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"RIGHT TO DIE" CASES: A MODEL FOR JUDICIAL DECISION-MAKING?

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A State Supreme Court rules that a trial court should have granted a doctor's motion to dismiss a malpractice action based upon the doctor's negligent failure to diagnose the patient's condition. The court rules that the patient's death was due to the disease from which he was suffering and not the doctor's failure to diagnose or treat it.[1] The wife of an incompetent inmate awaiting execution on death row sues her husband's lawyer to enjoin him from filing any further appeals, because the effect of the appeals could only be to set aside the death penalty and leave her husband facing a term of life imprisonment. Prior to becoming incompetent, her husband had told her that he preferred death to life in prison. The court grants the injunction, holding that the right to waive the right to appeal is an important personal right of the inmate which cannot be lost by reason of his incompetency. In order to prevent destruction of the right, his wife must be allowed to exercise it based upon her assessment as to what decision

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1. *Cf. In re* Gardner, 534 A.2d 947, 955-56 (Me. 1987); *see infra* note 8. Rasmussen v. Fleming, 154 Ariz. 207, 216-18, 741 P.2d 674, 685 (1987) (70 year old woman in nursing home kept alive by naso-gastric tube. The Supreme Court of Arizona agreed to decide the case, even though the patient had died. *Id.* at 222. The court held that the right to refuse medical treatment fell into the "zone of privacy" in both the federal and state constitutions. *Id.* at 219. Because the patient was not competent to express her wishes, the court relying on the doctrine of substituted judgment, held that the guardian could decide, based on the patient's best interests. *Id.* at 221; *In re* Conroy, 98 N.J. 321, 341, 486 A.2d 1209, 1226 (1985) (84 year old woman in chronic vegetative state who also died during the litigation. *Id.* at 341, 486 A.2d at 1219. She was kept alive by a naso-gastric tube. *Id.* at 336, 486 A.2d at 1216. The N.J. Supreme Court held, that under certain conditions, the tube could be removed by the guardian. *Id.* at 360-61, 486 A.2d at 1229).

he would want made.[2]

An individual now in a nursing home in a persistent vegetative state had not, prior to his incompetency, made a will. His family members write a will in his behalf based upon their assessment as to how he would want to dispose of his property. Following his death, the will is submitted to the probate court which accepts it as valid.[3]

A quadriplegic is subpoenaed to appear as a witness. When he fails to appear, the court issues a contempt citation. His lawyer argues that his client's failure to appear was not the result of any intent to disobey the subpoena but because of his inability to walk. The court not only agrees that there is no specific intent to disobey the court order but finds that he is merely exercising his fundamental liberty interest not to be required to use a wheelchair.[4]

The above cases did *not* happen. The citations given are real enough but the principles those cases announce have been applied to new factual circumstances. In the real cases the Maine, Arizona and New Jersey Supreme Courts held that withdrawing treatment which would have sustained the life of a patient is not the cause of death; rather, it was caused by each patient's underlying condition.[5] The New Jersey Supreme Court also held that the right to make medical treatment decisions cannot be lost by reason of the fact that the patient is now incompetent to make valid decisions. To avoid the loss, the patient's parents must be allowed to exercise this

2. *Cf. In re* Quinlan, 70 N.J. 10, 41-42, 355 A.2d 647, 664 (1976) (Although Karen Ann Quinlan was comatose and therefore incompetent, her family was allowed to exercise her right to refuse medical treatment.). *See infra* note 6.

3. *Cf.* Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 431, 497 N.E.2d 626, 634 (1986) (guardian authorized to remove incompetent from hospital to care of other physicians who would honor patient's wishes. *Id.*). *See also infra* note 7.

4. *Cf. Gardner*, 534 A.2d at 955-56.

