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NOTES

CONSTITUTIONAL LAW—RIGHT TO REFUSE MEDICAL TREATMENT—DECISIONS TO TERMINATE LIFE-PROLONGING TREATMENT FOR INCOMPETENT PATIENTS—*In re Spring*, No. 2030 (Mass., order of Jan. 14, 1980).

I. INTRODUCTION

In re Spring[1] is the most recent of a Massachusetts series of cases involving the right to refuse life-prolonging treatment on behalf of an incompetent patient. The patient in this case was a 78-year-old senile man who suffered from kidney disease requiring kidney dialysis. After his wife and son petitioned the probate court to have the dialysis treatments discontinued, the Massachusetts Supreme Judicial Court ruled that the probate court could grant the petition. The cases which form the background to *In re Spring* include the New Jersey case of *In re Quinlan*[2] and the Massachusetts cases of *Superintendent of Belchertown State School v. Saikewicz*[3] and *In re Dinnerstein*.[4] The rulings in these cases have important implications regarding society's treatment of incompetent patients, particularly those suffering from illnesses which would be terminal if not treated. This note will discuss *In re Spring*, the three cases which precede it, and the implications of this most recent case.

II. BACKGROUND

A. *In re Quinlan*

When *Quinlan*[5] was decided by the New Jersey Supreme Court in 1976, nationwide attention was focused on the kinds of ethical problems raised by the rapid advances made in medical technology.[6] Karen Ann Quinlan was in an irreversible coma which her physician characterized as a "chronic persistent vegetative

1. No. 2030 (Mass., order of Jan. 14, 1980).
2. 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied*, 429 U.S. 922 (1976).
3. 1977 Mass. Adv. Sh. 2461, 370 N.E.2d 417.
4. 1978 Mass. App. Ct. Adv. Sh. 736, 380 N.E.2d 134.
5. 70 N.J. at 10, 355 A.2d at 647.
6. The problem of deciding when someone should not be treated when previously no treatment was available and the problem of who shall be treated when dealing with scarce resources such as transplants and sophisticated machines, existed, of course, before the *Quinlan* case focused public attention on them. *See, e.g.*, Annas, *Medical Remedies and Human Rights: Why Civil Rights Lawyers Must Become Involved in Medical Decision-Making*, 2 HUMAN RIGHTS 151 (1972).

state."[7] Kept alive by a respirator,[8] she was described as emaciated, her posture fetal-like and grotesque. The medical prognosis was that she was unlikely to ever regain consciousness, and it was noted that there was no known treatment which promised to cure or to improve her condition.[9] Her father's request that life-sustaining mechanisms be removed was opposed by her doctors, the hospital, the Morris County prosecutor, the State of New Jersey, and her guardian *ad litem*.[10]

In acknowledging that life-sustaining apparatus may be removed even though death might ensue, the New Jersey court stated that the constitutional right of privacy[11] must be weighed against the state's interest in the preservation of life. This right of privacy allows a patient to decide to refuse treatment under certain circumstances,[12] and this right could be asserted on a patient's behalf by a guardian.[13]

The *Quinlan* decision focused on the medical prognosis that it was unlikely Karen would "return to cognitive and sapient life, as distinguished from the forced continuance of that biological vegetative existence to which [she] seems to be doomed."[14] The court's preference for allowing the physician, with the concurrence of the family, to make the decision to remove her from the respirator followed logically from this emphasis on medical prognosis. The court rejected the notion that such a decision should be made by the courts, characterizing it as a "gratuitous encroachment upon the medical profession's field of competence" as well as being "impossi-

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7. 70 N.J. at 24, 355 A.2d at 654.

8. This was the supposition of the court and all the medical authorities. At this writing, however, Karen Quinlan lives, still in a coma, despite the respirator having been withdrawn.

9. 70 N.J. at 26, 355 A.2d at 655.

10. *Id.* at 22, 355 A.2d at 653.

11. *See* Roe v. Wade, 410 U.S. 113 (1973) and Doe v. Bolton, 410 U.S. 179 (1973) (state criminal abortion statutes violate the right to privacy); Eisenstadt v. Baird, 405 U.S. 438 (1972) (statute prohibiting distribution of contraceptive devices or drugs to unmarried persons violates individual's right to privacy); Stanley v. Georgia, 394 U.S. 557 (1969) (statute prohibiting mere private possession of obscene material violates right to privacy); Griswold v. Connecticut, 381 U.S. 479 (1965) (statute forbidding use of contraception violates right of marital privacy). *See also*, Kindregan, *The Court as Forum for Life and Death Decisions: Reflections on Procedures for Substituted Consent*, 11 SUFFOLK U. L. REV. 919, 921 (1977); Comment, *Withholding Treatment from Defective Newborns: Substituted Judgment, Informed Consent, and the* Quinlan *Decision*, 13 GONZ. L. REV. 781, 790 (1978).

