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Medicine and Human Rights: Emerging Substantive Standards and Procedural Protections for Medical Decision-Making Within the American Family

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The American family is increasingly becoming a crucible for testing the great issues of ethics raised by advances in American medical technology. This trend is in part attributable to the fact that the technology itself does not stand still; it increasingly offers new and awesome choices which must be made by someone. For example: Shall an aged and terminally ill parent be kept alive indefinitely by machines that replace the natural functions of lungs and heart? Shall a fetus be carried to term and allowed to be born alive when amniocentesis reveals genetic characteristics that make the child undesirable to the parents? But this trend is also attributable in great part to developments of the last two decades that have seen medical treatment decisions increasingly taken out of the hands of physicians and placed in those of patients who are to make them on the basis of "informed consent." In 1971, the Supreme Court of New Jersey could believe it reflected the then-current state of the law when it allowed a hospital to force one of its patients to accept life-saving blood transfusions despite the fact that such acceptance violated her religious beliefs.¹ But by 1978, the right of a patient to refuse life-saving medical treatment could seem so well established that all par-

ties to the case agreed that such treatment could be forced upon her only if she could be proved to be legally incompetent:

The decision of the [lower-court] judge, as well as the opinion of Dr. Kelley, predicates the necessity for the appointment of a guardian chiefly on the irrationality [in medical terms] of Mrs. Candura's decision to reject the amputation. Until she changed her original decision and withdrew her consent to the amputation, her competence was not questioned. But the irrationality of her decision does not justify a conclusion that Mrs. Candura is incompetent in the legal sense. The law protects her right to make her own decision to accept or reject treatment, whether that decision is wise or unwise.  

As I shall point out in more detail later, the recognition of autonomy in the patient to make medical decisions is not yet complete, and there are forces at work that would return much decision-making power to the hands of physicians. Among these are lobbying efforts by many leaders of the medical profession. For example, the editor of the distinguished New England Journal of Medicine has answered an earlier article of mine in the following language:

Contrast my description of medical practice with the recent assertion made by Charles Baron that "our society has never conferred upon its medical community the power to decide which of society's members shall live and which shall die." Now, if by that statement he means that physicians do not have the authority arbitrarily to terminate a patient's life, he is of course correct. But if he means to convey that doctors have no business deciding whether to institute or to withhold treatment, when such decisions may have life-or-death implications, then he is simply ignorant of the facts of medical practice. As I have tried to show, those kinds of decisions—always with the informed consent of patients or their families, when such consent is reasonably available—are being made all the time. There is nothing more crucial to a physician's professional role than the making of such decisions. His responsibility for the welfare to his patients often requires that he deal with technical medical issues which are of vital importance to his patients but which they are unable to comprehend fully. If at all, and which they must therefore delegate to him. Unless he is willing to assume this decision-making role in the patient's behalf he is not really doing his job.

And even the courts have displayed a certain amount of willingness to delegate such life-and-death decisions to doctors in subtle ways. The most prominent examples of this phenomenon are the decisions of the Supreme Court of the United States that recognize a constitutional right to an abortion. In his opinion for the Court in Roe v. Wade, Justice Blackmun, who had close associations with the medical profes-

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sion before his appointment to the Court, recognizes a right to choose an abortion which resides not in the pregnant woman but rather in "the pregnant woman's attending physician." "This holding," he states, "... vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently and primarily a medical decision, and basic responsibility for it must rest with the physician." And, in the later case of Colautti v. Franklin, the Court, through Justice Blackmun again, confers upon the individual physician even the power to decide what statistical likelihood of survival outside the mother establishes sufficient "viability" for the state's "compelling interest" in fetal life to come into play.

However, despite the existence of these potentially reactionary

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5. Before coming to the Court, Justice Blackmun had served for about ten years as general counsel to the famed Mayo Clinic. That experience had left him with an awe of doctors which he acted out in writing the Roe opinion:

At Mayo, he had watched as Doctors Edward C. Kendall and Philip S. Hench won the Nobel Prize for research in arthritis. He rejoiced with other doctors after their first successful heart by-pass operation, then suffered with them after they lost their next four patients. He sat up late nights with the surgical staff to review hospital deaths in biweekly meetings, and recalled them in detail. He grew to respect what dedicated physicians could accomplish. These had been terribly exciting years for Blackmun. He called them the best ten years of his life.

If a state licensed a physician to practice medicine, it was entrusting him with the right to make medical decisions. State laws restricting abortions interfered with those medical judgments. Physicians were always somewhat unsure about the possible legal ramifications of their judgments. To completely restrict an operation like abortion, normally no more dangerous than minor surgery, or to permit it only with the approval of a hospital committee or the concurrence of other doctors, was a needless infringement of the discretion of the medical profession.

Blackmun would do anything he could to reduce the anxiety of his colleagues except spurn the assignment [to write the opinion in Roe v. Wade.] The case was not so much a legal task as an opportunity for the Court to ratify the best possible medical opinion.


Blackmun's tendency to defer continually to the medical profession has not escaped the notice of his colleagues on the court:

Blacknum's 1973 abortion opinion had subjected the Court to a great deal of ridicule. It was as if Blackmun had developed a special constitutional rule for handling medical questions. [Justice] White dubbed it Blackmun's "medical question doctrine." It seemed to hold that, under the Constitution, doctors rather than the Court, had the final authority on certain medical-legal questions. White found that notion ludicrous. Blackmun had created another "political questions" doctrine. The notion that the Court couldn't meddle in the internal affairs of the other branches of government had been broadened to include the medical profession.

WOODWARD & ARMSTRONG, supra note 5, at 416.
lines of force, the current state of the law seems to be that a legally competent patient has the right to refuse medical treatment of any sort—except in the most extraordinary circumstances. And this right is increasingly being recognized as having a constitutional basis. Thus, one of the most recent federal decisions in the area begins its analysis with:

[What seems to us to be an intuitively obvious proposition: a person has a constitutionally protected interest in being left free by the state to decide for himself whether to submit to the serious and potentially harmful medical treatment that is represented by the administration of antipsychotic drugs. The precise textual source in the Constitution of the protection of this interest is unclear, and the authorities directly supportive of the proposition itself are surprisingly few. Nevertheless, we are convinced that the proposition is correct and that a source in the Due Process Clause of the Fourteenth Amendment for the protection of this interest exists, most likely as part of the penumbral right to privacy, bodily integrity, or personal security.]

But what about this constitutionally protected right to make one's own medical decisions when the patient is not legally competent—when one is a child, mentally retarded, senile, or in coma? Who should make these decisions then and on what basis? If it is not to be doctors, then one is naturally led to consider the patient's "next of kin" as candidates, and it is here that the American family becomes caught up in the tangle of the new medical technology.

The general power of parents to make medical decisions for minor children seems well established in the United States. In most cases, this would be consistent with the policy basis for allowing parents the power to make legally binding decisions for their children generally. The child is considered not capable of making decisions in his own best interests. The parents are considered capable of making such decisions, and it is presumed that they will be desirous of doing only what is best for their child. Moreover, who else could possibly make decisions for the child? So many decisions must be made for the child on a regular basis that the state, even if it believed that it knew better what the child would or should want for himself, would not have the

8. A rare recent exception is Commissioner of Corrections v. Meyers. 1979 Mass. Adv. Sh. 2523, 399 N.E.2d 452 (1979), where the Supreme Judicial Court of Massachusetts denied a prison inmate the right to refuse lifesaving hemodialysis because the state's interest in preserving order in the prison outweighed the prisoner's right to privacy.


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resources for making all of the decisions that had to be made. Most of these decisions have relatively minor consequences. There is usually no clear "right decision." And the "rightness" of the decision for the child may be complicatedly influenced by the values of the family group, and by the fact that the child will have to function as a continuing part of that family group after the decision has been made for him.

Of course, in the area of medical decision making, many of these reasons for recognizing parental power do not carry the same weight that they do for parental decision making in general. For one thing, many medical decisions are likely to have enormous consequences as to the welfare of the child. For another, an objective cost-benefit analysis may make one of the choices seem overwhelmingly right and the other clearly wrong. Finally, decision-making intervention by some agency outside the family would seem feasible if it were restricted to those relatively rare situations in which the parents seemed to be making an objectively wrong and extremely important medical decision. Hence, it is not surprising that American courts seem increasingly inclined to intervene in medical decision making in order to protect the best interests of children. However, even in the medical area, a great deal of deference is accorded to parental discretion—at least where the parents sincerely believe that they are acting in the best interests of their child and evidence indicates that the efficacy or safety of the proposed treatment is open to question. Thus, courts have acceded to parents' wishes in refusing treatment for conditions such as rickets, disfigured arm, a speech impediment, and the need for a spinal fusion operation. On the other hand, courts have overridden the parents in cases involving vaccination, removal of tonsils and adenoids, and other medical procedures to cure non-life-threatening problems. And the courts have, of course, been much more ready to

The tension between concern for the welfare of the child and deference to the decision-making power of well-meaning parents is well illustrated by a comparison of two very similar cases in which the courts reached opposite results as to whether parents should be allowed to use the controversial drug laetrile in the treatment of a child's cancer.

