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Withholding Life-sustaining Treatment from the Incompetent Patient: The Need for Statutory Guidelines

I. INTRODUCTION

Because of developments in medical technology during the past several decades, today's health care professionals are able to prolong patients' lives. In some circumstances, however, the application of advanced medical technology does not treat the condition itself, but merely postpones the moment of death. Patients and their guardians are increasingly responding to medical prolongation of life by asserting a right to die by natural causes. Terminally ill patients have successfully refused life-sustaining medical intervention, preferring to "die with dignity" rather than suffer a slow death prolonged by painful medical treatment or life-support machines.

1. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: ETHICAL, MEDICAL AND LEGAL ISSUES IN TREATMENT DECISIONS, 1 (U.S.G.P.O. Mar. 1983) [hereinafter cited as PRESIDENT'S COMMISSION REPORT]. Chemotherapy, resuscitation, kidney dialysis, antibiotics and organ transplantation are among the medical treatments that today can retard or reverse conditions once deemed fatal. Id.


3. Note, The "Living Will"; The Right to Death with Dignity?, 26 CASE W. RES. L. REV. 485, 486 (1976). Many people execute a document known as a "living will," which instructs physicians not to employ life-prolonging medical procedures if there is no reasonable hope of recovery. Id. at 485; see infra notes 84-94 and accompanying text.

4. The right of the terminally ill patient to be removed from artificial life-support systems or to refuse life-sustaining treatment has been widely recognized. See Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334 (Del. 1980); John F. Kennedy Memorial Hosp. v. Bludworth, 432 So. 2d 611 (Fla. Dist. Ct. App. 1983); In re Spring, 380 Mass. 629, 405 N.E.2d 115 (1980); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); In re Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981); Leach v. Akron Gen. Medical Center, 68 Ohio Misc. 1, 426 N.E.2d 809 (1981); In re Colyer, 99 Wash. 2d 114,
In many instances, a patient is not sufficiently competent to make a decision to refuse medical treatment. When an individual lacks the competency to make an informed medical decision, he is unable personally to assert a right to die. Comatose patients with no reasonable chance of regaining consciousness can be kept legally alive for years by life-support systems. In recent years, sur-

660 P.2d 738 (1983). Under the California Natural Death Act, see infra note 88, life-sustaining treatment is defined as: “any medical procedure which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified [terminal] patient, would serve only to artificially prolong the moment of death . . . .” CAL. HEALTH & SAFETY CODE § 7187(c) (West Supp. 1986).

5. See infra notes 9-12 and accompanying text.

6. Advances in medical technology permit physicians to extend the “life” of a patient by resuscitation and supportive measures, even after the patient’s brain has been severely and irreversibly damaged. Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, A Definition of Irreversible Coma, 205 J. A.M.A. 337, 339 (1968).

Death has traditionally been defined as the cessation of cardiac and respiratory activity. Until recently, the traditional definition of death was appropriate because once respiration and the heart stopped, the brain died within a few minutes. However, with improvements in medical technology, physicians now can artificially maintain heart and lung functions in patients whose brains have been irreparably damaged. In response to this development, a committee of the Harvard Medical School redefined death to include the notion of brain death. The committee found that brain death exists when four conditions are satisfied: (1) unreceptivity and unresponsivity; (2) no movements or breathing; (3) no reflexes; and (4) a flat electroencephalogram (EEG). Id. at 337-39.


However, brain death statutes are conservative in defining death. As a result, an individual who has suffered severe brain damage and is in an irreversible vegetative coma may remain legally alive because his condition does not meet the statutory requirements of brain death. Comment, Law at the Edge of Life: Issues of Death and Dying, 7 HAMLINE L. REV. 431, 435 (1984); Comment, Discontinuing Treatment of Comatose Patients Who Have Not Executed Living Wills, 19 LOY. L.A.L. REV. 61, 62-64 (1985). For a
rogate decisionmakers have begun to assert a right to die on behalf of incapacitated patients.\footnote{For purposes of this note, an incompetent or incapacitated patient is an adult who is unable to understand the nature of his illness and make informed choices about treatment. Courts have allowed termination of life-sustaining treatment without the patient’s express consent when a surrogate has either satisfactorily effectuated the incompetent’s desire to die or appropriately determined that foregoing treatment would be in the patient’s best interests. See, e.g., Severson v. Wilmington Medical Center, Inc., 421 A.2d 1334 (Del. 1980); In re Spring, 380 Mass. 629, 405 N.E.2d 115 (1980); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); In re Torres, 357 N.W.2d 332 (Minn. 1984); In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); In re Quinlan, 70 N.J. 10, 355 A.2d 647, cert. denied sub nom. Garger v. New Jersey, 429 U.S. 922 (1976); In re Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).}

This note examines the impact of In re Quinlan\footnote{70 N.J. 10, 355 A.2d 647, cert. denied sub nom. Garger v. New Jersey, 429 U.S. 922 (1976); see infra notes 19-55 and accompanying text.} and its progeny upon a surrogate’s ability to make a decision to withdraw or withhold an incompetent patient’s life-sustaining treatment. Although many states have enacted “natural death acts,” which enable a competent adult to exercise his right to die, only a few states have extended these benefits to incompetents.\footnote{See infra notes 91, 94 and accompanying text.} As a result, surrogate decisionmakers must often rely on unclear case law in determining the propriety of terminating an incompetent’s medical treatment.

This note will explain why legislatures are the appropriate forum for development of right-to-die laws for incompetents. It will then suggest that legislatures establish clear standards as to when an incompetent’s treatment can be terminated and what procedures a surrogate should follow in implementing a decision to forego treatment. Finally, this note will propose a decisionmaking procedure which allows the family or guardian of an incompetent, in conjunction with the incompetent’s attending physician and a hospital ethics committee, to choose to forego the patient’s life-sustaining treatment.

