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An Appellate Court Shuts Out Parents and Physicians from Care Decisions

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I. INTRODUCTION

Are healthcare professionals required to provide life-sustaining medical treatment regardless of prognosis, parental input, or professional standards? Unfortunately for children, parents, and healthcare providers in the state of Wisconsin, a recent court decision suggests that the answer is "yes." In *Montalvo v. Borkovec*, the Wisconsin Court of Appeals ("the Court") applied the standard for the termination of treatment for incompetent adults with court-appointed guardians to a claim alleging that a physician violated Wisconsin's informed consent statute by performing life-saving resuscitation measures on a prematurely-born infant.[1] The Court concluded that the parents had no right to withhold life-sustaining medical treatment because the infant was not in a persistent vegetative state.[2]

This paper is an analysis of the *Montalvo* decision. It examines the *Montalvo* Court's informed consent analysis, reviews and distinguishes prior Wisconsin Supreme Court cases, *In re Guardianship of L.W.*[3] and *In re Guardianship & Protective Placement of Edna M.F.*,[4] and demonstrates

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1. Montalvo v. Borkovec, 647 N.W.2d 413 (Wis. Ct. App. 2002), *cert. denied*, 653 N.W.2d 890 (Wis. 2002), *and* 538 U.S. 907 (2003).
2. *Id.* at 419.
3. *In re* Guardianship of L.W., 482 N.W.2d 60 (Wis. 1992).
4. *In re* Guardianship & Protective Placement of Edna M.F., 563 N.W.2d 485 (Wis. 1997).

that these prior cases do not apply to medical decision-making for children. We argue that the emergency exception to the informed consent requirement was sufficient to dismiss this claim. Our discussion also critiques the *Montalvo* Court's application of the federal Child Abuse Prevention and Treatment Act (CAPTA) and the Court's public policy considerations as mandates for treatment.[5]

A. Montalvo v. Borkovec: *Facts and Procedural History*

On November 21, 1996, Nancy Montalvo was admitted to St. Mary's Hospital in Milwaukee, Wisconsin with a diagnosis of pre-term labor.[6] An ultrasound at the time of her admission showed that she was twenty-three and 3/7 weeks pregnant; her unborn infant weighed 679 grams.[7] An informed consent agreement for a cesarean procedure was executed prior to delivery of the infant.[8] When attempts to stop labor and prevent a premature birth did not succeed, Dr. Terre Borkovec, an obstetrician, performed a cesarean section.[9] Subsequently, Dr. Brent W. Arnold, a neonatologist, "successfully performed life-saving resuscitation measures" on the infant, Emanuel.[10]

Three years later, Emanuel's parents filed a complaint against St. Mary's Hospital and the three physicians involved in their son's premature delivery.[11] This discussion focuses on the second claim of the case, which alleged that the defendants violated Wisconsin's informed consent statute when they performed "life-saving measures" on Emanuel.[12] The trial court dismissed this claim, ruling that "Wisconsin law does not leave the resuscitation decision upon the birth of a child solely to the parents because

5. The authors in no way endorse or support the claims or positions of the parents and their attorneys in this case. Although we agree with the Court of Appeals of Wisconsin that the claim was properly dismissed, we disagree with the Court's rationale for doing so.

6. *Montalvo*, 647 N.W.2d at 415-16.

7. *Id.* at 416.

8. *Id.*

9. *Id.*

10. *Id.*

11. *See id.* The plaintiffs' complaint consisted of two claims. The first claim alleged that Dr. Terre Borkovec and Dr. Brent W. Arnold violated Wisconsin's informed consent statute in performing the cesarean section procedure, which the trial court dismissed. This first claim was not contested on appeal. The second claim alleged that Dr. Arnold, Dr. Jonathan H. Berkoff, and St. Mary's Hospital negligently violated the informed consent statute when they performed "life-saving measures" on Emanuel. The Court of Appeals affirmed the dismissal of St. Mary's Hospital because the statute places an obligation on physicians, not hospitals, to obtain a patient's informed consent. This article focuses on the second claim related to informed consent and Emanuel's resuscitation. *See id.* at 416, 418.

12. Montalvo v. Borkovec, 647 N.W.2d 413, 416 (Wis. Ct. App. 2002).

of the community's interest in protecting children, and the physicians' commitment to preserving life."[13]

B. The Wisconsin Court of Appeals' Holding and Rationale

According to the Court of Appeals, the plaintiffs claimed that because the physicians did not advise them "of 'the risks or potential consequences of a child born at [twenty-three] or [twenty-four] weeks gestation and/or with a birth weight of less than 750 grams,' consent was not informed and a variety of damages resulted."[14] The Court of Appeals noted that the plaintiffs were not alleging harm to Emanuel as a result of "extraordinary care measures."[15] Instead, the plaintiffs claimed that it should have been *their* decision as Emanuel's parents, rather than the physicians' decision, regarding whether to use these "extraordinary care measures."[16] The Court also noted that the complaint did not allege that Emanuel was disabled due to the defendants' actions.[17]

The Court of Appeals affirmed the trial court's dismissal of the claim and determined that the parents' informed consent was unnecessary.[18] The Court reasoned that no available and viable treatment alternatives existed to trigger the obligation to engage in the informed consent process due to (1) the Wisconsin Supreme Court's decision in *In re Edna M.F.* and (2) the federal Child Abuse Protection and Treatment Act.[19] The Appellate Court also applied the emergency exception to the informed consent requirement and provided public policy considerations in support of its dismissal.[20]

II. ANALYSIS

A. Informed Consent

A logical look at the Court of Appeals' analysis of informed consent in *Montalvo* suggests that the Court may have been confused about this doctrine. On one hand, the Court rationalized that informed consent was not necessary because there were no alternative treatment options available; on the other hand, in applying the emergency exception to Wisconsin's informed consent statute, the Court essentially presumed that informed consent would have been necessary except for the exigent circumstances of

13. *Id.*
14. *Id.*
15. *See id.*
16. *Id.*
17. *Id.*
18. *See* Montalvo v. Borkovec, 647 N.W.2d 413, 420-21 (Wis. Ct. App. 2002).
19. *Id.* at 418-19.
20. *See id.* at 420-21.

the case. The former assertion was an inaccurate interpretation of Wisconsin's informed consent law, while the latter assertion was consistent and applicable to the facts provided in *Montalvo*. The Court made the effort to articulate the reasons why the informed consent requirement did not apply, yet it had simultaneously agreed that the facts met the statutory exception to the requirement. However, if the doctrine of informed consent did not apply, then the exception was not necessary.

1. The Doctrine of Informed Consent in Wisconsin

The doctrine of informed consent developed out of a respect for individual autonomy.[21] Initially, physicians obtained informed consent prior to touching or treating a patient in order to avoid charges of battery.[22] As the doctrine evolved, physicians were required to disclose the risks of non-treatment, as well as information about alternatives to the proposed treatment.[23] Today, lack of informed consent can lead to charges of negligence or battery, depending on the jurisdiction.[24] Wisconsin Statute Section 448.30 codified the common law doctrine of informed consent in Wisconsin: "Any physician who treats a patient shall inform the patient about the availability of all alternate, viable medical modes of treatment and about the benefits and risks of these treatments."[25]

In *Montalvo*, the Court of Appeals interpreted Wisconsin Statute Section 448.30 to mean that informed consent is necessary *only when* there is more than one single treatment alternative available: "Doubtless, the doctrine of informed consent comes into play only when there is a need to make a choice of available, viable alternatives. *In other words, there must be a choice that can be made.*"[26] The Court indicated that the presence of treatment alternatives was the threshold for the informed consent requirement and found that "[t]he second reason why a viable alternative did not exist to *trigger* informed consent [was] the existence of the United States Child Abuse Protection and Treatment Act . . . ."[27] Under the Court's reasoning, informed consent is not required for diagnoses or conditions where only one treatment currently is known or available, and physicians may treat in those cases without informing the patient about the

21. BARRY R. FURROW ET AL., HEALTH LAW CASES, MATERIALS AND PROBLEMS 356 (5th ed. 2004).

22. *Id.* at 357.

23. *Id.* at 357-58.

24. *Id.* (noting further that some medical malpractice reform in the states have abrogated battery as a theory in informed consent cases).

