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Sharon F. DiPaolo

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Technical application of the doctrines of mootness, ripeness and standing, in the peculiar circumstances of right-to-die actions would lead to dismissing many of them. Yet, such considerations are often addressed summarily, if at all,[1] when courts wish to reach important policy issues.

At the federal level, mootness, ripeness and standing have their origins in the Article III "case or controversy" clause. It has been interpreted to mean that an actual dispute is a prerequisite to a court's jurisdiction.[2] In states that lack a constitutional "case or controversy" clause, courts nevertheless impose such requirements as a matter of common law.[3]

Although the doctrines have common origin and are often treated jointly, it is useful to separate them. At the most basic level, mootness concerns the existence of justiciable disputes, ripeness seeks to ensure that actions are not premature and standing, by far the most complex, addresses whether a particular party is properly before the court. This article will discuss each doctrine in order and argue that all should be liberally construed if important right-to-die issues are to be resolved.

* Ms. DiPaolo practices law with Doepken Keevican Weiss & Medved, P.C., in Pittsburgh, PA. She received a B.S. from Duquesne University and J.D. from the University of Pittsburgh. The views expressed here are those of the author and not of Doepken Keevican Weiss & Medved.

1 *E.g.,* Farnam v. Crista Ministries, 807 P.2d 830, 847 n.10 (Wash. 1991) (addressing mootness in a footnote); In re Browning, 568 So. 2d 4, 8 n.1 (Fla. 1990) (addressing mootness in a footnote).

2 Whitmore v. Arkansas, 495 U.S. 149, 154–55 (1990).

3 *E.g., In re* Lawrance, 579 N.E.2d 32, 37 (Ind. 1991) (Indiana constitution does not have "case or controversy" requirement).

Mootness

A case is moot if there is no longer a legal question to resolve or no effective relief can be given.[4] Although the requirement of an effective remedy is largely superceded by allowing declaratory judgments,[5] the mootness doctrine seeks a justiciable controversy.[6]

While courts generally dismiss cases if the issues are moot, most jurisdictions[7] provide an exception to dismissal for mootness if issues are of substantial public interest or are "capable of repetition, yet evade review."[8] Thus, in otherwise moot cases, courts may choose to address the issues.[9]

Actions involving the right to refuse treatment are often mooted on appeal as when the patient dies from natural causes, a blood transfusion has already been made pursuant to a lower court's order or treatment has been discontinued pursuant to such an order. Also, cases can be mooted if parties settle a dispute.[10]

Because right-to-die actions typically fit exceptions to the mootness doctrine, most courts decline to dismiss on that basis.[11] For example, courts often find the issues raised of sufficient public importance to warrant a hearing.[12] Also, even if an issue has been resolved for a

4 *Id.*

5 Note, *Mootness on Appeal in the Supreme Court*, 83 Harv. L. Rev. 1672, 1676–77 (1970).

6 "The chief purpose of mootness on appeal is to assure that the adversary system, once set in operation, remains properly fueled." *Id. at* 1688.

7 *E.g.*, *In re* Angela C., 573 A.2d 1235 (D.C. App. 1990); Mercy Hosp. Inc. v. Jackson, 510 A.2d 562 (Md. 1986) [hereinafter Mercy Hospital II]; *In re* Dorone, 502 A.2d 1271 (Pa. Super. Ct. 1985); Bartling v. Superior Court, 209 Cal. Rptr. 220 (Cal. App. 1984).

8 This oft-used phrase was coined in Southern Pacific Terminal Co. v. P.C.C., 219 U.S. 498 (1911).

9 Lawrance, 579 N.E.2d at 37.

10 *E.g.*, Clarke v. Clarke, 517 A.2d 816 (N.H. 1986) (case involving children with AIDS challenging denial of admission to school dismissed for mootness after children were admitted).

11 *E.g.*, Rasmussen v. Fleming, 741 P.2d 674 (Ariz. 1987); *In re* Storar, 420 N.E.2d 64 (N.Y. 1981), *cert. denied*, 459 U.S. 858.