5. *Rasmussen*, 154 Ariz. at 216-18, 741 P.2d at 685; *In re* Conroy, 98 N.J. at 369, 486 A.2d at 1226.

authority.[6] The Massachusetts Supreme Court held that the state must afford to incompetent persons "the same panoply of rights and choices it recognizes in competent persons."[7] Finally, the Maine Supreme Court held that withdrawing food and water from a patient did not constitute suicide because there was no specific intent to die.[8] This is not meant to single out these particular courts because these principles have been adopted by other courts when faced with whether to terminate treatment for an incompetent patient. However, there seems to be developing a judicial consensus that these principles represent an appropriate framework within which to decide these admittedly difficult and sensitive cases.

If the fictional decisions had been reached, it is quite likely that a large portion of the legal community would agree that the decisions were wrong. At a minimum, such decisions would be quite controversial for their legal reasoning alone, quite apart from the results reached. The failure to provide a treatment which would sustain the life of a patient is clearly the proximate cause of his death. When a doctor deliberately fails to so treat a patient, we must conclude that the doctor intended the natural and foreseeable consequences of that action, death. Most importantly, may we determine what duty is owed to an incompetent person by a party who, *a priori* or

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6. *In re Quinlan*, 70 N.J. at 41-42, 355 A.2d at 664 (21 year old woman in persistent vegetative state kept alive on a respirator. Supreme Court of New Jersey held patient's right to privacy extended to refusing medical treatment, and that her father, as guardian, could exercise that right for her. *Id.*). *See generally* Weinberg, *Whose Right is it Anyway? Individualism, Community, and the Right to Die: A Commentary on the New Jersey Experience*, 40 HASTINGS L.J. 119 (1988).

7. *Brophy*, 398 Mass. at 431, 497 N.E.2d at 634. (Young fireman suffered brain anuerism resulting in inability to eat or chew. A Gastric tube was inserted in his stomach, but his wife and family wanted it removed. The Supreme Judicial Court of Massachusetts held that although the hospital had a right to refuse to remove the tube, the family had the right to remove the patient to another hospital that would carry out its wishes. *Id.*). *See generally* Favour, *A Physician's Comments Prompted by the Massachusetts Brophy Case*, 7 PROB. L.J. 265 (1987).

8. *Gardner*, 534 A.2d at 955-56 (23 year old male fell from a pickup truck. He had been in a persistant vegetative state for two years and was kept alive by means of a naso-gastric tube. The Supreme Judicial Court of Maine held that there was "clear and convincing evidence" that the incompetent had expressed, prior to his incompetency, a desire not to be kept alive by arificial means and, therefore, the tube could be removed. *Id.*).

by proxy, exercises the incompetent person's rights. Yet these principles have been adopted and later applied by other courts with little or no comment in cases in which the issue is the termination of life-sustaining treatment for incompetent patients.[9] Why have courts been so willing to adopt in this particular context legal principles they would likely find highly questionable in any other context? There is no easy answer to the motivation behind these decisions and it would probably be fruitless to speculate. We can, however, deal with the reality of these decisions and, more particularly, with how, rather than why, they have been reached.[10]

The two questions which most immediately spring to mind from these decisions are: (1) whether they represent the adoption of new principles which will be applicable in other contexts or (2) whether they represent an "*ad hoc* nullification" of normal rules only in cases of termination of life-sustaining treatment.[11] Neither possibility is particularly attractive.

If cases involving termination of life-sustaining treatment for incompetent patients are in fact an aberration, then we must conclude that the decisions are totally result oriented. That fact alone seriously questions the wisdom of those results. Behind the evolutionary development of case law and the statutory enactments of legislative bodies is a presumption that we, as a society, are acting in a wise and prudent manner.[12] When a court discards those doctrines, it similarly discards the presumed wisdom which is their foundation. In addressing the constitutionality of capital punishment for a fifteen year old, a plurality of the United States Supreme Court in *Thompson*

9. *See supra* notes 1-8.

10. *See generally* Opperman, *Termination of Life-Sustaining Treatment: Who and How to Decide?*, 33 N.Y.L. SCH. L. REV. 469 (1988).