\section{II. Background}

Certain common-law and constitutional rights protect an individual facing a decision regarding medical treatment. An individual can control the nature and manner of his medical treatment based on the common-law right of bodily self-determination.\footnote{The right of an individual to assert control over his own body is a long-recognized concept in the common law. The first case to set forth the right of bodily self-determination was Union Pac. Ry. v. Botsford, 141 U.S. 250 (1891), in which the Supreme Court...}
Under the doctrine of informed consent, which protects an individual's interest in the integrity of his body, medical procedures may not be performed upon a patient without his consent, obtained after the patient has been adequately informed of the treatment, risks and alternative procedures. The doctrine of informed consent also encompasses a right to informed refusal of medical treatment. Thus, a competent adult generally has the right to accept or reject the initiation or continuation of any medical treatment.

In addition to these common-law rights, patients are also protected by the constitutional right of privacy. Courts have held that this right is broad enough to protect an individual's decision to reject medical intervention, even if the decision leads to death. However, the right to refuse medical treatment, whether based on a common-law right of bodily integrity or a constitutional right of privacy, is not absolute. Courts will weigh an individual's right to

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12. Cantor, A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life, 26 Rutgers L. Rev. 228, 237 (1973). The doctrine of informed consent presupposes that the patient has the capacity to reason and make judgments.


14. Buchanan, Limitations on the Family's Right to Decide for the Incompetent Patient, in Institutional Ethics Committees and Health Care Decision Making 209, 214 (R. Cranford & A. Doudera eds. 1984) [hereinafter cited as Health Care Decision Making]. “Both the law and the prevailing view in medical ethics now recognize that the competent patient has the right to decide whether to accept or reject medical treatment, even lifesaving medical treatment . . . .” Id.

die against the state's interests in keeping the person alive.\textsuperscript{16} If the state's interests are compelling, the individual's rights of privacy and bodily integrity can be overridden.\textsuperscript{17} However, when a patient is a competent adult suffering from a terminal illness, courts have seldom found state interests sufficient to outweigh the patient's unwillingness to undergo suffering or the burden of treatment.\textsuperscript{18}

\textbf{III. Discussion}

The decision to withhold treatment from a patient who is mentally unable to express his intent poses more difficult questions regarding the state's interest and the individual's rights. Several courts have struggled to find answers to these questions.

\textit{A. In re Quinlan}\textsuperscript{19}

\textit{In re Quinlan} was the first case to raise the basic issues concerning medical decisionmaking for patients lacking capacity.\textsuperscript{20} For reasons not entirely known, Karen Ann Quinlan sustained sudden and severe neurological damage, which left her permanently unconscious.\textsuperscript{21} Medical experts diagnosed her as being in a chronic and persistent vegetative state with no reasonable chance of ever


\textsuperscript{17} See, e.g., Commissioner of Correction v. Myers, 379 Mass. 255, 265, 399 N.E.2d 452, 458 (1979) (prisoner compelled to submit to kidney dialysis despite his protest); Application of President & Directors of Georgetown College, 331 F.2d 1000, 1008 (D.C. Cir.) (mother of infant ordered to allow child's blood transfusion despite her religious objections; order based on mother's responsibility to the community to care for the infant), \textit{cert. denied}, 377 U.S. 978 (1964).

\textsuperscript{18} State interests lessen as the level of bodily invasion increases and the patient's prognosis worsens. In re Quinlan, 70 N.J. 10, 41, 355 A.2d 647, 664, \textit{cert. denied sub nom. Garger v. New Jersey}, 429 U.S. 922 (1976). In Quinlan, where the patient was in an irreversible coma, the state's interests were secondary to the patient's right of privacy. \textit{Id. But see} Commissioner of Correction v. Myers, 379 Mass. 255, 265, 399 N.E.2d 452, 458 (1979) (individual's refusal of life-saving treatment overridden by state interests).


\textsuperscript{20} Prior to Quinlan, health care decisions were clearly being made for the incapacitated without court review. \textit{President's Commission Report}, supra note 1, at 154-55.

\textsuperscript{21} 70 N.J. at 23-24, 355 A.2d at 653-54. On April 15, 1975, for reasons not clear, Karen Quinlan stopped breathing for at least two fifteen-minute periods. \textit{Id.} Dr. Morse, the attending physician, concluded that the prolonged lack of oxygen in her bloodstream, known as anoxia, was associated with her condition. \textit{Id.}
Because her neurological damage affected her respiratory functions, she required an artificial respirator to sustain her life. Ms. Quinlan's father, Joseph Quinlan, sought to have his daughter adjudicated incompetent and himself appointed as her guardian. Reconciled to the hopeless prognosis, Mr. Quinlan requested that the letters of guardianship contain an express power to him as guardian to authorize removal of the respirator.

The trial court denied authorization for removal of the life-support system and withheld the letters of guardianship. On appeal, the New Jersey Supreme Court held that an individual's decision to allow his life to terminate by natural causes is protected by a constitutional right of privacy. Furthermore, the court found no reason to prevent that right from being extended to an incompetent. Because Ms. Quinlan was extremely debilitated and unable to either accept or reject the continuation of treatment, the court focused on the manner in which her constitutional right could be exercised. The court found that the only way to protect her right of privacy was to allow her father, as guardian, to determine whether his daughter would have chosen to die had she been able to expressly refuse the continued assistance of the respirator.

Although the court gave Joseph Quinlan power to make a medical treatment decision on behalf of his daughter, it imposed certain procedural safeguards to be followed prior to withdrawal of

22. *Id.* at 24, 355 A.2d at 654. Dr. Fred Plum, one of the physicians who examined Ms. Quinlan, defined an individual in a chronic persistent vegetative state as one who has "the capacity to maintain the vegetative parts of neurological function but who . . . no longer has any cognitive function." *Id.*

23. *Id.* at 25, 355 A.2d at 655.

24. *Id.* at 18, 355 A.2d at 651. Joseph Quinlan initiated the guardianship proceedings after his request to have his daughter's artificial respirator disconnected was denied by Ms. Quinlan's attending physician. *Id.* at 28, 355 A.2d at 656. The physician's refusal to disconnect the respirator was based upon his conception of then-existing medical standards, practices and ethics. *Id.* at 28, 355 A.2d at 657.

25. *Id.* at 18, 355 A.2d at 651.


27. 70 N.J. at 11, 355 A.2d at 647. The court stated that the constitutional right of privacy is "broad enough to encompass a patient's decision to decline medical treatment under certain circumstances in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions." *Id.* at 40, 355 A.2d at 663 (citing *Roe v. Wade*, 410 U.S. 113, 153 (1973)).