12 *E.g.*, McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990); *In re* E.G., 515 N.E.2d 286 (Ill. 1989); Dorone, 502 A.2d 1271; *In re* Quinlan, 355 A.2d 647, 661 (N.J.

particular patient, medical facilities are apt to face it in the future when it will again be mooted, even with expedited proceedings.[13] One court noted that, at the time of oral argument, a medical facility had 40 patients who were either comatose or terminally ill.[14]

Storar, consolidating two cases where guardians objected to continued medical treatment, is typical of those that do not dismiss.[15] In both, the patients had already died, but the New York Court of Appeals decided to hear the appeal.[16] Citing the need for judicial restraint, the court explicitly limited its holding to the facts of those cases.[17] Yet, the dissent urged that proper restraint required dismissal, claiming that "[f]ar better would it be if we accepted the conclusion nature has wrought and left the cases where they were."[18]

In contrast, the Maryland Court of Appeals dismissed *Hamilton,* an early case involving refusal of a blood transfusion, for mootness.[19] There, a patient who had been shot in the chest required an operation and blood transfusion that the patient refused on religious grounds.[20] The hospital under a court order had already administered the transfusion before appeal, but the patient argued that an alleged injury to his constitutional rights remained for resolution.[21]

The court disagreed. Because the transfusion had taken place and the court order expired, it reasoned that the patient did not satisfy mootness exceptions.[22] He did not allege a continuing personal injury and could not demonstrate a likely recurrence:[23]

1976), *cert. denied sub. nom.*, Garger v. New Jersey, 429 U.S. 922. *But see* Dockery v. Dockery, 559 S.W.2d 952 (Tenn. Ct. App. 1977).

13 *E.g.*, McKay v. Bergstedt, 801 P.2d at 619 n.1.

14 John F. Kennedy Memorial Hosp. v. Bludworth, 432 So. 2d 611, 614 (Fla. Dist. Ct. App.), *rev'd* 452 So. 2d 921 (Fla. 1984).

15 *In re* Storar, 420 N.E.2d 64.

16 *Id.* at 66 n.1.

17 *Id.* at 67 n.2.

18 *Id.* at 79 (Fuchsberg J., dissenting).

19 Hamilton v. McAuliffe, 353 A.2d 634 (Md. 1976).

20 *Id.* at 636.

21 *Id.*

22 *Id.* at 637–38.

> Whether an individual has the right to refuse a blood transfusion necessarily turns upon facts existing at the moment. The declaratory judgment process is therefore ill-fitted as a vehicle to declare the rights of parties in future circumstances as yet unknown.

Hamilton was moot because the transfusion had been administered, but the Maryland court seemed inadequately to consider the extent to which the issue was capable of evading future review.[24]

In contrast, the unique circumstances of *Mercy Hospital* do seem to justify dismissal by the same court.[25] There, a woman in premature labor required a Cesarean section. The hospital advised that without a transfusion the operation would pose a high risk of maternal mortality (but virtually no fetal risk). Both the patient and her husband were Jehovah's Witnesses and refused consent. Finding the risk unacceptable, the hospital petitioned for guardianship. A judge denied its request after a bedside hearing, and the operation took place without the transfusion. After the mother and child survived, the hospital appealed.

An intermediate appellate court found the case moot but heard the appeal, invoking exceptions.[26] The Court of Appeals reversed. Again finding no likelihood of recurrence, it held that the circumstances of the case were too unique to provide future guidance.[27]

In *Dockery,* another early action, the Court of Appeals of Tennessee dismissed for mootness where a patient died pending appeal.[28] There, the patient's husband had sought authority to remove a respirator from his semi-comatose wife.[29] The court recognized seven mootness exceptions, but, without examining them, dismissed because issues raised were of a personal, not public interest.[30] Even

23 *Id.*

24 "[A] transfusion ordered by a court in an emergency will always be given before the appellate process can be completed." Dorone, 502 A.2d at 1275.

25 Mercy Hospital II, 510 A.2d 562 (Md. 1986).

26 Mercy Hosp. Inc. v. Jackson, 489 A.2d (Md. App. 1985).

27 Mercy Hospital II, 510 A.2d, at 565.

28 Dockery v. Dockery, 559 S.W.2d 952.

29 *Id.* at 953.

30 *Id.* at 955.

now, *Dockery* is on the border of cases allowing treatment to be discontinued because the patient, not being fully comatose,[31] required a respirator because of her pulmonary, not neurological, condition and demonstrated "decortitate movement" "indicative of a higher level of brain function than [normally seen] in comatose patients...." [32]

Moot right-to-die actions should be heard when actions represent not merely an academic debate, but a real controversy. That a patient has died or a transfusion has been administered obviates the controversy only at the most superficial level. Adjudication is the only cure for potential violations of patients' constitutional rights.[33] In emergency situations hospitals seek, and generally obtain, permission to continue treatment because courts err on the side of life when faced with emergency situations. If appellate courts regularly dismiss for mootness, patients' rights will rarely be determined, and hospitals will have almost unlimited authority for treatment decisions. Complex constitutional issues should be determined after careful consideration and reflection at the highest appellate level, not at bedside hearings.[34]

Some courts take a narrow view of their role. Because each case is unique, it is argued that hearing moot cases may be harmful:[35]

> Given the precedential strictures of stare decisis, to lay down law, then, is needlessly to tie our own hands against the time when we are confronted by an appeal we have to decide.