11. *See* Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747, 814 (1985) (Justices O'Connor and Rehnquist dissenting) ("[n]o legal rule or doctrine is safe from *ad hoc* nullification . . . when an occasion for its application arises in a case involving state regulation of abortion." *Id.*).

12. 12.5 3 R. Pound, JURISPRUDENCE § 96 (1959).

v. Oklahoma[13] noted that the many statutes states have enacted pertaining to children reflect basic assumptions about their ability to act rationally in their own behalf. According to the plurality, it would be ironic if those same assumptions "were suddenly unavailable in determining whether it is cruel and unusual to treat children the same as adults for purposes of inflicting capital punishment."[14] The plurality, therefore, found consistency in the application of those assumptions to be a virtue in deciding the particular case before it.[15]

Similar assumptions, however, are also made with regard to the "insane, and those who are irreversibly ill with loss of brain function."[16] In addressing the needs of incompetent persons, states have established systems of statutory guardianships as an exercise of their *parens patriae* power to provide for those who are unable to care for themselves.[17] It has been recognized by both state and federal courts that a statutory guardian is an officer of the court who is always under the court's control and subject to its directions as to the person of the ward.[18] A state's *parens patriae* power is beneficent[19] and we should not readily or arbitrarily discard the assumptions behind the manner in which that power is exercised on behalf of incompetent persons.

It is undeniable that it is "the essence of federalism that states must be free to develop a variety of solutions to problems and not be forced into a common, uniform mold."[20]

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13. 108 S. Ct. 2687, 2693 n.23 (1988) (where the court held that the Eighth and Fourteenth Amendments prohibited execution of a fifteen year old defendant convicted of first-degree murder. *Id.*).

14. *Id.*

15. *Id.*

16. *Id.*

17. Addington v. Texas, 441 U.S. 418, 426 (1979).

18. *In re* Terwillinger, 304 Pa. Super. 553, 559-60, 450 A.2d 1376, 1380 (Pa. Super. Ct. 1982); Oyama v. State of California, 332 U.S. 269 (1948); Christoffel v. E.F. Hutton & Co., Inc., 588 F.2d 665 (9th Cir. 1978); Martineau v. City of St. Paul, 172 F.2d 777 (8th Cir. 1949).

19. The Late Corporation of the Church of Jesus Christ of Latter-Day Saints v. United States, 136 U.S. 1, 57 (1890).

20. *Addington*, 441 U.S. at 431.

Substantive and procedural standards regarding incompetents and guardianships may vary from state to state, as they might in any other area. Thus, the principles which have been applied in cases regarding termination of life-sustaining treatment may find their way into other areas of the law. For instance, New Jersey has also held that a guardian is merely acting to protect a ward's rights when the proposed action is sterilization of the incompetent ward.[21] Certainly, cases dealing with termination of medical treatment do not offer any principled basis upon which application of the principles could be restricted to the particular subject matter. Thus, the Massachusetts Supreme Court has broadly stated that: "[t]o 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 competent persons."[22] Given the inevitability that these principles will be extended, we cannot avoid asking whether the assumptions which underlie these decisions constitute a wise and sound exercise of the state's *parens patriae* power.

Certain basic assumptions underlie the decisions to allow termination of life-sustaining treatment for incompetent patients. Virtually without exception the courts conclude that the personal rights of the patient to choose or decide are at stake, despite the fact that these patients are admittedly incompetent to make any choice, informed or not.[23] Second, these courts assume that the inability of the incompetent patient to exercise the right is an intolerable situation which the state is required to overcome.[24] In other words, they hold

21. *In re* Grady, 85 N.J. 235, 426 A.2d 467 (1981) (parents of noninstitutionalized daughter afflicted with Down's Syndrome sought appointment of special guardian authorized to consent to sterilization of daughter by tubal ligation. *Id.*).

22. Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 431, 497 N.E.2d 626, 634 (1986).