12. 70 N.J. at 39-41, 355 A.2d at 663-64. The right of privacy takes precedent over the state's interest in preserving life as the degree of bodily invasion of the treatment increases and the medical prognosis worsens. *Id.* at 41, 355 A.2d at 664.

13. *Id.*

14. *Id.* at 51, 355 A.2d at 669.

bly cumbersome."[15] Furthermore, while essentially leaving the decision to the patient's doctor and family, the court held that the concurrence of a hospital ethics committee would be required before life-sustaining procedures could be withdrawn.[16] Such a committee would function both as a procedural safeguard and as an insurer that no civil or criminal liability would ensue.[17]

The *Quinlan* decision shattered precedent in its judicial recognition of the right to withhold treatment needed for the preservation of an incompetent patient's life.[18] Once this right was enunciated, however, the crucial questions became who should make such a decision and what criteria should be used. Viewing the decisive factor of the case as the medical prognosis, the *Quinlan* court saw no reason why decisions made on a medical basis should be evaluated by a court.[19]

B. *Superintendent of Belchertown State School v. Saikewicz*

Saikewicz[20] involved the issue of whether to administer chemotherapy to a severely retarded 67-year-old man suffering from leu-

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

16. *Id.* at 54, 355 A.2d at 671.

17. *Id.* The New Jersey court's requirement of an ethics committee with legal status to rule on the termination of life-sustaining treatment derives from an idea in a law review article written by a physician, Dr. Karen Teel. Teel, *The Physician's Dilemma, A Doctor's View: What the Law Should Be*, 27 BAYLOR L. REV. 6 (1975). Dr. Teel wrote of the ethical judgments which physicians make by virtue of their responsibility for medical judgments despite the lack of training to make these judgments, and despite the lack of moral and legal authority to make them. She embraced the idea of a committee to share responsibility, although noting that many physicians and families would oppose this intrusion on what she characterizes as "personal and private problems." *Id.* at 8-9. The *Quinlan* court cited with approval the idea of a diffusion of professional responsibility for such a decision. 70 N.J. at 49-50, 355 A.2d at 669. The approach of judicial intervention later adopted by the Massachusetts Supreme Judicial Court in *Saikewicz* is not considered in the article.

18. *See generally* Schultz, Swartz & Appelbaum, *Deciding Right-to-Die Cases Involving Incompetent Patients: Jones v. Saikewicz*, 11 SUFFOLK U. L. REV. 936, 938-39 (1977). Some commentators, following Quinlan, expressed fear at what was regarded as a devaluation of life. *See, e.g.*, Roddy, *The Karen Quinlan Case—A Constitutional Right to Die?*, 58 CHI. B. REC. 120, 123 (1976). *But see* Comment, *supra* note 11, at 782, 783.

19. *See* 70 N.J. at 50, 355 A.2d at 669. Annas, *Reconciling* Quinlan *and* Saikewicz: *Decision Making for the Terminally Ill Incompetent*, 4 AM. J.L. & MED. 367, 380 (1979). For more discussion of the *Quinlan* decision see Coburn, *In re Quinlan: A Practical Overview*, 31 ARK. L. REV. 59 (1977); Collester, *Death, Dying and the Law: A Prosecutorial View of the* Quinlan *Case*, 30 RUTGERS L. REV. 304 (1977); Note, *The Right to Die a Natural Death: A Discussion of* In re Quinlan *and the California Natural Death Act*, 46 U. CIN. L. REV. 192 (1977); Note, *The Legal Aspects of the Right to Die: Before and After the* Quinlan *Decision*, 65 KY. L.J. 823 (1977); Note, In re Quinlan: *Defining the Basis for Terminating Life Support Under the Right of Privacy*, 12 TULSA L.J. 150 (1976).

20. 77 Mass. Adv. Sh. 2461, 370 N.E.2d 417 (1977).

kemia. In affirming the probate court decision not to order treatment, the Massachusetts Supreme Judicial Court specifically rejected the *Quinlan* court's approach:

> We take a dim view of any attempt to shift the ultimate decision-making responsibility away from the duly established courts of proper jurisdiction to any committee, panel or group. . . . Thus, we reject the approach adopted by the New Jersey Supreme Court in the *Quinlan* case of entrusting the decision whether to continue artificial life support to the patient's guardian, family, attending doctors, and hospital's "ethics committee."[21]

While recognizing that the constitutional right of privacy allows a patient to refuse medical treatment[22] and that this right extends to an incompetent as well as to a competent patient,[23] the court held that the proper vehicle for the exercise of this right on behalf of an incompetent is the substituted judgment test[24] which allows the court to substitute its judgment for that of the incompetent patient. It was determined that a probate judge could issue the appropriate order should he or she "be satisfied that the incompetent individual would . . . have chosen to forego potentially life-prolonging treatment . . . . If the judge is not so persuaded, or finds that the interests of the state require it, then treatment shall be ordered."[25]