28. 70 N.J. at 41, 355 A.2d at 664.

29. *Id.* at 41-42, 355 A.2d at 664.

30. *Id.* The court, applying a "substituted judgment" standard, concluded that it was Joseph Quinlan's responsibility to determine whether his daughter, if competent, would have chosen to forego treatment.

31. *Id.* at 41, 355 A.2d at 664.
the life-sustaining system. First, the attending physicians were to conclude that there was no reasonable possibility that the patient would ever emerge from her comatose condition to a cognitive state and that this condition warranted disconnection of the life-support system. Second, both the guardian and the rest of the family were to concur in the decision to withdraw life support. Finally, a "hospital ethics committee," or other similar body, was to confirm the attending physician's prognosis that there was no reasonable possibility that the patient would emerge from a comatose state. If all three conditions were satisfied, the life-support system could be disconnected without Ms. Quinlan's express consent. The court further held that none of the participants in either the decision to terminate treatment or the implementation of the decision would be subject to civil or criminal liability.

The Quinlan court believed that the diffusion of decisionmaking responsibility among the incompetent patient's family, a physician and an ethics committee would ensure the reliability of the patient's prognosis and aid in the detection of any improper motives of the family or physicians. According to the court, judicial confirmation of a surrogate's decision to terminate an incompetent patient's life support would be not only burdensome and cumbersome, but an inappropriate encroachment on the medical profession.

B. Superintendent of Belchertown State School v. Saikewicz

Shortly after the New Jersey Supreme Court decided Quinlan, the Supreme Judicial Court of Massachusetts addressed the ques-
tion of whether an incompetent can assert a right to die. In *Superintendent of Belchertown State School v. Saikewicz*, an elderly incompetent in a mental health facility suffered from extreme mental retardation and leukemia.\(^4\) Chemotherapy treatment would have produced a thirteen-month remission at best,\(^4\) and without treatment, the patient was expected to die within weeks.\(^4\) The incompetent's guardian requested that chemotherapy not be initiated, believing that the adverse side effects of the treatment outweighed whatever limited benefits the patient would derive from such treatment.\(^4\)

The court, citing *Quinlan*,\(^4\) held that the constitutional right of privacy encompasses an incompetent's right to reject medical treatment.\(^4\) The court, however, flatly rejected the *Quinlan* approach of entrusting the decision regarding the withholding of life-sustaining treatment to the guardian, family, attending physician and hospital ethics committee.\(^4\) Instead, the court established as the appropriate procedure the judicial review of decisions to forego life-sustaining treatment.\(^4\) According to the court, the judicial

\(^{40.}\) *Id.* at 731, 370 N.E.2d at 420. Joseph Saikewicz had an I.Q. of ten and a mental age of approximately two years and eight months. He was diagnosed as having acute myeloblastic monocytic leukemia. Because of his profound mental retardation, he was unable to understand his illness and incapable of giving informed consent to treatment. *Id.* at 729, 370 N.E.2d at 419.

\(^{41.}\) *Id.* at 732, 370 N.E.2d at 420. Had remission occurred, its duration would probably have been two to thirteen months, although a longer period of remission was possible. *Id.*

\(^{42.}\) *Id.* at 733, 370 N.E.2d at 421. According to the medical testimony, a patient in Saikewicz's condition, if left untreated, would live for a few weeks, or perhaps several months. *Id.*

\(^{43.}\) *Id.* at 730, 370 N.E.2d at 419. The evidence indicated that adverse side effects of chemotherapy treatment include pain and discomfort, depressed bone marrow, anemia, increased chance of infection, bladder irritation, and loss of hair. *Id.* at 734, 370 N.E.2d at 421. The guardian concluded that these side effects, as well as the patient's inability to understand the nature of the treatment, outweighed the benefit from such treatment and that withholding chemotherapy would be in the patient's best interests. *Id.* at 730, 370 N.E.2d at 419.

\(^{44.}\) *See supra* notes 27-30 and accompanying text.

\(^{45.}\) 373 Mass. at 739, 370 N.E.2d at 424. The court also followed the *Quinlan* case insofar as it adopted a substituted judgment test to determine whether Saikewicz would have chosen to forego treatment had he been able to make such a decision. *Id.* at 751, 370 N.E.2d at 431. The court held that the facts indicated that Saikewicz would have chosen to forego chemotherapy treatments. *Id.* at 753, 370 N.E.2d at 431. The court stated that "the decision to withhold treatment from Saikewicz was based on a regard for his actual interests and preferences and . . . the facts supported this decision." *Id.* at 754-55, 370 N.E.2d at 432.

\(^{46.}\) *Id.* at 758, 370 N.E.2d at 434. The court, however, retained the incompetent's guardian as a representative of the patient's interests for purposes of litigation. *Id.* at 756, 370 N.E.2d at 433.

\(^{47.}\) *Id.* at 759, 370 N.E.2d at 434-35. Under the court's proposed procedure, a guard-
system is the best forum for such decisions because the courts are neutral, detached entities.48

Several issues emerged from the Quinlan and Saikewicz cases.49 Because the cases employed different procedural approaches to the incompetent’s right to die, questions arose concerning the judiciary’s proper role in a decision to forego treatment.50 While the
Quinlan court found judicial approval prior to termination of treatment to be unnecessary, the court in Saikewicz believed that the judiciary is the most appropriate forum for determining the propriety of foregoing an incompetent's treatment. Recently, however, the Massachusetts court modified the stance taken in Saikewicz. Under that state's current law, judicial approval is not required when the circumstances of a particular case render court intervention unnecessary.