23. *Id. In re* Gardner, 534 A.2d 947, 951-52 (Me. 1987).

24. *In re* Quinlan, 70 N.J. 10, 41, 355 A.2d 647, 664 (1976). *Brophy*, 398 Mass. at 431, 497 N.E.2d at 634-35.

that to avoid destruction of the right, a state must allow the decision to be made even when there had been no express directives from the patient.[25] These assumptions, however, are not only questionable, but dangerous.

First, the right to make medical treatment decisions, like the right of privacy, is a right to choose. It can only belong to a person who is competent to exercise that right.[26] The seminal case of *In re Quinlan*[27] reflects "a right of privacy gone wild."[28] Although the decision was based upon Karen Quinlan's personal right of choice, there was little, if any, basis upon which one could determine what her choice would be:

> Our affirmation of Karen's independent right of choice, however, would ordinarily be based upon her competency to assert it. The sad truth, however, is that she is grossly incompetent and we cannot discern her supposed choice based on the testimony of her previous conversations with friends, where such testimony is without sufficient probative weight.[29]

Of course, the New Jersey Supreme Court later allowed the consideration of prior statements as a basis for decision but as discussed, that presents problems of its own.[30]

It cannot be denied that incompetent persons retain constitutional rights. For instance, they could not be

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25. L. TRIBE, AMERICAN CONSTITUTIONAL LAW 1368 (2d ed. 1988).

26. Note, *The Refusal Of Life-Saving Medical Treatment vs. The State's Interest In The Preservation Of Life: A Clarification Of The Interest At Stake*, 58 WASH. U.L.Q. 85, 100 (1980).

27. *Quinlan*, 70 N.J. at 10, 355 A.2d at 647 (1976).

28. Note, *Due Process Privacy And The Path Of Progress*, 1979 U. ILL. L.F. 469, 517.

29. *Quinlan*, 70 N.J. at 41, 355 A.2d at 664 (citing the lower court's opinion, 137 N.J. Super. 227, 260 (Ch. Div. 1975)).

30. *In re* Peter, 108 N.J. 365, 378-79, 529 A.2d 419, 426-27 (1987).

institutionalized without due process of law.[31] However, a fundamental distinction must be drawn between rights which may be possessed passively and those which require affirmative exercise. Perhaps part of the analytical problem could be alleviated by the adoption of different terms. Thus, passive protections, such as procedural due process or equal protection, could be termed rights and matters of choice could be termed freedoms.[32] However, concluding that a freedom to choose survives incompetency is a legal fiction at best.[33]

> Given the fact that these patients are irreversibly comatose or in a chronic vegetative state, attributing "rights" to these patients at all is somewhat problematic. . . . To be sure, these patients are not "dead" in most of the increasingly multiple senses of the term, but the task of giving content to the notion that they have rights in the face of the recognition that they could make no decisions about how to exercise any such rights remains a difficult one.[34]

The matter was eloquently summarized by the Wisconsin Supreme Court in its response to the opinion of the New Jersey Supreme Court in *In re Grady*,[35] applying a right of personal choice to the decision to sterilize an incompetent.

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31. O'Connor v. Donaldson, 422 U.S. 563, 575 (1975) (patient's constitutional right to liberty violated when state involuntarily commited to mental hospital nondangerous individual who was capable of surviving safely in freedom by himself.); Parham v. J.R., 442 U.S. 584, 600, 606 (1979) (minor children's constituional right to liberty not violated by law permitting voluntary admission of children to mental hospital by parents or guardians, but since risk of error is inherent in such parental decision, some kind of inquiry should be made by a neutral factfinder to determine whether statutory requirements for admission are satisfied.).

32. *Garvey, Freedom And Choice In Constitutional Law*, 94 HARV. L. REV. 1756 (1981).

33. *In re* Drabick, 200 Cal. App. 3d 185, 208, 245 Cal. Rptr. 840, 854 (Cal. Ct. App. 6th Dist. 1988).

