January 1985

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Sheila Brutoco

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NOTES

THE BARBER DECISION: A QUESTIONABLE APPROACH TO TERMINATION OF LIFE-SUPPORT SYSTEMS FOR THE PATIENT IN A PERSISTENT VEGETATIVE STATE

I. INTRODUCTION

Recent advances in medical technology and science have placed us on the threshold of a new terrain — the penumbra where death begins but life, in some form, continues. Science and technology enable physicians to artificially maintain respiration when the patient’s capacity to breathe spontaneously has been lost. Artificially maintained patients such as those patients in a persistent vegetative state may never recover consciousness. A persistent vegetative state occurs when rudimentary brain stem functions remain but the major components of cerebral function, e.g., cognitive processes, are irreversibly lost and when chances for recovery are indeterminable. Therefore,

1. Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334, 1342 (Del. 1980). This case was decided by the Court of Chancery, 425 A.2d 156 (Del. Ch. 1980) after the Delaware Supreme Court determined that the lower court had the power to authorize the removal of life-support systems. 421 A.2d 1342-43.


3. President’s Commission: Defining Death, supra note 2, at 18. Such persons may exhibit spontaneous, involuntary movements such as yawns or facial grimaces, their eyes may be open and they may be capable of breathing without assistance. The condition is often described as awake but unaware since any apparent wakefulness does not represent awareness of self or environment. Id. Persons in a persistent vegetative state are considered to be permanently unconscious. President’s Commission for the Study of Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions, 173 (1983) [hereinafter cited as President’s Commission: Deciding to Forego Life-Sustaining Treatment]. However, there is still uncertainty about any judgment that a par-
as a result, we are now compelled to distinguish between death, as we have known it, and death in which the body lives in some fashion but the brain (or a significant part of it) does not. Attempts by attorneys, physicians, and clergy to draw this distinction have been made with varying degrees of success.

Even where it is possible to make this distinction, serious medical, ethical, and legal issues remain with regard to the type and level of treatment provided to these patients. For example, there is no single applicable law which exists to authorize a physician to terminate life-support systems for a patient in a persistent vegetative state. It is precisely this issue - that there are no particular patient's state is permanent:

The first uncertainty affects any scientific proposition about as-yet-unobserved cases. No matter how extensive the past evidence is for an empirical generalization, it may yet be falsified by future experience. Certainty in prognosis is always a matter of degree, typically based upon the quantity and quality of the evidence from which a prediction is made.

Second, this empirical qualification is especially serious in predictions about unconsciousness because the evidence relevant to a prognosis of permanence is still quite limited. The overall number of such patients is small, and most cases have not been carefully studied or adequately reported. Furthermore, the number of variables affecting prognosis (for example, the cause of unconsciousness, the patient's age and other diseases, the length of time the patient has been unconscious, and the kinds of therapy applied) is large and imperfectly understood.

Finally, any prediction that a patient will not regain consciousness before dying, regardless of the treatment undertaken, contains an implicit assumption about future medical breakthroughs. Since some such patients can be maintained alive for extended periods of time (often years rather than days, weeks, or months), this assumption about treatment innovations can be a long-range one. At the moment, however, it introduces only a very small uncertainty, since the possibility of repairing the neurologic injuries that destroy consciousness is exceedingly remote.

Id. at 176-77.
4. 421 A.2d at 1342.
5. See generally supra note 3.
7. See generally supra notes 3 and 6.
legal standards for the termination of life-support systems for the patient in a persistent vegetative state - which poses serious problems for the treating physicians. This lack of standards leaves the physician at risk for civil and criminal liability, as well as professional, ethical, and moral sanctions. Moreover, patients and their relatives are without the ability to control the patient’s course of treatment. A California Court of Appeal for the Second District has recently taken a major step in addressing these issues in Barber v. Superior Court. The Barber court found that the withdrawal of all life-support systems (respirator, nutrition and hydration) from a patient in a persistent vegetative state within only five days, was not an unlawful failure to perform a legal duty where the patient had virtually no chance of recovery.

This Note will review the major cases dealing with termination of life-support systems for patients in a persistent vegetative state. Although the discussion will focus primarily on these patients, many of the issues discussed are applicable to other patients in similar situations, i.e., those who have terminal cancer. The Note will specifically relate case law from the other states to the facts and holdings of Barber, the most recent California case in this area. Finally, in light of the various legal approaches taken by California and other states regarding termination of life-support systems for these patients, this Note will propose some alternatives to the Barber decision.

II. BACKGROUND

Fundamental to any consideration of withdrawal of life-support systems is the definition of death. Historically, the standard for defining death was the permanent cessation of respiration and circulation. Because of advances in medical technology, the law has shifted its emphasis toward a definition of brain death, recognizing cerebral function as that function which most clearly delineates human life. The medically accepted defini-

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9. Id. at 1020-22, 195 Cal. Rptr. at 492-93.
11. See M. Shapiro & R. Spece, Jr., supra note 2, at 24-42 for a discussion of this shift in emphasis and the concepts and policy consequences involved in a determination of death.
tion of brain death is an "irreversible loss of all brain function." Although there is no uniform law, 26 states have adopted legislation based on the Uniform Determination of Death Act, recognizing the absence of brain function as an acceptable criterion for the definition of death. Further treatment of a patient who is brain dead is unnecessary in those jurisdictions.

The definition of brain death excludes those patients who continue to exhibit lower brain function, but remain in a persistent vegetative state, will not regain consciousness, cannot speak, think, or feel but who breathe and maintain basic metabolic functions of body temperature, circulation and elimination. Thus, termination of treatment for a patient in a persistent vegetative state would be homicide under California statutes. The Barber case is illustrative of this type of situa-

12. Black, *Brain Death*, 299 NEW ENGL. J. MED. 338, 338-39 (1978). A total irreversible absence of all brain function is necessary. Some 30 different criteria have been proposed for the diagnosis of brain death, the most accurate and widely accepted being the "Harvard Criteria." Under the "Harvard Criteria," brain death is diagnosed upon the concurrence of four general conditions: (1) unreceptivity and unresponsivity to externally applied intense stimuli; (2) no movement or breathing; (3) no reflexes, and (4) flat or isoelectric electroencephalogram. D. Meyers, supra note 6, at 34-35.

13. D. Meyers, supra note 6, at 27. Alabama, Alaska, Arkansas, California, Connecticut, Georgia, Hawaii, Idaho, Illinois, Iowa, Kansas, Louisiana, Maryland, Michigan, Montana, Nevada, New Mexico, North Carolina, Oregon, Oklahoma, Tennessee, Texas, Virginia, West Virginia, Washington and Wyoming have adopted legislation recognizing the absence of brain function as acceptable criteria for the definition of death. Id. at 27 n.16. California’s brain death statute states: "[a]n individual who has sustained . . . irreversible cessation of all functions of the entire brain, including the brain stem, is dead." CAL. HEALTH & SAFETY CODE § 7180 (West Supp. 1984). The statute also requires that a second physician independently confirm the death and neither physician be involved in decisions regarding the transplantation of organs. Id. § 7181-7182.

14. 147 Cal. App. 3d. at 1013, 195 Cal. Rptr. at 488.

15. D. Meyers, supra note 6, at 27. When deprived of oxygen, the human brain dies in stages rather than all at once. The cortex is the most sensitive portion of the brain and, therefore, the first to die with the deprivation of normal oxygenated blood flow. This is the site of the highest centers of human intelligence. Some authorities believe that the lack of oxygen flow to the brain for a period of 4 to 6 minutes will result in a total and irreversible loss of cortical brain functions. However, the loss of oxygenated blood for a similar period of time may have no effect on the lower brain or brain stem, which is the part of the brain tissue that controls respiration, heart rate, and blood pressure. Id. at 24-25.

