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**Decisionmaking for the Incompetent Terminally Ill Patient: A Compromise in a Solution Eliminates a Compromise of Patients' Rights**

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Decisionmaking for the Incompetent Terminally Ill Patient: A Compromise in a Solution Eliminates a Compromise of Patients' Rights

State courts and legislatures continue to grapple with the problem of who may make decisions about discontinuing care for incompetent terminally ill patients. The multiple issues raised by the question "Who decides?" which include medical, legal, ethical, and social considerations, have resulted in a tug of war between medical and legal forums. Legislative action has been limited in this area, and the answers proposed by state courts lack uniformity.

This note focuses on the continuing battle between medical and judicial forums in those jurisdictions where the legislature has not acted. Courts confronting the question in the past have generally produced two different basic solutions. Some courts have opted against judicialization, leaving the decision of discontinuing care for incompetent terminally ill patients up to their doctors and families. Other courts think that more judicial control over the decisionmaking process is desirable. The advantages and


A popular legislative alternative is the "living will," which is an "instrument executed with the formalities necessary for a valid will, expressing an intention to refuse treatment and release medical personnel from all liability should the declarant become terminally ill and incapable of asserting the right to refuse treatment." Ufford, Brain Death/Termination of Heroic Efforts to Save Life—Who Decides?, 19 Washburn L.J. 225, 247 (1980). There are variations of the broadly defined "living will," see, e.g., Cal. Health & Safety Code §§ 7185-7195 (West Supp. 1978), yet living wills are generally not legally enforceable without legislation. See Note, supra, at 917. Living wills frequently prove to be insufficient because of the complexity of the terms included in the legislative guidelines. "Terminal condition," "life-sustaining procedures," and "artificial means" are only a few of the extremely complex phrases that provoke confusion and disagreement over their meanings. Id. at 920-21. Other flaws are that living wills cannot apply to minors and that sample forms lead patients to believe they have fewer rights than they do. Ufford, supra, at 248. Nevertheless, legislation provides an advantage by allowing a person to voice his decision, when there is no doubt of his competency, as to his ultimate treatment if he becomes incompetent and terminally ill. Living wills would thus release a physician from liability and remove the burden of decisionmaking from others. Due to the limited extent of legislative action, however, legislative solutions to the problem of who decides remain inadequate and are not considered extensively in this note.
disadvantages of each of these approaches will be explored in light of both the rights of the incompetent terminally ill patient and the interests of families, society, and the medical profession.

This note argues that the patient's interests are foremost and other considerations, while relevant, are secondary. Consequently, the decision-maker must be able to represent fully the interests of the patient. The solutions offered by existing court decisions do not deal clearly with these concerns. Yet, some guidance as to when the medical forum is an inadequate decisionmaker and when intervention by the legal system is needed to insure the protection of the rights of an incompetent terminally ill patient has been developed recently through Massachusetts decisions dealing with this issue.

This note proposes that a compromise solution is best suited to resolve the problem. An examination of previous court decisions and potential alternatives yields an answer involving both the medical and judicial forums. When the patient's interests are clearly being represented, the proper decisionmaker is the medical forum. If any conflicts arise and the decision concerning the patient's treatment is not unanimously accepted, then judicial intervention is necessary.

THE COMPETING FORUMS

The subject of facilitated death has been difficult for society to deal with. The questions raised have been couched in different forms ranging from "when life-prolonging technology should be used and when it should be withdrawn" to "not how death can be prevented, but how much effort, if any, should be made to postpone the moment of death." Crucial to the subject has been the question "Who should represent the interest of the incompetent terminally ill patient in the decision to withhold life-prolonging treatment?" The New Jersey case of In re Quinlan, favoring medical decisionmaking, and the Massachusetts case of Superintendent of Belchertown State School v. Saikewicz and its progeny, favoring judicial decisionmaking, illustrate the two main conflicting answers.

In re Quinlan: The Medical Forum as Decisionmaker

Unknown causes reduced twenty-one-year-old Karen Quinlan to a

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2 Ufford, supra note 1, at 236-37.
"'chronic persistent vegetative state.'" No known cure for her condition existed. Karen's father wished to be appointed guardian for the person and property of his daughter and sought the power to authorize the discontinuance of all extraordinary procedures required to sustain her vital processes. After such authorization was denied by the New Jersey Superior Court, based on the patient's right of privacy, the New Jersey Supreme Court reversed and announced the method for determining who should decide whether extraordinary care should be provided:

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 therefor on the part of any participant, whether guardian, physician, hospital or others.

The Quinlan case recognized the conflict existing between the medical and judicial forums as decisionmakers. This conflict prompted the New Jersey Supreme Court to note Judge Muir's comments in the lower court questioning what justification could exist for removing the responsibility for care of a patient from the medical profession to the judiciary. Quinlan asserted that the patient's doctors are the proper decisionmakers:

We glean from the record here that physicians distinguish between curing the ill and comforting and easing the dying; that they refuse to treat the curable as if they were dying or ought to die, and that they have sometimes refused to treat the hopeless and dying as if they were curable.

The decision did not call for any change in longstanding medical practice, except possibly for the routine involvement of an ethics committee.

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7 70 N.J. at 24, 355 A.2d at 654 (quoting expert witnesses). One of the experts defined this to be the state of a "subject who remains with the capacity to maintain the vegetative parts of neurological function but who . . . no longer has any cognitive function." Id.
8 Id. at 18, 355 A.2d at 651.
9 Id. at 54, 355 A.2d at 671 (footnote omitted).
10 Id. at 44, 355 A.2d at 665 (quoting In re Quinlan, 137 N.J. Super. at 259, 348 A.2d at 818).
11 Id. at 47, 355 A.2d at 667.
12 Relman, The Saikewicz Decision: A Medical Viewpoint, 4 AM. J.L. & MED. 233, 234 (1978). Quinlan suggested that after a concurrence by the attending physician and family, an ethics committee should be consulted. The traditional view of the family has developed into a general belief held by society that the family's wishes should always be taken into consideration. Traditionally, "[w]hen dying was a personal at-home occurrence, the law did not intervene, with limited exceptions, to question the family's wisdom or right to treat the dying as it deemed best." Note, No-Code Orders vs. Resuscitation: The Decision to Withdraw
Saikewicz and Progeny: Toward Judicial Decisionmaking

Superintendent of Belchertown State School v. Saikewicz: Setting the Pace

A year after Quinlan, the Supreme Judicial Court of Massachusetts rejected the medical forum approach in Superintendent of Belchertown State School v. Saikewicz. A succession of decisions in the Massachusetts courts have since expanded and clarified Saikewicz, outlining guidelines for the utilization of the judicial forum.