Other courts prefer to have complex moral and public policy issues resolved by legislatures.[36] However, Judge McAuliffe, dissenting in

31 *Id.* at 953.

32 *Id.* at 954.

33 *Cf. In re* Storar, 420 N.E.2d 64, 75 (Jones J., dissenting) (not a proper issue for adjudication because, e.g., "[t]he lapse of time necessarily consumed in appellate review before there can be a final judicial determination will almost always be unacceptable and makes recourse to judicial proceedings impractical").

34 Because such cases involve complex moral and public policy issues, "we should embrace the procedure that permits unhurried contemplation over that which mandates a rush to judgment." Mercy Hospital II, 510 A.2d at 567 (McAuliffe J., dissenting).

35 Storar, 420 N.E.2d at 79 (Fuchsberg J., dissenting) (citation omitted).

36 *Id.*

Mercy II, argued that: "Some areas of the law do not lend themselves to resolution by broad legislation, but are best developed through a case by case approach."[37] Also, even when legislatures have acted, courts must interpret and apply the law. Thus, they have an unavoidable role in developing the law.

Ripeness

While mootness involves being too late, ripeness involves being too early. The ripeness doctrine seeks present controversies rather than possible future ones. A major concern is that the controversy present a factual record adequate to resolve legal issues meaningfully.[38]

Right-to-die actions rarely suffer from being premature, and ripeness arises infrequently in right-to-die litigation. Nevertheless, a recent declaratory judgment action challenging the constitutionality of a Michigan statute prohibiting assisted suicides is a classic illustration of circumstances where it may be raised.[39]

In Michigan, declaratory judgment is appropriate if plaintiffs are distinguishable from those with sheer intellectual interest, and issues are susceptible to analysis without actual injury.[40] To avoid problems with the first, ten divergent plaintiffs brought suit: seven health care professionals, two terminally ill patients and a friend of one of the patients.

That aside, the State argued that the issue was not ripe. It likened the case to "a petition from potential criminals before they go forth in the night."[41] Plaintiffs responded that declaratory judgment was appropriate even if the controversy would only become real upon future contingencies.[42] Siding with the latter, the court held that it would be

37 Mercy Hospital II, 510 A.2d at 567–68.

38 *Mootness on Appeal in the Supreme Court, supra* note 5, at 1673.

39 Hobbins v. Attorney General, No. Civ.A.93-306-178 CZ, 1993 WL 276833 (Mich. Cir. Ct. May 20, 1993).

40 *Id.* at *3.

41 *Id.* at *2 (quoting Strager v. Wayne County Prosecuting Attorney, 10 Mich. App. 166, 171 (1968)).

42 *Id.*

unjust to withhold adjudication until the patient-plaintiffs would be incapacitated.[43]

Yet, the Washington Supreme Court invoked the ripeness doctrine in dismissing an action under the Uniform Declaratory Judgments Act to determine the validity of a living will executed to cover terminal illness in pregnancy.[44] Because plaintiff was presently neither terminally ill nor pregnant, the court found no actual controversy.[45] Yet, a dissent argued that, had the events come to pass and been mooted before appeal, the court would likely have heard the case:[46]

> [I]f, in its discretion, the court chooses to address the issues on mooted facts, would that determination be based on any less speculation than a determination under the circumstances now before us?

A New York case concluded differently when, a year later, a 70-year-old, suffering from emphysema and lung cancer,[47] sought a ruling on the validity and effectiveness of her living will. Citing estimates that 80,000 such documents had been executed in the State, the court found the issues to be of great public importance.[48] The court observed that "[r]esponsible parties who wish to comply with the law in cases where the legal consequences of the contemplated action is uncertain need not act at their peril."[49] Although the plaintiff had not yet entered the hospital or been denied her choice of treatment, a substantial controversy was found to exist, should contemplated events take place.[50]

Adjudicating such actions seems appropriate despite lack of a present controversy. Once a controversy exists, a patient is unlikely to

43 *Id.*

44 DiNino v. State, 684 P.2d 1297 (Wash. 1984).

45 *Id.* at 1300.

46 *Id.* at 1301.

47 Saunders v. State, 492 N.Y.S.2d 510 (N.Y. Sup. Ct. 1985).

48 In making its determination, the court also erroneously applied the exception to the mootness doctrine to the ripeness issue, and held that the issue was 1) of great public importance, 2) likely to recur, but 3) likely to evade review. *Id.* at 513.

49 *Id.* at 512.

50 *Id.*

be competent, and his or her rights should not be entirely dependent on third party actions that are often in danger of dismissal for mootness as addressed above or standing.

