, born of necessity out of sheer technological capability, have called into question the medical justification for applying all such technology to prolong the dying process.

**APPROPRIATE CARE FOR THE HOPELESSLY ILL PATIENT**

What has taken place in the definition of death is occurring in the arena of fixing appropriate care for the hopelessly ill patient. The medical consensus is not so obvious, but as it develops the courts will adopt and apply it to replace the fiction of right of privacy in that special class of cases for which it is appropriate.\textsuperscript{212}
It seems clear that good medicine no longer requires physicians treating the terminally ill patient to "employ whatever life-saving or life-prolonging treatments the current state of the art has put in his hands." Commentators are instead fashioning an important distinction between "care for the dying" or "cure for the living," and between "prolonging life" or "prolonging the act of dying." This distinction is in step with contemporary ethical, religious, medical, and legal views.

The effect of this trend in medicine and law will be to remove certain refusal cases from the traditional analysis. Because some contested treatment will be unnecessary or contraindicated medical care, no exercise of personal rights by the patient, his family, or the courts will be able to compel it. In time it will be withheld as a matter of medical judgment.

139. Dinnerstein does not expressly repudiate the right of privacy as the means to an end. It correctly notes that it is inapplicable in a case where there is hard medical opinion that the contested care is unnecessary while remaining potentially applicable where the contested treatment carries real alternatives. Id. at 138. However, other courts clearly recognize some distinction is due in refusal cases where the treatment would only prolong life. See, e.g., In re Nemsen, 51 Misc. 2d 618, 273 N.Y.S.2d 624, 626 (1966).


216. Pope Pius XII in his address to anesthesiologists of November 24, 1957, recorded in 4 The Pope Speaks 393, 395-96 (Spring 1958), summarized in Louisell, Euthanasia and Biathanasia: On Dying and Killing, 22 Catholic U.L. Rev. 723, 724 (1973) made the point for the Catholic Church that "[i]t is about as clear as human answers can be in such matters that there is no moral obligation to keep alive by artificial means those whose lives nature would forfeit and who wish to die." See also Elkinton, The Dying Patient, the Doctor and the Law, 13 Vill. L. Rev. 740 (1968); Kelly, The Duty to Preserve Life, 12 Theological Stud. 550 (1951); To Life in Christ Jesus: A Pastoral Reflection on the Moral Life, Vol. 84, No. 47 The New World 17, 17-18 (November 19, 1976); I. Jakovovits, Jewish Medical Ethics 275-76 (1975).

217. Los Angeles County "No Code" Guidelines for county facilities adopted by the Los Angeles County Board of Supervisors and reported in Catholic Hospital Association Law Reports 3-4 (May 1978). Guidelines appear to be based on two presumptions. First, it is good medicine not to initiate CPR when death is expected, imminent, and inevitable; second—most patients have not prepared proper legal documents to come with the Natural Death Act. See also Massachusetts General Hospital Patient Classification System, reported in Optimum Care for Hopelessly Ill Patients, 295 N. Eng. J. Med. 362 (1976).

CONCLUSION

The conclusions at least in the case of adults, are largely embodied in the Appendix to this article titled INSTRUCTIONS RELATING TO MEDICAL TREATMENT AND DEATH—REFUSAL OF FURTHER CARE. Drafted to illustrate the relationship between patient choice and medical necessity together with the respective role of the patient and his family, the document suffers from one of the major flaws of the so-called living will, namely, not many people will execute such a document before the fact. It embodies the following assumptions which are also the primary conclusions of this article respecting adults.

First, a competent adult patient may execute a binding refusal. The refusal is effective, whether or not in written form, even after the patient lapses into unconsciousness.219

Second, the patient's choice must yield to a lack of medical necessity in appropriate cases. A patient through the exercise of consent or through the physician-patient relationship, cannot bind the physician to render endless or unnecessary care. Therefore, any written instrument of this sort assumes that the physician will be able to act upon the medical criteria in the instrument before he would otherwise conclude that all further treatment is unnecessary. If the actual medical events prove this assumption false, then the physician must act on the distinction of necessary versus unnecessary medical care.220

Third, the patient's family has no right to override an adult patient's refusal unless they carry the burden of going to court to do so. The family's rights are separate from the patient's rights and inapplicable when the patient has expressed his choice.

Fourth, there is no viable right to die. The right is one of personal choice defining the limits of medical treatment that a patient will willingly receive, although it may require the patient to articulate the meaning of his choice, which may include certain death if treatment is withheld.221

Finally, a hospital and the attending physicians should be fully protected from liability in following the patient's instructions refusing care. In fact, they could quite clearly be liable for rendering further care in the face of the refusal.

