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Last Rights: An Analysis of Refusal and Withholding of Treatment Cases

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LAST RIGHTS: AN ANALYSIS OF REFUSAL AND WITHHOLDING OF TREATMENT CASES

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I. INTRODUCTION

In recent years, the subject of the legal rights of the terminally ill incompetent patient has become the focus for major public attention. Since the drama of the Karen Quinlan case¹ was played out in the media, the issues popularly labeled "right to die" or "right to refuse treatment" have been much debated in legal circles.² The debate has involved significant questions about the responsibility of society to the terminally ill, the role

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

2. The literature on the subject is voluminous. See Annas, *Reconciling Quinlan and Saikewicz: Decision Making for the Terminally Ill Incompetent*, 4 AM. J.L. & MED. 367 (1979); Brant, *The Right to Die in Peace: Substituted Consent and the Mentally Incompetent*, 11 SUFFOLK U.L. REV. 959 (1977); Cantor, *Quinlan, Privacy, and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 243 (1977); Clarke, *The Choice to Refuse or Withhold Medical Treatment: The Emerging Technology and Medical—Ethical Consensus*, 13 CREIGHTON L. REV. 795 (1980); Hirsch & Donovan, *The Right to Die: Medico-Legal Implications of In Re Quinlan*, 30 RUTGERS L. REV. 267 (1977); Liacos, *Dilemmas of Dying*, 7 MEDICOLEGAL NEWS 4 (Fall 1979); Relman, *The Saikewicz Decision: A Medical Viewpoint*, 4 AM. J.L. & MED. 233 (1978); Note, *In Re Quinlan: Defining the Basis for Terminating Life Support Under the Right of Privacy*, 12 TULSA L.J. 150 (1976); Note, *The Right to Die a Natural Death: A Discussion of In Re Quinlan and the California Natural Death Act*, 46 U. CIN. L. REV. 192 (1977); Note, *No-Code Orders vs. Resuscitation: The Decision to Withhold Life-Prolonging Treatment from the Terminally Ill*, 26 WAYNE L. REV. 139 (1979).

of individual decision-making, and the role of the judiciary in making ethical and medical decisions.

Over the past five years, there has been a flurry of legal activity in the area of medical treatment for the terminally ill. From that flurry of activity has come a body of case law which, while not entirely consistent, defines individual rights and judicial and governmental responsibilities for the seriously ill. This Article analyzes and critiques that body of law and the organic growth which has occurred.

II. BRAIN DEATH: RECOGNIZING THAT MODERN TECHNOLOGY DETERMINES WHEN LIFE ENDS

It is appropriate that an article attempting to define the limits of treatment responsibilities begin with an analysis of the legal standard of death. Obviously, the death of a seriously ill or injured person terminates any responsibility to provide medical treatment.

Until recently, there was little confusion about what constituted death. Death was the end of life. As one court stated, "Death is not an ambiguous term, and there is no room for construction. . . . Death has been defined as the termination of life; and as the state or condition of being dead."³ Life (and death) were primarily related to the functioning of the heart. *Black's Law Dictionary* defined death as the "cessation of life; the ceasing to exist; . . . a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc."⁴

For much of human existence, cardiac activity was an appropriate means for determining that life existed. The recent development of medical technology such as respirators, modern resuscitation techniques, and heart-lung machines, however, has made the traditional definition of death based on cardiac activity obsolete and meaningless.⁵ Medical scientists now advocate that the legal standard for death should be based on the operative state of the brain.⁶

Although some early attempts at getting courts to recognize brain death as the legal definition of death failed,⁷ the movement toward accep-

3. *Douglas v. Southwestern Life Ins. Co.*, 374 S.W.2d 788, 793 (Tex. Civ. App. 1964) (citation omitted).

4. *BLACK'S LAW DICTIONARY* 488 (4th ed. 1968).

5. Masland, *The Moment of Death*, 6 *LAW. MED. J.* 49, 50 (2d series 1977). See also *In re Bowman*, 94 Wash. 2d 407, ___, 617 P.2d 731, 734-35 (1980); Note, *Rejection of Extraordinary Medical Care by a Terminal Patient: A Proposed Living Will Statute*, 64 *IOWA L. REV.* 573, 576 (1979).

6. See generally R. VEATCH, *DEATH, DYING, AND THE BIOLOGICAL REVOLUTION* 55-77 (1976); Victor, *Brain Death: An Overview*, 27 *MED. TRIAL TECH. Q.* 37 (1980).

7. E.g., *Smith v. Smith*, 299 Ark. 579, 586-87, 317 S.W.2d 275, 279-80 (1958); *Vaegemast v. Hess*, 203 Minn. 207, 210-11, 280 N.W. 641, 643 (1938); <https://scholarship.law.missouri.edu/mlr/vol46/iss2/3>

tance of brain death accelerated with the publication in 1968 of a suggested standard by an interdisciplinary team at Harvard.⁸ These standards attempted to delineate conditions of irreversible comas in which it was certain that the person had lost all operational functioning in the brain.

The growth of the law since the Harvard standards has been speedy and dramatic. Some fourteen states have adopted statutes defining brain death as the legal standard of death.⁹ In addition, four states have adopted

Comment, *Defining the Exact Moment of Death: A Changing Concept*, 7 CAP. U.L. REV. 405, 406 (1978). Much of the early initiative for changes in the law came from the work of Capron and Kass. Capron & Kass, *A Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal*, 121 U. PA. L. REV. 87, 92-93 (1972).

8. Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 205 J.A.M.A. 337 (1968). The so-called Harvard standards require three elements: (1) unresponsiveness to normally painful stimuli, (2) absence of spontaneous movements or breathing, and (3) absence of reflexes. The Harvard standards have been the basis for other definitions of brain death. See, e.g., UNIFORM BRAIN DEATH ACT (superseded 1980). Despite their general acceptance, the Harvard standards are not without their critics. See van Till, *Diagnosis of Death in Comatose Patients Under Resuscitation Treatment: A Critical Review of the Harvard Report*, 2 AM. J.L. & MED. 1 (1976). See generally Ufford, *Brain Death/Termination of Heroic Efforts to Save Life—Who Decides?*, 19 WASHBURN L.J. 225, 228 (1980) ("Brain death can generally be defined as the permanent loss of all integrated neuronal brain functions.").

Recently, the National Conference of Commissioners on Uniform State Laws approved the Uniform Determination of Death Act, which is based on brain stem death. "An individual who has sustained either (1) irreversible cessation of circulatory or respiratory functions or (2) irreversible cessation of all functions of the entire brain including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards." UNIFORM DETERMINATION OF DEATH ACT § 1. Recently, the ABA has endorsed this Act. See *Boston Globe*, Feb. 11, 1981, at 10, col. 1.

Under this standard, brain death does not occur until there is no clinical evidence of brain function. "Brain death occurs when the swelling is so severe that the pressure within the cranial cavity exceeds the pressure of blood flowing into the brain and the brain stem, causing cerebral circulation to cease. In this condition, there is no clinical evidence of brain function." *In re Bowman*, 94 Wash. 2d 407, ____, 617 P.2d 731, 736 (1980). This is an extremely high standard for brain death and one which is rarely met. "The brain stem controls the primitive body functions of, among other things, breathing, blood pressure, and heart rate. . . . The brain stem functions, or the vegetative functions, by virtue of being primitive, tend to recover when injured." *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1337 (Del. 1980). See also Walker, *An Appraisal of the Criteria of Cerebral Death: A Summary Statement*, 237 J.A.M.A. 982 (1977).

9. ALA. CODE § 22-31-1 (Supp. 1979); ALASKA STAT. § 09.65.120 (Cum. Supp. 1980); CONN. GEN. STAT. ANN. § 19-139i(b) (West Cum. Supp. 1980); HAWAII REV. STAT. § 327C-1 (Supp. 1980); IDAHO CODE § 54-1819 (1979);

brain death as a definition of death through decisions of their respective highest courts.¹⁰

The importance of the increasing recognition of the brain death standard is that it defines the outer parameters of potential judicial involvement in decisions permitting the withholding of medical treatment. Because persons who meet established criteria for brain death are dead, there is no responsibility to seek judicial approval for the cessation of medical treatment.¹¹ Where brain death is recognized, the patient is dead and may be buried, and there is no need to revert to the courts to settle the matter.

III. RIGHTS OF COMPETENT PATIENTS TO REFUSE MEDICAL TREATMENT: EXPLORING LIMITS TO THE CONSTITUTIONAL RIGHT OF PRIVACY

It is established law that competent adults have the right to determine whether or not they will receive medical treatment. As the California Natural Death Act states, "[A]dult persons have the fundamental right to control the decisions relating to the rendering of their own medical care"¹² The rule is virtually absolute. A competent, conscious adult may refuse permission for the performance of any medical or surgical pro-

IOWA CODE § 702.8 (1979); KAN. STAT. ANN. § 77-202 (Cum. Supp. 1980); LA. REV. STAT. ANN. § 9:111 (West Cum. Supp. 1981); MICH. COMP. LAWS ANN. §§ 333.1021-.1023 (1980); MONT. REV. CODES ANN. § 50-22-101 (1979); TENN. CODE ANN. § 53-459 (1977); TEX. REV. CIV. STAT. ANN. art. 4447t (Vernon Cum. Supp. 1980-1981); VA. CODE § 54-325.7 (Cum. Supp. 1980); W. VA. CODE § 16-19-1(c) (Supp. 1980); WYO. STAT. § 35-19-101 (Cum. Supp. 1980). See *In re Bowman*, 94 Wash. 2d 407, ___, 617 P.2d 731, 737 (1980) (description of brain death statutes).

10. *State v. Fierro*, 124 Ariz. 182, 603 P.2d 74 (1979) (adopting Harvard standards); *Lovato v. District Court*, ___ Colo. ___, 601 P.2d 1072 (1979) (adopting Uniform Brain Death Act); *Commonwealth v. Golston*, 373 Mass. 249, 366 N.E.2d 744 (1977) (adopting Harvard standards), *cert. denied*, 434 U.S. 1039 (1978); *In re Bowman*, 94 Wash. 2d 407, 617 P.2d 731 (1980) (adopting Uniform Determination of Death Act). See also *State v. Shaffer*, 223 Kan. 244, 574 P.2d 205 (1977) (upholding constitutionality of Kansas statute). Other courts have recognized brain death in different contexts. See, e.g., *New York City Health & Hosps. Corp. v. Sulsona*, 81 Misc. 2d 1002, 367 N.Y.S.2d 686 (Sup. Ct. 1975) (kidney transplant). Persons who are brain dead are a major source of transplants. Veith, *Brain Death*, 238 J.A.M.A. 1651, 1653 (1977).

11. *In re Spring*, 80 Mass. Adv. Sh. 1209, 1214, 405 N.E.2d 115, 119 (1980) (*dicta*) ("There is no legal basis for a duty to administer medical treatment after death.").

12. CAL. HEALTH & SAFETY CODE § 7186 (West Cum. Supp. 1980). This language is almost identical to the classic statement from Judge Cardozo that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." *Schloendorff v. Society of the New York Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

cedure, notwithstanding medical opinion as to the need for such treatment, even if the ultimate result of the refusal is the patient's death.¹³

The origins of the principle that competent adults may decline medical treatment are twofold. First, there is the doctrine of informed consent, which provides that before any medical procedure is performed on a patient, the patient must be informed about the treatment before his consent is valid. He must be informed of the nature and purpose of the proposed procedure, the likelihood of success, the hazards of the procedure, and any alternative forms of treatment.¹⁴ This principle holds true except in an emergency.¹⁵ The doctrine of informed consent obviously has two elements. First, it must be *informed*; there must be adequate disclosure of the proposed procedure and its expected risks and benefits. Second, there must be *valid consent*, where the patient has a right to refuse treatment as well as to consent to it.¹⁶ The principle of informed consent is based on the notion of the inviolability of the human body and that persons should be protected from unwanted intrusions into their person.¹⁷

The United States Constitution is another source of the right to decline medical treatment. In recent years, the constitutional right to privacy¹⁸

13. Roth & Wild, *When the Patient Refuses Treatment: Some Observations and Proposals for Handling the Difficult Case*, 23 ST. LOUIS U.L.J. 429, 432 (1979).