In the well-publicized Chad Green cases, the courts of Massachusetts decided to take legal (but not physical) custody of a child from his parents and grant it to the Massachusetts Department of Public Welfare so that he would be given chemotherapy that had a 50 percent chance of causing remission of his acute lymphocytic leukemia. In the fall of 1977, when Chad was one-and-a-half years old, he had been put on a course of chemotherapy that had brought the disease into remission for a few months. Subsequently, he had become ill and his doctor discovered that Chad's mother had taken him off medication—apparently because she believed it had unpleasant side effects that made the treatment not in his best interest. The doctors then initiated a course of legal proceedings in which they were able to obtain a court order mandating chemotherapy. Some months later, the Greens reopened the proceedings in an attempt to win court approval for a course of "metabolic therapy"—involving laetrile, vitamins, and enzyme treatments—which they had been using to supplement the court-ordered chemotherapy. Presented with evidence that the laetrile treatment had brought about a level of cyanide in Chad's blood that could cause brain damage or death, and presented with no testimony from a Massachusetts physician in favor of the laetrile treatment, the court ordered it stopped. Subsequently, the Greens took their child to Mexico for the purpose of continuing their treatment of choice. Chad died there on October 12, 1979.

During this same period, In re Hofbauer, was wending its way
through the courts of New York. Joseph Hofbauer, aged seven, had been taken by his parents to Jamaica for a month of "metabolic therapy" (including laetrile) for treatment of his recently diagnosed Hodgkin's disease. When they returned to New York state, the parents were charged with neglect of their child and the Saratoga County Commissioner of Social Services sought custody for the purpose of having chemotherapy administered. The court refused to find Joseph a neglected child or award custody to the state. But here, unlike the situation in Chad Green, there was no finding that laetrile therapy had affected the child deleteriously, there was support from New York-licensed physicians for continuing the experiment with laetrile, and perhaps most important, the parents expressed a willingness to resort to chemotherapy if and when that became necessary. There is a sense of court recognition of good faith cooperation from the parents in Hofbauer that seems to be missing in Chad Green, despite the fact that the courts in neither case ever openly questioned the parents' sincere concern for the welfare of their children.

It is in those cases where they have had doubts about the parents' single-minded devotion to the patient-child that the courts have been most ready to intervene in the making of medical decisions. One situation which raises such doubts is presented by modern organ and tissue transplant technology. Important to the success of most such transplants is genetic similarity between the donor and the recipient patient. As a result, siblings of the potential recipient are very often the preferred or even the only feasible candidates for donation. Where an adult, living sister or brother is asked to contribute one of two functioning kidneys to a sibling who has none or to contribute small amounts of bone marrow for colonization within the bones of a sibling whose own bone marrow has been destroyed, the physicians may proceed only upon the consent of the competent donor. However, in the case of the potential donor-sibling who is still a minor (sometimes, in the case of bone marrow transplants, a minor of very tender years), the donor cannot give legally recognized consent, and one would normally look to the parents to do so. But, as was recognized very early, the parents in such a situation cannot be expected to concern themselves only with

23. Id. at 160.
the best interests of the donor-child—they are caught in a conflict-of-interest situation where they must consider trading off the interests of one child for those of another. Hence, the courts of Massachusetts and other states in which such transplants have been performed have made themselves available to give legal authorization for the transplant where that could be shown to be justified.\(^4\) The basis for justifying such consent has not always been easy to work out. In some cases where a consenting donor was near the age of majority, it has been based upon the "mature minor" rule.\(^5\) Most commonly, it has been based upon a theory of psychological benefit to the donor-child which leads the court to conclude that the incompetent consenting child would still consent were he competent to do so.\(^6\) However, the courts of Massachusetts also have used as justification a principle which recognizes that the interests of the donor-child in such a case cannot be abstracted completely from the interests of the family as a whole and which therefore grants to the parents the primary decision-making responsibility which the court then reviews for possible abuse.\(^7\)

Another area in which courts have circumscribed parental consent to medical treatment because of suspicions regarding parental motivation is that of sterilization of mentally retarded children. Here, worry that the parents have opted for sterilization to serve their own interests rather than those of the child is combined with special concern regarding the right to procreate which is constitutionally protected. Involuntary sterilization of incompetents on eugenic grounds enjoyed great vogue in many parts of the United States in the early part of this century. Although such practices were explicitly held to be constitutional by the Supreme Court in 1927,\(^8\) later cases have cast grave doubt on the continuing viability of that holding.\(^9\) Since the 1920s, medical and popular opinion in the United States have turned strongly against the notion of compulsory sterilization—in part in reaction to the specter of eugenics-gone-haywire in Nazi Germany. On the other hand, the same period has seen voluntary sterili-

\(^{24}\) Id. at 161-62, nn.15 & 16.
\(^{27}\) Nathan v. Farinelli, Eq. No. 74-87 (Mass., July 3, 1974).
zation become the birth control method of choice for a growing number of competent adults. Highly publicized concerns over "the pill" and intra-uterine devices (IUDs) have made tubal ligations increasingly popular with women, and, by 1975, the Association for Voluntary Sterilization reported that vasectomies had become the second most common operation performed on men—exceeded only by circumcision.\(^{30}\) As a result, there is a basis for arguing that one discriminates against the mentally retarded by not allowing parents to provide the "proxy consent" necessary for authorizing a birth control method which is available—indeed constitutionally protected in its availability\(^{31}\)—to all competent adults.

Because of shame over the period of eugenic involuntary sterilization, the courts have been cautious in developing new institutions for "voluntary" sterilization through proxy consent. They have been clearly unwilling to allow such consent to be given by parents without close judicial supervision. The worry is that parents may irreversibly deny their child the fundamental right to procreation by overreacting to their own fears of their child's sexuality, and to concerns that they will be burdened with possibly defective grandchildren. Indeed, the judicial worry has been so great that the courts might well be accused of overreacting in this area. During the past twenty years, a number of state courts have taken the unprecedented step of denying jurisdiction to exercise their general \textit{parens patriae} power in such cases even where substantial evidence could be presented that sterilization would be in the best interests of the retarded child.\(^{32}\) However, case law now seems to be settling into a pattern under which \textit{parens patriae} jurisdiction will be exercised as in other proxy consent cases—allowing sterilization, but only where the court is convinced that the child's best interests are truly advanced thereby.\(^{33}\)

The area of medical decision making for children in which parental power has been most circumscribed is that of abortion. Here the issue


\(^{33}\) See, \textit{e.g., In re Moe, 385 Mass. 555, 432 N.E.2d 712 (1982); In re Grady, 170 N.J. Super. 98, 405 A.2d 851 (1979)}. 
has not been whether parental consent to an abortion is *sufficient*, it has been whether such consent is *necessary* in those cases where the child herself has decided to abort. In 1976, shortly after the decision in *Roe v. Wade*, the Court decided that parents could not constitutionally be authorized by a state to veto their minor daughter's choice to have an abortion. In light of the fact that the parents' refusal might be, in the Court's view, "arbitrary"—based, perhaps, on vindictiveness or an effort to impose the parents' strict moral views on their child—the Court held that alternative procedures for obtaining authorization had to be made available. Three years later, in *Bellotti v. Baird*, the Court held that a state which provided such alternative procedures could not require that the parents should first be asked for their consent or even be informed that such procedures were being availed of. Because of the "unique nature of the abortion decision" under these circumstances (among other things, the fact that delay could decide by default the question of whether one child would be forced to take on the responsibilities of raising another), the Court decided that a pregnant minor must be provided the option of going directly to court for approval of her abortion decision without having to inform her parents of the decision. The Court acknowledged the delicate balancing of important interests that was involved:

There is an important state interest in encouraging a family rather than judicial resolution of a minor's abortion decision. Also, we have observed above, parents naturally take an interest in the welfare of their children—an interest that is particularly strong where a normal family relationship exists and where the child is living with one or both parents. These factors may properly be taken into account by a court called upon to determine whether an abortion in fact is in a minor's best interests. If, all things considered, the court determines that an abortion is in the minor's best interests, she is entitled to court authorization without any parental involvement. On the other hand, the court may deny the abortion request of an immature minor in the absence of parental consultation if it concludes that her best interests would be served thereby, or the court may in such a case defer a decision until there is parental consultation in which the court may participate. But this is the full extent to which parental involvement may be required.

Clearly, in the realm of family medical decision making, even the power of parents to make medical decisions for their minor children is

36. Id. at 648.
subject to growing areas of exception. When we look beyond the relationship of parent and minor child, exception becomes the rule. There is scant authority even for one spouse to make a medical decision for the other.37 Where a spouse, brother, or parent becomes incompetent to make such decisions for himself, developing case law indicates that another family member exercises decision-making authority for him most safely by obtaining court authority to do so as the patient's legal guardian. Until recently, few such cases seem to have been brought to court. In part, this probably reflects the fact that most medical decisions that had to be made for incompetent patients were either of a minor nature or involved an emergency. Frequently the incompetence was as well of a very temporary nature, e.g., the patient was anesthetized or otherwise temporarily unconscious. Under such circumstances, the physician would frequently be authorized by earlier-given consent of the patient or by law to make a "judgment call" on his own.38 Out of an abundance of caution, the physician might consult and obtain consent from next of kin on the scene. Such consultation would provide the doctor in a close case with a sense of what the patient might want for himself. It was also a humane, diplomatic, and sensible thing to do. If the patient regained consciousness, he would be less likely to think that the physician had acted in a "high-handed" fashion. If he did not regain consciousness, the most likely candidates for bringing suit against the doctor would have been made a part of the decision-making process. This simple scenario seems to have passed into history with the advent of the new medical technology and the awesome stakes it presents on each side of so many patient-care decisions.