Standing

Generally

Of the three threshold issues, the standing doctrine is the most complex and, for that reason, most thoroughly litigated. It seeks to ensure that the plaintiff is a proper party and requires a litigant to demonstrate a real stake in the litigation.[51] Also, to have standing, a plaintiff must demonstrate a specific personal interest rather than one shared generally by all members of a community.[52]

Courts are generally reluctant to permit a person to assert another's rights.[53] Sometimes, however, courts grant standing to plaintiffs asserting rights on behalf of the real party in interest, provided that certain conditions are met. For example, the U.S. Supreme Court requires: 1) a substantial relationship between the parties, 2) that the real party is unable to assert the claim on his own and 3) that the constitutional right of the real party would be diluted if a third party were not allowed to invoke it.[54]

For example, in NAACP v. Alabama,[55] the State of Alabama petitioned to have the names of NAACP members released. The NAACP argued that its members had a constitutional right not to have their identities revealed. The State responded that the organization had no standing to argue the constitutional rights of its members.[56] Recognizing the general rule prohibiting the invocation of another's

51 Nye v. Marcus, 502 A.2d 869 (Conn. 1985).

52 *Id.*

53 Pennsylvania Game Comm'n v. Department of Envtl. Resources, 555 A.2d 812 (Pa. 1989).

54 *See* Eisenstadt v. Baird, 405 U.S. 438 (1972); Griswold v. Connecticut, 381 U.S. 479 (1965); NAACP v. Alabama, 357 U.S. 449 (1958); *accord*, Rasmussen v. Fleming, 741 P.2d 674, 685 (Ariz. 1987).

55 NAACP v. Alabama, 357 U.S. at 459-60.

56 *Id.* at 425.

constitutional rights, the Court nevertheless granted the NAACP standing. To hold otherwise would have substantially infringed the rights of the individual members who, ironically, could not have asserted their rights without disclosure.[57]

Also, in a recent case of first impression, that Court addressed "next friend" standing.[58] This theory, tracing back to 17th century England, had been accepted by some federal courts.[59] It is invoked when a litigant advances the cause of action of the real party in interest.[60] The Court held that to invoke next friend standing, litigants must demonstrate why the real party could not appear, true dedication to his best interests and a significant relationship to that party.[61]

Patient Standing in Right-to-Die Cases

When legally competent plaintiff-patients assert their own rights, they generally have standing.[62] This is so even where, as in McKay v. Bergstedt, there is no adverse party.[63] Bergstedt was a competent quadriplegic who brought an action against the State of Nevada seeking removal of the respirator which he needed to live. Although Bergstedt fulfilled the requirement of asserting a personal interest, he could not demonstrate adverseness because the State assumed only a "token adversarial stance."[64] Because the State essentially agreed with Bergstedt, he could demonstrate no well-grounded fear of invasion of

57 *Id.* at 459–60. As an aside, the Court also considered that the NAACP had an economic stake in the outcome because of likelihood of diminished financial support if the names had been revealed. *Id.*

58 Whitmore v. Arkansas, 495 U.S. 161–66 (1990).

59 Next friend standing has typically been advanced on behalf of prisoners on the basis of 1) incompetency or 2) physical inaccessibility. *Id.* at 162. Next friend standing was successfully invoked in Groseclose v. Dutton where a death row inmate was judged incompetent to waive post-conviction remedies. 549 F. Supp. 949 (M.D. Tenn. 1984).

60 Whitmore v. Arkansas, 495 U.S. at 163.

61 *Id.* For example, a first cousin or a minister would not be sufficient to meet this requirement. *Id.* at 164.

62 Hobbins v. Attorney General, 1993 WL 276833; McKay v. Bergstedt, 801 P.2d 617; Kirby v. Spivey, 307 S.E.2d 538 (Ga. App. 1983).

63 McKay v. Bergstedt, 801 P.2d 617.

64 *Id.* at 619–20.

his right to refuse treatment. The court might have found that no justiciable controversy existed, but it found standing because the action raised issues "of such importance to the citizens of this State that an appellate resolution [was] virtually compelled."[65] Because *McKay* was the first Nevada case posing the right to refuse treatment, the court was amply justified in hearing it.

Standing has also been granted to patients for whom death is not imminent.[66] In a case discussed earlier, the Michigan Circuit Court held that two terminally ill patients had standing to challenge the constitutionality of a statute prohibiting assisted suicide.[67] In doing so, it rejected the State's argument that these plaintiffs were "not distinct in interest from the millions who consider the weighty issue of assisted suicide"[68] and recognized a distinction between plaintiffs with standing and persons for whom death is far less imminent.