16. "Murder is the unlawful killing of a human being . . . with malice aforethought." CAL. PEN. CODE § 187 (West Supp. 1984). The Barber court found that in the situation where the patient is in a persistent vegetative state and the patient’s family consents, the doctor has no legal duty to maintain life-sustaining techniques including intravenous therapy. 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484. Lacking this duty, there
In Barber, the patient's brain stem was functioning so that the standard of brain death did not apply.\textsuperscript{17} Complicating the lack of legal standards, is the difficulty in establishing with medical certainty when a persistent vegetative state exists.\textsuperscript{18} The decision to withhold or to withdraw life-support systems in these cases requires analysis of several issues. These issues include: the right of the incompetent patient in a persistent vegetative state to refuse treatment, the level of treatment that should be provided to the patient, the determination as to when treatment should be withheld, and who should make the decisions. Moreover, a clarification in terminology is important because it would allow physicians and the courts to characterize their conduct towards a patient with precision.\textsuperscript{19}

A. The Right To Refuse Treatment

Central to any discussion of what treatments can be withheld from those in a persistent vegetative state is the concept that the individual has a right to refuse treatment. The right of self-determination is a right basic in American law and generally includes the right of a competent adult to reject life saving medical care.\textsuperscript{20} This has been stated succinctly by Judge Cardozo, in the frequently-cited formulation: "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which can be no criminal liability when all life-support is discontinued. The court concluded that discontinuing futile treatment is not unlawful homocide. However, this holding should not be considered definitive since it is binding only on California's lower courts and for federal courts applying California law. The law in this extremely sensitive area must be regarded as unsettled until the California Supreme Court or the legislature set the final rules. Rubsamen, \textit{A Landmark Case on the Physician's Duty to Maintain Life}, PROF. LIABILITY NEWSLETTER, Oct. 1983. See also CALIFORNIA HOSPITAL ASSOCIATION, CONSENT MANUAL, 55, 61-64 (1984 ed.) for further discussion on the implications of the Barber case and the potential for criminal liability because of the lack of clear legislative guidance in this area.

A physician is exempt from this liability when there has been either (1) a designation of an attorney-in-fact for medical decisions under \textsc{Cal. Civ. Code} § 2434 (West. Supp. 1984), see \textit{infra} notes 100-05, or (2) a binding directive signed according to the Natural Death Act under \textsc{Cal. Health & Safety Code} §§ 7185-7195 (West. Supp. 1984), see \textit{infra} notes 90-99 and accompanying text.

\textsuperscript{17} 147 Cal. App. 3d at 1013, 195 Cal. Rptr. at 488.
\textsuperscript{18} \textit{See supra} note 3.
\textsuperscript{19} M. SHAPIRO \& R. SPECE, JR., \textit{supra} note 2, at 573-74.
\textsuperscript{20} J. ROBERTSON, \textit{The Rights of the Critically Ill}, 32 (1983).
he is liable in damages."21 The right to reject life saving medical care has been found by some state courts to be part of the fundamental constitutional right of privacy.22 It is necessary, however, to reconcile the individual's right to refuse treatment (right of privacy) with the state's interest in preserving life.23 There is a substantial distinction between the state's insistence that human life be saved where the affliction is curable, as opposed to a case where there is an incurable illness.24 It follows, then, that if competent persons may refuse treatment in certain situations, such as when the treatment merely prolongs the moment of dying but does not provide a substantial benefit, the same right, extended through a substitute judgment test, should be afforded to those who are incompetent since the value of human dignity extends equally to both.25 This right has been recognized by sev-

23. 373 Mass. at 744-45, 370 N.E.2d at 427. The state has a claimed interest in (1) the preservation of life, (2) the protection of the interests of innocent third parties, (3) the prevention of suicide, and (4) maintaining the ethical integrity of the medical profession. Id. at 741, 370 N.E.2d at 425.
24. Id. at 747, 370 N.E.2d at 425-26. However, in a recent California case, Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984), the Court of Appeal for the Second District, took a major step forward in expanding the right to refuse treatment for a competent adult patient who, although seriously ill, was not terminal. The court found that this type of patient's constitutionally guaranteed right of privacy includes the right to refuse medical treatment. Id. at 195-97 & n.8, 209 Cal. Rptr. at 225-26 & n.8. While the Bartling case represents a significant step towards an individual's right of self determination, it is limited to competent adult patients and not applicable to patients in a persistent vegetative state. For a discussion on the Bartling case, see Annas, Prisoner in the ICU: The Tragedy of William Bartling, 14 HASTINGS CTR. REP. 6, 28-29 (1984).
25. Id. at 747, 370 N.E.2d at 428. "To presume that the incompetent person must always be subjected to what many rational and intelligent persons may decline is to
eral state supreme courts for those patients who are in a persistent vegetative state or who are terminally ill.

B. Standards for Terminating Treatment for Patients in a Persistent Vegetative State

1. Ordinary and Extraordinary Treatments

The traditional test employed in decisionmaking regarding the requirement that a given treatment be provided to a patient is whether the treatment is ordinary or extraordinary. Historically, this distinction emerged in the Roman Catholic tradition to differentiate optional treatment from treatment that was obligatory for medical professionals to offer and patients to accept. Under these terms, treatments have been distinguished according to their simplicity, invasiveness, naturalness, and expense. Thus, a painful, intrusive treatment (such as use of a respirator) that would merely prolong a very impaired life would probably not be required, but treatment (such as the administration of intravenous fluids) that would keep the patient alive without undue suffering or risk of harm, although it would not relieve incompetency, could not be withheld. This concept of extraordinary treatment was used in In re Quinlan, the seminal case

downgrade the status of the incompetent by placing a lesser value on his intrinsic human worth and vitality." Id. See generally infra note 37 and accompanying text for a discussion of the substitute judgment test.

26. Id. at 754-55, 370 N.E.2d at 432; Severns, 421 A.2d at 1340; In re Spring, 380 Mass. 629, 634, 405 N.E.2d 115, 119 (1980); In re Colyer, 99 Wash. 2d at 120, 660 P.2d at 742.

27. LEGAL AND ETHICAL ASPECTS OF TREATING CRITICALLY AND TERMINALLY ILL PATIENTS, supra note 6, at 73.


29. Lynn & Childress, supra note 28, at 19. The terms “ordinary” and “extraordinary” are extremely vague and used inconsistently in literature. See generally M. Shapiro & R. Spece, Jr., supra note 2 at 726-28.

30. J. Robertson, supra note 20, at 50-51.

31. 70 N.J. 10, 355 A.2d 647. The patient, Karen Quinlan, suffered from irreversible brain damage resulting from two 15 minute periods when she stopped breathing. The actual cause of the respiratory arrest was unknown. She was determined to be in a persistent vegetative state. Medical experts believed she could not survive without a respirator. She had previously expressed her distaste for continuation of life by extraordinary medical procedures. Her father brought suit to be appointed as guardian and to request
regarding the treatment of those who exist in a persistent vegetative state. The Quinlan court found the use of a respirator on a 22 year old woman in a persistent vegetative state for over eleven months was extraordinary treatment.\footnote{Id.}

The terms “ordinary” and “extraordinary” incorporate a conclusion as to whether the benefits of the treatment justify its burdens but fail to indicate which medical treatments are required in any given case.\footnote{Id.} Courts need further refinement of these broad terms. In considering the effect of discontinuing life-support systems, prudence dictates that the balance of benefits and burdens be directly addressed.\footnote{Id.} In partial recognition of this problem, some courts require major weight be given to the needs and interests of the incompetent patient, rather than the needs and interests of families, doctors and society, with whom the patient’s interests may conflict.\footnote{Id.}

2. Substituted Judgment and Best Interests Tests

The majority of courts that have addressed the question of terminating treatment for the incompetent person have adopted the substituted judgment test.\footnote{See In re Quinlan, 70 N.J. 10, 355 A.2d 647; Saikewicz, 373 Mass. 728, 370 N.E.2d 417, where the courts took this approach.} This test attempts to treat the incompetent patient as an individual (capable of making informed choices) by asking what he would choose if cognizant of his interests and able to communicate.\footnote{J. ROBERTSON, supra note 20, at 51.} Where the patient, while competent, has previously made his wishes regarding treatment known, the court has a basis for inferring the wishes removal of the respirator. Id.

