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Incompetents and the Right to Die: In Search of Consistent Meaningful Standards

BY MARK STRASSER*

INTRODUCTION

Competent patients have the right to refuse medical treatment, including artificial nutrition and hydration, even if that refusal will ultimately lead to their deaths.1 Incompetent patients are said to have the same rights as competent patients, although those rights obviously cannot be exercised in the same way.2 The particular mechanisms by which those rights can be exercised have generated some controversy, both in their substantive content and in the rationales used to justify their existence. Regrettably, the lack of a coherent rationale has led to a variety of competing and ultimately incompatible rationales and policies.

The two most frequently discussed paradigms for medical decision-making for incompetents are substituted judgment and best interests. Regrettably, the standards are used inconsistently, both with respect to when and to how they are employed. This lack of consistency thwarts rather than promotes the goals which these standards are designed to

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1 See infra notes 2-7 and accompanying text.

2 See infra notes 25-66 and accompanying text.
achieve. Unless these standards are clarified, the number of pointless prolongations and premature cessations of life will only increase.

Part I of this Article discusses incompetents and the right to bodily integrity. If indeed incompetents and incompetents have the same rights to bodily integrity, it is important for courts or legislatures to make clear what those rights include and how they are to be implemented. Currently, neither is particularly clear. Part II discusses the two tests commonly used to determine when treatment may be withdrawn from incompetent patients—substituted judgment and best interests. The courts' conflation of these tests, which have different criteria and different goals, may ultimately undermine the very purposes which these tests are designed to serve. Part III discusses the roles of family and the courts in the decisionmaking process, examines the legal definition of death, and analyzes the current system of liability for medical personnel and institutions. The Article suggests a modification which would not only bring this area of medical jurisprudence into line with other areas of medical jurisprudence, but also do much to assure that patients' wishes are actually carried out.

I. INCOMPETENTS AND THE RIGHT TO BODILY INTEGRITY

A. Right to Bodily Integrity

The right to bodily integrity has long been recognized. In Union Pacific v. Botsford, the U.S. Supreme Court recognized: "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others ...." In Natanson v. Kline, the Supreme Court of Kansas suggested that competent adults may "expressly prohibit the performance of life-saving surgery or other medical treatment." Numerous other state supreme courts have also recognized that the right to bodily autonomy includes the right to refuse medical treatment.

3 See infra notes 8-66 and accompanying text.
4 See infra notes 67-236 and accompanying text.
5 See infra notes 237-354 and accompanying text.
6 See infra notes 296-354 and accompanying text.
7 See infra notes 237-354 and accompanying text and pp. 152-54.
8 141 U.S. 250, 251 (1891).
The right to refuse treatment does not merely include the right to refuse highly invasive or very risky procedures; it also includes the right to refuse artificial hydration and nutrition. Thus, informed, autonomous individuals can refuse artificially delivered food and liquids even if that refusal will ultimately lead to their own deaths. This Article addresses neither the wisdom of including artificial nutrition and hydration within the category of medical treatment nor of allowing people to starve to death while denying them assistance in achieving a quicker and more painless death. Rather, this Article discusses which policies are 

1987) (explaining that the right to privacy encompasses the right to refuse medical treatment); In re Browning, 568 So. 2d 4, 9-13 (Fla. 1990) (finding that a competent person has the right to refuse medical treatment); In re Longeway, 549 N.E.2d 292, 297 (Ill. 1989) (explaining that Illinois common law permits the patient to refuse medical treatment); Leach v. Akron Gen. Medical Ctr., 426 N.E.2d 809, 814 (Ohio 1980) (explaining that a terminally ill patient has the right to refuse medical treatment); In re Grant, 747 P.2d 445, 455 (Wash. 1987) (recognizing the right of the terminally ill patient to have life-sustaining treatment withheld); In re L.W., 482 N.W.2d 60, 65-66 (Wis. 1992) (noting that the state constitution guarantees an individual's right to refuse medical treatment).

11 See Bouvia v. Superior Court, 225 Cal. Rptr. 297, 300 (1986) ("[A] patient has the right to refuse any medical treatment or medical service, even when such treatment is labelled 'furnishing nourishment and hydration.'"); Longeway, 549 N.E.2d at 297 ("[T]he common law right to refuse medical treatment includes... artificial nutrition and hydration."); In re Lawrance, 579 N.E.2d 32, 39 (Ind. 1991) ("[T]he administration of artificial nutrition and hydration... is medical treatment which can be refused."); Delio v. Westchester County Medical Ctr., 516 N.Y.S.2d 677, 689 (1987) (explaining that medical procedures providing nutrition and hydration are evaluated in the same manner as other types of life-sustaining procedures); Grant, 747 P.2d at 455 ("[T]he right of a terminally ill patient to have life sustaining procedures withheld includes the right to withhold nasogastric tubes, intravenous feeding, and other artificial means of nutrition and hydration.").

12 Linda Carl, Comment, The Right to Voluntary Euthanasia, 10 WHITTIER L. REV. 489, 494 (1988) (explaining that the patient may control the course of her own life and death).

13 HELGA KUHSE, THE SANCITY-OF-LIFE DOCTRINE IN MEDICINE A CRITIQUE 201 (1987) (criticizing the view that passive but not active euthanasia is acceptable); George P. Smith, II, All's Well that Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?, 22 U.C. DAVIS L. REV. 275, 342 (1989) (pointing out that withdrawal of treatment does not always result in a swift and painless death); see also Famam v. Crista Ministries, 807 P.2d 830, 848 (Wash. 1991) (Dore, C.J., concurring in part, dissenting in part) (suggesting that lethal injection is "less painful and, therefore, more humane" than death by starvation and dehydration). For an extended discussion of this issue, see Mark Strasser, Assisted Suicide and the Competent, Terminally Ill: On Ordinary Treatments and Extraordinary Policies, OR. L. REV. (forthcoming Summer 1995).
appropriate for each state to adopt for incompetent patients, given its current policies concerning competent patients.

B. Who Is Incompetent?

Before an analysis of the appropriate paradigm for medical decision-making for incompetents can be offered, it must first be established who in fact is incompetent. Individuals who are unconscious, traumatized, senile, disoriented, overly emotional, or simply too young may all be held incompetent.\textsuperscript{14} Basically, the standard for a finding of competency is whether, "at the time and under the circumstances when his consent is required, [the patient has] the mental ability to make a rational, deliberate decision regarding the proposed treatment."\textsuperscript{15} That determination is a question of fact.\textsuperscript{16}

As a general matter, no universally accepted set of criteria exists to determine which people are competent and which are not.\textsuperscript{17} Even when subscribing to the basic principle that competency involves the ability to make rational, deliberate decisions,\textsuperscript{18} courts use different specific criteria to determine whether in fact that ability is present.

Suppose that a patient has the ability to understand what the doctor has said but nonetheless offers an irrational reason to justify a seemingly irrational decision. A court might hold that the individual was not competent, appearances to the contrary notwithstanding. Indeed, a court might reject that even a patient who can give a reasonable justification for her treatment decision is in fact able to weigh the various options appropriately.\textsuperscript{19}

\begin{footnotes}
\footnote{14}{See David W. Meyers, Medico-Legal Implications of Death and Dying § 6:8, at 109 (1981); \textit{id.} § 11:3, at 267.}
\footnote{15}{\textit{id.} § 6:8, at 110.}
\footnote{16}{\textit{id.} § 6:8, at 109.}
\footnote{18}{Stephen C. Kenney, \textit{Death and Life Decisions: Who Is in Control?}, 23 Loy. L.A. L. Rev. 791, 801 (1990) (noting that the three prerequisites for informed consent are the capacity to reason, voluntariness, and a clear understanding of the risks and benefits).}
\footnote{19}{As the court explained in \textit{In re Jeffers}, 606 N.E.2d 727, 732 (Ill. App. Ct. 1992): [W]e disagree that merely presenting a purportedly nondeluded reason for refusing the medication shows that respondent has the ability to make a reasoned decision. In addition, the mere fact that respondent understood the options available does not mean that she has the ability to appropriately balance}
Courts can make use of expert testimony when making a competency determination. Yet, experts themselves may have difficulty in ascertaining whether individuals are competent. Thus, two doctors interviewing the same patient might disagree about that individual’s competency. When a patient’s competency is disputed, the courts must make the ultimate decision.

Given the difficulties of ascertaining whether someone is competent, “[a] person is presumed to be competent unless shown by the evidence not to be competent.” Further, the wisdom of the patient’s decision cannot itself be the sole determinant of whether the person is competent; merely because someone makes an unwise decision does not make her incompetent.

While difficulties sometimes arise in determining whether an individual is in fact competent, in many cases no such difficulty exists. A person who is not conscious simply cannot make the requisite decision. Society must decide how medical treatment decisions will be made for individuals who cannot make those decisions for themselves.

C. Treating Competents and Incompetents Equally

If competent patients have the right to refuse treatment, then it might seem unfair not to extend the same right to incompetents. Each class

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20 The court in In re Quackenbush, 383 A.2d 785, 788 (N.J. Morris County Ct. 1978), was confronted with this problem.

Dr. Lenzer is of the opinion, based upon reasonable medical certainty, that Quackenbush has the mental capacity to make decisions, to understand the nature and extent of his physical condition, to understand the nature and extent of the operations, to understand the risks involved if he consents to the operation, and to understand the risks involved if he refuses the operation. However, “Dr. Giuliano ... concluded that Quackenbush’s mental condition was not sufficient to make an informed decision concerning the operation.” Id.


23 Id. at 1236 (“The law protects her right to make her own decision to accept or reject treatment, whether that decision is wise or unwise.”); MEYERS, supra note 14, § 11:2, at 266 (explaining that a rational decision need not be "reasonable").

24 MEYERS, supra note 14, § 11:6, at 274 ("If competent individuals may refuse lifesaving medical treatment, absent overriding state interests in compelling treatment, then the same right should be accorded to those who are not competent.").
consists of individuals worthy of respect. Yet, the two classes are recently dissimilar. By definition, incompetent patients cannot perform the deliberative processes which are prerequisites for informed, autonomous decisionmaking. Arguably, individuals who are incapable of deliberating cannot be said to have a right of self-determination. They themselves cannot currently determine what treatments they will or will not have because, quite simply, they lack that capacity. It is not clear that it makes any sense to talk about a right which cannot be exercised.

25 Id. ("It is axiomatic that the value of human dignity and bodily integrity extends to all human beings, whether thought to be mentally competent or not."); John A. Robertson, *Cruzan and the Constitutional Status of Nontreatment Decisions for Incompetent Patients*, 25 GA. L. REV. 1139, 1159 (1991) ("[E]qual respect for incompetent patients requires that they have a right to have a proxy refuse treatment on their behalf.").

26 *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 280 (1990) ("An incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right."); DOUGLAS N. WALTON, ETHICS OF WITHDRAWAL OF LIFE-SUPPORT SYSTEMS 107 (1983) ("The model of informed consent to medical treatment is predicated on the conception of a free moral agent operating on a knowledgeable appreciation of the available alternatives and then, by a process of rational deliberation, choosing among those alternatives."); Thomas W. Mayo, *Constitutionalizing the "Right to Die,"* 49 MD. L. REV. 103, 146 (1990) ("[O]nce a patient is incompetent (at least once irreversibly so), his or her status is incompatible with notions of autonomy and personal decision-making."); Tracy L. Merritt, Note, *Equality for the Elderly Incompetent: A Proposal for Dignified Death*, 39 STAN. L. REV. 689, 704 (1987) ("By definition, the incompetent cannot make free choices and exercise his individual autonomy.").

27 *In re Longeway*, 549 N.E.2d 292, 304 (Ill. 1989) (Ward, J., dissenting) (suggesting that "conceptual and practical difficulties" exist in discussing the right of incompetent persons to refuse medical care); Allen E. Buchanan, *The Limits of Proxy Decisionmaking for Incompetents*, 29 UCLA L. REV. 386, 394 (1981) ("The very notions of self-determination, and hence a right of self-determination, only apply to a being who possesses, or has the potential for developing, certain complex cognitive functions, including the ability to conceive of the future, discern alternative courses of action, and make judgments about his own good."); Mayo, supra note 26, at 146; Robertson, supra note 25, at 1160 ("[T]he right to consent to or refuse medical care is also dependent on some minimum degree of mental functioning. Unless a person has the capacity to recognize alternatives and make choices, a claim that she has the right to refuse treatment makes no sense."); Victor G. Rosenthal & Clark D. Forsythe, *The Right to Assisted Suicide: Protection of Autonomy or an Open Door to Social Killing?*, 6 ISSUES L. & MED. 3, 19 (1990) ("[T]he sine qua non of a right to 'choose' anything is cognitive ability to choose.").

28 Robertson, supra note 25, at 1160 ("An incompetent person cannot herself exercise the right to refuse treatment because the exercise of this right requires the mental capacity to be aware of the situation, to understand the alternatives and to make a choice.").
Courts have recognized that incompetents are relevantly dissimilar to competent patients but have nonetheless held that incompetent patients do not lose their rights merely because of an inability to exercise them. Yet, it becomes important to spell out the right which the incompetents still enjoy. Is it the right to self-determination or the right to have current interests and welfare promoted? Making clear the content of the right has important implications for the mechanisms by which treatment decisions are made. If incompetents have the right to have their current welfare interests taken into account but do not have the right to have their past expressed preferences respected, then living wills would be quite unimportant if not totally irrelevant. Alternatively, if incompetents have the right to have their previously expressed preferences taken into account in any current treatment decisions, then an incompetent’s previously signed living will would be quite relevant.

29 Drabick v. Drabick, 245 Cal. Rptr. 840, 854 (Ct. App. 1988) (suggesting that a claim that the patient who is in a noncognitive state has a “right to choose” is a “legal fiction”).

30 In re A.C., 573 A.2d 1235, 1247 (D.C. Cir. 1990) (en banc) (“This right of bodily integrity belongs equally to persons who are competent and persons who are not. Further, it matters not what the quality of a patient’s life may be; the right of bodily integrity is not extinguished simply because someone is ill, or even at death’s door.”); John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921, 924 (Fla. 1984) (suggesting that the “valuable right [of self-determination] should not be lost because the noncognitive and vegetative condition of the patient prevents a conscious exercise of the choice to refuse further extraordinary treatment”); In re Roe, 421 N.E.2d 40, 51 (Mass. 1981) (“To deny this right [to refuse treatment] to persons who are incapable of exercising it personally is to degrade those whose disabilities make them wholly reliant on other, more fortunate, individuals.”); In re Spring, 399 N.E.2d 493, 498 (Mass. 1979) (explaining that incompetents do not lose the right to choose by virtue of their incompetence); In re Quinlan, 355 A.2d 647, 664 (N.J. 1976) (noting that the only way to prevent destruction of an incompetent’s rights is to let the guardian exercise it); Meyers, supra note 14, § 11:4, at 269 (“The substituted judgment rule is grounded in the theory that the incompetent patient has the same rights and prerogatives as the competent patient to refuse lifesaving medical care.”).

31 Robertson, supra note 25, at 1167-68 (“The incompetent patient has a right to have her interests and present welfare respected . . . .”).

32 See Nancy K. Rhoden, Litigating Life and Death, 102 HARV. L. REV. 375, 378 (1988) (“If the values held when the patient was conscious are no longer relevant to a decision based on her current interests, then even values encapsulated in a living will would be, if not equally irrelevant, at least far from determinative.”).

33 But see Rebecca Dresser, Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law, 28 ARIZ. L. REV. 373, 394 (1986) (arguing that respecting a living will involves the decision to respect past rather than current self).
Part of the difficulty in making headway in determining the process by which medical decisions for incompetents should be made is that it is unclear which decisionmaking paradigm is most useful. The most frequently debated paradigms are best interests and autonomy, the latter allegedly being represented in the substituted judgment procedure.\(^\text{34}\)

It is unclear which paradigm to use because incompetents share some but not other features with competent individuals; they may at one time have been able to make informed, deliberate decisions about a variety of issues, but they cannot do so currently. Precisely because some features are shared while others are not, it is clear that any adopted paradigm will need modification.

Suppose that one decides to adopt the medical decisionmaking paradigm for competents but to tailor it to the abilities of incompetent patients. As an initial matter, it might seem unclear what modifications could make the paradigm useful in cases where there is no currently competent, informed individual to make decisions about her own health care. Indeed, some commentators suggest that if the necessary conditions for current autonomous decisionmaking cannot be met by the patient, then it does not make sense to talk about that patient's right of self-determination.\(^\text{35}\)

\(^\text{34}\) Mitchell ex rel. Rasmussen v. Fleming, 741 P.2d 674, 688 (Ariz. 1987) ("Courts have developed two standards to guide surrogate decisionmaking: 'substituted judgment' and 'best interests.'"); In re Jobes, 529 A.2d 434, 456 (N.J. 1987) (Handler, J., concurring) (discussing the "two major approaches to the making of medical treatment decisions for incompetent patients. . . . [o]ne focus[ing] upon the patient's right of self-determination, the other emphasize[ing] the patient's best interests"); In re Guardianship of Myers, 610 N.E.2d 663, 669 (C.P. Summit Co. Ohio 1993) ("Guardianship law has traditionally recognized two methods, the best interest test . . . and 'substitute judgment.'").

\(^\text{35}\) See, e.g., Edward D. Robertson, Jr., Is "Substituted Judgment" a Valid Legal Concept?, 5 ISSUES L. & MED. 197, 206 (1989) ("Incompetent persons are not autonomous; they have no ability to decide. Substituted judgment [for them] thus requires the acceptance of an oxymoron — that one's autonomy can be exercised by another."); see also Donald L. Beschle, Autonomous Decisionmaking and Social Choice: Examining the "Right to Die," 77 KY. L.J. 319, 328 (1988-1989) (describing the "attempt to approximate the [incompetent] patient's own decision" as involving "an analytical leap of great significance"); Buchanan, supra note 27, at 391 ("[I]t makes no sense to ascribe a right of self-determination to certain individuals in irreversible vegetative states."); Sandra S. Ikuta, Dying at the Right Time: A Critical Legal Theory Approach to Timing-of-Death Issues, 5 ISSUES LAW & MED. 3, 42 (1989) (finding the notion of substituted judgment to be logically contradictory); Robertson, supra note 25, at 1160 ("[I]t is not meaningful to speak of an incompetent patient's possession of the same right to refuse treatment that a competent person possesses." (emphasis omitted). But see Norman L. Cantor, Quinlan, Privacy and the Handling of Incompetent Dying Patients, 30 RUTGERS L. REV. 243, 252 (1977) ("Where a patient has, while competent, stated preferences as to course of action
It is not hard to understand why some commentators adopt that view. Consider Patient A, a competent individual who consents to a procedure despite not having been given all relevant information. A doctor who performs a medical procedure based on that "consent" may be subject to liability. Consider Patient B, who does not give consent for a non-emergency procedure to be performed. The doctor who performs that medical procedure on Patient B without authorization might also be subject to liability.

Arguably, the incompetent patient must be likened to Patient A, Patient B, or both. Insofar as the patient consented to a particular treatment regimen (for example, through her living will), she did so without knowing what her current condition would be like — either because she could not predict what it would be like to have her current symptoms or, at the very least, because she would not know what it would be like to be an incompetent with those symptoms. This individual would seem like Patient A since she has given her consent without being fully given all of the relevant information.

