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Medico-Legal Implications of "Orders Not to Resusitate"

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COMMENT

MEDICO-LEGAL IMPLICATIONS OF "ORDERS NOT TO RESUSCITATE"

Recent medical and technological advances have enabled physicians to artificially extend a patient's respiratory and cardiac capacities beyond the natural course of a terminal illness. As a result, physicians are often the ultimate judges concerning the time and manner of a patient's death. Even when the patient's family assumes this immense responsibility, they must rely almost exclusively upon the physician's recommendations due to his superior technical expertise. How a physician arrives at the decision to allow death to occur without medical intervention and whether or not there should be other parties involved in this decision are questions which pose a dilemma for the legal, as well as the medical, profession.

The medical community's solution for decreasing the suffering of terminally ill patients is the issuance of "orders not to resuscitate" (ONTR). ONTR are orders issued in anticipation of inevitable death, instructing the hospital staff that in the event of cardiac or respiratory failure, aggressive medical care is to be withheld.


2. As early as 1973, the National Conference on Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC) recognized the necessity of establishing a procedure by which physicians could indicate that additional medical treatment was not advantageous to the patient. The Conference suggested that "orders not to resuscitate" be indicated in the patient's progress notes and communicated to the rest of the hospital staff. See Standards for Cardiopulmonary Resuscitation (CPR) and Emergency Cardiac Care (ECC), 227 J. A.M.A. 837 (1974) [hereinafter cited as Standards for CPR and ECC].

ONTR are distinguished from other forms of medical care which terminate pre-existing patient support systems, such as the discontinuance of respirators. ONTR include instructions not to use inotropic or vasopressor drugs, which increase cardiac contractility and maintain blood pressure, respectively, or not to initiate cardiopulmonary resuscitation (CPR), which is the restoration of life and consciousness by means of artificial respiration or
Massachusetts, and New York court decisions\(^3\) reveals that because the physician is the party most capable of deciding whether aggressive medical treatment is in the best interests of the patient, ONTR should be issued at the sole discretion of the physician. Court involvement should occur only when there is a conflict between what the incompetent's family and physicians believe the patient's best interests to be.

It should first be noted that there is little professional opposition to the rationale underlying the use of ONTR.\(^4\) Most medical and ethical authorities would agree that there is a point at which further medical treatment contravenes the best interests of a terminally ill patient, making ONTR necessary.\(^5\) The problems with ONTR concern the definition of terms cardiac massage. For a more detailed explanation of these terms, see B. MILLER & C. KEANE, ENCYCLOPEDIA AND DICTIONARY OF MEDICINE AND NURSING (1972) and A. LEWIS, MODERN DRUG ENCYCLOPEDIA AND THERAPEUTIC INDEX (1979).

Many hospitals refer to ONTR as "no codes" due to the absence of emergency care that is required when cardiac or respiratory failure occurs. Several other terms have been employed to describe the situation which physicians refer to as a "no code." "Passive euthanasia" and "negative euthanasia" are two of the common terms used by ethicists to describe the idea that it is acceptable in some circumstances to allow a patient to die by withholding treatment. Inherent in these terms is the notion that the physician does not do anything to bring about the patient's death. See generally M. KOHL, ETHICAL ISSUES IN MODERN MEDICINE 723 (1975) and Brown, Bulger, Laws, & Thompson, The Preservation of Life, 211 J. A.M.A. 76 (1970).


4. For a closer look at the medical community's point of view, see Relman, The Saikewicz Decision: A Medical Viewpoint, 4 AM. J.L. & MED. 233 (1978). Relman states that judicial involvement in areas traditionally within the private realm of physicians and families fundamentally changes the manner in which medicine is to be practiced, thus generating unnecessary suffering among terminally ill patients.

An example of a hospital which has successfully formalized the procedure for issuing ONTR is Children's Hospital National Medical Center, in Washington, D.C. At any time, the attending physician may initiate the ONTR process by meeting with the family to discuss what will be done in case of cardiopulmonary arrest. After several meetings, a verbal agreement is reached as to the type of medical care to be administered, and this agreement is documented by the attending physician on the patient's progress notes. The agreement is also incorporated into the physician's orders which inform other physicians and the nursing staff of the degree of care required. See Resolution by the Children's Hospital National Medical Center Board of Directors concerning "No-Code 99" (Sept.24,1975) (available in the administration offices of Children's Hospital National Medical Center, Washington, D.C.). See also Le Blang, Does Your Hospital Have A Policy for No-Code Orders?, 9 LEGAL ASP. OF MED. PRAC. Mar.-Apr. 1981, at 1, 5.

5. The National Conference for Standards on Cardiopulmonary Resuscitation has stated: "Cardiopulmonary resuscitation is not indicated in certain situations, such as in cases of terminal irreversible illness, where death is not expected, or where prolonged cardiac arrest dictates the futility of resuscitation efforts. Resuscitation in these circumstances may
Physicians use in determining whether an illness is terminal and whether the efficient allocation of scarce medical resources and the quality of life are factors that should be considered in the decision-making process.

Who should play the major role in the decision to issue ONTR is a point represent a positive violation of an individual's right to die with dignity." Standards for CPR and ECC, supra note 2, at 864.

In 1957 Pope Pius XII, in an address entitled "The Prolongation of Life" before the International Congress of Anesthesiologists, said that if death is inevitable there is no obligation to use extraordinary means to save a patient's life. Concerning the rights and duties of physicians, the Pope stated:

[The doctor, in fact, has no separate or independent right where the patient is concerned. In general he can take action only if the patient explicitly or implicitly, directly or indirectly, gives him permission . . . [T]he patient, if he were capable of making a personal decision, could lawfully use [resuscitation] and, consequently, give the doctor permission to use it.

The Prolongation of Life, 4 THE POPE SPEAKS 393, 397 (1957). The Pope continued, stating that "the interruption of attempts at resuscitation is never more than an indirect cause of the cessation of life." Id.

6. See Rabkin, supra note 1, at 365 which defines some of these terms as follows: The disease is 'irreversible' in the sense that no known therapeutic measures can be effective in reversing the course of illness; the physiologic status of the patient is 'irreparable' in the sense that the course of illness has progressed beyond the capacity of existing knowledge and technic to stem the process; and when death is 'imminent' in the sense that in the ordinary course of events, death probably will occur within a period not exceeding two weeks.

7. How to best distribute limited medical resources is not just an academic debate; it poses a real and constant dilemma for physicians. An example of a limited medical resource is the number of beds in a hospital's intensive care unit. The number of hospital beds is limited, and if several of the beds are occupied for long periods of time by terminally ill patients, persons whose lives could otherwise be saved will die. Kidney dialysis machines are another example of a limited medical resource that is in great demand. One author suggests that a lay hospital committee be formed that could relieve the physician of the burden of allocating limited medical resources. This committee would reach a decision after considering factors such as age, sex, marital status, dependents, income, net worth, emotional stability, past contributions to society, and future potential. P. Ramsey, The Patient As Person 239-46 (1970).