\footnote{Id. at 48, 355 A.2d at 668. The use of a respirator can be considered ordinary in the context of a possibly curable patient, but extraordinary in the context of the forced sustaining of cardiorespiratory functions of an irreversibly doomed patient. Id.}

\footnote{J. ROBERTSON, supra note 20, at 50.}

\footnote{Id.}

\footnote{See In re Quinlan, 70 N.J. 10, 355 A.2d 647; Saikewicz, 373 Mass. 728, 370 N.E.2d 417, where the courts took this approach.}


\footnote{J. ROBERTSON, supra note 20, at 51. This test is helpful when the patient is in a persistent vegetative state and has not designated an attorney-in-fact with power over health care decisions. See also In re Quinlan, 70 N.J. at 41, 355 A.2d at 644.}
of the patient.\textsuperscript{38} If, however, the patient has not made his wishes clear, those close to the patient can provide the court with their feelings about what the patient would have wanted if competent.\textsuperscript{39} The goal of the substituted judgment test is to maximize the individual's right of self-determination and privacy.\textsuperscript{40}

Another approach is the best interests test, which is perhaps less confusing to decisionmakers in those cases where there has been no prior expression of preference by the patient.\textsuperscript{41} Instead of determining what the patient's choice would be under the circumstances, this test involves a determination of whether the treatment, in light of the extended life made possible and the burden of this extended life, serves the patient's best interests.\textsuperscript{42} In fact, the substituted judgment test (a subjective approach) and best interests test (an objective approach) should often reach identical results for an incompetent patient, who, if competent and able to make intelligent choices, would presumably choose that which would best serve his interests.\textsuperscript{43} The substituted judgment and best interests tests recognize the right of a competent adult to reject lifesaving medical care and extend this right to the incompetent patient.\textsuperscript{44}

C. Application of the Standards

1. Withdrawal of Respirators and Intravenous Feeding Devices

In some states medical treatment involving the use of respirators, surgery, and chemotherapy may be legally terminated or withheld from incompetent patients by the application of the substituted judgment test to determine what the patient would

\textsuperscript{38} J. Robertson, \textit{supra} note 20, at 51. For example, in the \textit{Eichner} case, Brother Fox had previously indicated that if he were in a persistent vegetative state, he would want a respirator removed. 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980), \textit{aff'd sub nom., In re Storar}, 52 N.Y.2d at 371-72, 420 N.E.2d at 68, 438 N.Y.S.2d at 270.

\textsuperscript{39} D. Meyers, \textit{supra} note 6, at 347.

\textsuperscript{40} Id. at 277.

\textsuperscript{41} J. Robertson, \textit{supra} note 20, at 51.

\textsuperscript{42} Id.


\textsuperscript{44} J. Robertson, \textit{supra} note 20, at 51-52.
have chosen if competent. However, there is less legal and medical agreement as to whether other less invasive forms of medical care, (such as nutrition, hydration, and antibiotics) can be withheld. If the basis for stopping treatment is its intrusive or burdensome nature, and not a decision concerning quality of life, then medical treatments that do not impose this burden but which do extend life, could not legitimately be withheld from patients such as those in a persistent vegetative state. However, if continued life, regardless of how easily sustained, is not in the best interests of the patient, there seems to be little justification in continuing to provide nutrition and hydration for those patients identified as being in a persistent vegetative state. Also, if there is no legal requirement to use a respirator to supplant a patient’s breathing functions because of a hopeless and terminal prognosis, there appears to be little obligation to require continued artificial intravenous feeding.

45. Severns, 421 A.2d 1334; In re Quinlan, 70 N.J. 10, 355 A.2d 647; In re Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266; Leach v. Akron General Medical Center, 68 Ohio Misc. 1, 22 Ohio Op. 3d 49, 426 N.E.2d 809 (1980); In re Colyer, 99 Wash. 2d 114, 660 P.2d 738. There have been a limited number of cases that have treated this issue and have reached this consensus. In the absence of case law and statute, this right is not recognized in other jurisdictions.

46. See infra notes 51-58 and accompanying text.

47. See infra note 55. A related issue with unique considerations involves decisions to discontinue life-sustaining treatment for seriously ill newborns and infants. It is accepted community practice that infants should receive all therapies that are clearly beneficial to them. Decisions should not be withheld on the basis of the infant’s anticipated or actual limited potential or the present and future lack of available community resources. Life-sustaining treatment should not be withheld simply because the infant is retarded. In cases where it is uncertain whether medical treatment will be beneficial, the generally accepted standards require a presumption in favor of treatment. CALIFORNIA HOSPITAL ASSOCIATION, supra note 16, at 66e-66p.

48. J. ROBERTSON, supra note 20, at 59. Since nutrition and antibiotics do not ordinarily involve such burdens as to make the additional life they provide undesirable, they would be legally required under this approach. Id.

49. PRESIDENT’S COMMISSION: DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT, supra note 3, at 181, 190 & n.49.

50. See D. MEYERS, supra note 6, at 54 (Cum. Supp. 1983). One problem that arises is how to determine what is a hopeless and terminal prognosis. For example, in the Quinlan case, the physicians believed that withdrawal of the respirator would result in the patient’s death, 70 N.J. at 25, 355 A.2d at 655. She was removed from the respirator in 1976 and continued to live in an extended care facility, until she died of pneumonia at the age of 31 years. S.F. Chronicle, June 12, 1985, at 1. Likewise, in the Barber case, the patient’s wife testified at the preliminary hearing that Mr. Herbert’s physicians said he would live for approximately a minimum of 30 minutes to a maximum of couple of hours after the respirator was removed. L.A. Times, Jan. 29, 1983, Part II at 1.
Only three cases besides Barber, In re Severns, In re Conroy, and In re Hier have involved placing or removing intravenous and nasogastric feeding tubes from, or the provision of nutrition to, comatose, semicomatose, or seriously ill adult patients. In Severns, the patient had been comatose for over five months when, after an evidentiary hearing, the court concluded that all medical life-supports, including feeding, could be discontinued if it became necessary to surgically implant a feeding tube in her trachea [sic]. In Conroy, the New Jersey Supreme Court extended the Quinlan holding to allow removal, in certain circumstances, of all life-sustaining treatment, including feeding, for elderly incompetent patients who are neither comatose nor vegetative, but whose mental and physical functioning is severely and permanently impaired and whose life expectancy, even with life-sustaining treatment, is one year or less.