Insofar as the incompetent patient did not manifest what she would have wanted before she in fact became incompetent, she did not give her consent at all. This person should be likened to Patient B. Arguably, any "decision" of a now-incompetent person cannot be considered valid because she gave either uninformed consent or no consent at all.

See Natanson v. Kline, 350 P.2d 1093, 1101 (Kan. 1960) (explaining that consent must be informed to be effective).

See Pema v. Perozzi, 457 A.2d 431, 438 (N.J. 1983) (explaining that a doctor performing non-emergency surgery without consent would be subject to liability); DAVID CUNDIFF, EUThANASIA Is NOT THE ANSWER A HOSPICE PHYSICIAN’S VIEW 51 (1992); Merritt, supra note 26, at 699 (explaining that a physician may be subject to tort liability for treating a patient without first obtaining the patient’s informed consent).

Cf. Beschle, supra note 35, at 360 (suggesting that in cases involving a prior declaration not to have extraordinary treatment which is made well in advance, the declarant is too far removed to make an informed decision).

James Bopp, Jr. & Daniel Avila, The Due Process “Right to Life” in Cruzan and Its Impact on “Right-to-Die” Law, 55 U. PITT. L. REV. 193, 201 (1991) (“An unconscious person is rendered incompetent by his present lack of consciousness, and by his former inability to anticipate his present predicament and contemporaneous intent.”).
This argument proves too much. One often makes legally binding decisions without being fully informed about how one will feel in the future. An individual who observes others in particular circumstances and then makes a judgment about whether she would want treatment for herself under those same circumstances must make a judgment about whether she believes that life under such circumstances would be worthwhile, presumably recognizing that she is making her judgment based on incomplete information.

When an individual previously expressed a desire not to have treatment in particular circumstances, it is important to know whether the individual was adequately (even if not “fully”) informed and whether the individual’s manifestation accurately reflected her deeply held and carefully considered views. An individual’s articulation of a position might have involved an unexamined acquiescence in then-current societal views rather than a reflection of deeply held beliefs; arguably, only statements running counter to popular societal views should be given much weight.

Yet, it would be ironic at best to hold that an individual should be permitted to choose life over death only if most people would not make that choice. While it is clear that some method must be used to determine whether the stated preferences actually represent deeply held values, it would be inappropriate to have a policy in which only those views which would not be shared by society would be respected.

Suppose that it were possible to determine which of an individual’s articulations accurately reflected that individual’s deeply held beliefs. An individual’s spontaneous, ill-considered comments would be discounted, whereas an individual’s carefully considered conclusions about different treatment scenarios would be given great weight.

Even if one could make this determination, it would not follow that the patient would continue to hold those beliefs several years after having made those carefully considered comments. People often change their minds over time. Yet, if the incompetent had changed her mind after manifesting certain preferences, she would be unable to currently communicate that change and she might have failed to have communicated that change while competent. Thus, even if there were some way to

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40 See Beschle, supra note 35, at 362 (“Where the prior statement of the individual merely reflects prevailing social attitudes, it is . . . far less certain that the prior statement was made for reasons other than its social acceptability.”).

41 In re Westchester County Medical Ctr. ex rel. O’Connor, 531 N.E.2d 607, 613 (N.Y. 1988) (“[T]here always exists the possibility that, despite his or her clear expressions in the past, the patient has since changed his or her mind.”).
determine which of the incompetent's past statements were made only after careful deliberation, there would be no guarantee that those statements would accurately reflect what the incompetent would currently say if able to do so. Arguably, the comments of a previously competent patient should not be used to determine what she, a currently incompetent patient, would want because she might have changed her mind without telling anyone. Were she currently competent, we could require that she confirm her previous wishes. Because she is not competent, no confirmation is possible, and the previous statement must be discounted if not ignored completely.

An even stronger argument has been offered to show why the previously articulated wishes of the now-incompetent patient should be ignored. Even if the patient's previously expressed wishes accurately represented her wishes at the time of that expression and even if there had been no subsequent change of mind, the interests of the current, incompetent person may be much different from those of the past, competent person, even though the same individual is being considered. Further, precisely because the lives of the competent person and the incompetent person are so qualitatively different, the competent person could not understand the life of the incompetent and thus could not make an informed decision about what treatments would be appropriate for such a person. Arguably, having the guardian determine what values or beliefs the patient once had would be pointless even if possible. The guardian should instead seek to determine what would serve the patient's current interests.

At least two weaknesses are present in the argument that because of the competent person's inability to understand what her own life as an

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42 But cf. Martyn & Jacobs, supra note 17, at 790 (reporting that a survey found that only half the patients who drafted directives before becoming terminally ill remained conscious for the 14 days required after prognosis to revalidate the directive).

43 See Robertson, supra note 25, at 1167-68 ("The incompetent patient has a right to have her interests and present welfare respected to the extent that she has interests. Her present welfare is served by treating her in terms of her current interests, not in terms of interests that she previously had but which are no longer relevant.").

44 Beschle, supra note 35, at 350 ("Even if the proxy decision maker quite faithfully carries out detailed advance instructions executed by the patient prior to the fatal illness, the patient was very much a different person at that time.").

45 Cf. Westchester County Medical Ctr., 531 N.E.2d at 617 (Hancock, J., concurring) ("There is simply no way of excluding the possibility that the patient has had a change of mind so that her past wishes do not indicate her present wishes.").

46 Robertson, supra note 25, at 1162 ("[R]espect for the incompetent patient merely requires that her current interests and welfare be respected . . . .").
incompetent would be like, the patient's autonomy interests must be ignored and the patient's current best interests must be considered dispositive. Determining what in fact would be in the incompetent patient's current best interests may be much easier said than done. Presumably, the individuals who are now making that decision are also unable to understand what the life of the incompetent patient is like. If indeed the competent person's inability to understand what it is like to be incompetent implies that she should be barred from making judgments about her own future care should she become incompetent, then it would seem that all competent individuals should likewise be barred from making those judgments for others. Yet, it would hardly be appropriate for an incompetent person to make treatment decisions for an incompetent patient. Thus, the above analysis would seem to suggest that no one should be making treatment decisions for the incompetent patient. If this absurd result is to be avoided, it will have to be admitted that competent individuals can appropriately make decisions about the care of the incompetent. If some competent individuals should be allowed to do so, it is hard to imagine why the person herself should not be among that select few.

An additional reason exists for courts to be loath to accept the rationale barring individuals from making decisions about their own future medical care. Such a jurisprudence would radically change much that is currently accepted in law. For example, analogous reasoning would suggest that individuals should be precluded from disposing of their property via wills, since they cannot currently know what they will want in the future. They will have to dispose of their property when the "appropriate" time comes. Those unable to do so at the time of their deaths would simply lose their rights to dispose of their property in accord with their wishes, just as the incompetent on the above account has no right to be treated in accord with the wishes expressed while competent.

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47 Cf. In re Hamlin, 689 P.2d 1372, 1375-76 (Wash. 1984) (pointing out that decisions must be made on a case-by-case basis concentrating on the best interests of the specific individual).

48 Cf. Dresser, supra note 33, at 389 ("To base medical decisions on their former competent preferences or on imputed reasonable person values is to treat [incompetent] patients in conformance with things that no longer matter to them, and indeed, in potential disregard of things that do matter to them.").

49 See Beschle, supra note 35, at 345 ("[N]o response can be said to be a genuinely informed one until the full reality of the choice is present to the individual, that is, until death has 'come his way.'").
The above analogy is not undermined by the cy pres doctrine, which permits, in certain circumstances, a court to modify the terms of a will or trust in order to fulfill the donor's wishes. While it is true that in such a case the court does not allow the specific directions of the donor to be followed because of illegality, impracticality, or impossibility, the court nonetheless seeks to act in accord with the general intent of the donor; the court does not ignore the intent of the donor as the above theory would analogously imply.

Perhaps it could be thought that the intent of the individual could be taken into account when considering property issues but should not be taken into account when considering a person's medical care. Yet this argument is unpersuasive. All else being equal, the more important the interest, the more important it is for the individual to have her intentions respected. If it is important that individuals' autonomy be respected in the disposition of their property, then it is even more important that individuals' autonomy be respected in something of such vital concern as their own future medical care.

The state cannot credibly argue that, because of its great concern that the incompetent's intent be accurately reflected at the time of the procedure, the state must ignore all previous manifestations of intent. Such an argument is especially unpersuasive given that the individual cannot currently manifest his intent because of his incompetence. Basically, the state would be arguing that in order to avoid problems with accurately determining a patient's intent, it would ignore the patient's manifestations of intent entirely. While the state might justify its refusal to consider a previous manifestation of intent on other grounds such as best interests, the state cannot credibly base its refusal to consider any manifestation of intent out of an alleged concern for the patient's autonomy.

50 See In re Gerber, 652 P.2d 937, 940 (Utah 1982) (explaining that cy pres doctrine allows courts to fulfill the intention of the donor).

51 See Howard Sav. Inst. v. Peep, 170 A.2d 39, 42 (N.J. 1961) (explaining that cy pres is a judicial mechanism which allows a court to apply trust funds to a general charitable purpose as nearly as possible to the particular purpose of the settlor, when that particular purpose has become impossible, impractical, or illegal).

52 Norman L. Cantor, A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life, 26 RUTGERS L. REV. 228, 241 (1993) ("No more basic aspect of personal privacy can be found than bodily integrity, and this interest is entitled to concomitant constitutional protection."); Merritt, supra note 26, at 700 ("The right to reject medical treatment represents an extreme example of the exercise of an important personal decision concerning physical integrity and personal autonomy.").
The policy that only current manifestations of intent should be considered valid would have important implications for the treatment of competent patients. Such a policy would have absurd results, both medically and legally. For example, it would seem to imply that surgery could not be performed under general anesthesia. Not only would the unconscious patient be unable to give consent currently, but (for all the doctor knows) the patient's desires and intentions might have changed once the general anesthesia had been administered. Further, such a policy would suggest that an unconscious person who had previously explicitly rejected having a blood transfusion and whose religion was known to prohibit such transfusions could nonetheless be subjected to a transfusion, because no current refusal of treatment would be present. Not surprisingly, courts have rejected the claim that a person must be conscious in order for her right to refuse treatment to be exercised.5

Courts are correct to reject the argument that previous manifestations of intent by living will should be ignored. However, courts must entertain the possibility that the intention as manifested in the living will does not accurately represent the individual's last considered judgment about what she would want done. An individual while competent might change her mind without also changing her living will. Because of this possibility, courts might employ a rebuttable presumption that the living will represented the patient's current intent. If there is evidence meeting the

5 See Bopp & Avila, supra note 39, at 201 (“An unconscious person is rendered incompetent by his present lack of consciousness, and by his former inability to anticipate his present predicament and contemporaneous intent.”).

54 While individuals may be prevented from refusing transfusions if their deaths would orphan their children, individuals are generally allowed to refuse transfusions. Thus, courts have upheld the patient's refusal of a transfusion as long as the children, even if young, would still have one parent. See Public Health Trust v. Wons, 541 So. 2d 96, 97-98 (Fla. 1989) (finding that the state's interest in having children raised by two parents does not override the right to refuse blood transfusions); Norwood Hosp. v. Munoz, 564 N.E.2d 1017, 1023 (Mass. 1991) (finding that the state's interest in preserving life does not override the right to refuse transfusion invoked by a Jehovah's Witness).

55 See In re Jobes, 529 A.2d 434, 451 (N.J. 1987) (“An incompetent patient does not lose his or her right to refuse life-sustaining treatment. Where such a patient has clearly expressed her intentions about medical treatment, they will be respected.”) (citation omitted); In re Eichner, 426 N.Y.S.2d 517, 546 (App. Div. 1980) (“To deny the exercise because the patient is unconscious is to deny the right.”); Cantor, supra note 35, at 252 (“An unconscious person presumably retains the right to be free of government monitoring or bodily invasion even if the person can no longer sense the invasion of privacy. Similarly, an unconscious patient ought to be entitled to have a prior choice honored.”).
relevant standard (e.g., clear and convincing evidence)\textsuperscript{56} that the patient had changed her mind,\textsuperscript{57} then the living will might be ignored.

It is reasonable for courts to employ a rebuttable presumption that the living will represents the competent individual's informed preferences. When a person makes out a living will, good reason exists to think that the person is taking the issues seriously.\textsuperscript{58} Further, the person will be on notice that should she subsequently change her mind, she should clearly manifest that change.\textsuperscript{59} Precisely because of possible subsequent changes which have not been adequately recorded, however, the living will should not irrebuttably be presumed to represent the patient's final considered preferences; other events might have occurred which would lead one to believe that the individual had indeed changed her mind.\textsuperscript{60} Nonetheless, absent contrary evidence, a living will should be given great weight.\textsuperscript{61}


\textsuperscript{57} See ALA. CODE § 22-8A-5(a)(1)-(3) (1975) (outlining methods of revoking a living will).

\textsuperscript{58} In re Westchester County Medical Ctr. ex rel. O'Connor, 531 N.E.2d 607, 613 (N.Y. 1988) ("The existence of a writing suggests the author's seriousness of purpose and ensures that the court is not being asked to make a life-or-death decision based upon casual remarks."); T.A. Tucker Ronzetti, Comment, \textit{Constituting Family and Death Through the Struggle with State Power: Cruzan v. Director, Missouri Department of Health}, 46 U. MIAMI L. REV. 149, 198 (1991) ("[T]he very act of signing a written document may occasion greater reflection than would be an off-handed remark to a friend.").

\textsuperscript{59} Westchester County Medical Ctr., 531 N.E.2d at 613-14 ([A] person who has troubled to set forth his or her wishes in a writing is more likely than one who has not to make sure that any subsequent changes of heart are adequately expressed, either in a new writing or through clear statements to relatives and friends.); cf. John G. Strand, Note, \textit{The "Living Will": The Right to Death with Dignity}, 26 CASE W. RES. L. REV. 485, 516 (1976) ([A]ny problems posed by a possible failure to appreciate fully the significance of a Living Will at the time of execution are minimized by the opportunity to revoke.").

\textsuperscript{60} See ALA. CODE § 22-8A-5(a)(3) (1975) (providing that a verbal declaration of intent to revoke will suffice if a witness, 19 years of age or older, signs and dates a writing confirming that such an expression of intent was made).

\textsuperscript{61} John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921, 926 (Fla. 1984) ("If such a person, while competent, had executed a so-called 'living'or 'mercy'will, that will would be persuasive evidence of that incompetent person's intention and it should be given great weight by the person or persons who substitute their judgment on behalf of the terminally ill incompetent.").
Individuals need not make use of a living will to insure that their wishes regarding medical care will be taken into account should they become incompetent. They might instead designate someone to be a proxy decisionmaker should the need arise. That way, the individual would not be forced to try to anticipate in detail the particular circumstances under which she would want treatment. Instead, the proxy decisionmaker would be allowed to apply her understanding of the patient's wishes to the particular circumstances at the time they arise and make a decision accordingly. As a further benefit, the patient would then have someone advocating that her wishes be respected rather than a mute piece of paper which a physician might choose to ignore. Finally, living wills only apply in a fairly narrow set of circumstances; the set of circumstances in which the proxy decisionmaker may make medical decisions is much less narrowly restricted.

II. STANDARDS FOR MAKING TREATMENT DECISIONS

The two most frequently used tests for medical decisionmaking for incompetents are substituted judgment and best interests. The tests involve different criteria and are designed to achieve different ends. Regrettably, they are becoming more and more difficult to distinguish,
which may lead not only to theoretical confusion but also to regrettable and inappropriate outcomes.

A. Substituted Judgment

The situation in which one individual designates someone else to be a proxy decisionmaker is a paradigmatic case of substituted judgment. Yet, the notion of substituted judgment should not be misunderstood. The proxy does not try to substitute her own judgment for the patient's but instead substitutes the beliefs, values, and desires of the patient for her own and then makes a treatment decision.

Substituted judgment is not limited to situations in which someone has been chosen by the patient to make a decision in light of the patient's previously expressed beliefs, desires, and values. Rather, it is used in a variety of contexts. Basically, "[t]he 'substituted judgment' rule of decision making for an incompetent patient [is used] to replicate what the patient himself would decide, if competent to do so, under the circumstances at hand."67

To understand the numerous contexts in which substituted judgment may be employed, it is helpful to understand the rationale behind its use. The Supreme Court of Massachusetts suggested that it is appropriate "to shift the emphasis away from a paternalistic view of what is 'best' for a patient toward a reaffirmation that the basic question is what decision will comport with the will of the person involved, whether that person be competent or incompetent."68

It is easiest to ascertain which treatment would comport with the will of the patient when the patient has clearly and explicitly articulated what she would want done in precisely the situation which currently exists.


67 Mack v. Mack, 618 A.2d 744, 762 (Md. 1993) (McAuliffe, J., dissenting) ("'Substituted judgment' is not a particularly apt term — the very result we wish to avoid is the substitution of someone else's judgment for that of the ward. Rather, the aim is to determine, by reference to all that may be known about the ward, what decision he or she would make if present competent and possessed of complete information concerning all relevant factors.").

68 MEYERS, supra note 14, § 11:6, at 215 (Cum. Supp. Dec. 1993); see also In re A.C., 573 A.2d 1235, 1249 (D.C. Cir. 1990) (en banc) ("[T]he substituted judgment inquiry is primarily a subjective one: as nearly as possible, the court must ascertain what the patient would do if competent"); NORMAN L. CANTOR, LEGAL FRONTIERS OF DEATH AND DYING 63 (1987) ("Under the substituted judgment approach, the surrogate decision-maker must effectuate, to the extent possible, the course of conduct which the patient would have desired.").

However, patients often are not sufficiently specific or explicit. Sometimes their statements are only slightly lacking in the relevant degree of specificity or clarity, while at other times the patient might have made no relevant statement at all. Situations in which there had been no statement at all might include scenarios in which the person had once been competent but had nonetheless not expressed any preferences as well as scenarios in which the individual had never been competent and thus could never have had preferences formed as a result of the requisite deliberation.

Thus, substituted judgment might potentially be used in four different scenarios:

1. the individual, while competent, had previously made precise statements about what she would want done in exactly the situation presented;

2. the individual, while competent, had made general statements about what she would want but those statements were not precise enough to indicate the particular course of action appropriate in the existing circumstances;

3. the individual, while competent, had never addressed the issue; and

4. the individual, having always been incompetent, could thus never have articulated an explicit considered judgment.

1. Individual Made a Precise Directive While Competent

In a situation in which the person had clearly described what she would want done in precisely the existing circumstances, her wishes will normally be carried out. Some courts suggest that this situation presents the paradigmatic case of substituted judgment. Others disagree, suggesting not only that the case is not paradigmatic, but that the case does not even involve substituted judgment. Rather, such courts think that such a case should be viewed in the same light as one in which the patient herself makes a current expression of intent. Substituted

70 MEYERS, supra note 14, § 11:4, at 270 (noting that an incompetent’s unequivocal wishes not to be treated will generally be upheld).

71 See In re Conroy, 486 A.2d 1209 (N.J. 1985) (holding that competent adult generally has the right to refuse medical treatment).