By now, Karen Quinlan's name must be one of the best known in the world. In re Quinlan,39 the lawsuit that brought her to prominence, was filed by Karen's father for the purpose of having his twenty-two-year-old daughter found legally incompetent, and to have himself appointed her guardian with authority to turn off the machines that were keeping her alive. Although not "brain dead," Karen had severe brain damage that had left her in a chronic and persistent vegetative state of coma. There was no known cure for her condition, it was predicted that

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38. PROSSER, supra note 10, at 103.
she would never be restored to cognitive or sapient life, and the prognosis was that even her vegetative state could not continue without life-support machinery. While there was no certainty that she experienced pain, she was intubated, constantly connected to a mechanical respirator, and was described as "emaciated, having suffered a weight loss of at least forty pounds, and undergoing a continuing deteriorative process. Her posture is described as fetal-like and grotesque; there is extreme flexion-rigidity of the arms, legs and related muscles, and her joints are severely rigid and deformed." When Karen's family, after months of tortured indecision, became reconciled to the fact that her condition was hopeless, they asked her attending physician to remove her life-support apparatus. He refused to do so, unless and until she could be proven to be brain dead, on the ground that such action, in his view, would be contrary to prevailing medical standards, practice, and ethics. It was in the face of this refusal that Mr. Quinlan decided to go to court.

In a landmark decision, the Supreme Court of New Jersey held essentially that Mr. Quinlan had a right to a "second opinion" from the medical community on behalf of his daughter. At the outset, the court determined that, on the medical facts presented, Karen's constitutional right of privacy would entitle her to demand "death with dignity" were she competent to do so. Since she was not competent to do so, the court permitted Karen's family to decide that it would be her judgment to decline further intrusive life-prolonging treatment. But, apparently because it was not Karen herself demanding cessation of life support, the court held that the medical community should be accorded some discretion to determine whether life support should in fact be ceased. The lower court had delegated such discretion in extraordinarily broad terms:

The nature, extent and duration of care by societal standards is the responsibility of a physician. The morality and conscience of our society places this responsibility in the hands of the physician. What justification is there to remove it from the control of the medical profession and place it in the hands of the courts? While expressing unwillingness to go this far in deferring to physicians, the supreme court was concerned about the fact that it, "a

40. Id at 26, 355 A.2d at 655.
41. Id. at 39, 355 A.2d at 663.
court, having no inherent medical expertise, [might be] called upon to overrule a professional decision according to prevailing medical practice and standards. . . ." It therefore looked at and weighed a developing medical-ethical literature that discussed the question of what should be done in cases like Karen's, and it concluded that it was not clear that Karen's physician had made his decision according to what could be called generally prevailing medical practice and standards. The trend, indeed, seemed to be in the direction of allowing patients such as Karen to "die with dignity." Moreover, it seemed to the court that resistance to this trend on the part of many doctors rested less on medical-ethical considerations than on fear of the law's response to what might be seen as an act of homicide. Here, the court saw it could do a service to the medical profession by clarifying the law in a way that would free the development of medical ethics from the shadow of this fear.

The court ruled that, in cases like Karen's, the "life-support system may be withdrawn and said action shall be without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital, or others"—but only if certain procedures are followed. First, the family must agree, for the patient, to the act of withdrawal. Second, responsible attending physicians must agree to it. Third, in order to deal with the problem of divergent opinions regarding the developing medical practice and standards in this area, agreement must also be obtained from a hospital "ethics committee." In order to provide Karen's family with an opportunity

43. Quinlan, supra note 39, at 45, 355 A.2d at 666.
44. Id. at 54, 355 A.2d at 671.
45. Here the court was responding to a published suggestion by Dr. Karen Teel that doctors would be wise to establish such committees in order to broaden responsibility for making medical-ethical decisions:

Physicians, by virtue of their responsibility for medical judgments are, partly by choice and partly by default, charged with the responsibility of making ethical judgments which we are sometimes ill-equipped to make. We are not always morally and legally authorized to make them. The physician is thereby assuming a civil and criminal liability that, as often as not, he does not even realize as a factor in his decision. There is little or no dialogue in this whole process. The physician assumes that his judgment is called for and, in good faith, he acts. Someone must, and it has been the physician who assumed the responsibility and the risk.

I suggest that it would be more appropriate to provide a regular forum for more input and dialogue in individual situations and to allow the responsibility of these judgments to be shared. Many hospitals have established an Ethics Committee composed of physicians, social workers, attorneys, and theologians, . . . which serves to review the individual circumstances of ethical dilemma and which has provided much in the way of assistance and
to avail itself of this process, the court appointed Mr. Quinlan guardian of Karen's person with authority to choose an attending physician agreeable to termination of life support—although it recognized as well that "her present treating physicians may give reconsideration to her present posture in the light of this opinion."  

As might be expected, the Quinlan decision was received warmly by the medical community. Not only did it give legal sanction to an act of "passive euthanasia" on the facts of the case brought before the court, it seemed to delegate to the medical community and its hospital ethics committee the power to decide what other fact situations might justify termination of life-prolonging treatment. However, as Professor George Annas has pointed out, the medical community and its lawyers may have read Quinlan too broadly.  

Although the court talked in terms of an ethics committee which comprised "physicians, social workers, attorneys, and theologians," the job it assigned the committee in the Quinlan case was merely the medical prognostic task of agreeing "that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state. . . ." Although the court says at one point in the opinion:

> We consider that a practice of applying to a court to confirm such decisions would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome.

It cautions at another:

> [N]otions as to the distribution of responsibility [between physicians and courts], heretofore generally entertained, should however neither impede this court in deciding matters clearly justiciable nor preclude a reexamination by the court as to underlying human values and rights. Determinations as to these must, in the ultimate, be responsive not only to the concepts of medicine but also to the common moral judgment of the community at large. In the latter respect the court has a nondelegable judicial responsibility.

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safeguards for patients and their medical caretakers. Generally, the authority of these committees is primarily restricted to the hospital setting and their official status is more that of an advisory body than of an enforcing body.


46. Quinlan, supra note 39, at 54, 355 A.2d at 671.


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

50. Id. at 50, 355 A.2d at 669.

51. Id. at 44, 355 A.2d at 665.
Moreover, once the medical facts of Karen's case could be settled, there seemed little question about what would be best for her from an ethical point of view. As the court had noted, a decision to let Karen die "should be accepted by a society the overwhelming majority of whose members would, we think, in similar circumstances, exercise such a choice in the same way for themselves or for those closest to them."\(^{52}\) Not every case would implicate only ethical issues as to which there could be said to be such a societal consensus.

In the year following *Quinlan*, the Supreme Judicial Court of Massachusetts decided a case whose facts forced the court to deal directly with value questions that the facts of *Quinlan* had allowed to be left on the sidelines. As a result, the decision seemed to differ from *Quinlan* in ways that threatened the satisfaction of the medical community. *Superintendent of Belchertown School v. Saikewicz\(^ {53}\)* began as an application on the part of doctors at an institution for the mentally retarded for permission to provide chemotherapy to an inmate who had been diagnosed as terminally ill with leukemia. Joseph Saikewicz was sixty-seven years of age but had an IQ of only 10. Although he had living relatives, he had had almost no contact with them during a lifetime of institutionalization. In the two weeks between filing a petition for appointment of a guardian for Mr. Saikewicz and the first hearing on the petition before the court, the attending physicians had decided to recommend against chemotherapy. The evidence was that refusing treatment for leukemia might mean death for Mr. Saikewicz within a period ranging from a few weeks to several months, but the death would be relatively comfortable. Giving him chemotherapy might prolong life for as much as thirteen months, but it might shorten it, and it would have side effects including anemia, bleeding, infections, "severe nausea, bladder irritation, numbness and tingling of the extremities, and loss of hair."\(^ {54}\) After hearing, the trial court concluded that "not treating Mr. Saikewicz would be in his best interests,"\(^ {55}\) but because of the importance of the issues involved, the court reported the central questions in the case to the Massachusetts Appeals Court. There was then an application for direct appellate review in the Supreme Judicial Court which was granted. On July 9,

\(^{52}\) *Id.* at 41-42, 355 A.2d at 664.


\(^{54}\) *Id.* at 773, 370 N.E.2d at 421.

\(^{55}\) *Id.* at 730, 370 N.E.2d at 419.
1976, the Supreme Judicial Court affirmed the trial court's decision and promised that an opinion would follow.

In the opinion which was promulgated some sixteen months after the decision, the court mirrored the reasoning in Quinlan up to a point. For the first time in Massachusetts, the court recognized a constitutional right on the part of a patient to refuse life-prolonging treatment so long as certain enumerated compelling state interests did not outweigh it in the particular case.\textsuperscript{56} It held that, on the facts of the case before it, those state interests were not overwhelming and that Mr. Saikewicz, were he competent, would therefore have the right to refuse chemotherapy. The court then went beyond Quinlan in holding that any incompetent person should have the same right to refuse medical treatment as a competent one; the sole question should be one of what the incompetent patient would want for himself were he competent for a moment to make that decision. Of Quinlan, the Saikewicz court said:

The court's observation that most people in like circumstances would choose a natural death does not, we believe, detract from or modify the central concern that the guardian's decision conform, to the extent possible, to the decision that would have been made by Karen Quinlan herself. Evidence that most people would or would not act in a certain way is certainly an important consideration in attempting to ascertain the predilections of any individual, but care must be taken, as in any analogy, to ensure that operative factors are similar or at least to take notice of the dissimilarities.\textsuperscript{57}