Another issue which arose from Quinlan is the question of how seriously ill an incompetent patient must be before life-prolonging treatment can be terminated. In Quinlan, the court allowed a respirator to be disconnected from a hopelessly ill patient who had no reasonable chance of regaining consciousness. The court's opinion

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51. The medical community has criticized the Saikewicz court's advocacy of judicial participation in medical decisionmaking, believing court involvement to be an unwarranted intrusion into the traditional doctor-patient-family relationship. See Buchanan, Medical Paternalism or Legal Imperialism: Not the Only Alternatives for Handling Saikewicz-type cases, 5 AM. J.L. & MED. 97, 99 (1979); Relman, The Saikewicz Decision: A Medical Viewpoint, 4 AM. J.L. & MED. 233, 237 (1978) [hereinafter cited as A Medical Viewpoint]; Relman, The Saikewicz Decision: Judges as Physicians, 298 NEW ENG. J. MED. 508, 508-10 (1978) [hereinafter cited as Judges as Physicians]. Dr. Arnold Relman strongly disagrees with court intervention, believing that it is inconsistent with existing sound medical practice and that it requires lengthy and cumbersome procedures which may unjustifiably prolong the suffering of an incompetent patient. Relman believes that a decision for or against treatment that prolongs the incompetent's life should be made privately by the physician in consultation with the patient's family. A Medical Viewpoint, supra, at 235-37. But see Baron, Medical Paternalism and the Rule of Laws: A Reply to Dr. Relman, 4 AM. J.L. & MED. 337, 362 (1979), in which it is suggested that a physician take all steps necessary to prolong a patient's life until court permission to terminate medical treatment is obtained.


53. In re Spring, 380 Mass. 629, 636, 405 N.E.2d 115, 120-21 (1980). The Spring court suggested certain factors to be taken into account in deciding whether there should be a prior court order with respect to medical treatment of an incompetent patient. Among these factors are the extent of impairment of the patient's mental facilities; the prognosis; the urgency of the decision; the consent of the patient, spouse or guardian; the good faith of those who participate in the decision; and the administrative requirements of any institution involved. Id. at 637, 405 N.E.2d at 121. Compare In Custody of a Minor, 385 Mass. 697, 434 N.E.2d 601 (1982) (requiring judicial involvement when there were no family members with whom the physician could consult) with In re Dinnerstein, 6 Mass. App. 466, 380 N.E.2d 134 (1978) (dispensing with judicial approval of withholding of treatment when incompetent's son and daughter, in consultation with attending physician, agreed on proposed course of treatment).

54. 70 N.J. at 55, 355 A.2d at 671.
ion, however, expressly left open the question of whether the holding applies in medical situations involving incompetents who have not lost all cognitive life. In 1985, the New Jersey Supreme Court considered this question.

C. In re Conroy

In In re Conroy, the New Jersey Supreme Court was confronted for the first time with the issue of whether the rationale and procedure established in Quinlan apply to a decision to withdraw life-sustaining treatment from an incompetent patient who is awake and conscious. The patient, Claire Conroy, was an elderly nursing home patient who remained conscious despite serious physical and mental impairments. Her nephew, as guardian, sought permission from the court to have the patient's nasogastric feeding tube removed. Without the tube, Claire Conroy was expected to die of dehydration within one week.

The trial court held that the feeding tube could be removed. The court justified removal of the tube by concluding that the patient's life had become so burdensome to her that prolonging her life would be pointless and cruel. The appellate court reversed,
holding that the right to terminate life-sustaining treatment based on a guardian's judgment is limited to patients who are either brain dead or in a persistent vegetative state and who would gain no medical benefit from continued treatment. The appellate court concluded that withdrawing Claire Conroy’s nasogastric tube would be tantamount to homicide.

The Supreme Court of New Jersey reversed the appellate court, holding that patients like Claire Conroy need not be given nasogastric feeding and other forms of life support under certain circumstances. The court established specific standards which must be satisfied prior to withholding or withdrawing life-sustaining treatment from critically ill nursing home patients. According to the court, the application of a particular standard is to be based on evidence indicating what the patient would have done if he had been competent. The court held that if the evidence clearly establishes that the patient would have refused treatment under the circumstances, life-sustaining treatment may be foregone without pending.

65. Id. at 475, 464 A.2d at 315.
66. The court expressly limited its holding to patients who fit the Claire Conroy description: elderly, incompetent nursing home patients with serious physical and mental impairments, and with less than one year to live. Conroy III, 98 N.J. at 342 n.1, 486 A.2d at 1219 n.1.
67. Id. at 384, 486 A.2d at 1242. Only one other court has found the withdrawal of nasogastric tubes to be legal. Barber v. Superior Court, 147 Cal. App. 3d 1006, 1016-17, 195 Cal. Rptr. 484, 490 (1983). Some commentators distinguish failure to provide food and water from the cessation of other medical treatment. See Curran, Defining Appropriate Medical Care: Providing Nutrients and Hydration for the Dying, 313 NEW ENG. J. MED. 940, 940 (1985). The Conroy court stated that removal of a feeding tube should not be distinguished from cessation of other treatments. Conroy III, 98 N.J. at 373-74, 486 A.2d at 1236-37. The court also rejected all distinctions between ordinary and extraordinary treatment and active and passive medical conduct, believing that such distinctions are irrelevant once a decision not to prolong a patient’s life is made. Id. at 369-74, 486 A.2d at 1233-37; see also supra note 49.
69. The court proposed three different standards: (1) the subjective test, (2) the limited-objective test, and (3) the pure-objective test. Id. at 360-68, 486 A.2d at 1229-33. The subjective test is based on the substituted judgment doctrine, under which the surrogate determines, based on evidence of the patient’s preferences, what the patient would have done if able to express a choice. The remaining standards, the limited-objective test and the pure-objective test, are based on best interest principles. Under these standards, the surrogate does not have sufficient evidence to determine what course of treatment the incompetent would have chosen and, therefore, must arrive at a decision by ascertaining what action would be in the patient’s best interests. Id.
judicial review.\textsuperscript{70}

The court articulated other standards for situations where there is inadequate evidence of a patient's desires concerning treatment.\textsuperscript{71} In order to forego life-sustaining treatment under these standards, the surrogate must establish that the burdens of the patient's life with treatment clearly and markedly outweigh any benefits that the patient could derive from living.\textsuperscript{72} In order for the surrogate to make this showing, the patient must be suffering from recurring pain that will continue throughout the duration of his life.\textsuperscript{73} The patient's life expectancy, prognosis, and level of functioning should also be considered.\textsuperscript{74} The \textit{Conroy} court expressly denied surrogates the authority, in the absence of clear evidence of a patient's preferences, to terminate life-sustaining treatment of a conscious patient not suffering from pain.\textsuperscript{75} The court determined that such wide-ranging decisionmaking power would create substantial risks for incompetent patients.\textsuperscript{76}

The court then focused on the decisionmaking procedure and found that the procedure approved in \textit{Quinlan} was not entirely appropriate for nursing home residents.\textsuperscript{77} Because of the differences

\textsuperscript{70} \textit{Id.} at 360-61, 486 A.2d at 1229. According to the court, the requisite intent may be embodied in a living will, or evidenced by an oral directive, durable power of attorney, previous reactions by the patient to medical treatment administered to others, the patient's religious beliefs, or the patient's conduct in prior health care situations. \textit{Id.} at 361-63, 486 A.2d at 1229-30.