Saikewicz was an incompetent with an incurable illness, undergoing life-prolonging treatment. In deciding whether to allow discontinuation of treatment, the court recognized that one of the main issues it had to confront was what particular procedures are necessary to insure the rights of the incompetent. The court held that incompetent patients have the same rights as competent ones and that those rights include declining medical treatment under certain circumstances. It was further held that the probate court should, upon petition, decide whether a patient is mentally incompetent under state law and, if so, should appoint a guardian to present arguments in favor of prolonging the patient's life by treatment. An ethics committee could be consulted, but was not required.

Saikewicz was a sweeping decision that called for routine judicialization of cases dealing with incompetent terminally ill persons. The court did not view the judicial resolution "as constituting a 'gratuitous encroachment' on the domain of medical expertise. Rather, such questions of life
and death . . . require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. A subjective test was seen as the answer, the goal of which was to determine accurately the wants and needs of the individual involved.

In re Dinnerstein: Applying Saikewicz

In In re Dinnerstein, a lower court narrowly interpreted the holding of Saikewicz by upholding for the first time, with limitations, the validity of a no-code order entered without prior judicial approval. Dinnerstein's attending physician recommended that resuscitation efforts not be undertaken, and the family concurred with the decision. The doctor wanted to enter a no-code order, which is entered in a patient's medical record and "instructs the nursing staff, as part of the attending physician's ongoing instructions to the nursing staff for the care of the patient, not to summon the code team in the event of cardiac or respiratory arrest." Specifically, the court held that, under the circumstances, it was lawful not to resuscitate unless a court had previously determined that resuscitation was in the patient's best interests. The court recognized that a contrary holding would have devastating results:

The practical results of such a reading would, of course, be very far reaching, since it is obvious on reflection that cardiac or respiratory arrest will signal the arrival of death for the overwhelming majority of persons whose lives are terminated by illness or old age; indeed, they are part of the normal act of death.

Dinnerstein interpreted Saikewicz as requiring prior court approval for withholding or withdrawing treatment only when an incompetent person is suffering from a treatable or curable condition and some individual responsible for the care of that incompetent does not believe that such treatment should be rendered. The opinion may best be viewed as refusing to require resuscitative procedures that would operate as "a pointless, even cruel, prolongation of the act of dying."

Despite the seeming clarity of the rationale underlying the decision,
many legal issues were still left unsettled after Dinnerstein. The decision did not answer whether a no-code order could be used in situations where the patient was not permanently incompetent, a guardian had not been appointed, or third party interests were involved. The court also failed to discuss the propriety of using a no-code order where the patient's family and physician were not in agreement as to treatment, and where the disease might be terminal, but death not imminent.

In re Spring: Expanding Saikewicz

A recent Massachusetts case, In re Spring, both clarified and clouded matters dealt with previously. Spring was an incompetent with permanent and irreversible senility and kidney disease. He experienced unpleasant side effects from the treatment he was receiving, and his family believed that if he were competent, he would request withdrawal of the treatment.

Reaffirming Saikewicz, the Supreme Judicial Court of Massachusetts recognized the right of an incompetent to refuse medical treatment and applied a substitute judgment standard—a standard requiring the court to decide as it thinks the incompetent would decide if he were competent. The court rejected the suggestion that Saikewicz always requires prior court approval before withholding life-prolonging treatment from an incompetent patient. Spring reiterated the procedures outlined in Saikewicz and suggested "a variety of circumstances to be taken into account in deciding whether ... prior court [approval is necessary] with respect to the treatment of an incompetent patient." The court listed the following circumstances:

-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 treat-

24 Note, supra note 12, at 159-60.
25 Id.
26 In re Spring, Mass., 405 N.E.2d 115 (1980).
27 Id. at 405 N.E.2d at 119.
28 See notes 118-23 & accompanying text infra.
29 See Mass. at 405 N.E.2d at 120-22. Some persons had said that Saikewicz required prior judicial approval "even in cases of 'brain death.'" Mass. at 405 N.E.2d at 119 (citing Annas, supra note 3, at 387). The court observed that neither Spring nor Saikewicz involved the legality of action taken without judicial authority, but that "[t]here is no legal basis for a duty to administer medical treatment after death," including brain death. Mass. at 405 N.E.2d at 119.
30 Mass. at 405 N.E.2d at 120-21.
ment, 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, the consent of the patient, spouse, or guardian, the good faith of those who participate in the decision, the clarity of professional opinion as to what is good medical practice, the interests of third persons, and the administrative requirements of any institution involved.\textsuperscript{23}

Although the court listed specific items to be considered, it was noncommittal about which combination of circumstances might render prior court approval necessary.\textsuperscript{24}

The Massachusetts Supreme Court in \textit{Spring} left open the possibility that in certain cases no prior judicial approval may be needed to withdraw life-prolonging treatment from a terminally ill patient. The court's guidelines are unclear, however, because they are so general, and little direction can be gleaned from the court's discussion of prior Massachusetts decisions. \textit{Spring} only mentioned \textit{Dinnerstein} in passing, saying that it was consistent with the holding in \textit{Saikewicz}.\textsuperscript{25} Nevertheless, the \textit{Spring} court felt strongly that legal questions dealing with whether treatment should be withheld should not be delegated to a private person or group if they have been properly presented to a court.\textsuperscript{26} The open-ended quality of the \textit{Spring} opinion therefore allows considerable flexibility in decision-making procedures for withdrawal of life-prolonging treatment. Such flexibility, however, is gained only at the cost of added ambiguity. While physicians and families are allowed a degree of freedom from judicial involvement, the ultimate authority of the legal system to decide is still very much present.