34. L. TRIBE, *supra* note 25, at 1368 n.25.

35. 85 N.J. 235, 426 A.2d 467 (1981).

> We find it somewhat too facile when discussing the right of privacy, which by definition necessarily refers to the person involved, to find that there is a genuine choice when that choice cannot be personally exercisable. It is indeed true that in Grady there was a decision, but it was not the decision of Lee Ann Grady pursuant to her right of privacy. We believe it somewhat inconsistent for the New Jersey court to equate in a single breath "the choice made in her behalf" and "providing her with a choice"
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> The fault we find in the New Jersey case is in the *ratio decidendi* of first concluding, correctly we believe, that the right to sterilization is a personal choice, but then equating a decision made by others with the choice of the person to be sterilized. It clearly is not a personal choice, and no amount of legal legerdemain can make it so.[36]

To continue to deal with these cases in terms of rights of the incompentent patient constitutes a dangerous illusion. The use of the term "right to die" fosters the belief "[t]hat when society makes significant and painfully difficult decisions about life and death, we are maiking no decision at all, but merely deferring to individual autonomy."[37] In short, in any case which does not involve a competent patient we must "abandon the language of individual rigths and accept the reality of the situation."[38]

The reality of the situation is simply that a decision is being made for the incompetent patient and not by the

36. *In re* Eberhardy, 102 Wis. 2d 539, 566, 307 N.W.2d 881, 893 (1981) (citation ommitted) (dismissal of guardian's petition seeking court approval for their consent to surgical sterilization of their severely retarded adult daughter).

37. Beschle, *Autonomous Decision Making And Social Choice: Examining The "Right To Die,"* 77 KY. L.J. 319, 322 (1988).

38. *Id.* at 360.

incompetent patient. Even in instances where a court concludes that a guardian has the right to make that choice, it must be recognized that that decision is not based upon the personal rights of the patient.[39] Once this reality is acknowledged, we begin to be on more familiar terrain: normal guardianship principles. We can recognize now that there are two fundamental questions which are presented. First, who is to make a decision on behalf of the incompetent person and upon what basis should that person act. The answers to such questions may vary from state to state, but the analysis will invoke vastly different legal principles than would cases in which a state seeks to limit or override a personal choice of a fully competent person.

Despite the rhetoric in these cases concerning individual rights, many of these courts intuitively recognize this point. For instance, the New Jersey Supreme Court imposed a requirement of independent confirmation by a hospital prognosis committee.[40] However, assuming that the right to refuse medical treatment is of constitutional magnitude, like the right to choose an abortion,[41] a requirement of independent confirmation by hospital commission would infringe that right.[42] However, when an individual's personal right of choice is not at stake, a requirement of independent confirmation is a perfectly acceptable, and perhaps constitutionally required, protection against arbitrary state action.[43] Thus, due process requires independent medical confirmation regarding a parental decision to institutionalize their minor child.[44] There must be some level of protection

39. *In re* Drabick, 200 Cal. App. 3d 185, 212, 245 Cal. Rptr. 840, 857-58 (Cal. Ct. App. 6th Dist. 1988).

40. *In re* Jobes, 108 N.J. 394, 421-22, 529 A.2d 434, 468 (1987). *See generally* McElvaine, *Withholding and Withdrawing Life-Sustaining Medical Treatment: Procedures for Subjective and Objective Surrogate Decision Making in In re Jobes, In re Peter and In re Farrell*, 19 RUTGERS L.J. 1029 (1988).

41. Roe v. Wade, 410 U.S. 113 (1973).

42. Doe v. Bolton, 410 U.S. 179, 198 (1973).

43. *See generally, In re* Jobes, 108 N.J. at 394, 529 A.2d at 434; *Doe*, 410 U.S. at 179.