72 In re Swan, 569 A.2d 1202, 1206 (Me. 1990) (explaining that the decision was based on the patient’s own conclusion and not on a theory of substituted judgment); Gieszl & Velasco, supra note 63, at 729-30 (“Arguably, when a patient has a written directive, particularly a detailed one such as a medical directive, there is no ‘substituted judgment.”
judgment might be reserved by such courts for cases in which the patient had not stated her intent or desire with sufficient clarity or specificity.\endnote{73}

Basically, the disagreement with respect to what is the paradigmatic case of substituted judgment might be understood in terms of how much the term "judgment" is emphasized. Insofar as judgment involves a third party's having to weigh various considerations and then arrive at some conclusion about what the patient would have said, substituted judgment seems inappropriate in a case in which the patient had explicitly and specifically manifested what should be done in precisely the existing situation. In those circumstances, the patient had already made quite clear what she would like done, and a mechanical application of the person's wishes would suffice. Insofar as the substituted aspect is emphasized and insofar as one pictures the third party as the individual who is supposed to represent the judgment of the patient because the patient cannot act on her own behalf, it is quite appropriate to talk about substituted judgment in a case in which the patient had quite clearly manifested her wishes.

2. Individual Made General Comments While Competent

Where the person was once competent, she might have made comments which, even if not dispositive, would at least be indicative of what the person would have wanted. Courts and commentators disagree about how much weight to give to statements which are not sufficiently "clear and convincing" to satisfy the relevant test.\endnote{74} For example, one might take into account the patient's personality, values, and what she had said about various medical issues, and then "extrapolate" what she would have chosen.\endnote{75} Alternatively, one might argue that unless the patient had been very specific about what course of action she would want and very specific about the circumstances under which she would want that course taken, the patient should not be

Rather, the surrogate decisionmaker serves as an agent, or an attorney-in-fact, to assure that the patient's previously expressed wishes are followed.\endnote{76} 

\endnote{73}{\textit{In re} Gardner, 534 A.2d 947, 950 (Me. 1987) (finding no need for substituted judgment when the patient had made his "pertinent wishes well known").}

\endnote{74}{See \textit{In re} Jobes, 529 A.2d 434, 443 (N.J. 1987).}

\endnote{75}{\textit{Id. at 444} ("The surrogate considers the patient's prior statements about and reactions to medical issues, and all the facets of the patient's personality that the surrogate is familiar with — with, of course, particular reference to his or her relevant philosophical, theological, and ethical values — in order to extrapolate what course of medical treatment the patient would choose.") (footnote omitted); see also \textit{In re} Westchester County Medical Ctr. \textit{ex rel.} O'Connor, 531 N.E.2d 607, 619 (N.Y. 1988) (Simons, J., dissenting) ("[T]he surrogate's decision should take into account the patient's personal values and religious beliefs, prior statements on the subject, attitudes about the impact his or her condition will have on others, and any other factors bearing on the issue.").}
considered to have expressed any relevant desires at all. One would simply ignore the nonspecific comments and opt for a best interests analysis.\textsuperscript{66}

Advantages exist in requiring great clarity and specificity in the patient's comments before assuming they represent the patient's desires accurately and fully. One might worry that an individual who had made vague, general comments about medical treatment would not have considered the relevant subject matter with sufficient gravity,\textsuperscript{77} while someone who had precisely specified the conditions under which she would want treatment would seem more likely to have considered the relevant issues carefully.

An additional worry is that the individual might have made the comments a long time ago.\textsuperscript{78} The person might subsequently have had the opportunity to examine the issue in greater depth and might not have reached the same conclusion. Indeed, a person who had made vague, general comments a long time ago might not even realize that those comments would be considered evidence of her considered judgment.\textsuperscript{79}

One must also worry that courts might use the clarity and specificity requirements to thwart the wishes of individuals. Indeed, because most people do not clearly express their desires, strictly enforcing a requirement of clarity and specificity would mean that most people could not have treatment withheld using the substituted judgment test.\textsuperscript{80} Further, such a policy would not protect minors.\textsuperscript{81}

\textsuperscript{66} See infra notes 186-236 and accompanying text. See also Michele Yuen, Comment, Letting Daddy Die: Adopting New Standards for Surrogate Decisionmaking, 39 UCLA L. REV. 581, 619-20 (1992) (suggesting that best interests be the test where the patient's wishes are not clear).

\textsuperscript{67} Jobes, 529 A.2d at 443 ("All of the statements about life-support that were attributed to Mrs. Jobes were remote, general, spontaneous, and made in casual circumstances. Indeed, they closely track the examples of evidence that we have explicitly characterized as unreliable."); Westchester County Medical Ctr., 531 N.E.2d at 613 ("[T]here exists the danger that the statements were made without the reflection and resolve that would be brought to bear on the issue if the patient were presently capable of making the decision.").

\textsuperscript{68} Cf. In re Hughes, 611 A.2d 1148, 1152 (N.J. Super. Ct. App. Div. 1992) ("The probative value of the evidence must also be considered, and may vary depending on remoteness, consistency and thoughtfulness of prior actions and statements.").

\textsuperscript{69} Cf. Westchester County Medical Ctr., 531 N.E.2d at 614 ("[A] person whose expressions of intention were limited to oral statements may not as fully appreciate the need to 'rescind' those statements after a change of heart.") (footnote omitted).

\textsuperscript{70} Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 323 (1990) (Brennan, J., dissenting) ("Too few people execute living wills or equivalently formal directives for such an evidentiary rule to ensure adequately that the wishes of incompetent persons will be honored.") (footnote omitted); In re L.W., 482 N.W.2d 60, 67-68 (Wis. 1992) ("Relatively few individuals provide explicit written or oral instructions concerning their treatment preferences should they become incompetent.") (footnote omitted).

\textsuperscript{71} Cruzan, 497 U.S. at 339 (Stevens, J., dissenting) (finding that such a policy would
Consider *In re Westchester County Medical Center*, a case which involved a patient, Mary O'Connor, who had expressly stated that she wished not to be kept alive on artificial support.\(^2\) She had comforted relatives during their prolonged final illnesses and knew that she did not want to undergo a similar fate.\(^3\) However, she had not specified that she would want to refuse treatment even if that would mean that her death would be painful.\(^4\) Because it was unclear whether someone in her condition would in fact experience pain were she to die of thirst and starvation\(^5\) and because she had not specified that she would want nutrition and hydration withdrawn even if, in fact, that withdrawal would be painful, the court held that her wishes were not clear enough to be dispositive.\(^6\) In this case, the court seemed to ignore the wishes of the patient because it did not agree with the result which would otherwise occur.\(^7\) Unless suitable precautions are mandated, courts can use the specificity requirement to thwart the wishes of patients.\(^8\)

Even where courts have not imposed an artificially high specificity requirement, the patient’s previous comments may not have been sufficiently specific. When the expressed desires of the individual are not clear enough to be dispositive, different ways exist for taking the desires into account. One might adopt a kind of hybrid test in which evidence about intent (even if not

\(^2\) *Westchester County Medical Ctr.*, 531 N.E.2d at 609; *see also* Sewems v. Wilmington Medical Ctr., 421 A.2d 1334, 1338 n.2 (Del. 1980) (involving a patient who had been an active member of the Euthanasia Council of Delaware and who had said that she did not want to be kept alive as a “vegetable” or by extraordinary means).

\(^3\) *Westchester County Medical Ctr.*, 531 N.E.2d at 609.

\(^4\) *Id.* at 890; *see also* DeGrella *ex rel.* Parrent v. Elston, 858 S.W.2d 698, 713 (Ky. 1993) (Wintersheimer, J., dissenting) (involving a patient who had never specifically considered the question of the withdrawal of nutrition and hydration).

\(^5\) *Westchester County Medical Ctr.*, 531 N.E.2d at 610 (noting that the doctor could not be “medically certain” that the patient would not suffer). But *see In re Doe*, 583 N.E.2d 1263, 1269 (Mass. 1992) (noting that medical evidence indicates that a person in a persistent vegetative state will not suffer physical or psychological discomfort from the withdrawal of treatment).

\(^6\) *Westchester County Medical Ctr.*, 531 N.E.2d at 613.

\(^7\) *See id.* at 626 (Simons, J., dissenting) (“[T]he majority, disguising its action as an application of the rule on self-determination, has made its own substituted judgment by improperly finding facts and drawing inferences contrary to the facts found by the courts below.”).

\(^8\) *Id.* at 619 (Simons, J., dissenting) (“The majority “has for all practical purposes foreclosed any realistic possibility that a patient, once rendered incompetent, will have his or her wishes to forego life-sustaining treatment enforced.”).
rising to the appropriate standard to be determinative) would be considered. Casual comments made about other people's situations might meet this standard, even if they would not meet the clear and convincing standard. Precisely because the expression of intent would not meet the relevant standard of reliability, however, one might require additional safeguards to assure that the decision would be appropriate; for example, an objective benefits-burdens test could be employed to make sure that the burdens of continued life would outweigh the benefits.

Perhaps it would seem that use of a hybrid test would be inappropriate because it involves mixing two very different things — the individual's own desires or preferences or intentions on the one hand and the individual's "objective" best interests on the other. Yet, there is reason to believe that courts do and perhaps should conflate these. If the patient had made general comments suggesting that she would not want treatment if in great pain with no hope for recovery, it would be cruel and inhumane not to discontinue treatment, even if she did not in fact say that she wanted treatment discontinued in precisely these circumstances.

Some courts use a system involving different thresholds:

(1) If the person had clearly and explicitly specified earlier that she would not want treatment in the existing circumstances, then her wishes will normally be granted. Here, a fairly exacting standard must be met (or

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89 In re Conroy, 486 A.2d 1209, 1232 (N.J. 1985) (providing a test in which desires "not unequivocally expressed" are taken into account).
90 Id. at 1232 ("[I]nformally expressed reactions to other people's medical conditions and treatment — might be sufficient."). But see Bopp & Avila, supra note 39, at 214 ("[T]he states should not presume that expressions of sympathy for the plight of others, remarks of distaste for nursing homes, or general exclamations that 'I don't want to be like that' (meaning severely or otherwise disabled) are serious, informed and specific waivers of the right to receive health care needed to sustain life.").
91 See Conroy, 486 A.2d at 1232.
93 Glanville Williams, "Mercy-Killing" Legislation — A Rejoinder, 43 WASH. L. REV. 1, 1 (1958) ("[I]t is cruel to allow a human being to linger for months in the last stages of agony, weakness and decay, and to refuse him his demand for merciful release.").
94 In re Jobes, 529 A.2d 434, 456 (N.J. 1987) (Handler, J., concurring) ("When the patient is suffering under conditions that are so extreme that discontinuation of treatment seems to be in her 'best interests,' the courts are less troubled by the doubt that this treatment decision does not truly express the patient's right to self-determination.").
95 MEYERS, supra note 14, § 11:4, at 268 ("If the patient's determined desire would have been to refuse consent to further care, then the court will normally follow that wish . . ."); see also Yuen, supra note 76, at 629 ("If a patient's treatment preferences can be shown by clear evidence, they should be followed regardless of any best interests
threshold reached) before the wishes will be thought sufficiently explicit and specific to be honored.

(2) If the above threshold is not reached, then another test is used. If the person had made a fairly clear statement about her wishes, it might be considered sufficiently reliable to be relevant to the eventual decision, even if not specific or clear enough to be dispositive.

(3) If the person had not made comments sufficiently clear or specific to meet the requirements of standard (2), then the comments will be ignored entirely.96

Other courts do not use a system which deems a statement irrelevant if it fails to meet the appropriate standard.97 They instead have a system which involves a continuum, in which the greater the degree of uncertainty regarding the person’s preferences, the greater the showing that is required to establish that the patient’s best interests would be served by nontreatment.98 However, whether using the threshold or the continuum analysis, courts are seeking to effectuate the patient’s intent. It is only when the patient’s intent cannot be established with the requisite degree of certainty that the best interests analysis will be employed.99

Courts need not adopt an approach in which the paramount concern is the effectuation of the patient’s intent. In *Drabick v. Drabick*, the court suggested that California gives the conservator a great deal of leeway.100 Not only did the court reject a requirement that a particular threshold be met in order for the patient’s preferences to be considered,101 but the court implied that the patient’s specific, expressed preferences were merely relevant rather than dispositive.102
The Drabick court justified its devaluation of the importance of the patient's previously expressed preferences by suggesting that an incompetent's right to choose is a "legal fiction at best."\(^{103}\) The court reasoned that the patient's inability to choose did not entail that he had "no protected, fundamental interest in the medical treatment decisions that affect him."\(^{104}\) However, because the incompetent could not choose for himself, the court decided the only way within its power "to continue to respect him as an individual"\(^{105}\) was to have a conservator.

Courts might recognize the need for a conservator but also consider expressed, specific comments dispositive. One of the most ironic aspects of the Drabick opinion involved its recognition that whether "the benefits of treatment outweigh its detriments is a decision that engages personal and medical values, including ideas about the quality of life."\(^{106}\) The court argued that such a calculation is not one which "courts are constituted or especially well-qualified to make,"\(^{107}\) apparently believing that the conservator was in a better position to make such a decision engaging personal and medical values than the actual patient, even if the patient had left clear and explicit instructions.\(^ {108}\)

The guardian's task is by no means an easy one. The Supreme Judicial Court of Massachusetts suggested that the guardian should make the treatment decision "which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person."\(^{109}\)

On first reading, the court seemed to offer conditions which are impossible to fulfill. The guardian is to make the decision which the person would make were she competent while at the same time taking into account the patient's present and future incompetency. The court seemed to ask the guardian to adopt the mantle of a person who is simultaneously competent and incompetent.\(^ {110}\)

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\(^{103}\) Id. at 854 (footnote omitted).

\(^{104}\) Id.

\(^{105}\) Id. at 855.

\(^{106}\) Id. at 846.

\(^{107}\) Id.

\(^{108}\) But see CANTOR, supra note 68, at 85 ("The one instance in which a guardian's decision to preserve an incompetent patient ought to be overridable — though again there is as yet no precedent available — is where the patient's previously expressed wishes are clearly being contravened.").


\(^{110}\) Cf. Robertson, supra note 35, at 207 ("Substituted judgment endorses a second
The court was not trying to give the guardian an impossible task; rather, it was trying to make sure that certain factors which might otherwise be overlooked were considered. Suppose that an individual might be able to tolerate a treatment much more easily if she knew what the treatment involved, why it was being given, and how long it would last. The treatment would then seem not like the capricious infliction of torture but instead like a painful regimen which was tolerable given the long-term benefits. Someone who could not understand these aspects of the treatment would have much more difficulty enduring the same side effects. When courts ask guardians to consider present and future incompetency, they want guardians to remember, among other things, that treatments may be harder to endure when it cannot be understood why something is being done or how long it will last.

What is becoming increasingly clear is that courts are not consistent with respect to the duties that they expect guardians to fulfill. Some expect the guardian to make a substituted judgment, others want the guardian to determine the best interests of the patient, and still others want the guardian to use her best judgment about what should be done. Not only is this situation potentially confusing for conservators, but it makes it more difficult for patients to have their wishes respected even if they know precisely the circumstances in which they would or would not want treatment. Further, an additional issue raised by the lack of consensus among the states as to the appropriate standards for conservators is whether individuals who wish to have their own or their loved ones' treatment decisions evaluated in light of different standards will forum-shop. Courts might then be in the position of deciding whether it would be in the best interests of the incompetent patient to have the standards of a sister state used to determine the patient's treatment plan.

oxymoron — the idea of the competent incompetent person.

Cf. In re Spring, 399 N.E.2d 493, 499 (Mass. App. Ct. 1979) (distinguishing the situation before the court from a previous one because the "ward could then understand the necessity for the treatments and the accompanying discomfort and cooperate in their administration").

In re Colyer, 660 P.2d 738, 747 (Wash. 1983) ("[T]he guardian's duty is to use his best judgment in deciding whether or not to assert the personal right of the incompetent to refuse life sustaining treatment.") (emphasis omitted).

See In re Busalacchi, No. 59582, 1991 WL 26851 (Mo. Ct. App. 1991) (deciding whether a guardian should be allowed to transfer a ward from Missouri to Minnesota). See generally Lea Brilmayer, Interstate Preemption: The Right to Travel, the Right to
3. Individual Expressed Nothing Relevant While Competent

Sometimes, a formerly competent individual had made no directly relevant comments at all with respect to whether she would want medical treatment in particular circumstances. At least two issues are raised in such situations: (1) is it possible to figure out with a reasonable degree of reliability what the person would have said, and (2) if so, should one consider that reasonably reliable hypothesis about what the person would have said?

Even if no directly relevant comments had been made, a guardian might be able to infer with a reasonable degree of certainty what the individual would have wanted. Basically, the guardian must try to put herself in the patient's position and, based on her intimate knowledge of the patient, make the best judgment she can about what the patient would have chosen. Courts can employ numerous criteria. This judg-

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114 Foody v. Manchester Memorial Hosp., 482 A.2d 713, 721 (Conn. Super. Ct. 1984) ("An expression of intent while competent is not essential . . . ".)

115 Mack v. Mack, 618 A.2d 744, 762 (Md. 1993) (McAuliffe, J., dissenting) ("The substituted judgment approach comes into play when the ward has made no prior statements bearing on the issue, or the statements attributed to the ward do not produce a clear and convincing answer."). But see MEYERS, supra note 14, § 11:6, at 215 (Cum. Supp. Dec. 1993) ("The substituted judgment rule can only be relied upon where the patient has at one time been competent and, while competent, has expressed his or her preferences or views on the subject, or in a way relevant to the treatment decision at hand.").

116 In re Longeway, 549 N.E.2d 292, 305 (Ill. 1989) (Ward, J., dissenting) ("[T]he majority must presume that a surrogate decisionmaker will acquire such intimate knowledge of the patient's basic views or philosophy that the surrogate can formulate a reliable opinion regarding how the incompetent would have reacted to his current predicament even if the incompetent had never previously expressed views upon the subject.").

117 Mack, 618 A.2d at 771 (Chasanow, J., concurring in part, dissenting in part) (discussing different types of evidence which would support withdrawal of life support); In re Hughes, 611 A.2d 1148, 1152 (N.J. 1992) ("This intent might be embodied in a living will; oral directives to family, friends and health care providers; a durable power of attorney; religious beliefs or tenets of a religion; or from the patient's consistent pattern of conduct with respect to prior medical decisions.") (citations omitted); Kenney, supra note 18, at 813 ("Trustworthy evidence that the incompetent patient would have wanted the treatment terminated can be presented in various forms, such as the patient's competently expressed reactions to other people's medical conditions and treatment, or the patient's personal philosophies or religious beliefs."); Yuen, supra note 76, at 583 ("This decisionmaking standard considers individual factors such as statements made by the patient while competent regarding medical decisions as well as religious, moral, and philosophical convictions.").
ment may be based on what the patient has said in the past\textsuperscript{118} or on what relatives and others currently say about the patient.\textsuperscript{119} Or the guardian might instead look at the patient’s values.\textsuperscript{120} Thus, if the patient had not said anything about her wishes should she require aggressive treatment for a particular condition but had stated that she believes life to be sacred, one might infer that she would want aggressive treatment performed.\textsuperscript{121}

When a court uses the patient’s desires and values to make a determination, it does not simply use a reasonable person standard,\textsuperscript{122} but instead tries to reflect what the patient herself would have said if confronted with the existing situation.\textsuperscript{123} The Supreme Court of New

\textsuperscript{118} In re A.C., 573 A.2d 1235, 1250 (D.C. Cir. 1990) (en banc) (“[T]he greatest weight should be given to the previously expressed wishes of the patient. This includes prior statements, either written or oral, even though the treatment alternatives at hand may not have been addressed.”); see also Brophy v. New England Sinai Hosp., 497 N.E.2d 626, 631 (Mass. 1986) (“The judge considered various factors including the following: (1) Brophy’s expressed preferences; (2) his religious convictions and their relation to refusal of treatment; (3) the impact on his family; (4) the probability of adverse side effects; and (5) the prognosis, both with and without treatment.”).