\textbf{Eichner v. Dillon: Reshaping \textit{Saikewicz}}

New York chose to follow \textit{Saikewicz'} approach by favoring a judicial forum, but required stricter procedures than Massachusetts in the 1980 case of \textit{Eichner v. Dillon}.\textsuperscript{27} There the court outlined a procedure to follow

\textsuperscript{23} Id. at ____, 405 N.E.2d at 121.
\textsuperscript{24} Id. On the specific facts presented in \textit{In re Spring}, the court held that treatment should be withheld. Id. at ____ , 405 N.E.2d at 123. The court expressed a desire that cases should be expedited, as there are serious costs produced by a lack of finality. Id. at ____, 405 N.E.2d at 122. The court suggested some possible routes to achieve expedition. "The probate judge may expedite the subsequent hearing, and may report a question arising on an interlocutory order.... If there are substantial reasons ... a joint application for direct appellate review by this court may be appropriate. ... If other remedies fail, an application may be made to a single justice of this court to exercise our power of general superintendence." Id. at ____ , 405 N.E.2d at 123-24.
\textsuperscript{25} Id. at ____ , 405 N.E.2d at 120.
\textsuperscript{26} Id. at ____ , 405 N.E.2d at 122.
\textsuperscript{27} 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980). Brother Joseph Fox, an 83-year-old member of the Roman Catholic Order of the Society of Mary, was in an "irreversible and permanent vegetative coma." Id. at 442, 426 N.Y.S.2d at 528. Eichner, Fox's guardian, instituted
whenever the withdrawal of extraordinary life-sustaining measures from the incompetent terminally ill patient is proposed. First, the attending physician must certify that the patient is terminally ill and in an irreversible, chronic, or permanent vegetative coma, and that the prospects of his regaining cognitive brain function are extremely remote. Second, the person to whom the certification is made must present the prognosis to an appropriate hospital committee, which must then reject or accept the proposal. If there is no existing committee, then one must be appointed by the hospital's chief administrative officer, with confirmation of the prognosis requiring a majority vote. After confirmation by the committee, a proceeding may be commenced for the granting of permission to have the life-sustaining measures withdrawn. The court will appoint a guardian to represent the patient in such a proceeding. The Eichner court recognized that the outlined procedures might appear time-consuming, but felt that such a procedure was necessary to protect the rights of the incompetent. The court decided that “the societal interests to be safeguarded are so great that the courts have no choice but to intervene and examine each case on an individual, patient-to-patient basis.” Eichner does not allow any discretion in the allocation of decisionmaking powers and, as a result, rejects the Quinlan medical forum approach as firmly as the Massachusetts decisions.

THE PATIENT'S RIGHTS

Representing an incompetent terminally ill person's rights should be the chief concern in making decisions about his continued treatment, and a test balancing this paramount concern against competing interests may be employed to protect the patient's rights. There is strong support for the idea that a person's right of choice and recognition of his inherent

proceedings to have Brother Fox declared incompetent, and to obtain a judicial order for the withdrawal of the respirator. Eichner testified that were Fox competent, he would not want any of the extraordinary procedures, and he had, in fact, expressed this desire. Id. at 439-40, 426 N.Y.S.2d at 526.

Id. at 476-77, 426 N.Y.S.2d at 550. If the court concluded that the treatment should be withdrawn, then no participant would be subject to criminal or civil liability.

Id. at 477, 426 N.Y.S.2d at 550.

Id. at 477, 426 N.Y.S.2d at 551. See Paris, Court Intervention and the Diminution of Patient's Rights: The Case of Brother Joseph Fox, 303 New Eng. J. Med. 876, 877 (1980). Judge Mollen, writing for the majority, acknowledged that any decision would be easier if the patient had written a “living will” or had clearly expressed his desires, as Brother Fox had, before becoming incompetent.

Id. at 474-75, 426 N.Y.S.2d at 549. For other examples of cases rejecting the Quinlan approach, see In re Benjamin C., No. J914419 (Super. Ct., Los Angeles County, Cal. Feb. 15, 1979); Saad v. Wesley Medical Center, No. 77C 460 (Kan. 18th Jud. Dist. Feb. 25, 1977). See also Ufford, supra note 1, at 254, 258; 6 Fam. L. Rep. (BNA) 49 (1980).

See Note, supra note 1, at 914 & n.3.
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dignity and value should have high priority. The foundation of such an idea is deeply imbedded in our history:

The notion that a person is an autonomous being with inherent dignity and value and whose life and actions are—to the greatest extent compatible with the rights of others—to be controlled by his own choices, has been a dominant theme in the philosophy and politics of Western Civilization since the Enlightenment.44

The court in Superintendent of Belchertown State School v. Saikewicz45 stated that "[t]here is implicit recognition in the law . . . that a person has a strong interest in being free from nonconsensual invasion of his bodily integrity."46 While there is no legally recognized "right to die,"47 a competent adult may nevertheless refuse life-sustaining treatment, even if the result of a recognition of this right will be to induce or hasten death.48 The importance of protecting a patient's dignity and privacy has also been recognized by legislation.49

Both In re Quinlan50 and Saikewicz found that a patient's rights were supported by the Constitution. "Of even broader import [than the implicit recognition that a person should be free from nonconsensual invasion], but arising from the same regard for human dignity and self-determination, is the unwritten constitutional right of privacy found in the penumbra of specific guarantees of the Bill of Rights."51 This right of privacy is broad enough to include a patient's decision to decline medical treatment under


44 Id. at 738-59, 370 N.E.2d at 424. See Union Pac. Ry. v. Botsford, 141 U.S. 250, 252 (1891); Thibault v. Lalumiere, 318 Mass. 72, 60 N.E.2d 349 (1945); Commonwealth v. Clark, 43 Mass. (2 Met.) 23 (1840). "In short, the law recognizes the individual interest in preserving 'the inviolability of his person.'" 373 Mass. at 739, 370 N.E.2d at 424 (quoting Pratt v. Davis, 118 Ill. App. 161, 166 (1905), aff'd, 224 Ill. 300, 79 N.E. 562 (1906)). "Courts have long recognized the principle that every human being of adult years and sound mind has a right to determine what shall be done with his body." Note, supra note 1, at 913 & n.3 (quoting Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914)); Accord, Cantebury v. Spence, 464 F.2d 772, 780 (D.C. Cir.), cert. denied, 409 U.S. 1084 (1972).