Under the "substituted judgment" test\textsuperscript{58} employed in Saikewicz,

\begin{itemize}
  \item \textsuperscript{56} Those state interests were identified as: "(1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) maintaining the ethical integrity of the medical profession." \textit{Id.} at 741, 370 N.E.2d at 425.
  \item \textsuperscript{57} \textit{Id.} at 749, 370 N.E.2d at 429.
  \item \textsuperscript{58} As the court noted, this doctrine had had long-standing legitimacy in the field of administration of the estate of an incompetent person. \textit{See Ex Parte Whitbread in re Hinde a Lunatic}, 35 Eng. Rep. 878 (1816). However, there was more recent authority for using it in cases involving medical treatment. \textit{See Strunk v. Strunk}, 445 S.W.2d 145 (Ky. Ct. App. 1969).
\end{itemize}
one of the relevant dissimilarities from other patients faced with chemotherapy which had to be considered was Joseph Saikewicz's profound mental retardation. The court was careful to point out that this was not to be considered from the point of view of devaluing the "quality of life" which was at stake. "The [lower court] judge," the court said, "as well as the parties, were keenly aware that the supposed ability of Saikewicz, by virtue of his mental retardation, to appreciate or experience life had no place in the decision before them."\textsuperscript{59} However, because of his grave mental disability, Saikewicz was found incapable of understanding the "continuing state of pain and disorientation precipitated by the chemotherapy treatment."\textsuperscript{60} As a result, the court concluded that this fact, "together with the other factors properly considered by the judge, [satisfies us] that the decision to withhold treatment from Saikewicz was based on a regard for his actual interests and preferences and that the facts supported this decision."\textsuperscript{61}

The major departure from the Quinlan opinion was reserved for the last part of the Saikewicz opinion where the court discussed the procedures which should be used for deciding such cases in the future. Here the court explicitly rejected Quinlan's delegation of
draw upon, the "substituted judgment" test would seem to collapse into the "best interests" test. See Baron, Botsford, & Cole, supra note 22, at 170, n.54.

The court seemed to think that the "substituted judgment" test was required if it was to be able to take into consideration Saikewicz's inability to understand the purpose of undergoing the pain and disorientation of chemotherapy. But this could have been weighed in the balance even under the "best interests" test. Costs and benefits of treatment are a function of each person's peculiar physical and mental make-up and the circumstances in which he finds himself. Thus, Saikewicz's inability to reduce the rigors of chemotherapy through understanding and gaining hope from its purpose presents a clear cost item. The "substituted judgment" test would come into play only if we knew what his competent decision-making foibles would be and if we were willing to take those into consideration even though they might lead us to a decision that might not fully accord with what we would think would be in his "best interests."

Some evidence that the Supreme Judicial Court has refined its distinction between the two tests since Saikewicz is provided by the following language from a more recent decision:

If the judge feels that the "best interests" of the ward demand one outcome but concludes that the ward's substituted judgment would require another, then in the absence of an overriding State interest, the substituted judgment prevails. In short, if an individual would, if competent, make an unwise or foolish decision, the judge must respect that decision as long as he would accept the same decision if made by a competent individual in the same circumstances. We digress concerning this "right to be wrong" only to establish the relationship between the "best interests" standard and the substituted judgment determination.


\textit{Saikewicz}, supra note 53, at 754, 370 N.E.2d at 432. \textsuperscript{60}

\textit{Id.} \textsuperscript{61}

\textit{Id.} at 754-55, 370 N.E.2d at 432.
decision-making power to an ethics committee and held that legal protection for termination-of-care participants could be provided only by the courts. Although the court thought it might be desirable for a judge to consider the conclusions of an ethics committee in a given case, it warned:

We take a dim view of any attempt to shift the ultimate decision-making responsibility away from the duly-established courts of proper jurisdiction to any committee, panel, or group, ad hoc or permanent. Thus, we reject the approach adopted by the New Jersey Supreme Court in the Quinlan case of entrusting the decision whether to continue artificial life support to the patient's guardian, family, attending doctors, and hospital "ethics committee." 62

We do not view the judicial resolution of this most difficult and awesome question—whether potentially life-prolonging treatment should be withheld from a person incapable of making his own decision—as constituting a "gratuitous encroachment" on the domain of medical expertise. Rather, such questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is our responsibility and that of the lower court, and is not to be entrusted to any other group purporting to represent the "morality and conscience of our society," no matter how highly motivated or impressively constituted. 63

Whereas the reaction of the medical community to Quinlan had been warm, its reaction to Saikewicz was heated. An editorial in the New England Journal of Medicine accused the Supreme Judicial Court of wanting to "play doctor" and saw the Saikewicz decision as evidencing "total distrust of physicians' judgment" in termination of care cases:

Traditionally, doctors responsible for the care of "incompetent" patients have abided by the wishes of the next of kin, who are, of course, greatly influenced by the doctor's professional opinion. In the absence of relatives, physicians have customarily used their own best judgment, aided by the advice of colleagues and frequently the opinions of other health professionals, ministers and lawyers; sometimes they are also advised by special hospital committees organized for this purpose. 64

The argument was that these "life-and-death" decisions were essentially medical in nature and therefore should be left to those who are experts in medicine. But, as a number of commentators, including this author, 65 have pointed out, these decisions are not merely

62. Id. at 758, 370 N.E.2d at 434.
63. Id. at 759, 370 N.E.2d at 435.
medical in nature. Although it is within the expertise and authority of doctors to make determinations regarding diagnosis, prognosis, and treatment alternatives available to a patient, they have no expertise nor delegated authority to determine what the patient will accept by way of treatment—be he competent or incompetent. Nor do physicians have the training, the authority, or the institutional framework needed for dealing with the issues of societal ethics raised by these decisions.

Cases like Saikewicz and Quinlan raise questions that implicate basic values in our society, and the answers that are given to these questions can have profound consequences in situations seemingly far removed from the case at hand. If it is justifiable to remove Karen Quinlan from a respirator in order to let her die with dignity, why is it not justifiable to take other steps, such as injecting her with a lethal but painless drug, when she continues to breathe on her own once the respirator is removed? Is it because there is some important difference between acts of omission and those of commission? If so, why is the difference considered important and why is it that “pulling the plug” is considered an act of omission? If we may not consider Joseph Saikewicz’s profoundly retarded state in weighing the value of continued life to him, why is that we may take into consideration the minimal value to Karen Quinlan of a future “vegetative” existence? We do, in fact, allow abortions to women who discover that they are pregnant with a child who is likely to be born with some level of mental retardation. Indeed, we allow abortions on all sorts of grounds which relate not to the best interests of the child but to the best interests of the mother and her family. Why should we at the moment of birth suddenly become restricted to considering only the best interests of the individual whose life is in question? If we are not to back into answers to these questions in a way which is ultimately destructive of our society, we must early on see to it that they are answered within a system which forces us, among other things, to face potential consequences as we decide individual cases.

As I have said elsewhere:

The choice between doctors and courts of law as proxy decision makers for incompetents is not primarily a decision between two kinds of people on the basis of their relative competence as individual decision makers. It is not a question of whether doctors or judges are better trained to make life-and-death decisions for persons who cannot decide for themselves. Properly viewed, the choice is between, on the one hand, unsystematic determination by individual
persons, be they doctors or judges, and, on the other hand, the type of systematic determination of questions which characterizes the ideal of Anglo-American court systems. Hence, in deciding to entrust life-and-death decision making for incompetents to the court systems rather than to individual doctors, the Saikewicz court was not expressing distrust for doctors. Rather the court was expressing its special faith in the judicial system by requiring for the deciding of these very important questions the special qualities of process that characterize the ideal of our courts and give empirical content to the concept of "the rule of law." 66

One fundamental aspect of this process is the fact that the judicial decisions are supposed to be principled. When a judge decides the case before him, he must do so in terms of a principle that is applicable to other cases as well. Unless the court is ready to overrule earlier cases, the principle must be consistent with what has been done before. At the same time, the court must anticipate future cases that may come before it, since today's decision will be precedent for tomorrow's. Of course, there is room here for fine tuning of principles when fact situations arise which are significantly unlike those which may have been anticipated earlier. Thus, a principle which now seems to have been stated in too-sweeping form in an earlier case may be cut back so as to exclude a case that comes within the principle's letter but not its spirit. On the other hand, a principle that seems to have been stated in too-limited form may be extended to cover a case that comes under the principle's spirit but not its letter. "All occasions do not arise at once," Lord Mansfield once observed, "a statute very seldom can take in all cases, therefore, the common law, that works itself pure by rules drawn from the fountain of justice, is for this reason superior to an act of parliament." 67 Professor Lon Fuller has made much the same point with an example from Wittgenstein:

Someone says to me: "Show the children a game." I teach them gaming with dice and the other says "I did not mean that sort of game." Must the exclusion of the game with dice have come before his mind before he gave me the order? 68

A second critical quality of the judicial process is its effort to keep the decision-maker impartial. Only those facts that are made relevant by the legal principle that is to be applied are to be considered in reaching a decision. Of course, judges are human, so the law does

66. Id at 346-47.
67. Omychund v. Barker, 26 ENG. REP. 15, 22-23 (Ch. 1744).
68. Fuller, Human Purpose and Natural Law, 53 J. PHILOS. 697, 700 (1956).
not rely merely on the judge's self-control to keep him from rendering
decisions based in part on prejudicial irrelevancies. As much as
possible, the system tries to provide to litigants triers of fact who
know nothing about the case before evidence is introduced. Then, at
trial, rules of evidence provide advocates with the right to object to
the introduction of evidence which is legally irrelevant.