\textsuperscript{119} Longeway, 549 N.E.2d at 305-06 (Ward, J., dissenting) (“A surrogate and the court must piece together any available testimony from relatives and other sources to construct a persona.”).

\textsuperscript{120} A.C., 573 A.2d at 1250 (suggesting that courts in substituted judgment cases “should pay special attention to the known values and goals of the incapacitated patient, and should strive, if possible, to extrapolate from those values and goals what the patient’s decision would be”).

\textsuperscript{121} Longeway, 549 N.E.2d at 299 (“Where no clear intent exists, the patient’s personal value system must guide the surrogate . . . .”).

\textsuperscript{122} MEYERS, supra note 14, § 11:6, at 216 (Cum. Supp. Dec. 1993) (“Under the doctrine, the question is not what a reasonable or what an average person would want done under the circumstances, but rather what the particular patient would have decided if able to choose for himself.”).

\textsuperscript{123} Mack v. Mack, 618 A.2d 744, 757 (Md. 1993) (“The inquiry focuses on whether the ward had determined, or would determine, that treatment should be withdrawn under the circumstances of the case.”); MEYERS, supra note 14, § 11:2, at 266 (“The decision of a patient to refuse medical treatment, in order to be rational, must be based on reason and understanding. However, it need not be wise or sensible in the mind of the physician, the court, or anyone else.”) (footnote omitted); JAMES RACHELS, THE END OF LIFE 119 (1986) (“We should not, without very strong reasons, compel people to do what they think is wrong, even if their beliefs are mistaken.”); Bym, supra note 21, at 29 (“The law of informed consent would be rendered meaningless if patient choice were subservient to conscientious medical judgment”) (footnote omitted); Richard Delgado, Euthanasia Reconsidered – The Choice of Death as an Aspect of the Right of Privacy, 17 ARIZ. L. REV. 474, 484 (1975) (“If a competent and informed decision has been made, traditional legal notions of autonomy and self-determination favor the protection of individual choice,
Jersey made clear that the “question is not what a reasonable or average person would have chosen to do under the circumstances but what the particular patient would have done if able to choose for himself.”\textsuperscript{124} The court held that “life-sustaining treatment may be withheld or withdrawn from an incompetent patient when it is clear that the particular patient would have refused the treatment under the circumstances involved.”\textsuperscript{125} As the Supreme Judicial Court of Massachusetts explained: “Individual choice is determined not by the vote of the majority but by the complexities of the singular situation viewed from the unique perspective of the person called on to make the decision.”\textsuperscript{126} Thus, the guardian may consider a variety of factors when attempting to determine what the patient herself would have decided. What the guardian should not do, however, is try to place herself in the patient’s shoes and then use her own (i.e., the guardian’s) subjective standards and values to make the relevant decision.\textsuperscript{127}

Even if one makes clear that the guardian is not to use her own values, the risk is always present that the guardian will nonetheless do that, consciously or unconsciously.\textsuperscript{128} However, it would be false to

\textsuperscript{124} In re Conroy, 486 A.2d 1209, 1229 (N.J. 1985); see also In re L.W., 482 N.W.2d 60, 73 (Wis. 1992) ("[T]he guardian must assess these factors from the standpoint of the patient, and should not substitute his or her own view of the ‘quality of life’ of the ward.").

\textsuperscript{125} See Conroy, 486 A.2d at 1229.


\textsuperscript{127} Cf. In re Longeway, 549 N.E.2d 292, 306 (Ill. 1989) (Ward, J., dissenting) ("The determination is obviously fraught with the danger that the surrogate’s decision will reflect the surrogate’s value system (or a mistaken view of the incompetent’s value system) and be opposed to the patient’s personal value system.").

\textsuperscript{128} In re A.C., 573 A.2d 1235, 1250-51 (D.C. Cir. 1990) (en banc) (noting that “sometimes family members will rely on their own judgments or predilections rather than serving as conduits for expressing the patient’s wishes”); Longeway, 549 N.E.2d at 306 (Ward, J., dissenting) ("Allowing a guardian to substitute his judgment for that of an incompetent ward creates a grave risk that . . . there will be wards who will undergo the death described in frightening terms in the majority opinion, without ever having had such an intent to do so."); see also DeGrella ex rel. Parrent v. Elston, 858 S.W.2d 698, 711 (Ky. 1993) (Lambert, J., concurring) (noting that “the perceived moral and ethical values of the patient may be lost or significantly influenced by the values of the surrogate”); Rhoden, supra note 32, at 377 (stating that “the proxy’s assessment of what the patient
assume that the only danger posed by this inappropriate substitution of preferences is that guardians will terminate treatment too early. Abuses might also occur if treatment is continued when the patient would have wanted it stopped. The damage to the individual from prolonged treatment might involve not only a denial of autonomy but also great, unnecessary pain and a permanent alteration in the memories of loved ones. Rather than remembering their grandmother as a strong, vibrant character, grandchildren might have a last picture of a woman in great pain connected to an imposing machine. The possible costs of a premature death obviously might also be greatly burdensome and do not need elaboration here. Thus, the importance of the role of the guardian should by no means be undervalued.

When one discusses the injury which may occur from a denial of autonomy, one may have in mind the injury which occurs when someone’s explicit statement is ignored or, instead, when the course of treatment is not what the patient would have wanted even if in fact the patient had never manifested her desires. When an individual has not manifested her preferences, the possibility always exists that the guardian will make an incorrect judgment about what she in fact would have wanted. Even putting aside the worry that the guardian will inaccurately reflect the patient’s preferences, some commentators suggest that one should not even consider what the incompetent person would have

would want, no matter how scrupulously performed, relies to some extent upon the proxy’s values in addition to the patient’s); Debra L. Dippel, Comment, Someone to Watch Over Me: Medical Decision-Making for Hopelessly Ill Incompetent Adult Patients, 24 AKRON L. REV. 639, 667 (1991) (“Unless a patient has executed an advance directive while competent, or there is irrefutable evidence of the patient’s beliefs and wishes, the surrogate must act upon his own intuition.”); Ronzetti, supra note 58, at 155 (“Substituted judgment risks displacing the patient’s desires with those of the surrogate decisionmaker, because no surrogate can make such a decision without somehow incorporating her own values.”).

In re Jobes, 529 A.2d 434, 453 (N.J. 1987) (Handler, J., concurring) (holding that “‘abuse’ includes not only discontinuing treatment for a patient who would have wanted treatment continued, but also the continuation of treatment for a patient who would have wanted treatment stopped”).

See CANTOR, supra note 68, at 65 (“Whether their concern is to avoid suffering, or to avoid crippling expenses to their estate, or simply not to be remembered in a deteriorated condition, people can appreciate the assurance that their wishes will be honored.”).

In re Jeffer, 606 N.E.2d 727, 730 (Ill. App. Ct. 1992) (“Great care should be and is taken . . . to ensure that the guardian exercises the incompetent person’s wishes because of the final, irreversible nature of that decision.”).
said. Such a view holds that if the person did not in fact express her preferences, then her interest in having her previous manifestations of autonomy respected would not be violated if the unexpressed preferences were not considered in the relevant determination.

If one adopts the approach in which autonomy is only violated if explicit instructions are ignored, then patients who have expressed a preference which is only slightly less clear or specific than the standard requires will be treated as if they had expressed no preferences at all, at least insofar as their autonomy interests are concerned. Especially if the standards for what counts as sufficiently explicit are relatively difficult to meet, large numbers of individuals might then be precluded from having their preferences even considered, much less from having them be dispositive.

While autonomy interests would not be violated by a refusal to consider insufficiently precise directions dispositive, those interests would be violated by a refusal to consider the comments at all, if the comments were sufficiently clear to indicate what the general wishes would have been.

A theory which holds that autonomy interests are not violated by the refusal to give any weight at all to slightly imprecise directions would inappropriately privilege form over substance. It would be as if the individual were being punished for her failure to meet the requisite standards of precision. The goal of substituted judgment is not to grant a privilege to individuals with good crafting or speaking skills; rather, it is to effectuate even the not-clearly-expressed wishes of patients.

Where it is unclear what the patient would have wanted not merely because of slight imprecision but because the patient has not said enough

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133 See Cantor, supra note 68, at 62; Robertson, supra note 25, at 1190 n.182; see also Meyers, supra note 14, § 11:10, at 289-91.

134 Robertson, supra note 25, at 1168 ("If the competent person has not made such a choice, there is no interest in any particular exercise of autonomy. Being treated as one might have chosen, when one has not made a choice, cannot be required out of respect for the competent person's autonomy.").


136 Cruzan, 497 U.S. at 323 (Brennan, J., dissenting) ("Too few people execute living wills or equivalently formal directives for such an evidentiary rule to ensure adequately that the wishes of incompetent persons will be honored."); In re L.W., 482 N.W.2d 60, 67-68 (Wis. 1992) ("Relatively few individuals provide explicit written or oral instructions concerning their treatment preferences should they become incompetent.").

137 Cruzan, 497 U.S. at 273.

138 In re Conroy, 486 A.2d 1209, 1229 (N.J. 1985); Cantor, supra note 68, at 63.
to reliably indicate what her wishes would have been, no violation of autonomy occurs by refusing to use a substituted judgment test. In fact, some commentators argue that no violation of autonomy occurs by the failure to use substituted judgment for two classes of individuals: those previously competent individuals who have never expressed a preference and always-incompetent individuals. Perhaps paradoxically, while these commentators may be correct about the previously competent patient, they are incorrect about the always-incompetent patient.

4. Individual Always Incompetent

This category includes individuals whose mental age precludes their being competent regardless of their chronological age and individuals whose chronological age precludes their being competent regardless of their mental age. Substituted judgment decisionmaking for individuals in this category can be very difficult to justify, unless one makes some important distinctions.

When analyzing the appropriate paradigm for always-incompetent patients, it is important to consider who is included in that category. Both the adult with the mental age of an eighteen-month-old and the teenager who has not yet reached the age of majority are within the

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132 See MEYERS, supra note 14, § 12:29, at 376.
140 Id. at 372 (noting that “where the patient has not clearly expressed his or her desires before the onset of unconsciousness, a ‘best interests’ analysis is normally considered appropriate by the courts”); Dresser, supra note 33, at 378 (noting that the best interest test is preferable to the substituted judgment standard where there is no evidence of the preferences of the formerly competent patient); Splaine, supra note 56, at 931, 933 (arguing for the best interest test rather than the substituted judgment standard in circumstances where the preference of the formerly competent patient cannot be determined).

141 Cf. In re C.A., 603 N.E.2d 1171, 1180 (Ill. App. Ct. 1992) (“The substituted judgment test, however, is of limited relevance in the case of immature minors. If anyone’s judgment is being substituted it is that of the parents or some other person with a close interest in the child’s welfare.”); see also MEYERS, supra note 14, § 6:8, at 104 (“The test for whether or not an incompetent can consent to medical treatment is really the same as to whether or not a child may consent to medical treatment, minority simply being one form of inability to consent.”).
143 MEYERS, supra note 14, § 11:6, at 216 (“Application of the ‘substituted judgment’ rule necessarily presumes that the patient was at one time competent and did, while competent, express himself or herself on the subject of when he would want life-sustaining treatment withdrawn or withheld.”).
144 See, e.g., In re Storrer, 438 N.Y.S.2d 266, 270 (1981).
145 See, e.g., In re Swan, 569 A.2d 1202, 1204 (Me. 1990).
same group, although it is not at all clear that the same standard should be applied to both. Courts must be very careful when they make use of the substituted judgment procedures for individuals who have always been incompetent. Two different issues might arise with respect to their treatment: (1) was the correct result reached, and (2) was the process by which that result was reached a credible one? Even if one reaches the "correct" result, the process may nonetheless appear tainted if obviously specious rationales are used.

For example, the Supreme Judicial Court of Massachusetts affirmed a lower court's use of substituted judgment in a case involving a five-year-old who had been in a persistent vegetative state since before reaching the age of one. While the lower court may have reached the correct result in determining that the child would refuse resuscitation, courts need to be more honest about what they in fact are doing. The court had no basis upon which to make a decision about what this child would have said based on her "considered judgments" before the unfortunate accident had occurred.

While it is clear that a child not yet the age of one cannot be assumed to have the requisite competence to make an informed, autonomous decision, it is equally clear that someone slightly below the age of majority might well have the requisite abilities. Consider someone who, while a minor, decides in a "serious and deliberative manner" that he would not want to be maintained in a persistent vegetative state should he be reduced to such a state. Had the person been an adult, a court would have allowed the patient's wishes to be respected. However, given the minority of the individual, the court could not act so summarily. An additional finding that the person had been sufficiently mature to make such a judgment would be required. Thus, although a court

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145 See MEYERS, supra note 14, § 11:25, at 241-44.
146 In re C.A., 603 N.E.2d 1171, 1180 (Ill. App. Ct. 1992) (noting that the determination of whether a proposed cause of action is in actually [sic] in the child's best interests may be subject to differing opinions.
148 Id. at 1383 (Nolan, J., dissenting) (“The trial judge did not have a smidgen of evidence on which to conclude that if this child who is now about five and one half years old were competent to decide she would elect certain death to a life with no cognitive ability.”).
149 In re Swan, 569 A.2d 1202, 1203 (Me. 1990) (holding that a minor’s pre-accident decision that he did not wish to be kept alive in a persistent vegetative state should be respected).
150 In re Gardner, 534 A.2d 947, 953, 956 (Me. 1987).
151 See Swan, 569 A.2d at 1205.
could respect an articulated wish despite the person's minority if it could be established by "clear and convincing evidence" that the minor had been sufficiently mature and had considered the question in a "clear and deliberative" manner, it would not follow as a matter of law that the wish would be respected.

The person who is only a month short of attaining majority should have his clear wishes respected, assuming that all other conditions are met. As the U.S. Supreme Court pointed out in Planned Parenthood of Central Missouri v. Danforth: "Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors as well as adults are protected by the Constitution and possess constitutional rights."

Suppose that an incompetent had not been sufficiently mature and deliberative to decide what course of action to take. A court might nonetheless take into consideration what that individual would have wanted by looking at expressed discomfort or pain as a way of measuring how disagreeable a particular procedure was. Such a process would not involve a claim that the individual had made a rational and deliberative judgment either about whether to have treatment or about what kind of treatment to have, but merely a claim about how onerous the burden imposed by the treatment might be. The New York Court of Appeals had to decide whether a terminally ill adult cancer patient with an infant's mentality should receive blood transfusions. The court considered how onerous the treatment would be and decided that the transfusions should be administered because they "did not involve excessive pain."

Basically, the court

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152 Id. at 1203, 1205.
153 Id. at 1203.
154 Id.
155 428 U.S. 52, 74 (1976) (citations omitted) (holding that the state may not require a generally applicable provision for an unmarried minor to attain an abortion in the first 12 weeks of pregnancy "provided she is sufficiently mature to understand the procedure and to make an intelligent assessment of her circumstances with the advice of her physician").
157 See Hier, 464 N.E.2d at 964-65 ("The expressions of opposition by Mrs. Hier, while those of an incompetent person, and thus not to be given legal effect, are nevertheless to be taken into consideration in applying the substituted judgment test because they are indicative of the burden that she feels in being subjected to advanced medical technologies.").
158 In re Storar, 438 N.Y.S.2d 266 (1981) (holding that blood transfusions which did not cause excessive pain and which were necessary for the incompetent patient's health should be continued).
159 Id. at 275-76.
decided that it would be in the best interests of the individual to receive that treatment.\textsuperscript{160}

Arguably, the case which is farthest from the paradigm involving an autonomous decisionmaker is one involving an individual who has always had an infant's mental age. Some courts have suggested that the appropriate approach in such cases is the best interests test.\textsuperscript{161} However, other approaches have been suggested; for example, a court might believe it reasonable to assume that an individual who has never been capable of mature decisionmaking would, if competent, have chosen as the patient's close family members would have chosen.\textsuperscript{162} Even were this assumption borne out statistically, to use it as a basis for substituted judgment would be to stand substituted judgment on its head. The whole point of substituted judgment is to figure out what the patient would have said with her own values and deliberative processes had she been competent and had she been confronted with the existing circumstances.\textsuperscript{163} It is bad enough that practicalities require that guesses be made in light of such factors as the patient's past articulations of values or preferences; it is much worse when the values themselves must be supplied.

\textbf{B. On Straining the Limits of Paradigms}

When a theoretical paradigm does not allow certain results to be achieved, a few different options are available. One might accept the limitations of the theory and say that a particular outcome is not possible because of those limitations.\textsuperscript{164} Alternatively, one might adopt a new theory to cover those cases which seem to be outside the scope of the

\textsuperscript{160} Id. The court's decision went against the suggestion of the patient's mother who had argued that it would be in the best interests of the patient not to receive transfusions. Id. at 268, 275-76.

\textsuperscript{161} See DeGrella ex rel. Parent v. Elston, 858 S.W.2d 698, 705 (Ky. 1993) (suggesting that best interest is "synonymous with the decision the ward would choose to make if conscious and competent to do so"); In re Custody of a Minor, 379 N.E.2d 1053, 1065 (Mass. 1978) (noting that "the best interest analysis . . . requires a court to focus on the various factors unique to the situation of the individual for whom it must act"); Cantor, supra note 35, at 259 (noting that "persons are presumed to act in their own best interests, and efforts to discern a patient's unexpressed preferences will stress the patient's best interests").

\textsuperscript{162} Mack v. Mack, 618 A.2d 744, 772 (Md. 1993) (Chasanow, J., concurring in part, dissenting in part) ("It is reasonable to assume that an infant or incompetent child, if capable of rendering a decision, would reflect the values and views of parents and close family members.").

\textsuperscript{163} See MEYERS, supra note 14, § 11:6, at 215.