51. 425 A.2d 156 (Del. Ch. 1980).
53. 18 Mass. App. Ct. 200, 464 N.E.2d 959, reh’g denied, ___ Mass. ___, 465 N.E.2d 261 (1984). In Leach v. Akron General Medical Center, 426 Ohio Misc. 1, 22 Ohio Op. 3d 49, 426 N.E.2d 809, a common pleas court (probate division) allowed removal of a respirator from a terminally ill 70 year old woman, but specifically stated that the court’s order removal was only for removal of the respirator and not the other life-supports, which included a nasogastric tube and a catheter. Id. at 3, 13, 22 Ohio Op. 3d at 49-51, 56, 426 N.E.2d at 810, 816.
54. 425 A.2d at 160. The court apparently misinterpreted the medical data. A feeding tube would not be inserted in the trachea, since the trachea connects with the lungs. This decision was made following an earlier decision on this case by the Delaware Supreme Court, which concluded that the Court of Chancery (lower court) had the power to approve to continue or not restore any of Mrs. Severns’ life-sustaining systems. 421 A.2d at 1344. The Severns case involved a 55 year old woman who was in a comatose state as the result of an auto accident and who had previously made it clear she did not want hopeless treatment to continue. Her husband sought appointment as guardian and authorization to remove life-sustaining supports. 425 A.2d at 157-58.
55. 98 N.J. at ___, 486 A.2d at 1228, 1231, 1236-37. The court found that this treatment may be withdrawn or withheld when: (1) it is clear that the particular patient would have refused the treatment under such circumstances involved; or (2) there is trustworthy evidence that patient would have refused treatment and decisionmaker is satisfied that burdens of patient’s continued life with treatment outweigh benefits of that life for patient; or (3) absent any evidence that patient would have refused treatment, net burdens of patient’s life with treatment clearly and markedly outweigh benefits that patient derives from life. Id. at ___, 470 A.2d at 1229, 1232.

However, there remains substantial disagreement among ethicists whether the provision of food and water should ever be considered extraordinary treatment. For example, to some ethicists both the natural and ordinary quality of feeding requires that it should never be withdrawn. See Healy, Medical Ethics, 61-77 (1960); McFadden, Medical Ethics, 227-47 (1961); O’Donnell, Morals in Medicine, 57, 66-68 (1959). A code of treatment for severely ill children, drafted by the Nassau (N.Y.) Pediatric Society Committee on Ethics and Survival, provides that “ordinary measures are food, fluids, oxygen,
The Hier case involved an appeal by a guardian ad litem regarding the correctness of a lower court order relative to surgery for a seriously ill 92 year old woman with a long history of mental illness who repeatedly refused to allow placement of a gastric feeding tube. The Hier court found that it was unnecessary to put an unwilling patient through a major surgical procedure in order to provide adequate nutritional support which could not be provided by intravenous feeding. The distinction drawn by the Hier court, in contrast to the Conroy and Barber cases, was between supplying nutritional support with only modest intrusiveness and supplying it through the use of highly intrusive surgical procedures.

2. Do Not Resuscitate Orders

In addition to the patient’s right to have treatment withdrawn, common practice has also recognized a right to have treatment withheld, such as the right not to be resuscitated. A decision not to be resuscitated is accomplished through the use of a “No Code” or “Do Not Resuscitate” order which specifies there is to be no resuscitation in the event of a cardiac or pulmonary arrest. A “No Code” order was used in the case of In re

antibiotics and pain killers.” Waldman, Medical Ethics and the Hopelessly Ill Child, 88 J. Ped. 890, 892 (1976). This position was advocated by Surgeon General C. Everett Koop who stated that: “withholding fluids or nourishment at any time is an immoral act.” Time, April 11, 1983, at 69.

On the other hand, several scholars are of the opinion that if the patient is beyond all hope of recovery, the burden of continued feeding is disproportionate to the benefit it will effect. See Wilson, Death by Decision 70-71 (1975); Ramsey Prolonged Dying: Not Medically Indicated, 6 Hastings Ctr. Rep. 14 (1976). The American Medical Association Judicial Council, in Opinion 2.11 (Jan. 10, 1981), reprinted in 45 Conn. Med. 721 (1981), concluded that when a patient is irreversibly comatose or in a permanent vegetative state, “all means of life support may be discontinued.”

56. 18 Mass. App. Ct. at 200-01, 464 N.E.2d at 960-61. The tube was required because she suffered from a hiatal hernia and a cervical diverticulum in her esophagus that impeded her ability to ingest food orally. The tube could be reinserted through the abdomen without surgery if reinsertion was accomplished in a relatively short time. In Mrs. Hier’s case, reinsertion would require surgery. Mrs. Hier’s guardian ad litem appealed from a lower court judgment ordering the appointment of a temporary guardian to consent to the administration of drugs but without authority to consent to the surgery. Id.

57. Id. at 208-10, 465 N.E.2d at 964-65.

58. Id.

59. D. Meyers, supra note 6, at 188-89. The use of “No Code” orders has become generally accepted practice. Nevertheless, it must be understood that no California statutory provisions or precedential judicial decisions expressly approve the use of “No Code” orders. It is possible that any physician who issues such orders and any hospital
Dinnerstein,\(^6^0\) where the court held that the law does not prohibit a course of medical treatment which excludes attempts at resuscitation in the event of a cardiac or respiratory arrest.\(^6^1\) The Dinnerstein case involved a 67 year old woman with Alzheimer's disease who was confined to a hospital in an essentially vegetative state after a stroke.\(^6^2\) A “No Code” order is not used when treatment of the patient’s underlying illness offers a hope of restoration to a normal existence, but rather when the patient is in the terminal stages of an unremitting, incurable fatal illness.\(^6^3\)

D. The Decision Makers

One of the difficult issues involved in the treatment of patients in a persistent vegetative state is who should participate in a decision that treatment should be discontinued. The approaches taken by the various state courts involve the family and physician either making the decision alone or in combination with judicial approval, the use of ethics committees or prognosis boards, or the appointment of a guardian ad litem.\(^6^4\) The following cases illustrate the different approaches.

1. The Quinlan Approach

The Quinlan court found that the decision to terminate lifesupport systems should be made by the patient’s family and

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61. Id. at 475-76, 380 N.E.2d at 139.
62. Id. at 466-67, 380 N.E.2d at 134-35.
63. Id. at 474, 380 N.E.2d at 138. Due to the highly intrusive nature of resuscitation procedures and the fact that under some circumstances these procedures merely allow the patient to continue the inevitable process of dying, doctors sometimes decide against these measures in cases when an incompetent or terminally ill patient suffers cardiac arrest. J. Robertson, supra note 20, at 71. For a case study on the magnitude of this practice in a county hospital, see Levy & Lambe-Shear, Do Not Resuscitate Orders in a County Hospital, 140 West. J. Med. 111 (1984).
64. See infra notes 65-107 and accompanying text.
physicians, as long as a hospital-appointed ethics committee concurred with this decision.\(^6\) Judicial intervention was termed inappropriate, not only because it would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome.\(^6\) The concept of an ethics committee, composed of medical and non-medical personnel, is to serve as an advisory body "to provide a regular forum for more input and dialogue in individual situations and to allow the responsibility of these judgments to be shared."\(^7\) The Quinlan rationale of leaving the choice to the physician and family, unless disagreement occurs, requires a determination by the physicians that there is no reasonable possibility that the patient will return from the comatose state to a cognitive, sapient state,\(^8\) a determination by the family of the patient's probable choice, and concurrence of an ethics committee.\(^9\)

### 2. The Saikewicz Approach

In contrast to Quinlan, after the decision in Superintendent of Belchertown State School v. Saikewicz,\(^7\) the Massachusetts courts require the appointment of a guardian and the use of the judicial system to resolve decisions concerning life-prolonging treatment for incompetent patients. The Saikewicz case concerned a severely retarded 67 year old man suffering from acute myelomonocytic leukemia, an invariably fatal disease of the blood.\(^7\) While chemotherapy is the established treatment