In Medical Care and the Social Worth of Man, 36 AM. J. OF ORTHOPSYCHIATRY 96-99 (1966), Shatin endorses a pragmatic approach to the distribution of medical care. He states that to argue against assigning a relative value to an individual who is one of many persons competing for limited medical care merely avoids the problem since physicians must, and in fact do, continually choose who shall receive limited resources. He suggests that the following factors be considered in order to create "an index of the social value of a person": the economic productivity of the individual when well, his age and the number of productive years left, his marital and family status and responsibilities, whether any responsibility for the welfare of others exists, the medical prognosis, community relationships, previous and future social and cultural contributions, and whether or not a history of anti-social behavior exists. Id. at 98-99.

For a radically different approach to this problem, see Childress, Who Shall Live When Not All Can Live?, SOUNDINGS, Winter 1970, at 53. The author suggests that a system of random selection be utilized in the allocation of scarce resources.
of contention between the medical and legal professions. The medical profession argues that, historically, patients have relied on the professional judgment of physicians. It asserts that physicians are well trained to deal with life-death decisions, whereas the courts are ill-equipped to enter this particular realm of medicine. Furthermore, present hospital procedures can effectively safeguard a patient's rights. The legal profession, on the other hand, labels the physicians' approach to ONTR "medical paternalism" and insists that judicial intervention is necessary due to the awesome powers that technological advances have conferred upon physicians.

Cases concerning the withholding of medical treatment are scarce. In fact, there is to date only one case that deals specifically with the issuance of ONTR, In re Dinnerstein, a Massachusetts appellate court case. Therefore, this Comment will consider cases that are important, not for the legal guidelines they establish, but because they are indicative of the direction that the courts are going in this area. An analysis of these cases demonstrates that the courts are beginning to voluntarily diminish their participation in the controversy over withholding medical treatment. The following discussion of several withholding treatment cases will reveal that the courts, having previously dealt with issues beyond their expertise, are now demanding that state legislatures assume more responsibility in this sensitive area.

For a discussion of the issue as to whether "the quality of life" is a factor that should enter into the decision-making process, see McCormick, A Proposal for "Quality of Life" Criteria for Sustaining Life, 56 Hosp. Progress, Sept. 1979, at 76.

8. See Baron, Assuring "Detached But Passionate Investigation and Decision": The Role of Guardians Ad Litem in Saikewicz-type Cases, 4 AM. J.L. & MED. 111 (1978). Baron asserts that decisions involving the withholding of medical treatment must be made in an adversary setting in order to safeguard the patient's rights. See also Baron, Medical Paternalism and the Rule of Law: A Reply to Dr. Relman, 4 AM. J.L. & MED. 337 (1979).

9. See Buchanan, Medical Paternalism or Legal Imperialism: Not the Only Alternatives for Handling Saikewicz-type Cases, 5 AM. J.L. & MED. 97 (1979) [hereinafter cited as Medical Paternalism]. Buchanan asserts that it is proper to assume that the family of an incompetent, terminally ill patient has a defeasible right to decide the course of his treatment, and that the family should receive help from an ethics committee in order to develop a framework within which to make its decision. The ethics committee should consist of medical, administrative and lay persons. If the ethics committee thought that the patient's best interests were not being served by the family's decision, it would seek legal intervention.

For a discussion of the necessity of court participation in decisions concerning prolonged death, see Problem of Prolonged Death, supra note 1.


11. So far, 11 states have responded to the need for right-to-die legislation. In 1981, 37 right-to-die bills were introduced in 21 state legislatures. These so-called "living will" laws are an attempt to guarantee that the individual's right to decline treatment will be exercised when he becomes incompetent. A typical "living will" includes a definition of terms, execution and revocation provisions, and an immunity provision to protect medical personnel from penalties. Yale University law students, in conjunction with the Society for the Right
I. BACKGROUND ISSUES AND EARLY CASE LAW

Before examining the pertinent case law, it is necessary to make several initial observations. Though existing case law provides general guidelines for the withholding of medical treatment and the administration of ONTR, the grey areas of ONTR have yet to be examined. Problems associated with ONTR create such a logistical and ethical tangle that the courts would be well-advised to keep their distance. For example, what is the physician's role when ONTR were intended, but not issued, due to an administrative error? If the patient goes into cardiac arrest after the decision to withhold treatment has been made, but before ONTR have been communicated to the rest of the staff, what should the physician do? He may feel compelled to either needlessly prolong the suffering of a terminally ill patient by administering emergency care, or to risk being accused of medical negligence for withholding treatment without having triggered the necessary support system.  


To date, no physician has been found either civilly or criminally liable for causing a patient's death by withholding treatment. One reason is that it is extremely difficult to prove that a terminally ill patient actually would have lived had resuscitative measures been attempted. Another problem is whether a distinction should be made between causing someone to die by commission of a positive act and allowing someone to die through inaction, i.e., withholding treatment. Whether one physician would be held criminally liable for "pulling the plug" when another would not be liable for failing to start the initial treatment is unclear. Certainly, however, to maintain that there is a difference in the degree of culpability may have the undesirable effect of promoting nontreatment over treatment. See Memel & Lemkin, The Legal Status of "No Code Orders", 7 Hosp. Med. Staff, May 1978, at 2.

The absence of a formalized hospital procedure for the issuance of ONTR becomes a tragic omission when a patient's best interests are served by not prolonging his death. In such a situation, the unfortunate result is the so-called "slow code" in which emergency care is administered, but less than wholeheartedly so that the patient will die. The "slow code" is universally disavowed by hospitals but occurs nonetheless as a consequence of not having an
Furthermore, what degree of compliance by the doctor is necessary to carry out the ONTR according to the wishes of the parents or other close relatives? ONTR quite often represent a compromise by which the parents, aware that death is inevitable, allow the omission of certain procedures (i.e., the injection of inotropic drugs) but, perhaps in order to justify their decision, insist on the commission of others (i.e., “bagging”—a form of manual artificial respiration). How many times a patient should be bagged or for how long are questions of degree left to the physician who carries out the orders. Whether the physician’s response to the situation is actually reflective of the wishes of the family may be impossible to ascertain.

In addition, to what extent is a family coerced by the medical staff in formulating their decision to withhold therapy? An obvious problem is that the nature of ONTR necessitates that the decision to withhold treatment be a private one. It is unknown, therefore, how well versed the family is in the options available to it. Can a troubled family assimilate the information necessary to make such a difficult decision?\(^\text{13}\)

Finally, how does a court guarantee that a family’s wishes will be complied with? The delicacy and intricacy involved in carrying out a court’s orders in this field make it almost impossible to know whether or not there has been substantial compliance. If the doctor did not in fact comply with the family’s wishes, can it be proven that the patient’s death resulted from the doctor’s omission?