44. Parham v. J.R., 442 U.S. 584 (1978).

against arbitrary action in this category of cases as well because states are not being asked to maintain neutrality on the question of whether life-sustaining treatment should be withdrawn for incompetent patients. Instead, they are being asked to confer this life-and-death power upon third persons.

The assumption that a state is obligated to delegate this right so that it may not be lost is simply incorrect, at least insofar as the federal Constitution is concerned. A patient's incompetency is simply a naturally occurring obstacle to the *exercise* of the patient's rights. It is not a state imposed forfeiture thereof. A state, however, is not constitutionally compelled to take steps to overcome that obstacle, even when the failure to do so prevents a person from exercising a liberty interest. "[A]lthough government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation."[45]

Quite apart from whether this particular delegation of authority is required, a failure to recognize the fundamental difference between the right of patient to choose and the authority of a surrogate to choose for the patient can only "lead to poorly reasoned decisions."[46] When viewed from the perspective of protection of the incompetent patient, the decision of many of these courts to limit the judicial role is quite troubling because so few constraints are placed upon the surrogate's authority. As stated by the New Jersey Supreme Court "[w]e emphasize that in this as in every case, the ultimate decision is not for the Court. The decision is primarily that of the patient, competent or incompetent, and the patient's family or guardian and physician.[47]

If a parental decision to institutionalize a minor child contains such a risk of error that there should be a neutral

45. Harris v. McRae, 448 U.S. 297, 316 (1980).

46. 2 R. ROTUNDA, J. NOWAK, & YOUNG, TREATISE ON CONSTITUTIONAL LAW 606-07 (1986).

47. *In re* Peter, 108 N.J. 365, 385, 529 A.2d 419, 430 (1987).

decision-maker,[48] why is the risk of error in a familial decision to terminate life-sustaining treatment not great enough to justify or require judicial intervention? The doctrine of third-party consent, particularly without court supervision, may actually authorize the third party to consent to an action that would be forbidden to the state itself.[49]

> [Third-party] type of consent is really nothing short of an extended conceit on the proposition of voluntariness. It is a fiction which authorizes the state to intervene because a party other than the subject provides the green light. . . . By characterizing the transaction as "consensual" rather than "compulsory," third-party consent allows the truly involuntary to be declared voluntary, thus by-passing constitutional, ethical, and moral questions, and avoiding the violation of taboos. Third-party consent is a miraculous creation of the law -- adroit, flexible, and useful in covering the unseemly reality of conflict with a patina of cooperation.[50]

The doctrine of third-party consent, without court oversight, is simply "inadquate to protect" the fundamental rights of the incompetent.[51]

A point often overlooked by many courts is that more than the incompetent's asserted right to refuse medical treatment is at stake in these cases. The withdrawal of treatment is not only the exercise of a purported liberty interest, but the waiver of the patient's right to life. The basis upon which many of these courts have found the implicit

48. *Parham*, 442 U.S. at 584.

49. Price, *Sterilization, State Action, And The Concept Of Consent*, 1 LAW & PSYCHOLOGY REV. 57, 78 (1975).

50. *Id.* at 58.

51. Conservatorship of Valerie N., 40 Cal. 3d 143, 191, 707 P.2d 760, 793, 219 Cal. Rptr. 387, 420 (1985) (Chief Justice Bird dissenting).

waiver of such a fundamental right is tenuous at best.[52] The evidence offered in many cases to indicate what choice an incompetent patient would have made is often woefully inadequate to constitute the "intentional relinquishment or abandonment of a known right."[53] For instance, the statements of Nancy Jobes were "remote, general, spontaneous, and made in casual circumstances."[54] The idea that a person can either exercise or waive a fundamental constitutional or common law right "unintentionally through informal statements years in advance" is "dangerously unpredictable"[55] and has not been applied in any cases other than termination of treatment.[56]

However, the lack of specific directives from the patient prior to incompetency does not remove the need to make a decision on the patient's behalf. Decisions will continue to have to be made and society must have some articulable basis upon which to do so. Here again, many courts falter because any such decision cannot be based upon an assessment of the quatlity or worth of the patient's life. According to the New Jersey Supreme Court "[w]e do not believe that it would be appropriate for a court to designate a person with the authority to determine that someone else's life is not worth living simply because, to that person, the patient's "quality of life" or value to society seems negligible."[57] However, only two years later, the same court specifically approved different tests for making termination of treatment decisions, depending

52. *See* Johnson v. Zerbst, 304 U.S. 458 (1938) (petitioner convicted without counsel; Court held that there was insufficient proof to show that petitioner waived this fundamental right to counsel.).