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65. 70 N.J. at 54, 355 A.2d at 671.
66. Id. at 50, 355 A.2d at 669.
67. Id. at 49, 355 A.2d at 688 (citing Teel, The Physicians' Dilemma: A Doctor's View: What The Law Should Be, 27 BAYLOR L. REV. 6, 8 (1975)). This concept was criticized in the case of In re Colyer, 99 Wash. 2d at 134, 660 P.2d at 749-50.
68. The use of the word "sapient" appears in other cases such as Saikewicz, 373 Mass. 728, 370 N.E.2d 417; Quinlan, 70 N.J. 10, 355 A.2d 647, and is again illustrative of the problems in terminology in this area. The definition of the word "sapient" is "possessing or expressing great sagacity or discernment," WEBSTER'S NINTH NEW COLLEGIATE DICTIONARY. 1042 (1983). If treatment were required only when it would return a patient to a sage or discerning state, one could anticipate that medical treatment would not be required, for example, for those afflicted with Down's Syndrome. This seems unlikely to be the court's intent. Probably the family of a person in a persistent vegetative state would be willing to accept a lesser standard of consciousness than "sapient," when assessing the benefits of continued treatment.
69. 70 N.J. at 55, 355 A.2d at 671-72.
70. 373 Mass. at 756-58, 370 N.E.2d at 432-34.
71. Id. at 731, 370 N.E.2d at 420.
for this disease, the patient's guardian ad litem and attending physicians advised against the treatment because they felt it was not in the patient's best interests since the adverse side effects and discomfort as well as the inability of the patient to understand the treatment outweighed the limited prospect of any benefit. The Saikewicz court found that the resolution of the issue of determining who should decide whether life-prolonging treatment should be withheld from a person incapable of making his own decision requires:

the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is [the] responsibility [of the judiciary] . . . , and is not to be entrusted to any other group purporting to represent the 'morality and conscience of our society,' no matter how highly motivated or impressively constituted.

Saikewicz is considered the leading case for those jurisdic-

72. Id. at 730, 370 N.E.2d at 419. The physicians stated that chemotherapy would offer only a 30-40% chance of remission lasting 2-13 months and no cure. Chemotherapy would also result in serious adverse side effects, including pain and severe nausea, and the treatment requires the patient's cooperation over several weeks. Because of his mental retardation, the patient would be unable to cooperate. The physicians testified that the patient was in no pain and probably would die painlessly within a matter of weeks or months if the leukemia ran its natural course without chemotherapy. Id. at 733-34, 370 N.E.2d at 421. The Saikewicz court affirmed the lower court's decision that the medical personnel should not administer chemotherapy. Id. at 735, 370 N.E.2d at 422. Today some hematologists might question the conclusion that treatment of acutemymphelomonocytic leukemia offers no hope of cure. See Wilkinson, Legal Resolution of Denial of Access to Medical Technology, 14 Golden Gate U. L. Rev. 203, 221 (1984).

73. Id. at 759, 370 N.E.2d at 435. The Saikewicz court's holding is illustrative of some of the problems in terminology in that a distinction should be made between "life-prolonging treatment," which usually refers to treatment offering some chance of extending the patient's life in a meaningful way, and "life-sustaining treatment" or artificial life support, which serves merely to prolong the patient's existence in a hopeless comatose state. Note, Law and Medicine-Individual Rights-The Incompetent's Right to Refuse Treatment, 51 Tenn. L. Rev. 145, 151-52 n.59 (1983).

In rejecting the Quinlan court's approach with specific reference to 'artificial life-support' and in holding judicial intervention necessary with specific reference to 'potentially life-prolonging treatment,' the Saikewicz court creates ambiguity about whether it recognizes a distinction between life-prolonging treatment and life-sustaining treatment, or whether it requires judicial intervention in all cases concerning withholding or withdrawing treatment from incompetents.
tions requiring judicial intervention in every case involving the decision to withdraw or withhold life-sustaining treatment from an incompetent.74 The Saikewicz decision was clarified to some degree with respect to “No Code” orders, in Dinnerstein, where the appellate court held that prior judicial approval is unnecessary in giving orders not to resuscitate where the patient is in the terminal stages of an unremitting, fatal illness.75 Saikewicz was affirmed by the Massachusetts Supreme Court in the case of In re Spring,76 and followed by the Delaware Supreme Court in the Severns case.77

74. 99 Wash. 2d at 125, 660 P.2d at 745.
75. 6 Mass. App. Ct. at 475, 380 N.E.2d at 138-39. The Dinnerstein court distinguished the Saikewicz situation by the following:

 Attempts to apply resuscitation, if successful, will do nothing to cure or relieve the illnesses which will have brought the patient to the threshold of death. The case does not, therefore, present the type of significant treatment choice or election which, in light of sound medical advice, is to be made by the patient, if competent to do so. The latter is the type of lay decision which the court in the Saikewicz case had in mind when it required judicial approval of a negative decision . . . by the physician in attendance and by the family or guardian of a patient unable to make the choice for himself. This case does not offer a life-saving or life-prolonging treatment alternative within the meaning of the Saikewicz case. It presents a question peculiarly within the competence of the medical profession of what measures are appropriate to ease the imminent passing of an irreversibly, terminally ill patient in light of the patient’s history and condition and the wishes of her family. That question is not one for judicial decision, but one for the attending physician.

 Id. at 474-75, 380 N.E.2d at 139.
76. 380 Mass. at 631, 405 N.E.2d at 117. In a somewhat confusing opinion, the supreme court stated that while prior judicial approval might not exist, once a court is properly presented with a legal question regarding the withholding of treatment, it must decide that question and not delegate to some private person or group. Id. at 636-39, 405 N.E.2d at 120-22. The Spring case involved a son seeking to terminate dialysis treatment for his 79 year old father who suffered from chronic organic brain syndrome and end-stage kidney disease which required hemodialysis treatment three days a week, five hours a day. The patient resisted the treatment which caused unpleasant side effects, while he would not suffer any side effects if the treatment were terminated. There was no evidence that the patient when competent had expressed any wish to withdraw treatment in such circumstances. Id. at 632-33, 405 N.E.2d at 118. The supreme court reversed a lower court decision which delegated decision making to the family and physicians. Id. at 630, 405 N.E.2d at 117.

77. 421 A.2d at 1345. The supreme court found that in the absence of statutory relief, the Court of Chancery (court of equity) was the appropriate authority to grant relief. Id. at 1344.
3. The Storar Approach

A third and more conservative approach was taken by the New York Court of Appeals in consolidating two appeals from lower court decisions, *In re Storar* and *Eichner v. Dillon.* In the first case, *In re Storar,* the court of appeals reversed a lower court’s decision to discontinue blood transfusions for a 52 year old severely retarded man suffering from terminal cancer. In the second case, *Eichner v. Dillon,* also referred to as the Brother Fox case, the court of appeals found that a respirator could be legally removed from an 83 year old patient in a vegetative state where the patient had previously expressed a desire not to have his life prolonged by artificial means. The ruling of the Storar court for a Brother Fox-type situation can be summarized as follows: life-sustaining respirators can be withdrawn from an incompetent patient if there is clear and convincing proof that the patient, when competent, indicated that would have been his choice, if he were in a situation without hope of}

78. *78 A.D.2d 1013, 434 N.Y.S.2d 46, rev’d, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266. Both Storar and Eichner, *73 A.D.2d 1013, 434 N.Y.S.2d 517 (1980), aff’d sub nom., In re Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981), involved guardians of incompetent persons objecting to the continued use of medical treatment or measures to prolong lives of patients diagnosed as fatally ill with no chance of recovery. In each case the patients died, rendering the controversy moot, yet the appellate court heard the cases to resolve the issues raised. 52 N.Y.2d at 369-70, 420 N.E.2d at 66-67, 438 N.Y.S.2d at 268-69.


80. *52 N.Y.2d at 382, 420 N.E.2d at 73, 438 N.Y.S.2d at 275-76. The patient lived in a state facility where he was visited almost daily by his mother. When doctors recommended that he receive radiation therapy for cancer of the bladder, his mother applied to be appointed legal guardian to give consent. Although the disease was in remission for a while, it reoccurred. With transfusions, his life span was estimated to be between three to six months, while without transfusions death would occur within weeks. He found the transfusions disagreeable and his mother requested they be discontinued. *Id.* at 373-74, 420 N.E.2d at 68-69, 438 N.Y.S.2d at 270-71. The court found that the patient’s fatal illness had not affected his limited mental ability and that he remained alert and carried on usual activities. While the transfusions caused him some pain and could not cure the disease, the pain was not excessive. With the transfusions, the patient could maintain his usual activities; however, without them, he would bleed to death. *Id.* at 381-82, 420 N.E.2d at 73, 438 N.Y.S.2d at 275.