These are but a few of the uncharted areas surrounding ONTR. The following examination of the relevant case law will establish what issues are settled in this emerging field.

A. Quinlan: The Seminal Case

The first case to draw national attention to the plight of a family wishing to terminate medical care for one of its own was *In re Quinlan*.\(^\text{14}\) *Quinlan* involved a comatose twenty-one-year-old girl, Karen, who was placed on a respirator upon being admitted to a hospital. Her family sought to have the respirator withdrawn when it became apparent that she was in a “vegetative” state, having no awareness of her surroundings and existing at only a primitive reflex level.\(^\text{15}\) When the attending physicians refused to discontinue the respirator, the family filed a complaint asking that she be de-

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\(^{15}\) Id. at 25, 355 A.2d at 655.
clared incompetent and that her father be appointed general guardian with specific permission to withdraw the life-support apparatus. The New Jersey Supreme Court appointed Karen's father guardian with authority to exercise Karen's right to privacy, which encompassed the right to decline life-prolonging treatment when there no longer existed the possibility of her returning to a "cognitive, sapient state."\textsuperscript{16}

It is important to note that \textit{Quinlan} involves an incompetent patient's right to terminate a pre-existing life support system, as distinguished from the initial withholding of ameliorative therapy. Also, \textit{Quinlan} is of limited significance because the holding has been subsequently challenged.\textsuperscript{17} Yet, three aspects of the \textit{Quinlan} decision retain importance in a discussion of withholding medical treatment. First, \textit{Quinlan} represents judicial acknowledgement that continuing medical treatment merely to prolong the life of an irreversibly ill patient is not mandatory.\textsuperscript{18} Second, the \textit{Quinlan} court predicated its holding on the fourteenth amendment's guarantee of the right to privacy, which it said applies equally to both competent and incompetent patients and forms a valid basis for the refusal of medical care.\textsuperscript{19} Third, the court appointed Karen's father as her guardian based upon the theory of substituted judgment.\textsuperscript{20}

\begin{itemize}
\item[16.] \textit{Id.} at 54, 355 A.2d at 671.
\item[17.] The \textit{Quinlan} court called legal intervention in the area of terminating medical treatment "cumbersome" and "a gratuitous encroachment" upon the domain of medical expertise. \textit{Id.} at 50, 355 A.2d at 669. In contrast, a subsequent Massachusetts court stated that life and death questions should benefit from "the detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created." Superintendent v. Saikewicz, 373 Mass. 728, 729, 370 N.E.2d 417, 435 (1977).
\item[18.] 70 N.J. at 47, 355 A.2d at 663. Margaret Randall argues, in \textit{The Right to Die a Natural Death: A Discussion of In re Quinlan and the California Death Act}, 46 U. OF CINN. L. REV. 192, 202-03 (1977), that the state action which must be present in order to invoke the fourteenth amendment is arguably absent in the \textit{Quinlan} case. Rather than making the forced argument that the physicians' actions are part of state action, she suggests that the courts view a patient's right to privacy "as a common law right to control her own body." Four years later, the New York Court of Appeals took precisely this position in \textit{In re Storar}. 52 N.Y.2d 363, 377, 438 N.Y.S.2d 266, 272 (1981). \textit{See infra} note 71 and accompanying text.
\item[19.] 70 N.J. at 41, 355 A.2d at 664. Under the theory of substituted judgment, a court can "[d]on the mantle of the incompetent and . . . substitute itself as nearly as may be for the incompetent . . . to act upon the same motives and considerations as would have moved her." Robertson, \textit{Organ Donations by Incompetents and the Substituted Judgment Doctrine}, 76 COLUM. L. REV. 48, 57-58 (1976). As Professor Robertson explains, the interests of an incompetent must be determined "with the characteristics, tastes, preferences, history, and prospects of the incompetent . . . those he presently has and those he is likely to have in the future." \textit{Id.} at 65. \textit{See also} Withholding Medical Treatment, \textit{supra} note 1, at 66, for a discussion of the distinction between a guardian ad litem, who is a guardian with the limited role of representing the incompetent in litigation, and a general guardian, who has general custody of the person and property of the ward. The authors assert that the general guardian is
The aspect of the *Quinlan* decision which is particularly relevant to a discussion of withholding medical treatment is the rationale which underlies the court's decision to allow Karen's respirator to be discontinued. Though Karen's physical condition did not meet the criteria for brain death, and her illness was not considered terminal, the court sanctioned the withdrawal of the life-support system because there was no possibility of her returning "to a cognitive, sapient state." The court's decision was not "judicious medical neglect," as one author has called it, but an affirmation of the private nature of death and the integral role that the family's physician historically has played in choosing the manner in which a patient dies.

Although the *Quinlan* court required that the incompetent patient's wishes be represented through the use of substituted judgment, it failed to suggest a process for the determination of the patient's wishes. The court presumed that Karen would wish the respirator discontinued because her family and the ethics committee decided there was no "reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state." Thus, it is safe to conclude that the nature of Karen's illness and her physical condition, rather than her own wishes, were the decisive factors in the court's order to allow termination of treatment.

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21. More than half the states recognize through either statutes or judicial decisions that a patient is dead when all brain functions irreversibly cease. However, since there is presently no uniform criteria for determining "brain death," in order to establish guidelines representative of current medical practice, the following model statute has been proposed by the A.M.A., the A.B.A., and the President's Commission for the Study of Problems in Medicine and Biomedical and Behavioral Research: "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards." *Guidelines for the Determination of Death*, 246 J. A.M.A. 2184 (1981). See also McCabe, *The New Determination of Death Act*, 67 A.B.A. J. 1476 (1981).

22. 70 N.J. at 26, 355 A.2d at 656.

23. Id. at 54, 355 A.2d at 671.


25. Buchanan, in *Medical Paternalism*, supra note 9, at 110 states: "It is not just that the family is likely to be better acquainted than the court with the patient's personal interests and distinctive preferences; in addition, members of the family have a special responsibility for each other's welfare . . . the judicialization model inappropriately denies any special role to the family . . . ."

26. 70 N.J. at 54, 355 A.2d at 671.

27. The court's purely theoretical application of the doctrine of substituted judgment
B. Post-Quinlan: The Tempest Brews

One year after the Quinlan decision was handed down, a Massachusetts case concerning the withholding of medical treatment caused a similar controversy and gained as much notoriety as Quinlan. Superintendent v. Saikewicz provided the Massachusetts courts with an opportunity to decide to what extent they would become involved in this sensitive area. In a holding seemingly in total disagreement with Quinlan, Saikewicz established a new basis for court involvement by requiring advance court approval on the issue of whether or not life-prolonging treatment should be provided.