46 Kindregan, supra note 47, at 921.


certain circumstances, but complications arise when a person is incapable of voicing his choice as to treatment. Recent cases, however, have extended the right to refuse treatment to comatose and incompetent patients. The fact of incompetency alone should not rob an individual of his rights. The Saikewicz court noted: "We think that principles of equality and respect for all individuals require the conclusion that a choice exists. The recognition of that right must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both." When life has become a miserable physical burden to a patient who has no hope of recovery, that patient, even though incompetent, should not have to endure further treatment when his competent counterpart has the right to say "enough." It is the individual who is the subject of a medical decision who has the final say and . . . this must necessarily be so in a system of government which gives the greatest possible protection to the individual in the furtherance of his own desires.

Even when the state has a competing interest, the courts have given primary consideration to the patient’s rights. A balancing test is applied to weigh the patient’s right to individual autonomy against the claimed interests of the state. Courts have found that the state’s interests weaken and the individual’s right to privacy grows “as the degree of bodily invasion increases and the prognosis dims.” Such regard for an incompetent’s rights is a necessary counterpart to the traditionally high value assigned to any person’s dignity and privacy. A utilitarian approach protecting society alone would have disastrous results for individuals, as the application of this philosophy would rarely protect the individual. "The good of one individual is seldom strong enough to withstand the combined utility of many. Thus scarce resources, including personal rights and even life,
may be allocated on the basis of social worth criteria." The need to preserve a person's rights has thus properly been viewed by the courts to be of paramount concern in the step-by-step decision of when to terminate treatment.

The recognition of the right of an incompetent person to decline or continue treatment requires an examination of how such a right may be most effectively exercised, so as to afford the incompetent patient the fullest expression of his individual preferences and desires. Reconciling the claims of both the medical and legal forums provides a solution that offers the most adequate protection for the rights of the incompetent patient.

THE MEDICAL FORUM

The essence of the question "Who decides?" is the insurance of adequate representation and protection of the patient's rights. As in Quinlan, many feel that the physician is best qualified to serve such interests. A physician is already obligated to keep his patient's interests paramount, and one commentator has remarked that a doctor is also "obligated to confer with his patients or their next of kin, to keep them fully informed, and to be guided by their wishes." Physicians are also obligated by their traditional responsibilities to decide whether to treat someone, "which in effect will determine whether, and for how long, and in what condition the patient is likely to live or die." Trust is the essence of the relationship between the physician and the patient. Both patients and their families rely heavily on the professional judgment of their doctor. Emergency situations often arise, and a doctor may be forced to make a decision concerning treatment without advance consultation with the patient or his family. Many medical questions of a highly technical nature may arise which cannot be fully appreciated or understood by lay persons. Such considerations all favor the physician as the decisionmaker. Further, one commentator has argued that because of the fiduciary relation-

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62 373 Mass. at 747, 370 N.E.2d at 428.
63 "Medical paternalism" is a term often used to describe the proposition that physicians should be allowed to make their own decisions concerning the discontinuation of treatment for incompetent terminally ill patients. See, e.g., Buchanan, Medical Paternalism, 7 PHIL. & PUB. AFF. 370 (1978).
64 Reiman, supra note 12, at 236.
65 Id.
66 Id.
67 Id.
68 Id.
69 Id. at 237.
ship between a doctor and a patient, a doctor is obligated to make decisions for his patients.70

Recent polls indicate that a high percentage of medical practitioners are inclined to practice passive euthanasia on “hopelessly ill patients.”71 This suggests a duty felt by many physicians that the physician’s role is not just to heal but also to recognize the patient’s right to die. One critic of judicial intervention has stated:

[S]ociety and the law must recognize that physicians have been particularly trained with a technical competence that judges do not have and have learned to distinguish between “curing the ill and comforting the dying.” Judicial review should not be necessary to confirm a physiological diagnosis that a patient is dying.72

Only a small chance of abuse by physicians exists,73 and no recent research has reported lawsuits charging a doctor with civil or criminal liability for failure to treat a terminally ill patient.74

The view that physicians are the ideal decisionmakers is an oversimplification of the problem. Each patient will attach a different value to the possible benefits and costs that will lead him to his individual decision.

A decision to end the life of a terminally ill patient is no more a mere “medical question” to be decided by doctors than a decision to declare war is a mere “military question” to be decided by generals. . . . There is [a] decision which must be made before treatment can begin which can be made only by the patient himself: . . . What course of treatment offers me the chances of benefit that I wish at risks that I am willing to accept?75

As even Quinlan recognized, medical custom is persuasive authority, but it is never controlling as only courts can determine “human values and rights.”76 Physicians can be influenced or guided by self-interest or self-protection, “which would inhibit their independent medical judgments for the well-being of their dying patients.”77 The possibility of malpractice suits and the threat of liability remain forever a shadow at physicians’ sides.78 A doctor who is overly concerned with the legal ramifications of his actions may neglect to treat his patient’s interests as primary considerations.

70 Relman, supra note 12, at 237.
71 Note, supra note 1, at 915 & n.5. See Cantor, Law and the Termination of an Incompetent Patient’s Life Preserving Care, in THE DILEMMAS OF EUTHANASIA (J. Behnke & S. Bok eds. 1975).
72 Note, supra note 12, at 165.
73 Id.
74 Id.
75 Baron, Medical Paternalism & The Rule of Law: A Reply to Dr. Relman, 4 AM. J.L. & MED. 337, 340 (1979).
76 70 N.J. at 44, 355 A.2d at 665.
77 Id. at 43, 355 A.2d at 665.
Empirical data also suggest that many doctors are not in fact particularly adept at judging what their patients want. One commentator has argued that doctors cannot make rational decisions for patients despite the "paternalistic" relationship which may exist. He explained that in order to respect the patient's wishes, the doctor would have to have a profound knowledge of the patient's life history, personality, beliefs, aspirations, and capacity to cope, all of which is realistically impossible under the present conditions of highly impersonal specialist medical practice. Doctors are human, and sometimes "the motivation and technical skills of physicians lead them to see hope and health as ends in themselves," which results in some not being "able to accept as rational a patient's desire to know about and resign himself to impending death or to refuse treatment whose benefits the doctor believes outweigh concomitant risks."