81. *Id.* at 371-72, 379, 420 N.E.2d at 67-68, 72, 438 N.Y.S.2d at 269-70, 274. The patient, Brother Fox, a member of a Catholic religious order, sustained a cardiac arrest during surgery to repair a hernia. He was placed on a respirator. After he was diagnosed as being in a permanent vegetative state, his superior, Father Eichner, requested to be appointed guardian with authority to direct removal of the respirator. *Id.* at 370-71, 420 N.E.2d at 67, 438 N.Y.S.2d at 269.
recovery. The court of appeals found that seeking prior judicial approval might be appropriate but that any such procedure is optional.

4. The Colyer Approach

The Washington Supreme Court modified the Quinlan position regarding the use of ethics committees by requiring the unanimous concurrence of a prognosis board of physicians to agree that there was no reasonable medical probability that the patient would return to a sapient state in the case of In re Colyer. The court also required the judicial appointment of a guardian prior to decision making by the family and physicians. The Colyer case concerned a husband seeking a court order to withdraw a respirator from his 69 year old wife who was in a chronic vegetative state as the result of a cardiopulmonary arrest. Establishing guidelines for future cases, the Colyer court found that the courts need no longer be involved once the appointment of a guardian to assert the rights of the incompetent was completed through the judicial process and the physicians on a prognosis committee agreed on the diagnosis. The court, however, becomes the final safeguard in this procedure, either in cases where there is disagreement among physicians on the prognosis committee, or when any participant in the decision or member of the family petitions for court intervention.

82. Id. at 379, 420 N.E.2d at 72, 438 N.Y.S.2d at 274.
83. Id. at 382-83, 420 N.E.2d at 74, 438 N.Y.S.2d at 276.
84. 99 Wash. 2d at 134, 660 P.2d at 749-50. The prognosis board, composed of the patient's physician and at least two other disinterested and qualified physicians who have an understanding of the patient's condition, would be responsible for confirming the attending physician's diagnosis and would protect against an erroneous diagnosis as well as questionable motives. The court criticized the Quinlan type of ethics committee as being too bureaucratic and cumbersome since it would be composed of non-medical personnel. Id. at 134, 660 P.2d at 749. A slightly different approach, that does not require the judicial appointment of a guardian, was taken by the Florida Supreme Court in John F. Kennedy Memorial Hospital Inc. v. Bludworth, 452 So. 2d 921 (Fla. 1984). In Bludworth, the Florida Supreme Court found that close family members may refuse extraordinary life-sustaining measures when a patient is certified by a physician to be in a "permanent vegetative state" if the certification is concurred in by two other physicians. Id. at 926.
85. Id. at 128-29, 660 P.2d at 746.
86. Id. at 117, 660 P.2d at 740.
87. Id. at 129, 660 P.2d at 746.
88. Id. at 136-37, 660 P.2d at 750.
5. The California Approach

California's response to the question of when to terminate treatment for patients in a persistent vegetative state is found in the Natural Death Act\(^9\) enacted in 1976, which recognizes a person's right to control medical treatment decisions in the instance of a terminal condition.\(^9\) Under the Natural Death Act, a competent adult may issue a directive, similar to a will,\(^1\) to his physician which will take effect only if the following requirements are met: (1) the patient is suffering from an incurable injury or illness; (2) the illness is certified by two physicians as terminal; (3) the use of life-sustaining procedures would only artificially prolong the moment of death for the patient; and (4) the attending physician determines death is imminent regardless of whether such life-sustaining procedures are applied.\(^1\) After these requirements are met, the physician, if he believes the proposed procedure will not change the prognosis of imminent death, will be absolved of any further liability for carrying out the patient's wishes in withholding life-sustaining treatment.\(^1\) Life-sustaining procedure is defined as: (1) any medical technique which uses mechanical or other artificial means to sustain, restore or supplant a vital function; and (2) serves only to artificially prolong the moment of death.\(^1\) Failure by a physician to

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90. Id. § 7186. The section in relevant part states that "[A]dult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decisions to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition." Id.
91. CAL. HEALTH & SAFETY CODE §§ 7186, 7188 (West Supp. 1984). A living will is another term to describe this type of procedure in that "it controls events at a later time when the patient is still alive, but incompetent, in contrast to wills devising property which control events upon a person's death." J. ROBERTSON, supra note 20, at 97. For a discussion of some of the problems inherent in living wills, see Eisendrath & Jonsen, The Living Will - Help or Hindrance? J. A.M.A. 2054-58 (1983).
92. CAL. HEALTH & SAFETY CODE §§ 7186, 7188 (West Supp. 1984). Legislation also exists to allow the pronouncement of death when there has been a total and irreversible cessation of brain function. Id. § 7180. See supra note 13 and accompanying text.
93. CAL. HEALTH & SAFETY CODE § 7190 (West Supp. 1984). Also, those who act under the direction of a physician will not be guilty of any criminal act or unprofessional conduct. Id. The wishes of the patient's family have no effect on a valid and binding directive. CALIFORNIA HOSPITAL ASSOCIATION, supra note 16, at 58. Withholding life-sustaining procedures in compliance with a directive is not mercy-killing or euthanasia; rather, it is "a method recognized under California law, by which a physician can respect a patient's instruction to permit an imminent death to proceed naturally." Id. at 72.
94. CAL. HEALTH & SAFETY CODE § 7187(c) (West Supp. 1984). Life-sustaining procedures do not include the administration of medication or the performance of any medical
effectuate a binding directive will constitute unprofessional conduct, if the physician refuses to make the necessary arrangements, or fails to take the necessary steps to effect the transfer of the patient to another physician who will implement the patient's directive.\textsuperscript{95}

The difficulty with this legislation lies in its limitations.\textsuperscript{96} For example, the Act requires that a directive be made in accord with prescribed terms, so that if a patient prepares a different directive, it is ineffective.\textsuperscript{97} Furthermore, for the directive to be binding, the patient must have been informed of the diagnosis of a terminal condition at least 14 days prior to the time he signs the directive, so that it does not apply to those who are not diagnosed as terminal at the time of execution, where death may be weeks, months, or even years away.\textsuperscript{98} Consequently, the directive procedure deemed necessary to alleviate pain. \textit{Id.} Death must be considered to be imminent, in the opinion of the attending physician, regardless of whether or not life-sustaining procedures are utilized. \textit{Id.}

\textsuperscript{95} \textit{Id.} § 7191(b).

\textsuperscript{96} Note, \textit{A Proposed Amendment to the California Natural Death Act to Assure the Statutory Right to Control Life Sustaining Treatment Decisions}, 17 U.S.F. L. Rev. 579, 605 (1982-1983). Some proposed changes to expand the scope of the Natural Death Act include allowing (1) any competent adult to execute the directive rather than only those diagnosed as terminal, (2) any directive to be used with wording that is in substantial compliance with the prescribed form, (3) the directive to be effective until revoked, and (4) the family of an incompetent patient to assert the patient's rights. \textit{Id.} at 606-08.