\textsuperscript{164} Id. § 11:10, at 287-88.
first theory.\textsuperscript{165} Or, one might simply expand the old theory, perhaps beyond its theoretical constraints, to accommodate a perceived good.\textsuperscript{166}

Arguably, the substituted judgment approach has been modified beyond its theoretical limits to achieve good results — for example, allowing someone to escape an agonizing existence despite her never having previously given any indication that she would choose that option and her currently being unable to express such a view.\textsuperscript{167} Yet, that same result might be achieved in other ways, such as using a best interests analysis. Further, some of the costs of expanding a paradigm beyond its theoretical limits might thereby be avoided. For example, the court in \textit{In re Hier} rejected an analysis of the substituted judgment approach offered in another jurisdiction because that analysis did not allow the “withholding of life-prolonging measures to a patient incompetent to make the decision for himself, unless the patient (1) had, at some time, been competent, and (2) had expressed a wish when competent not to receive such measures.”\textsuperscript{1168} Because the purpose of substituted judgment is “to secure to incompetent persons the same right to choose or reject treatment that is accorded to competent persons by the law of consent,”\textsuperscript{169} the \textit{Hier} court believed that the purpose was not being served by such a narrow construction of the doctrine.\textsuperscript{170} The court’s point that a narrow construction of substituted judgment does not serve the purposes of the doctrine is well taken.\textsuperscript{171} Nonetheless, while narrow constructions

\textsuperscript{165} \textit{Id.}

\textsuperscript{166} See \textit{id.} at 288 (“To rely on the substituted judgment rule where the patient has not expressed his views as to the treatment in question, neither specifically nor in general, is to cloud the issue.”); see also \textit{Dresser, supra} note 33, at 378-79 (“By failing to articulate clearly the proper components of the substituted judgment standard and the evidence necessary for its application, these courts have exposed themselves to charges that they covertly subordinated the interests of seriously ill incompetent patients in favor of economic and other third-party concerns.”).

\textsuperscript{167} See \textit{MEYERS, supra} note 14, § 11:6, at 215.


\textsuperscript{169} \textit{Id.}

\textsuperscript{170} \textit{Id.} at 963-64.

\textsuperscript{171} Ironically, it is not clear that the court actually analyzed what in fact the patient would have wanted or what would have promoted her own interests. See \textit{Dresser, supra} note 33, at 386:

The \textit{Hier} decision is vulnerable to criticism on two grounds. First, in determining whether the operation would benefit Hier, the court omitted a comprehensive examination of her interests. . . . Second, the court interpreted Hier’s resistance as representing a concern with privacy and dignity. Yet the facts presented in the opinion fail to supply any basis for this interpretation.
should be avoided, very broad constructions such as performing substituted judgment for someone with a permanent mental age of a one-year-old should also be avoided. Otherwise, there is a great danger that the whole purpose of substituted judgment could be subverted.\textsuperscript{172}

Some courts and commentators have suggested that in the case of incompetents, the substituted judgment test is equivalent to the best interests test.\textsuperscript{173} Yet, it must be remembered that substituted judgment is not designed to reflect the best judgment — it is designed to reflect the person’s own judgment.\textsuperscript{174} The two tests should not be conflated. Patients sometimes make mistakes because of unrealistic expectations\textsuperscript{175} or emotional considerations.\textsuperscript{176} If the person has competently and clearly expressed her wishes and has been adequately informed, those wishes must be carried out, even if reasonable people would have chosen differently.\textsuperscript{177} The New Jersey Supreme Court has suggested that even if nontreatment would promote a patient’s best interests, a court must nonetheless refuse to choose that option if the individual had made clear that she wanted the non-optimal treatment.\textsuperscript{178} To suggest that substituted judgment and best interests analyses are equivalent may lead courts

\textsuperscript{172} See MEYERS, supra note 14, § 11:6, at 216.

\textsuperscript{173} See In re Custody of a Minor, 379 N.E.2d 1053, 1065 (Mass. 1978) (“In a case like this one involving a child who is incompetent by reason of his tender years, we think that the substituted judgment doctrine is consistent with the “best interests of the child” test.”); Cantor, supra note 35, at 259 (“Where substituted judgment is based on the presumed rather than the actual intentions of the now incompetent, the formula should yield essentially the same results as a ‘best interests’ of the patient standard.”).

\textsuperscript{174} Buchanan, supra note 27, at 389-90 (“The right of self-determination, both for incompetents and incompetents, is understood to include the right to refuse treatment even when such refusal would be neither in one’s best interest, nor in agreement with what most rational or reasonable persons would elect to do in similar circumstances.”).

\textsuperscript{175} As illustrated in David V. Schapira, The Right to Die: Perspectives of the Patient, the Family, and the Health Care Provider, in To DIE OR NOT TO DIE? 3, 4 (Arthur S. Berger & Joyce Berger eds., 1990):

The majority of patients felt they would live at least three years or longer, and an appreciable percentage felt they would “beat the cancer.” In fact, over 75 percent of the patients expired within a year of participating in the study. If patients have a very optimistic view of their prognosis, discussions regarding resuscitation may seem incongruous.

\textsuperscript{176} Id. at 4-5.

\textsuperscript{177} Buchanan, supra note 27, at 389 n.17.

\textsuperscript{178} In re Conroy, 486 A.2d 1209, 1232 (N.J. 1985) (holding that “even in the context of severe pain, life-sustaining treatment should not be withdrawn from an incompetent patient who had previously expressed a wish to be kept alive in spite of any pain that he might experience”).
and guardians to mistakenly believe that substituted judgment is appropriate only when the “correct” decision is being made.\textsuperscript{179}

Suppose that nontreatment were deemed by a court to promote the patient’s best interests. If best interests and substituted judgment were equivalent, then the court could feel comfortable in presuming that the individual would have chosen nontreatment. Yet, someone who believed in the sacredness of life might not have made that choice. Indeed, even if the court knew that the person would not have made that choice, the court might be tempted to ignore the patient’s wishes because of a belief that her “true” choice would have been to promote her own “best interests.”\textsuperscript{180}

Consider a judgment which held that it would be in the best interests of a patient to have a treatment \((X)\) and that a different course of treatment \((Y)\) would be non-optimal. Such a judgment might mean that: (a) reasonable, informed people would prefer \(X\), even though \(Y\) is an acceptable second-best choice; or (b) \(X\) is so much more preferable than \(Y\) that no competent individual would even consider the latter acceptable.\textsuperscript{181} The latter is an extremely strong position, which would imply that if \(X\) represents a course of nontreatment and \(Y\) represents a form of treatment, then individuals who believed life to be sacred and thus desired aggressive treatment would be considered to be acting unreasonably \textit{as a matter of law}. By the same token, a court which held that treatment would be in the best interests of the patient would hold that it would be unreasonable as a matter of law \textit{not} to prolong life in the existing circumstances. Conflation of the notions of best interests and substituted judgment might lead courts to ignore option (a) because such courts would never believe that a non-optimal treatment could nonetheless be acceptable to reasonable, informed people.

Best interests and substituted judgment are equivalent only if the patient could not while competent have chosen the non-optimal treatment — i.e., only if the choice of the non-optimal treatment was unreasonable as a matter of law and thus could not have been made by a competent

\textsuperscript{179} See MEYERS, supra note 14, § 11:6, at 219-20.

\textsuperscript{180} Id.

\textsuperscript{181} But see ROBERT M. VEATCH, DEATH, DYING, AND THE BIOLOGICAL REVOLUTION 131 (1989), arguing:

Were someone to argue that there is “benefit” in preserving even permanently vegetative life, there is no scientific argument in opposition. It simply violates the insights of most religious and secular systems of morals and values. While not everyone must agree, there is plausibility to the position that society ought not override the surrogate who reaches such a conclusion in good faith.
person. In many cases, a particular treatment would indeed promote the patient's best interests even though alternative treatments would not be unreasonable as a matter of law. To talk about the equivalence of substituted judgment and best interests might induce courts to ignore a whole set of options — those non-optimal treatments which an informed, competent individual might nonetheless have chosen.

Substituted judgment and best interests are different tests designed to do different things. The former is designed to capture what the patient would have said if competent, while the latter is designed to promote the patient's best interests. The two need not coincide, and courts make a mistake when implying that they must.

C. Best Interests

When autonomy cannot be used as a paradigm, some version of the best interests test should be used. The guardian might use an objective best interests test in which the formerly articulated values or preferences of the patient are completely ignored or, instead, might use a more subjective test in which those values or preferences are allowed to play a role. Traditionally, the best interests test is an objective determination in which the patient's previously expressed preferences or values are considered irrelevant. The Supreme Court of Wisconsin

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182 Id. at 114-15.
183 See id.
185 Id.
186 Mack v. Mack, 618 A.2d 744, 759 (Md. 1993) ("Best interest is not based on the patient's right of self-determination as to whether treatment should be received or rejected, because the absence of any conclusion as to the patient’s judgment on that issue is precedent to applying the best interest analysis."); In re Conroy, 486 A.2d 1209, 1231 (N.J. 1985) (noting that "the state's parens patriae power supports the authority of its courts to allow decisions to be made for an incompetent that serve the incompetent's best interests, even if the person's wishes cannot be clearly established"); In re Guardianship of Grant, 747 P.2d 445, 457 (Wash. 1987) (holding that "where it cannot be ascertained what choice the patient would make if competent . . . , the guardian must make a good-faith determination of whether the withholding of life sustaining treatment would serve the incompetent patient’s best interests"); In re L.W., 482 N.W.2d 60, 68 (Wis. 1992) ("[T]he common law, where the individual was never competent or where the conduct of the individual while competent never was of a kind from which one could draw a reasonable inference upon which to make a substituted judgment, requires that decision to be resolved by a surrogate decision maker acting in the best interests of the incompetent.").
187 See MEYERS, supra note 14, § 11:6, at 217, 220.
188 Cf. John D. Gorby, Admissibility and Weighing Evidence of Intent in Right to Die
has suggested that past statements of someone who is currently incompetent will not be considered in best interests analysis. In particular, the question for the decisionmaker will be what the reasonable person would want done.

In order for treatment to be withdrawn using the objective best interests test, the burdens of continued life must outweigh the benefits. However, this balancing standard does not mean that if the burdens posed by treatment would slightly outweigh the benefits, then no treatment should be given. The Supreme Court of New Jersey has suggested that in order to withhold treatment, "the recurring, unavoidable and severe pain of the patient's life with the treatment should be such that the effect of administering life-sustaining treatment would be inhumane. Yet, to hold that only inhumane administrations of life-sustaining treatments may be withheld under the objective best interests standard may be too difficult a standard to meet. The Supreme Judicial Court of Massachusetts worried that incompetent individuals might be forced to undergo procedures that competent individuals would not choose for themselves and suggested that such a policy devalues the worth of incompetent human beings. Regrettably, a state which

Cases, 6 Issues L. & Med. 33, 34-35 (1990) (noting that "if the 'meaningfulness' of the patient's life in an objective sense is determinative, the patient's comments and thoughts about living on a respirator in a vegetative state may be of no importance or relevance to the court in making its judgment").

L.W., 482 N.W.2d at 70 (noting that "the best interests standard focuses solely on what is currently in the patient's best interests"). But see CANTOR, supra note 68, at 70 (concluding that "deference to the personal value systems of the patient...might serve a useful function, even under what would normally be a purely objective best interests formula").

See L.W., 482 N.W.2d at 70.

MEYERS, supra note 14, § 11:6, at 217 ("Under the best interests standard, the surrogate decision-maker attempts to decide whether...or not the benefits offered by the medical treatment are sufficient to outweigh the burdens that it imposes.").

In re Conroy, 486 A.2d 1209, 1232 (N.J. 1985); see also In re Moorhouse, 593 A.2d 1256, 1259 (N.J. Super. Ct. App. Div. 1991) (explaining that, in New Jersey, a guardian may withhold or withdraw life-sustaining medical treatment if it is clear that the subjective test, the limited-objective test, or the pure-objective test has been met).

Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 428 (Mass. 1977) ("To presume that the incompetent person must always be subjected to what many rational and intelligent persons may decline is to downgrade the status of the incompetent person by placing a lesser value on his intrinsic human worth and vitality."); see also CANTOR, supra note 68, at 93 (noting that "courts promote the human dignity of [always-incompetent] patients by affording access to beneficial results which competent patients could, and likely would, choose under similar circumstances").
adopts the New Jersey standard might well force incompetents to undergo such procedures.\footnote{The New Jersey Supreme Court also adopted a modified best interests test in which the subjective preferences of the patient were taken into account and in which the objective component did not involve as strict a standard. See Conroy, 486 A.2d at 1232. Nonetheless, the unmodified objective best interests test — i.e., the “pure” best interests test — makes use of a standard which may be unduly difficult to meet. Id. at 1233.}

Some courts have suggested that continuing the life of someone in a persistent vegetative state\footnote{In re Guardianship of Myers, 610 N.E.2d 663, 670 (C.P. Summit Co. Ohio 1993) (suggesting that maintaining someone in a persistent vegetative state, “when there is no hope for recovery, is not only against the best interest, but is inhumane”); see also Marvin M. Moore, The Case for Voluntary Euthanasia, 42 UMKC L. Rev. 327, 336 (1974) (noting that such individuals need “not to be relieved of pain, but rather, to be unburdened of an irrational, meaningless existence whose prolongation provides no benefits to themselves or to those about them”); Yuen, supra note 76, at 623 (noting that “the vast majority of people would choose death over existence in a vegetative state attached to life-sustaining equipment with only a negligible chance of emerging from unconsciousness and a high probability of brain damage if they were to emerge”).} would be against that person’s best interests.\footnote{Mitchell ex rel. Rasmussen v. Fleming, 741 P.2d 674, 689 (Ariz. 1987) (“Under the best interests standard, the surrogate decisionmaker assesses what medical treatment would be in the patient’s best interests as determined by such objective criteria as relief from suffering, preservation or restoration of functioning, and quality and extent of sustained life.”).} Such a determination implies that objective criteria are used to evaluate what indeed would be in the best interests of such a patient\footnote{As explained by Cantor, supra note 35, at 257: Even where a patient has reached an irreversibly comatose state in which all feeling and awareness have ceased, best interests cannot automatically be equated with continued existence. ... To the extent that withdrawal of life support reflects what the comatose patient would have wanted done, such a course can also be viewed as being in the patient’s best interests. Richard Sherlock, Liberalism, Public Policy and the Life Not Worth Living: Abraham Lincoln on Beneficent Euthanasia, 26 AM. J. JURIS. 47, 51 (1981) (noting that “what the defenders of the various forms of euthanasia must argue for is a publicly announced, non-arbitrary standard that specifies some human lives as having those characteristics that render them not worth living”). But see In re Doe, 583 N.E.2d 1263, 1276-77 (Mass. 1992) (O’Connor, J., dissenting): [T]he court’s approval of the withdrawal of Jane Doe’s nutrition and hydration is given for Jane Doe’s benefit. That leads me to ask how she benefits from an early death. She is not burdened by life. She need not “go” to be in peace. For} and that it may objectively be best for someone to die.\footnote{See supra note 14, § 4:3, at 27 (noting that a “person in a persistent vegetative state... will never regain consciousness, cannot speak, think, feel or emote, but... breathes and maintains basic metabolic functions of body heat, pulse, food conversion, and elimination”).} This position
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presents at least two difficulties. First, if it would be in the best interest of one person in a persistent vegetative state to have treatment withdrawn, and there is no role in that determination played by the intent or values of the patient, then it would seem that all patients in a persistent vegetative state should have treatment withheld or withdrawn, even if they had expressed preferences to the contrary while still competent.

Second, the objective, reasonable person standard is less determinative than might first appear, since it is unclear what benefits or burdens to include in a cost-benefit analysis involving individuals in a persistent vegetative state. For example, it is unclear whether the prolongation of life is itself a benefit for such an individual. If so, then extending the life of someone in a persistent vegetative state might be thought to promote that person's interests.

Arguably, where the patient is permanently unconscious and can feel no pain whatsoever, it does not make sense to talk about promoting her best interests because there are no interests to promote. Yet, such a

all that appears, with food and drink and care she can "stay" in peace.

199 In re L.W., 482 N.W.2d 60, 72-73 (Wis. 1992) ("For an incompetent patient in a persistent vegetative state, such as L.W., there may be a point at which as objectively viewed it is in his or her best interests to refuse further medical treatment.").

200 See Mack v. Mack, 618 A.2d 744, 761 (Md. 1993) ("[A] conclusion that it is in [the patient's] best interest to die would be based on his existence in a persistent vegetative state. That being the precedent, artificially administered sustenance should be withheld from all persons in a persistent vegetative state . . . ").

201 But see id. at 760 (noting that if the patient had expressed a preference for treatment under those circumstances, that preference would be respected).

202 But see L.W., 482 N.W.2d at 68 (suggesting that for someone in a persistent vegetative state, a "dignified and natural death may outweigh the interest of maintaining a physiological life as long as medically possible").

203 But see In re Peter, 529 A.2d 419, 425 (N.J. 1987) (holding that cost-benefit analyses "should not be applied to patients in the persistent vegetative state").

204 Compare Buchanan, supra note 27, at 402 (discussing "the implausible assertion that it is in the patient's best interest to die, even when life can be preserved without suffering") with Paul Ramsey, Ethics at the Edges of Life 269 (1978) (stating that "no treatment is beneficial to a comatose dying patient when it can alter the dying process in no way and serves only to prolong it").

205 See Buchanan, supra note 27, at 402 ("[R]egardless of whether one assumes that the patient's vegetative state is reversible or irreversible, the best interest standard requires perpetual support for every such patient.").

206 Edward M. Scher, Comment, Legal Aspects of Euthanasia, 36 Alb. L. Rev. 674, 689 (1972) ("[T]he hypothetical patient . . . [is] permanently unconscious and feels no pain whatsoever. In this situation, the best interest criterion seems to make no sense.").
view raises serious questions about whether someone who is alive and thus presumptively has interests is wrongly being treated as if she had none. Even were it appropriate to treat individuals who are permanently unconscious and unable to feel pain as not having interests, courts would still have to decide what would promote the best interests of incompetents who could feel pain. The court in Foody v. Manchester Memorial Hospital suggested: “If the exercise of the right is to be maintained where no expression has been made by an incompetent patient as to treatment, it must take place within the context of an analysis which seeks to implement what is in that person’s best interests by reference to objective societally shared criteria.” Here, the best interests analysis is “objective” — criteria which are agreed upon by society will be used, even if there is no evidence that the patient herself would have used those criteria when making the relevant decision.

If indeed societal criteria are to be used, some agreement must be reached about what those criteria are. The Foody court offered some of the relevant criteria: the nature of the treatment, the length of time life would be extended, and the quality of life possible with treatment. Within that quality of life consideration might be an analysis of whether the individual would have any cognitive function after treatment.

Yet, it is misleading to suggest that there is a societal consensus about which factors should be considered in best interests analysis and how heavily those different factors should be weighed. For example,
the New Jersey Supreme Court seems to find pain to be the most important factor in an objective best interests analysis — as is indicated by its holding that the condition for nontreatment is that “the recurring, unavoidable and severe pain of the patient’s life with the treatment should be such that the effect of administering life-sustaining treatment would be inhumane.”

While pain should be a factor in any objective best interests analysis, it should not be the only factor. The patient who is “marginally cognitive” may have feelings of frustration, helplessness, rage, contentment, satisfaction, and joy, although they may be difficult to quantify. Patients also have an interest in having a dignified death. Indeed, some individuals reject pain-controlling drugs to avoid a stupor, with the accompanying loss of alertness or consciousness, precisely because of dignity considerations.

Death with dignity might involve two very different sorts of considerations: the current feelings and beliefs of the patient and the treatment resolve the issue. The significant decisions of life are more complex than statistical determinations.