14. Meisel, *The "Exceptions" to the Informed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decision-Making*, 1979 WIS. L. REV. 413, 420. The term "informed consent" dates back only as far as 1957. Two early cases recognizing the concept are *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093 (1960), and *Mitchell v. Robinson*, 334 S.W.2d 11 (Mo. 1960) (overruled in part in *Aiken v. Clary*, 396 S.W.2d 668 (Mo. 1965)). See generally *Canterbury v. Spence*, 464 F.2d 772, 790 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 317 P.2d 170 (1957). A recent Comment provides a good definition of informed consent: "An 'informed consent' is an agreement between the doctor and patient whereby the patient grants his permission to allow the hospital staff to proceed with a specific method of treatment." Comment, *The Right to Refuse Medical Treatment: Under What Circumstances Does It Exist?*, 18 DUQ. L. REV. 607, 608 (1980).

15. See *Dunham v. Wright*, 423 F.2d 940, 941 (3d Cir. 1970); Clarke, *supra* note 2, at 804-05.

16. Clarke, *supra* note 2, at 800.

17. See *Union Pac. Ry. v. Botsford*, 141 U.S. 250, 251 (1891); *Pratt v. Davis*, 118 Ill. App. 161, 166 (1905), *aff'd*, 224 Ill. 300, 79 N.E. 562 (1906); *Mohr v. Williams*, 95 Minn. 261, 268, 104 N.W. 12, 14 (1905). *But see* FED. R. CIV. P. 35.

18. The right to privacy was first recognized in *Griswold v. Connecticut*, 381 U.S. 479 (1965), and expanded in *Roe v. Wade*, 410 U.S. 113 (1973). The constitutional right of privacy is limited to "matters [such as those] relating to marriage, procreation, contraception, family relationships, and child rearing and education." *Paul v. Davis*, 424 U.S. 693, 713 (1976).

has been broadened to include the right of patients to decline medical treatment.¹⁹ As one court has stated, "[T]he right of privacy includes a right to die with which the State should not interfere where there are no minor or unborn children and no clear and present danger to public health, welfare or moral."²⁰

Courts have recognized that the effect of judicial decisions allowing personal decision-making may lead to the death of a patient, but they have allowed individual decision-making to prevail even when troubled by the potential result.²¹ Where the patient is competent, the generally accepted rule is that the patient has the right to withdraw consent and refuse any potentially lifesaving treatment. This applies even in the extreme case where the result is certain death and the prognosis with treatment is good.²² As one court has described the principle,

The constitutional right to privacy, as we conceive it, is an expres-

19. The first case to expand the right of privacy to decisions not to treat was *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976). See also *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977). See generally Note, *In Re Quinlan: Defining the Basis for Terminating Life Support Under the Right of Privacy*, 12 TULSA L.J. 150, 166 (1976) ("It is ostensibly a recognition that the right of privacy protects a patient's decision to have a life-support system discontinued in order that the natural process of death may accomplish its mission."); Note, *Roe v. Wade and In Re Quinlan: Individual Decision and the Scope of Privacy Constitutional Guarantee*, 12 U.S.F.L. REV. 111 (1977).

20. *In re Yetter*, 62 Pa. D. & C.2d 619, 623 (C.P. Northampton County 1973).

21. See *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *approved*, 379 So. 2d 359 (Fla. 1980); *In re Estate of Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); *In re Dinnerstein*, 78 Mass. App. Ct. Adv. Sh. 736, 380 N.E.2d 134 (1978); *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (Morris County Ct. 1978); *Erickson v. Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962).

Occasionally, the courts have found implied consent and ordered treatment. See *Long Island Jewish-Hillside Medical Center v. Levitt*, 73 Misc. 2d 395, 342 N.Y.S.2d 356 (Sup. Ct. 1973); *Collins v. Davis*, 44 Misc. 2d 622, 254 N.Y.S.2d 666 (Sup. Ct. 1964). In light of the strong constitutional privacy rights articulated by such cases as *Quinlan* and *Saikewicz*, the precedential value of these older cases is dubious. But see *In re Dell*, 1 Pa. D. & C.3d 655 (C.P. Allegheny County 1975) (transfusion ordered over religious objection of Jehovah's Witness); *State Dep't of Human Servs. v. Northern*, 563 S.W.2d 197 (Tenn. Ct. App.) (amputation ordered for elderly woman), *appeal dismissed as moot*, 436 U.S. 923 (1978).

22. *Eichner v. Dillon*, 73 A.D.2d 431, 459, 426 N.Y.S.2d 517, 539 (1980); Note, *No-Code Orders vs. Resuscitation: The Decision to Withhold Life-Prolonging Treatment from the Terminally Ill*, 26 WAYNE L. REV. 139, 147 (1979) (as a matter of constitutional law, a competent adult who is incurably and terminally ill has the right, if he so chooses, not to resist death and to die with dignity).

sion 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 decision to refuse treatment, but by the failure to allow a competent human being the right of choice.²³

If a patient is competent, his or her right to accept or refuse treatment is unlimited in the abstract, whether based on the constitutional right of privacy or on the common law notions of bodily integrity.²⁴ This is not to say that the state maintains no interest in medical decisions. Rather, the state retains four fundamental interests: (1) preservation of life, (2) protection of the interests of innocent third parties (usually minor children), (3) prevention of suicide, and (4) preservation of the ethical integrity of the medical profession.²⁵ In the above discussion, the only interest which has been involved is the state's interest in the preservation of life. This interest, standing alone, does not confer absolute power on a state to intervene in private medical decisions.²⁶ Rather, the courts balance the personal interests of the patient with the state interests in preserving life. In the limited situation where the sole state interest is the preservation of life, personal decision-making necessarily prevails.²⁷

23. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 742, 370 N.E.2d 417, 426 (1977).

24. *Clarke*, *supra* note 2, at 821. See *Satz v. Perlmutter*, 362 So. 2d 160, 163 (Fla. Dist. Ct. App. 1978), *approved*, 379 So. 2d 359 (Fla. 1980); *Palm Springs Gen. Hosp., Inc. v. Martinez*, No. 71-12678 (Cir. Ct. Dade County, Fla., July 2, 1971); *Eichner v. Dillon*, 73 A.D.2d 431, 454, 426 N.Y.S.2d 517, 536 (1980) ("There exists a solid line of case authority recognizing the undeniable right of a terminally ill but competent individual to refuse medical care, even if it will inexorably result in his death.").

25. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 741, 370 N.E.2d 417, 425 (1977). These principles were derived from *In re President & Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964). See also *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *approved*, 379 So. 2d 359 (Fla. 1980).

26. This principle is not without its critics. Roddy, *The Karen Quinlan Case—A Constitutional Right to Die?*, 58 CHI. B. REC. 120 (1976).

27. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 741-42, 370 N.E.2d 417, 425-26 (1977). In emergency situations, courts will assume consent. See, e.g., *Kritzer v. Citron*, 101 Cal. App. 2d 33, 39, 224 P.2d 808, 811 (1950); *McGuire v. Rix*, 118 Neb. 434, 440, 225 N.W. 120, 123 (1929). To some extent the fourth amendment may provide protection from nonconsensual surgery to remove bullets. See *Bowden v. State*, 256 Ark. 820, 824, 510 S.W.2d 879, 881 (1974) (no surgery without search warrant); *Creamer v. State*, 229 Ga. 511, 518, 192 S.E.2d 350, 355 (1972) (surgery allowed if search warrant obtained); *State v. Overstreet*, 551 S.W.2d 621, 627-28 (Mo. 1977) (hearing required before surgery); *People v. Smith*, 80 Misc. 2d 210, 215, 362 N.Y.S.2d 909, 914 (Sup. Ct. 1974) (surgery prohibited by due process clause and fourth amendment); Note, *Nonconsensual Surgery: The Unkindest Cut of All*, 53 NOTRE DAME LAW. 291, 303 (1977) ("If it is medically determined that the suspect's operation would be major surgery, the search warrant should not issue.")

The general statement that competent adults have the right to decline medical treatment raises the question of how competence is determined. It is clear that determination of competency is a prerequisite to determining whether an individual has the right to decline treatment.²⁸ As noted above,²⁹ the mere rejection of medical treatment which will lead to death is not by itself incompetent behavior.³⁰ Nonetheless, certain behavior may indicate the incompetence which renders an individual incapable of asserting the right to decline medical treatment. For example, in *State Department of Human Services v. Northern*,³¹ the state of Tennessee petitioned for permission to perform an amputation for an elderly woman with a gangrenous leg. Contrary to the decisions in other states permitting elderly persons with gangrenous limbs to decline amputations,³² the *Northern* court determined that the woman was suffering from delusions regarding her feet because she thought that they were black from dirt rather than disease.³³ Having deemed the patient to be incompetent, the court was empowered to overcome her stated preference and grant the state's request. This decision is today somewhat of an anomaly.

At one time, courts were more willing to disallow the stated preferences of patients than is the case now.³⁴ For example, several courts have recently held that committed mental patients have the constitutional right to refuse psychotropic medication. In *Rogers v. Okin*,³⁵ the lower court stated,

The committed patient has a right to be . . . unwise—as long as the consequences of such error do not pose a danger of physical harm to himself, fellow patients or hospital staff. And so, while the state may have an obligation to make treatment available, and a legitimate interest in providing such treatment, a competent pa-

28. Clarke, *supra* note 2, at 808.

29. See notes 12-24 and accompanying text *supra*.

30. *In re Estate of Brooks*, 32 Ill. 2d 361, 372-73, 205 N.E.2d 435, 442 (1965); *Lane v. Candura*, 78 Mass. App. Ct. Adv. Sh. 588, 593, 376 N.E.2d 1232, 1235-36 (1978).

31. 563 S.W.2d 197 (Tenn. Ct. App.), *appeal dismissed as moot*, 436 U.S. 923 (1978).

32. *Lane v. Candura*, 78 Mass. App. Ct. Adv. Sh. 588, 376 N.E.2d 1232 (1978); *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (Morris County Ct. 1978); *In re Nemser*, 51 Misc. 2d 616, 273 N.Y.S.2d 624 (Sup. Ct. 1966).

33. 563 S.W.2d at 210. See also *In re Dell*, 1 Pa. D. & C.3d 655 (C.P. Allegheny County 1975) (ordering transfusion over objection of competent Jehovah's Witness on ground there is no right of self-destruction).

34. *In re Hospitalization of B.*, 156 N.J. Super. 231, 234, 383 A.2d 760, 762 (Law Div. 1977) ("The court finds the patient's refusal to take prolixin is not, however, based entirely on rational considerations but reflects delusional thinking."). See Comment, *Madness and Medicine: The Forcible Administration of Psychotropic Drugs*, 1980 WIS. L. REV. 497.

35. 478 F. Supp. 1342 (D. Mass. 1979), *rev'd in part*, 634 F.2d 650 (1st Cir. 1980).

tient has a fundamental right to decide to be left alone, absent an emergency situation.³⁶

In *Rennie v. Klein*,³⁷ another case regarding the rights of mental patients, a federal district court held explicitly that "the right to refuse treatment extends to mental patients in non-emergency circumstances."³⁸ Further, the court stated that "[t]he fact that the patient is dangerous in free society may give the state power to confine, but standing alone it does not give the power to treat involuntarily."³⁹ As a general rule, forcible medication is allowed only during emergencies⁴⁰ or if the patient has been declared incompetent by a court and a guardian has been appointed.⁴¹

The discussion thus far should not give the impression that individual choice is absolute. There are some significant exceptions to the basic principle that competent adults can elect to refuse necessary medical treatment. The principle situation involves decisions by adults who have major parental responsibilities.⁴² Courts will simply not leave young children destitute by allowing their parents to die.⁴³ The principle has been carried further to order treatment of a woman carrying a thirty-two-week-old fetus over her objection.⁴⁴

One court has refused to permit a twenty-four-year-old competent inmate to decline dialysis treatments for kidney failure which he needed to remain alive. In *Commissioner of Correction v. Myers*,⁴⁵ the court

36. *Id.* at 1367. Needless to say, this decision is not popular with mental health professionals. See, e.g., Applebaum & Gutheil, *The Boston State Hospital Case: "Involuntary Mind Control," the Constitution, and the "Right to Rot,"* 137 AM. J. PSYCH. 720 (1980).