25. WIS. STAT. § 448.30 (2006).

26. Montalvo v. Borkovec, 647 N.W.2d 413, 418 (Wis. Ct. App. 2002) (emphasis added).

27. *Id.* at 419 (emphasis added).

procedure or treatment and potential risks involved. Yet Wisconsin's well-established informed consent law requires that information be provided to the patient *even if there is only one treatment alternative available.*[28] While a physician is not required to inform a patient about treatment alternatives that are not viable or not available,[29] it does not follow that a lack of alternatives negates the need to obtain a patient's informed consent prior to treatment.

Past Wisconsin Supreme Court decisions have set forth the reasons why informed consent is required regardless of whether there is more than one treatment alternative available.[30] These cases demonstrate that the underlying goal of the informed consent requirement is to provide information to the patient. "The concept of informed consent is based on the tenet that in order to make a rational and informed decision about undergoing *a particular treatment* . . . a patient has the right to know about significant potential risks involved *in the proposed treatment or surgery.*"[31] Additionally, "well-settled law provides that a physician, absent exigent circumstances, may not perform a procedure on a competent adult without consent."[32] The Wisconsin Supreme Court did not limit the requirement to provide information only in those situations where multiple treatment options were available.

The crux of the doctrine is to ensure that patients are well informed about the procedure, or choice of procedures, prior to implementation. "In order to insure that a patient can give an informed consent, a 'physician or surgeon is under the duty to provide the patient with such information as may be necessary under the circumstances then existing' to assess the significant potential risks which the patient confronts."[33] This includes information about alternative treatment options: "[Wisconsin Statute Section 448.30] requires physicians to disclose information to patients about the viable medical modes of treatment so that when the patient chooses a method of treatment, that choice is made *knowing* both the reasonable risks and benefits of her decision."[34] The information disclosed may vary from case to case: "[W]hat a physician must disclose is contingent upon what, under the circumstances of a given case, a reasonable

28. *See* WIS. STAT. § 448.30 (2006).

29. *Montalvo*, 647 N.W.2d at 418.

30. *See generally, e.g.*, Johnson *by* Adler v. Kokemoor, 545 N.W.2d 495, 500-03 (Wis. 1996) (describing a series of Wisconsin Supreme Court decisions that developed the doctrine of informed consent).

31. *Id.* at 501 (citing Scaria v. St. Paul Fire & Marine Ins. Co., 227 N.W.2d 647, 652 (Wis. 1975)) (emphasis added).

32. Schrieber v. Physicians Ins., 588 N.W.2d 26, 32 (Wis. 1999).

33. *Johnson*, 545 N.W.2d at 501 (citing *Scaria*, 227 N.W.2d at 652).

34. *Schreiber*, 588 N.W.2d at 30-31 (emphasis added).

person in the patient's position would need to know in order to make an intelligent and informed decision."[35] Wisconsin law recognizes that informed consent not only protects a patient's right to obtain information, but also a patient's right to choose among medically viable treatments.

Informed consent was not required for the *Montalvo* infant's resuscitation; this was not because of an absence of treatment options, but rather because the circumstances were exigent.

2. Emergency Exception Applicable to *Montalvo* Facts

Common law and statute have recognized a longstanding emergency exception to the informed consent requirement.[36] As early as 1931, a court determined that "if a surgeon is confronted with an emergency which endangers the life or health of the patient, it is his duty to do that which the occasion demands within the usual and customary practice . . . without the consent of the patient."[37] The prominent informed consent decision, *Canterbury v. Spence*,[38] also noted this exception. In that decision, a federal court of appeals explained:

> [A]s important as is the patient's right to know, it is greatly outweighed by the magnitudinous circumstances giving rise to the privilege. The first [exception] comes into play when the patient is unconscious or otherwise incapable of consenting, and harm from a failure to treat is imminent and outweighs any harm threatened by the proposed treatment.[39]

The emergency exception to informed consent applies to treatment for children and courts generally will allow a hospital's request to provide life-saving treatment over parental refusal.[40] The rationale for this emergency exception is that the risk of harm in not providing treatment outweighs the risk of harm in not obtaining informed consent.[41]

The Wisconsin Supreme Court recognized the emergency exception in *Scaria v. St. Paul* when it stated, "We do recognize there must be some limitation upon the doctor's duty to disclose risks involved . . . . Likewise, a doctor's duty to inform is further limited in cases of emergency or where

35. *Johnson*, 545 N.W.2d at 504-05 (noting that whether information is material to a patient's decision and therefore requires disclosure is "rooted in the facts and circumstances of the particular case").

36. FURROW, *supra* note 21, at 409.

37. Jackovach v. Yocum, 237 N.W. 444, 449 (Iowa 1931).

38. Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972).

39. *Id.* at 788.

40. WILLIAM L. PROSSER ET AL., CASES AND MATERIALS ON TORTS 97 (9th ed. 1994).

41. *Canterbury*, 464 F.2d at 788-89.

the patient is a child . . . ."[42] The Wisconsin legislature codified the common law set forth in *Scaria*.[43] The Wisconsin informed consent statute provided for six exceptions, including emergencies.[44] "The physician's duty to inform the patient under this section does not require disclosure of . . . [i]nformation in emergencies where failure to provide treatment would be more harmful to the patient than treatment."[45]

The emergency exception to Wisconsin's informed consent statute alone justified dismissal of the *Montalvo* claim. The Court of Appeals wrote, "The allegations suggest that an emergency arose requiring an immediate response . . . ."[46] Dr. Arnold performed life-saving resuscitation measures on Emanuel after the cesarean procedure.[47] According to the Court of Appeals, these circumstances were "exigent."[48] Under the circumstances as described, failing to provide treatment would have been more harmful to the infant than the treatment itself.[49] Again, the plaintiffs were not alleging harm to their son as a result of the measures, described as "life-saving," performed by Dr. Arnold.[50] In rationalizing why Dr. Arnold did not have to engage in the informed consent process, the Court lost sight of the only valid reason he did not have to do so— it was an emergency.

Although not raised as an issue in *Montalvo*, another component of Wisconsin's informed consent common law considers reasonableness when imposing a duty on a physician to obtain a patient's informed consent.[51] Under the common law, a doctor has a duty to make disclosures that appear reasonably necessary under the circumstances to enable an individual to intelligently exercise his or her right to consent.[52] In *Johnson by Adler v. Kokemoor*, the Wisconsin Supreme Court explained that the amount of information that must be provided to the patient varies from case to case and is governed by "what a *reasonable person in the patient's position* would want to know."[53]

It may be argued that by this objective standard, a mother, having consented to a cesarean procedure in order to improve the chances of a live (although premature) birth, would want her infant resuscitated if necessary.

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42. Scaria v. St. Paul Fire & Marine Ins. Co., 227 N.W.2d 647, 653 (Wis. 1975).
43. Johnson *by* Adler v. Kokemoor, 545 N.W.2d 495, 501 (Wis. 1996).
44. WIS. STAT. § 448.30 (5) (2006).
45. *Id.*
46. Montalvo v. Borkovec, 647 N.W.2d 413, 420 (Wis. Ct. App. 2002).
47. *Id.*
48. *Id.*
49. *See id.*
50. *Id.* at 416.
51. Scaria v. St. Paul Fire & Marine Ins. Co., 227 N.W.2d 647, 654 (Wis. 1975).
52. *Id.*
53. Johnson *by* Adler v. Kokemoor, 545 N.W.2d 495, 502-03 (Wis. 1996) (emphasis added).

Would a reasonable person consent to a cesarean procedure in order to improve the chances of a live birth and healthy premature infant, but then refuse to consent to the infant's resuscitation?[54]

B. *Misapplication of* In re Guardianship & Protective Placement of Edna M.F.

The first reason the Appellate Court gave to explain why a viable alternative did not exist to trigger the informed consent statute was the existence of legal precedent in Wisconsin in the case of *In re Guardianship & Protective Placement Edna M.F.*[55] *In re Edna M.F.* was one of two prior Wisconsin Supreme Court cases that addressed the issue of withholding and withdrawing medical treatment for incompetent adults. The Supreme Court in *In re Edna M.F.* specifically relied on *In re Guardianship of L.W.* in its decision.[56] Both *In re L.W.* and *In re Edna M.F.* involved incompetent adults with court-appointed guardians as decision-makers. Both of these Wisconsin Supreme Court decisions made clear that their respective holdings were limited to decisions made by these state actors.