In determining what Mr. Saikewicz would have wanted were he competent to formulate such a desire, the Massachusetts Supreme Judicial Court weighed the factors considered by the probate judge. Two factors were cited in favor of treatment: Most people elect such treatment; and such treatment would offer the chance of a longer life.[26] Six factors, however, were cited as weighing against the administration of chemotherapy: Saikewicz's age; his inability to cooperate in the treatment; the probable adverse side effects; the low chance of producing remission; the certainty that the treatment would cause immediate pain and suffering; and the quality of life possible for him even if remission did occur.[27] The

21. *Id.* at 2499-2500, 370 N.E.2d at 434.

22. *Id.* at 2474-75, 370 N.E.2d at 424.

23. *Id.* at 2482-83, 370 N.E.2d at 427.

24. The common law doctrine of substituted judgment has long been used to allow courts and guardians to make a variety of decisions for an incompetent. *See* Schultz, Swartz & Appelbaum, *supra* note 18, at 943-49 for a summary of the history of this doctrine.

25. *Id.* at 2498-99, 370 N.E.2d at 434.

26. *Id.* at 2469, 370 N.E.2d at 422.

27. *Id.*

supreme judicial court reviewed these factors, carefully qualifying two of them. Saikewicz's age was to be considered only because medical evidence showed that people of his age do not tolerate chemotherapy as well as younger people and that remission is less likely. The question of age was irrelevant "of course" to the value of his life.[28] The term "quality of life" was to be understood solely "as a reference to the continuing state of pain and disorientation precipitated by chemotherapy."[29] The value of life was not to be equated in any way with the quality of life.[30] Based on these factors, the court found that Saikewicz would have rejected treatment if he were miraculously competent and had knowledge of his own incompetence.

The Massachusetts court's rejection of the *Quinlan* court's solution led to controversy. The medical community was outraged at what it viewed as a usurpation of the role and the responsibility of the medical profession.[31] The feelings of affront were exacerbated by the knowledge that the *Saikewicz* court was declaring that medical decisions that some doctors routinely make, as in decisions not to treat defective newborns,[32] could be reviewed by the courts. The resentment was also aggravated by legal advisors' misconstruing the court's decision as requiring judicial intervention for *every* life or death decision.[33] Confusion reigned, but was partially abated by the appeals court decision in *In re Dinnerstein*. This decision delineated one situation, at least, not intended to be covered by the *Saikewicz* decision.

C. *In re Dinnerstein*

The *Dinnerstein*[34] case was described by Justice Liacos, the author of the *Saikewicz* decision, as "a case that need never have

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28. *Id.* at 2493 n.17, 370 N.E.2d at 432 n.17.

29. *Id.* at 2494-95, 370 N.E.2d at 432.

30. *Id.* at 2494, 370 N.E.2d at 432.

31. *See* Baron, *Assuring "Detached but Passionate Investigation and Decision": The Role of Guardians Ad Litem in Saikewicz-type Cases*, 4 AM. J. L. & MED. 111, 116 (1978); Curran, *The Saikewicz Decision*, 298 NEW ENG. J. MED. 499, 500 (1978); Liacos, *Dilemmas of Dying*, Medicolegal News Fall 1979, at 6; Relman, *The Saikewicz Decision: A Medical Viewpoint*, 4 AM. J.L. & MED. 233, 234 (1978).

32. For a discussion of this issue see Duff & Campbell, *Moral and Ethical Dilemmas in the Special-Care Nursery*, 289 NEW ENG. J. MED. 890 (1973); Robertson, *Involuntary Euthanasia of Defective Newborns: A Legal Analysis*, 27 STAN. L. REV. 213 (1975).

33. *See* Curran, *supra* note 31, at 500; Liacos, *supra* note 26, at 6; Relman, *supra* note 31, at 234, 237.

34. 78 Mass. App. Ct. Adv. Sh. 736, 380 N.E.2d 134 (1978).

been litigated because it was clearly without the scope of *Saikewicz*."[35] *Dinnerstein* involved a 67-year-old woman suffering from Alzheimer's disease, a degenerative disease of the brain. The court's opinion described her as being "in an essentially vegetative state, immobile, speechless, unable to swallow without choking, and barely able to cough."[36] She was fed through a naso-gastric tube, required a catheter and bowel care, suffered from high blood pressure, which was difficult to control, and had arteriosclerosis.[37] The patient's family, along with the doctor and hospital, brought an action for declaratory relief, asking that the doctor be permitted to enter an order not to resuscitate in the event of cardiac or respiratory arrest free from judicial authorization. Alternatively, the family sought judicial authorization for such an order.[38]