The presence of these advocates introduces a third important ele-
ment of process—the adversary system. As unsavory as this aspect of
Anglo-American procedure may seem to the outsider, it deals sens-
ibly with some inescapable facts about human nature. The first is
the fact that judges, like other human beings, prefer to cut short the
anxiety of indecision by reaching decisions as quickly as possible.
The second is that lawyers, if placed in a competitive situation, will
prefer winning to losing and thus will do all they can to counteract
any tendency they may detect on the part of the judge to precipitately
decide a case against them. "Failure generally attends the attempt to
dispense with the distinct roles traditionally implied in
adjudication," a body of distinguished American legal scholars and
practitioners once warned. "What generally occurs in practice [where
advocates have been eliminated] is that at some early point a familiar
pattern will seem to emerge from the evidence; an accustomed label
is waiting for the case and, without awaiting further proofs, this label
is promptly assigned to it."69 Within prescribed limits, the advocate
is encouraged to harness his competitive instincts toward pressing
upon the judge all of the evidence and arguments that support the
case of his client and to keep out all evidence which would undo the
impartiality of the judge toward his client. Moreover, since the ad-
vocate's job is not limited to proof of facts, he also plays a critical role
in the development of the governing principles. As Justice Holmes
has observed:

The external and immediate result of an advocate's work is but to win or lose a
case. But remotely what the lawyer does is to establish, develop, or illuminate
rules which are to govern the conduct of men for centuries; to set in motion
principles and influences which shape the thought and action of generations
which know not by whose command they move.70

69. Report of the Joint Conference on Professional Responsibility of the American Bar
an empirical study that supports the conclusions of the Joint Conference Report, see J. THIBAUT

70. Holmes, Eulogy on S. Bartlett. in SPEECHES at 43 (1913).
It is the contending advocates who, in the first instance, force the judge's attention to adjudicative and legislative facts related to the fairness and practical value of the rules which they wish to have him mold to their case. And it is they who force him to consider the consequences in future cases, of adopting a principle opposed to the interests of their clients in the present case.

The last, and perhaps most important, element of judicial process which needs to be addressed is its public nature. What the judge does is done for the most part in a goldfish bowl. Sir William Blackstone characterized a trial as in "open examination of witnesses, viva voce, in the presence of all mankind." Not only are the hearings open to the public and the press, but decisions involving important questions of law most often end up in the form of published written opinions. As a result, many more minds and mouths than those of the parties' advocates have the chance to participate in the judge's effort at the development of legal principles. The judge knows that his opinion may come under scholarly scrutiny in law reviews and scholarly texts. He knows as well that it may become grist for criticism and even humorous jibes in innumerable law school classes. And, through coverage in the popular media, the whole of society may come to play a role in setting limits on judges' rulings. Controversial decisions such as *Quinlan* and *Saikewicz* have in fact provoked continuing and widespread public dialogue. Gradually, such dialogue may develop lines of consensus regarding societal values upon which the courts can draw.

But what makes publicity the most important of the elements of judicial process is its tendency to protect all elements of the process from serious erosion. One need not be a cynic to observe that the operation of the judicial process in the real world endemically departs, in one way or another, from the ideal of "detached but passionate investigation and decision" which was held high in *Saikewicz*. But the public nature of these departures provides the opportunity for discovery and criticism which may force the process back onto course. The judge who renders biased or unprincipled decisions is

72. 3 W. Blackstone, *Commentaries* *373.*
readily subject to exposure and censure. Failures of advocacy on the part of counsel—whether self-imposed or court-mandated—may lead to public embarrassment. And even the decision to withdraw a particular proceeding from public view is subject to public criticism since that decision itself must normally be made public. It should come as no surprise, then, that Jeremy Bentham, who disagreed with Blackstone on so many other issues, agreed heartily regarding the importance of publicity to public process. "Without publicity," he said, "all other checks are insufficient: in comparison of publicity, all other checks are of small account. Recordation, appeal, whatever other institutions might present themselves in the character of checks, would be found to operate rather as cloaks than checks; as cloaks in reality, as checks only in appearance." Of course, these elements of process are not present when physicians make decisions for incompetents. Medical personnel are placed under no institutional constraints to make their termination-of-care decisions consistent with each other under some articulated principle, to base them only upon facts relevant to such a principle, to open them to zealous advocacy of all interests, or to make all aspects of the process available to public scrutiny. As I have observed previously:

My own experience in working with medical personnel faced with medical-ethical problems suggests that there is no consistency as to principle from doctor to doctor or time to time, and that any given physician may not be able to articulate and defend a principle which justifies his particular decision. This should come as no surprise, of course. Doctors are so preoccupied making the medical decisions for which they have been trained, they have neither the time nor training for developing consistently applied principles for medical-ethical decisions. As a result, they accommodate these constraints by reaching a decision that will leave them feeling the least misgiving. Nonetheless, these misgivings are still sufficiently great to result in a remarkable degree of "burn out" by staff in intensive care units.

Under the circumstances, one might have expected that physicians would have welcomed Saikewicz as an opportunity to give up responsibility for these troubling decisions and turn them over to the courts. However, as we have seen, that was not the reaction. Instead, the

73. It was, for example, the order of the Illinois Supreme Court sealing the records in a recent infanticide case that led to furor in the press over that case and the secrecy with which it was surrounded. See Rights in Conflict: Who Lives, Who Dies, and Who Decides?, Chicago Tribune, May 2, 1982, § 1, at 6, col. 1.
74. J. BENTHAM, RATIONALE OF JUDICIAL EVIDENCE 524 (1827).
reaction was to feel misunderstood, unappreciated, and hurt and to threaten civil disobedience:

"No-treatment" or "withdrawal-of-treatment" decisions for incompetent patients are being made all the time throughout the hospitals of Massachusetts, but very few are being brought to judicial attention. The reasons are obvious enough, and are implicit in what has already been said. Neither relatives nor physicians want to go to the trouble or expense of obtaining a court judgment, particularly when they have no confidence that the judgment will be medically or ethically sound. If there is real doubt that the court will consider the quality of life involved, and if the medical recommendations of the physicians in charge of the case, as well as the wishes of the family, are to be examined in an adversarial courtroom proceeding, then most families and physicians would prefer to stay away from the courts. At present, it commonly is believed that they take very little risk in doing so, but that view could of course be changed by future developments.1

The gauntlet had been thrown down at the feet of the judiciary, and it is still unclear how the courts will ultimately respond. Even in Massachusetts, decisions since Saikewicz have shown wavering regarding the question of whether termination-of-care decisions are properly to be brought to the courts. Seven months after the opinion in Saikewicz, the intermediate Appeals Court of Massachusetts rendered a decision which seemed to place it on the side of the doctors. That decision, In re Dinnerstein,77 arose out of an action seeking a court declaration as to whether physicians attending an incompetent patient terminally ill with Alzheimer's disease could lawfully "no-code"78 the patient—i.e., direct that no efforts be made to resuscitate her in the event of cardiac or respiratory arrest. Plaintiffs argued that the court should find such action lawful on either of two grounds. One was based on the substituted judgment test of Saikewicz: that the facts justified a finding that Mrs. Dinnerstein would request a "no-code" if she were competent to do so. The other ground (preferred by the plaintiffs), was that a doctor may lawfully "no-code" a patient without prior court approval. The

76. Relman, supra note 3, at 241.
78. The term is one of several items of medical jargon which have grown up around the development of advanced methods of cardiopulmonary resuscitation (CPR). One "codes" a patient when one signals for teams of medical personnel to descend on the patient for the purpose of giving him emergency CPR. This term derives from the "Code 99" or "Code Blue" that would be announced over the hospital intercommunications system for the purpose of mustering all available personnel to the patient's room. One "no-codes" a patient when one gives orders (written or verbal) that no CPR or other extraordinary resuscitative measures are to be given the patient in the event of cardiac or respiratory arrest. A "no-code" is sometimes called an ONTR (order not to resuscitate) or DNR (do not resuscitate).
appeals court held for the plaintiffs on the latter ground by concluding that the case presented:

[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, and subject to court review only to the extent that it may be contended that he has failed to exercise "the degree of care and skill of the average qualified practitioner, taking into account the advances in the profession."[8]

In reaching that conclusion, the court attempted to distinguish Saikewicz on grounds which, as I have argued elsewhere,[80] are patently insufficient. But the real grounds for the decision are apparent: the appeals court had openly retreated in the face of the medical community's stance of massive resistance to Saikewicz. As the court said:

[Saikewicz] would appear to establish a rule of law that unless such a court determination has been obtained, it is the duty of a doctor attending an incompetent patient to employ whatever lifesaving or life-prolonging treatments the current state of the art has put in his hands. As it cannot be assumed that legal proceedings such as the present one will be initiated in respect of more than a small fraction of all terminally ill or dying elderly patients, the Saikewicz case, if read to apply to the natural death of a terminally ill patient by cardiac or respiratory arrest, would require attempts to resuscitate dying patients in most cases, without exercise of medical judgment, even when the course of action could aptly be characterized as a pointless, even cruel, prolongation of the act of dying.[81]

Dinnerstein, which had gone beyond Quinlan by not requiring ethics committee approval of physicians' termination-of-care decisions, was received by the medical community with a sense of cautious relief. The caution was occasioned by the fact that the decision had not come from the highest court of the state. There was uncertainty about the extent to which Dinnerstein could be considered to state the law of the commonwealth.[82] Thus, it was hoped that the Supreme Judicial Court would clarify matters when it faced the same issues two years later in the case of In re Spring.[83] That case had first come before the appeals court, which had decided it in a fashion consistent with its