Third Parties in Right-to-Die Cases

• *Generally*

In right-to-die cases, standing is usually in issue where the patient is incompetent because of age or medical condition and a third party seeks to invoke the patient's right, e.g., to remove life-sustaining equipment or refuse a blood transfusion.[69] Courts are reluctant to allow one person to speak for another in life-or-death decisions:[70]

> [W]e approach this case of first impression involving the right to die with extreme caution and humility, mindful of the overwhelming sense of responsibility that accompanies the power to resolve what in this and similar future medical treatment cases are all too often life-and-death issues.

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65 *Id.* at 620.

66 Hobbins v. Attorney General, 1993 WL 276833.

67 *Id.*

68 *Id.* at *2–3.

69 *But see, e.g.,* Hobbins v. Attorney General, 1993 WL 276833; McKay v. Bergstedt, 801 P.2d 617; Kirby v. Spivey, 307 S.E.2d 538 (Ga. App. 1983) (cases where courts have addressed standing where the action is brought by a competent patient). Cases involving actions brought by patients are discussed *supra.*

70 Rasmussen v. Fleming, 741 P.2d 674, 679 (Ariz. 1987).

An incompetent patient does not, however, lose his constitutional rights.[71] Unless *some* third party can bring action, however, those rights are devoid of meaning.[72] Comparing such persons with those who are legally competent, one court has asked: "What possible societal policy objective is vindicated or furthered by treating the two groups of terminally ill differently?"[73] Yet, there are important differences.

Actions on behalf of incompetent patients are most often brought by guardians or close family members, e.g., spouses, parents and adult children.[74] Actions are also brought by medical facilities, prisons and state institutions that oppose a family's treatment decision.[75]

As noted above, a major purpose of the standing requirement is to ensure a justiciable "case or controversy."[76] Where treatment decisions are contended, a controversy exists, regardless of *who* brings the action That an action is not brought by the real party does not negate the existence of a controversy. Where the family members and treating physician agree, decisions are usually made privately. Therefore, any case is likely to pose a serious dispute with a real possibility of liability.

Where a party cannot meet technical tests for standing, the interests of justice may nevertheless dictate that a court hear the case.[77] In this

71 Severns v. Wilmington Medical Ctr., Inc., 421 A.2d 1334 (Del. 1980).

72 *Id.* at 1347 ("[T]o deny the exercise because the patient is unconscious would be to deny the right.")

73 Eichner v. Dillon, 426 N.Y.S.2d 517, 542–43 (N.Y. App. Div. 1980).

74 Grace Plaza v. Elbaum, 1993 WL 406654 (N.Y. Oct. 14, 1993) (husband); In re O'Connor, 72 N.Y.2d 517 (N.Y. 1988) (adult children); Weber v. Stony Brook Hosp., 456 N.E.2d (N.Y. 1983), *cert. denied,* 464 U.S. 1026 (1983) (guardian); Quinlan, 355 A.2d 647 (father).

75 Custody of a Minor, 434 N.E.2d 601 (Mass. 1982) (medical facility); Commission of Correction v. Myers, 399 N.E.2d 452 (Mass. 1979) (prison); Superintendent v. Saikewicz, 370 N.E.2d 417 (Mass. 1977).

76 Lawrance, 579 N.E.2d 37.

77 In contrast, federal courts under the constraint of the "case or controversy" clause are less likely to disregard the standing requirement:

> [T]he requirement of an Article III "case or controversy" is not merely a traditional "rule of practice," but rather is imposed directly by the Constitution. It is not for this Court to employ untethered notions of what might be good public policy to expand our jurisdiction in appealing a case.

Whitmore v. Arkansas, 495 U.S. at 161. *Cf.* Eisenstadt v. Baird, 405 U.S. 438, 445 n.5 (1972) (Supreme Court relaxed third party standing requirements where denying

regard, one court noted New Jersey's practice of "sweepingly rejecting procedural frustrations in favor of 'just and expeditious determinations on the ultimate merits'."[78]

Yet, when cases are to be heard, the court must ensure the best possible litigants.[79] For example, one can imagine a situation in which a disinterested, but unrelated third person might try to invoke a patient's rights.[80] Requiring a showing of a substantial relationship between the litigant and the patient ensures that actions are not initiated by virtual strangers.

• *Family Members*

Third party actions by close family members asserting the right to refuse treatment are often permitted because they are most able to know what an incompetent patient would have wanted. However, caring for a loved one in a chronic vegetative state is emotionally taxing, and medical treatment can be prohibitively expensive. Thus, family interests may conflict with those of an incompetent patient.[81] Such concerns exist in many third party actions but seem insufficient to categorically deny standing. Rather, courts should make a preliminary case-by-case determination.