The appeals court decided that the *Saikewicz* rule, requiring court determination before treatment could be refused for an incompetent patient, did not apply in this case. The court stated that cardiac and respiratory arrest are part of the normal act of death.[39] *Saikewicz* referred to potentially life-prolonging treatments, not to "a mere suspension of the act of dying."[40]

> [T]he *Saikewicz* case, if read to apply to the natural death of a terminally ill patient by cardiac or respiratory arrest, would require attempts to resuscitate dying patients in most cases, without exercise of medical judgment, even when that course of action could aptly be characterized as a pointless, even cruel, prolongation of the act of dying.
>
> We think it clear that such a result is neither intended nor sanctioned by the *Saikewicz* case.[41]

Saikewicz, therefore, is relevant only when treatment involves a lifesaving or life-prolonging alternative in a situation when death is not inevitable.[42]

Dinnerstein held that the question of "what measures are appropriate to ease the imminent passing of an irreversibly, terminally ill patient" is a medical decision, not a judicial one.[43] Like

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35. Liacos, *supra* note 31, at 7.
36. 78 Mass. App. Ct. Adv. Sh. 737, 380 N.E.2d 135 (1978).
37. *Id.* at 738, 380 N.E.2d at 135.
38. *Id.* at 740, 380 N.E.2d at 136.
39. *Id.* at 741, 380 N.E.2d at 136.
40. *Id.* at 744, 380 N.E.2d at 138.
41. *Id.* at 742, 380 N.E.2d at 137.
42. *Id.* at 746, 380 N.E.2d at 139.
43. *Id.* at 746, 380 N.E.2d at 139.

the *Quinlan* court, the Massachusetts Appeals Court affirmed the view that decisions based solely on medical prognosis are to be made by doctors with the approval of the patient's family. The court distinguished the considerations involved in cases such as Mrs. Dinnerstein's from the considerations involved in cases such as Saikewicz. The latter involve alternatives which offer "hope of restoration to normal, integrated, functioning, cognitive existence."[44]

Dinnerstein, too, generated confusion in areas ranging from the lack of definition of such terms as "terminal illness" to the issue of the quality of life, seemingly introduced by the appeals court's mentioning "normal, integrated, functioning, cognitive existence."[45] Some commentators found the *Dinnerstein* decision inconsistent with *Saikewicz*.[46] *In re Spring*[47] exemplifies this confusion.

III. *In re Spring*

The *Spring*[48] case is one calculated to revive the fears of those who viewed *Quinlan* and *Saikewicz* as indicating a diminution in society's traditional belief in the sanctity of life.[49] Mr. Spring was a 78-year-old senile man suffering from kidney disease. He was being sustained by dialysis which substituted for his absent kidney function. Without dialysis he would die.[50] Somewhat confused when the dialysis treatments began in February 1978, his confusion or incompetency subsequently worsened. Aside from the lack of kidney function, his general physical condition was good for a man of his age. With dialysis and no other complications he could conceivably have lived another five years.[51]

About a year after the dialysis treatments began, Mr. Spring's son (his temporary guardian) and his wife, petitioned the probate

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44. *Id.* at 746, 380 N.E.2d at 138.

45. *See* text accompanying notes 52-62 *infra*.

46. *See, e.g.*, McCarthy, *Withholding of Medical Treatment from a Terminally Ill, Incompetent Patient—A Departure from Saikewicz*, 63 MASS. L. REV. 263, 264 (1978); Note, *Constitutional Law—Right of Privacy—Qualified Right to Refuse Medical Treatment May Be Asserted for Incompetent Under Doctrine of Substituted Judgment*—Superintendent of Belchertown State School v. Saikewicz, ___Mass.___, 370 N.E.2d 417 (1977), 27 EMORY L.J. 425, 459 (1978).

47. No. 2030 (Mass., order of Jan. 14, 1980).

48. *Id.*

49. *See* Collester, *supra* note 19, at 327.

50. 79 Mass. App. Ct. Adv. Sh. 2469, 2471, 399 N.E.2d 493, 495 (1979).

51. Transcript of Probate Court hearing at 10-11.

court for an order allowing the dialysis to be terminated. The probate judge appointed a guardian *ad litem* who opposed such an order. After a hearing, a judgment was entered ordering that no further treatment be authorized. The guardian *ad litem* appealed from, and obtained, a stay of that judgment. Shortly thereafter, the probate judge *sua sponte* vacated the first judgment and entered a new judgment allowing the wife, son, and attending physician to make the decision whether to terminate dialysis treatment.[52] In the second judgment the judge paraphrased language found in the *Dinnerstein* opinion, stating that the court's authority to make a decision was limited by *Saikewicz*. The court held, however, that since the facts "do not offer a lifesaving or life-prolonging treatment alternative" as formulated in *Saikewicz*, doctors, not judges, must determine "what measures are appropriate to ease the passing of an irreversibly ill, terminal patient, in light of the patient's history and condition and the wishes of his supportive family."[53]