\textsuperscript{71} Under the limited-objective test, see supra note 69, the surrogate has some trustworthy evidence that the patient would have wanted treatment terminated. Such evidence may include casual comments made by the patient about other people's medical treatment, or other evidence that is too vague to show clear intent of the incompetent. \textit{Conroy III}, 98 N.J. at 365-66, 486 A.2d at 1232. Under the pure-objective test, see supra note 69, the surrogate has no trustworthy evidence whatsoever of the patient's preferences concerning life-sustaining medical procedures. \textit{Conroy III}, 98 N.J. at 366, 486 A.2d at 1232.

\textsuperscript{72} \textit{Conroy III}, 98 N.J. at 365, 486 A.2d at 1232. Under the pure-objective standard, see supra note 69, the court additionally required a showing that the administration of life-sustaining treatment would be inhumane. The court imposed a higher standard because the pure-objective test applies when there is no trustworthy evidence that the patient would have wanted treatment terminated. \textit{Conroy III}, 98 N.J. at 366, 486 A.2d at 1232.

\textsuperscript{73} \textit{Conroy III}, 98 N.J. at 366, 486 A.2d at 1232.

\textsuperscript{74} \textit{Id.}

\textsuperscript{75} \textit{Id.} at 367, 486 A.2d at 1233.

\textsuperscript{76} \textit{Id.}

\textsuperscript{77} \textit{Id.} at 374-75, 486 A.2d at 1237. The court justified its conservative procedural treatment of nursing home residents by distinguishing nursing home patients from hospital patients on several grounds: residents of nursing homes are particularly vulnerable and often are without any surviving family, physicians have a much more limited role in nursing homes than in hospitals, and nursing homes suffer from problems to which hospitals are less prone. \textit{Id.} at 374-76, 486 A.2d at 1237. Documented evidence indicates that
between hospitals and nursing homes, the Conroy court required a guardian contemplating termination of treatment of a nursing home resident to notify a state agency for the elderly. The agency was then responsible for obtaining confirmation of the patient’s medical condition and prognosis from two impartial physicians. If the guardian believed, based on the medical evidence, that the appropriate standard was satisfied, and if the attending physician and the incompetent’s family concurred in the decision to terminate treatment, life-sustaining treatment could be foregone.

Based on the facts before it, the Conroy court concluded that the evidence concerning the extent of Claire Conroy’s pain was insufficient to establish that the burdens of treatment outweighed the benefits of life. The court therefore refused to authorize the withdrawal of the feeding tube.

D. Statutory Law

An individual who wishes to preserve his right to die if he should become mentally unable to refuse life-prolonging treatment can prepare a directive to that effect while he is competent. Many people, fearing a slow death prolonged by painful treatment

the particular problems of nursing homes include cruel and negligent treatment of patients; danger from fires, food poisoning, and virulent infections; and lack of human dignity. The result is often needless injury or death to nursing home residents. SUBCOMM. ON LONG-TERM CARE OF THE AGING, NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, INTRODUCTORY REPORT, S. REP. NO. 1420, 93d Cong., 2d Sess. 16 (1974).

78. Conroy III, 98 N.J. at 383, 486 A.2d at 1241. The New Jersey legislature had established an Office of the Ombudsman for the Institutionalized Elderly and charged it with the responsibility of protecting the elderly from “abuse.” Id.; see also N.J. STAT. ANN. §§ 52.27G-1 to 52.27G-7 (West 1986).


80. Id. at 384-85, 486 A.2d at 1242. If the limited-objective or pure-objective test is used, see supra note 69, both the attending physician and the patient’s immediate family (spouse, parents, children, or next of kin if the patient has no immediate family) must concur in the guardian’s decision. However, if the subjective test is used, see supra note 69, only the attending physician must concur with the guardian. Conroy III, 98 N.J. at 384-85, 486 A.2d at 1242.


82. Id. at 385-87, 486 A.2d at 1242-44. The court found insufficient evidence of clear intent under the subjective test and insufficient indication of the patient’s pain under the limited-objective or pure-objective tests. Id.; see also supra notes 69-72.

83. Conroy III, 98 N.J. at 385-87, 486 A.2d at 1242-44.

84. There are two general types of advance directives. Living wills, see infra notes 84-94 and accompanying text, specify certain forms of medical treatment that a patient does or does not want to have. Durable power of attorney documents, see infra note 94, allow an individual to designate a surrogate to make health care decisions in the event that the individual becomes incompetent. See Buchanan, supra note 14, at 211. Advance directives are not confined solely to decisions to forego life-sustaining treatment. They
or life-support machines, express a desire to die by natural causes in a directive known as a "living will." The legality of living wills was at one time in question. Prompted in part by the Quinlan case, California passed legislation which gave legal effect to living wills. Under the terms of the California Natural Death Act, a physician can forego a patient's life-sustaining treatment if the patient is terminally ill and has executed a valid living will. Twenty-two other states have passed similar legislation which enables a competent adult to preserve his right to die by means of a living will. However, only a few states have extended the benefits

may be drafted for use in other health care situations. President's Commission Report, supra note 1, at 137.

85. Note, supra note 3, at 486. A "living will" is a document in which an individual expresses, in anticipation of sickness and mental incompetency, a desire not to be subjected to life-supporting medical procedures if no reasonable hope of recovery exists. Note, Equal but Incompetent: Procedural Implementation of a Terminally Ill Person's Right to Die, 36 U. Fla. L. Rev. 148, 149 n.6 (1984).