Joseph Saikewicz was a profoundly retarded, sixty-seven year old man suffering from incurable leukemia. Though the disease would ultimately result in his death, he experienced no pain or side effects from the leukemia. In fact, when the issue of chemotherapy arose, his general health was described as good. Though there was a thirty to fifty percent chance that chemotherapy would cause Saikewicz to go into remission for two to thirteen months, serious adverse side effects, such as nausea and bladder irritation, were also almost certain consequences. The Massachusetts Supreme Judicial Court held that the fourteenth amendment's right to privacy allowed Saikewicz to decline treatment if that was his wish. Further, the court ruled that an incompetent patient's wishes must be determined by a probate court in order to guarantee that the incompetent had properly exercised his right to refuse treatment. The medical community viewed this controversial decision, especially the requirement of prior probate court approval, as an unwarranted judicial intrusion which would necessitate a major change in the way medicine would be practiced in the future.

suggests that the court felt that the type of life which Karen led in the coma presented no choices concerning the respirator. Gold, Book Review, 3 AM. J.L. & MED. 89, 93 (1977), would agree. Gold states that considering the quality of life Karen was leading, she was already dead, having "lost all the rights appurtenant to being human." Id. He argues that "it is not merely life, but 'human' life, that we deem worthy of protection." Id. at 92. A similar distinction is made in other cases concerning the withholding of medical treatment between patients who are alive and for whom there is a meaningful choice to be made concerning the type of treatment they wish, and patients who are in the process of dying for whom the right to treatment is irrelevant. See infra note 49 and accompanying text.

29. Id. at 733, 370 N.E.2d at 421.
30. Id. at 739, 370 N.E.2d at 424. The Saikewicz court said that not only was the probate court granted equity jurisdiction by statute, but it had the inherent and specific authority to act in all matters concerning guardianship. Id.
31. See Curran, The Saikewicz Decision, 298 NEW ENG. J. OF MED. 499, 500 (1978) and Relman, The Saikewicz Decision: A Medical Viewpoint, 4 AM. J.L. & MED. 233 (1978). Curran says that the Saikewicz court's disagreement with the Quinlan court shows "a lack of understanding and a distrust of the current medical-care system." He concludes that the
The *Saikewicz* court reconciled its decision with *Quinlan* by saying that both cases shared the same goal of determining "with as much accuracy as possible the wants and needs of the individual involved." Parental determination in *Quinlan* was appropriate because the father knew his daughter well and could draw on experience to determine what her choice would have been had she been cognizant. In *Saikewicz*, there was no similarly interested relative, so the court was compelled to intervene and subjectively decide what Saikewicz would have chosen, utilizing the doctrine of substituted judgment. In order to guarantee that the best interests of the patient were represented, while simultaneously promoting the state interest in the preservation of life, judicial oversight was necessary. Perhaps the cornerstone of the *Saikewicz* decision was not the use of the doctrine of substituted judgment but the application of the "benefit versus risk" rule. The thirty-to-fifty percent chance of a two to thirteen month remission procedure suggested by the *Saikewicz* court for handling life-death decisions is so slow and cumbersome that it will merely result in the prolongation of treatment. *Id.* Relman, in the article entitled *The Saikewicz Decision: Judges as Physicians*, 298 NEW ENG. J. OF MED. 508 (1978), says that "the general intent of the Court is unmistakable. This astonishing opinion can only be viewed as a resounding vote of 'no confidence' in the ability of physicians and families to act in the best interests of the incapable patient suffering from a terminal illness."

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32. 373 Mass. at 750, 370 N.E.2d at 430.
33. As discussed previously, it is not at all clear whether Karen's choice of treatment was merely assumed as a result of her physical condition, or was actually determined through the use of substituted judgment. *See supra* note 27 and accompanying text.
34. 373 Mass. at 752-53, 370 N.E.2d at 431. Precisely how implied consent is to be obtained from minors, mentally ill and retarded persons, and the comatose is not clear. In the past, family members were considered to have the patient's best interests at heart. More recently, the courts have appointed guardians to represent the patient's wishes, especially when there were no close relatives, as was the case in *Saikewicz*. The *Saikewicz* court developed the most stringent requirement for determining the wishes of incompetents. It stated that judges were the proper source of substituted judgment. *Id.* at 755-59, 370 N.E.2d at 432-35. For a criticism of this holding, see Gutheil & Applebaum, *Substituted Judgment and the Physician's Ethical Dilemma: With Specific Reference to the Problem of the Psychiatric Patient*, 41 J. CLIN. PSYCHIATRY 303, 305 (1980) [hereinafter cited as *Substituted Judgment*].

Whether the doctrine of substituted judgment is even applicable to a profoundly retarded man is a point of controversy. *See* Annas, *Quality of Life in the Courts: Earle Spring in Fantasyland*, 10 HASTINGS CENTER REP., Aug. 1980, at 9. Annas says the substituted judgment test can never apply to severely retarded persons, because in attempting to guess their wishes by using this subjective standard, courts create "make-believe" reasons. *See also* Ramsey, *The Saikewicz Precedent: What's Good for an Incompetent Patient*, 8 HASTINGS CENTER REP. Dec. 1978, at 36. Ramsey says since Saikewicz could not and had never been able to communicate, there was nothing to guide the court in determining his wishes. The court merely "made up their subjective minds, without foundation in any adequate discovery or finding or test, what would be good for Joseph Saikewicz." Ramsey, 8 HASTINGS CENTER REP. at 40.
35. 373 Mass. at 737, 370 N.E.2d at 423.
36. *Id.* at 741, 370 N.E.2d at 425.
simply did not justify the use of chemotherapy with its painful side-effects.37

It is not surprising that the medical community viewed the *Saikewicz* decision with dismay. Many commentators felt that Saikewicz’s prognosis was more within the realm of medical certainty than Quinlan’s had been; yet, the court, from the physician’s viewpoint, denied them the responsibility of deciding Saikewicz’s care whereas physicians had been given great leeway in the *Quinlan* case.38 While the consequences of turning off Karen Quinlan’s respirator were a matter of conjecture, and therefore judicial intervention was arguably necessary to protect Quinlan’s interests, Saikewicz’s prognosis was a matter of fact. Anemia, chronic infections, severe nausea, numbness and loss of hair are some of the side-effects associated with chemotherapy that Saikewicz would have experienced.39

The medical profession’s reaction to *Saikewicz* was thus one of anger and disbelief.40 It appeared that the courts were asserting that they were more qualified than physicians to assume the responsibility for determining what treatment was in a patient’s best interests. Within a year, however, the courts were presented with the opportunity to answer the physicians’ complaints in the case of *In re Dinnerstein*.41

*Dinnerstein* was the first case to specifically address the issuance of ONTR. The medical community hoped that *Dinnerstein* would serve as a clarification and perhaps a modification of *Saikewicz*.