Furthermore, although some medical decisions are of a technical nature, studies have indicated that patients do not generally believe they have delegated decisionmaking power to their doctors by virtue of the physician-patient relationship. Moreover, as one commentator noted:

Advocates of medical paternalism have not provided hard evidence for the sweeping generalization that decisions concerning life-prolonging treatment for terminally-ill patients typically or even frequently require technical medical knowledge beyond the ken of the patients' families. Yet only if such a generalization were firmly established would the medical paternalistic model of decision-making be plausible, for that model takes as paradigmatic the case in which the physician alone is able to understand what is in the patient's best interest. No concrete safeguards are provided as an assurance that the doctor can or will make a decision that will better represent the patient's interests than a decision by the family.

The flexibility offered by physicians as decisionmakers may thus be viewed as a liability as well as an asset. One crucial problem with the
medical forum as a decisionmaker is that it lacks essential safeguards found in the judicial forum. It has been stated that:

There are no institutional frameworks that require doctors to develop principles of decision making that are consistent from one doctor to another and from one time to another. As a result, few doctors have worked out principles of decision making that will survive even the most rudimentary criticism, and decisions which are made on the same set of facts will differ from day to day and doctor to doctor.\textsuperscript{86}

On a broad-based scale, the lack of uniformity that could occur in these important decisions would foster piecemeal results. The development of ethics committees could help solve this problem, however, because such committees may review decisions and offer structured guidance.\textsuperscript{87}

\textit{Quinlan} required the consultation of an ethics committee, even after a joint decision by the family and attending physician to discontinue treatment. The court supported its mandate by referring to an article by Dr. Karen Teel, a physician.\textsuperscript{88} Teel called for an ethical rather than a technical review of the decision to terminate treatment by a committee composed of social workers, attorneys, physicians, theologians, and others.\textsuperscript{89} In contrast, the \textit{Quinlan} court gave the committee the single task of confirming that there was “no reasonable possibility of Karen’s ever emerging from her present comatose condition to a cognitive, sapient state.”\textsuperscript{90} The hospital ethics committee was formed because staff and hospital administrators perceived a need for a way to deal with perplexing internal problems.\textsuperscript{91} An ethics committee could be a weapon against the possibility of collusive manipulation by families and by physicians and may also provide a “meaningful avenue” for patients and families to exercise their rights.\textsuperscript{92}

The inherent nature of a committee structure reduces the possibility of collusion by doctors or families by serving as an additional internal check within the decisionmaking process.\textsuperscript{93} These committees allow much needed dialogue, force an exploration of all the patient’s options, diffuse the responsibility for decisionmaking, and may eventually assume a legal status that would lessen the concern for potential liability.\textsuperscript{94} One commentator has recognized many positive aspects of an ethics committee:\textsuperscript{95}

\begin{itemize}
  \item \textsuperscript{86} Baron, \textit{supra} note 75, at 349-50.
  \item \textsuperscript{87} For a discussion of hospital ethics committees, see notes 88-101 & accompanying text infra.
  \item \textsuperscript{88} 70 N.J. at 49, 355 A.2d at 668 (citing Teel, \textit{The Physician’s Dilemma: A Doctor’s View: What the Law Should Be}, 27 \textit{BAYLOR L. REV.} 6 (1975)).
  \item \textsuperscript{89} Teel, \textit{supra} note 88, at 8-9.
  \item \textsuperscript{90} 70 N.J. at 55, 355 A.2d at 671.
  \item \textsuperscript{92} Id. at 27.
  \item \textsuperscript{93} Id., supra note 88, at 9.
  \item \textsuperscript{94} Id.
  \item \textsuperscript{95} Buchanan, \textit{supra} note 85, at 115.
\end{itemize}
decisions would be subject to review and further investigation if commit-
tees were available, thereby producing more consistent decisions; such
decisions would also be supported by reasons and would be rendered more
quickly and economically than decisions by a judicial forum. Moreover,
people’s moral opinions could be heard and responses elicited from within
the framework provided by an ethics committee. The major benefit is
seen as being the “restoration of a sense of shared responsibility for the
patient and family and, above all, the maximizing of support for the respon-
sible physician....” This benefit will insure the primary representation
of the patient’s rights and will allow the balancing of other considerations.

Teel recognized that use of an ethics committee may also present some
difficulties, including opposition by many families and physicians to in-
trusion on their freedom to make independent judgments. The court in
Saikewicz implicitly criticized Teel’s approach because it thought the
Quinlan court had permitted the “ethics committee” to make legal deci-
sions as opposed to simply acting as a consultant. It is also clear that
“committees are slow to act; [and] large hospitals may find it difficult
to assemble a readily available group....”

Despite its advocacy of the use of ethics committees, the Quinlan court
left unclear guidelines as to their proper role. Four possible tasks of the
committee are to review ethical and other values found in individual pa-
tient care decisions, to make more general ethical and policy decisions,
to counsel, and to make prognoses. With such a broad mandate, the
ethics committee as an institution may degenerate into an amorphous and
unwieldy body incapable of producing uniformity or being widely adopted.
An ethics committee could be valuable in the decisionmaking process, but
only when used in conjunction with physicians as decisionmakers. Ethics
committees could limit collusion, consider more factors, and eliminate a
technical monopoly held by physicians that may occur in certain cases.
Yet only if hospitals use such committees routinely can they supply a
stability useful in decisionmaking.

Despite these shortcomings associated with the medical forum, having
doctors as decisionmakers for incompetent terminally ill patients’ treat-

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96 Clinical Care Comm. of Mass. Gen. Hosp., Optimum Care for Hopelessly Ill Patients,
98 Annas, supra note 3, at 381.
99 Note, supra note 12, at 170.
100 Veatch, Hospital Ethics Committees: Is There a Role?, Hastings Center Rep., June,
101 Many other questions have been raised concerning the procedural aspects of ethics
committees, including who should be on the committee, who should appoint the committee,
who should call the meeting, who should be the chairman, when the committee should meet,
when and how voting should be done, what should constitute a quorum or controlling ma-
jority vote, what notice requirements should be observed, and whether the incompetent
should have representation on the committee. Annas, supra note 3, at 385.
ment offers many advantages. A decision by the attending physician effectively represents the patient’s rights when the family’s opinion and the ethics committee’s opinion are taken into consideration. The medical forum can offer strong protection for an individual’s rights.