In an opinion by Justice Armstrong[54] the appeals court affirmed the probate court's second judgment. The opinion, however, failed to affirm explicitly that *Spring* does not come within *Saikewicz*. Reference was made to *Saikewicz*, but the opinion noted that since the role of the incompetent's family did not arise in *Saikewicz* because Mr. Saikewicz was a ward of the state, there was nothing in that case which would prohibit the family from having an important role.[55] The opinion questioned the form of the second judgment which authorized the physician and the family to decide whether to continue dialysis, contrasting it with the first judgment which was a direct order that the legal guardian refrain from consenting to continued treatment, but stated that since "the second judgment will have the substantial effect of carrying out the needs and desires of the ward," it need not be disturbed.[56] Perhaps this is an implicit acknowledgment that the substituted judgment test enunciated by *Saikewicz* does rule.

The appeals court decision left many disturbing questions unanswered. The appeals court did not question the probate court's finding that Mr. Spring was "an irreversibly ill, terminal patient."[57]

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52. 79 Mass. App. Ct. Adv. Sh. at 2469, 399 N.E.2d at 495.

53. Record at 31. ***But see*** note 58 ***infra***.

54. It is interesting to note that Justice Armstrong is also the author of the *Dinnerstein* opinion.

55. 1979 Mass. App. Ct. Adv. Sh. at 2484, 399 N.E.2d at 503.

56. *Id.* at 2485, 399 N.E.2d at 503.

57. Record at 31.

Terminal illness was not defined. Certainly, the kidney dysfunction is irreversible; and just as certainly Mr. Spring will die without dialysis. The crucial question, however, is whether a condition is terminal if a treatment exists which will take the place of the malfunctioning organ. An analogy may be made to diabetes. Insulin replaces the function of the pancreas; without insulin diabetics will die. Few people, however, think of diabetes as a terminal illness.[58]

Procedurally, the appeals court interpreted *Saikewicz* as requiring judicial intervention only when there is uncertainty as to the course of treatment a patient would choose. Typically such uncertainty would be evidenced by disagreement among members of the family, or between the family and the medical professional, as to the appropriate course of action.[59] In *Spring*, where family and physician were in agreement, there was, presumably, no need to go to court at all according to the appeals court criteria, except to assure the physician that he was immune from possible criminal or civil liability. The appeals court, however, does understand *Saikewicz* as requiring "that treatment decisions in cases of incompetent patients be made in accordance with what the patient would himself choose, where that choice is not in violation of State policy or medical ethics."[60] Nevertheless, the court does not explain any procedure to ensure that the family and physician are indeed making their decision on the basis of what the patient would want. The court discusses the law's role as one which does not displace the traditional role of the family and the physician, but which acts to protect the rights of the incompetent person by determining what his wish would be.[61] There is no indication, however, how this protection can be afforded if the family and the physician are free to act on their own initiative as long as they agree.

This view seems at variance with the *Saikewicz* court's explicit rejection of the *Quinlan* approach. It is difficult to distinguish the appeals court's approach from that in *Quinlan*. Conceivably, even the New Jersey court might reject such an approach under the

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58. The nature of kidney disease was an element in another recent Massachusetts decision in which state interests were found to outweigh a competent, adult prisoner's desire to refuse dialysis. Here the court stated that although the kidney disease could be technically classified as incurable, it was not life threatening in the sense that he would die regardless of the treatment received. Commissioner of Corrections v. Myers, 79 Mass. Adv. Sh. 2523, 2530, 399 N.E.2d 452, 456 (1979).

59. 79 Mass. App. Ct. Adv. Sh. at 2484, 399 N.E.2d at 502-03.

60. *Id.* at 2484, 399 N.E.2d at 502.

61. *Id.* at 2483, 399 N.E.2d at 502.

facts of *Spring*. The *Quinlan* case was decided on the basis of the medical prognosis that Karen Quinlan would never regain consciousness. Mr. Spring, however, was conscious; and with dialysis he functioned physically as he would have if he did not have kidney disease. The apparent determining factor was his senility. The decision to terminate his treatment, therefore, was not a decision made on the basis of medical prognosis, but one influenced by a judgment made about the value of the life of a senile person.

The appeals court accepted the probate court's finding that the ward would wish to have the dialysis treatments discontinued on the ground that it was a finding of fact that was not clearly erroneous.[62] The court rejected the argument that an expression of such intent by the ward, when competent, was necessary for such a finding, contending that such a ruling would nullify the privacy rights of incompetents enunciated by *Saikewicz*.[63] Consequently, the court determined that other evidence could be used to determine the ward's wishes. Unfortunately, the important question of what quantum of evidence is necessary to support a finding of the ward's alleged wish was not answered.