37. See *The Right to Die*, supra note 24, at 297.

38. Dr. Relman, Editor of the New England Journal of Medicine, is representative of the medical community’s point of view concerning *Saikewicz*: “[T]he Court seems to be saying that even under emergency situations, where medical decisions could not possibly have prior judicial sanction, physicians must not be allowed to use their own professional judgment, but should be guided instead by governmental regulations.” Relman, *The Saikewicz Decision: Judges as Physicians*, 298 New Eng. J. of Med. 508 (1978); see generally *Curran, The Saikewicz Decision*, supra note 31 and *Trout, The Courts and the Practice of Medicine*, 4 J. of Legal Med. Oct. 1976, at 2.

39. 373 Mass. at 733, 370 N.E.2d at 421.

40. See *Allan, No-Code Orders vs. Resuscitation: The Decision to Withhold Life-Prolonging Treatment from the Terminally Ill*, 26 Wayne L. Rev. 139, 157-58 (1979). Discussing *Saikewicz*, Allan states:

[At the very time when a few major health care institutions were beginning to establish and publish guidelines for the withholding of medical treatment in an attempt to provide some kind of certainty of procedure and uniform patient protection . . . the status of the commonly practiced No-Code procedure was thrown into doubt.

*Id.*

II. CURRENT CASE LAW CONCERNING THE WITHHOLDING OF MEDICAL TREATMENT

A. Dinnerstein Calms the Medical Profession

At first glance, the Dinnerstein decision appears antithetical to Saikewicz, providing the medical profession with the very freedom from judicial restraint that they claimed was their perogative. The two cases can be reconciled, however, by examining the factual differences between them.

Sixty-seven year old Shirley Dinnerstein suffered from a degenerative brain illness called Alzheimer's disease. There is no known cure for this progressive disease which eventually destroys the brain tissue, leading to the loss of all intellectual and motor functions and inevitable death. By the time the case and its issue of whether or not a physician could lawfully issue ONTR without advance approval by a probate court reached the Appeals Court of Massachusetts, Dinnerstein was in a vegetative state, paralyzed on her left side, and fed through a naso-gastric tube. Her attending physician recommended that when cardiac or respiratory failure occurred, she not be resuscitated. The Dinnerstein court agreed and held that an attending physician may lawfully direct that resuscitative measures be withheld from an incompetent and terminally ill patient without prior approval from a probate court. The court said that, in this case, the decision to lessen the suffering of a terminally ill patient was within the competency of the medical profession.

Several factors are important in explaining how the Dinnerstein court arrived at a decision seemingly at odds with Saikewicz. First, the medical care of Dinnerstein was custodial rather than treatment-oriented. There was no chance, as in Saikewicz, of "a remission of symptoms enabling a

42. Id.
43. Id. at 737-38, 380 N.E.2d at 135.
44. Id. at 747-48, 380 N.E.2d at 139.
45. This case ... presents a question peculiarly within the competence of the medical profession of what measures are appropriate to ease the imminent passing of an irreversibly, terminally ill patient in light of the patient's history and condition and the wishes of her family. That question is not one for judicial decision, but one for the attending physician, in keeping with the highest traditions of his profession ...

Id. at 746-47, 380 N.E.2d at 139.

It should be noted that whereas both Saikewicz and Dinnerstein are Massachusetts cases, Dinnerstein was decided by the lower appeals court. Because Dinnerstein was not appealed, the highest state court never had the opportunity to affirm or reject it, though they did consider a similar issue in In re Spring. See infra notes 52-63 and accompanying text for a discussion of In re Spring.
return towards a normal, functioning, integrated existence."  

47. Id. at 739-40, 380 N.E.2d at 136. In this respect, Dinnerstein is similar to Quinlan. Dinnerstein's son, who was also a physician, and her daughter, with whom she lived before her admission to the nursing home, were adamant about the type of care their mother received. Such close and interested relatives were absent in Saikewicz.
48. Id. at 738-39, 380 N.E.2d at 135-36. Though the proposed chemotherapy for Saikewicz was certainly not as violent and dramatic as a defibrillator, which utilizes electric shock in order to induce the heart to start working again, certainly the degree of pain and discomfort both patients would have experienced is similar. See Note, Withholding of Medical Treatment from a Terminally Ill, Incompetent Patient—A Departure from Saikewicz, 63 Mass. L. Rev. 263 (1978). The author argues that there is no valid distinction between these cases in that neither Saikewicz nor Dinnerstein could benefit from any life prolonging treatment:

Just as the Appeals Court was concerned with the increased suffering that would be inflicted on Mrs. Dinnerstein through resuscitation efforts, the Supreme Judicial Court noted that if Saikewicz took chemotherapy treatment, he would be subject to a continuing state of pain the reason for which he would never understand.

50. 373 Mass. at 753, 370 N.E.2d at 431.
size the validity of this distinction two years later when it decided *In re Spring*.

**B. In the Matter of Earle M. Spring**

*Spring* concerned the issue of whether or not to continue hemodialysis for an incompetent patient. Spring was a seventy-eight year old, senile man who was suffering from "end stage kidney disease." The kidney disease was permanent and irreversible, but, like Saikewicz, Spring's general health was good. The hemodialysis treatment, which mechanically filtered Spring's blood, "did not cause a remission of the disease or restore him even temporarily to a normal, cognitive, integrated, functioning existence, but simply kept him alive."

Unpleasant side effects resulted from the hemodialysis treatment. Spring kicked nurses, resisted being transported to the treatment, and tried to pull the needles out of his arm. Spring's wife and his son (his son was also his temporary guardian) sought a judgment decreeing that, together with Spring's physician, they be allowed to discontinue the dialysis treatment. The supreme court of Massachusetts held, citing *Saikewicz*, that the probate court, not Spring's family and physician, was the proper decision-making party. Utilizing the doctrine of substituted judgment, the court concluded that Spring wished the hemodialysis treatment terminated.

Spring's condition was similar to Dinnerstein's because his kidney disease was terminal and the medical care was merely custodial. The same court that decided *Saikewicz* considered *Spring* to be a "right to treatment" case because, as with Saikewicz, Spring's physical condition mandated a choice of treatment. As had been the case in *Saikewicz*, the *Spring* court felt that though death was inevitable, Spring was quite alive, and, therefore, whether or not to continue the hemodialysis was a decision concerning treatment that Spring should have the opportunity to make. Affirming the holding in *Saikewicz*, the supreme court of Massachusetts said that the proper party to make the decision for Spring was the probate court judge and stated that "[i]t was error to delegate the decision to the attending physician and the ward's wife and son."