37. 462 F. Supp. 1131 (D.N.J. 1978).

38. *Id.* at 1144.

39. *Id.* at 1145.

40. *Rogers v. Okin*, 478 F. Supp. at 1365.

41. *Id.* at 1364. See also *In re Boyd*, 403 A.2d 744, 752-53 (D.C. 1979); *In re Spring*, 79 Mass. App. Ct. Adv. Sh. 2469, 2474, 399 N.E.2d 493, 496 (1979), *modified*, 80 Mass. Adv. Sh. 1209, 405 N.E.2d 115 (1980) ("A patient's mental condition will in certain circumstances be a relevant factor in determining whether he would elect if competent to do so, to undergo an intrusive life-saving or life prolonging treatment."); *New York City Health & Hosps. Corp. v. Stein*, 70 Misc. 2d 944, 946, 335 N.Y.S.2d 461, 464 (Sup. Ct. 1972); *In re K.K.B.*, 609 P.2d 747, 750 (Okla. 1980). See generally Symonds, *Mental Patients' Rights to Refuse Drugs: Involuntary Medication As Cruel and Unusual Punishment*, 7 HASTINGS CONST. L.Q. 701 (1980); Comment, *supra* note 34.

42. *In re President & Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1008 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964).

43. See *Powell v. Columbian Presbyterian Medical Center*, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (Sup. Ct. 1965).

44. *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964).

45. 79 Mass. Adv. Sh. 2523, 399 N.E.2d 452 (1979). *Myers* involves significant intrusions from the treatment.

acknowledged the competence of the inmate and the right of persons on the street to decline medical treatment, but determined that "the State's interest in upholding orderly prison administration tips the balance in favor of authorizing treatment without consent."⁴⁶ *Myers* is an anomaly in light of the mental health cases cited earlier,⁴⁷ but a mitigating factor was that the inmate was attempting to manipulate the prison system by withholding consent to medical treatment until such time as he could obtain a more favorable security placement. The inmate had a practice of consenting eventually to medical treatment on his own before lapsing into a coma or otherwise creating a medical emergency.

Despite the inmate's manipulative intent, the *Myers* court should not have overridden the inmate's stated refusals of treatment. The case is inconsistent with the general body of law concerning consent to medical treatment, and particularly so with regard to cases involving patients in state custody (whether mental hospitals or prisons). It is difficult to reconcile the fact that an involuntarily committed mental patient is deemed able to refuse psychotropic medication prescribed for the purpose of assisting in his treatment, while an inmate cannot refuse consent to dialysis treatment which he understands is necessary to keep him alive. The *Myers* decision is particularly anomalous in light of consistent decisions and commentary that treatment is appropriate only with the consent of competent adults.⁴⁸

Although individual choice concerning treatment is nearly absolute, there are some other significant limitations on patient decision-making. The government retains the authority to regulate drugs on the market so that persons who want a particular form of treatment may not be able to obtain it legally. For example, laetrile is not approved for sale in the United States, and governmental efforts to prevent sale and distribution have been upheld even against constitutional privacy claims. Thus, individuals do not have an absolute right to choose a *particular* treatment.⁴⁹

intravenous medications, dialysis exacts a significant price . . . in return for saving . . . life. In spite of the fact that dialysis does not require the sacrifice of a limb or entail substantial pain, it is a relatively complex procedure, which requires considerable commitment and endurance from the patient who must undergo the treatment three times a week.

Id. at 2531, 399 N.E.2d at 457.

46. *Id.* at 2533, 399 N.E.2d at 458. The court cites *Jones v. North Carolina Prisoners' Union, Inc.*, 433 U.S. 119, 126 (1977), for support in giving deference to the views expressed by the Commissioner of Corrections. 79 Mass. Adv. Sh. at 2532, 399 N.E.2d at 457.

47. See notes 35-41 and accompanying text *supra*.

48. See notes 12-27 and accompanying text *supra*. See also *Liacos, supra* note 2.

49. *Rutherford v. United States*, 616 F.2d 455, 457 (10th Cir. 1980). See generally *United States v. Rutherford*, 442 U.S. 544 (1979); *People v. Privitera*, 23 Cal. 3d 697, 591 P.2d 919, 153 Cal. Rptr. 431 (1979) (sustaining anti-laetrile statutes against attack brought on privacy grounds).

Further, the law does not sanction active euthanasia or assisting another person in killing himself. Regardless of the motivation of a person who assists another in killing himself, it is still murder.⁵⁰ Finally, the government can require certain medical procedures such as inoculations to protect the public health.⁵¹

When only personal interests are involved, the right of individual choice is protected. One manner of protecting that free choice is through "living will" statutes⁵² which allow competent adults to specify in advance that they do not want extraordinary treatment. These statutes provide a procedural mechanism by which individual free choice can be expressed. They are consistent with the judicially established principle that competent adults should be able to choose for themselves whether to receive medical treatment.

IV. RIGHTS OF INCOMPETENT PATIENTS: WHO MAKES WHAT DECISIONS?

While the legal analysis for competent adults is relatively clear, the analysis becomes more complicated with regard to persons who are unable to consent to medical treatment. In such circumstances, it is apparent that other persons must be entrusted with the responsibility for the treatment decision. Much of the ongoing debate concerns identification of the ap-

50. See *People v. Roberts*, 211 Mich. 187, 195-98, 178 N.W. 690, 692-93 (1920) (husband who helped wife kill herself committed murder); *Turner v. State*, 119 Tenn. 663, 671, 108 S.W. 1139, 1141 (1908) ("Murder is no less murder because the homicide is committed at the desire of the victim. He who kills another upon his desire or command is, in the judgment of the law, as much a murderer as if he had done it merely of his own head."). See generally *Ufford*, *supra* note 8, at 237. Prosecutors are rarely successful obtaining convictions for mercy killing. *Id.* at 239.

51. *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (compulsory vaccination).

52. ARK. STAT. ANN. §§ 82-3801 to -3804 (Cum. Supp. 1979); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Cum. Supp. 1980); IDAHO CODE §§ 39-4501 to -4508 (Cum. Supp. 1980); KAN. STAT. ANN. §§ 65-28, 101-109 (Cum. Supp. 1980); NEV. REV. STAT. §§ 449.540-.690 (1977); N.M. STAT. ANN. §§ 244-7-1 to -11 (1978); N.C. GEN. STAT. §§ 90-320 to -321 (Cum. Supp. 1979); OR. REV. STAT. §§ 97.050-.090 (1977); TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon Cum. Supp. 1980-1981); WASH. REV. CODE ANN. §§ 70.122.010-.905 (Cum. Supp. 1981). See generally *Kutner, The Living Will: Coping With The Historical Event of Death*, 27 BAYLOR L. REV. 39 (1975); *Steinberg, The California Natural Death Act: A Failure to Provide for Adequate Patient Safeguards and Individual Autonomy*, 9 CONN. L. REV. 203 (1977); *Comment, supra* note 14, at 607-10; *Note, supra* note 5, at 576; *Note, The Right to Die: A Proposal for Natural Death Legislation*, 49 U. CIN. L. REV. 228 (1980); *Comment, The Kansas Natural Death Act*, 19 WASHBURN L.J. 519 (1980); *Comment, North Carolina's Natural Death Act: Confronting Death With Dignity*, 14 WAKE FOREST L. REV. 70 (1978).

propriate responsible party and whether the judicial system should be actively involved in decision-making.

The first case which focused attention on this matter was that of Karen Ann Quinlan,⁵³ a twenty-year-old woman who lapsed into a coma after apparently mixing drugs and alcohol. Ms. Quinlan was placed on a respirator, but showed no signs of improvement and remained in a vegetative state.⁵⁴ The Quinlans asked the treating physicians to remove the respirator, but they refused on the ground that she did not meet the legal definition of brain death.⁵⁵ The family then commenced a legal action asking that the father as legal guardian be given authority to terminate the life-support system. The trial court denied the petition on the ground that Ms. Quinlan did not meet the standard for brain death, and in view of convincing evidence that she could survive indefinitely on the respirator.⁵⁶

On appeal, the New Jersey Supreme Court reversed and granted the relief sought by the Quinlan family.⁵⁷ The court first determined that "the focal point of decision should be the prognosis as to reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of that biological vegetative existence to which Karen seems to be doomed."⁵⁸ The *Quinlan* court utilized the constitutional right of privacy as a means of protecting Karen from the highly intrusive effects of the respirator. The court noted, "Presumably . . . [the right of privacy] is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain circumstances."⁵⁹ The court recognized that the probability of Karen returning to cognitive life was nil, and therefore, determined that she need not suffer the continuous attachment to a respirator which offered no real hope for medical progress. The court concluded:

[N]o . . . compelling interest of the state could compel Karen to endure the unendurable, only to vegetate a few measurable months with no realistic possibility of returning to any semblance of cognitive or sapient life. We perceive no thread of logic distinguishing between such a choice on Karen's part and a similar choice which, under the evidence in this case, could be made by a

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

54. Vegetative state means that while there is some brain activity there is no evidence of higher cortical function. *Eichner v. Dillon*, 73 A.D.2d 431, 442, 426 N.Y.S.2d 517, 528 (1980).

55. 70 N.J. at 41-42, 355 A.2d at 664.

56. *Id.* at 26, 355 A.2d at 656.

57. *Id.* at 55, 355 A.2d at 671-72.

58. *Id.* at 51, 355 A.2d at 669.

59. *Id.* at 50, 355 A.2d at 667.

competent patient terminally ill, riddled by cancer and suffering great pain; such a patient would not be resuscitated or put on a respirator . . . and a *fortiorari* would not be kept *against his will* on a respirator.⁶⁰

The most important aspect of the *Quinlan* decision is its procedural result. The court left the decision concerning termination of the respirator with the family and treating physicians. The court advocated a three-tier procedure for termination:

Upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued they shall consult with the hospital "Ethics Committee" or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefore on the part of any participant, whether guardian, physician, hospital, or others.⁶¹

In its decision, the *Quinlan* court made two interesting observations. First, it placed great emphasis on the family's knowledge of and concern for Karen.⁶² Second, the court limited the involvement of the judiciary, in one sense, in decisions not to treat incompetent patients.⁶³ The *Quinlan* decision permits the termination of life-prolonging treatment for the incompetent patient without court involvement if the guardian, physician, and ethics committee concur.⁶⁴ Thus, one impact of the *Quinlan* decision is to eliminate the necessity for the substantial formalities of court pro-

60. *Id.* at 39, 355 A.2d at 663.

61. *Id.* at 55, 355 A.2d at 671. By providing immunity, the *Quinlan* court satisfied most of the physicians' problems with the case. See generally Hirsch & Donovan, *supra* note 2; Note, *The Termination of Life-Support Measures and the Law of Murder*, 41 MOD. L. REV. 423 (1978); Note, *The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State*, 51 N.Y.U.L. REV. 285 (1976); Note, *In re Quinlan: One Court's Answer to the Problem of Death with Dignity*, 34 WASH. & LEE L. REV. 285, 305-07 (1977).