In *Quinlan,* the earliest right-to-die decision, a father sought guardianship of his daughter who was in a persistent vegetative state.[82] Specifically, he sought to discontinue life-sustaining treatment. The New Jersey Supreme Court held that the father had standing to raise both his daughter's constitutional rights and his parental rights. Regarding the daughter's rights, the court simply stated that a parent had standing to invoke the constitutional rights of an incompetent

standing would have "intolerable, inhibitory effect on freedom of speech").

78 *In re* Quinlan, 355 A.2d 647, 661 (quoting Crescent Park Tenants Ass'n v. Realty Equities Corp., 275 A.2d 433 (N.J. 1971)).

79 Nye v. Marcus, 502 A.2d 869 (Conn. 1985).

80 *E.g.,* Weber v. Stony Brook Hosp., 456 N.E.2d 1186, 1186–87 (N.Y. 1983) (where unrelated individual sought to enjoin parents from following conservative treatment plan for their handicapped infant).

81 *See, e.g.,* Grace Plaza v. Elbaum, 1993 WL 406654 (N.Y. Oct. 14, 1993).

82 Quinlan, 355 A.2d 647.

child.[83] However, it seems important that the court also found that his "strength of purpose and character" outweighed his natural grief and sorrow.[84] Moreover, the court found that the father had standing to assert parental rights. He was not simply an "interloper" and asserted a real and adverse interest. Also, questions before the court were of "surpassing importance."

Parents often bring actions on behalf of children adjudged incompetent on the basis of minority status or physical or mental conditions.[85] Most courts apply the general rule that parents can assert the constitutional rights of their children.[86] While most courts do not examine the rationale behind this rule, it is consistent with general requirements for third party standing. First, few relationships are more significant. Second, age or incompetence prevent the child from personally asserting the claim. Finally, the child's constitutional right would be void unless the parent had the authority to invoke it.

That case may be contrasted with *Dorone.*[87] There a twenty-two-year-old Jehovah's Witness, unconscious as a result of an automobile accident, required a blood transfusion and had previously signed a medical alert card refusing blood transfusions.[88] The parents challenged an order appointing a hospital administrator as the patient's temporary guardian, but the court denied standing.

Dorone is difficult to understand. The right of parents to challenge a guardianship appointment regarding their child implicates their own rights as well as those of the incompetent child. A more proper resolution seems require that the court grant standing and then determine parental fitness to be guardians.

83 *Id.* at 661.

84 Quinlan, 355 A.2d 647.

85 *E.g.*, *In re* Rosebush, 491 N.W.2d 633 (Mich. App. 1992) (parents' action on behalf of 10-year-old daughter in persistent vegetative state); Quinlan, 355 A.2d 647.

86 Prince v. Massachusetts, 321 U.S. 158 (1944); *In re* Baby "K", No. Civ. A.93-104-A, 1993 WL 343557, ___ F. Supp. ___ (E.D. Va. 1993); Lawrance, 579 N.E.2d 32; *In re* Rosebush, 491 N.W.2d 633; *In re* E.G., 515 N.E.2d 286; Quinlan, 355 A.2d 647. *But see,* Dorone, 502 A.2d 1271.

87 Dorone, 502 A.2d 1271.

88 *Id.* at 1273.

• *Actions by guardians*

There are several types of guardians with the degree of medical decisionmaking authority afforded to each type differing. A limited guardian for medical decision making is treated as the patient's surrogate and has complete authority to decline treatment on the patient's behalf.[89] A plenary guardian has authority to make all decisions, including medical decisions, on behalf of another who is incapable of administering their own affairs.[90] A plenary guardian's concurrence should be sought if treatment decisions are made by the family and physician.[91] Most common are general guardians whose authority derives from a state guardianship statute. If the statute is not clear, a court must examine the statute in order to determine if a general guardian has medical decisionmaking authority.[92] A guardian *ad litem* is a special guardian appointed by the court for the sole purpose of representing the patient's best interests in the pending litigation.[93] While a guardian *ad litem* might advocate for or against a decision, it has no authority to decide or to enforce a treatment.[94]

Some, but not all, guardians with medical decisionmaking authority will meet requirements for standing. Although rarely acknowledged, empirically courts grant standing to a guardian only if his or her proposed decision is not at odds with the wishes of the patient's family.[95] Under the three-prong third party standing analysis, reliance on wishes of family members is appropriate in adjudicating a guardian's standing. The guardian will meet the first two prongs of the test,[96] but

89 Alan Meisel, The Right to Die 181 (1989).

90 *Id.* at 178–79.