People increasingly wish to participate in deciding whether they will be administered life-sustaining treatment in a given situation. As a result, the popularity of living wills has increased dramatically. Adams & Adams, An Overview of Georgia's Living Will Legislation, 36 Mercer L. Rev. 45, 46 (1984).


87. See supra notes 84-86 and accompanying text.


89. See supra notes 84-86 and accompanying text.

of right-to-die legislation to incompetents.\footnote{91}

IV. ANALYSIS

Although the enactment of the first natural death act was inspired by a case involving an incompetent patient, most such acts do not adequately protect an incompetent’s right to die. Under most statutes, patients who were never competent,\footnote{92} or who did not execute a binding living will\footnote{93} prior to incompetency, are not provided with a means of exercising their right to forego life-sustaining treatment.\footnote{94} When a statute contains no established proce-

\begin{itemize}
\item CODE ANN. §§ 6-2421 to 6-2430 (Supp. 1985); FLA. STAT. §§ 765.01 to 765.15 (1984);
\item 91. Only Louisiana, New Mexico, North Carolina, Oregon and Virginia have extended the benefits of their statutes to incompetent patients without valid living wills. These statutes provide for surrogate medical decisionmaking on behalf of incompetent patients who have never expressed a “right to die.” Louisiana and Oregon restrict their statutes to irreversibly vegetative comatose patients, LA. REV. STAT. ANN. § 40:1299.58.5 (West Supp. 1985); OR. REV. STAT. § 97.083 (1983), while New Mexico, North Carolina and Virginia also include incompetent patients with terminal illnesses. N.M. STAT. ANN. § 24-7-8.1 (Supp. 1984); N.C. GEN. STAT. § 90-322 (Supp. 1983); VA. CODE § 54-325.8:6 (Supp. 1984).
\item 92. All living wills statutes provide, at a minimum, that a directive be issued by a competent adult. See, e.g., CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1986).
\item 93. A living will may not be binding if it is executed in a state that does not statutorily recognize living wills or if the conditions specified in the state’s natural death act are not satisfied. See supra note 89 for a discussion of the restrictions in the California Natural Death Act, for example.
\item 94. Only five states have established a surrogate decisionmaking procedure for an incompetent who has not issued a living will. See supra note 91. There does exist in many states, however, another legal means for allowing a surrogate to make health care decisions on behalf of an incompetent. Durable power of attorney statutes allow a competent adult to appoint an “agent” to make health care decisions in the event that he becomes incompetent. However, like natural death acts, this method is of no use when an individual did not or could not take advantage of the statute at a time of competency. PRESIDENT’S COMMISSION REPORT, supra note 1, at 146. To date, forty-two states have durable power of attorney statutes. See, e.g., ARIZ. REV. STAT. ANN. § 14-5501 (1975);
dure for dealing with incompetent patients who have not executed valid living wills, situations involving such patients may be forced into the court system. Although some courts have indicated that judicial approval is not necessary for termination of an incompetent’s life-sustaining treatment, courts have not clearly stated what circumstances justify allowing the patient’s death. As a result, families and health care professionals, unsure of the law and fearful of liability, often seek court review of their decisions not to extend an incompetent patient’s life.

State legislatures should formulate clear standards for establishing when the right to terminate an incompetent’s treatment arises and what procedures must be followed to exercise that right. The legislature is a more appropriate forum than the courts for formulation of guidelines for decisionmaking on behalf of incompetent patients. Several factors lead to the conclusion that courts generally should not be involved in the substantive decision to withhold or discontinue life-saving medical treatment.

Durable power of attorney statutes were not expressly enacted to facilitate health care decisionmaking on behalf of incompetents. President’s Commission Report, supra note 1, at 147. They were enacted primarily to avoid the time and expense of guardianship proceedings when certain property interests were involved. As a result, the statutes contain no express language limiting the scope of a surrogate’s power to make medical treatment decisions for an incompetent patient. Id. Recognizing that a lack of guidelines could lead to abuse by surrogate medical decisionmakers, the President’s Commission nonetheless encourages the use of durable power of attorney statutes as a “simple, flexible and powerful device for making health care decisions on behalf of incapacitated patients.” Id. at 146.

Durable power of attorney statutes are useful in a much broader range of situations than natural death acts. Unlike natural death acts, durable power of attorney statutes are not restricted to persons who are diagnosed as terminally ill. They permit surrogates to make more subjective decisions concerning the medical treatment of an incompetent, rather than limiting the surrogate to mere implementation of a terminally ill patient’s previous instruction to forego all life-prolonging procedures. Id. at 145-47. However, a durable power of attorney is still of no use to an incompetent patient who did not nominate a surrogate under the statute at a time of competency.

95. See supra note 50.

96. As an elected body, the legislature is an open forum for the viewpoints of all interested institutions and disciplines. In re Conroy, 98 N.J. 321, 336, 486 A.2d 1209, 1220 (1985). The legislature has the ability to synthesize data and opinions on the legal, medical, ethical, moral and social aspects of the right to die and to then formulate guidelines that best reflect the values of society. In re Hamlin, 102 Wash. 2d 810, 821-22, 689 P.2d 1372, 1379 (1984).

97. See supra note 51 and accompanying text; infra notes 98-102 and accompanying text. Dr. Arnold Relman believes that judicial involvement in cases concerning the medical care of incompetent patients should be limited to three instances: (1) when the patient has no next of kin, the court must appoint a guardian; (2) when there are differences of opinion, among the family or between physicians and family, as to what should be done,
By establishing specific guidelines, legislatures can eliminate case-by-case judicial review of decisions to forego life-sustaining treatment of an incompetent patient.\textsuperscript{98} While courts are limited by the facts of particular cases, legislatures can establish guidelines applicable to a broad range of situations, thereby providing certainty to guardians and health care professionals during the decisionmaking process.