62. 70 N.J. at 55, 355 A.2d at 671. See Note, *In re Quinlan: One Court's Answer to the Problem of Death with Dignity*, 34 WASH. & LEE L. REV. 285, 302-03 (1977) ("This essentially moral judgment that the family unit constitutes the most appropriate forum for decision should ensure that, in most cases, the guardian will have the patient's best interests at heart.").

63. 70 N.J. at 55, 355 A.2d at 671. For a similar result, see *Dockery v. Dockery*, 559 S.W.2d 952, 954 (Tenn. Ct. App. 1979). See generally McKenney, *Death and Dying in Tennessee*, 7 MEM. ST. L. REV. 503 (1977).

64. Cantor, *supra* note 2.

ceedings in most cases, assuming good faith on the part of the family and physicians.⁶⁵

A somewhat different procedural approach was taken by the Supreme Judicial Court of Massachusetts in *Superintendent of Belchertown State School v. Saikewicz*.⁶⁶ Mr. Saikewicz was an incompetent sixty-seven-year-old man suffering from acute monocytic leukemia, an incurable disease. The evidence established that chemotherapy treatments might have prolonged his life for a period of between two and thirteen months, but would also pose severe side effects.⁶⁷ The Massachusetts court concluded that treatment should be withheld.

The court began its analysis by examining the rights of competent persons to decline life-prolonging medical treatments. As described above, competent adults generally have such a right to refuse treatment. The *Saikewicz* court concluded that "the substantive rights of the competent and the incompetent person are the same in regard to the right to decline potentially life-prolonging treatment."⁶⁸ The court set for itself the duty of determining "the incompetent person's actual interests and preferences."⁶⁹ Because of the patient's incompetency, however, the court recognized the imprecision in actually determining the wants and desires of the patient. Rather, the court sought to establish a mechanism to insure the most appropriate decision.⁷⁰

In making the decision for the patient, basic decency dictates that a court should not devalue the life of the patient merely because the patient is incompetent or retarded. The *Saikewicz* court explicitly rejected consideration of "quality of life" in making its decision.⁷¹ As such, the decision to treat or terminate turns on an analysis of the medical evidence. The determination of the best interests of the patient is governed by the medical evidence concerning probability of recovery, potential side ef-

65. Note, *supra* note 62, at 307. One supporter of the *Quinlan* formulation has written, "By allocating an important role to a patient's conscientious guardian, the court wisely resisted suggestions that decision-making authority be lodged exclusively in medical hands or in the courts." Cantor, *supra* note 2, at 244. See Note, *supra* note 22, at 168.

66. 373 Mass. 728, 370 N.E.2d 417 (1977).

67. *Id.* at 732, 370 N.E.2d at 420-21.

68. *Id.* at 747, 370 N.E.2d at 428. "To protect the incompetent person within its power, the State must recognize the dignity and worth of such a person and afford to that person the same panoply of rights and choices it recognizes in incompetent persons." *Id.* at 746, 370 N.E.2d at 428.

69. *Id.* at 759, 370 N.E.2d at 431.

70. *Id.* The court styled its formulation "substituted judgment" after *Ex parte Whitbread in re Hinde*, 35 Eng. Rep. 878 (Ch. 1816). See *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. 1969) (use of substituted judgment in transplant case).

71. 373 Mass. at 758, 370 N.E.2d at 430.

fects, and the nature of the treatment.⁷² As the author has noted in another article:

[I]t is not a subjective judgment of the quality of another person's life—whether mentally competent or retarded—that is relevant to a decision to decline treatment. Rather, it is the objective consideration of observable changes, caused by . . . [the treatment], in the character of each patient's life that should be a factor in the decision whether to treat.⁷³

The *Saikewicz* court permitted chemotherapy treatments to be withheld because the state interest in the preservation of life was overcome by the patient's individual privacy interest.⁷⁴ Further, by allowing the disease to run its course, the patient was not committing suicide since there was no specific intent to induce death.⁷⁵ Rather, the natural processes were allowed to run their course.

In the analysis of Mr. Saikewicz's condition and the factors which enter into a decision to withhold treatment, the Massachusetts court was on strong ground and its result has been generally applauded.⁷⁶ Nevertheless, its strong rejection of the hospital committee approach adopted in *Quinlan* made the *Saikewicz* decision highly controversial. The court asserted:

We take a dim view of any attempt to shift the ultimate decision-making responsibilities away from the duly established courts of proper jurisdiction to any committee, panel or group, ad hoc or permanent. Thus, we reject the approach adopted by the New

72. Brant, *Beyond Quinlan and Saikewicz: Developing Legal Standards for Decisions Not to Treat Terminally Ill Patients*, 21 BOSTON B.J. 5, 11 (June 1977). Professor Annas takes a somewhat different view:

The issue in the *Saikewicz* case, on the other hand, was much more complex. It was not a question of medical prognosis, but of whether to use an accepted medical treatment on a mentally retarded individual whose life could be sustained for an indefinite period of time. The court determined that such a question can only be answered on the basis of "substituted judgment," and since this is a legal standard, a court hearing is required.

Annas, *supra* note 2, at 382.

73. Brant, *supra* note 2, at 969.

74. 373 Mass. at 759, 370 N.E.2d at 431.

75. *Id.* at 743 n.11, 370 N.E.2d at 426 n.11. "[T]he refusal of medical treatment is not suicide if the patient lacks specific intent and ultimately dies from natural causes." Note, *supra* note 22, at 148. See Note, *The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State*, 51 N.Y.U.L. REV. 285, 309 (1976).

76. Even Dr. Arnold Relman, a severe critic of the decision, has concluded: "There was much in the *Saikewicz* opinion to be applauded. There was the forthright statement that incompetent patients have the same rights as those who are competent, and the assertion that these rights include the privilege of declining medical treatment under certain circumstances." Relman, *supra* note 2, at 234.

Jersey Supreme Court in the *Quinlan* case of entrusting the decision whether to continue artificial life support to the patient's guardian, family, attending doctors, and hospital "ethics committee."⁷⁷

The *Saikewicz* court recognized the storm of controversy its strong judicial approach would generate from the medical profession and attempted to explain its rationale.

We do not view the judicial resolution of this most difficult and awesome question—whether potentially life-prolonging treatment should be withheld from a person incapable of making his own decision—as constituting a "gratuitous encroachment" on the domain of medical expertise. Rather, such questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is our responsibility and that of the lower court, and is not to be entrusted to any other group purporting to represent the "morality and conscience of our society," no matter how highly motivated or impressively constituted.⁷⁸

The court was correct in anticipating the criticism from members of the medical profession who assert that decisions to withhold medical treatment should be made quietly without judicial or other scrutiny.⁷⁹ More fundamentally, the ability of the courts to make these decisions has been challenged. As one critic has asserted, "The courts cannot be expected to exercise sound judgment when moral issues are so intertwined with complex medical consideration nor can they act promptly and flexibly enough to meet the rapidly changing needs of clinical situations."⁸⁰ Further, critics have alleged that the impact of *Saikewicz* will be to flood the courts with more cases than could be handled.⁸¹

77. 373 Mass. at 758, 370 N.E.2d at 434. See also *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1342 (Del. 1980) (discussing the differences between the *Quinlan* procedure and the *Spring-Saikewicz* approach).

78. 373 Mass. at 759, 370 N.E.2d at 435.

79. Relman, *The Saikewicz Decision: Judges as Physicians*, 298 NEW ENG. J. MED. 508 (1978).

80. Relman, *supra* note 2, at 240.

81. "The number of potential *Saikewicz* cases is huge. That so few have reached the courts thus far simply indicates the widespread confusion following in the wake of the original decision, which has led to the avoidance of difficult decisions or, more likely, to 'closet' decisions, without discussion or legal approval." Relman, *supra* note 2, at 241. One commentator wrote that the Massachusetts Supreme Judicial Court "really did mean that all decisions on either removal of life-support systems or continuation of life-extending therapy in otherwise dying patients who are incompetent . . . must go before a probate court for approval." Curran, *The Saikewicz Decision*, 298 NEW ENG. J. MED. 499, 500 (1978).

The *Saikewicz* opinion, as explained by a court member,⁸² is based largely on a fundamental notion of the role and authority of courts in this society as the resolvers of difficult moral problems. The major strength of the *Saikewicz* opinion, as Justice Liacos argues, is its recognition of the right of incompetent individuals to have their interests protected and the primacy of court involvement in making the substituted-judgment decisions.⁸³ In *In re Spring*,⁸⁴ the Massachusetts Supreme Judicial Court recently reaffirmed its position that "when a court is properly presented with the legal question whether treatment may be withheld, it must decide that question and not delegate it to some private person or group."⁸⁵

A central argument for court involvement derives from the nature of the decisions to be made. In deciding whether to withhold life-prolonging treatment, there is no right or wrong answer and the problems to be decided are complex and varied.⁸⁶ Family members are often not in the best position to make an unbiased decision because of their economic self-interest, emotional turmoil, and personal feelings for the loved one.⁸⁷ The fact-finding ability of a court and its status as a neutral arbiter assures that all viewpoints are expressed and considered.

The medical profession asks too much when it seeks the unlimited right to make termination of treatment decisions without judicial scrutiny.⁸⁸ The determination of what Joseph Saikewicz would have

82. Liacos, *supra* note 2. See also Note, *Family Law—Guardians of Incompetent Persons Can Refuse Life-Prolonging Treatment for Their Wards*, 12 SUFFOLK U.L. REV. 1039, 1055 (1978) ("The procedures delineated by the *Saikewicz* court, unlike the prognosis committees in *Quinlan*, confer on the vulnerable incompetent person the benefit of judicial expertise in performing the traditional balancing tests and the protection of impartiality and due process of law.").

83. Liacos, *supra* note 2, at 6-7. See also *Constitutional Law—Right of Privacy—Qualified Right to Refuse Medical Treatment May Be Asserted for Incompetent under Doctrine of Substitute Judgment*, 27 EMORY L.J. 425, 450 (1978) ("The major strength of the case, however, lies in its departure from *Quinlan*. Rather than shifting responsibility for treatment decisions involving incompetents to families, physicians, and hospital ethics committees, the *Saikewicz* court properly places full authority for such decisions with the courts."). See generally *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334 (Del. 1980).

84. 80 Mass. Adv. Sh. 1209, 405 N.E.2d 115 (1980).

85. *Id.* at 1219, 405 N.E.2d at 122. See also Note, *supra* note 82, at 1049.

86. See Kindregan, *The Court as Forum for Life and Death Decisions: Reflections on Procedures for Substituted Consent*, 11 SUFFOLK U.L. REV. 919, 932 (1977).

87. *Id.* at 933.

88. Baron, *Assuring "Detached but Passionate Investigation and Decision": The Role of Guardians Ad Litem in Saikewicz-Type Cases*, 4 AM. J.L. & MED. 111, 112 (1978).

wanted had he been competent is a judgment which a court is uniquely suited to make.⁸⁹ Without judicial scrutiny, it is impossible to determine whether family members or physicians are acting in accordance with appropriate standards in making a decision which will terminate the life of another. Although the judicial process is somewhat awkward for parties who must confront a formal mechanism at a time of great emotional stress, the courts should make the judgment in the most difficult of withholding of treatment situations because of their neutrality.

In order for the court to make an appropriate decision, the issues must be clearly framed and the facts adequately presented. Because such decisions have great import for the bench and bar, it is imperative that both become knowledgeable in the legal, medical, and social issues inherent in decisions to withhold treatment from incompetents.

Unlike *Quinlan*, the *Saikewicz* decision did not explicitly provide immunity for physicians. As a practical matter, however, *Saikewicz* also offers the potential for immunity since court approval of termination will certainly create an acceptable standard of patient care.⁹⁰ Thus, despite criticism to the contrary, the case provides a means for physicians to assure that their actions in withholding treatment are protected from liability.⁹¹

The *Saikewicz* and *Quinlan* cases stand as the two principal precedents concerning decisions to withhold medical treatment from incompetent patients. Both recognize that the constitutional right of privacy protects incompetent patients from having intrusive treatments imposed on them when those treatments offer little more than palliation.⁹² As described earlier, *Saikewicz* and *Quinlan* differ sharply on the manner in which termination decisions may be made, the former requiring court approval and the latter permitting family and treating physicians to make the decision without court involvement.