THE JUDICIAL FORUM

A strong foundation also supports the proposition that courts are best suited to serve as decisionmakers. Saikewicz supported the legal forum approach, quoting Justice Cardozo’s view on the necessary function of the judiciary:

You may say that there is no assurance that judges will interpret the mores of their day more wisely and truly than other men. I am not disposed to deny this, but in my view it is quite beside the point. The point is rather that this power of interpretation must be lodged somewhere, and the custom of the constitution has lodged it in the judges. If they are to fulfill their function as judges, it could hardly be lodged elsewhere.102

The basis for judicial decisionmaking rests on a “gradual development of a body of common law principles, based in societal values, that can be used for deciding fundamental questions with which a ‘new technology’ is now challenging our society.”103 Courts have always been faced with reconciling new facts with old principles. The judicial system is vitally interested in defining and safeguarding the individual’s and society’s interests and, as a result, may judge that the neutral presence of the law is necessary to weigh such factors as the patient’s wishes, the views of the family, and the interests of society.104 The Eichner court made it clear that the courts do not distrust doctors; the court must ultimately rely on a physician’s medical prognosis.105 The judicial forum, therefore, does not eliminate input by physicians; however, it refuses to rely solely on the doctor’s opinion.

There are advantages in allowing courts to decide when to discontinue life-supporting treatment for incompetent terminally ill persons. The public nature of judicial proceedings, the requirement that a judge’s decision be principled, the impartiality of the decisionmaker, and the adversary nature of the judicial system are the main desired aspects furnished by the legal forum.106 Another positive feature is the factfinding process central to the legal system. “[T]he fact-finding process of a court is necessary to protect society’s interests in affording each of its members an impar-

102 73 A.D.2d at 453, 426 N.Y.S.2d at 535 (quoting B. CARDOZO, THE NATURE OF THE JUDICIAL PROCESS 135-36 (1921)).
103 Baron, supra note 75, at 353.
104 73 A.D.2d at 475, 426 N.Y.S.2d at 550.
105 Id.
106 Baron, supra note 75, at 347-49.
tial determination of his best interests, when he is incapable of making that determination on his own. Courts can provide a forum where different groups are able to coordinate their concerns and their input of information. Of course, courts must rely on the medical profession in deciding the medical aspects of a problem and are not ignorant of or insensitive to the expertise and needs of the medical community on various intersecting issues. The judicial forum remains necessary because "questions of life and death . . . require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch was created."

Without court involvement, it is possible that the patient would not have a representative; the adversary system provides this. A guardian ad litem can insure that the patient will have vigorous representation. Courts, as referees within an adversary system, are impartial by design and because of this characteristic are able to exclude from the decision-making process criteria that should not be considered. In Saikewicz, for example, the court made clear that the patient's life will not be viewed

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107 Kindregan, supra note 47, at 933. But see, e.g., Thibaut & Walker, A Theory of Procedure, 66 Cal. L. Rev. 541, 563 (adversarial system should consist of two-tiered procedure; first stage would resolve questions of fact with objective of determining truth; second would resolve questions of policy in separate procedure).


110 Kindregan, supra note 47, at 929 ("Although a high standard of proof is required of the plaintiff, our present procedures do not insure an adversary process"). The importance of the role of a guardian ad litem was recognized by the Saikewicz court: he will represent the interests of the person he is appointed to represent and is charged with an additional responsibility if there is a finding of incompetency. This responsibility is to present to the judge all reasonable arguments in favor of administering treatment to prolong the life of the individual involved. 373 Mass. at 756-57, 370 N.E.2d at 433-34. The court thought that this insured that all viewpoints and alternatives would be considered, and assured objectivity and fairness in the administration of cases. Id. "The hardest question is whether a guardian can assume a modicum of altruism on the part of a patient even in the absence of previously expressed concern for survivors' interests." Cantor, Quinlan, Privacy, and the Handling of Incompetent Dying Patients, 30 Rutgers L. Rev. 243, 260 (1977). Certain problems are evident in the use of guardians ad litem. Courts neither require that a guardian be appointed in each case nor offer guidance as to when such an appointment is necessary or desirable. The adversarial nature of the judicial process may also be lacking when the guardian ad litem is on the same side as those who initiated the proceedings. Baron, Assuring "Detached but Passionate Investigation and Decision": The Role of Guardians Ad Litem in Saikewicz-type Cases, 4 Am. J.L. & Med. 111, 119-21 (1979). The court speaks of the guardian arguing for treatment, but says nothing about arguing against treatment. Appointment of a guardian may be meaningless because there is no visible guarantee that a guardian, when weighing what is in the best interests of the patient, will consider viewpoints other than continuing treatment. Id.

111 Only facts which are made relevant by the legal principles to be applied may be considered by the court in reaching a decision. . . . Of course, judges are human, so the law prefers relying on more than the judge's self-control to eliminate consideration of prejudicial irrelevancies. First it attempts to assure
in utilitarian terms because "the chance of a longer life carries the same weight for Saikewicz as for any other person, the value of life under the law having no relation to intelligence or social position." The court system assures that other impermissible factors, such as hospital expenses, need for hospital beds, or the inconvenience of treating a terminally ill patient will not be controlling considerations in determining whether to treat a patient.

The courts also can balance the countervailing interests between the patient and the state. The patient's constitutional rights may be weighed against the interest of the state in prolonging life. One of the state's interests is in "maintaining the ethical integrity of the medical profession by protecting physicians against the compelled violation of their professional standards and against exposure to the risk of civil or criminal liability." This state interest may be accommodated by choosing the legal forum as the decisionmaker. As one commentator has stated: "[T]he court is not chosen as the forum because judges are wiser than other men. Rather, the court is the forum because only the judges can provide civil and criminal immunity to the person who withholds treatment." Even if the court does not provide immunity, it can provide the most reliable guidelines to inform physicians of the risk of civil or criminal liability.

Another attractive feature of the judicial forum is the substitute judgment standard used to protect an individual's rights. The standard gives paramount importance to the rights of the incompetent patient, and courts following the Saikewicz reasoning have all praised it. The court is required by the doctrine "to substitute itself as nearly as may be for the incompetent, and to act upon the same motives and considerations as

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to the parties a trier of fact who knows as little as possible about the case in advance of trial. Second, at trial, through the rules of evidence, it attempts to keep the trier of fact from learning anything which might be persuasive on grounds of prejudice (that is, reasons which are not relevant under the legal principle) rather than on grounds which are relevant to the legal principle involved.