The underpinning of this decision is the court's distinction between a patient for whom treatment is useless and one for whom further treatment is a viable alternative. As in *Saikewicz*, the court relied upon the theory of

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53. *Id.* at 1212, 405 N.E.2d at 118.
54. *Id.* at 1220, 405 N.E.2d at 122.
55. *Id.* at 1212, 405 N.E.2d at 118.
56. *Id.* at 1210, 405 N.E.2d at 117.
substituted judgment, maintaining that the incompetent's wishes regarding treatment must first be determined before the "general right to refuse medical treatment . . . [is balanced] . . . against the State interest in the preservation of life." Yet, a question exists whether a determination of Spring's wishes was really made. Spring had never stated any treatment preferences. His wife offered her opinion that he wouldn't want to live but did not back this feeling up with any evidence. Though the court says that the quality of life "has no analogue in the present case," was the judge's interpretation of Spring's supposed wishes anything but a decision based solely on Spring's poor prognosis?

*Spring* affirms *Saikewicz* and, therefore, seems to endorse the *Saikewicz* court's approach to the problem of withholding medical treatment. According to *Saikewicz* and *Spring*, the first step is to decide whether the case is a "right to treatment" one or not. Is the patient presently and irrevocably in the process of dying, or will he die sometime in the future? According to *Spring*, if the patient is not presently dying, no matter how certain his death is, it is a "right to treatment" case, and the courts, using substituted judgment, must decide what the patient's wishes are.

The *Spring* court also affirmed *Dinnerstein*: "[W]e think the result reached on the facts shown in that case (Dinnerstein) was consistent with our holding in the *Saikewicz* case." The court listed criteria that the medical profession should consider when deciding if prior probate court approval must be obtained. The factors that the court considered to be important included the degree of impairment, the complexity and risk involved in the proposed medical treatment, the patient's level of understanding, how quickly the treatment decision must be made, the family's wishes, and whether the treatment or the withholding of treatment is good medical practice.

Though *Spring* provides the medical profession with a blueprint for handling future problems concerning the withholding of treatment, whether the case actually provides the medical profession with any real answers is doubtful. The court relies so heavily upon the particular facts in *Spring* that its opinion has no predictive value for the medical profession.

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57. *Id* at 1214, 405 N.E.2d at 119.
58. *Id* at 1220, 405 N.E.2d at 122.
59. *Id* at 1220, 405 N.E.2d at 123.
60. *Id* at 1215, 405 N.E.2d at 120.
61. *Id* at 1216-17, 405 N.E.2d at 121. Using these criteria, the court viewed Spring's prognosis as similar to Saikewicz's in that neither man was in the process of dying and that hemodialysis and chemotherapy, respectively, might control and defer the course of their illness.
Physicians are left in the position of second-guessing whether a court will view a patient's condition as treatable or not.

Fortunately for physicians, the *Spring* court stated that the medical community's second-guessing must either be "grievously unreasonable" or in bad faith before physicians would be judged culpable. The court also stressed that "neither the *Saikewicz* case nor the present case [*Spring*] presented any issue as to the legal consequences of action taken without court approval."\(^{63}\)

Although the Massachusetts courts devised the first uniform approach to withholding treatment cases, the persuasive value of *Saikewicz* and *Spring* remains a question. The first court of another jurisdiction to strongly endorse these Massachusetts decisions was the New York appellate court in the case of *Eichner v. Dillon*.\(^{64}\) However, the same state signaled a dramatic change in direction when its highest court rejected the appellate court's decision one year later in *In re Storar*.\(^{65}\)

**C. *In re Storar*: Prophetic or Archaic?**

In early 1981, the highest New York state court, the Court of Appeals for New York, vacated the seventy-three page unanimous decision which the appellate court had handed down one year earlier.\(^{66}\) The voluminous appellate court opinion had generated much controversy due to the vast procedural demands it required of the medical profession before they could terminate treatment.\(^{67}\) The recent Court of Appeal's decision is likely to generate a similar amount of controversy due to its brevity and its failure to provide any guidelines.

*In re Storar* and its companion case, *In re Eichner*, are significant because they are indicative of at least one court's reluctance to become further entangled in withholding treatment cases. Though the holdings in these cases will probably be favorably received by physicians in New York, they are so contrary to the previously discussed Massachusetts

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62. *Id.* at 1219, 405 N.E.2d at 122.
63. *Id.* at 1214, 405 N.E.2d at 119. For a general discussion of possible medical liability incurred as a consequence of withholding treatment, see *supra* note 12.
66. *Id.*
67. 73 A.D.2d 431, 426 N.Y.S.2d 517 (App. Div. 1980). The appellate court's opinion required that before life-sustaining measures were withdrawn, a hospital committee had to confirm the attending physician's prognosis and a "committee of the incompetent," as well as a guardian ad litem, had to be appointed by the court to represent the patient in an adversary setting. 426 N.Y.S.2d at 550.
courts' rulings that their effect outside of New York will only be to add to the existing judicial disarray and further confuse the medical profession. 68

The first of the companion cases to be considered by the court was In re Eichner, nicknamed the "Brother Fox" case. It involved an eighty-three year old member of the Society of Mary who suffered a cardiac arrest during a routine hernia operation and was without oxygen for several minutes. Brother Fox was placed on a respirator in a comatose state. He had suffered substantial brain damage and had no reasonable chance of recovery. Fox's close friend, Father Philip Eichner, requested that the respirator be removed. The hospital refused, and Eichner initiated judicial proceedings to be appointed "committee of the person and property of" Fox with specific authority to discontinue the respirator. 69

In the exhaustive opinion of Eichner v. Dillon, the appellate court had found that, in addition to a common law right to decline treatment, Fox was protected by the fourteenth amendment's right to privacy which encompassed the right to decline treatment. The court held that this right could be exercised through the use of substituted judgment. 70

On appeal, the highest New York state court, the Court of Appeals, rejected much of the appellate court's holding. In a short opinion, the Court of Appeals refused to consider whether Fox's right to decline treatment was part of the fourteenth amendment's right to privacy because the relief sought was "adequately supported by common-law principles." 71 It also did not consider the issue of substituted judgment, stating that it was unnecessary to decide whether "a decision to discontinue life sustaining medical treatment [could] be made by some one other than the patient . . . [because] . . . Brother Fox made the decision for himself before he became incompetent." 72 The court said that there must be "clear and convincing evidence" 73 of the patient's intent and that, in this case, there was compelling proof that Brother Fox would have wanted the respirator discontinued. 74 Although this is the extent of the court's holding, In re Eichner is clarified in its companion case, In re Storar.