The *Saikewicz* decision has led to some confusion concerning precisely which cases have to be brought to court. In *In re Dinnerstein*,⁹³ the Massachusetts Appeals Court considered whether decisions to place "do not resuscitate orders" into a medical chart required prior judicial ap-

89. See McKenney, *supra* note 63, at 535.

90. Obviously, state legislatures can provide such immunity if they choose to do so. Several courts have urged legislatures to act. See *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1346 (Del. 1980); *Satz v. Perlmutter*, 379 So. 2d 359, 360 (Fla. 1980); *Eichner v. Dillon*, 73 A.D.2d 431, 461, 426 N.Y.S.2d 517, 534 (1980).

91. See Annas, *The Incompetent's Right to Die: The Case of Joseph Saikewicz*, 8 HASTINGS CENTER REP. 21 (Feb. 1978); Note, *supra* note 22, at 162.

92. See *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1347 (Del. 1980); Recent Developments, *Constitutional Law—Due Process—Fundamental Right to Bodily Integrity—Protective Services for Elderly Persons*, 46 TENN. L. REV. 425, 430 (1979).

93. 78 Mass. App. Ct. Adv. Sh. 736, 380 N.E.2d 134 (1978).

proval. The case involved an elderly woman suffering from Alzheimer's disease, an incurable condition which causes progressive deterioration of neurological functions. The physicians intended to leave instructions dictating that at such time as the patient lapsed into cardiac or pulmonary failure, resuscitation efforts should not be attempted. The *Dinnerstein* court limited *Saikewicz* to its facts and concluded that court involvement was required only when the proposed treatment, if administered, would offer some possibility of temporary cure or remission of the disease.⁹⁴

Dinnerstein does not stand as a direct attack on the principle of court involvement in termination of treatment decisions enunciated in *Saikewicz*. Rather, it addressed a somewhat different issue and recognized that there must be a controversy before the judicial process can be invoked.⁹⁵ In *Saikewicz*, the controversy was whether the benefits derived from chemotherapy were sufficiently positive to outweigh the expected severe side effects.⁹⁶ *Dinnerstein* presents an entirely different treatment situation. The patient in *Dinnerstein* was suffering from a progressive disease which could not be stopped or remitted through aggressive treatment. Resuscitative efforts offered only a temporary arresting of the process of dying, and curative intent was lacking. Therefore, the judiciary had nothing to decide and the case properly belonged within the province of the medical profession.⁹⁷ When persons are terminally ill and no medical

94. *Id.* at 742, 380 N.E.2d at 135-38.

95. See Glantz, *Post-Saikewicz Judicial Actions Clarify the Rights of Patients and Families*, 6 MEDICOLEGAL NEWS 10 (Winter 1978).

96. Liacos, *supra* note 2, at 6. The medical profession generally approves of *Dinnerstein*. See Flaherty, *The Nurse and Orders Not to Resuscitate*, 7 HASTINGS CENTER REP. 27 (Aug. 1977); Schram, Kane & Roble, "No Code" Orders: Clarification in the Aftermath of *Saikewicz*, 299 NEW ENG. J. MED. 875 (1978). The executive director of one large Boston hospital took the position that *Dinnerstein* "effectively removed from the courts the medical decision-making process in virtually all circumstances in which heroic measures might ultimately be used to sustain life." Sanders, *Medical Technology: Who's To Say When We've Had Enough*, 52 HOSPITALS 66, 68 (Nov. 16, 1978).

Many hospitals are developing standards for "do not resuscitate" orders. See Pontikes, *Optimum Care for Hopelessly Ill Patients*, 295 NEW ENG. J. MED. 362 (1978); Rabkin, Gillerman & Rice, *Orders Not to Resuscitate*, 295 NEW ENG. J. MED. 363 (1978). National medical bodies are also developing policy statements. "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." *Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC)*, 227 J.A.M.A. 837, 864 (1974).

97. *Dinnerstein* does not foreclose competent adults from choosing "do not resuscitate" orders. See Note, *supra* note 22, at 160-61. Similarly, *Dinnerstein* does not require physicians to enter no-code orders. See Clarke, *supra* note 2, at 832.

intervention offers any hope of even slowing down the course of the disease, physicians together with family can make a decision to withhold active treatment measures. This is not to say that they can engage in active euthanasia, but merely that court involvement is restricted to situations where some controversy exists.

The law concerning when court involvement is necessary is further clarified by two recent decisions. In *In re Spring*,⁹⁸ the Massachusetts Supreme Judicial Court reaffirmed the *Saikewicz* principle that the courts are the ultimate authority for making medical treatment decisions for incompetents.⁹⁹ *Spring* involved a seventy-eight-year-old man suffering from kidney failure. While competent, he had consented to dialysis treatments. In the interim, he had become mentally incompetent, and his family petitioned for permission to terminate the dialysis treatment. The lower appellate court, fashioning a procedure based apparently on *Dinnerstein*¹⁰⁰ and *Quinlan*,¹⁰¹ allowed the decision to withhold treatment to be made by the family and the treating physicians.¹⁰² The appeals court gave great deference to the close family relationship and recognized the toll that formal legal proceedings appeared to be taking on the family.¹⁰³

Nonetheless, the Massachusetts Supreme Judicial Court reiterated its belief that these decisions belong in court and modified the decision. This was true even though the treatment in this case had not caused a remission of the disease nor given any hope of cure.¹⁰⁴ The court, however, left considerable confusion as to the future application of the *Saikewicz* doctrine by failing to clearly spell out when judicial involvement is required. The court merely set out situations in which judicial involvement might be contemplated.

The cases and other materials we have cited suggest a variety of circumstances to be taken into account in deciding whether there should be an application for a prior court order with respect to medical treatment of an incompetent patient. Among them are at least the following: the extent of impairment of the patient's mental faculties, whether the patient is in the custody of a State institution, the prognosis without the proposed treatment, the prognosis with the proposed treatment, the complexity, risk, and novelty of the proposed treatment, its possible side effects, the patient's level of understanding and probable reaction, the urgency of decision,

98. 80 Mass. Adv. Sh. 1209, 405 N.E.2d 115 (1980).

99. *Id.* at 1216-17, 405 N.E.2d at 119.

100. 78 Mass. App. Ct. Adv. Sh. 736, 380 N.E.2d 134 (1978).

101. 70 N.J. 10, 355 A.2d. 647, *cert. denied*, 429 U.S. 922 (1976).

102. 79 Mass. App. Ct. Adv. Sh. 2469, 2475, 399 N.E.2d 493, 502-03 (1979).

103. *Id.* at 2473, 399 N.E.2d at 499.

104. 80 Mass. Adv. Sh. at 1216-17, 405 N.E.2d at 119. The *Spring* court did indicate its belief that *Dinnerstein* was consistent with *Saikewicz*. *Id.* at 1215, 405 N.E.2d at 118.

the consent of the patient, spouse, or guardian, the good faith of those who participate in the decision, the clarity of the professional opinion as to what is good medical practice, the interests of third parties, and the administrative requirements of any institution involved.¹⁰⁵

All of these factors may well affect the outcome of any court case. Unfortunately, the *Spring* court did not provide sufficient guidance for attorneys to know how to balance the various competing interests in order to determine whether court involvement is necessary in a particular situation. Generally, court involvement is necessary when life-prolonging or life-saving treatment is available but withheld, and the treatment, if applied, offers some benefit as well as some significant detriment such as side effects. Certain factors listed by the court, such as whether the patient is a ward of the state, provide added impetus for judicial involvement. Since the Massachusetts Supreme Judicial Court did not spell out any detriment which would occur should court involvement not be sought, however, the net result is likely to be that fewer cases end up in court. The court suggested that criminal liability was unlikely for any physician acting in good faith¹⁰⁶ but did not provide immunity regardless of whether court proceedings were sought.

Spring is confusing for another reason. The record contained testimony that Mr. Spring had been an active outdoorsman before he became ill. He had also consented to dialysis for his failed kidneys before he began to suffer mental deterioration.¹⁰⁷ The Massachusetts Supreme Judicial Court, although requiring that a court make the decision, affirmed the lower court's judgment that the decision to terminate treatment was proper. This was done even though there was testimony that if the dialysis were terminated, Mr. Spring would need to receive pain-killing medication until death.¹⁰⁸

Given the major concern expressed by the court in *Saikewicz*¹⁰⁹ that medical considerations predominate and that quality of life factors not enter into decisions to withhold treatment, the *Spring* decision allowing withholding of dialysis treatment is difficult to understand. It hardly seems in Mr. Spring's best medical interests to die a painful death as a result of the dialysis being withdrawn.¹¹⁰ When a court is asked to substitute its judgment for that of the incompetent, *Saikewicz* dictates that the medical evidence concerning relative success of the treatment versus any

105. *Id.* at 1216-17, 405 N.E.2d at 120-21.

106. *Id.* at 1217, 405 N.E.2d at 122.

107. 79 Mass. App. Ct. Adv. Sh. at 2469-70, 399 N.E.2d at 495-96.

108. 80 Mass. Adv. Sh. at 1212, 405 N.E.2d at 116.

109. 373 Mass. 728, 370 N.E.2d 417 (1979).

110. Mr. Spring later died without the treatment having been stopped. See Goodman, *Who Lives? Who Dies? Who Decides?*, Wash. Post, Feb. 5, 1980, at A17, col. 2; Knox, *Spring Case: New "Competency" Line*, Boston Globe, Feb. 5,

deleterious consequences be weighed without regard to the quality of the life of the incompetent person if treated.¹¹¹ Here the prognosis with treatment was for a normal lifespan, and there was no evidence concerning side effects or other negative consequences of the treatment.¹¹² Therefore, although the *Spring* decision appears to be procedurally correct in reaffirming the *Saikewicz* principle of court involvement, the decision appears to depart from *Saikewicz* in failing to take as careful an examination of the medical evidence as *Saikewicz* seems to require.

The decision in *Spring* may be contrasted with that of the Appellate Division of the Supreme Court of New York in the case of *Eichner v. Dillon*.¹¹³ The issue in *Eichner* was whether Brother Fox, an eighty-three-year-old priest in a chronically vegetative state, should remain on a respirator. The *Eichner* court, following the *Saikewicz* model and recognizing the need for judicial involvement to assure uniformity of decision-making,¹¹⁴ concluded, "We agree with the *Saikewicz* court that the neutral presence of the law is necessary to weigh these factors, and, thus, judicial intervention is required before any life-support system can be withdrawn."¹¹⁵ The court recognized the interests of the medical profession and discussed the suspicion of medical personnel toward judicial involvement in medical decision-making, but nonetheless determined that the balance between the prerogatives of the medical profession and the public interest in enlightened termination decisions favored significant judicial involvement in the decision-making process.¹¹⁶

111. 373 Mass. at 756-58, 370 N.E.2d at 424-25.

112. 80 Mass. Adv. Sh. at 1215, 405 N.E.2d at 116.

113. 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980). *Eichner* has been followed in *In re Storar*, ___ Misc. 2d ___, ___, 433 N.Y.S.2d 388, 392-93 (Sup. Ct.), *aff'd*, ___ A.D.2d ___, 434 N.Y.S.2d 46 (1980) (allowing termination of transfusions to a profoundly retarded child dying of bladder cancer). *Storar* and *Eichner* have been consolidated and are pending before the New York Court of Appeals.