211 In re Conroy, 486 A.2d 1209, 1232 (N.J. 1985).
214 See id. at 1247 (Handler, J., concurring in part, dissenting in part) (suggesting that the court’s concentration on pain “eclipses a whole cluster of other human values that have a proper place in the subtle weighing that will ultimately determine how life should end”); Mary R. Barrington, Apologia for Suicide, in EUTHANASIA AND THE RIGHT TO DEATH 152, 155 (A.B. Downing ed., 1969) (stating that “analgesics will not help a patient to live with total incontinence, reduced to the status of a helpless baby after a life of independent adulthood”); Carl, supra note 12, at 534 (“Pain is only one form of suffering. There is extreme fatigue, oftentimes itching, incontinence, and a host of other symptoms.”); Moore, supra note 196, at 336 (“Terminally ill patients are, depending on the specific affliction, often tormented by one or more of the following: nausea, giddiness, incontinence of the bowels and/or bladder, partial or total paralysis, shortness of breath, difficulty in swallowing, compulsive coughing, and blindness.”).
215 In re Peter, 529 A.2d 419, 425 (N.J. 1987) (noting the difficulty medical experts have in determining the mental and emotional capacities of those patients unable to communicate verbally).
216 Id. at 424-25.
217 In re Guardianship of Grant, 747 P.2d 445, 451 (Wash. 1987) (“The individual’s right to die with dignity must not be ignored.”).
218 Stephen A. Newman, Euthanasia: Orchestrating “The Last Syllable of Time,” 53 U. PITP L. REV. 153, 185 (1991) (“Some people will reject the invitation to choose drugs that induce mental stupor in order to avoid pain. For the incurably ill, losing alertness, control and even consciousness may not be acceptable as a way to prolong existence.”) (footnote omitted). But see CUNDIPF, supra note 37, at 116-17 (“Although patients may become unusually sleepy for two or three days after beginning appropriate doses of oral morphine, they soon return to being alert and mentally sharp.”).
219 In re Conroy, 486 A.2d 1209, 1233 (N.J. 1985) (“The right of an adult who...
past feelings and beliefs of the patient while competent.\textsuperscript{220} If only the current feelings and beliefs of the patient are taken into account, then a permanently insensate person cannot have her dignity violated by treatment because she will never become aware of that treatment. However, if having one’s dignity respected includes considering one’s past feelings and beliefs, then extending the life of a patient in a way which runs counter to the patient’s past feelings and beliefs would not allow her to die with dignity, even if she would never become aware of that indignity.\textsuperscript{221}

While it seems clear that a permanently insensate individual could be treated in a way that offends her dignity, even if she never become aware of that undignified treatment, it is important to establish the basis for this reasoning. If such treatment would be offensive because it would violate the past expressed beliefs and attitudes of the patient, then it would seem that someone who was now insensate and had never expressed such attitudes would be unprotected.\textsuperscript{222} Yet, even for those individuals, there is a sense that certain kinds of treatment “objectively” offend their dignity.\textsuperscript{223} Thus, death with dignity does not require that the patient herself is conscious of what is being done — an individual may be and always have been insensate and nonetheless be thought to be treated in a way which violates her dignity.\textsuperscript{224}

was once competent to determine the course of her medical treatment remains intact even when she is no longer able to assert that right or to appreciate its effectuation.\textsuperscript{a}).

\textsuperscript{a} In re Jobes, 529 A.2d 434, 444 (N.J. 1987) ("Where an incompetent’s wishes are not clearly expressed, a surrogate decisionmaker considers the patient’s value system for guidance.").

\textsuperscript{21} A separate question is whether the family’s view of what a dignified death would involve corresponds to what the patient, while competent, would have said. See Cruzan v. Director, Mo. Dep’t of Health, 497 U.S. 261, 286 (1990) (holding that there is “no automatic assurance that the view of close family members will necessarily be the same as the patient’s would have been had she been confronted with the prospect of her situation while competent”).

\textsuperscript{22} See, e.g., In re Doe, 583 N.E.2d 1263, 1268 (Mass. 1992) (noting that the situation is similar to that of an infant who had not yet formed the necessary mental processes to express its will).

\textsuperscript{221} See Jobes, 529 A.2d at 444 (noting that “the individual’s right to privacy becomes stronger ‘as the degree of bodily invasion [effected by the medical treatment at issue] increases and the prognosis [for recovery to a cognitive, sapient state] dims.’”).

\textsuperscript{222} At some point, such a course of treatment upon the insensate patient is bound to touch the sensibilities of even the most detached observer. . . . When cherished values of human dignity and personal privacy, which belong to every person living or dying, are sufficiently transgressed by what is being done to the individual, we should be ready to say: enough.
When considering the various factors which promote the patient’s best interests, one must further decide which values should be used when making that determination. One might use society’s values (assuming that a consensus exists) or, instead, use the patient’s values. When using the patient’s own values, the court or guardian might seem less open to the charge of paternalism and less open to the charge that it is imposing its own values on the patient.

At least two difficulties are posed by a court’s or guardian’s imposing its own values on a patient. First, there is no reason to prefer those values over the values of someone else or society. Second, even if those values are “correct” in that they coincide with society’s, there is still the

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Id. at 459 (Handler, J., concurring) (citation omitted); see also In re Guardianship of Crum, 580 N.E.2d 876, 883 (P. Ct. 1991) (“[I]t is the opinion of the court that it is in the best interest of Dawn M. Crum to authorize the withdrawal of nutrition and hydration and allow her to die peacefully, painlessly, and with dignity.”).

221 H. Tristam Englehardt, Jr. & Michele Malloy, Suicide and Assisting Suicide: A Critique of Legal Sanctions, 36 Sw. L.J. 1003, 1006-07 (1982) (“A judgment of another’s best interests requires an ordering of the significance of benefits and banes. This ordering, however, presupposes a particular moral or evaluational sense, and is therefore irradically subjective.”); see also Gary U. Schorff, Note, In re Quinlan Revisited-The Judicial Role in Protecting the Privacy Right of Dying Incompetents, 15 Hastings Const. L.Q. 479, 499 (1988) (“Which interest is ‘best’ for the patient should be determined by the patient’s values.”).

226 But see Jobes, 529 A.2d at 457-58 (Handler, J., concurring) (“A ‘best interests’ standard assumes a consensus that is not there regarding when discontinuation of treatment is in a patient’s best interests.”); Hamann, supra note 56, at 117 (“A best interest standard assumes a consensus that does not exist in society on the issue of whether to discontinue treatment.”).

227 Jobes, 529 A.2d at 462 (Pollock, J., concurring) (“The patient’s preferences ... should be considered in a best-interests analysis.”); Yuen, supra note 76, at 629 (“A patient’s statements regarding medical decisions that do not meet the clear evidence standard should be considered by the doctor and patient in assessing best interests.”).

228 Ronzetti, supra note 58, at 155-56 (“Best interest decisionmaking risks being paternalistic and denying the patient’s values entirely.”).

229 Joanna K. 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, 127 (1988) (“[J]udges and protective service agencies have had considerable discretion in making decisions and in applying the best interests doctrine. As a result, they often have been accused of abusing their discretion by applying their own social values and standards.” (footnote omitted)); see also Dresser, supra note 33, at 388 (arguing that “attempts to incorporate reasonable person values in the best interests standard yield confusion and potential abuse”).

230 See Ikuta, supra note 35, at 42 (“If a third party, no matter how well intentioned, makes a choice for [another] individual, the choice can no longer be called autonomous.”).
difficulty that the patient's own values seem to be ignored. The Supreme Court of Illinois has suggested that use of the best interests test with its objective criteria and analysis seems to undermine the "foundation of self-determination and inviolability of the person upon which the right to refuse medical treatment stands."

One cannot talk about the patient's values if the patient had never formed or developed any values or any deliberative capacities. The difficulty with imputing values to such a person would not merely be that such a patient would never have expressed a view about whether she would want treatment continued in a particular situation, but that she would not have been able to form an opinion or even to have developed values. In such a case, it makes sense to use an objective best interests test, because another viable option does not seem to be available. Nonetheless, one should not claim that one is thereby doing what the patient would have done but should admit that one is using a different test which does not claim to predict what the patient herself would have decided.

III. FAMILY, THE COURTS, AND LIABILITY

A. Family

Arguably, in those cases in which the incompetent has not left explicit directions about her care, family members should make the

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231 See Jobes, 529 A.2d at 457 (noting that the approach involving the substituted judgment of another is "fraught with guesswork" and expresses concern for the patient rather than determining what his actual wishes would be).

232 In re Longeway, 549 N.E.2d 292, 299 (Ill. 1989) (holding that the guardian of a comatose patient may exercise the patient's right to terminate artificial life support); Liacos, supra note 21, at 221 ("Allowing others to decide what is objectively in a patient's best interest demeans the person's humanity by ignoring the subjective wishes and circumstances of the individual on whose behalf the decision is ostensibly being made.").

233 In re Doe, 583 N.E.2d 1263, 1268 (Mass. 1992) (concluding that "in situations in which there is an attempt to use substituted judgment for a never-competent person, it is a legal fiction"); In re Colyer, 660 P.2d 738, 745 (Wash. 1983) (holding that a guardian cannot use best judgment to exercise the "patient's personal choice" where the patient has "always been severely retarded").

234 See In re Hamlin, 689 P.2d 1372, 1374 (Wash. 1984) (concluding that "patient has been severely mentally retarded since birth, therefore never expressing his wishes about termination of life support").

235 See supra note 222 and accompanying text.

236 But see MEYERS, supra note 14, § 11:15, at 302 ("Absent prior, relevant, competent expressions by the patient, that reasonable minds believe it best for the patient, or in his best interests, is perhaps the best test for determining what the patient would have decided, if competent to do so.").
necessary decisions. Family members would be more likely to know what the patient would have wanted and, further, would seem more likely to have the best interests of the patient at heart. In many jurisdictions, medical decisionmaking is generally left to the family in consultation with the medical community, although some courts will allow a patient's family to decide to withdraw treatment only where there is evidence that the patient has no reasonable chance of returning to a cognitive state.

When a family member is acting as a guardian, she, like any other guardian, is supposed to make a treatment decision using either a substituted judgment or a best interests analysis. If substituted judgment is used, it might seem plausible that family members would have the most intimate knowledge of the patient and thus could most accurately reflect the judgment the patient would have made. Yet,
some commentators suggest that such intimate knowledge should not be presumed. There is reason to doubt that family members know their loved one’s preferences as well as they might think, even when the individuals have been living together for a long time. A further complicating factor is that in our very mobile society, family members may live far apart and thus may no longer know each other very well at all. Indeed, even if the family members live close to each other, they may not see each other very often. For example, elderly individuals who live in nursing homes may not have much contact with their family, and the family may thus be unable to adequately protect their interests.

Arguably, even if the family members no longer know each other very well, they will still have the best interests of the patient at heart and thus no other guardian need be appointed to assure that those interests are protected. Yet, there is reason to believe that a stranger who was appointed guardian would also have the patient’s best interests at heart, so long as the guardian did not have a financial interest in the outcome. If the guardian did have a financial interest — for example, if the guardian were employed by a hospital that had an interest in determine whether the incompetent relative would be likely to consider the quality of life’).

243 Bopp & Avila, supra note 39, at 215 (footnote omitted) (stating that “absent sufficient evidence of a patient’s choices or views about quality of life, there can be no assurance that even close family members could determine what the patient actually would choose”).

244 Gieszl & Velasco, supra note 63, at 774 (“In one study, spouses accurately predicted the other spouse’s preference for resuscitation only about one-half the time . . . . Other studies document similar disparities in treatment preferences . . . .”).

245 The same argument can be used to undercut the ability of the physician to know the patient’s preference. See Hamann, supra note 56, at 161.

246 See In re Peter, 529 A.2d 419, 429 (N.J. 1987) (holding that “many elderly nursing home patients do not have any close family members and even if they do, the relatives may not be able to adequately represent the patient’s interests”).

247 See In re Jobes, 529 A.2d 434, 447 (N.J. 1987) (“If there are close and caring family members who are willing to make this decision there is no need to have a guardian appointed.”); see also Thomas Rivosecchi, Comment, Medical Self-Determination: A Call for Uniformity, 31 Duq. L. Rev. 87, 92 (1992) (“The frequently practiced procedure is for the physician and the incompetent patient’s family to confer and make treatment decisions concerning the patient.”) (footnote omitted)). But see Ikuta, supra note 35, at 43 (“In invoking the themes of the loving family and the inclusive community, the court ignores or covers up the reality that family and community are as likely to have rejecting as loving attitudes towards the patient.”).

248 See, e.g., In re Hamlin, 689 P.2d 1372, 1381 (Wash. 1984) (Rosellini, J., dissenting) (stating that disagreement by family members is no reason to disregard the decision of a court-appointed guardian).
continuing the care of paying patients for as long as possible — then there might be reasons to doubt the guardian’s objectivity.249

Family members may also have interests adverse to those of the patient.250 Suppose that the family is financially responsible for some or all of the patient’s care251 or, perhaps, stands to inherit from the estate.252 The family members would have an interest in avoiding large medical expenses, although that interest might be outweighed by other factors.

It is simply unclear what to do when the family has financial or emotional interests adverse to the interests of the patient.253 While one

250 Cruzan v. Director, Mo. Dept’ of Health, 497 U.S. 261, 353 (1990) (Stevens, J., dissenting) (noting that “in some cases there may be a conflict between the interests of an incompetent patient and the interests of members of his or her family”); CANTOR, supra note 68, at 108 (“A lingering death can impose emotional and financial strains on the surrounding family. Or the next of kin asked to make decisions may stand to benefit financially from the patient’s demise — through inheritance or life insurance proceeds.”); Beschle, supra note 35, at 364 (noting that it is “unrealistic to expect a family member to make a decision about continuing medical treatment without some consideration of his or her own values, emotions and, perhaps, practical concerns such as the financial effect on the entire family of continued treatment”); Robertson, supra note 25, at 1171 (“The risk that their decisions will serve the family’s own interest instead of the interests of the incompetent patient is too great to be ignored.”); Smith, supra note 13, at 382 (“The state must protect the patient from . . . families who can no longer bear the social and economic costs of maintaining the patient’s life.”); Yuen, supra note 76, at 607-08 (stating that “personal financial considerations such as inheritance and the financial drain of caring for an ill person could create pressures to choose withdrawal of treatment”).
251 Courts do look at the financial interests of the parties. See Foody v. Manchester Memorial Hosp., 482 A.2d 713, 717 (Conn. Super. Ct. 1984) (concluding that the family “has no financial interest in the outcome of this proceeding”). Where there is such an interest, courts seem to react differently. Compare In re Longeway, 549 N.E.2d 292, 300 (Ill. 1989) (holding that “court intervention is necessary to guard against the remote, yet real possibility that greed may taint the judgment of the surrogate decisionmaker”) with Drabick v. Drabick, 245 Cal. Rptr. 840, 861 n.38 (Ct. App. 1988) (noting that the conservator has a financial interest but is nonetheless allowed to make a relevant decision).
252 According to Hamam, supra note 56, at 151:
The family members who are forced to make life and death decisions for an incompetent person are generally the same people who will inherit if the person dies. Moreover, if a person is kept on life support for an extended period of time, his estate may be drained by the substantial cost, leaving little for the survivors to inherit.
253 See, e.g., CANTOR, supra note 68, at 108 (“Some authorities have questioned whether family members are tainted by a potential conflict of interest between their own interests and the well being of the dying patient.”).
could include the costs and benefits to the family in the determination of what was in the best interests of the patient, it is not at all clear that such factors should be considered in treatment decisions unless the patient would have wanted them considered. While the mere fact that an adverse financial interest exists does not establish that the family member will not act in the best interests of the incompetent patient, the cases nonetheless pose problems which are not susceptible to easy solution.

It might seem that a sensible prophylactic policy would require that whenever a family member has an adverse financial interest, a decision to withdraw treatment should be subjected to a disinterested person’s appraisal, such as that of a judge. Yet, such a policy would ignore the very real possibility that because of guilt or perhaps as a way to make sure that finances are not driving the treatment decisions, families may overcompensate and demand that everything possible be done for the patient. One could subject all decisions to oversight by having a

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254 Famam v. Crista Ministries, 807 P.2d 830, 848-49 (Wash. 1991) (Dore, C.J., concurring in part, dissenting in part) (“Where a persistently vegetative patient is indeed completely insensate, this entire debate concerns not the feelings of the terminally ill and incompetent, but the feelings of family and friends of the unfortunate patient.”); Gelfand, supra note 35, at 773 (“Who was suffering in the Quinlan case? Certainly not Karen in her comatose state. The so-called mercy-killing decision in that case was certainly not intended to end Karen’s suffering. The decision ended her family’s suffering.”). But see Beschle, supra note 35, at 365 (noting that “society’s claim to override the decisions of the family become stronger if and when society assumes at least the financial consequences of its decision”).

255 Cantor, supra note 35, at 260 (“This problem would be mitigated somewhat if avoidance of burdens to survivors were considered only when the patient’s own instructions included such factors.”). But see CUNDIFF, supra note 37, at 62 (“Frail, disabled elderly people who are financial and emotional burdens on their families may feel some pressure to ask for euthanasia to spare their families further suffering.”).

256 In re Conroy, 486 A.2d 1209, 1218 (N.J. 1985) (concluding that “there was no question that the nephew had good intentions and had no real conflict of interest due to possible inheritance when he sought permission to remove the tube”); Hamm, supra note 56, at 152 (stating that for family, financial reasons are “rarely the prime motivating factors behind a decision to cease treatment”).

257 See CANTOR, supra note 68, at 108-09.

258 See Ikuta, supra note 35, at 43 (noting that the court is better suited to determine the best course of action for a patient by securing the necessary information from the patient’s family and by screening outside interests).

259 Schapira, supra note 175, at 5 (“For reasons of grief or guilt, the family may press for disproportionately aggressive management . . . .”); id. at 6 (“In order to avoid the responsibility and guilt associated with adopting a passive approach, they choose a safe course of action and request that ‘everything be done’ for the patient.”).
court review all decisions, but such an approach would not seem to be a good use of resources. One could preclude all individuals with a financial interest from making medical decisions for another, but this approach would prevent the people who might care most about the individual and who might best know what the patient would have wanted from making the relevant decision.

Insofar as it is impossible to make a reliable prediction about what the person would have wanted (and thus substituted judgment cannot be used) and insofar as best interests is an objective determination which does not require knowledge of the patient, some of the justification for having a family member as the guardian disappears. The presumed special knowledge possessed by the family member of the patient's desires and values is then no longer relevant. Still, there are additional reasons to have a family member be a guardian — namely, that she would be more likely to be a zealous advocate for the patient and the patient would likely prefer that a family member be the guardian.

The guardian's duties are varied. Her "procedural duties will involve drafting and mailing to all interested parties any legal documents affecting the incapacitated person," as well as "receiving and responding to all

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260 See infra notes 277-95 and accompanying text.

261 But see Hamann, supra note 56, at 152 ("A family member should not be disqualified from making the decision to withdraw treatment simply because he or she will benefit from the person's will.").

262 See id. at 154 ("[P]erceived conflict of interest should not be used as a basis for removing family decisionmaking authority from those who know the person best, who care most for the person and who the person would probably want to make the decision."). Indeed, one commentator goes several steps further by suggesting that individuals who engage in mercy killing should not be precluded from inheriting. See Kent S. Berk, Comment, Mercy Killing and the Slayer Rule: Should the Legislatures Change Something?, 67 TUL. L. REV. 485, 506-07 (1992) ("For true right to die to exist, states must allow others to assist individuals who wish to experience that right without fear of civil forfeiture.").