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79. Dinnerstein, supra note 77, at 475, 380 N.E.2d at 139.
80. Baron, supra note 65, at 369 n.65.
81. Dinnerstein, supra note 77, at 471, 380 N.E.2d at 137.
decision in Dinnerstein. Earle Spring was a seventy-eight-year-old man who had gone into rapid mental decline contemporaneously with his succumbing to a series of illnesses which had culminated in "end stage kidney disease." His physical condition required that he be taken to a hospital three times a week and connected to a machine for five-hour stints of dialysis. There was evidence that Mr. Spring, who had previously led a healthy and active life, was resisting the treatments which were uncomfortable and debilitating. Mr. Spring's son had sought court authority as his guardian to have the dialysis stopped on the ground that, were his father not senile, he would prefer death over continued treatment. The trial court ultimately determined that "the ward's attending physician, together with the ward's wife and son, are to make the decision with reference to the continuance or termination of the dialysis treatment." That decision was affirmed by the appeals court in language which echoed its earlier opinion in Dinnerstein:

The importance of the role of the family and the doctor is highlighted by the self-evident fact that the vast majority of treatment decisions relative to persons who are incompetent by reason of senility or retardation are made for them by their family and the doctor, without court proceedings.85

The Supreme Judicial Court granted expedited review of the appeals court decision and arguments were heard only three weeks later. Four days after that it issued an order reversing the appeals court. "[I]t was error," the court said, "to delegate the decision to the attending physician and the ward's wife and son."86 It seemed a clear setback for the doctors, but, when the court's opinion in the case appeared some four months later, it appeared as if they had actually won something of a victory—albeit a victory stated entirely in the form of dictum rather than holding. "Neither the present case nor the Saikewicz case involved the legality of action taken without judicial authority," the court said, "and our opinions should not be taken to establish any requirement of prior judicial approval that would not otherwise exist."87 As to whether there is any risk of criminal liability for the doctor who acts without such approval before causing the death of a patient, the court hints that the answer is no so long as the doctor acts "on a good faith judgment that is not

84. Id. at 1211, 405 N.E.2d at 118.
86. Spring. supra note 83. at 1210, 405 N.E.2d at 117.
87. Id. at 1216, 405 N.E.2d at 120.
grievously unreasonable by medical standards." The court also hints at a no answer to the question of civil liability for battery. "Unless there is an emergency or an overriding state interest, medical treatment of a competent patient without his consent is said to be a battery, but there is serious question whether it is useful to think about medical treatment of incompetent patients in terms of battery." Besides, maybe consent could be given by some person other than the patient—a parent, spouse, or guardian. And, even if not, "[w]ithholding of treatment does not fit neatly into the category of battery" since the doctor need not ever touch the patient in order to withhold treatment. As a result, the standard of liability which would seem to apply to a doctor who withholds treatment from an incompetent patient is that merely of whether or not he has been negligent, and that standard is not a function of whether or not prior consent has been obtained from a court. "Thus absence of court approval does not result in automatic civil liability for withholding treatment. . . ."91

"What, then, is the significance of our disapproval [in Saikewicz] of a shift of ultimate responsibility away from the courts?" the court asks. The answer seems to reduce to a piddling, procedural point the court's earlier bold statement of commitment to the process of "passionate but detached investigation and decision making." "When a court is properly presented with the legal question, whether treatment may be withheld," it states, "it must decide that question and not delegate it to some private person or group." In light of the fact that no one had ever suggested such a delegation in Saikewicz, it is hard to take seriously the court's suggestion that this was all that it meant to say in that case. As a result, Spring seemed to constitute an acceptance of the retreat represented by Dinnerstein, and the court hinted as much. "Without approving all that is said in the opinion of the Appeals Court," the court stated, "we think the result reached on the facts shown in that case was consistent with our holding in the Saikewicz case."94

88. Id. at 1217, 405 N.E.2d at 121.
89. Id. at 1218, 405 N.E.2d at 121 (emphasis supplied).
90. Id. at 1218, 405 N.E.2d at 122.
91. Id. at 1219, 405 N.E.2d at 122.
92. Id.
93. Id.
94. Id. at 1215, 405 N.E.2d at 120.
However, cases decided by the Supreme Judicial Court since \textit{Spring} suggest that its dictum in that case will not prevent it from gradually resuscitating \textit{Saikewicz} as the need for doing so manifests itself. In \textit{Guardianship of Roe},\textsuperscript{95} the court held in 1981 that court approval must be sought before antipsychotic drugs may be forced upon an incompetent mental patient on a nonemergency basis.

The question presented by the ward's refusal of antipsychotic drugs is only incidentally a medical question. Absent an overwhelming State interest, a competent individual has the right to refuse such treatment. To deny this right 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 order to accord proper respect to this basic right of all individuals, we feel that if an incompetent individual refuses antipsychotic drugs, those charged with his protection must seek a judicial determination of substituted judgment. No medical expertise is required in such an inquiry, although medical advice and opinion is to be used for the same purposes and sought to the same extent that the incompetent individual would, if he were competent. We emphasize that the determination is \textit{not} what is medically in the ward's best interests—a determination better left to those with extensive medical training and experience. The determination of what the incompetent individual would do if competent will probe the incompetent individual's values and preferences, and such an inquiry, in a case involving antipsychotic drugs, is best made in courts of competent jurisdiction.\textsuperscript{96}

In 1982, the court determined that prior court approval should be required in two additional categories of cases. In the controversial "Baby Billy" case,\textsuperscript{97} the court held that the facts justified no-coding a terminally ill infant on a substituted judgment basis and that the prior court determination which had been sought on the question was mandatory in such a case.

\[W\]e conclude that, although this case appears similar to \textit{Dinnerstein} because the entry of a "no-code" order is in issue and the child is terminally ill, the principles enunciated in \textit{Saikewicz} are applicable. Absent a loving family with whom physicians may consult regarding the entry of a "no-code" order, this issue is best resolved by requiring a judicial determination in accordance with the substituted judgment doctrine enunciated in \textit{Saikewicz}.\textsuperscript{98}

And \textit{In re Moe},\textsuperscript{99} the court was presented for the first time with the question of whether "substituted judgment" could be exercised for a mentally retarded ward on the question of whether she should accept

\begin{itemize}
  \item \textsuperscript{95} \textit{Supra} note 58.
  \item \textsuperscript{96} \textit{Id.} at 1001–2, 421 N.E.2d at 51–52.
  \item \textsuperscript{97} \textit{Custody of a Minor}, 385 Mass. 697, 434 N.E.2d 601 (1982).
  \item \textsuperscript{98} \textit{Id.} at 709–10, 434 N.E.2d at 608.
  \item \textsuperscript{99} 385 Mass. 555, 432 N.E.2d 712 (1982).
\end{itemize}
sterilization as the birth control method of choice. The answer was yes, but the court added:

Since sterilization is an extraordinary and highly intrusive form of medical treatment that irreversibly extinguishes the ward's fundamental right of procreative choice, we conclude that a guardian must obtain a proper judicial order for the procedure before he or she can validly consent to it. Guardians and parents, therefore, absent statutory or judicial authorization, cannot consent to the sterilization of a ward in their care or custody.100

Perhaps inadvertently, the court also cited Saikewicz, Spring, and Roe for the following sweeping proposition: "[O]ur prior cases have established that prior judicial approval is required before a guardian may consent to administering or withholding of proposed extraordinary medical treatment."101

While there are cases from other states in which courts have determined that they have jurisdiction to decide questions regarding terminating life support for incompetent patients, there are few decisions other than Quinlan and Saikewicz as to when court approval is required. A Delaware case, Severns v. Wilmington Medical Center,102 raises the question and then seems to leave it for the determination by the state legislature.103 The "Brother Fox" case, Eichner v. Dillon,104 deals with the issue head-on answering it differently in the Court of Appeals of New York than it had been answered in the intermediate appeals court of that state. The Appellate Division of the New York Supreme Court had adopted the approach of Saikewicz and gone beyond it, laying out a complicated procedure in which the court was to review medical as well as societal questions that were raised in each case.105 The court of appeals set aside this aspect of the decision of the appellate division, stating that "[i]f it is desirable to enlarge the role of the courts in cases involving discontinuance of life-sustaining treatment for incompetents by establishing, as the appellate division suggested in the Eichner case, a mandatory procedure of successive approvals by physicians, hospital personnel, relatives and the courts, the

100. Id. at 559, 432 N.E.2d at 716-17.
101. Id. at 559, 432 N.E.2d at 716.
102. 421 A.2d 1334 (Del. 1980).
103. Id. at 1346.
change should come from the Legislature."

Of course, it is easy to see why the courts would be reluctant to require that all such decisions should be brought before them. Besides the resistance of the medical community that such a requirement would create, there are, as the physicians are fond of pointing out, so many such decisions that must be made every day they would threaten to completely overwhelm the courts. However, the "substituted judgment" aspect of such cases could be easily taken care of in many cases. Legislation empowering individuals to write "living wills"—which are designed to handle in advance the question of what the patient would want for himself were he to become incompetent—has been passed in thirteen states and is pending in twenty-two others. Moreover, there is nothing to suggest that the courts do not have the power to create such an institution without express legislative authority. Where such expressions of advance authority were availed of with regularity, the "substituted judgment" questions would remain largely only for children and the mentally retarded. Left for the courts also, of course, would be the difficult job of working out, on a case-by-case basis, all of the difficult societal-ethical issues as to which principles for consistent decision making is so badly needed. But even this task should become less burdensome as time goes on. As I have suggested previously, the courts should be able gradually to carve out classes of cases for which advance court ap-

106. Eichner v. Dillon, supra note 104, at 382–83, 438 N.Y.S.2d at 276, 420 N.E.2d at 74. In re Storar, a case decided with Eichner v. Dillon and sharing its opinion and citation in the court of appeals, is noteworthy for also seeming to leave important questions to the legislature. That case involved a profoundly retarded and terminally ill adult whose mother had refused to give her consent to continued life-prolonging treatment on the ground that it was bothersome, intrusive, and outweighed by the benefits of permitting her son a peaceful death. While allowing a proxy decision for "death with dignity" for Brother Fox, because there was evidence in that case to justify that substituted judgment, the court denied John Storar's mother the opportunity to make such a decision for him. Unfortunately, the short opinion can be read as disallowing, until the New York legislature changes the law, any decision to terminate life-prolonging care in cases where there is no evidence to support a substituted judgment. On the other hand, some of the language in the opinion suggests that the court is merely holding that, in the absence of such evidence, a rigid "best interests" test is to be applied and that Mrs. Storar's decision did not pass that test. Id. at 380–81, 438 N.Y.S.2d at 275, 420 N.E.2d at 73.