114. 73 A.D.2d at 472-73, 426 N.Y.S.2d at 549. The trial court, following the *Quinlan* model, allowed the Reverend Eichner to act as the committee (or guardian) for his priestly colleague, Brother Fox. *In re Eichner*, 102 Misc. 2d 184, 212-13, 423 N.Y.S.2d 580, 604 (Sup. Ct. 1979), *modified*, *Eichner v. Dillon*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980). *See also* *Leach v. Akron Gen. Medical Center*, No. C80-10-20 (Ct. C.P. Ohio Dec. 18, 1980) (allowing termination of respirator).

115. 73 A.D.2d at 475, 426 N.Y.S.2d at 550.

116. *Id.* at 474-76, 426 N.Y.S.2d at 549-50. The court stated:

Certainly, this bespeaks no distrust of the good faith or competence of the physician for courts inevitably must trust the doctor's judgment as to medical prognosis. Rather, our decision recognizes that the societal interests to be safeguarded are so great that the courts have no choice but to intervene and to examine each case on an *individual*, patient-to-patient basis.

Id. at 475, 426 N.Y.S.2d at 550.

The *Eichner* decision is significant for another reason. Brother Fox was a member of a religious community which discussed the pros and cons of maintaining life-support systems during the pendency of the Karen Quinlan case.¹¹⁷ Immediately before he entered the hospital, while still lucid, Brother Fox expressed the view that should he become incompetent, he did not wish to remain on a respirator. The *Eichner* court believed that his views were entitled to great weight since they were given with the realistic expectation that he might become incompetent to withhold consent at some future date.¹¹⁸ The court, however, did not impose a requirement that such an expression of opinion be made before it would uphold a decision to withhold treatment. The *Eichner* court recognized, as did the *Saikewicz* court, that the substituted judgment decision might well favor a peaceful death rather than the maintenance of intrusive treatment, offering no real promise for improvement.¹¹⁹

Finally, the New York court specifically granted immunity to medical personnel if the court procedures it outlined were followed.¹²⁰ In granting immunity, the court followed the lead not of *Saikewicz* but of *Quinlan*.¹²¹

The subject area of withholding medical treatment for the terminally ill incompetent adult is the most controversial of the withholding of treatment categories.¹²² While there is general agreement that incompetent pa-

117. Brother Fox was in a chronically vegetative state similar to Karen Quinlan's; he possessed "no significant cognitive functions," although he did exhibit "some primitive cerebral reflexes." *Id.* at 442, 426 N.Y.S.2d at 529.

118. *Id.* at 445, 426 N.Y.S.2d at 547.

119. The lower court in *Spring* made the same point:

An expression of opinion by the patient when competent would obviously be of great assistance, especially where the expression indicates a contemplation or understanding of the circumstances later obtaining; but the right secured by the *Saikewicz* case is not conditioned on the patient's having had the presence of mind to formulate such an expression of his wishes when competent.

79 Mass. App. Ct. Adv. Sh. at 2474, 399 N.E.2d at 498.

120. 73 A.D.2d at 475, 426 N.Y.S.2d at 550.

121. *Saikewicz* was silent on the issue of immunity, but *Quinlan* specifically granted immunity to the guardian, treating physicians, and the ethics committee. 70 N.J. at 51, 355 A.2d at 669. The Massachusetts Supreme Judicial Court hinted of immunity at least from criminal prosecution in *In re Spring*, 80 Mass. Adv. Sh. 1209, 1216, 405 N.E.2d 115, 121 (1980).

122. The impact of a jurisprudence which allows courts to authorize the death of some patients has been hotly debated. Paul Ramsey has argued that no moral society can permit itself to choose nontreatment or it will rapidly sanction active euthanasia. See generally P. RAMSEY, ETHICS AT THE EDGES OF LIFE (1978). I have argued elsewhere that Ramsey's concern about the morality of abortion overwhelms his analysis of right to die issues. Brant, *Book Review*, 19 J. FAM. L. 137 (1980-1981). Other philosophers are more comfortable with the role of law in attempting to define the parameters of life and death matters. See generally R. VEATCH, DEATH, DYING, AND THE BIOLOGICAL REVOLUTION

(1976). Finally, Robert Brustein, utilizing psychoanalytic theory, has argued that

tients should not always be forced to endure therapy which offers little hope for cure or remission, there is, as described here, considerable debate concerning the appropriate mechanism for obtaining a proper decision. The medical profession has consistently taken the position that such decisions should best be made privately as decisions between physicians and family.¹²³ This position has been harshly criticized by supporters of the view that the courts are the only body which can assure "detached but passionate investigation."¹²⁴

In light of *Saikewicz*, *Spring*, and *Eichner*, it appears that the courts are going to assert their role in deciding right to treatment issues. These cases indicate that decisions to withhold life-prolonging or life-saving medical treatment from an incompetent patient must be brought to court if the proposed treatment offers some probability of obtaining an objective improvement in the patient's condition but, because of probable side effects or other expected negative consequences, the treating physicians or the family do not wish the treatment to be commenced or continued. In such situations, the court should appoint a guardian ad litem to represent the interests of the patient, and that guardian should then marshal all available arguments in favor of the treatment which the petitioners are seeking to terminate or withhold.¹²⁵

In order for the judicial model to be successful, it will be incumbent on the judges in the probate courts or other courts where jurisdiction for these matters lie to develop procedures so that the cases may be handled expeditiously. The courts will need to develop lists of experienced attorneys able to act as counsel and guardians ad litem, and judges themselves will need to develop an expertise such that they are able to comprehend the often complicated medical testimony which will be presented. Further, since these cases will often arise in contexts requiring speedy decision-

neither patient nor judge nor physician should have ultimate decision-making authority in these matters. Decisions should emerge from a consensus among the participants. R. BURT, *TAKING CARE OF STRANGERS* 144-74 (1979). Burt's suggestions generally have not been well received. See Book Note, 93 *HARV. L. REV.* 1608 (1980).

123. Relman, *supra* note 2; Relman, *supra* note 79.

124. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 759, 370 N.E.2d 417, 435 (1977). See Baron, *Assuring "Detached but Passionate Investigation and Decision": The Role of Guardians Ad Litem in Saikewicz-Type Cases*, 4 *AM. J.L. & MED.* 111 (1978). Professor Baron has labeled the view that physicians should make the decisions, "medical paternalism." Baron, *Medical Paternalism and the Rule of Law: A Reply to Dr. Relman*, 4 *AM. J.L. & MED.* 337 (1979). The view that such decisions always belong in court has been called "legal imperialism." Buchanan, *Medical Paternalism or Legal Imperialism: Not the Only Alternatives for Handling Saikewicz-Type Cases*, 5 *AM. J.L. & MED.* 97 (1979).

125. See Baron, *Assuring "Detached but Passionate Investigation and Decision": The Role of Guardians Ad Litem in Saikewicz-Type Cases*, 4 *AM. J.L. & MED.* 111 (1978).

making, the courts should create mechanisms such as "hotlines" to insure that a judge is available outside of normal working hours.¹²⁶

The type of judicial mechanism described above is necessary only for decisions to withhold treatment when there is some doubt as to the efficacy of the proposed treatment. In instances where treatment is clearly warranted, these procedures are not required, although the growing recognition of the rights of incompetent patients suggests the need for institutions to obtain guardians for persons incompetent to consent in order that valid consent be obtained in every case.¹²⁷

Contrary to the assertions of many representatives of the medical profession, involvement of the judiciary in decisions to withhold medical treatment is not an infringement upon the prerogatives of the medical profession. Rather, it is a recognition that difficult decisions involving conflicting rights be made by judges who are selected for that purpose. Certainly, no one can say that the mere wearing of a black robe grants a person special expertise to make life and death decisions; indeed, the magnitude of the decisions requires that judges train themselves specially for the task. Nonetheless, the growth of a body of precedent should permit a rational development in the process of making substituted judgment decisions for incompetent patients.

V. THE RIGHTS OF CHILDREN TO BE TREATED WHEN THEIR PARENTS REFUSE TO CONSENT

Many of the early cases regarding refusal of medical treatment involved Jehovah's Witnesses who declined blood transfusions on religious grounds. From the early cases, basic principles emerged which have been utilized to decide the most recent cases. As described earlier, competent adults could refuse blood transfusions for themselves in most circumstances, even though the decision to refuse medical treatment meant probable death.¹²⁸ The major exception to this principle arose when the adult had responsibility for the care of a young child¹²⁹ or was pregnant,¹³⁰

126. I explain in more detail my proposal for judicial response in Brant, *Commitment and Competency*, in E. DOUDERA & J. SWAZEY, *THE RIGHT TO REFUSE TREATMENT* (to be published).

127. See *Rogers v. Okin*, 478 F. Supp. 1342, 1368 (D. Mass. 1979) (incarcerated mental patients not under guardianship could refuse psychotropic medication), *rev'd in part*, 634 F.2d 650 (1st Cir. 1980).

128. See, e.g., *In re Estate of Brooks*, 32 Ill. 2d 361, 372-73, 205 N.E.2d 435, 442 (1965); *In re Osborne*, 294 A.2d 372, 373 (D.C. 1972); *In re Melideo*, 88 Misc. 2d 974, 975, 390 N.Y.S.2d 523, 524 (Sup. Ct. 1976).

129. *In re President & Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1008 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964); *Powell v. Columbian Presbyterian Medical Center*, 49 Misc. 2d 215, 215, 267 N.Y.S.2d 450, 451 (Sup. Ct. 1965) (mother of young children ordered to receive transfusions even though Jehovah's Witness).

130. *Raleigh v. University of Missouri School of Law Scholarship Repository*, 429 F.2d 421, 422 (8th Cir. 1970) (mother of young child ordered to receive transfusions even though Jehovah's Witness).

in which case the courts decreed that the responsibility to care for the child (born or unborn) outweighed the competent adult's right to refuse treatment.¹³¹ The exception applied even though the parents were seeking to exercise first amendment rights or religious practice in their decision to refuse the transfusions.¹³²

The Jehovah's Witnesses cases have also presented situations where parents (or legal guardians) have sought to refuse blood transfusions on behalf of other children (or wards). Here the courts have uniformly ordered the transfusions, declaring that the children have independent rights to life which cannot be asserted by their parents.¹³³

Notwithstanding the holdings in the Jehovah's Witnesses cases, it is clear that parents do have the right, in most cases an absolute right, to make fundamental decisions with regard to their children including decisions concerning education and lifestyle.¹³⁴ As the United States Supreme Court has stated, "[I]t is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder."¹³⁵

Nevertheless, parental decision-making with regard to children is not absolute. Parents hold children as if in a trust, and when that trust is broken the state has a responsibility to protect the children from the ac-

201 A.2d 537 (competent adult woman Jehovah's Witness could not refuse blood transfusion because of duties to protect her 32-week-old fetus), *cert. denied*, 377 U.S. 985 (1964).

131. See *In re President & Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964); *Superintendent of Belcher-town State School v. Saikewicz*, 373 Mass. 728, 740, 370 N.E.2d 417, 427 (1977) (state interest in protecting innocent third parties).

132. *In re President & Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964).

133. *Jehovah's Witnesses In Washington v. King County Hosp. Unit No. 1*, 278 F. Supp. 488 (W.D. Wash. 1967), *aff'd*, 390 U.S. 598 (1968); *People ex rel. Wallace v. Labrenz*, 411 Ill. 618, 104 N.E.2d 769, *cert. denied*, 344 U.S. 824 (1952); *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971). See Note, *State Intrusion into Family Affairs: Justification and Limitations*, 26 STAN. L. REV. 1383 (1974).

134. *Wisconsin v. Yoder*, 406 U.S. 205 (1972) (right of Amish to educate their children); *Pierce v. Society of Sisters*, 268 U.S. 510, 534-35 (1925) (right to choose parochial schools). See *United States v. Orito*, 413 U.S. 139 (1973) (right of privacy extends to certain aspects of the family relationship).