Although the Wisconsin Appellate Court relied upon *In re Edna M.F.* in *Montalvo*,[57] its interpretation of *In re Edna M.F.* was not an accurate reflection of that decision. The *In re Edna M.F.* decision was narrow and applied to court-appointed guardians or "state actors," but the *Montalvo* claim did not involve state actors.[58] Absent judicial determination, parents are not "court-appointed guardians" and children are not "incompetent

54. *See generally,* Dana Wechsler Linden & Mia Wechsler Doron, *Eyes of Texas Fasten on the Life, Death and the Premature Infant,* N.Y. TIMES, Apr. 30, 2002, at F5. To consider the question and rationale for litigation, compare this case with *Miller v. HCA, Inc.*, 118 S.W.3d 758 (Tex. 2003) (reversing an award of $60 million at the trial level in 1998 to the plaintiff parents, whose child suffered severe physical and mental impairments).

55. *In re* Guardianship & Protective Placement of Edna M.F., 563 N.W.2d 485 (Wis. 1997).

56. *Id.* at 486.

57. The *Montalvo* court did not explain why it used *In re Edna M.F.* rather than *In re L.W.* as case law precedent. *In re Edna M.F.* involved an incompetent person who had been competent most of her life, and *In re L.W.* involved an incompetent person who had probably never been competent. *In re L.W.* would seem to have been the more appropriate comparison because decision-making for children is often compared to decision-making for those who have never been competent. *See generally* Irene Hurst, *The Legal Landscape at the Threshold of Viability for Extremely Premature Infants: A Nursing Perspective, Part I*, 19 J. PERINATAL & NEONATAL NURSING 161, 165-66 (2005) ("The court in Montalvo did not explain how the condition of a 71-year-old woman with dementia who had lived a full life correlated with that of an infant on the threshold of viability for whom medical care options would involve the uncertainty of risk, pain, and unknown consequences.").

58. *See* Montalvo v. Borkovec, 647 N.W.2d 413, 416 (Wis. Ct. App. 2002).

wards."[59] Thus, the precedent derived from *In re Edna M.F.* cannot be applied to *Montalvo* without providing a rationale for broadening the scope of these former decisions.

In order to distinguish *Montalvo* from *In re Edna M.F.*, we must first examine *In re L.W.* The context and language of the *In re L.W.* and *In re Edna M.F.* decisions are significant and contribute to a more thoughtful understanding of Wisconsin's common law regarding treatment decision issues.

1. *In re Guardianship of L.W.*

a. Facts and Procedural History

According to the Wisconsin Supreme Court, L.W. was a seventy-nine-year-old man with a history of undifferentiated schizophrenia who had been institutionalized since 1951.[60] In May of 1989, LE Phillips Career Development Center (a not-for-profit corporation) was appointed as the guardian of his person and his estate.[61] He had no close friends or relatives and no one was aware of whether he had ever indicated his wishes concerning life-sustaining medical treatment; the record also suggested that L.W. may have never been competent.[62] On May 31, 1989, L.W. suffered a cardiac arrest and was taken to a hospital where physicians informed the guardian that L.W. was in a persistent vegetative state.[63] The physicians indicated that if L.W.'s condition did not improve over the following weeks, they would request that the guardian consent to withdrawal of life-sustaining medical treatment, including artificial nutrition and hydration.[64] "On June 8, 1989, the guardian petitioned the circuit court for a declaratory judgment to determine whether [a] guardian had the authority to consent to

59. *See, e.g.*, Stierman v. McPherson, 655 N.W.2d 487, 493-94 (Wis. Ct. App. 2002) (indicating that a guardian may be appointed for incompetents *or* minors, and parents are not court-appointed guardians).

60. *In re* Guardianship of L.W., 482 N.W.2d 60, 63 (Wis. 1992).

61. *Id.*

62. *Id.*

63. *See id.* at n.1 (describing the characteristics of persistent vegetative state, in part as: Irreversible loss of all neocortical functions; brain stem functions intact; awake but unaware; eyes-open unconsciousness; sleep/wake cycles present; and respirator independence). *See generally* The Multi-Society Task Force on PVS, *Medical Aspects of the Persistent Vegetative State – First of Two Parts*, 330 NEW ENG. J. MED. 1499 (1994) (summarizing current knowledge of the medical aspects of persistent vegetative states in adults and children).

64. *In re L.W.*, 482 N.W.2d at 63-64.

such withdrawal."[65] The trial court appointed a guardian *ad litem*.[66] The trial court concluded that a guardian has the authority to consent to withdrawal of all life-sustaining medical treatment if withdrawal is determined by the guardian to be in the ward's best interests.[67] The guardian *ad litem* appealed the trial court's order and the guardian and hospital cross-appealed.[68]

Although L.W. had died in February 1991, the Wisconsin Supreme Court accepted the appeal for two issues: "Whether an *incompetent* individual in a persistent vegetative state has a right to refuse life-sustaining medical treatment, including artificial nutrition and hydration, and whether a *court-appointed guardian* may exercise that right on the *ward's* behalf."[69]

b. Holding and Rationale

The Wisconsin Supreme Court in *In re L.W.* determined that incompetent individuals have the right to refuse unwanted life-sustaining medical treatment.[70] The court stated that this right "emanates from the common law right of self-determination and informed consent, the personal liberties protected by the Fourteenth Amendment, and from the guarantee of liberty in Article I, section 1 of the Wisconsin Constitution."[71] However, the court held that a court-appointed guardian could only refuse life-sustaining medical treatment on behalf of an incompetent ward when certain legal safeguards are met, stating:

> [A] *guardian* may consent to the withholding or withdrawal of life-sustaining medical treatment on behalf of one who was never competent, or a once competent person whose conduct never was of a kind from which one could draw a reasonable inference upon which to make a substituted judgment, when:
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> (1) [T]he *incompetent* patient's attending physician, together with two independent neurologists or physicians, determine with reasonable medical certainty that the patient is in a persistent vegetative state and has no reasonable chance of recovery to a cognitive and sentient life; and

65. *Id.* at 64.
66. *Id.*
67. *Id.*
68. *Id.*
69. *Id.* at 63 (emphasis added).
70. *In re* Guardianship of L.W., 482 N.W.2d 60, 67 (Wis. 1992).
71. *Id.* at 65.

> (2) the *guardian* determines in good faith that the withholding or withdrawal of treatment is in the *ward's* best interests, according to the objective factors outlined below.[72]

The court wrote that a best interests determination must begin with a presumption that continued life is in the best interests of the ward.[73] The *In re L.W.* court provided a list of objective factors that a guardian may consider in overcoming this presumption, including: (1) The degree of humiliation, dependence, and loss of dignity probably resulting from the condition and treatment; (2) the life expectancy and prognosis for recovery with and without treatment; (3) the various treatment options; and (4) the risks, side effects, and benefits of each of these options.[74]

c. *Limitations of the* In re L.W. Holding

In its discussion in *In re L.W.*, the Wisconsin Supreme Court specified that its holding was limited to state actors,[75] and that "[a]n incompetent is a ward of the state and [Wisconsin's] *parens patriae* power requires [the] court to ensure that the ward's best interests are protected."[76] The court explained that "court appointed guardians fulfill the *parens patriae* duty of the state to protect the best interests of an incompetent ward."[77] The court further noted that "a guardian is a state actor . . . [whose] authority *derives* from the state's *parens patriae* power and is purely statutory."[78]

A final and particularly significant distinction can be found in a footnote where the Wisconsin Supreme Court specifically excluded from its holding decisions involving family members:

> We do not decide today whether a family member may consent to the withholding or withdrawal of life-sustaining medical treatment from a patient, because that question is not before us. Our review is limited to whether a court appointed guardian, where there can be no familial decisional process, may consent to the withholding or withdrawal of such treatment from a patient in a persistent vegetative state.[79]

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72. *Id.* at 71-72 (emphasis added).

73. *Id.* at 72.

74. *Id.* at 72-73 (citing *In re* Conroy, 486 A.2d 1209, 1231 (N.J. 1985)) (noting that the guardian must assess these objective factors from the patient's standpoint as opposed to a guardian's view of the patient's quality of life).

75. *See id.* at 71-72.

76. *In re* Guardianship of L.W., 482 N.W.2d 60, 68 (Wis. 1992).

77. *Id.* at 71.

78. *Id.* (emphasis added).