The *Saikewicz* decision appeared expressly to prohibit consideration of some of the evidence actually considered by the probate court in *Spring*. For instance, despite the *Saikewicz* court's determination that age was relevant only with respect to an assessment of the efficacy of the treatment considered and not in terms of the value of life, the appeals court allowed consideration of the patient's age. In applying the balancing test between the patient's privacy rights and the state's interest in the preservation of life, the appeals court stated that the state's interest carried far less weight "where the patient is approaching the end of his normal life span."[64] The appeals court also was willing to assess the patient's quality of life in a way rejected by the *Saikewicz* court. The court stated that Mr. Spring's mental condition would be a relevant factor, as his case is factually distinguishable from *Saikewicz*. In *Saikewicz* the patient was mentally retarded and had never known any other condition. In *Spring* the patient had been competent. Mental condition was, therefore, relevant when there was evidence that the state of incompetency would be a factor the patient himself would consider.[65] The court noted that Mr. Spring's having

62. *Id.* at 2476, 399 N.E.2d at 498.
63. *Id.* at 2474-75, 399 N.E.2d at 498.
64. *Id.* at 2483, 399 N.E.2d at 502.
65. *Id.* at 2476-77, 399 N.E.2d at 499.

consented to, or at least acquiesced in, the initiation of the dialysis treatment was probably the strongest factor for finding that he would not want the treatment discontinued. Nevertheless, the court held that this factor was undermined by Mr. Spring's diminished ability to understand the necessity for treatment.[66]

Besides extrapolating what the patient would wish, considering his age and mental condition, the court gave great weight to Mrs. Spring's belief that the treatments ought to be terminated and that discontinuance would be her husband's desire, although the matter had never been discussed by them.[67] The court found that if a patient was fortunate enough to have a close family which was in agreement with the physician, the law should give its collective opinion substantial weight. The court stated that there is nothing in *Saikewicz* which casts doubt on the importance of the role of the family in such a decision.[68] Perhaps there is nothing in *Saikewicz* which states that the family's role is not important, but the *Saikewicz* court was very explicit in not entrusting to the patient's family and physician the decision to discontinue life support; yet, this is essentially what the appeals court did.

On appeal the supreme judicial court reversed the probate court's second judgment, concluding that the facts of the case bring it within the rule of *Saikewicz* and that it was in error to delegate the decision to the family and to the attending physician.[69] The court concluded, however, that the judge's finding that the ward would choose to discontinue the life-prolonging treatment was warranted by the evidence.[70]

IV. ANALYSIS OF *SPRING*

The supreme judicial court's order in *Spring* reaffirmed its decision in *Saikewicz* that a court is the appropriate tribunal to decide whether to discontinue or to withhold life-prolonging treatment. This decision is sound in cases where the issue is social and

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66. *Id.* at 2478, 399 N.E.2d at 499.

67. Transcript at 32.

68. 79 Mass. App. Ct. Adv. Sh. at 2484, 399 N.E.2d at 503. Noting that the Springs had been married for 55 years and that their son lived across the street from them for 15 years and visited frequently, the court stated that "It is evident that we are dealing with a close-knit family unit, with a long history of mutual love, concern and support." *Id.* at 2477, 399 N.E.2d at 499. The court shows a touching, if naive assumption of congruence between the longevity of a relationship and affection.

69. *In re* Spring, No. 2030, at 2 (Mass., order of Jan. 14, 1980).

70. *Id.* On remand, the probate court ordered that treatment be discontinued. *In re* Spring, No. 49076 (Mass. P. Ct., order of Jan. 17, 1980).

ethical rather than solely medical. In both *Quinlan* and *Dinnerstein* the patients were in irreversible comas, and there was no hope that either patient would resume any kind of human functioning. In such cases, a decision to allow a patient to die rather than to prolong artificially what scarcely can be considered life is a decision based on medical criteria and can appropriately be made by a physician with the concurrence of the family. In both *Saikewicz* and *Spring*, however, the patients were functioning human beings, although mentally incompetent. The decision to withhold chemotherapy for Mr. Saikewicz and the decision to discontinue dialysis for Mr. Spring were not based solely on medical prognoses and were contrary to similar decisions made by the vast majority of competent adults suffering from cancer or from kidney disease. Apparently, the decisions differed from those customarily made by similar patients because Mr. Saikewicz and Mr. Spring were mentally incompetent. *Saikewicz* and *Spring*, therefore, were social and ethical decisions, not decisions based on medical criteria.