91 *Id.*

92 *Id.* at 179.

93 Black's Law Dictionary 706 (6th ed. 1990).

94 *In re* Greenspan, 558 N.E.2d 1194 (Ill. 1990).

95 *Id.;* Lawrance, 579 N.E.2d 32; and Rasmussen, 741 P.2d 674.

96 First, because guardians are only appointed where the patient is incompetent, it is clear that the patient would be unable to assert the claim personally. Further, the guardian demonstrates a substantial relationship to the patient by virtue of their court appointment and absolute duty to act in the patient's best interest.

where concerned family members are available, the guardian will fail the third prong — that incompetent's rights would otherwise be diluted. Where immediate family members make their wishes known and invoke the incompetent's rights, granting standing to an unrelated guardian is unnecessary unless family members permit personal interests to interfere with the patient's interests.

In *Greenspan,*[97] a general guardian for a 76-year-old nursing home patient in a chronic vegetative state petitioned for leave to order the removal of artificial nutrition and hydration.[98] The patient's wife, adult children and rabbi concurred in the decision, testifying that the patient had made statements to the effect that "life was not worth living without the capacity to enjoy it."[99] The trial court held that the general guardian lacked standing.[100] On appeal, the guardian argued that he had standing under the Illinois Probate Act. The Supreme Court of Illinois agreed. Notably, in reaching its decision, the court assumed that the guardian sought to exercise not the right of the patient, but his own right under the Act.[101]

Similarly, the Supreme Court of Arizona found that a general guardian had standing under the state guardianship statute to assert the patient's right to refuse medical treatment.[102] Here, although the patient's immediate family did not take an active role in the decision they had agreed to abide by a "do not resuscitate" order and were aware of the guardianship proceedings.[103] In granting standing, the court observed that "[t]o hold otherwise would... reduce the guardian's control over medical treatment to little more than a mechanistic rubberstamp for the wishes of the medical treatment team."[104]

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97 *In re* Greenspan, 558 N.E.2d 1194 (Ill. 1990).

98 *Id.* at 1195–96.

99 *Id.* at 1198.

100 *Id.* at 1195.

101 *Id.* at 1199–1200.

102 Rasmussen, 741 P.2d 674.

103 *Id.*

104 *Id.*

However, standing was denied to a guardian *ad litem* in *Lawrance,* where the guardian opposed a family's decision.[105] The patient was a forty-two-year-old woman who had undergone two craniotomies. The first caused permanent brain damage, and the second placed her in a permanent vegetative state. Her parents, four siblings and treating physicians unanimously agreed to withdraw nutrition and hydration.[106] The parents petitioned for, and were granted, this authority.[107] However, after the trial court decision, a group representing disabled persons petitioned for guardianship.[108] The trial court appointed the group as her temporary limited guardian with authority to seek a stay or appellate review. On appeal, however, the Indiana Supreme Court denied the guardian standing, holding that courts are available to guardians only where there is no unanimity among the patient's family and the treating physicians.[109]

Likewise, in Weber v. Stony Brook Hospital, the New York Court of Appeals denied standing to an unrelated guardian who sought judicial authorization to override the treatment decision of an infant's parents.[110] The infant, Baby Jane Doe, was born with spina bifida and other serious complicating disorders.[111] After consulting with religious counselors, a social worker, neurological experts and nurses, the parents decided to avoid surgery, opting instead for conservative treatment.[112] The guardian had no direct interest or relationship to the child and had failed to follow proper procedures. Under New York's Family Court Act, parents were found to have the primary responsibility to choose medical care for their child:[113]

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105 Lawrance, 579 N.E.2d 32.
106 *Id.* at 35.
107 *Id.*
108 *Id.* at 36.
109 *Id.* at 44.
110 456 N.E.2d at 1186–87 (N.Y. 1983).
111 *Id.* at 1187.
112 *Id.*
113 *Id.* at 1188.

> [T]he proposition [the guardian] espouses would be to recognize the right of any person,... to institute judicial proceedings which would catapult him into the very heart of the family circle, there to challenge the most private and most precious responsibility vested in the parents for the care and nurture of their children....

• *Actions by health care professionals and medical facilities*

Health care facilities that seek standing in right-to-die actions do not generally assert patient's interests, but, rather, their own — including minimizing liability, adhering to principles of medical ethics and reducing emotional strain.

If there is a real threat of liability, standing is granted.[114] Where little or no potential exists, hospitals have an insufficient interest in treatment decisions to assert standing. For example, a hospital does not have standing to compel a blood transfusion simply because a patient has standing to refuse.[115] Further, although the medical profession may have a moral obligation to preserve life, its right is not legally-protected.[116] Therefore, where exposure to liability is minimal as when the family and physician agree on treatment, a facility "generally would lack sufficient interest to warrant any court relief."[117] Treatment can be expensive, offering potential incentive to continue. Thus, granting standing to hospitals that lack a real threat of liability may encourage unnecessary actions, contrary to a policy of judicial economy.