109. Baron, supra note 65, at 359.
proval is not required. The Appeals Court of Massachusetts did just this in the Dinnerstein case. 110 I think they may have been right in doing so, but for reasons other than those primarily relied upon by the court. 111 The courts have done this also with the cases involving refusal of lifesaving care by competent patients. The principle of patient autonomy in such situations is sufficiently well established by now that cases need to be brought only where a novel fact situation raises some doubt under the rationale of the earlier decisions. 112 But such classes of exception cannot be developed in the abstract. The courts can develop substantive principles for such classes of cases and conclude that the principles can be safely applied without court intervention to the facts of each case as it arises, only out of a process that, in the first instance, requires them to confront them all.

Of course, more than the sheer numbers of such cases makes the courts reluctant to take on this task. It is likely that it is the prospect of being forced continually to confront the "future shock" problems that the cases raise that disturbs judges the most about taking such cases on as a regular fare for decision. Difficult as such decisions are for the doctors to make, doctors at least have the luxury of making them in secret and in a fashion which may allow them to believe that they are not even making a decision. As we have seen, the process requirements of the "rule of law" do not allow this luxury to judges. It may well be for this very reason that the Supreme Court decisions mentioned earlier, Roe v. Wade and Colautti v. Franklin, show their distressing tendency to throw a cloak over difficult ethical decisions by calling them "medical questions" and delegating them to doctors. In contrast to this example of unwillingness to take on the difficult tasks of statecraft is the image which has been left by the work of the great American jurist Lemuel Shaw. During thirty years as Chief Justice of the Massachusetts Supreme Judicial Court, Shaw shaped

110. Supra note 77.
111. What would justify the decision is that the medical facts of the case would have presented Mrs. Dinnerstein with no real choice if she were competent. It is arguable that anyone would prefer no-coding over being kept alive in Mrs. Dinnerstein's hopeless condition. Thus the court could have used the case to carve out an exception to the requirement of advance court approval for those cases whose medical facts present such an open-and-shut issue of substituted judgment. See Baron, supra note 65, at 362 n.65. The Quinlan case arguably presents the same sort of situation and should be read as articulating the same narrow rule. See Annas, supra note 47.
112. For example, Commissioner of Correction v. Myers, supra note 8.
the common law in Massachusetts to respond to such nineteenth-century challenges as the rise of the railroads, the development of steam power, the growing use of the factory system, and the spread of the corporate form of doing business. One contemporary said of Shaw: "If the simplest motion were made, Chief Justice Shaw had to unlimber the heavy artillery of his mind, go down to the roots of the question, consider the matter from all possible relations, and deal with it as if he were besieging a fortress." The forces which were transforming society in the America of the nineteenth century must have been every bit as frightening at the time, as are, today, the forces which threaten to transform contemporary American society. Yet, Shaw took them on with a courage, creativity, and intelligence which earned him the title, America's Greatest Magistrate. His landmark decisions in nearly every area of the law earned him a nationwide reputation and provided a foundation for modern American jurisprudence.

Happily, while debate continues on the question of whether Saikewicz-type cases must be brought to court, enough such cases are being brought to court that "future shock" issues are being faced by judges and substantive principles are being developed for dealing with them. As might be expected of any beginning effort, the development is gradual and random and the principles are largely inchoate. On the one hand, very little has been done by way of facing the important question of the significance of distinguishing between acts and omissions to act. For the most part the courts have acted as if common sense makes clear that certain acts under certain circumstances merely "allow nature to take its course" while others are clear acts of homicide. Sometimes they employ the screen of distinguishing medical treatment which is "lifesaving" from that which is merely "life prolonging." However, on the other issues, the courts have mounted a much more forthright attack and seem gradually to be developing a body of ever-refining principle. One

114. See, e.g., Quinlan, supra note 39 at 43, 355 A.2d at 665.
115. Saikewicz, supra note 53, at 741-42, 370 N.E.2d at 425-26. However, that distinction was implicitly eroded by the Appeals Court of Massachusetts in Lane v. Candura, supra note 2, and seemingly abandoned by the Supreme Judicial Court in Commissioner of Correction v. Myers, supra note 8, in favor of weighing of the "obtrusiveness" of the treatment which is proposed.
such issue is that of the extent to which a competent person may choose death over continued medical treatment. As was earlier mentioned, the courts were slow to recognize such a right at all. In Quinlan and Saikewicz they recognized such a right, but only where it was not outweighed by certain state interests which included:

1. the preservation of human life;
2. the protection of the interests of innocent third parties;
3. the prevention of suicide; and
4. maintaining the ethical integrity of the medical profession.\textsuperscript{116}

Although the importance of such state interests is still mentioned in later cases,\textsuperscript{117} there appears to be only one recent case in which they were held to outweigh a patient's right to refuse treatment—that being Commissioner of Correction v. Myers,\textsuperscript{118} an unusual Massachusetts case in which a prisoner refused to submit to kidney dialysis unless the state agreed to transfer him to a minimum security prison. The clear trend seems to be toward recognizing increased personal autonomy over one's physical and psychological health and the length of one's life.

The same trend toward autonomy is evident in cases which deal with the subtle and difficult issues surrounding the notion of "legal incompetence." As we saw earlier, the courts are unwilling to equate incompetence with mere irrationality—even "medical irrationality."\textsuperscript{119} They are also unwilling to equate it with insanity.\textsuperscript{120} The presumption in every case is in favor of competence, and new notions are developing of "limited incompetence" and "limited guardianships" even for those cases where it can be proved that the proposed ward is incapable of making certain decisions for himself.\textsuperscript{121} Finally, the ward, whether he is incompetent by reason of minority or by reason of mental defect, is being looked to more and more as a source of direction to the guardian or court in the effort to make a "substituted judgment."\textsuperscript{122}

\textsuperscript{116} Id. at 741, 370 N.E.2d at 425.
\textsuperscript{117} For example, In re Spring, supra note 83.
\textsuperscript{118} Supra note 8.
\textsuperscript{119} See Lane v. Candura, supra note 2.
\textsuperscript{120} In Massachusetts, this is provided for in part by statute, see Massachusetts General Law ch. 123, § 25. However, it is recognized as well as by case law. See Boyd v. Board of Registrars of Voters, 368 Mass. 631, 334 N.E.2d 629 (1975).
the courts' use of the "substituted judgment" test and the almost complete exclusion of consideration of interests other than the ward's also represent commitment to the notion of personal autonomy. As we have seen, this seems to have become the dominant, if not exclusive, test for making medical decisions of all sorts for children and other persons held to be legally incompetent.

Obviously, the fact that the courts have relatively consistently stated these high-sounding principles does not mean that they have consistently and impartially applied them in fact. In at least two cases it is rather clear that they have not. In the 1979 California case In re Phillip B., the Court of Appeal for the First District let stand a lower-court decision permitting parental veto of an operation to correct a congenital heart defect in a twelve-year-old mentally retarded child. Without the surgery, Phillip would live at most another twenty years, and, during that time, he would "suffer from a progressive loss of energy and vitality until he is forced to lead a bed-to-chair existence." In part because his parents had refused to consent to medical treatment some six years earlier, Phillip's physical condition created a risk of mortality from the operation of from 5 to 10 percent, but his doctor believed that the risks were clearly outweighed by the potential benefits to him. Despite the fact that the parents had institutionalized Phillip at birth and despite the fact that the court states at one point that "the underlying consideration is the child's welfare and whether his best interests will be served by the medical treatment," the court allowed the parental decision to stand while observing: "[S]ince the state should usually defer to the wishes of the parents, it has a serious burden of justification before abridging parental autonomy by substituting its judgment for that of the parents." As commentators have noted, it is hard to believe that the court would have reached this same conclusion in a case where the child was not mentally retarded. Therefore, the case seems to have been decided in part on bases other than the substituted judgment of the child, i.e., judicial bias based, presumably, upon the court's sense

123. For one exception, see Nathan v. Farinelli, supra note 27.
125. Id. at 800, 156 Cal. Rptr. at 50.
126. Id. at 802, 156 Cal. Rptr. at 51.
127. Id.
of the lessened value to the parents and society of the life of a mentally retarded child.

More shocking failures of judicial process than just lack of impartiality were involved in the second, and very recent, case. There, the Supreme Court of Indiana undid as well the public nature of the proceedings by condoning a series of secret court hearings and ordering records sealed. Newspaper reports tell us that these secret proceedings authorized the parents of “Infant Doe” to instruct his doctors to allow him to die of starvation rather than to surgically remove an esophageal blockage which prevented him from taking nourishment by mouth. The reason, as with Phillip B., was the presence of Down’s syndrome with its prognosis of some degree of mental retardation. The newspaper accounts suggest that the decision purported to be based, at least in part, on a theory of substituted judgment. “These people loved the baby,” one county official is quoted as saying. “It was not an act of anything but absolute love. This was a parent’s ultimate act of love, given the child’s medical condition.”