In our society the courts have been given the social mandate to make social and ethical decisions.[71] It is important that these decisions be made in a forum whose procedures assure patients of at least a modicum of due process. As the *Saikewicz* court stated, "[S]uch questions of life and death seem . . . to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created."[72] One commentator enumerated the qualities of the judicial process which make the courts the appropriate forum for such decisions as follows: The public nature of judicial proceeding; the fact that the judge's decision must be principled, with appellate courts, legislative bodies, and legal commentators functioning as backstops; the impartiality of courts as decisionmakers; and the adversary nature of judicial proceedings.[73] Since these decisions affect societal attitudes toward human life, it is important that they be made in public and be made by individuals who are "institutionally responsible to the public for making principled and impartial decisions."[74] A further benefit of the court's functioning as the decisionmaker will

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71. *See* Annas, *supra* note 19 at 384; Liacos, *supra* note 31, at 7.

72. 77 Mass. Adv. Sh. at 2501, 370 N.E.2d at 435.

73. Baron, *Medical Paternalism and the Rule of Law: A Reply to Dr. Relman*, 4 AM. J. L. & MED. 337, 347-49 (1979). *See also* Comment, *The Problem of Prolonged Death: Who Shall Decide?*, 27 BAYLOR L. REV. 169, 172-73 (1975).

74. Baron, *supra* note 73, at 362.

be the development of a body of common law based on societal values to aid decisions in future cases.[75]

Allowing the physician and the family to decide whether to withhold life-prolonging treatment would grant the power of decision to potentially biased parties. Although well-meaning, physicians and relatives may be influenced by factors irrelevant to what the patient would want if competent to decide. Furthermore, in such a situation the family is not likely to be in an emotional condition conducive to making a reasoned decision.[76]

The *Spring* court's affirmation of the necessity of judicial determination is eminently sensible, but the facts of the case and the quantum of evidence deemed sufficient for the court to determine that a patient would wish to discontinue treatment do not induce confidence in the substituted judgment test. By affirming the probate court's decision that under the substituted judgment test Mr. Spring would wish to have the dialysis treatment discontinued, the supreme judicial court seems to be relying predominantly on Mrs. Spring's belief that that would be her husband's desire. Without any expression on the part of the patient while still competent and without any other evidence, it appears that the court is in reality allowing the family and physician to make the decision as long as they resort to a court for ratification of the decision. At the hearing held at the probate court, only three witnesses testified: The physician who is director of the kidney center where Mr. Spring received dialysis; Mr. Spring's wife; and Mr. Spring's son.[77] There was no testimony from a neutral medical expert, nor from a physician having a more personal and long-standing relationship with the patient, nor from any of the personnel of the nursing home where Mr. Spring resides.[78] The testimony of such people would be appropriate. The circumstances in this case may serve to confirm the fears of commentators that judicial decisions will function

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75. *Id.* at 353.

76. *See id.* at 350; Corbett & Raciti, *Withholding Life-Prolonging Medical Treatment from the Institutionalized Person—Who Decides?*, 3 NEW ENG. J. ON PRISON L. 47, 77 (1976); Kindregan, *supra* note 11, at 933. *But see*, Cantor, *Quinlan, Privacy, and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 243, 255 (1977); Relman, *supra* note 31, at 241.

77. Record at 2, 28, 33.

78. Newspaper reports indicated concern about the decision on the part of nursing home personnel. *See* Marchand, *Mr. Spring is Not Comatose . . . Mr. Spring is Very Sick*, Boston Herald American, Dec. 30, 1979 at 1, Col. 1; *Spring 'no sicker than many'*, Greenfield Recorder, Jan. 17, 1980 at A1, Col. 3.

to immunize physicians from liability, without a truly adversary proceeding.[79]

In *Spring* objective consideration did not conclusively indicate that Mr. Spring would wish to discontinue treatment. The prognosis for him indicated that his mental condition would not improve[80] and that the kidney disease was irreversible.[81] Dialysis treatments, however, replace the function of the kidneys; and the kidney disease is terminal only if the dialysis is stopped. With dialysis he could have lived possibly another five years.[82] The dialysis was described as uncomfortable rather than as painful.[83]

In view of the fact that the vast majority of competent patients suffering from kidney disease elect to undergo dialysis treatment, it is clear that Mr. Spring's senility was the determinative factor in finding that he would choose to die. This is akin to finding that most senile patients would choose to reject intrusive medical treatment in favor of dying. This conclusion is disputable. As one commentator has stated, "When a majority of competent individuals have already weighed these interests and chosen life, a court should not transform an incompetent's legitimate interest in bodily privacy into a judicially enforced right to die."[84]

V. PROPOSED STANDARDS

The forthcoming supreme judicial court opinion should clearly state both the criteria to be used in determining the wishes of the incompetent patient and the burden of proof that must be satisfied before the supposed wishes of the patient outweigh the state's interest in the preservation of life. Perhaps it is more likely than not that Mr. Spring would have wished to die, but it is not clear and convincing to this observer, and certainly is not beyond a reasonable doubt. Where medical treatment is uncomfortable rather than painful, the presumption should be that a patient would choose to live. The appeals court focused on the description of Mr. Spring as having been previously an avid outdoorsman[85] implying that someone who had been very active when younger would prefer death to a life of forced inactivity. It is just as logical to conclude that such a man would cling to life. One commentator has argued that people