69. 438 N.Y.S.2d at 269.
70. 426 N.Y.S.2d at 537-41. The appellate court modeled its opinion after Saikewicz and Spring, citing these Massachusetts cases often.
72. Id. at 378, 438 N.Y.S.2d at 273-74.
73. Id.
74. Id.
John Storar was a fifty-two year old, profoundly retarded man with terminal bladder cancer. Lesions in his bladder caused him to continuously lose blood. Storar's mother, as guardian, wanted to discontinue the blood transfusions that Storar was receiving. Though Storar did not like the transfusions and resisted them, he had more energy after the transfusions and could resume his usual lifestyle.  

The Court of Appeals said that Storar was an infant mentally, and it was "unrealistic to attempt to determine whether he would want to continue potentially life prolonging treatment if he were competent." Thus, in a case with facts surprisingly similar to those of Saikewicz, the New York Court of Appeals rejected the Massachusetts courts' use of substituted judgment. Rather, the court held that because an infant's parent or guardian "may not deprive a child of lifesaving treatment," the transfusions should have been continued.

Finally, concerning the need for advance court approval, the court took a decidedly pro-physician stance, stating:

We emphasize, however, that any such procedure is optional. Neither the common law nor existing statutes require persons generally to seek prior court assessment of conduct which may subject them to civil and criminal liability. If it is desirable to enlarge the role of the courts in cases involving discontinuance of life sustaining treatment for incompetents by establishing . . . a mandatory procedure of successive approvals by physicians, hospital personnel, relatives and the courts, the change should come from the Legislature.

The Storar court's refusal to invoke the doctrine of substituted judgment, at first glance, appears to be a welcome relief from its contrived application in Saikewicz. But, is the holding actually anything more than a "knee-jerk" reaction to Saikewicz? The Storar court establishes an unrealistically high standard when it insists that only "clear and convincing" evidence of a patient's own wishes prior to his illness justify the decision to terminate treatment. The practical result is that all incompetent patients without "living wills" or an equivalent explicit statement of intent and all minors forfeit the right to decline treatment.

The impact of Storar outside of New York is yet to be known. It is, as of

75. Id. at 374-75, 438 N.Y.S.2d at 271-72.
76. Id. at 380, 438 N.Y.S.2d at 274.
77. Id. at 380, 438 N.Y.S.2d at 275.
78. Id. at 382-83, 438 N.Y.S.2d at 276.
79. See supra note 34 and accompanying text.
80. 52 N.Y.2d at 379, 438 N.Y.S.2d at 274.
now, the only recent case to reject the use of substituted judgment. It does join two other state supreme courts, as well as Massachusetts, in calling for increased legislative involvement.\textsuperscript{81} Although \textit{Storar}'s scope is narrow, it is apt to be criticized for rejecting the doctrine of substituted judgment without providing any analytical tools to take its place. It is a significant case because it indicates that the courts have now acknowledged the complexity of problems associated with the right to decline treatment and are ready to extricate themselves from this area at the earliest opportunity.\textsuperscript{82}

81. Two other "right to refuse treatment" cases have recently been decided by the state supreme courts of Florida and Delaware. 

Satz v. Perlmutter, 379 So. 2d 359 (Fla. 1980), concerned a 73 year old man with amyotrophic lateral sclerosis (Lou Gehrig's disease) who wished to have his respirator discontinued. The court, in an opinion which cited \textit{Saikewicz} often, held that a competent terminally ill patient had a constitutional right to refuse or discontinue extraordinary medical treatment. \textit{Id.} at 360. The \textit{Perlmutter} court found that the same four state interests discussed by the \textit{Saikewicz} court (the interest in the preservation of life, the duty to prevent suicide, the need to protect innocent third parties, and the need to maintain the ethical integrity of the medical profession) were outweighed by Mr. Perlmutter's constitutional right of privacy.

Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334 (Del. Sup. Ct. 1980), concerned an incompetent's right to refuse medical treatment. Mrs. Severns was a 55-year old woman who had been in a vegetative state for almost a year as the result of a car accident. Her husband wanted all supportive medical treatment withdrawn so that she could die a natural death. Specifically, he requested that she not be placed on a respirator, that a feeding tube not be surgically inserted in her trachea, that no antibiotics or other medicines be given to her (besides those necessary for bodily hygiene), and that a no-code order be entered on her chart. Citing \textit{Saikewicz}, \textit{Dinnerstein}, \textit{Spring}, and \textit{Eichner} as support, the \textit{Severn} court held: one, the Court of Chancery had the statutory authority to appoint the husband as guardian of Mrs. Severns' person; two, as guardian, the husband could apply for an order authorizing removal of life-sustaining support; and three, the Chancery Court would have power to authorize removal of support if the evidence warranted it. \textit{Id.} at 1334-35.

Both the \textit{Perlmutter} and the \textit{Severns} courts urged the state legislatures to promptly address the problems of withholding and terminating medical treatment and to enact legislation to alleviate the many difficulties courts have encountered in this area. The Florida Supreme Court stated: "[T]he issue . . . is not one which is well-suited for resolution in an adversary judicial proceeding. It is the type of issue which is more suitably addressed in the legislative forum." \textit{379 So. 2d} at 360.

82. Paris, in \textit{The New York Court of Appeals Rules on the Rights of Incompetent Dying Patients: The Conclusion of the Brother Fox Case}, 304 NEW. ENG. J. OF MED. 1425 (1981) (quoting Lewis, \textit{Machine Medicine and Its Relation to the Fatally Ill}, 206 J. A.M.A.at 387-88 (1968)), calls \textit{Storar} "an abrogation by the highest court of New York of the centuries-old ethical standard that no one—competent or incompetent, articulate or uninformed—need be subjected to 'extraordinary means of prolonging life . . . when it becomes apparent that there is no hope for the recovery of the patient.' " In this article, he continues:

If physicians continue to care for terminally ill incompetent patients in conformity with the highest traditions of the profession and make judgments on the propriety of actions in consultation with learned, prudent colleagues and the patient's family, the \textit{Eichner-Storar} ruling will have little impact on the practice of medicine. If, on the other hand, physicians opt for legal approbation for their actions, they will place both the rights of their patients and the exercise of their professional responsibility in jeopardy.
III. THE IMPORTANCE OF ONTR

"A dying man needs to die, as a sleepy man needs to sleep, and there comes a time when it is wrong, as well as useless, to resist."\textsuperscript{83}