53. *See id.* at 464-65.

54. *In re* Jobes, 108 N.J. 394, 412, 529 A.2d 434, 443 (1987).

55. *In re* Drabick, 200 Cal App. 3d 185, 211, 245 Cal. Rptr. 840, 856 (Cal. Ct. App. 6th Dist. 1988).

56. *Id.* The California Court of Appeals pointed out that a conservator's rights and authority over medical decisions were exclusive. *Id.* For other cases involving questions involving termination of treatment, *see* Matter of Quinlan, 70 N.J. 10, 335 A.2d 647 (1976); and Matter of Beth Israel Medical Center, 136 Misc.2d 931, 519 N.Y.S.2d 511 (1987).

57. *Matter of Conroy*, 98 N.J. 321, 367, 486 A.2d 1209, 1233 (1985).

upon whether the patient is in a persistent vegetative state.[58] In devising a test for vegetative state patients which made it easier to decide to terminate treatment, the court held: "[l]ife-expectancy analyses assume that there are at least some benefits to be derived from the continued sustenance of an incompetent patient. That assumption, which is usually valid . . . is not appropriate in the case of persistently vegetative patients . . . ." [59] This is nothing less than a court's value judgment that the life of a vegetative state patient is not worthy of the same degree of protection as some other class of incompetent patient. Having courts focus on a patient's prognosis in determining whether a patient's desire to refuse treatment should be effectuated raises the specter of the worst kind of state paternalism: having the state regularly make judgments about the value of a life.

This implicit value judgment regarding the worth of the patient's life may explain why courts are so quick to deviate from or ignore generally accepted legal principles. In other words, the judges apparently agree with the purported decision of the incompetent patient and, therefore, look for a means to effect it.[60] However, this process says more about the values and judgments of the judges involved than it does a about the patient's. Because in the final analysis the patient's wishes are unknown and unknowable, society must tread carefully in formulating a basis upon which these treatment decisions can be made. To avoid even an implicit state judgment on the value of an incompetent's life, a state should establish objective factors which should be considered when making treatment decisions on behalf of such persons. The application of explicit, objective standards affords the best protection against possible arbitrary and discriminatory

58. *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987).

59. *Id.* at 374-75, 529 A.2d at 424.

60. *See, e.g., Peter*, 108 N.J. at 365, 529 A.2d at 419; Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977).

actions.[61]

Thus, any system of decision-making on behalf of incompetent persons should include significant judicial oversight, if not outright judicial decision-making. This was the approach taken by the Missouri Supreme Court in *Cruzan v. Harmon*.[62] The court held that under Missouri law a guardian's statutory duty was to assure that the ward received medical care.[63] Any deviation from this statutory duty could only be approved by a court.[64] This result was consistent with other Missouri provisions which required judicial approval of decisions of less significance than terminating life-sustaining treatment: Commitment to a mental institution, psychosurgery and electroshock therapy.[65] Similarly, some states require judicial approval, rather than a guardian's, prior to sterilization of a ward of the court.[66] Ironically, the District Court of Connecticut disagreed with the *Quinlan* rationale, although both cases relied upon the United States Supreme Court privacy decisons: parents may neither validly consent to nor veto sterilization of their minor child.[67]

Even in matters in which a substantive constitutional right is at stake, such as abortion, judicial decision-making has been approved, at least in instances where the person is not able to make a valid decision.[68] Apart from being constitutionally permissible, sound policy would also appear to call for a stronger judicial role. Because of the possible, unconscious reliance upon personal motives, it is by no means sure that parents or family members would be the most

61. *See In re* Westchester County Med. Ctr., 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988).