79. Kindregan, *supra* note 11, at 931.
80. Transcript at 23.
81. *Id.* at 5.
82. *Id.* at 10.
83. *Id.* at 9.
84. Schultz, Swartz & Appelbaum, *supra* note 18, at 958.
85. 79 Mass. App. Ct. Adv. Sh. at 2470, 2475, 399 N.E.2d at 495, 498.

care about how they will be remembered and would not wish to exist in a debilitated, helpless state of which they are not conscious.[86] Undoubtedly, some individuals feel this way. Conversely, some people hope that they will be cared for and will not be left to die because they are old and no longer mentally alert. The truth, of course, is that without some prior expression we simply do not know how a particular individual would feel. Without such evidence, it is the position of the author that we should err on the side of valuing life for its own sake.

In *Saikewicz*, the court held that decisions to withhold or to terminate life-prolonging treatment on behalf of incompetents should be made by the courts rather than by the patient's physician and family. While affirming *Saikewicz* and using the subjective substituted judgment test, the court in *Spring* found that the incompetent would choose to discontinue treatment based primarily on the family's feeling that that was what he would desire. In essence, this allows the family and physician to make the decision with the court's ratification. A better standard would be to determine the patient's desire using an objective test. When there has been no prior expression of what the patient would wish in such a situation, a determination of what that patient would want is virtually impossible. In these cases it would be appropriate to consider what most persons are likely to do in a similar situation.[87]

In summary, the author recommends that the following factors be examined in any decision involving the termination of medical treatment that might result in death. The risks or pain involved in a particular treatment should be considered.[88] The quality of another person's life, however, cannot be properly assessed and, therefore, should not be a consideration. Along with giving incompetents the right to refuse treatment, we must also dignify their status with the acknowledgement that they are still human beings. It is not clear that senile adults in need of dialysis or other medical treatment would be better off dead than alive. We must assume, therefore, that unless there is persuasive evidence to the contrary, an incompetent would wish to undergo treatment in the same circumstances that a competent patient would. The financial and emotional burdens of a patient's family should be a consideration only to the extent that there is evidence that these burdens would be

86. Cantor, *supra* note 76, at 258.

87. *See id.* at 259.

88. The probate court in *Saikewicz* found the side effects of chemotherapy to be a factor in arriving at a decision. 77 Mass. Adv. Sh. at 2467, 2469, 370 N.E.2d at 421-22.

considered by the patient. Our society must find ways to ease these burdens without cutting short the patient's life.

VI. CONCLUSION

In a decision based primarily on a hopeless medical prognosis, the New Jersey Supreme Court ruled in *Quinlan* that an incompetent patient's family and physician, in conjunction with a hospital ethics committee, could decide to terminate life-prolonging treatment in the exercise of the patient's constitutional right to privacy. The Massachusetts Supreme Judicial Court in *Saikewicz* affirmed that an incompetent patient has the same right to refuse treatment as a competent patient but rejected the *Quinlan* approach. The Massachusetts court designated the probate court as the appropriate decisionmaker, directing the probate court to use a subjective substituted judgment test in arriving at its decision.

In re Spring affirms *Saikewicz* in placing the decision with the probate court rather than with the patient's family and physician. *Spring* is disappointing, however, for it allows the probate court to find that a patient would wish to die solely on the basis of a statement by his wife that she thinks he would want to die. In not stipulating the quantum of evidence necessary or the burden of proof to be weighed, the court undermines the substituted judgment test by allowing the family and physician to decide to terminate life-prolonging treatment with the probate court's ratification. A better approach would be to require clear and convincing evidence, or even evidence beyond a reasonable doubt, and to rebut a presumption that most people would prefer to live. In criminal cases the reasonable doubt standard is used because of the seriousness of depriving a person of his liberty.[89] Surely, the deprivation here is as serious. Where no evidence regarding the patient's wishes exists, an objective test should be used. The court should consider the risks or pain involved in the treatment and the course of action taken in a similar situation by most competent patients.[90]

Marian Solomon Lubinsky

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89. *See* Speiser v. Randall, 357 U.S. 513, 525-26 (1958).

90. After affidavits were filed by a nurse and a physician stating that they had spoken to Mr. Spring, the guardian *ad litem* filed a motion in the probate court asking that the court order a rehearing. No. 80-37 (Mass., memorandum and order, of Feb. 4, 1980, 8). On appeal from the probate court's denial of this motion, Justice Quirico, sitting alone, granted the motion, ordering that a panel of three physicians be appointed to report on whether or not Mr. Spring was competent to make his own decision. No. 80-37 (Mass., interlocutory judgment of Feb. 4, 1980, 2-4). Earle Spring died of natural causes on Apr. 6, 1980, the day before the panel was to report.