79. *Id.* at 72 n.16. *See generally* Ardath A. Hamann, *Family Surrogate Laws: A Necessary Supplement to Living Wills and Durable Powers of Attorney*, 38 VILL. L. REV. 103 (1993) (proposing that families should have medical decision-making authority for

2. *In re Guardianship & Protective Placement of Edna M.F.*

a. Facts and Procedural History

When Ms. Edna M.F.'s appeal reached the Wisconsin Supreme Court in January 1997, she was a seventy-one-year-old woman diagnosed with Alzheimer's-type dementia.[80] She was able to breathe without assistance but otherwise was immobile, bedridden with contracted limbs, and dependent upon others for her care.[81] She exhibited no purposeful response, although her physicians indicated that she responded to voice or movement stimulation and that she appeared alert at times with her eyes open.[82] She also responded to noxious stimuli.[83] She had a feeding tube surgically inserted in 1988.[84] Ms. M.F. lived and was cared for at the Marshfield Nursing and Rehabilitation ("Marshfield").[85] Her condition was not likely to improve.[86]

Justice Bablitch's concurring opinion noted that "[n]either of the two physicians who examined Ms. [M.F.] were neurologists. The only doctor who was asked his opinion on whether Ms. [M.F.] was in a persistent vegetative [state], testified that she was not."[87] The concurrence noted that this physician used an arguably outdated neurology definition from 1989 to render this opinion.[88]

Ms. M.F. had a court appointed guardian who was also her sister, Ms. Betty Spahn.[89] Ms. Spahn sought permission to withhold Ms. M.F.'s nutrition and claimed that her sister would not have wanted to live in this

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incompetent persons and that courts should intervene only when a family's motivation is questioned).

80. *In re* Guardianship & Protective Placement of Edna M.F., 563 N.W.2d 485, 487 (Wis. 1997).

81. *Id.* at 487, 492 (Abrahamson, C.J., concurring).

82. *Id.*

83. *Id.*

84. *Id.* at 487.

85. *Id.*

86. *In re* Guardianship & Protective Placement of Edna M.F., 563 N.W.2d 485, 487 (Wis. 1997).

87. *Id.* at 497 (Bablitch, J., concurring).

88. *Id.*

89. *Id.* at 487.

manner.[90] Ms. Spahn testified at trial that Ms. M.F. once told her, "'I would rather die of cancer than lose my mind.'"[91] Their conversation had taken place thirty years beforehand in a discussion about their mother, who was recovering from depression, and Spahn's mother-in-law, who was dying of cancer.[92] No other evidence or expressions of Ms. M.F.'s values or end-of-life wishes were provided.[93] Ms. Spahn testified that "this was the only time that she and Edna discussed the subject and that Edna never said anything specifically about withholding or withdrawing life-sustaining medical treatment."[94]

Marshfield's Ethics Committee met in October 1994 to consider whether to comply with Ms. Spahn's request to withhold artificial nutrition for Ms. M.F.[95] The committee approved the request on the condition that no family member objected.[96] The committee wanted to have each family member sign a statement approving this withdrawal,[97] but one of Ms. M.F.'s nieces refused to sign.[98] Ms. M.F.'s niece did not object to withholding nutrition, but her religious views precluded her from consenting in writing.[99] Ms. Spahn then filed a petition with the circuit court as a guardian of an incompetent person asking for the court's confirmation of her decision to withhold nutrition from Ms. M.F.[100] The Wisconsin Supreme Court accepted the case on bypass from the court of appeals.[101] As Ms. M.F.'s guardian and guardian *ad litem* both agreed and argued to withhold nutrition, the Supreme Court appointed a separate attorney as "respondent-designate" to argue for sustaining Ms. M.F.'s life.[102]

The *In re Edna M.F.* case presented two issues for the Wisconsin Supreme Court:

> (1) Whether the *guardian* of an *incompetent person* who has not executed an advance directive and is not in a persistent vegetative state has the authority to direct withdrawal of life sustaining medical treatment from the incompetent person; and (2) Whether *in this case*, notwithstanding

90. *Id.*
91. *Id.*
92. *In re* Guardianship & Protective Placement of Edna M.F., 563 N.W.2d 485, 487 (Wis. 1997).
93. *Id.*
94. *Id.*
95. *Id.*
96. *Id.*
97. *Id.* at 487, 496 n.8 (Abrahamson, C.J., concurring).
98. *In re* Guardianship & Protective Placement of Edna M.F., 563 N.W.2d 485, 487, 496 n.8 (Abrahamson, C.J., concurring) (Wis. 1997).
99. *Id.* at 496 n.8 (Abrahamson, C.J., concurring).
100. *Id.* at 487 (appointing a guardian *ad litem* and denying Spahn's petition).
101. *Id.*
102. *Id.*

> the fact that she is not in a persistent vegetative state, there is a clear statement evidenced in the record of Edna's desire to die rather than have extreme measures applied to sustain her life under circumstances such as these.[103]

b. Holding and Rationale

The Wisconsin Supreme Court specifically relied on and affirmed *In re L.W.* in its holding.[104] It held that "a guardian may only direct the withdrawal of life-sustaining medical treatment [] if the incompetent ward is in a persistent vegetative state and the decision to withdraw" is in the ward's best interests.[105] That court reasoned that Ms. M.F.'s statements to her sister made thirty years earlier did not constitute a clear statement of intent that served as a basis for the guardian to authorize the withholding of her nutrition.[106] Finally, the court explicitly declined to extend the scope of *In re L.W.* to incompetent wards with incurable or irreversible conditions, holding that it only would authorize the withholding of life-sustaining medical treatment when the patient is in a persistent vegetative state.[107]

c. Discussion and Analysis

(1) Given the circumstances of *In re Edna M.F.*, the Wisconsin Supreme Court could not expand *In re L.W.*

At first glance, the description of Ms. M.F. provided by the majority and concurring opinions might appear to justify granting the guardian's request to withdraw treatment: Her physical condition had deteriorated, she was mentally incompetent, her mental condition was declining, and her family agreed that withdrawing treatment would be best for her.[108] Upon closer inspection of the facts in this case, however, and recognizing that this decision would serve as a template for future guardian requests to withdraw treatment, the court's denial of the guardian's request and refusal to expand *In re L.W.* under these circumstances was understandable. The rationale for the court's decision had less to do with whether the right to discontinue treatment exists for incompetent adults who are not in a persistent

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103. *Id.* at 486 (emphasis added).

104. *In re* Guardianship & Protective Placement of Edna M.F., 563 N.W.2d 485, 486, 491-92 (Wis. 1997).

105. *Id.* at 486.

106. *Id.*

107. *Id.* at 491.

108. *See id.* at 487.

vegetative state, and more to do with ensuring that the process that leads to such requests provides for consistent and adequate protections or safeguards for incompetent wards of the state.

The safeguards presumed present in treatment decisions involving incompetent adults were missing or deficient in Ms. M.F.'s case. In addition to the obvious safeguard of an accurate medical diagnosis, the Wisconsin Supreme Court identified two others in its *In re L.W.* decision: (1) The importance of ascertaining the patient's wishes; and (2) the use of an ethics committee in the decision making process.[109] The process in *In re Edna M.F.* lacked those safeguards to ensure that the determination to discontinue treatment was in Ms. M.F.'s best interests. The physician who examined Ms. M.F. used an outdated neurological assessment standard to determine whether she was in a persistent vegetative state.[110] The only evidence of Ms. M.F.'s wishes or values consisted of a single statement she had made thirty years prior.[111] Although the opinion identified that Ms. M.F. was a Roman Catholic and her family loved her, there was no clear evidence of Ms. M.F.'s personal values or objectives related to withdrawal of nutrition.[112] Finally, the nursing home's ethics committee did not function in an effective manner.[113] Chief Justice Abrahamson elaborated on this factor in her concurring opinion and noted that the focus of the ethics committee in Ms. M.F.'s case seemed to be on avoiding legal liability rather than determining her best interests.[114]

The court's discussion of the slippery slope[115] illustrates its hesitancy to give way to an undisciplined withdrawal of artificial nutrition. Although Chief Justice Abrahamson indicated a willingness to give family more leeway,[116] and although *In re L.W.* clarified in a footnote that its holding did not apply to family members,[117] Ms. Spahn never raised this issue as a

109. *In re* Guardianship of L.W., 482 N.W.2d 60, 70, 73-74 (Wis. 1992).

110. *In re* Guardianship & Protective Placement of Edna M.F., 563 N.W.2d 485, 497 (Bablitch, J., concurring).

111. *Id.* at 487.

112. *Id.* at 491.