\textsuperscript{97} \textsc{Cal. Health \\& Safety Code §§ 7187(b), 7188, 7191(c) (West Supp. 1984).} Section 7187(b) requires that the written document be executed in accordance with the requirements of § 7188. \textit{Id.} § 7187(b). However, if the directive is no longer binding, the attending physician may give weight to the directive as evidence of the patient's directions regarding the withholding of life-sustaining treatment. \textit{Id.} § 7191(c). In the event of a non-binding directive, guidelines from the California Hospital Association suggest that the physician may withhold or withdraw life-sustaining procedures when, in his judgment, death is imminent. \textsc{California Hospital Association, supra} note 16, at 60. The physician should also consult the patient's family and consider factors such as information provided by the family, as well as the nature of the patient's illness, disease, or injury in determining whether the totality of the circumstances justifies effectuating the directive. \textit{Id.} The physician should also consult the hospital administrator prior to terminating treatment in cases where the directive was signed before the patient was diagnosed as having a terminal illness. \textit{Id.}

\textsuperscript{98} \textsc{Cal. Health \\& Safety Code § 7191(b) (West Supp. 1984).} "If the declarant [were] a qualified patient at least 14 days prior to executing or reexecuting the directive, the directive shall be conclusively presumed . . . to be the directions of the patient . . . ." \textit{Id.} A "[q]ualified patient means a patient diagnosed and certified in writing to be afflicted with a terminal condition." \textit{Id.} § 7187(e). A terminal condition is defined to be an incurable condition caused by injury, disease, or illness which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death. \textit{Id.} § 7187(f).
would not be binding on the physician if it were signed by a patient in good health. Furthermore, a valid directive, unless revoked, is effective for only five years from the date of its execution.\(^9\)

Some of these shortcomings were addressed in 1983 with the passage of California Civil Code, Section 2434, which permits an individual to designate an attorney-in-fact who has the durable power of attorney over health care decisions when the individual becomes incompetent.\(^{10}\) The statute which provides for oral and written revocation requires that two non-interested witnesses attest that the principal appears to be of sound mind.\(^{101}\) This legislation is naturally restricted by the need for the individual to have designated an attorney-in-fact prior to becoming incompetent and the fact that the designation lasts for a period of only seven years, unless at the end of the seven years the principal lacks capacity to make health care decisions for himself.\(^{102}\) When a patient who has designated an attorney-in-fact for health care decisions becomes incompetent, the designated attorney-in-fact should be consulted.\(^{103}\) An order to withdraw or withhold life-sustaining treatment cannot be issued without the concurrence of the attorney-in-fact unless specific court authorization has been secured.\(^{104}\) Assuming that the durable power of attorney for health care is executed properly, it provides a good method for effectuating the wishes of patients in a persistent vegetative

99. Id. § 7189.5. There is no criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to statute unless that person had actual knowledge of the revocation. Id. § 7189(3)(b).

100. CAL. CIV. CODE § 2434 (West Supp. 1984). An attorney-in-fact may not make health care decisions unless the principal is unable to give informed consent. Id. The attorney-in-fact also has priority over any other person to act for the principal in all matters of health care decisions. Id. Health care refers to any care, treatment, or procedure to maintain, diagnose or treat the patient's physical or mental condition. Id. 2430(b). Health care decisions refer to consent, refusal of consent, or withdrawal of consent to health care. Id. § 2430(c).

101. Id. § 2432. Witnesses may not be health care providers, operators of community facilities, or their employees. Id. § 2432B(d)(1)(4)(5). Furthermore, at least one witness shall not be an heir by devise or intestacy or a relative. Id. § 2432B(e)(1)(2). The durable power of attorney is not effective, if a principal is a patient in a nursing facility, unless one of the witnesses is a patient advocate or ombudsman. Id. § 2432B(f).

102. Id. § 2436.5.

103. Id. § 2434(a). This power does not allow the attorney-in-fact to consent to commitment in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. Id. § 2435(a)-(e).

104. CALIFORNIA HOSPITAL ASSOCIATION, supra note 16, at 66r.
state, since the responsibility of the attorney-in-fact is to act in a manner consistent with the desires of the patient.\textsuperscript{105}

In addition to this legislation, in 1981, a joint Biomedical Ethics Committee of the Los Angeles County Bar Association and Los Angeles Medical Association along with the local District Attorney's Office and the County Coroner's Office, issued guidelines for withdrawing respirators from terminally ill patients.\textsuperscript{106} Under these guidelines, a respirator can be removed in three instances: (1) when the patient has suffered a total and irreversible cessation of brain function, i.e., brain death; (2) under the provisions of the California Natural Death Act; or (3) when the patient's medical record contains a written diagnosis of an irreversible coma or persistent vegetative state.\textsuperscript{107} These guidelines, however, do not discuss the removal of food and water.

Consequently, in California, while there are medical guidelines for the termination of treatment of patients in a persistent vegetative state, the guidelines have no statutory authority regarding termination of treatment unless the patient meets the standard of brain death, has previously designated an attorney-in-fact, or has executed a binding directive to authorize termination. The \textit{Barber} case is an illustration of some of the problems that can arise in California due to the absence of legislation regarding the termination of treatment for patients in a persistent vegetative state.

\section*{III. THE BARBER DECISION}

\subsection*{A. The Factual Setting and Procedural History}

In \textit{Barber}, a unanimous three judge appellate court panel

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\item \textsuperscript{105} \textit{CAL. CIV. CODE} § 2434 (West Supp. 1984). If the patient's desires are unknown, the attorney-in-fact is to act in the best interests of the patient. \textit{Id}.
\item \textsuperscript{106} \textit{JOINT AD HOC COMMITTEE ON BIOMEDICAL ETHICS OF THE LOS ANGELES MEDICAL ASSOCIATION AND THE LOS ANGELES COUNTY BAR ASSOCIATION, Guidelines for Discontinuance of Cardiopulmonary Life-Support Systems under Specified Circumstances}, (1981) [hereinafter cited as \textit{JOINT AD HOC COMMITTEE}]. These guidelines have been endorsed by the California Medical Association and the California Hospital Association. \textit{CALIFORNIA HOSPITAL ASSOCIATION}, \textit{supra} note 16, at 62.
\item \textsuperscript{107} \textit{JOINT AD HOC COMMITTEE}, \textit{supra} note 106.
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from the Second Appellate District held that Doctors Barber and Nedjl were not guilty of murder and conspiracy to commit murder for removing a respirator, other life-sustaining equipment, intravenous feeding, and nasogastric tubes from a 55 year old comatose patient over a three to five day period. The circumstances precipitating removal occurred after successful completion of routine surgery for closure of an ileostomy, when the patient, Clarence Herbert, suffered a cardiorespiratory arrest in the recovery room. Reasons for the cardiorespiratory arrest remain uncertain. The patient was resuscitated by a medical team and immediately placed on a respirator.

Within the three days following the arrest, Doctors Barber and Nedjl determined that Mr. Herbert had suffered severe brain damage that left him in a persistent vegetative state. This determination was made as a result of tests and examinations made by several physicians, including Doctors Barber (Mr. Herbert's internist) and Nedjl, (Mr. Herbert's surgeon). At that time, the defendants informed Mr. Herbert's family of their opinion of his condition and chances for recovery. Following this meeting, the family convened and drafted a written request to the hospital indicating they wanted all life-sustaining machines removed. Consequently, three days after the cardiorespiratory arrest, the respirator was disconnected. Mr. Herbert continued to breathe after removal of the respirator, but showed no signs of improvement, such as recovery of consciousness.
Two days later, the defendants, after consulting with the family, ordered the removal of the intravenous tubes which provided nourishment and hydration. Six days later Mr. Herbert died.