135. *Quilloin v. Walcott*, 434 U.S. 246, 255 (1978); *Smith v. Organization of Foster Families for Equality & Reform*, 431 U.S. 816, 842 (1977); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944). The Court recently added "affirmative sponsorship of particular ethical, religious, or political beliefs is something we expect the State *not* to attempt in a society constitutionally committed to the ideal of individual liberty and freedom of choice." *Bellotti v. Baird*, 443 U.S. 622, 638

tions of their parents.¹³⁶ With regard to decisions concerning medical care, a key principle is that parents do not hold life and death authority over their children,¹³⁷ and for that reason cannot elect to refuse medical treatment for their children which is life-saving.¹³⁸ Thus, where a child requires medical care in order to survive and the parents are unwilling to provide it, the state through its *parens patriae* authority will invariably intercede to protect the child by insuring that the life-saving care is provided.¹³⁹ For example, consider the much publicized case of Chad Green,¹⁴⁰ a

136. In *Prince v. Massachusetts*, the United States Supreme Court stated that "[p]arents 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." 321 U.S. at 170. The state may exercise its *parens patriae* responsibilities for various reasons. See, e.g., MASS. GEN. LAWS ANN. ch. 76, § 1 (West Cum. Supp. 1981) (compulsory education); *id.* ch. 119, §§ 51A-51E (prohibiting child abuse); *id.* ch. 119, § 24 (mechanism for removing children from home under care and protection statutes). Children have independent constitutional rights which the state is seeking to protect when parents are not protecting those rights. See *Bellotti v. Baird*, 443 U.S. 622, 634 (1979); *Planned Parenthood v. Danforth*, 428 U.S. 52, 74 (1976) ("Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority."). The state interest becomes significant only when parents make decisions which are not in the child's best interests. See Goldstein, *Medical Care for the Child at Risk: On State Supervision of Parental Autonomy*, 86 YALE L.J. 645, 647 (1977).

137. *Prince v. Massachusetts*, 321 U.S. 158, 166-67 (1944).

138. *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971) (ordering transfusions for 22-year-old comatose patient over parental objections); *Custody of a Minor*, 375 Mass. 733, 379 N.E.2d 1053 (1978) (ordering chemotherapy for leukemia-stricken child over parental objections). As one court stated:

The child is a citizen of the State. While he "belongs" to his parents, he belongs also to his State. Their rights in him entail many duties. Likewise the fact [that] the child belongs to the State imposes upon the State many duties. Chief among them is the duty to protect his right to live and to grow up with a sound mind in a sound body, and to brook no interference with that right by any person or organization.

In re Clark, 21 Ohio Op. 2d 86, 90, 185 N.E.2d 128, 132 (1962). See *In re Penny N.*, ___ N.H. ___, ___, 414 A.2d 541, 542 (1980) ("parents have the duty to recognize a child's symptoms of illness and to seek and follow medical advice"). See also *In re W.S.*, 152 N.J. Super. 298, 377 A.2d 969 (Essex County Juv. & Dom. Rel. Ct. 1977) (incompetents primarily are the responsibility of the state). Treatment for minors can be sanctioned prospectively. See *Younts v. St. Francis Hosp. & School of Nursing*, 205 Kan. 292, 469 P.2d 330 (1970). Of course, in seeking to protect the child, the "State intervention should then be no more extensive than is necessary to alleviate the problem causing the difficulty." *Doe v. Irwin*, 428 F. Supp. 1198, 1206 (W.D. Mich.), *vacated mem.*, 559 F.2d 1219 (6th Cir. 1977).

139. *Custody of a Minor*, 375 Mass. 733, 738, 379 N.E.2d 1053, 1060 (1978) (without chemotherapy, child would die; with chemotherapy, child had 50% chance of cure).

child suffering from acute lymphocytic leukemia. His parents stopped chemotherapy treatments, but the treating hospital went to court on a care and protection proceeding¹⁴¹ and sought to have the chemotherapy resumed. The evidence at trial revealed that without chemotherapy Chad would die within a few weeks, but with chemotherapy he had a fifty percent chance of complete cure. The court ordered chemotherapy to be resumed.¹⁴²

Most of the precedents for overcoming parental objections to medical treatment have involved situations where comatose children needed transfusions,¹⁴³ but there are other situations where courts have ordered medical treatment after concluding that the best interests of the child would be protected by having the medical procedure performed.¹⁴⁴ The

141. MASS. GEN. LAWS ANN. ch. 119, § 24 (West Cum. Supp. 1981).

142. 375 Mass. at 756, 379 N.E.2d at 1064. This did not end the Chad Green case. The parents then tried to bring an action in federal district court asserting a constitutional right to give Chad Green laetrile, but their action was dismissed on res judicata grounds. *Green v. Truman*, 459 F. Supp. 342 (D. Mass. 1978). They then petitioned the state courts for a review and redetermination of the original order and revealed that, without medical supervision, they were giving Chad "metabolic therapy" consisting of laetrile, megadoses of vitamins A and E, an enzyme enema, and other supplements. At a subsequent trial, medical evidence revealed that the laetrile had caused chronic cyanide poisoning. The megadoses of vitamin A had caused hypervitaminosis A, and the enzyme enema was likely to cause colon damage. The court proscribed these substances because they were causing such harm to Chad. *Custody of a Minor*, 79 Mass. Adv. Sh. 2124, 393 N.E.2d 836 (1979). The family fled to Mexico where Chad died. *Boston Globe*, Oct. 14, 1979, at 1, col. 5. See Brant & Graceffa, *Rutherford, Privitera, and Chad Green: Laetrile's Setbacks in the Courts*, 6 AM. J.L. & MED. 151 (1980); Horwitz, *Of Love and Laetrile: Medical Decision Making in a Child's Best Interests*, 5 AM. J.L. & MED. 271 (1979).

143. See authorities cited note 133 *supra*.

144. *E.g.*, *Maine Medical Center v. Houle*, No. 74-145 (Sup. Ct. Cumberland County Me., Feb. 13, 1974) (heart surgery for newborn); *In re McNulty*, No. 9190 (P. Ct. Essex County Mass., 1978) (court ordered heart surgery for newborn); *In re Sampson*, 65 Misc. 2d 658, 317 N.Y.S.2d 641 (Fam. Ct. 1970) (ordered facial surgery over parental objections because of psychic harm to child if surgery not performed), *aff'd*, 37 A.D.2d 668, 323 N.Y.S.2d 253 (1971), *aff'd*, 29 N.Y.2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 686 (1972); *In re Rotkowitz*, 175 Misc. 948, 25 N.Y.S.2d 624 (Dom. Rel. 1941); *Mitchell v. Davis*, 205 S.W.2d 812 (Tex. Civ. App. 1947) (ordered treatment for arthritis victim where parents relied on faith healing). See Robertson, *Involuntary Euthanasia of Defective Newborns: A Legal Analysis*, 27 STAN. L. REV. 213 (1975); Comment, *Withholding Treatment from Defective Newborns: Substituted Informed Consent and the Quinlan Decision*, 13 GONZ. L. REV. 781 (1978); Note, *A Dilemma for the Legal and Medical Professions: Euthanasia and the Defective Newborn*, 22 ST. LOUIS U.L.J. 501 (1978). See generally P. RAMSEY, *supra* note 122, at 121-52.

medical situation does not have to be life-threatening, but if the child will suffer some clear detriment from failure to receive ordinary medical care, the courts will overcome parental wishes.¹⁴⁵ For example, in the second Chad Green case,¹⁴⁶ the medical evidence revealed that laetrile had caused chronic cyanide poisoning which might lead to blindness, that megadoses of vitamin A had caused hypervitaminosis A leading to stunting of growth, and that an enzyme enema would cause colon damage.¹⁴⁷ The court overrode parental intent and proscribed these substances because of their harm to the child.

The most troubling of this series of cases are the so-called defective newborn cases. These involve children born with a variety of handicaps whose parents, facing the trauma of raising a severely handicapped child, are seeking to have treatments withheld.¹⁴⁸ Very few of these cases have come to court, but where they have, the courts have ordered treatment on the basis of the child's independent right to life and bodily privacy.¹⁴⁹

parents seek permission for transplants of kidneys or bone marrow from an incompetent donor sibling. The courts have generally approved of the operation. *E.g.*, *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. 1969); *Milwaukee Children's Hosp. Ass'n v. George*, No. 532078 (Ct. Milwaukee County Wis., Oct. 13, 1980). Occasionally, they have refused to consent. *E.g.*, *In re Pescinski*, 67 Wis. 2d 4, 226 N.W.2d 180 (1975). See generally Baron, Botsford & Cole, *Live Organ and Tissue Transplants From Minor Donors in Massachusetts*, 55 B.U.L. REV. 159 (1975); Robertson, *Organ Donations by Incompetents and the Substituted Judgment Doctrine*, 76 COLUM. L. REV. 48 (1976).

145. *State v. Chenoweth*, 163 Ind. 94, 71 N.E. 197 (1904); *In re Sampson*, 65 Misc. 2d 658, 317 N.Y.S.2d 641 (Fam. Ct. 1970), *aff'd*, 37 A.D.2d 668, 323 N.Y.S.2d 253 (1971), *aff'd*, 29 N.Y.2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 686 (1972); *Mitchell v. Davis*, 205 S.W.2d 812 (Tex. Civ. App. 1947).

146. *Custody of a Minor*, 79 Mass. Adv. Sh. 2124, 393 N.E.2d 836 (1979).

147. *Id.* at 2136, 393 N.E.2d at 845. See generally Brant & Graceffa, *supra* note 142 (documenting medical testimony in the Chad Green trial); Horwitz, *supra* note 142.

148. There is much commentary in the medical literature on the practice of benign neglect in allowing defective newborns to die. Duff & Campbell, *Moral and Ethical Dilemmas in the Special-Care Nursery*, 289 NEW ENG. J. MED. 890 (1973); Fletcher, *Abortion, Euthanasia, and Care of Defective Newborns*, 292 NEW ENG. J. MED. 75 (1975); Lorber, *Selective Treatment of Myelomeningocele: To Treat or Not to Treat?*, 53 PEDIATRICS 307 (1974). See also P. RAMSEY, *supra* note 122, at 121-52 (condemning practice of allowing defective newborns to die). The legal literature laments the lack of standards and renewal of decisions to allow such children to die. See Comment, *supra* note 144; Note, *Birth Defect Infants: A Standard for Nontreatment Decisions*, 30 STAN. L. REV. 599 (1978); Note, *supra* note 144.

149. *Maine Medical Center v. Houle*, No. 74-145 (Sup. Ct. Cumberland County Me., Feb. 13, 1974); *In re McNulty*, No. 9190 (P. Ct. Essex County Mass., 1978) (court ordered heart surgery for newborn). See Robertson, *Involuntary Euthanasia of Defective Newborns: A Legal Analysis*, 27 STAN. L. REV. 213, 215 (1975). See generally R. YEATCH, *supra* note 122, at 77-115.

If quality of life considerations do not enter into treatment decisions regarding defective newborns, the critical factor in such decisions should be the prognosis of the proposed medical procedures. In many of these cases,¹⁵⁰ the child may require multiple medical procedures, at least some of which are unlikely to be successful. At some point, the child's privacy interest in being protected from highly intrusive medical procedures which offer little probability of medical success supports a decision to withhold treatment. Because of the difficult nature of the questions concerning treatment, these decisions should be made by courts.¹⁵¹

There are two principal situations in which parental refusals are upheld. The first is when the medical condition is not life-threatening,¹⁵² and the court simply decides that there is little reason to overcome the parental decision because it is not obviously irrational or contrary to the interests of the child.¹⁵³ For example, in the controversial case *In re Phillip*

150. This was true of three cases in the literature. See *Maine Medical Center v. Houle*, No. 74-145 (Sup. Ct. Cumberland County Me., Feb. 13, 1974); *In re McNulty*, No. 9190 (P. Ct. Essex County Mass., 1978); *In re Cicero*, 101 Misc. 2d 699, 421 N.Y.S.2d 965 (Sup. Ct. 1979). See also *Repouille v. United States*, 165 F.2d 152 (2d Cir. 1947) (father put defective newborn to death).