113. *Id.* at 495-96 (Abrahamson, C.J., concurring) (contrasting the nursing home's ethics committee with *In re L.W.*'s favorable comments towards ethics committees and their functions). The role of ethics committees is precisely to sort out these difficult issues and conflicting ethical principles involved in withdrawal of treatment. *See* American Academy of Pediatrics Committee on Bioethics, *Institutional Ethics Committees*, 107 PEDIATRICS 295, 205-09 (2001) (detailing the roles of institutional ethics committee in clinical ethics).

114. *In re Edna M.F.*, 563 N.W.2d at 495-96 (Abrahamson, C.J., concurring).

115. *Id.* at 490.

116. *Id.* at 494 (Abrahamson, C.J., concurring) ("It is a fundamental premise of *L.W.* that ordinarily decisions to withhold or withdraw life-sustaining medical treatment of a ward are to be made by a guardian in conjunction with doctors and the family, not by the courts.").

117. *In re* Guardianship of L.W., 482 N.W.2d 60, 72 n.16 (Wis. 1992).

distinguishing factor in spite of the facts that Ms. Spahn was a sibling[118] and that all family members (except for one niece) agreed that discontinuing nutrition was in Ms. M.F.'s best interest.[119]

It is likely that the Wisconsin Supreme Court recognized that the *In re Edna M.F.* decision would have a greater impact for future cases involving incompetent wards of the state and medical treatment, especially those wards of the state without a prior familial relationship or friendship with their court-appointed guardian. In situations where there is no family or friend to care about an incompetent ward, process can serve as an additional protection.

(2) *In re Edna M.F.* should not be applied to children

Until the *Montalvo* decision, it was unclear whether *In re Edna M.F.* applied to children with parents as decision-makers.[120] Arguably, the language chosen by the Wisconsin Supreme Court indicates that it did not intend for *In re Edna M.F.* to apply to children. The court consistently articulated that its decision applied to incompetent wards and court-appointed guardians or state actors.[121] The law distinguishes between "children" and "incompetent wards" and between "parents" and "court-appointed guardians"; these roles and definitions are not interchangeable.[122] Indeed, to interchange these terms within the law would render absurd results.[123] Recall also that *In re L.W.*, upon which *In re Edna M.F.* relied, specified that its decision was not applicable to situations where *family members* sought to withhold or withdraw treatment.[124]

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118. *In re Edna M.F.*, 563 N.W.2d at 487.

119. *Id.* at 496 n.8 (Abrahamson, C.J., concurring).

120. Scott D. Obernberger, *What About Children?*, 8 HEALTH L. WIS., STATE BAR OF WIS., Winter 1998, at 2-4.

121. *See generally In re Edna M.F.*, 563 N.W.2d at 485-501.

122. *See generally In re* Guardianship of L.W., 482 N.W.2d 60, 71 & n.14 (Wis. 1992) (explaining how a *court determines* a guardian's authority to make decisions for an individual the *court finds* to be an incompetent ward).

123. For illustrations of how these terms are not fungible, substitute the italicized terms with the bracketed terms in the following examples: *See, e.g.*, Parham v. J.R., 442 U.S. 584, 602 (1979) ("Our jurisprudence historically has reflected Western civilization concepts of the family as a unit with broad *parental* [court-appointed guardian] authority over *children* [incompetent wards]."); *see also, e.g.*, Newmark v. Williams, 588 A.2d 1108, 1115 (Del. 1991) ("*Parental* [court-appointed guardian] autonomy to care for *children* [incompetent wards] free from government interference therefore satisfies a *child's* [incompetent ward's] need for continuity and thus ensures his or her psychological and physical well-being."); *see also, e.g.*, *In re* Guardianship of Pescinski, 226 N.W.2d 180, 180 (Wis. 1975) ("The appellant, Janice Pescinski Lausier, on her own petition, was appointed *guardian* [parent] of the person of her brother, the respondent, Richard Pescinski.").

124. *In re L.W.*, 482 N.W.2d at 72 n.16.

It is troubling that the *Montalvo* Court appeared to ignore the context and limitations of *In re Edna M.F.* when it paraphrased that decision: "It thus concluded that either withholding or withdrawing life-sustaining medical treatment is not in the best interests of *any patient* who is not in a persistent vegetative state."[125] It is important to note that the *In re Edna M.F.* decision did not include that sweeping language in its decision, but instead limited its scope to medical decision-making for incompetent adults: "This brings us to the situation at hand – whether this court should allow surrogate decision makers to decide to withhold or withdraw life-sustaining medical treatment from an *incompetent adult* who is not in a persistent vegetative state."[126]

Additionally, the Wisconsin Supreme Court limited the application of the *In re Edna M.F.* decision to those under the formal protection of the state:

> However, if that person is not in a persistent vegetative state, this court has determined that, as a matter of law, it is not in the best interests of the *ward* to withdraw life-sustaining treatment, including a feeding tube, unless the *ward* has executed an advance directive or other statement clearly indicating his or her desires.[127]

Finally, in its conclusion, *In re Edna M.F.* reiterated that its holding was limited to guardians and incompetent wards: "Consequently, we hold that *a guardian* may only direct the withdrawal of life-sustaining medical treatment, including nutrition and hydration, if the *incompetent ward* is in a persistent vegetative state and the decision to withdraw is in the best interests of the *ward*."[128]

A "ward" is "a person, especially a child or incompetent, *placed by the court* under the care and supervision of a guardian or conservator."[129] In order to qualify as a "ward," some sort of legal or judicial action is required.[130] Similarly, judicial action is required to declare a person "incompetent" or to appoint someone as a "guardian."[131] Absent judicial determination, children are not "wards" and parents are not "guardians."[132] Given these clear limitations provided by the Wisconsin Supreme Court, *In*

125. Montalvo v. Borkovec, 647 N.W.2d 413, 419 (Wis. Ct. App. 2002) (citing *In re* Guardianship & Protective Placement of Edna M.F., 563 N.W.2d 485 (Wis. 1997)) (emphasis added).

126. *In re Edna M.F.*, 563 N.W.2d at 489 (emphasis added).

127. *Id.* at 489-90 (emphasis added).

128. *Id.* at 491-92 (emphasis added).

129. BLACK'S LAW DICTIONARY 1583 (6th ed. 1990) (emphasis added).

130. *See, e.g.*, WIS. STAT. § 880.01 (10) (2006).

131. *See, e.g.*, WIS. STAT. § 880.01 (3)-(4) (2006).

132. *See, e.g.*, WIS. STAT. § 880.01 (10) (2006).

re Edna M.F. cannot reasonably be applied to claims involving children with parents as decision-makers.

(3) *In re Edna M.F.* affirmed the safeguards of *In re L.W.*

As shown from the discussion above, in relying on *In re L.W.*, the Wisconsin Supreme Court in *In re Edna M.F.* continued to allow a guardian to withdraw life-sustaining medical treatment on behalf of an incompetent ward if the ward was in a persistent vegetative state and the decision to withdraw was in the best interests of the ward. The Court of Appeals in *Montalvo* interpreted *In re Edna M.F.* as setting a threshold for treatment withdrawal in general: "[O]ur supreme court set forth the preconditions required for permitting the withholding or withdrawal of life-sustaining medical treatment."[133] However, neither *In re Edna M.F.* nor *In re L.W.* actually set forth preconditions for permitting withholding or withdrawal of life-sustaining medical treatment. Instead, these Wisconsin Supreme Court decisions outlined affirmative criteria for *guardians of incompetent adult wards* in making these treatment decisions.[134] With *In re L.W.* and *In re Edna M.F.*, in Wisconsin, guardians of incompetent wards in a persistent vegetative state may withdraw treatment if it is in the best interests of the ward without obtaining a court order.[135] Neither case precluded a guardian from seeking such a court order to discontinue treatment under different circumstances. Court orders sought on a case-by-case basis provide an opportunity for judicial review, which serves as an additional safeguard for incompetent wards of the state.

C. *Misapplication of Child Abuse Prevention and Treatment Act (CAPTA)*[136]

Recall that the Appellate Court concluded that informed consent was not required in *Montalvo* because there were no alternative treatments available for the Montalvo infant.[137] The court cited two reasons why no alternative treatments existed.[138] The first reason, *In re Edna M.F.*, has been discussed above. The second reason that the Appellate Court gave to explain why no viable alternative treatments existed (and thus to explain why the informed consent statute did not apply) was because of the existence of the federal

133. Montalvo v. Borkovec, 647 N.W.2d 413, 418 (Wis. Ct. App. 2002).

134. *See generally In re* Guardianship & Protective Placement of Edna M.F., 563 N.W.2d 485, 485-501 (Wis. 1997); *see generally In re* Guardianship of L.W., 482 N.W.2d 60, 60-79 (Wis. 1992).