Also with health professionals, potential liability exposure is likely to be key. In the recent *Hobbins* decision, only two of seven professionals challenging Michigan's newly-enacted statute prohibiting assisted suicide were granted standing.[118] Five doctors argued that the threat of

114 Hobbins v. Attorney General, 1993 WL 276833; *In re* Storar, 420 N.E.2d at 69 n.3.

115 *In re* President of Georgetown College, Inc., 331 F.2d 1010, 1015 (D.C. Cir. 1964) (Burger, J., dissenting).

116 *Id.*

117 Storar, 420 N.E.2d at 69 n.3.; *accord* President of Georgetown College, 331 F.2d at 1015 (Burger J., dissenting) (hospital's argument of potential liability insupportable where husband and wife offered to sign waiver of liability).

118 Hobbins v. Attorney General, 1993 WL 276833.

prosecution would have a "chilling effect" on their dispensation of pain medications, but the court found their interests too remote.[119] Yet, standing was granted to a psychiatrist who was potentially liable for prescribing medications that could hasten death, as well as to a pharmacist concerned about filling prescriptions in lethal quantities.[120]

• *Actions by criminal defendants*

Standing of criminal defendants trying to continue treatment to avoid murder charges has been uniformly rejected.[121] Such persons "may never legally overrule" others' treatment decisions.[122] A Washington case is typical.[123] There, Yates had allegedly kidnapped three teenage girls; strangled, stabbed and shot them all; and left them for dead.[124] All survived, but two were severely injured. After one, Bunnie Brown, was diagnosed as permanently vegetative, it was decided to remove her feeding tubes.[125] Police had waited with regard to Brown, but later charged aggravated murder in the first degree.[126]

Meanwhile, Yates had unsuccessfully sought to enjoin removal of her life-support system.[127] Although Brown had already died, the court affirmed his lack of standing on appeal, noting that to hold otherwise would be "unconscionable."[128]

> Yates is a legal stranger to the decision of whether Brown's life support should have been removed. After confessing to the acts that caused her to require the support devices, he then sought to minimize his own jeopardy by keeping her on life support.

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119 *Id.* at *3.

120 *Id.*

121 *See, e.g.,* State v. Yates, 824 P.2d 519 (Wash. App. 1992) and *In re* J.N., 406 A.2d 1275 (D.C. 1979).

122 *In re* J.N., 406 A.2d at 1282 (purse snatcher who hit 83-year-old woman on the head sought to maintain life-support needed for the injuries suffered in the attack).

123 Yates, 824 P.2d 519.

124 *Id.* at 520–21.

125 *Id.* at 521.

126 *Id.*

127 *Id.*

128 *Id.* at 522.

Conclusion

Decisions to discontinue life-support do not require court approval. On the contrary, courts generally discourage judicial intervention:[129]

> [T]here are myriads of problems and troubles which judges are powerless to solve and this is as it should be. Some matters of essentially private concern and others of enormous public concern are beyond the reach of judges.

Also, in *Quinlan,* for example, intervention was said to place the court in an inappropriate advisory role and encroach upon medical autonomy — as well as to be potentially cumbersome for courts.[130]

Yet, courts should hear two types of actions. In cases of first impression, they should guide those who fear criminal or civil liability. Also, they should hear cases where conflicts exist within a family,[131] or with a physician, regarding appropriate treatment[132] because, at such times, "[t]he failure to go to court... is an invitation to liability."[133]

Judges must avoid resolving important novel issues or true controversies merely because of the peculiar circumstances involved in right-to-die litigation. Nor should they be too quick to defer to legislators: Legislative machinery moves slowly and, in any event, does not have the power to resolve constitutional questions. Even where legislatures have authority, it is unjust to make terminally ill patients or their families wait for the resolution of life-or-death issues. Barring procedural obstacles, as rights and responsibilities become better defined, more decisions can be made in private, by patients, families and physicians — and fewer by courts.

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129 *In re* President of Georgetown College, Inc., 331 F.2d at 1015 (Burger J., dissenting) .

130 *In re* Quinlan, 355 A.2d at 699.

131 *E.g.*, *In re* Baby "K", 1993 WL 343557, (granting standing to mother of anencephalic baby who insisted on continuing treatment, contrary to the wishes of biological father, hospital, and guardian *ad litem*).

132 Meisel, *supra* note 89, at 162.

133 *Id.* at 164.