Do these cases, with their failures of basic elements of the judicial process, demonstrate that the process virtues ascribed to the judiciary earlier in this article are illusory? By way of answer, consider the fact that both cases, as a result of having been brought to court, became subject to widespread public discussion and criticism. This has been true even of the “Infant Doe” case, which was supposed to have been kept secret, and debate over the case continues on radio, on television, and in the newspapers even as I write. Physicians admit that the “Infant Doe” scenario is quietly acted out every day in obstetrical intensive care units across the United States. Because these nonjudicial decisions are made in secrecy, there is no opportunity for public input into the decision-making process despite the fact that attitudes toward the sanctity of life in American society may well be gradually changed thereby. Where such decisions are made in public, the public has an opportunity to clamor for correction of what it may see as departures from the “rule of law”—whether

130. Id.
131. Id.
substantive or procedural. And judges, lawyers, and legal scholars have an opportunity to educate and lead the public in this effort.

The responsibility of the legal profession is especially heavy, it seems to me, to police the system for failures in the basic elements of process. One such failure has been the lack of adequate adversary process in many of these cases. Because the patient in the vast majority of these cases is incompetent, he is unable to retain and direct counsel for the purpose of protecting what he sees as his interests in the case. In the early cases involving kidney transplants from minor-donors, it was assumed that the other parties to the case would carry the burden of adversary development of the record. But neither the hospital, on one side, nor the parents, nominally on the other, could be depended upon to carry the burden of arguing against the donation. Both sides were concerned only with seeing the court do "what was right" and were eager to save the life of the recipient child. Later, in the early bone marrow transplant cases, the courts began to appoint guardians ad litem to represent the interests of the ward. However, in most cases, this improved protection of the ward very little. In addition to the fact that such guardians of the interests of the ward were frequently persons associated with the hospital in question rather than independent advocates, their job assignment was that of investigating the case and coming up with a proposal as to what they considered to be in the best interests of the ward. The job of determining this "best interests" question was ultimately for the judge. Instead of ensuring that this determination was made upon a record made full by advocacy on both sides of the donation question, the guardian ad litem was simply premasticating the "best interests" question on an information base which itself suffered from lack of adversary development. To counter this problem, an article that I wrote with two coauthors proposed:

Courts should be required to appoint guardians ad litem to represent prospective minor donors in all transplant proceedings. The guardian's role should be defined as that of an advocate of the child's interest in not acting as a donor; the guardian should be instructed to present all the evidence and arguments against his ward's donation and to oppose the positions taken by the hospital and family, regardless of the guardian's personal perception of the child's actual interests.

133. Baron, Botsford & Cole, supra note 22, at 181–86.
134. Id.
In transplant cases there are only two possible dispositions, and the parents and the hospital will provide all the evidence and arguments in support of authorization. What is institutionally necessary if the prospective donor is to be protected adequately is not the guardian's more objective opinion whether the operation is in the child's best interests but a party to present the arguments that support denying authorization.135

Subsequently, there was some perceivable increase in the incidence of zealous advocacy on the part of guardians ad litem, including the first case in which a guardian ad litem was successful in preventing donation from his client—a mentally retarded relative in a family that included other candidates.136 And, in recent years, guardians ad litem have performed heroically in a number of "substituted judgment" cases.137 However, less-than-zealous advocacy is still widespread. It is interesting to note that this appears to have been a basic failing of process in both In re Phillip B. and the "Infant Doe" case. One wonders if the other elements of process would have failed if there had been the presence of vigorous advocacy. Even the Saikewicz decision suffered from lack of adversariness. There the guardian ad litem joined the other parties at the original hearing in recommending to the court that Mr. Saikewicz not be given chemotherapy. Presumably because of that, it fell to advocates who intervened at the appellate level to try to introduce into the record "a number of recent empirical studies which cast doubt on the view [presented at trial] that patients over sixty are less successfully treated by chemotherapy."138 The Supreme Judicial Court refused to receive the evidence because "[n]one of these authorities was brought to the consideration of the probate judge."139 However, the court appeared to attempt to head off such problems in future cases by suggesting:

As an aid to the judge . . . , it will often be desirable to appoint a guardian ad litem, sua sponte or on motion, to represent the interests of the person.

135. Id. at 186-87.
137. Perhaps most notable was the performance of Mark I. Berson of the Greenfield, Massachusetts, Bar as guardian ad litem in the Spring case. Despite pressure from all other parties to the case and vilification from the Massachusetts press, he provided his client with all of the protection the situation seemed to require. This included: (1) a successful appeal of the case-in-chief to the Supreme Judicial Court from an adverse decision in the Appeals Court of Massachusetts; and (2) a separate successful appeal to a single justice of the Supreme Judicial Court of the probate judge's subsequent order disallowing the introduction of newly discovered evidence on the question of Mr. Spring's competency. See In re Spring, No. 80-37, (Sup. Jud. Ct., Suffolk County, February 4, 1980).
138. Saikewicz, supra note 53, at 732 n.4, 370 N.E.2d at 421 n.4.
139. Id.
Moreover, we think it appropriate, and highly desirable, in cases such as the one before us to charge the guardian ad litem with an additional responsibility to be discharged if there is a finding of incompetency. This will be the responsibility of presenting to the judge, after as thorough an investigation as time will permit, all reasonable arguments in favor of administering treatment to prolong the life of the individual involved. This will insure that all viewpoints and alternatives will be aggressively pursued and examined at the subsequent hearing where it will be determined whether treatment should or should not be allowed.\textsuperscript{140}

Even under the procedure suggested in \textit{Saikewicz}, there are still patent problems of absence of advocacy in important ways. First, the procedure assumes the appointment of a guardian ad litem before the proposed ward is found to be incompetent. What would seem more appropriate would be the appointment of counsel whose job it is to defend his client from the petitioner's effort to prove him incompetent.\textsuperscript{141} Second, the court should have required that a guardian ad litem be appointed for every patient found to be incompetent unless he already has an advocate representing him.\textsuperscript{142} Third, the procedure provides for advocacy only in those cases where the petition requests that medical care be terminated. Where the petition attempts to force medical care on the patient, the guardian ad litem should present the evidence and arguments in favor of termination of care. Fourth, the guardian ad litem should be directed to play only the role of an advocate and should not mix this role with that of a neutral investigator reporting or making recommendations to the judge.\textsuperscript{143} Finally, in those cases where the petitioner is unwilling to aggressively present either side of the case (as is the case at times with family members), the court should appoint two advocates—each to be responsible for only one side of the case.\textsuperscript{144} However, the \textit{Saikewicz} procedure represented a significant improvement over that which had existed previously. And in the recent \textit{Moe} case, the Supreme Judicial Court improved the procedure still further:

Upon a guardian's petition for an order authorizing the sterilization of his or her ward, the court must appoint a guardian ad litem to represent the ward.

\textsuperscript{140} \textit{Id.} at 757, 370 N.E.2d at 433-34.  
\textsuperscript{142} See Baron, \textit{Assuring Detached but Passionate Investigation and Decision: The Role of Guardians Ad Litem in Saikewicz-type Cases}, 4 AM. J. L. MED. 111, 127-130 (1978).  
\textsuperscript{144} Baron, \textit{supra} note 142, at 128-29.
The guardian ad litem is to be charged with the responsibility of zealously representing the ward, and must have full opportunity to meet with the ward, present proof, cross-examine witnesses at the hearing. In order to guarantee a thorough adversary exploration of the difficult question posed, the guardian ad litem should present all reasonable arguments in favor of the court's denial of the petition so that "all viewpoints and alternatives will be aggressively pursued and examined at the subsequent hearing." This adversary posture will ensure that both sides of each issue which the court must consider are thoroughly aired before findings are made and a decision rendered.

Still more could be asked for the procedure that is under development. But one could do much worse than the process which is developing it—the process of gradual growth of common law that "works itself pure" from case to case.

Winston Churchill is reputed to have once said: "Democracy is the worst of all political systems, except for every other system." Much the same can be said for democracy's companion—the rule of law. Each puts away with "Father Christmas" the notion of an all-wise Platonic philosopher-king capable of promulgating and implementing right rules for the government of society. What we are left with then is each other, and the ongoing task of working out for ourselves institutions and principles which make it possible for us to live together with some measure of happiness. For better or for worse, modern medicine has made the American family an arena in which are raised questions fraught with large implications for the rest of society. In the fifth century B.C., a great Athenian politician observed: "Although only a few may originate a policy, we are all able to judge it." That notion seems to have stood the test of time. "In my course I have known and, according to my measure, have cooperated with great men," Edmund Burke said over two thousand years later, "and I have never yet seen any plan which has not been mended by the observations of those who were much inferior in

145. Supra note 99 at 566-67, 432 N.E.2d at 721.
146. For one thing, the court still envisions the guardian ad litem as serving the inconsistent "mixed roles" of advocate and something else:

The guardian ad litem, in his recommendation should attempt to ascertain the ward's actual preference for sterilization, parenthood, or other means of contraception. Id. at 570, 432 N.E.2d at 722. Emphasis supplied. In making this "recommendation," does the guardian ad litem function as fact investigator, or expert witness, or master? Does he make these recommendations subject to the rules of evidence in open court? If he is a lawyer, does he warn his ward-client that he may breach the attorney-client confidence by testifying regarding the substance of his conversations with his ward-client? See Baron, supra note 143.
147. Pericles, Funeral Oration. in Thucydides, History of the Peloponnesian War, Book II, § 40.
understanding to the person who took the lead in the business." The opportunity to benefit from such observations is maximized when life-and-death questions are answered in our public courts of law; we minimize that opportunity when we leave them to be answered in private by Platonic physician-kings.