135. *In re Edna M.F.*, 563 N.W.2d at 491-92; *In re L.W.*, 482 N.W.2d at 75.

136. *See* 42 U.S.C. § 5104 *et seq.* (2005).

137. *Montalvo*, 647 N.W.2d at 418.

138. *Id.*

Child Abuse Prevention and Treatment Act (CAPTA).[139] However, the Court's application of CAPTA as a mandate for treatment does not withstand closer scrutiny.

CAPTA has been described as a federal funding statute that conditions each state's receipt of federal funding for child abuse prevention programs on maintaining a procedure for responding to reports of neglect of newborns.[140] The federal regulations relating to CAPTA require states to establish programs and/or procedures within their Child Protective Service (CPS) systems to respond to reports of "medical neglect, including instances of withholding of medically indicated treatment from disabled infants with life-threatening conditions (commonly known as 'Baby Doe')."[141] Wisconsin has interpreted CAPTA in this way: "All states receiving child abuse and neglect funds from the federal government must have procedures for handling a report of possible medical neglect of an infant in place."[142]

Thus, while CAPTA provides states with a powerful incentive to establish programs of this nature, it actually does not require or mandate treatment of premature infants. Furthermore, a *report* of suspected medical neglect does not necessarily lead to actual charges of medical neglect. CAPTA and its corresponding federal and state regulations set a trigger for investigating reports of medical neglect; they are not proof positive that medical neglect has, in fact, occurred.[143]

Additionally, in its *Guidelines in Handling a Report of Possible Medical Neglect of a Disabled Infant (Baby Doe)* ("Guidelines"), the Wisconsin Department of Health and Family Services (DHFS) goes to great lengths to stress the primacy of the parent as decision-maker, as well as the seriousness and individualized nature of the circumstances involved in any charge of withholding medical treatment.[144] The Guidelines encourage healthcare providers to respect parents' needs, feelings, and rights, and to

139. *Id.* at 419.

140. FURROW, *supra* note 21, at 1460.

141. DEP'T OF HEALTH & FAMILY SERV. DIV. OF CHILDREN & FAMILY SERV., BUREAU OF PROGRAMS & POLICY, GUIDELINES IN HANDLING A REPORT OF POSSIBLE MEDICAL NEGLECT OF A DISABLED INFANT (BABY DOE) 1 (1996) [hereinafter GUIDELINES].

142. *Id.* at 2.

143. There is disagreement among medical professionals regarding CAPTA's application to extremely premature infants. *See* American Academy of Pediatrics, Committee on Bioethics, *Ethics and the Care of Critically Ill Infants and Children*, 98 PEDIATRICS 149, 149-52 (1996) [hereinafter *Critically Ill Infants*]; Loretta M. Kopelman, *Are the 21-Year-Old Baby Doe Rules Misunderstood or Mistaken?*, 115 PEDIATRICS 797, 797-802 (2005); John A. Robertson, *Extreme Prematurity and Parental Rights after Baby Doe*, HASTINGS CENTER REPORT, July-Aug. 2004, at 32-39.

144. GUIDELINES, *supra* note 141, at 3, 7.

assume that parents are loving and concerned guardians.[145] The Guidelines acknowledge parents as decision-makers: "Parents have traditionally had the legal right and obligation as well as the personal insight, concern, and love to make decisions regarding the health and welfare of their children. In the vast majority of instances, parents are the most enlightened and thoughtful decision-makers for their children."[146] The Guidelines also suggest collaboration between parents and physicians when making a decision:

> Movement toward resolution of a Baby Doe case may occur if . . . it is ascertained that: . . . [T]he current level of medical treatment has been reviewed by prudent physicians who are "knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved" . . . and is considered the appropriate treatment of choice by the treating physicians and by the parent(s).[147]

The Guidelines specifically recognize that this is a gray area and do not draw a bright line for making these decisions.

The Guidelines support the use of many interdisciplinary resources, including ethics committees, to resolve a case and encourage "[i]nformal, nonjudicial resolution, if possible."[148] Contrary to the Appellate Court's interpretation,[149] CAPTA does not require that a premature infant be resuscitated without regard for prognosis, parental input, or medical standards.

Another point of confusion, though arguably minor, in the Appellate Court's *Montalvo* analysis is its justification of the application of CAPTA: "Because Wisconsin has fulfilled the necessary obligations to receive federal funds under CAPTA, CAPTA and its regulations are fully applicable in this state."[150] First, an examination of the source cited by the Court of Appeals, *Jeanine B. v. Thompson,* does not lead to this conclusion.[151] Second, the burden is on the federal agency to determine

145. *Id.* at 7.

146. *Id.* at 8.

147. *Id.* at 22.

148. *Id.* at 10-12, 22.

149. Montalvo v. Borkovec, 647 N.W.2d 413, 419 (Wis. Ct. App. 2002).

150. *Id.* (citing Jeanine B. v. Thompson, 967 F.Supp. 1104, 1111-12, 1118 (E.D. Wis. 1997)).

151. *See Jeanine B.*, 967 F. Supp. at 1104-12. The *Montalvo* interpretation of CAPTA has been cited as "judicial validation of CAPTA's authority to severely limit the situations in which physicians may permissibly withhold medical treatment." Sadath A. Sayeed, *Baby Doe Redux? The Department of Health and Human Services and the Born-Alive Infants Protection Act of 2002: A Cautionary Note on Normative Neonatal Practice*, 116 PEDIATRICS e576, e581 (2005).

whether a state meets its funding criteria prior to disbursement.[152] Presumably, a state has met the federal funding criteria if it has received the federal monies. Under CAPTA, state programs are not required to be the same or uniform; state programs will vary.[153] "CAPTA grants states flexibility in how they choose to 'provide that' investigations shall be initiated."[154] The question of whether Wisconsin qualified for federal funding under CAPTA was not before the Appellate Court.[155]

Finally, the Appellate Court provided no explanation of how CAPTA or Wisconsin regulations pertaining to medical neglect would apply to the specific facts in *Montalvo*.[156] No evidence was presented to demonstrate that a report of medical neglect would have been made, an investigation would have ensued, or actual charges would have been filed.

D. Wisconsin Court of Appeals' Public Policy Considerations in Montalvo

The Appellate Court in *Montalvo* provided three public policy reasons for upholding the trial court's dismissal of the claim: (1) The interest in preserving life; (2) concern for placing physicians in a "continuing damned status"; and (3) concern for variations in parental determinations of which disabilities are "worse than death."[157] The Court's explanations for its public policy reasons were vague and unconvincing. Ironically, a closer examination of the Court's considerations supports the withdrawal and withholding of medical treatment in some circumstances for children who are not in a persistent vegetative state.

1. Preserving Life

The state has an interest in preserving life; however, regarding medical treatment decisions, does the state have an interest in preserving life without regard for potential or certain burdens of treatment and suffering that may be imposed on a child? The Wisconsin Appellate Court appeared to answer in the affirmative despite legal precedent to the contrary.

In its discussion of this initial public policy point, the Appellate Court cited *In re L.W.*[158] Yet the Court ignored the following guidance from the Wisconsin Supreme Court in that same decision: "Moreover, we do not view the withdrawal of life-sustaining treatment as depriving the patient of

152. *See generally* 42 U.S.C. § 5106a (1996) (current version at 42 U.S.C. § 5106a (2003)).

153. *Jeanine B.*, 967 F. Supp. at 1115.

154. *Id.*

155. *See generally* Montalvo v. Borkovec, 467 N.W.2d 413, 417 (Wis. Ct. App. 2002).

156. *See generally id.* at 419.

157. *Id.* at 421.