Judicial review of questions concerning the propriety of withholding medical treatment needlessly encroaches on the medical profession.\textsuperscript{99} Medical decisionmaking for incompetents should be a collaborative effort by physicians and families or guardians, rather than a court battle between competing interests.\textsuperscript{100} Furthermore, the judicial process is expensive and slow.\textsuperscript{101} Judicial involvement subjects families and physicians to burdensome and time-consuming proceedings. A requirement of court approval would compel a physician to continue administering treatment until termination was approved, and could result in an unnecessarily painful and lengthy prolongation of the patient's life.\textsuperscript{102}

\textit{A. The Role of the Incompetent Patient's Family}

To preserve the traditional doctor-patient-family relationship, legislatures should establish the right of families or guardians of incompetent patients, in conjunction with the attending physician, to make decisions concerning the withdrawal or initiation of the patient's medical treatment.\textsuperscript{103} The special relationship that usu-
ally exists between the family and its incompetent member justifies the designation of the family as a surrogate decisionmaker for an incapacitated patient.\textsuperscript{104} Family members are ordinarily the people most concerned about the patient’s welfare and most knowledgeable about the values and beliefs of the patient. The family of the incompetent patient, guided by the ascertainable beliefs and preferences of the patient,\textsuperscript{105} should make the actual decision as to the withdrawal or initiation of treatment. Life-sustaining treatment should be withdrawn or withheld only if all family members concur in the decision.

Although many courts have advocated the participation of the family in a decision to withhold life-sustaining treatment from its incompetent member,\textsuperscript{106} the term “family” has not always been defined.\textsuperscript{107} The definition of “family” should be precise. Inclusion in the decisionmaking process should perhaps be restricted to the patient’s immediate family, or the next of kin if the patient has no immediate family. Without such a restriction, the participation of more distantly-related family members could result either in a dis-

\textsuperscript{104} Buchanan, supra note 51, at 97. Dr. Allen Buchanan suggests that the proper presumption in a decision concerning an incompetent’s treatment is that the family plays the dominant role in the decisionmaking process. \textit{Id.} at 110-11. Buchanan criticizes other commentators’ suggestions that either the court or the patient’s physician should be the primary decisionmaker, believing the former to be too paternalistic legally and the latter too paternalistic medically. \textit{Id.} at 97. See \textit{A Medical Viewpoint, supra} note 51, at 236; Baron, \textit{supra} note 51, at 362.

\textsuperscript{105} The goal of decisionmaking on behalf of incompetent patients should be to effectuate the decision the incompetent would have made if competent. \textit{In re Conroy}, 98 N.J. 321, 360, 486 A.2d 1209, 1228 (1985). The substituted judgment doctrine allows a surrogate to assert an incompetent’s right to die if the surrogate believes that the patient would have done the same. See \textit{infra} note 122.


interested party making the decision to terminate treatment or in lengthy delays in soliciting the concurrence of all family members.108

B. The Role of the Hospital Ethics Committee

Leaving decisions to forego life-sustaining treatment solely in the hands of family members and physicians is potentially dangerous. The absence of any review procedure might allow a patient to die prior to confirmation of the reliability of the prognosis or the propriety of the decisionmakers' motives. As discussed earlier, judicial review of such decisions is also inappropriate because court involvement is cumbersome, costly and an unnecessary encroachment on the medical profession.109

A hospital ethics committee110 or similar impartial body111 is an effective and efficient alternative to court review.112 Once a deci-

108. Limiting the family members required to concur in a decision to forego an incompetent member's treatment does not necessarily preclude other family members from participating in the decision; it merely limits the number of people whose concurrence is required. If a more distant relative or other interested party believes that a decision to forego treatment is not in the patient's best interests or has some evidence of the patient's desire to the contrary, it is appropriate for that party to challenge the family's decision. Accord, Buchanan, supra note 14, at 214.

109. See supra notes 98-102 and accompanying text.

110. An ethics committee is broadly defined as follows: "a multidisciplinary group of health care professionals within a health care institution that has been specifically established to address the ethical dilemmas that occur within the institution." Cranford & Doudera, The Emergence of Institutional Ethics Committees, in HEALTH CARE DECISION MAKING, supra note 14, at 6-7. In a recent survey conducted by the American Hospital Association, 60% of the hospitals polled had ethics committees. Hospital News, Nov. 1, 1985, at 60, col. 1.

111. If the incompetent patient is in a health care institution other than a hospital, an impartial body appropriate to that facility should serve substantially the same role as the hospital ethics committee in medical treatment decisions for incompetents. For example, in In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985), a governmental agency for the elderly reviewed a decision to forego a nursing home resident's life-sustaining treatment. See supra note 78 and accompanying text.

112. Lynn, Roles and Functions of Institutional Ethics Committees: The President's Commission's View, in HEALTH CARE DECISION MAKING, supra note 14, at 24. Institutional participation in decisions to forego treatment is preferable to court review because health care professionals (1) are usually concerned about the patient's welfare and are educated or educable about the medical decisionmaking process, (2) can be held accountable for their actions, and (3) can respond quickly to a given situation. Id.


Several commentators have heralded the ethics committee as a well-founded alternative to court review. Comment, Judicial Intervention in the Exercise of the Incompetent's
sion to forego an incompetent's treatment has been made by the incompetent's family and physicians, the ethics committee may serve as a reviewing body, thus providing an objective review of the decisionmaking process. The ethics committee’s primary role would be to protect the interests of the patient and to ensure that health care decisions are morally and legally acceptable.

C. The Decisionmaking Procedure

In creating specific procedures to be followed before an incompetent patient's life-sustaining treatment is foregone, legislatures should categorize incompetent patients in two broad groups. The first group of patients should be limited to those who, like Karen Quinlan, are unconscious and possess no reasonable hope of regaining consciousness. Individuals who are permanently unconscious are immobile, speechless, unresponsive to human contact, and devoid of emotion. Although not legally brain dead,
their brain activity is so minimal that they have lost all cognitive life.\textsuperscript{118}

The second group of patients should include all incompetent patients who are extremely ill, but who are not permanently unconscious.\textsuperscript{119} Although these patients may be conscious, they are still not considered mentally competent to personally exercise their right to die.\textsuperscript{120} Because the prognosis of the critically ill conscious patient is ordinarily not clearly hopeless as it is in the case of the permanently unconscious patient, this group of incompetents must be afforded greater procedural protection. Unlike the vegetative patient who is gaining no recognizable benefits from life, these patients may be deriving some satisfaction from life despite a dim prognosis or a limited level of functioning.