151. *In re Spring*, 80 Mass. Adv. Sh. 1209, 405 N.E.2d 115 (1980); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *Eichner v. Dillon*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980). From the dearth of cases and the wealth of commentary, it would appear that these matters are being resolved in the newborn nursery rather than the courts. See Robertson, *supra* note 149.

152. *In re Green*, 448 Pa. 338, 292 A.2d 387 (1972) (surgery to correct curvature of the spine); *In re Tuttendario*, 21 Pa. Dist. 561, 562 (Phil. Quar. Sess. 1912) (surgery to cure rickets). The justification for allowing parental decision-making is confidence in the family relationship. "Parents are uniquely capable of making health care decisions for their children. In favoring parental authority over state regulation, judges should recognize that parents can make better decisions regarding health care than the state, since they are more familiar with the psychological and physical dynamics of the family." Levy, *The Rights of Parents*, 1976 B.Y.U. L. REV. 693, 698. See Baker, *Court Ordered Non-Emergency Care for Infants*, 18 CLEV.-MAR. L. REV. 296 (1969); Brown & Truitt, *The Right of Minors to Medical Treatment*, 28 DE PAUL L. REV. 289 (1979). Nevertheless, "[t]his right of parental discretion and control, like the right of religious freedom, may clash with the child's best interests. . . . 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." Clarke, *supra* note 2, at 812-13.

153. *In re C.F.B.*, 497 S.W.2d 831, 834 (Mo. App., K.C. 1973) (court allowed mother to choose among types of psychiatric care for child); *In re Seiferth*, 309 N.Y. 80, 127 N.E.2d 820, 148 N.Y.S.2d 80 (1955) (court would not order surgery to correct harelip causing speech problems for child over parental objections); *In re Vasko*, 238 A.D. 128, 263 N.Y.S. 552 (1933) (parental refusal to consent overruled when treatment offered 50% chance of cure); *In re Hudson*,

B.,¹⁵⁴ a California court refused to order heart surgery for a child suffering from Down's Syndrome over parental objections on the grounds that the risks of the surgery would be greater for the child and also that the child could live for twenty years without the surgery.¹⁵⁵

Another situation where parental refusal to consent to medical treatment for a child will be upheld arises when the court determines that the child's condition is terminal and that the child is better off not having to endure the effects of the proposed medical procedure.¹⁵⁶ For example, in *In re Green*,¹⁵⁷ a child who already had been diagnosed as having a ter-

13 Wash. 2d 673, 126 P.2d 765 (1942) (refusal to order treatment for deformed arm). The court in *Saikewicz* said of these cases that they "stand for the proposition that, even in the exercise of the *parens patriae* power, there must be respect for the bodily integrity of the child or respect for the rational decision of those parties usually the parents, who for one reason or another are seeking to protect the bodily integrity or other personal interest of the child." *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 746, 370 N.E.2d 417, 428 (1977).

154. 92 Cal. App. 3d 796, 156 Cal. Rptr. 48 (1979), *cert. denied*, 445 U.S. 949 (1980).

155. *Id.* at 800, 156 Cal. Rptr. at 50. The court set out the following test for whether state intervention would be justified:

The state should examine the seriousness of the harm the child is suffering or the substantial likelihood that he will suffer serious harm; the evaluation for the treatment by the medical profession; the risks involved in medically treating the child; and the expressed preferences of the child. Of course, the underlying consideration is the child's welfare and whether his best interests will be served by the medical treatment.

Id. at 802, 156 Cal. Rptr. at 51. The adequacy of the court's attempted distinction is questionable. *See Note, In re Phillip B., What Happened to the Best Interests of the Child?*, 12 U. TOL. L. REV. 151, 170 (1980). *See also In re Hofbauer*, 47 N.Y.2d 648, 393 N.E.2d 1009, 419 N.Y.S.2d 936 (1979), in which the court in the absence of any proof of harm permitted parents to choose laetrile rather than chemotherapy or radiation as a treatment for their child's Hodgkin's disease. *But see Custody of a Minor*, 79 Mass. Adv. Sh. 2124, 393 N.E.2d 836 (1979) (proscribing laetrile treatments for leukemia in light of proof of toxicity); *In re Rotkowitz*, 175 Misc. 948, 25 N.Y.S.2d 624 (Dom. Rel. 1941) (ordering treatments over parental objections even when condition not life-threatening); *In re Sampson*, 65 Misc. 2d 658, 317 N.Y.S.2d 641 (Fam. Ct. 1970) (ordering facial surgery for child over parental objections because of psychic trauma of the condition for the child), *aff'd*, 37 A.D.2d 668, 323 N.Y.S.2d 253 (1971), *aff'd*, 29 N.Y.2d 900, 278 N.E.2d 918, 328 N.Y.S.2d 836 (1972). *See also In re Cicero*, 101 Misc. 2d 699, 421 N.Y.S.2d 965 (Sup. Ct. 1979).

156. This is a rationale which could be applied to the defective newborn cases in some situations. *In re Green*, 12 Crim. & Rel. 377, 384-85 (Ct. Milwaukee County Wis., March 18, 1966) (child with terminal case of sickle cell anemia also needed a splenectomy; upheld parental refusal to consent on the grounds that the child could be spared the ordeal of the surgery).

157. 12 Crim. & Rel. 377 (Ct. Milwaukee County Wis., March 18, 1966).

minal case of sickle cell anemia needed a splenectomy. Failure to perform the splenectomy would shorten the child's life. The court determined, however, that because the child was dying, he should be spared the ordeal of the surgery and thus the parental refusal was upheld.¹⁵⁸

For parental refusals of treatment to be sustained, there must be evidence that the child will live without the proposed treatment or that the proposed treatment is not really beneficial.¹⁵⁹ When parents refuse to consent, the hospital of that state may petition a court for an order to have custody of the child given to the state for purposes of providing medical treatments.¹⁶⁰ Thus, the courts are frequently involved in review of parental refusals to consent and often overcome such refusals by ordering treatment.¹⁶¹ The courts will move aggressively under the doctrine of *parens patriae* to protect children who risk being denied necessary medical care.¹⁶²

158. *Id.* at 384-85.

159. Conversely, it is clear that where the proposed treatment has a good probability of success and is "attended by no risk greater than such as is inescapable in all of the affairs of life," parental refusal to consent will be overridden. *Morrison v. State*, 252 S.W.2d 97, 103 (Mo. App., K.C. 1952). See *Custody of a Minor*, 375 Mass. 733, 379 N.E.2d 1053 (1978) (chemotherapy gave Chad Green 50% chance of cure).

160. MASS. GEN. LAWS ANN. ch. 119, §§ 21-24 (West Cum. Supp. 1981). See also *Custody of a Minor*, 375 Mass. 733, 379 N.E.2d 1053 (1978) (care and protection procedure used in the Chad Green case).

161. 375 Mass. at 747 & n.8, 379 N.E.2d at 1062 & n.8.

162. *In re Phillip B.*, 92 Cal. App. 3d 796, 801, 156 Cal. Rptr. 48, 51 (1979), *cert. denied*, 445 U.S. 949 (1980). Another effect of judicial involvement is apparently to provide immunity for the treating physicians. As one commentator has noted, "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." Clarke, *supra* note 2, at 810 n.73.

Another situation involving parental consent for medical treatment for their children involves parents of mentally retarded adolescents seeking permission from courts to have their children sterilized. Many courts have refused to permit such sterilization in the absence of specific statutory authorization. *Hudson v. Hudson*, 373 So. 2d 310, 312 (Ala. 1979); *In re Estate of Kemp*, 43 Cal. App. 3d 758, 763-65, 118 Cal. Rptr. 64, 67-69 (1974); *A.L. v. G.R.H.*, 163 Ind. App. 636, 638, 325 N.E.2d 501, 502 (1975), *cert. denied*, 425 U.S. 936 (1976); *In re M.K.R.*, 515 S.W.2d 467, 470-71 (Mo. En Banc 1974); *In re Eberhardy*, 97 Wis. 2d 654, 665, 294 N.W.2d 540, 545-47 (1980). *Contra*, *In re Grady*, 170 N.J. Super. 98, 117-27, 405 A.2d 851, 861-66 (Ch. Div. 1979).

As a matter of constitutional law, there appears to be no reason why appropriate courts would not have jurisdiction to order sterilization when appropriate procedural protections are followed. *Stump v. Sparkman*, 435 U.S. 349, 364 (1978) (judicial immunity applies to judge who ordered sterilization); *Buck v. Bell*, 274 U.S. 200, 207 (1927); Burgdorf & Burgdorf, *The Wicked Witch*

VI. CONCLUSION

The right to refuse medical treatment is a right which competent adults maintain. Adults who are able to make such an election may accept or decline medical treatment, and with few exceptions no court or other governmental or private authority will intervene. The applicable exceptions are that the state maintains an interest in protecting minor children who may be left destitute if a parent or guardian dies, the state maintains an interest against suicide, and the state may force a prisoner to be treated against his will in order to insure the orderly administration of prisons.

Incompetent adults have the same basic right as competent persons to receive and refuse medical treatment. The patient's incompetence, however, requires that someone other than the patient must necessarily elect whether treatment will be administered. Increasingly, the courts are acting as the body to make such substitute judgments, particularly in situations where the proposed treatment offers some reasonable possibility of a cure or remission of the disease but at the same time offers probability of deleterious side effects or other negative consequences. The courts, when called on to make such substitute judgments, will weigh the medical benefits against the probable negative consequences and seek to make a decision which reflects the true interest of the incompetent.

With regard to children, parents have the primary responsibility to insure that their children receive necessary medical care. In instances where the parents seek to have necessary medical treatment withheld, the courts will generally act aggressively to override parental decision-making unless

is Almost Dead: Buck v. Bell and the Sterilization of Handicapped Persons, 50 TEMP. L.Q. 995, 1022 (1977).

Many courts have asserted jurisdiction to decide petitions for permission to sterilize. *In re Penny N.*, ___ N.H. ___, 414 A.2d 541 (1980); *In re Grady*, 170 N.J. Super. 98, 405 A.2d 851 (Ch. Div. 1979); *In re Sallmaier*, 85 Misc. 2d 295, 378 N.Y.S.2d 989 (Sup. Ct. 1976); *In re Simpson*, 180 N.E.2d 206 (P. Ct. Ohio 1962); *In re Hays*, 93 Wash. 2d 228, 608 P.2d 635 (1980).

Because sterilization impacts on the privacy rights of the incompetent minor, *North Carolina Ass'n for Retarded Children v. North Carolina*, 420 F. Supp. 451, 458 (M.D.N.C. 1976), courts which have asserted jurisdiction have been very reluctant to approve the requested sterilization. *See, e.g., In re Hays*, 93 Wash. 2d 228, 608 P.2d 635 (1980) (sharply divided court refused relief requested). Most courts have appointed a guardian ad litem for the incompetent child and required the parents to meet the "clear and convincing" standard of proof which they have generally been unable to meet. *Id.* at ___, 608 P.2d at 641-42 (standard of "clear, cogent, and convincing" evidence not met and heavy presumption against sterilization not overcome). *See also In re Penny N.*, ___ N.H. ___, ___, 414 A.2d 541, 543 (1980) (case remanded for consideration under "clear and convincing" standard of proof). *Contra, In re Grady*, 170 N.J. Super. 98, 120-27, 405 A.2d 851, 862-66 (Ch. Div. 1979) (approves parents' petition using *Quinlan* and *Parham* to support presumption favoring parental request).

the child can survive without the medical procedure, or unless the proposed procedure will not prevent the child's death.

The law of refusal of medical treatment has grown rapidly in the past few years, particularly as the result of some highly controversial and publicized cases. Despite the rapid growth, there is a relative consistency to the body of law which has developed. This body of law provides assistance to attorneys, physicians, ethicists, and others who are wrestling with the real and very difficult questions which these cases present.