158. *Id.* (citing *In re* Guardianship of L.W., 482 N.W.2d 60 (Wis. 1992)).

life; rather, it 'allows the disease to take its natural course.'"[159] Also, "[t]he state does not deprive an individual of life by failing to ensure that every possible technological medical procedure will be used to maintain that life."[160] The Wisconsin Supreme Court limited the state's interest because "[a]n unqualified state interest in preserving life irrespective of . . . the patient's best interests transforms human beings into unwilling prisoners of medical technology."[161] Additionally, "this interest [in preserving life] weakens as the degree of bodily intrusion increases and the chance of recovery wanes."[162] The court indicated that death may be preferable than continued life dependent upon technology, stating that "[a] dignified and natural death may outweigh the interest of maintaining a physiological life as long as medically possible."[163] Finally, the court made a strong statement that affirmed withholding or withdrawing treatment as a viable option: "We conclude that in some circumstances it may well be in the patient's best interests to have treatment withheld or withdrawn."[164]

Rather than mandating treatment, as the Court held in *Montalvo*, it is more likely that, prior to this opinion, a parent's decision to forego life-sustaining treatment at the child's birth or later in the child's life would have been supported, as long as a thoughtful and careful best interests analysis was conducted in concert with healthcare professionals and in consideration of burdens imposed on and suffering experienced by the child.

2. Concerns for Physicians' "Damned" Status

Regarding its second policy point, the *Montalvo* Court reasoned that "[i]f treating physicians can be sued for failing to resuscitate a baby they feel is not viable, and for resuscitating a viable baby such as Emanuel, they are

159. *In re L.W.*, 482 N.W.2d at 71 (citing *In re* Conroy, 486 A.2d 1209, 1224 (N.J. 1985)).

160. *Id.*

161. *Id.* at 74.

162. *Id.*

163. *Id.* at 68.

164. *Id.* at 68. *See* American Academy of Pediatrics, Committee on Bioethics, *Guidelines on Forgoing Life-Sustaining Medical Treatment, Pediatrics*, 93 PEDIATRICS 532 (1994) [hereinafter *Forgoing Life-Sustaining Medical Treatment*] ("Sometimes limiting or stopping life support seems most appropriate, especially if treatment only preserves biological existence or if the overall goal of therapy has shifted to the maintenance of comfort."); *see also* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 215 (U.S. Government Printing Office 1983) ("Public policy should resist state intrusion into family decision making unless serious issues are at stake and the intrusion is likely to achieve better outcomes without undue liabilities.").

placed in a continuing 'damned' status."[165] The Court compared its case to the Wisconsin Supreme Court's decision in *Burks v. St. Joseph's Hospital*.[166] This comparison is misleading. The *Burks* decision addressed the specific issue of whether the Patients Compensation Fund was required to provide coverage for violations of the federal Emergency Medical Treatment and Active Labor Act (EMTALA);[167] the merits of the EMTALA claim were not addressed.[168] The legal analysis for an EMTALA claim[169] and an informed consent claim[170] are quite different. Furthermore, individual physicians were not sued in *Burks*.[171] Even if they had been, merely being named as a defendant in a lawsuit is not conclusive of wrongdoing or negligence on the part of that defendant.

Moreover, physicians' professional and moral statuses are compromised if the law requires that well-established professional standards and ethics be ignored as in *Montalvo*. The legal precedent set in *Montalvo* does not allow for the option of treatment withdrawal in the course of care for an infant unless that infant is in a persistent vegetative state.[172] This law conflicts with professional standards, which allow for treatment withdrawal if the parents and care providers believe this decision to be in the child's best interests, even if the patient is not in a persistent vegetative state.[173]

Finally, the conflict between the law set in *Montalvo* and professional standards may leave healthcare providers in a quandary over how to practice. For example, one hospital in Wisconsin acknowledged this conflict on its website and encouraged its physicians to practice in accordance with the patient's interests and long-established ethical and legal standards.[174]

3. Variations in Parental Determinations

In its last public policy point, the Appellate Court discussed its potential role in determining whether some persons with disabilities are allowed to

165. Montalvo v. Borkovec, 647 N.W.2d 413, 421 (Wis. Ct. App. 2002).

166. *Id.*; Burks v. St. Joseph's Hosp., 596 N.W.2d 391 (Wis. 1999).

167. *Burks*, 596 N.W.2d at 392.

168. *Id.* at 402.

169. *Id.* at 394-95 (discussing the legal analysis of an EMTALA claim).

170. *See Montalvo*, 647 N.W.2d at 417 (discussing the informed consent framework).

171. *Burks*, 596 N.W.2d at 392 (dealing with a complaint filed against the hospital and the Wisconsin Patient Compensation Fund).

172. *Montalvo*, 647 N.W.2d at 419.

173. *See generally Forgoing Life-Sustaining Medical Treatment*, *supra* note 164, at 532-36; *see also Critically Ill Infants*, *supra* note 143, at 149-52.

174. W.J. Hisgen & Ralph V. Topinka, Patient Center Advance Medical Directives Discussion of Two Recent Wisconsin Court Cases, "Edna M.F." and "Montalvo" (Apr. 23, 2003), http://www.meriter.com/mhs/patient_center/dir_cases.htm.

live and others allowed to die.[175] "[C]ourts will be required to decide which potential imperfections or disabilities are no . . . 'worse than death.' . . . One set of parents may view a particular disability as 'worse than death,' while another set of parents would not."[176]

This determination is not as arbitrary as the court suggested. The situations in which parents ponder these decisions do not arise from "imperfections" or minor disabilities; they arise when profound physical devastation and suffering are very real probabilities for their child despite the best of medical care and use of the most advanced technology.[177] These decisions are a struggle for parents and healthcare professionals, not theoretical queries.[178]

There are no clear answers in these situations, and that is precisely why no bright line should be drawn to require treatment absent a persistent vegetative state in children.[179] Each situation is unique, with variables in prognosis and parental perspectives; each situation deserves careful, fact-intensive consideration by those involved in the care of the child.

This country has long recognized the right of parents to raise their children in different ways, including making different decisions regarding medical treatment.[180] "That some parents 'may at times be acting against the interests of their children' . . . creates a basis for caution, but is hardly a reason to discard wholesale those pages of human experience that teach that parents generally do act in the child's best interests."[181] It is precisely because the "right" course of action is unclear that we defer to parents' judgments. Social safeguards exist, not only in professional standards for nurses and physicians, but also in mandatory reporting laws including those for withholding of treatment.[182] Additionally, well-functioning ethics committees and other professionals can assist parents in making these types

175. *See Montalvo*, 647 N.W.2d at 421.

176. *Id.*

177. *See, e.g.*, *Critically Ill Infants*, *supra* note 143, at 151 ("[C]ontroversy still rages about the appropriate limits, if any, to place on the treatment of extremely low birth weight and premature infants, about infants with hypoplastic left heart syndrome, about children with chromosomal abnormalities with known very limited life spans, about infants with complex congenital abnormalities, and about children in the final states of terminal cancer or other fatal chronic disorders.").

178. *See id.* ("Physicians should recommend the provision or foregoing of critical care services based on the projected benefits and burdens of treatment, recognizing that parents may perceive and value these benefits and burdens differently from medical professionals.").

179. *See generally In re* Jane Doe, 418 S.E.2d 3 (Ga. 1992) (parents disagreed between themselves as to the best treatment decision for their child).

180. *See* Susan D. Hawkins, *Protecting the Rights and Interests of Competent Minors in Litigated Medical Treatment Disputes*, 64 FORDHAM L. REV. 2075, 2080-82 (1996).

181. Parham v. J.R., 442 U.S. 584, 602-03 (1979) (quoting Bartley v. Kremens, 402 F.Supp. 1039, 1047-48 (E.D. Pa. 1975)).

182. WIS. STAT. § 48.981 (2006).

of decisions.[183] The CAPTA regulations cited by the Court and interpreted by Wisconsin's DHFS acknowledge the important role of parents in decision-making for children, and especially for those with severe disabilities.[184] The decisions and viewpoints of those who love and provide daily care for the child should carry greater weight than those of the courts or others who merely observe or read about the child whose treatment is in question.[185]

E. Another Consideration: Best Interests of the Child

Another potential implication of the *Montalvo* decision is the Appellate Court's apparent disregard for any consideration of the "best interests" of the child.[186] Fundamental to any discussion about medical decision-making for children is the question of "what is in the best interests of the child?"[187] The answer should involve a careful discussion of the benefits and burdens of treatment and encompass not only the physical, but also the emotional, social, and spiritual effects of a particular treatment decision on a child. "The best interests standard protects another's well-being by assessing risks and benefits of various treatments and alternatives to treatment, by considering pain and suffering, and by evaluating restoration or loss of functioning."[188]

The *Montalvo* Court failed to provide any semblance of a "best interests" analysis for Emanuel.[189] Instead, the Court referenced best interests as if it

183. *See generally, e.g.*, *Forgoing Life-Sustaining Medical Treatment*, *supra* note 164 (discussing elements in decisions to forgo life-sustaining medical treatment).