263 See In re Hamlin, 689 P.2d 1372, 1378 (Wash. 1984) ("The surrogate decision maker, like a family, provides an objective viewpoint to evaluate the medical prognosis.").

264 It seems clear that zealous advocates may be necessary. See Arthur S. Berger, Last Rights: The View from a U.S. Courthouse, in To Die or Not to Die? 129, 140 (Arthur S. Berger & Joyce Berger eds., 1990) ("One of the chief complaints patients have is that their living wills are ignored by physicians."); see also Hamann, supra note 56, at 162 (discussing the advocacy role).

265 In re Lawrance, 579 N.E.2d 32, 39 (Ind. 1991) (recognizing that "most Americans want the decisions about their care, upon their incapacity, to be made for them by family and physician, rather than by strangers or by government").

266 Mitchell ex rel. Rasmussen v. Fleming, 741 P.2d 674, 690 (Ariz. 1987) ("A guardian ad litem is appointed during guardianship proceedings to represent an
legal documents mailed to the incapacitated person.\textsuperscript{257} The "principal substantive duty" is to discover and analyze "all facts relevant to medical treatment of the patient," i.e., to act as fact-finder.\textsuperscript{258} When the incompetent has not previously made clear her treatment wishes, a guardian is needed to promote the patient's best interests.\textsuperscript{259} To do so, the guardian must ascertain what those interests are and, further, act as an 
\textit{advocate} to ensure that those interests are promoted.\textsuperscript{270} When courts suggest that the family will make sure that the patient's best interests will be protected, they presumably are suggesting that the family will play both roles.\textsuperscript{271}

No matter who is appointed guardian, the potential for difficulties will loom. Family members may have adverse financial or emotional interests, while strangers may not care enough to zealously promote the patient's interests. A choice must be made between the two, and it seems reasonable to choose the former.\textsuperscript{272} Medical personnel can provide a check on obvious abuses.\textsuperscript{273} Given that check, it seems most sensible to appoint a family member as guardian.\textsuperscript{274} Yet, it is important to note incapacitated person if such person has no counsel.

\textsuperscript{257} Id.

\textsuperscript{258} Id.

\textsuperscript{259} See id. at 686-87 (concluding "that Rasmussen's right to refuse medical treatment still existed despite her incompetency and her failure to articulate her medical desires prior to becoming incompetent" and that her guardian had standing to enforce that right).

\textsuperscript{270} Id. at 689 ("Under the best interests standard, the surrogate decisionmaking [guardian ad litem] assesses what medical treatment would be in the patient's best interest as determined by such objective criteria as relief from suffering, preservation or restoration of functioning, and quality and extent of sustained life.").

\textsuperscript{271} In re C.A., 603 N.E.2d 1171, 1180 (Ill. App. Ct. 1992) ("As primary caregivers, parents or other close family members ordinarily are the ones charged with making the difficult determination of what is in a terminally-ill child's best interests.").

\textsuperscript{272} See Parham v. J.R., 442 U.S. 584, 637-38 (1979) (Brennan, J., concurring in part, dissenting in part) (stating that deference due to parents should not be extended to state social workers).

\textsuperscript{273} In re Colyer, 660 P.2d 738, 747-49 (Wash. 1983) ("Concurrence by professional colleagues, who are not attending physicians but who nonetheless have an understanding of the patient’s condition, would protect against erroneous diagnoses as well as questionable motives.").

\textsuperscript{274} But see Mitchell ex rel. Rasmussen v. Fleming, 741 P.2d 674, 692 (Ariz. 1987) (Feldman, Vice C.J., concurring) ("[E]ven where there is unanimity of opinion between the guardian, the family, and the doctors . . . 'substituted judgment' and 'best interest' decisions [should] be validated by court order."); In re Hamlin, 689 P.2d 1372, 1381 (Wash. 1984) (Rosellini, J., dissenting) ("Where family members all stand to benefit by termination, they would naturally agree and present a unified front. Moreover, medical professionals cannot guard against improper motives on the part of the family because they are neither suited by training nor situation to discover such impropriety.").
that where "family" is discussed, no particular biological or legal relation
is presumed. The important issue would be whether the person knew
and cared for the patient.

B. On Court Approval

When deciding whether courts must be consulted before particular
treatment regimens are adopted, at least two competing considerations
arise: (1) the desire to choose the right treatment, and (2) the fact that any
procedure making use of the courts will necessarily be slow. Further,
the prospect of having to go to court might have a chilling effect on
cessation of treatment even in cases where doing so would not only
fulfill the desires of the patient but would also promote her best
interests.

Courts have differed about whether judicial approval of termination
of treatment is necessary before such treatment may be implemented.

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275 According to MEYERS, supra note 14, § 11:6.2, at 225:
So long as the criteria of that person knowing what the patient would have
wanted, if anyone would, and wanting to act out of affection and caring for
the patient in a way consistent with the patient’s best interests are met, there is no
reason to restrict either private or court appointed surrogates to members of the
family in all cases.

See Ronzetti, supra note 58, at 156 (“There is no reason, however, for kinship or
marriage to empower a class of decisionmakers, beyond the intuitive probability that those
related by kinship or marriage are in fact emotionally attached to the patient.”). As
Ronzetti continued, id. at 181,
The danger of empowering certain persons as family members is that it may
exclude other “loved ones” with whom the patient has a mutual emotional bond.
This situation occurs primarily in so-called “non-traditional” relationships,
where the loved one was neither married to the patient nor a member of the
patient’s conventional family.

See also Hamann, supra note 56, at 169 (arguing that “some persons may not get along
with their families or may have parents who disapprove of their lifestyle”).

individual who has known and loved the patient personally, presumably for years, can
best determine what the patient would have wanted under the circumstances”).

277 In re Longeway, 549 N.E.2d 292, 301 (Ill. 1989) (“The slow, deliberate nature of
the court system may frustrate the family and loved ones of the patient.”).

278 In re Jobes, 529 A.2d 434, 449 (N.J. 1987) (“The mere prospect of a cumbersome,
intrusive and expensive court proceeding, during such an emotional and upsetting period
in the lives of a patient and his or her loved ones, would undoubtedly deter many persons
from deciding to discontinue treatment.”).

279 Compare John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921, 925
(Fla. 1984) (“To require prior court approval for termination of the life support systems
Some suggest that no court approval is necessary unless such parties as the family, the physician, or the hospital disagree. This judicial restraint is recommended both because the family is presumed to be seeking to promote the wishes and best interests of the patient and, as a practical matter, because this practice has been common for years.

A related question involves what the court should say when family members disagree about the appropriate course of action. One district court analyzing a case in which two parents disagreed about the appropriate course of treatment for their child wrote: "When one parent asserts the child's explicit constitutional right to life as the basis for continuing medical treatment and the other is asserting the nebulous liberty interest in refusing life-saving treatment on behalf of a minor child, the explicit right to life must prevail." Such an analysis implies that treatment should always be given when there is any disagreement, a surprising implication if the child's best interests would not thereby be advanced. In In re Baby Y, the husband, the guardian ad litem, and the hospital all asserted that the anencephalic child's best interests would not

in this type of case is too burdensome, is not necessary to protect the state's interests or the interests of the patient, and could render the right of the incompetent a nullity." with In re A.C., 573 A.2d 1235, 1247 (D.C. Cir. 1990) (en banc) ("To protect that right against intrusion by others — family members, doctors, hospitals, or anyone else, however well-intentioned — we hold that a court must determine the patient's wishes by any means available, and must abide by those wishes unless there are truly extraordinary or compelling reasons to override them.") (emphasis added).

Bludworth, 452 So. 2d at 926-27 ("Disagreement among the physicians or family members or evidence of wrongful motives or malpractice may require judicial intervention . . ."); In re Lawrance, 579 N.E.2d 32, 44 (Ind. 1991) ("When there is not unanimity amongst those with tangible professional or personal interest in the patient, the courts are available to resolve the dispute if need be."); In re Warren, 858 S.W.2d 263, 265 (Mo. 1993) (concluding that "a guardian has statutory authority to make medical decisions and consent to medical treatment or the withholding of medical treatment in the best interests of the ward without specific court authorization"); In re Hamlin, 689 P.2d 1372, 1377 (Wash. 1984) (concluding that guardianship proceedings are not necessary when family members all agree on the best interests of the patient).

Longeway, 549 N.E.2d at 295 ("[F]or many years, members of a patient's family, together with doctors and clergy, have made decisions to withdraw life-sustaining equipment from incompetent, hopeless patients without seeking judicial approval.").

See In re Doe, 418 S.E.2d 3, 7 (Ga. 1992) ("We reject the argument that only the parent who has given consent [to forego cardiopulmonary resuscitation] may effectively revoke consent.").

In re Baby K, 832 F. Supp. 1022, 1031 (E.D. Va. 1993) (emphasis added) (citation omitted) ("Parents have standing to assert the constitutional rights of their minor children.").
be promoted by treatment, because that care would be “futile.” The court rejected the claim of futility, arguing that such a holding would imply that no terminally ill patient should receive treatment. The court apparently did not consider relevant the fact that most anencephalic children die within days of birth or that the child was permanently unconscious and could not see, hear, or feel pain. Had the treatment indeed been futile, the doctor would not have had to perform it. Usually, medical personnel rather than courts make the judgment about which treatments are futile.

When family members are present, it seems safe to assume (absent evidence to the contrary) that they will protect the patient’s interests. If no family members are present, however, it might be feared that no one would be looking out for those interests and thus courts should not presume that the absence of objection implies that the patient’s interests are being protected. For precisely this reason, a guardian will be appointed to protect the patient’s interests where there are no family members present. If the guardian, physicians, and other relevant hospital personnel (e.g., review committees) all agree that it would be in the patient’s best interest to withhold or withdraw treatment, court approval will not be necessary and the treatment may be withdrawn. Whether a stranger or a family member is acting as guardian to protect the patient’s interests, it is not anticipated that there will be many situations in which there will be disagreements among the relevant personnel, thus requiring court intervention.

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284 Id. at 1025.
285 Id. at 1027.
286 Id. at 1025.
287 See Byrn, supra note 21, at 36 (arguing that “under no circumstances may medical personnel be required to engage in procedures which are contradicted by reasonable medical judgment”).
288 Barber v. Superior Court, 195 Cal. Rptr. 484, 491 (Ct. App. 1983) (noting that the decision about medical futility “is essentially a medical one to be made at a time or on the basis of facts which will be unique to each case”).
290 In re Hamlin, 689 P.2d 1372, 1378 (Wash. 1984) (holding court involvement unnecessary where all parties agree); In re L.W., 482 N.W.2d 60, 63 (Wis. 1992) (holding that a guardian may consent to withdrawal of treatment of a patient in a persistent vegetative state with prior permission from the court if such action is in “best interests” of patient).
291 In re Jobes, 529 A.2d 434, 451 (N.J. 1987) (stating that the court expected that such “disagreements [will] be rare and that intervention seldom will be necessary”).
Currently, it is not always clear which decisions should be made by guardians and which should be left to the courts. This situation is unsurprising, given the competing interests at stake. Courts want to prevent guardians from acting contrary to the desires of the patient, and thus it seems that courts should take a more active oversight role. However, a long and expensive court proceeding at such a difficult time hardly seems desirable, and thus it seems that courts should take a more passive role.

Courts and legislatures must clarify what guardians should decide and what criteria should be used to make those decisions. Further, they must more clearly specify which decisions do not need court approval, perhaps taking into account the fact that guardians (especially when not strangers to the patient) would seem at least as likely as anyone else to look out for the interests of the patient as anyone else.

C. Definition of Death

One of the implicit issues underlying the appropriate treatment of incompetents is determining when in fact people should be defined as dead and as thus no longer having rights. While much debate occurs regarding what the definition of death ought to be, the current definition involves whole-brain death. According to this definition, an individual is dead only if there is no brain activity, not even of the

\[29^2\] In re Roe, 421 N.E.2d 40, 51-52 (Mass. 1981) ("There is no bright line dividing those decisions which are (and ought to be) made by a guardian, from those for which a judicial determination is necessary.").

\[29^3\] In re Browning, 568 So. 2d 4, 15 (Fla. 1990) ("We cannot ignore the possibility that a surrogate might act contrary to the wishes of the patient.").

\[28^4\] Id. ("Yet, we are loath to impose a cumbersome legal proceeding at such a delicate time in those many cases where the patient neither needs nor desires additional protection.").

\[28^5\] See Hamann, supra note 56, at 156-57 (suggesting that right-to-life groups may undermine the autonomy and best interests of individuals).

\[28^6\] In re Bowman, 617 P.2d 731, 732 (Wash. 1980) (raising the issue of defining death and who should determine the criteria).

\[28^7\] See, e.g., David R. Smith, Legal Recognition of Neocortical Death, 71 CORNELL L. REv. 850, 872 (1986) ("A more just and sensible position is to consider irreversibly unconscious noncognitive patients legally dead.").

\[28^8\] John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921, 923 (Fla. 1984) (holding that person who has "minimal brain functioning" does not "meet the [statutory] definition of 'brain death'"); see also Severns v. Wilmington Medical Ctr., Inc., 421 A.2d 1334, 1344 (Del. 1980) (involving a court compelled "to distinguish between 'death,' as we have known it, and death in which the body lives in some fashion but the brain (or
One doctor who applied the whole-brain death criterion to his patient concluded that "while Andrew was not dead by the definition of brain death per se, ... medically speaking he has no life." Advances in medical technology have allowed individuals to be kept alive even though they cannot feel, think, or perform in a manner normally associated with living.

When courts are deciding whether to allow treatment to be withdrawn from a patient who is brain dead, they are referring to an individual whose upper brain is dead but who registers some brain or brainstem activity. This condition can occur because the brain may die in stages. An individual may have permanently lost the ability to think and feel while retaining the ability to breathe spontaneously and to maintain a pulse.

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a significant part of it) does not"; In re Eichner, 426 N.Y.S.2d 517, 529 (App. Div. 1980) ("Since Brother Fox's EEG showed 'minimal activity,' he did not meet the criteria of 'brain death' at the time of the hearing.").

In re Barry, 445 So. 2d 365, 369 (Fla. Dist. Ct. App. 1984) (holding that the patient did not meet Florida's definition of brain dead "because there is a minimal function of his brain stem"); see also In re T.A.C.P., 609 So. 2d 588, 595 (Fla. 1992) (suggesting that anencephalics are not dead according to the accepted standard); People v. Eulo, 482 N.Y.S.2d 436, 445 (App. Div. 1984) ("Considering death to have occurred when there is an irreversible and complete cessation of the functioning of the entire brain, including the brain stem, is consistent with the common-law conception of death.").

According to one commentator:

The brain dies in stages, depending on degree and duration of oxygen deprivation. The upper brain, site of the highest centers of intelligence, conscious thought, and emotion, dies first. The cortex or neocortex will die within four to six minutes if deprived of oxygenated blood flow. The brain stem or medulla, which controls respiration and other vegetative bodily functions, can survive substantially longer.

MEYERS, supra note 14, § 2:2, at 12.

Id. § 4:2, at 25 ("A patient may well be rendered unconscious, and incapable of recovering consciousness and any capacity for thought, emotion, and intellectual
One reason sometimes offered to justify using whole-brain death as the criterion for death involves a fear of misdiagnosis. Some commentators suggest that it is better to err on the safe side. Whole-brain death is the preferred criterion because this standard greatly reduces the possibility of mistake. Yet, if proper procedures are followed, misdiagnosis of death can be overcome. Further, if higher-brain death is the "appropriate" criterion, then other ways exist to ensure that the relevant criteria would be appropriately applied — for example, by creating liability for their misapplication. Finally, an analogous argument can be made with respect to any set of criteria: if the relevant procedures are not going to be followed, then any definition is fallible.

A variety of courts and commentators suggest that not medically treating someone who is permanently unconscious and cannot feel would perception, but may have the ability to spontaneously breathe and maintain pulse and circulation.”); id. § 4:9, at 22 (“While a patient who has lost all upper brain function will be in a persistent vegetative state without self-awareness or perception of surroundings, that patient still has a functioning brain stem which can carry out certain metabolic functions, including respiration and circulation, and is not brain dead by any definition.”).

305 See VEATCH, supra note 181, at 41 (noting that under some medical standards used to determine brain death, some patients recover consciousness).

306 WALTON, supra note 26, at 82 (advocating "stick[ing] to the safer, known way in the absence of the highest probability for proceeding otherwise").

307 Smith, supra note 297, at 850-51 ("Whole brain death' means the irreversible cessation of all functions of the entire brain, including the brain stem. 'Neocortical death' means the irreversible loss of consciousness and cognitive functions.").

308 See id. at 860.

309 But see WALTON, supra note 26, at 73 (arguing that "no matter how perfect any set of criteria is, misapplication of the criteria, through haste or for whatever cause, is always possible").

310 VEATCH, supra note 181, at 22 ("If a person is dead when and only when there is an irreversible loss of consciousness and ability to interact socially, then it makes no sense to pronounce him dead on some other basis."); WALTON, supra note 26, at 53 (arguing that "if irreversibly persistent and permanent vegetative states could be diagnosed with a degree of confidence and certainty, reasonably adequate to satisfy ethical standards, then . . . such persons may be considered dead."); Sheff D. Olinger, Medical Death, 27 BAYLOR L. REV. 22, 23 (1975) ("[H]uman life is, in its essential nature, the sum product of these phenomenon of consciousness, awareness, memory, emotion and anticipation. There is no human life in the absence of these."); Ronzetti, supra note 58, at 201 ("A neocortical definition of death seems preferable to a whole-brain basis of death because the higher function of the brain — human consciousness — seems to be the sine qua non of humanity."); Scher, supra note 206, at 688 ("Life is most essentially consciousness. With such consciousness gone forever, all that is left of life is a piece of respiring matter.").

311 MEYERS, supra note 14, § 4:3, at 32 (arguing that "clinical criteria alone may not be sufficient to diagnose brain death accurately in difficult cases").
not rob the individual of anything of value. Yet, if the person is alive, then such a policy would seem to contradict the state’s interest in promoting the sanctity of life, depending on what the sanctity of life includes. If individuals with no higher brain functioning are going to be defined as dead, then that fact should be made clear. If they are considered to be alive, however, then courts should take great care when explaining why the removal of treatment is appropriate. For example, the courts should make clear whether the withdrawal of treatment is based on a substituted judgment or on a best interests analysis. If the latter, then the courts should make clear whether the withdrawal is appropriate because the patient’s values so indicate or because society’s values so indicate. If it is because society’s values so indicate, then “objective” best interests analysis would seem to imply that such patients have no more interests than patients with no brain activity, except perhaps an interest in having treatment continued if they had previously manifested a desire to have treatment in such a condition.

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312 See John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921, 923 (Fla. 1984) (noting that procedures which “sustain ... vital bodily functions ... can be accurately described as a means of prolonging the dying process rather than a means of continuing life”); In re Doe, 418 S.E.2d 3, 6 (Ga. 1992) (noting that “the life support system was prolonging her death, rather than her life”); In re Dinnerstein, 380 N.E.2d 134, 137-38 (Mass. App. Ct. 1978) (“Prolongation of life contemplates, at the very least, a remission of symptoms enabling a return towards a normal, functioning, integrated existence.”). Cf. MEYERS, supra note 14, § 12:29, at 373 (“Whether the decision is to commence, continue, or terminate treatment, it seems quality of life is the fundamental determinant where prognosis is negative. Courts would be honest to recognize this.”); Robertson, supra note 25, at 1157-58 (“Nontreatment leading to total brain death would not deprive her of anything of value to her because she had already lost the experiences and capacities that make life a good for persons.”).