Baron, supra note 75, at 348 (footnotes omitted).

113 373 Mass. at 753, 370 N.E.2d at 431.

114 Note, supra note 12, at 168.

115 Brant, The Right to Die in Peace: Substituted Consent and the Mentally Incompetent, 11 SUFFOLK U.L. REV. 959 (1977). Brant proposes a "rational calculus" which would recognize that the state's interest in prolonging life diminishes as the prognosis approaches the incurable and the prospects for even temporary extension are poor, while the individual's interest in bodily privacy increases with the severity of the treatment and its impact upon the character of his life. Id. at 973.

116 73 A.D.2d at 456, 426 N.Y.S.2d at 537.

117 Kindregan, supra note 47, at 919-20.

118 The doctrine of substitute judgment in its "original inception called on the court to 'don the mental mantle of the incompetent.'" 373 Mass. at 752, 370 N.E.2d at 431, (quoting In re Carson, 39 Misc. 2d 544, 545, 241 N.Y.S.2d 298, 289 (N.Y. Sup. Ct. 1962)). The doctrine was first used to aid in the administration of the estate of an incompetent person. See
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The original purpose of the doctrine of substitute judgment was to maintain the integrity of the incompetent person, and the doctrine still possesses merit “because of its straightforward respect for the integrity and autonomy of the individual.” The guardian and judge are both to be guided by this test, which insures that the wishes of the patient will be respected and that only those factors relating to what decision the incompetent would have made if competent will be taken into account.

The judicial system, however, also possesses weaknesses as a decision-maker. The judicial model avoids medical paternalism, but at the price of legal imperialism, which may be defined as “any position that extends the domain of the legal process beyond its proper boundaries, unjustifiably encroaching on other, nonlegal spheres of decision making.” A judicial decision may thus be seen as failing to take seriously the unique moral relation existing between the incompetent patient and his family. The legal system is also subject to some of the same criticisms as the medical forum, such as a lack of consistency and the inability of a court to know enough of a patient’s relevant characteristics to make a decision identical to the one he would have made were he competent. One critic has stated that routine judicialization also intrudes on sound medical practice. The courts cannot be expected to make sound judgments when “the moral issues are so intertwined with complex medical considerations, nor can they act promptly and flexibly enough to meet the rapidly changing needs of clinical situations.” Courts try to carry out objective standards, but it is not clear that they “refrain from making their own subjective value judgments.” The promise of judicial safeguards must also be qualified because of the impossibility of avoiding collusive lawsuits by families and physicians, which cannot always be discovered in order to prevent them.

Further problems in the judicial process include the large potential case load, which leads to delay, and the high costs involved. These factors

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120 373 Mass. at 751, 370 N.E.2d at 431.

121 For a discussion of the substitute judgment test, see text accompanying note 145 infra.

122 Buchanan, supra note 85, at 110.

123 Id. at 112.

124 See text accompanying notes 86-87 supra.

125 See text accompanying notes 80-81 supra.

126 See Relman, supra note 12, at 235-36.

127 Id. at 240.

128 Note, supra note 12, at 164.

129 Baron, supra note 111, at 117.

130 See Relman, supra note 12, at 241.
could result in "closet" decisions and a reluctance by both relatives and physicians to take a case to court, since they trust the medical decision and want to avoid expenses. Two kinds of costs are incurred: those incurred by participants in the hearing process, and those incurred by the court system. Father Eichner, the patient's guardian in *Eichner v. Dillon*, commented on the costs incurred because of hospitalization and litigation and wrote that the result of the litigation in that case was "a lawyers' paradise, not to mention a doctors' bonanza.... While this may be fine law, .... it certainly is not true justice."  

A POSSIBLE SOLUTION

Each of the possible alternatives has distinct advantages and disadvantages of differing degrees, and no solution will be without problems. The recent case *In re Spring* suggests a starting point by attempting to incorporate the best of each alternative. *Spring* sets the groundwork for a solution that will allow doctors to make decisions with the family's concurrence in some factual situations and will require courts to be decisionmakers under other circumstances. This solution will also enable other approaches, such as hospital ethics committees and guardians ad litem, to develop more fully, in order to deal with the problems that undermine their potential to contribute to the representation of incompetent terminally ill patients' rights.

The proposed solution consists of two main parts. One method of deciding right-to-die cases is to defer to the unanimous decision of doctors regarding the incompetent patient's treatment, if it is not in conflict with the wishes of the family. *Spring* stated that the court did not want its previous decisions to be taken as establishing a uniform requirement of prior judicial approval for discontinuing treatment. The court gave some guidelines indicating when prior judicial approval would be necessary, but did not specify what combination of factors would require application for a prior court order. This allows physicians some discretion to make a decision, but the propriety of the decision will vary with different fact situations. As the *Spring* court stated, "since the scientific underpinnings of medical practice and opinion are in a constant state of development, our opinion as to a particular set of facts may not be a reliable guide to the proper solution of a future medical problem."

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131 *Id.* "Closet" decisions are decisions made by the physician, family, or both without discussion or legal approval. *Id.*
132 See *id.*
133 See Baron, *supra* note 75, at 358.
134 *Paris*, *supra* note 40, at 877.
136 *Id.* at ___, 405 N.E.2d at 120.
137 *Id.* at ___, 405 N.E.2d at 121.
The reluctance of the court to assign a rule to any set of facts thus rested on the very pragmatic realization that future medical developments might very well render the rule obsolete, and its wisdom questionable. This reason for the court’s caution, however, does not suggest that doctors, with the concurrence of families, may not act when there is no dispute regarding medical prognosis, and no difference of medical opinion regarding treatment. Allowing doctors to act under such circumstances would solve many problems. The painful prolonging of a situation involving an incompetent terminally ill person that may result from resorting to the legal system would be eliminated. Frequently, doctors do not make a decision alone; the concurrence of either another physician or an ethics committee is usually involved in the process. Such mechanisms also allow the family to play a role in the decision. The chance of collusion would be minimized as the two groups, families and physicians, could provide a system of checks and balances, with the opportunity to resort to the legal system if any conflict arose.