62. 760 S.W.2d 408 (Mo. 1988).

63. *Id.* at 424.

64. *Id.* at 425.

65. *See* MO. ANN. STAT. § 475.121-23 (Vernon 1956 & Supp. 1990).

66. *In re* Penny, 120 N.H. 269, 414 A.2d 541 (N.H. 1980); *In re* Johnson, 45 N.C. App. 649, 263 S.E.2d 805 (N.C. Ct. App. 1980).

67. Ruby v. Massey, 452 F. Supp. 361, 371 (D. Conn. 1978).

68. Bellotti v. Baird, 443 U.S. 622 (1979).

appropriate persons to make the sugnificant life-and-death decisions which are at stake in these cases.[69]

In considering prior statements or directives of a patient, the court should insist upon reliable evidence "that the patient had a firm and settled commitment to the termination of life supports under the circumstances like those presented."[70] A decision to refuse life-sustaining treatment should be as informed as a decision to accept treatment.[71] In addressing both the exercise of a right to refuse treatment, as well as the waiver of something as fundamental as the right to life, courts should not stray too far from normal waiver doctrines. They should not, for instance, assume what a patient may have wanted.[72] Assessing the evidence of a patient's wishes which is typically available is not an easy task. Most persons have made statements, at one time or another, which might later be argued to evince an intent to refuse treatment.[73] Yet it is a task which must be undertaken because whatever system of decisionmaking is adopted "must also provide shelter for those who would choose to live--if able to choose--despite the inconvenience that choice might cause others."[74]

Finally, in assessing an incompetent patient's best interests, a state should not treat different forms of proposed treatment identically. Presumably a competent patient would not do so when making his own decision and neither should a court on making the decision on behalf of an incompetent patient. Therefore, a court should consider whether the treatment may be characterized as ordinary or extraordinary, whether the treatment will have its desired effect even if that

69. *See* Parham v. J.R., 442 U.S. 584, 632 (1979); In the Matter of the Guardianship of Eberhardy, 307 N.W.2d 881, 897 (Wis. 1981).

70. *In re* O'Connor, 72 N.Y.2d 517, 531, 531 N.E.2d 607, 613, 534 N.Y.S.2d 886, 892 (1988).

71. Cruzan v. Harmon, 760 S.W.2d 408, 417 (Mo. 1988) (*en banc*).

72. *O'Connor*, 72 N.Y.2d at 529-30, 531 N.E.2d at 613-15, 534 N.Y.S.2d at 891-92.

73. *Id.* at 532-33, 531 N.E.2d at 614, 534 N.Y.S.2d at 893.

74. *Cruzan*, 760 S.W.2d at 419.

effect is not to cure totally, and whether it presents any substantial risks to the patient. The court might also consider whether an incompetent patient has been diagnosed as being terminally ill.[75]

CONCLUSION

Far too many cases dealing with the termination of life-sustaining treatment for incompetent patients have resulted in decisions based upon questionable legal fictions or distortions of normal prinicples which most courts would not tolerate in a case dealing with any other subject matter. The fundamental difficulty with the cases is that they have gotten too wrapped up in the rhetoric of individual rights and lost sight of the fact that what really is called for is a decision which will adequately protect all of the rights of the incompetent patients, not just the asserted right to refuse medical treatment. This is a traditional sort of inquiry that courts are often called upon to make. The assumptions that courts and legislatures make when acting on behalf of incompetent persons in other areas of the law should not suddenly become irrelevant when the question is withdrawal of life-sustaining treatment. To do so neither furthers any personal rights of choice of the incompetent patient, nor provides adequate protection against the incompetent person's right to life.

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75. *Id.*