1. Permanently Unconscious Patients

In order to give legal guidance to those involved in a decision to terminate a permanently unconscious patient's life, legislatures should enact a decisionmaking procedure similar to that proposed by the Quinlan court, which permitted life-sustaining treatment to be terminated without the patient's consent and without court approval if three conditions were satisfied.\textsuperscript{121} First, the attending physician must conclude that there is no reasonable possibility that the patient will ever emerge from a comatose condition to a cognitive state. Second, the family must concur in a decision to withdraw the life-support system. Finally, a hospital ethics committee, or other similar body, must confirm the attending physician's prognosis.\textsuperscript{122}

\begin{enumerate}
\item [117] See supra note 6.
\item [119] For purposes of this note, the term "conscious" will be used to describe all incompetent patients not permanently unconscious, see supra note 115, including those with partial impairments of consciousness.
\item [120] See supra notes 11-14 and accompanying text.
\item [122] In arriving at a decision concerning an incompetent's treatment, courts require a surrogate to follow either substituted judgment or best interest principles. Under the substituted judgment doctrine, a surrogate can determine whether an incompetent would have elected to forego treatment, but only when the patient was once capable of expres-
Although the *Quinlan* court required that a guardian decide initially whether or not to forego an incompetent's life-prolonging treatment, a court-appointed guardian should not be mandatory when immediate family members are available and willing to make the decision.\(^2\) Guardianship proceedings are unnecessarily cumbersome and costly when there are family members who can make treatment decisions on behalf of the hopelessly ill patient. Furthermore, the concurrence of the treating physician and a prognosis confirmation by an ethics committee provide adequate protection against the danger that family members will act in a manner inconsistent with the patient's best interests.

2. Conscious Patients

In formulating a procedure for surrogates to follow in deciding whether to terminate treatment of an incompetent but conscious patient, legislatures should establish a more stringent decisionmaking procedure to protect this vulnerable group of patients. In contrast to the irreversibly comatose or vegetative patient who has suffered extreme brain damage, the conscious patient is cognitive. Because his mental capability is at least minimal, he must be adjudged incompetent to make his own health care decisions before any life and death decisions are made for him. Once a court has

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When a patient has never been sufficiently competent to understand the nature of life-sustaining medical treatment, the surrogate decisionmaker will decide what medical treatment is in the patient's best interests. The surrogate is to make this decision after weighing the benefits and costs of the patient's options. Buchanan, *supra* note 14, at 211. For a more detailed discussion of legal limitations on the best interest and substituted judgment principles, see Capron, *The Authority of Others to Decide about Biomedical Interventions with Incompetents*, in *Who Speaks for the Child?* 115-52 (W. Gaylin & R. Macklin eds. 1982).

\(^2\) Several courts have found that where the family agrees in a decision to withdraw or withhold treatment from its incompetent member, an appointment of a guardian to represent the patient's interests is unnecessary. *See*, e.g., Barber v. Superior Court, 147 Cal. App. 3d 1006, 1020-21, 195 Cal. Rptr. 482, 492-93 (1983); John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921, 926 (Fla. 1984); *In re Hamlin*, 102 Wash. 2d 810, 819, 689 P.2d 1372, 1377 (1984).

Furthermore, it has been argued that the *Quinlan* court did not require the appointment of a guardian, even though the holding was couched in terms of what the family and guardian should do. *Comment, The Right to Die — A Current Look*, 30 Loy. L. Rev. 139, 152 n.84 (1984).
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adjudged the patient incompetent, questions concerning medical treatment should be resolved outside of the judicial system.

To guide the incompetent’s family in deciding whether to terminate life-sustaining treatment, medical evidence of the patient’s condition, treatment and prognosis, in addition to evidence of the patient’s wishes, must be considered. The patient’s condition must be terminal, incurable and irreversible. Additionally, the medical evidence must establish that if treatment were administered, the patient would suffer such pain that the burden of living would outweigh any satisfaction the patient might derive from living. The evidence should clearly establish that the treatment would only prolong the patient’s suffering and would not provide him with any real benefit. If the surrogate decisionmaker, after consultation with the attending physician, believes that the medical evidence warrants discontinuation of the patient’s treatment, he may make a decision to withdraw or withhold the incompetent’s life-sustaining treatment. After the immediate family has concurred in the decision, an ethics committee must review the decision. The committee must independently confirm the prognosis and determine whether the medical evidence establishes that the patient’s prognosis and level of pain with treatment warrant termination of treatment. If the family, the physician and the committee comply with the proposed procedure, life-sustaining treatment may be withheld or withdrawn without court approval.

D. Liability

A participant in a decision to forego treatment on behalf of an incompetent, or in the implementation of that decision, should not be subject to civil or criminal liability for any action taken in accordance with legislative guidelines. Participants in the decision-


125. This standard was used in In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); see supra note 71 and accompanying text.

126. Once a decision to terminate an incompetent’s life-sustaining treatment is properly made, the law should permit any form of medical treatment except basic nursing care to be withheld or withdrawn. Distinctions between ordinary and extraordinary treatment, and active and passive medical conduct, are unnecessary when a decision has been made not to prolong a patient’s life. See supra notes 49, 66.

sionmaking process should be protected by the law, but only if the decisions are made in good faith. Any decision allegedly made in bad faith should be judicially reviewed for a determination of whether the decision makers are liable under civil or criminal laws.

V. CONCLUSION

Developments in medical technology that allow physicians to prolong lives are an unquestionable benefit to society. However, when an individual has no chance of ever regaining consciousness, or when he is conscious but in severe pain and facing imminent death, no one benefits from prolongation of his life, and the family may be substantially burdened, both financially and emotionally. Family members and guardians are increasingly asserting a right to die on behalf of individuals unable to do so. However, the lack of legislation in this highly sensitive and complex area is not providing surrogates with sufficient guidelines concerning their decisions. Specific legislation must be adopted in order to define the legal limits of surrogate decision making and to ensure protection of the incompetent's rights. Legislatures should provide surrogate decision makers with consistent and uniform procedures for withholding or withdrawing an incompetent's treatment in situations where the incompetent has not previously executed a valid living will. Provided that the statutory guidelines were followed, surrogates could terminate treatment without seeking court review and without fear of liability. Surrogates guided by statute would no longer need to rely upon confusing case law or limited living will legislation.

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