A. The Present Status of ONTR

From the foregoing cases, several considerations can be gleaned. Putting \textit{In re Storar} aside for the moment\textsuperscript{84} and reading \textit{Dinnerstein} in conjunction with \textit{Saikewicz}, advance court approval of a medical decision to withhold treatment is required only when the choice of starting life-prolonging treatment is actually a meaningful election for the patient. The decision to withhold medical care from a patient for whom no existing care can improve his prognosis remains solely within the realm of the medical profession. However, if judicial intervention in this decision-making process is initiated by the family or physicians, the courts should not decline to participate when the question is finally presented to them. The courts have specifically enumerated several factors relevant to a decision concerning whether or not the patient has a right to choose his treatment. These factors are, in turn, balanced against the state’s interest in the preservation of life in order to arrive at a decision whether judicial representation of the incompetent should be provided or judicial review of the medical decision is necessary. The issue of what sanctions would apply when judicial approval is not sought has yet to be specifically dealt with by the courts, but it is clear that no fault will lie with the physicians unless their conduct is "grievously unreasonable" or taken in "bad faith."\textsuperscript{85}

B. Proposal for the Implementation of ONTR

The implementation by hospitals of the following proposals will help abate unnecessary anguish and litigation. First, the hospital should develop a statement reflecting its general policy towards ONTR. This statement should include an overview of the ethical, legal, financial, and medical aspects of ONTR. Important terms, such as "terminal illness" and "imminent" should be carefully defined so they can be understood by the patient and also function as the basis of a uniform approach by the hospi-

\textsuperscript{83} S. Alsop, \textit{Stay of Execution; A Sort of Memoir} 299 (1973).
\textsuperscript{84} \textit{Storar}’s immediate effect will be to signal the courts’ reluctance to become further involved in this area to the legal and medical professions and to act as a catalyst for legislative action. Whether it will be favored over \textit{Saikewicz} and \textit{Spring} remains to be seen.
tal's practicing physicians. The roles that the hospital, physicians, family, and patient play in the implementation of the ONTR should also be described in this statement.\textsuperscript{86} If the patient is a competent adult, the issuance of ONTR need only be discussed with him.\textsuperscript{87} If the patient is incompetent or a minor, ideally, the family will be the one to recognize that death is inevitable and will initiate the request for ONTR.

In the absence of such a request, it is the physician's responsibility to discuss the incompetent patient's prognosis with the family. A suggestion on his part to issue ONTR (because there is no meaningful treatment available to improve the patient's condition and resuscitative measures will merely prolong his suffering) should be the result of sound medical judgment based on the best interests of the patient. The medical decision should first include a consideration of the purely medical and technical aspects of the patient's care, which a physician is presumed to possess. It should further represent a concurrence of the opinions of all the staff physicians attending the patient. Nonmedical and social factors, such as those mentioned in the Dinnerstein opinion,\textsuperscript{88} should be considered secondly by the physicians in order to further crystalize and legitimatize their decision.

Hospital committee review should be made available upon the request of either the family or the physician. The committee could consist of social workers, physicians who are part of the administrative staff of the hospital, nurses attending the patient, clergy, and members of the hospital's legal staff. The committee's purpose would be to act either as counselor to the family, or as arbitrator between the physician and the family, as the situation would require. Its role would be supportive, and its advice would not be binding on either party. The committee would attempt merely to provide objectivity in the decision-making process.

The party whose judgment should be substituted for that of an incompetent patient remains one of the most troublesome questions in withholding-treatment cases. An incompetent patient has the same right to refuse medical treatment as a competent patient does. Though far from ideal, the only way to guarantee that the incompetent patient exercises this right is through implication. Someone must guess what the incompetent, if he were competent, would have wished. The people most apt to know the personal history and wishes of the incompetent are family and friends. If these people are not available, or are incapable of or unwilling to consent to a discontinuance of medical treatment, the incompetent's physician

\textsuperscript{86} See LeBlang, Does Your Hospital Have a Policy for No-Code Orders?, supra note 4, pt. 2, April 1981, at 5-8.

\textsuperscript{87} Id. at 6.

\textsuperscript{88} See supra notes 46-49 and accompanying text.
should take responsibility for that decision. Of course, the more competent physician would not make the decision to withhold treatment without first seeking the advice of other members of the hospital staff (e.g., other physicians, nurses, social workers, psychologists, and clergy). Only rarely, would the situation arise in which a physician would be justified in withholding treatment based solely upon his judgment and analysis of the patient’s condition and needs.

This proposal is not apt to meet with universal approval, but there are several reasons why it is preferable for physicians, rather than judges, to determine the course of an incompetent’s medical treatment. First, it is likely that the physician has had a personal rapport with the patient. Often, the physician knew the patient when he was competent and, therefore, may have a more accurate impression of his personality. Second, the physician has had the opportunity to deal closely with the incompetent’s family during the course of the illness. The physician’s contact with the family is less formal than a judge’s, providing the physician with the opportunity to better understand not only the family, but the patient, as mirrored by the family’s actions. Third, it cannot be assumed that the medical profession is less able than the legal profession is to make detached, unbiased decisions regarding a patient’s treatment. If anything, because death is an integral part of a physician’s work, physicians are better equipped to deal honestly with this emotional issue. Fourth, judicial absolution is all too often sought merely to placate the physicians involved in a particular case. The patient and family gain nothing from the unnecessary prolonging of their mental anguish. Fifth, a physician must treat a patient as his conscience dictates. A judge’s treatment decision, that conflicts with his own, places the physician in an ethical dilemma. For a physician to follow a decision that he disagrees with may be “the moral equivalent of abandoning the patient.” Finally, it is wrong for the courts to become involved in medical treatment decisions under the guise of protecting individual autonomy. An incompetent patient never makes a treatment decision—there is always a third party involved.


90. See Bayley, Terminating Treatment: Asking the Right Questions, HOSP. PROGRESS Sept. 1980, at 50.

91. See Substituted Judgment, supra note 34, at 305.
IV. Conclusion

The widespread use of ONTR as a tool for relieving the suffering of terminally ill patients necessitates that hospital physicians not be thwarted in their attempt to administer good health care by court holdings that are obscure and unpredictable. Though the implementation of ONTR presents less of a problem to the practicing physician than does the termination of already existing medical treatment, the problems associated with the use of ONTR must be clearly and uniformly addressed so that explicit guidelines can be established to protect patients and physicians.

Death is an inevitable and inescapable concern for everyone. Families and physicians have been working together in dealing with the death of family members for centuries. There has never been a suit against a physician charging that ONTR should not have been issued. (The issue in Dinnerstein was whether court approval was necessary prior to the issuance of ONTR.) The courts should interpret this as representative of the fact that the medical profession is presently handling the problem of easing the suffering of a dying patient in a manner that is acceptable to the patient’s family. The enactment of formalized ONTR procedures by hospitals will prevent haphazard treatment of the terminally ill and will bring the emotional issue of death into the open so physicians, hospital staff, and families can benefit from each others advice and support.

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