184. *See* GUIDELINES, *supra* note 141, at 7 (acknowledging the devastation parents of a disabled, pre-term, genetically impaired, or at risk infant can feel, encouraging close physical and emotional contact between the parent(s) and the infant, and advocating for shielding the parents from additional stress).

185. *See Forgoing Life-Sustaining Medical Treatment*, *supra* note 164, at 532, 533 (recognizing the primacy of parental decision-making by the American Academy of Pediatrics); *see generally* LAINIE FRIEDMAN ROSS, CHILDREN, FAMILIES AND HEALTH CARE DECISION MAKING (John Harris & Soren Ho eds., Oxford University Press 1998) (examining healthcare decision-making for children).

186. *See* Montalvo v. Borkovec, 647 N.W.2d 413, 421 (Wis. Ct. App. 2002).

187. The best interests standard originated in child custody disputes. *See* Daniel B. Griffith, *The Best Interests Standard: A Comparison of the State's* Parens Patriae *Authority and Judicial Oversight in Best Interests Determinations for Children and Incompetent Patients*, 7 ISSUES IN L. & MED. 283, 291 (1991).

188. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 102 (Oxford University Press 2001) (1979) ("Under the best interests standard, a surrogate decision maker must determine the highest net benefit among the available options, assigning different weights to interests the patient has in each option and discounting or subtracting inherent risks or costs.").

189. *See generally Montalvo*, 647 N.W.2d at 419 n.4 (citing Ialfelice v. Zarafu, 534 A.2d 417, 418 (N.J. 1987), which also did not provide an evaluation of a child's best interests, but where a child was four weeks old and nothing in the record suggested that the

were a uniform standard applicable to all circumstances.[190] It merely stated, "Thus, in Wisconsin, in the absence of a persistent vegetative state, the right of a parent to withhold life-sustaining treatment from a child does not exist."[191] In this proverbial stroke of the pen, the Court of Appeals may have unwittingly abolished the best interests standard of decision-making for children without providing a more meaningful standard.[192]

As discussed earlier, the Wisconsin Supreme Court in both *In re L.W.* and *In re Edna M.F.* provided thorough "best interests" analyses for their respective plaintiffs.[193] For the pediatric population, the objective factors as articulated by the *In re L.W.* court are compounded by additional factors related to the burden of treatment: Will loving parents or individuals care for the child? Will the child be able to flourish to the best of her/his ability? Will the child suffer in daily cares or routines? Will the child respond and relate to others? Can the child be cared for at home in a loving environment or will s/he be confined to a hospital for the likely remainder of her/his life?

It is also troubling that the plaintiff parents in *Montalvo* were not arguing that they had the right to determine what was in their son's best interests. The plaintiffs appeared more concerned with their right to make medical decisions for Emanuel rather than their right or status as being the most appropriate persons, legally and ethically, to determine his best interests. In the absence of harm to their son, it is difficult to comprehend the basis for this litigation. The *Montalvo* plaintiff parents later published an article in which their discussion seemed to express more concern over the impact of Emanuel's birth and life on the quality of *their* lives, rather than on any suffering or hardships that Emanuel experienced or would experience, or on his perceived quality of life.[194] In that article, the parents explained:

> We feel that we have been subjected to a medical assault, an assault that has devastated our lives . . . . Our dreams of a decent and normal family

physician should have been able to foretell the full extent of the infant's disability).

190. *See generally id.* at 419-21; *see also* Hurst, *supra* note 57, at 160-61 (discussing abandonment of best interests standard by Wisconsin courts).

191. *Montalvo*, 647 N.W.2d at 419.

192. *See* BEAUCHAMP & CHILDRESS, *supra* note 188, at 102-03 (providing a general overview of a "best interests" as a standard for medical decision-making for children); ROSS, *supra* note 185, at 43 (discussing decision-making for children and proposing a revision to the "best interests" standard); Hamann, *supra* note 79, at 117-19 (describing how the "best interests" standard is flawed because it is not objective); Douglas S. Diekema, *Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention*, 25 THEORETICAL MED. 243, 246 (2004) (noting that a "best interests" standard does not help the courts decide whose conception of the child's best interest should prevail).

193. *In re* Guardianship & Protective Placement of Edna M.F., 563 N.W.2d 485, 490-92 (Wis. 1997); *In re* Guardianship of L.W., 482 N.W.2d 60, 76 (Wis. 1992).

194. *See generally* Nancy Montalvo & Brian P. Vila, *Parents Grand Rounds Speech on Neonatal Intensive Care Unit Experience*, 7 J. OF PERINATOLOGY 525 (1999).

> life are gone . . . . Emanuel's compromised survival has also drastically altered our relationships with our former friends and family members . . . . We and our son will never experience many of these things. Instead, we will experience the desolation of watching from the sidelines as our neighbors' children attain these milestones, knowing they will be permanently out of our reach.[195]

It is important to remember that, in language and inference, children are not chattel, and decisions made on their behalf should be for their benefit and overall well being, not for the primary benefit of their parents.[196]

Medical ethics policies and guidelines related to decision-making for children, including the withdrawal or withholding of medical treatment, do not distinguish between children in persistent vegetative state and those with other diagnoses.[197] A mandate of treatment for children without a diagnosis of persistent vegetative state clearly contradicts well-established medical ethical policies and guidelines. Wisconsin's DHFS has recognized that a best interests analysis is fact specific and that it is not always clear-cut because the ability to help more infants live means that some infants may be harmed in the process of attempting to help them.[198] In some cases, the standard of doing what is in the "best interests of the child" has become blurred in the face of medical technology that increases our capacity to keep infants alive indefinitely.[199] The American Academy of Pediatrics also has recognized that these decisions are difficult and must incorporate considerations of best interests for a child.[200]

The legal framework for complex medical treatment decisions involving children and their parents must, at a minimum, start with a best interests

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195. *Id.* at 526.

196. *See Forgoing Life-Sustaining Medical Treatment*, *supra* note 164, at 533 ("The phrase 'quality of life' refers to the experience of life as viewed by the patient, i.e., how the patient, not the parents or health care providers, perceives or evaluates his or her existence."); *see also* E.F. Krug III, *Law and Ethics at the Border of Viability*, 26 J. OF PERINATOLOGY 321, 322-23 (2006).

197. *See, e.g., Critically Ill Infants*, *supra* note 143, at 151 (discussing treatment options, including withholding life-sustaining medical treatment, for newborns with a myriad of issues, not only those in a persistent vegetative state).

198. GUIDELINES, *supra* note 141, at 9.

199. *Id.*

200. *Critically Ill Infants*, *supra* note 143, at 150 (advocating that parents and physicians should make reasoned decisions together about critically ill infants considering treatment alternatives). *See* American Medical Association, E-2.215 Treatment Decisions for Seriously Ill Newborns (2005), *available at* http://www.ama-assn.org/ama/pub/category/8460.html (stating that it is not necessary to attain absolute or near absolute prognostic certainty before life-sustaining treatment is withdrawn since this goal is often unattainable and risks unnecessarily prolonging infant's suffering).

analysis specific to the child and family in question, and it ideally would incorporate values of compassion and care into the decision-making process.

III. CONCLUSION

The *Montalvo* decision certainly gives credence to the oft-quoted phrase, "Bad facts make bad law." Without alleging any harm, the parents sued the physicians for a failure to obtain informed consent to provide emergency care, and the Court summarily dismissed the claim without a careful analysis of previous Wisconsin case law. The law, which had been intended to apply to complex cases involving incompetent adult wards of the state with court-appointed guardians, has been extended to include cases involving parents and children. In effect, the Wisconsin Appellate Court has created law that may conflict with ethical duties of healthcare providers under some circumstances and that denies parents the ability to act in their children's best interests.

In its dismissal of the *Montalvo* claim, the Appellate Court neglected to consider the reality that children experience medical conditions where life-sustaining treatment is not a benefit or where medical treatment causes pain, further disability, or removes them from the care of loved ones. The Court ignored the great difficulty that parents have in deciding whether to have their child endure further treatment for questionable results and a potentially burdensome future. As technology and medicine move swiftly into the future, our courts must tread carefully into these areas, while remaining mindful that their decisions are creating a legal landscape in which children and families are living and pediatric healthcare professionals are providing care.