Dinnerstein could also be applied if the Spring opinion is followed. Spring did not comment extensively on the holding in Dinnerstein, but stated that it was consistent with Saikewicz. The Saikewicz line of cases illustrated that it is necessary to distinguish the facts of each case. The important distinction in Dinnerstein was between treatment which aims for a temporary or permanent cure and treatment which merely seeks to delay imminent and inevitable death. Dinnerstein concluded that if the treatment is neither life-saving nor life-prolonging, but is only meant to delay impending death, then the treatment decision may be made without a court proceeding. The court narrowly held that a case that presented the question of “what measures are appropriate to ease the imminent passing of an irreversibly, terminally ill patient in light of the patient’s history and condition and the wishes of her family” is one within the competence of the medical profession. The Dinnerstein decision stated that the facts of that case did not present a “significant treatment choice or election” subject to judicial scrutiny because “[a]ttempts to apply resuscitation, if successful, will do nothing to cure or relieve the illnesses which will have brought the patient to the threshold of death.” Although there are still questions left unanswered after Dinnerstein, many of them can be answered, and Dinnerstein does offer a solution to specific decisionmaking problems. The incompetent patient will have his rights pro-

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120 Id. at ___, 405 N.E.2d at 120.
121 Dinnerstein interpreted the terms “life-saving” and “life-prolonging,” used in the Saikewicz opinion, as referring to treatment which seeks a result beyond “a mere suspension of the act of dying.” 6 Mass. App. Ct. at 472-73, 380 N.E.2d at 137-38.
122 Id. at 472-73, 380 N.E.2d at 139.
tected because no-code orders are only issued after a detailed medical evaluation that considers whether the patient's condition is irreversible, irreparable, and imminently fatal.

The protection of a patient's rights and the representation of an incompetent person can thus both be achieved if the physician and family are given decisionmaking authority. If there is any possibility, however, that the incompetent's rights are being violated, then the legal system is a necessary alternative. The Spring court admonished that "private medical decisions must be made responsibly, subject to judicial scrutiny if good faith or due care is brought into question in subsequent litigation." The family or a hospital ethics committee could raise the issue of whether a medical decision was made responsibly.

When a question dealing with the termination of an incompetent terminally ill patient's life arises, the courts have applied the substitute judgment doctrine, following Saikewicz. The precise definition of what it means to choose what the incompetent would do if competent is unclear. One commentator sees substitute judgment as combining subjective and objective elements:

The subjective elements are the present tastes and preferences of the incompetent and those which he might have if competent, if he has a reasonable chance of becoming so. The objective aspect is the determination of what a reasonable person with the characteristics and present and future wants of the incompetent would choose to maximize his interests.

Viewed in a skeptical light, the application of the substitute judgment doctrine may allow courts to impose their own subjective view on what the patient would desire. Yet the principle behind the doctrine is commendable and when properly used will protect the patient's rights. The application of the doctrine of substitute judgment by Saikewicz and its progeny becomes, in reality, a weighing of different interests. The courts use the doctrine to try to ascertain the incompetent patient's own wishes through available evidence and by asking what a reasonable person in the patient's particular factual situation would wish to do. Substitute judgment, as used by the Massachusetts courts, attempts to determine what a patient would choose, while protecting his rights and insuring that improper considerations, such as financial concerns or collusive motives, do not enter into the decision. This test is a more formal version of the subjective decisionmaking processes that physicians, families, and ethics committees also go through.

The guidelines presented in the Massachusetts line of cases and others

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144 __________ Mass. at __________, 405 N.E.2d at 122.
145 Robertson, supra note 43, at 68.
146 See Robertson, supra note 43, at 62. See also Kindregan, supra note 46.
that have followed Saikewicz provide the courts with an opportunity to create uniformity. The judicial system is a powerful safeguard for the rights of the incompetent individual because decisions can be reviewed and are subject to the scrutiny of the public. The impartiality and fairness inherent within the legal system147 and its ability to give a doctor's decision immunity recommend it as the final decisionmaker whenever conflicts arise which threaten the rights of an incompetent patient.

The main hurdles to be overcome within the judicial system are the problems of cost and delay. Each of these problems may be exacerbated due to the potentially great number of cases which may arise. If physicians are free to make decisions with the concurrence of families and/or hospital ethics committees, the potential case load will be smaller because the need for judicial intervention will be lessened.148

CONCLUSION

The chief concern regarding who should have the responsibility to decide when to terminate the life of an incompetent terminally ill patient is adequate protection of the patient's rights. In re Spring, the most recent opinion in the line of decisions following Saikewicz, offers groundwork for the answer to the question "Who decides?." Spring recognizes that factual differences among cases dictate different solutions. Medical practitioners frequently must deal with the question of when to terminate treatment for an incompetent terminally ill patient and can often deal properly with the problem. The rapid growth of medical technology prevents the court from providing specific guidelines for the physician and other decisionmakers. The freedom granted in Spring is at least a tentative solution to the multifaceted problem of "Who decides?."

Judicialization also provides a forum for answering the difficult question involved in decisionmaking and offers a method to assert an incompetent patient's rights. The substitute judgment test used by the court is a means for weighing different considerations involved in each factual situation and for upholding a patient's rights in the best possible manner. The judicial system can also provide continuing guidelines over time.

At first glance, it may appear that the growth of cases concluding with Spring has circled back to that deference toward medical decisionmaking which prevailed before any court involvement. This ironic perspective is fallacious as many changes have evolved because of judicialization. Judicial decisions have established a method of analysis that primarily focuses on the preservation of a patient's rights. As a result, more certainty regarding the extent of a physician's immunity from criminal and

147 See text accompanying notes 112-15 supra.
civil liability now exists. Decisions are less hampered by the self-defensive concerns of doctors, and the compromise solution as proposed by this note is more desirable and workable. Doctors and families should decide whether to terminate treatment without prior judicial approval when the decision is unanimous; such a process will be more expeditious than judicial proceedings and will be as able as a court to fit the particular facts of any case to a decision corresponding to what the patient would have wanted. The judicial system in cases of disagreement or uncertainty will then insure the availability of fairness to the incompetent. The solution proposed here achieves the best utilization of the qualities of each forum, leading to a more certain protection of the rights of incompetent terminally ill patients. The importance placed on guarding an individual's rights by the proposed solution may also provide a strong guiding emphasis for legislators should they decide to act upon this issue.

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