Minors and incompetents may not execute binding refusals except to the extent that incompetents have the capacity to partici-

219. See Dying Person, supra note 27, at 198-200.
pate in the treatment decision. Surrogates may not refuse necessary life-saving care on their behalf. To the contrary, the weight of the law suggests that all necessary care will be rendered to advance the best interest of minors and incompetents. The role of surrogates in the case of minors and incompetents is more limited than is generally understood. Where they may not refuse, as in the case of life-saving care, they may still consent, but their consent is not a prerequisite to treatment. The surrogate’s principal role is in selecting among treatment options where the patient’s best interest, or the means to advance it, are unclear.

Finally, today’s frontier of difficult consent and refusal cases typified by *Quinlan* and *Dinnerstein* will cease to be considered in terms of consent or refusal at all. These cases arise because of a technology which has outpaced the legal and ethical framework which must cope with it. In the long run these cases must be decided on the basis of accepted medical judgment and practice distinguishing between necessary and unnecessary care and acting on that distinction. The legal and ethical framework now exists. Privately the medical practice frequently exists as well. Ultimately, the law only requires physicians to practice good medicine. In the minds of a growing number of practitioners, life support apparatus such as respirators are not and can not be considered as long term warehousing devices for the terminally ill or vegetative patient but instead are short term therapeutic aids. It is the misuse of this technology, born solely out of concern for liability rather than good medicine, which has created an unwelcome place for lawyers, judges, and legislators to inject the consent issue as well as the right of privacy into this unfortunate class of cases.
APPENDIX

INSTRUCTIONS RELATING TO MEDICAL TREATMENT AND DEATH—REFUSAL OF FURTHER CARE

TO: MY TREATING PHYSICIAN AND ANY HOSPITAL OR OTHER HEALTH CARE FACILITY IN WHICH I SHOULD BECOME A PATIENT

A. I, ____________, insist that just as I have the right to consent to medical and surgical treatment of any injury or condition affecting my health or threatening my life, so too I have the right to withhold consent and to refuse treatment. I insist that I have the right now, while I am fully lucid and competent, to give binding directions not to treat me (or not to continue to treat me) in the event that I become incompetent and that my condition becomes as described in the following paragraph B, even though this refusal of treatment will result in my death.

B. If, due to injury or illness, sudden or gradual, I become incompetent, and my condition becomes such that:

1. I am in irreversible coma, in the opinion of my treating physician; or
2. I have been continuously unconscious for a period of one week and, in the opinion of my treating physician, I have suffered severe irreversible brain damage which will permanently render me incompetent; (or that even partial physical recovery would be accompanied by severe, irreversible brain damage rendering me incompetent); or
3. My condition is terminal and hopeless and death is imminent;

then, as of that time, I withdraw my actual or implied consent to, and substitute this REFUSAL of, all further treatment of me by artificial means and devices (such as the use of a respirator) and all further therapeutic or emergency care; and I direct that all further treatment of me or my condition by such artificial means and devises or the rendition of such further therapeutic or emergency care shall cease.

C. The determination of the effective time of this refusal is a medical decision and I empower my treating physician, with or
without the assistance of consultant physicians as he sees fit, to make the determination and honor this refusal with or without the approval and even over the express objections of one or more members of my family.

I fully recognize that the practice of medicine and surgery is not an exact science and I only request of my physician that in reaching his opinion as to my condition, the appropriateness of further care, or the time when this REFUSAL takes effect, he apply his own medical judgment (unless he voluntarily seeks out consulting opinions).

D. For myself, my estate, and for my heirs and next of kin, I hereby absolve and release any physician or physicians and any hospital or other health care institution from any legal liability whatsoever on account of honoring this refusal, and reaffirm that this is my REFUSAL and that any such physician or hospital is acting in accordance with my own directions.

E. I am not claiming any so-called "right to die" nor any right to commit suicide through this REFUSAL. Rather, I am insisting upon my right as a competent adult to refuse to submit to medical and surgical procedures although the inevitable consequences of my decision will be my death.

F. Nothing in this document and in the description of the conditions in part B of this document shall be construed as requiring more or different care or the prolongation of care beyond what my physician, in his own medical judgment, would render or provide in the absence of this document.

IN WITNESS WHEREOF, I have hereunto subscribed my name to these INSTRUCTIONS RELATING TO MEDICAL TREATMENT AND DEATH, REFUSAL OF FURTHER CARE, this ___ day of __________, 19__.

We, whose names are hereunto subscribed, hereby certify that ____________________________, above named, subscribed his name to this instrument in our presence and while competent and lucid; and in the presence of each of us and at the same time in our presence and hearing declared this instrument to be his INSTRUCTIONS RELATING TO MEDICAL TREATMENT, REFUSAL OF FURTHER CARE, and we, at his request, sign our names hereto in his presence and in the presence of each other as attesting witnesses. 224

224. The witnesses should not include anyone who may have an interest in impeaching the document as, for example, a spouse who may disagree with it.
IN TESTIMONY WHEREOF, witness our signatures at 

[Signature]

NAME

ADDRESS

[Signature]

NAME

ADDRESS