313 KUSE, supra note 13, at 15-16 (“On the sanctity-of-life view, it would, for example, be just as wrong to terminate the life of a permanently comatose patient as it would be to take the life of a conscious or self-conscious human being.”).

314 See CALLAHAN, supra note 65, at 179-80 (“The ‘sanctity of life’ has to be the sanctity of personhood, not merely the possession of a body ... [and] must at least encompass the capacity to reason, to have emotions, and to enter into relationships with others.”); RACHELS, supra note 123, at 5 (discussing the difference between having a life and being alive).

315 Thus, it is not clear that commentators who criticize defining these “live” people as dead are really offering much of an alternative. See Alexander M. Capron & Leon R. Kass, A Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal, 121 U. PA. L. REV. 87, 115 (1972) (“The condition of ‘neocortical death’ may well be a proper justification for interrupting all forms of treatment and allowing these patients to die, but this moral and legal problem cannot and should not be settled by ‘defining’ these people ‘dead.’”).

316 See Mack v. Mack, 618 A.2d 744, 759-60 (Md. 1993) (discussing the importance
Someone who had previously requested that treatment be continued even if he had no brain activity would not have his wishes followed should that eventuality occur. If patients in a permanent vegetative state objectively have no interests, then it is unclear what advantage is gained by not saying that they are dead and, further, why previously expressed wishes to be maintained in a permanent vegetative state should be respected.\(^\text{317}\)

If courts are clear about why treatment may be withdrawn in such cases, then inappropriate withdrawals will be much less likely to occur. For example, if treatment may be withdrawn from patients in a permanent vegetative state only when doing so would be in accord with their own former preferences or values, then there would be no de facto equivalence between higher brain death and death simpliciter. If, however, the reason treatment may be withdrawn is that such patients “objectively” have no interests, then courts and commentators must explain why people with no brain functioning cannot have their treatment continued in accord with their previously expressed preferences but people with merely no higher brain functioning can.\(^\text{318}\)

It is important to recognize that someone who only has brainstem activity may “live” for an extended period. If terminal illness is defined in terms of when the patient will die — for example, in six months\(^\text{319}\) — then a patient in a permanent vegetative state need not be terminally ill. Terminal illness does not have to be defined in terms of when the patient is expected to die.\(^\text{320}\) Instead, it may be defined in terms of whether the individual has any cognitive functioning \(^\text{321}\) and whether the

\(\text{of self-determination and its conflict with best interests analysis); see also In re Conroy, 486 A.2d 1209, 1232 (N.J. 1985) ("[L]ife sustaining treatment should not be withdrawn from an incompetent patient who had previously expressed a wish to be kept alive in spite of any pain he might experience.").}\(^\text{317}\)

\(\text{Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626, 645 (Mass. 1986) (advocating termination decisions consistent with the patient’s "view respecting a personally preferred manner of concluding life").}\(^\text{318}\)

\(\text{See Alvarado v. New York City Health Hosps. Corp., 547 N.Y.S.2d 190, 195 (1984) (discussing the loss of higher brain function).}\(^\text{319}\)

\(\text{See McKay v. Bergstedt, 801 P.2d 617, 630 (Nev. 1990) (noting that a patient is non-terminal if his life expectancy is six months or greater); see also CUNDIFF, supra note 37, at 62 (stating that hospice benefits require a prognosis of less than six months).}\(^\text{320}\)

\(\text{Mayo, supra note 26, at 136 ("Terminal condition is, of course, a nontechnical term that is capable of being infused with different meanings.").}\(^\text{321}\)

\(\text{See also Karen Teel, The Physician's Dilemma A Doctor's View: What the Law Should Be, 27 BAYLOR L. REV. 6, 7-8 (1975) (using examples of infants with varying degrees of cognitive capabilities to illustrate terminal illness); cf. Drabick v. Drabick, 245 Cal. Rptr. 840, 852 (Ct. App. 1988) (holding that the medical advice that would support}\)
person is only able to live on artificial life support. However, with these kinds of definitions, one could be “terminally ill” for years. Not only does this result seem to be an abuse of language, but it also will have treatment option implications.

Courts and legislatures sometimes limit certain treatment options to those who are terminally ill. Such a limitation merely invites individuals to redefine “terminally ill” so that patients will have a greater number of options even if in fact their prognosis is greater than six months. Even if this redefinition problem could be avoided, however, there are other difficulties with limiting treatment options to those who are terminally ill. As a practical matter, it may not always be easy to tell who in fact will die in six months. Further, there seems to be no principled reason to allow one with an expectancy of less than six months to die while not affording that same option to one with a longer expectancy. The person who is suffering great pain and who is expected to live for more than six months would seem to have at least as a decision to terminate life support “must include the prognosis that there is no reasonable possibility of returning to cognitive and sapient life”).

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324 In re Longeway, 549 N.E.2d 292, 298 (Ill. 1989) (holding that “an incompetent patient must be terminally ill before this right to refuse artificial sustenance may be exercised”); see also KY. REV. STAT. ANN. § 311.635(1) (Michis/Bobbs-Merrill 1994) (holding individuals who authorize in good faith the withholding of treatment from a terminally ill patient in accord with an advance directive immune from liability); LA. REV. STAT. ANN. § 40:1299.58.8(A)(1) (West 1992) (holding medical personnel who withhold or withdraw life support from a qualified patient who has a terminal and irreversible condition immune from liability). But see Bartling v. Superior Court, 209 Cal. Rptr. 220, 223 (Ct. App. 1984) (concluding that “the trial court was incorrect when it held that the right to have life-support equipment disconnected was limited to comatose, terminally ill patients or representatives acting on their behalf”).


326 See CUNDIFF, supra note 37, at 62 (discussing difficulties in predicting how long patients will live).


328 Bouvia v. Superior Court, 225 Cal. Rptr. 297, 302 (Ct. App. 1986) (concluding that “there is no practical or logical reason to limit the exercise of this right to ‘terminal’ patients”).
much of a need for the option of death or nontreatment. If competents and incompetents are to be treated equally, then nonterminal incompetents cannot be precluded from exercising their rights to refuse treatment when nonterminal competents are not so precluded.

D. Liability

Any policy regarding treatment or nontreatment of patients must address issues of legal liability. Doctors and hospitals may be dissuaded from withholding or withdrawing treatment if they might face liability as a result. Furthermore, even if they are granted immunity from liability, they may have no incentive to act in accord with the patient’s wishes unless they are subjected to sanctions for failing to do so.

Where all interested parties agree with respect to whether to treat and that judgment is in accord with reasonable medical judgment, no issues of liability are raised. Further, if treatment is withdrawn because all parties agree but one of the family members changes her mind after death has occurred, courts will hold the hospital and medical personnel blameless. However, disagreement among the parties may occur at the outset because the patient, through her guardian, wants treatment withdrawn, but the physician or hospital refuses.

Suppose that a patient had clearly expressed her wishes not to have treatment continued should she have no hope of recovery. Suppose further that the hospital has a policy of continuing treatment even in such situations. If the hospital has not made its policy clear to the patient and her family beforehand, the hospital may be forced to accede to the family’s wishes. At the very least, the hospital may be forced to

329 Smith, supra note 13, at 414 (“What of the nonterminal yet severely suffering patient who can expect little more than years of suffering, incapacitation and personal degradation . . .? Surely, she should have the same rights of self-determination as other less-afflicted citizens.”).  
332 See In re Jobes, 529 A.2d 434, 451 (implying that courts will not be involved where the parties agree).  
335 Jobes, 529 A.2d at 450 (involving a nursing home which, in the absence of any
transfer the patient, assuming that another facility is willing to take the patient.\footnote{See Gray, 697 F. Supp. at 591 (holding that a hospital which did not alert the patient's family of its policy on life-sustaining treatment must either transfer the patient to another hospital or accede to the patient's wishes). As one court discussed such a situation:

In view of (1) the hospital staff's personal moral objections to removing the tube, (2) the evidence that [the patient] could be transferred to another local facility within two weeks, (3) the hospital's willingness to transfer [the patient] at no expense to her or [the conservator], and (4) [the conservator's] failure to show that no physician could be found who would follow her direction, there was no basis for the court to require the hospital to remove the tube.\footnote{Childs v. Ambramovice, 253 Cal. Rptr. 530, 535 (Ct. App. 1988)\footnote{Berger, supra note 264, at 140 ("Many statutes also do not make it mandatory for physicians or health care facilities to honor the patient's wishes as expressed in a living will. Such statutes impose no penalties on a physician who refuses to follow the declaration.")}; Delgado, supra note 123, at 487 (noting that "the physician is not compelled to euthanize anyone, but is merely protected from criminal sanctions if he does so").\footnote{See In re Gardner, 534 A.2d 947, 951 (Me. 1987) (noting that "when a competent patient has expressly refused to receive some form of medical care, a doctor would be acting tortiously if he insisted on providing the treatment against his patient's will"); Strand, supra note 59, at 486 ("If the physician ignores the expressed desires of his patient and administers unwanted treatment, he may be civilly and criminally liable for assault and battery.").\footnote{Childs, 253 Cal. Rptr. at 534 ("[A] physician has the right to refuse on personal moral grounds to follow a conservator's direction to withhold life-sustaining treatment, but must be willing to transfer the patient to another physician who will follow the conservator's direction."); see also id. at 531 ([A] conservator can authorize the removal of a nasogastric feeding tube from a conservatee . . . but cannot require physicians to remove the tube against their personal moral objections if the patient can be transferred to the care of another physician who will follow the conservator's direction."); Berger, supra note 264, at 140 ("All that most statutes require is that if physicians are not willing to comply with a living will, they take reasonable steps to transfer the patient to another physician.").}}

However, they may not be allowed to treat\footnote{Doctors who object to withholding life-sustaining treatment will not be forced to do so. However, they may not be allowed to treat but instead, may have to transfer the patient to another physician.\footnote{A hospital or doctor might refuse to withdraw treatment for any of a number of reasons, including religious reasons or perceived best interests of the patient. Yet, the hospital might also be inclined to refuse to withdraw treatment because it wants to continue to receive payments from the patient. Arguably, medical personnel, hospitals, and nursing}

formal policy on artificial feeding, was forced to defer to the choice of medical treatment made by the patient's family).
homes would be less likely to give unnecessary care if they could not force the family or estate to pay for that care.  

It may be feared that making the caregiver responsible for unwanted and unnecessary care might induce the caregiver to be too ready to follow the commands of the guardian. Further, when a guardian makes a decision, it is not as if the patient herself had refused treatment. Rather, the guardian is asserting the patient's right for her, with all of the uncertainty attendant on having someone else speak for the patient. Arguably, the guardian's directions may be ignored as a way of protecting the patient's autonomy, and the family should then have to pay for the care which the guardian rejected.

Yet, this rationale for forcing the patient or her family to pay for unwanted care should be rejected for several reasons. First, even where the patient had made clear her wishes in a living will, those wishes are all too often being ignored. It simply is not credible to claim that a patient must be treated despite her wishes to the contrary out of a concern for her autonomy. Second, even where no living will is present, the guardian is the person who is presumed to be representing the intentions and best interests of the patient. Indeed, the patient may have chosen the proxy decisionmaker precisely because certain decisions cannot be included in a living will, either because of the difficulties in explicitly and precisely covering all the relevant possibilities or

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340 See Grace Plaza of Great Neck, Inc. v. Elbaum, 588 N.Y.S.2d 853, 860 (App. Div. 1992) (Rosenblatt, J., dissenting) (noting that "the majority's decision enables nursing homes to carry out their own policies regarding the prolongation of artificial life support, even if those policies are founded on motives and interests that are diametrically opposed to the wishes of the patient").

341 Id. As one court explained: "[H]ealth care providers would have an additional financial incentive to obey, without question, the orders of those conservators who might prematurely despair of their conservatee's recovery, or the orders of those conservators whose judgment might be tainted by motives less altruistic than Mr. Elbaum's." Id.

342 See, e.g., Elbaum, 588 N.Y.S.2d at 856 ("The rule which prevents physicians from recovering payment for medical services which are not desired... should not be applied in cases where, because the patient is comatose, her desires cannot be known, but can only be deduced, with a greater or lesser degree of certainty, from evidence of her past conduct and past statements.") (citation omitted).

343 CALLAHAN, supra note 65 ("A continuing problem with 'living wills' has been the unwillingness of many physicians to honor them . . . ").

344 See In re Browning, 568 So. 2d 4, 15 (Fla. 1990) (noting that "when the patient has taken the time and the trouble to specifically express his or her wishes for future health care in the event of later incapacity, the surrogate need not obtain prior judicial approval to carry out those wishes").

345 See American Bar Ass'n, supra note 64, at 29-30.
because those decisions legally cannot be covered by a living will.\textsuperscript{346} Allowing the guardian’s directions to be ignored out of a alleged concern for the patient’s autonomy may well involve ignoring the only way that the patient’s autonomy could be represented.

While physicians and hospitals cannot be required to give unreasonable medical care (thus providing a check on unreasonable requests by a guardian), they cannot be given the option to ignore a patient’s or guardian’s directives whenever they so choose.\textsuperscript{347} It is bad enough that the patient may have had her autonomy denied and, perhaps, may have been forced to have painful, unwanted treatment. It adds insult to injury to then demand that the individual (or her estate) pay for such treatment.

Physicians who follow the dictates of a living will will be protected as long as they act in good faith.\textsuperscript{348} By the same token, a physician should be immune from liability if she treats in good faith — for example, because she neither knows nor could have reasonably known about the existence of a living will or because the competence of the guardian is itself at issue.\textsuperscript{349} However, where the patient had explicitly directed that no treatment be given in the existing circumstances or the guardian (whose competence or objectivity is not at issue) reasonably decides that treatment should be withheld, courts should neither provide nor recognize immunity for the knowing failure to respect those wishes. Even if “life is not a compensable harm,”\textsuperscript{350} the patient should be compensated for the denial of autonomy and the possible pain and suffering caused by unwanted treatment.\textsuperscript{351}

\textsuperscript{346} In re Greenspan, 558 N.E.2d 1194, 1200-01 (Ill. 1990) (suggesting that under the relevant living will statute, nutrition and hydration may not be withdrawn unless done so at the direction of a guardian).

\textsuperscript{347} Hummel v. Reiss, 608 A.2d 1341, 1350 (N.J. 1992) (“Neither physicians nor hospitals may override or ignore the choices of patients or their guardians. . . .”).


\textsuperscript{349} See John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921, 926 (Fla. 1984) (“To be relieved of potential civil and criminal liability, guardians, consenting family members, physicians, hospitals or their administrators need only act in good faith.”).

\textsuperscript{350} See Anderson v. St. Francis-St. George Hosp., 614 N.E.2d 841, 845 (Ohio Ct. App. 1992) (holding that “life is not a compensable harm; therefore, there is no cause of action for wrongful living”).

\textsuperscript{351} Cf. Holmes v. Silver Cross Hosp., 340 F. Supp. 125, 130 (N.D. Ill. 1972) (noting that compensation will not automatically be awarded but depends on a balancing of such factors as the amount of support the dependents received from the decedent).
In other contexts, a physician who treats without getting consent from the patient or guardian or without getting authorization from a court will be subject to liability. Having a different policy in a context implicating such fundamental personal values involved in the choice of how and when one should die is entirely inappropriate. If indeed competents and incompetents are entitled to the same rights, then it is hard to understand why a physician who intentionally or negligently ignores the wishes of a competent patient is liable but a physician who intentionally or negligently ignores the wishes of an incompetent patient is not. Further, if the provision of nutrition and hydration is considered a form of medical treatment, then there is no rational basis upon which this differential treatment could be based.

CONCLUSION

Although incompetents are said to have the same rights as competents, the rationales underlying how and when those rights can be implemented are hopelessly confused. Substituted judgment may be used for individuals who have always had the mentality of an infant but need not be used for someone a month short of majority. The best interests test may involve an objective assessment (despite the lack of a consensus about which values are appropriately considered and about the weight to be given to each value) or a subjective assessment employing the patient's own values. Given the lack of clarity regarding the appropriate rationales, it is unsurprising that the guardian's role itself is unclear.

325 Wall v. Brim, 138 F.2d 478, 481 (5th Cir. 1943) (stating that an operation "performed without consent, express or implied, is a technical battery or trespass"); Natanson v. Kline, 350 P.2d 1093, 1100-01 (Kan. 1960) (involving the issue of lack of informed consent because the risks had not been fully explained to the patient).

326 But see Estate of Leach v. Shapiro, 469 N.E.2d 1047, 1050 (Ohio Ct. App. 1984) (stating that an incompetent is presumed to consent).

327 See Bouvia v. Superior Court, 225 Cal. Rptr. 297, 300 (Ct. App. 1986) ("[A] patient has the right to refuse any medical treatment or medical service, even when such treatment is labeled 'furnishing nourishment and hydration.'"); In re Longeway, 549 N.E.2d 292, 297 (Ill. 1989) ("[T]he administration of artificial nutrition and hydration . . . is medical treatment which can be refused."); In re Lawrance, 579 N.E.2d 32, 39 (Ind. 1991) ("[T]he administration of artificial nutrition and hydration . . . is medical treatment which can be refused."); Delio v. Westchester County Medical Ctr., 516 N.Y.S.2d 677, 689 (App. Div. 1987) ("In our review of the decisions in other jurisdictions we failed to uncover a single case in which a court confronted with an application to discontinue feeding by artificial means has evaluated medical procedures to provide nutrition and hydration differently from other types of life-sustaining procedures.").
The paramount consideration in deciding how incompetents should be treated involves respecting their current (or past) autonomy. Where the patient has explicitly and specifically made her preferences clear, those preferences should be respected and, absent reason to invoke a good faith exception, liability should be imposed for a failure to do so. Where the guardian explicitly finds that nontreatment would be in accord with the patient’s intention or her best interests and the guardian’s good faith is not doubted, the guardian’s finding should be honored unless doing so would be medically unreasonable.

Physicians who treat or fail to treat should be immune from liability as long as their decisions to act or refrain from acting are made in good faith. However, if a physician knowingly or negligently ignores the specific wishes of the patient as represented through her guardian or through her living will, then a court should hold such a physician liable, just as it would if the physician had knowingly or negligently ignored a competent patient’s wishes.

The medical jurisprudence surrounding the care of incompetents must be changed if incompetents are to be given the respect they deserve. The substituted judgment and best interests standards must be clarified both with respect to what they require and to when they should be utilized. The not unreasonable judgments of guardians must be respected, absent evidence of bias or other impropriety. Such respect entails that physicians will be potentially liable for treating a patient whom they knew or should have known had refused that treatment. Unless these changes are made, it seems likely that some courts will continue to consider the alleged wishes of one-year-olds dispositive, while other courts will continue to ignore the prior explicit directives made by individuals while competent. This situation cannot help but further erode confidence in the courts and in the medical profession, a cost which society as a whole, and patients in particular, can ill afford to bear.