The murder and conspiracy to murder charges were initially dismissed by the magistrate who concluded that (1) the defendants did not "kill" Mr. Herbert since their conduct was not the proximate cause of death (the principal cause listed on the death certificate was diffuse encephalomalacia); (2) the defendants' conduct under the circumstances was the result of good faith, ethical and sound medical judgment and not unlawful; and (3) the defendants' state of mind did not amount to malice. The superior court judge reinstated the complaint since he concluded that "as a matter of law the petitioners' conduct, however well motivated, and however ethical or sound in the eyes of the medical profession, was, under California law, 'unlawful.' " The defendants then petitioned the court of appeal for a review of the trial court ruling. The court of appeal issued a peremptory writ of prohibition restraining the trial court from taking further action in the matter other than to vacate its order reinstating

117. Id. at 1011, 195 Cal. Rptr. at 486. Testimony at the preliminary hearing by an attending nurse indicated that two days after the respirator was removed, two family members at Mr. Herbert's bedside were adamant that the intravenous tubes should be removed. The nurse refused to remove the tubes because she had no order from a doctor. Shortly thereafter she received the order. L.A. Times, supra note 50, at 1. After the removal of the intravenous tubes, Mr. Herbert received nursing care which preserved his dignity and provided a clean and hygienic environment. 147 Cal. App. 3d at 1011, 195 Cal. Rptr. at 486.

118. Steinbock, supra note 110, at 13. Mr. Herbert died from dehydration and pneumonia. Id.

119. 147 Cal. App. 3d at 1011, 195 Cal. Rptr. at 487. The charges were brought following information given by a nursing supervisor who went to the authorities because she disagreed with the defendants' actions. At the preliminary hearing the prosecution alleged that even if the removal of the respirator were legal in other contexts, it was part of a conspiracy to kill Mr. Herbert to hide malpractice. The prosecution claimed that malpractice occurred since basic medical standards of care were not followed in the recovery room and if the standards had been followed, the injury to Mr. Herbert's brain could have been prevented. Steinbock, supra note 110, at 13-14.

120. 147 Cal. App. 3d at 1011, 195 Cal. Rptr. at 487. The decision to reinstate charges was apparently based neither on the prosecution's "cover up" theory, nor on acceptance of any important legal difference between disconnecting a respirator and removal of intravenous feeding tubes, but rather that California law does not allow anyone to shorten another's life, and that the magistrate failed to find Mr. Herbert's condition irreversible. Steinbock, supra note 110, at 15.

121. 147 Cal. App. 3d at 1010, 195 Cal. Rptr. at 486.
the complaint and to enter a new order denying the prosecution's motion for reinstatement of the charges.\textsuperscript{122} The reversal writ issued by the appellate court was based on the grounds that existing state legislation did not require guardianship proceedings or judicial approval prior to the termination of treatment.\textsuperscript{123} Moreover, the court found that the failure to continue treatment, though intentional and with the knowledge that the patient would die, was not an unlawful breach of legal duty.\textsuperscript{124}

B. The Court's Reasoning

The Barber court, expressing a reluctance to evaluate the petitioners' conduct in the context of the inadequate framework of the criminal law, began its review by stating that the issues in this case required determination against a background of legal and moral considerations which had not as yet been adequately addressed by the legislature.\textsuperscript{125} Having established that existing legislation did not address withdrawal of life-support systems for patients in a persistent vegetative state, the court found that the termination of life-support measures is not an affirmative act, but rather an omission or withdrawal of further treatment.\textsuperscript{126} The court reasoned that the withdrawal of mechanical support devices is comparable to withholding manual administration of medicines.\textsuperscript{127}

The court then turned its inquiry to the issue of whether the withdrawal of treatment, i.e., the failure to act, was a breach of a legal duty, and found that there was no duty to continue treatment once it has proved to be ineffective.\textsuperscript{128} The court stated that "[a]lthough there may be a duty to provide life-sustaining machinery in the immediate aftermath of a cardio-re-
spiratory arrest, there is no duty to continue its use once it has become futile in the opinion of qualified medical personnel."\^129

The court also determined that there was no rational distinction between the use of respirators and the provision of nutrition and hydration in situations such as Barber.\^130 The court found that respirators, nutrition and hydration are forms of life-support and should be regarded in the same manner as any other medical procedure, rather than as typical human ways of providing nutrition and hydration.\^131 Hence, the court concluded that medical nutrition and hydration may not always provide net benefits to patients.\^132

Disagreeing with the Quinlan and Saikewicz approaches of distinguishing which life-sustaining procedure should be used and for how long its use must be maintained in terms of ordinary and extraordinary means of treatment,\^133 the Barber court found a benefits and burdens test more logical.\^134 Under this test the decision to continue treatment is made by considering whether the treatment will provide benefits which outweigh the burdens to the patient.\^135 Therefore, the burden of even a minimally intrusive treatment maybe disproportionate to its benefits when the patient’s prognosis is hopeless.\^136 The court concluded this situation was applicable to the Barber case, based on evidence presented at the preliminary hearing, which supported the conclusions that “Mr. Herbert had virtually no chance of recovering his cognitive or motor functions.”\^137

\^129. Id. at 1017-18, 195 Cal. Rptr. at 491.
\^130. Id. at 1016, 195 Cal. Rptr. at 490. The court found that the intravenous administration of nourishment and fluids is the same as the use of the respirator in that one is a mechanical feeding device and the other is a mechanical breathing device. Id. at 1016-17, 195 Cal. Rptr. at 490 (citing President's Commission: Deciding to Forego Life-Sustaining Treatment, supra note 3, at 192 n.52).
\^131. 147 Cal. App. 3d at 1016-17, 195 Cal. Rptr. at 490. This evaluation would consider the benefits and burdens of providing nutrition. Id.
\^132. Id. at 1016, 195 Cal. Rptr. at 490. Although this position is consistent with the findings of the President's Commission: Deciding to Forego Life-Sustaining Treatment, supra note 3, at 190, it remains controversial. See California Hospital Association, supra note 16, at 63.
\^133. See In re Quinlan, 70 N.J. at 47-48, 355 A.2d at 667-68; Saikewicz, 373 Mass. at 738, 370 N.E.2d at 423-24.
\^134. 147 Cal. App. 3d at 1018-19, 195 Cal. Rptr. at 491-92.
\^135. Id. at 1019, 195 Cal. Rptr. at 491.
\^136. Id.
\^137. Id. at 1020, 195 Cal. Rptr. at 492. The court stated that:
Acknowledging that there was no applicable legislation requiring the appointment of a legal guardian, the Barber court found that Mrs. Herbert (the decedent's wife) and children were the proper persons to determine the best interests of the patient. 138 The court stated that any surrogate ought to be guided by knowledge of the patient's own desires, or if this were not possible, by what would be in the patient's best interests. 139 Finally, based on the absence of applicable legislation requiring legal proceedings, the court concurred with the Quinlan decision by determining that prior judicial approval of the decision to terminate treatment was unnecessary and possibly unwise. 140

IV. ANALYSIS

A. The Problem

While appropriately acknowledging the drawbacks of designing an ethical and moral code for doctors through the prosecution of a lawsuit, 141 the Barber court inadequately addressed [t]he most optimistic prognosis provided by any of the testifying experts was that the patient had an excellent chance of 'recovery.' However, recovery was defined in terms of a spectrum running from a persistent vegetative state to full recovery. A persistent vegetative state was described as that state in which the patient would have no contact with the environment but parts of the brain would continue to live. The doctor who was of course approaching the case after the fact and from a hindsight view, was unable to predict where on this continuum Mr. Herbert was likely to end up. Several studies on which the expert relied, however, indicated that the chances for unimpaired or full recovery were miniscule. The results of these studies coincided with the diagnoses of the physicians who had actually examined and dealt with the patient before his demise.

138. 'Id. at 1021 n.2, 195 Cal. Rptr. at 493 n.2. The court acknowledged that "[d]espite the fact that Mr. Herbert apparently entered the name of his sister-in-law on a hospital form (the purpose of which was unclear from the evidence), his wife and children were the most obviously appropriate surrogates in this case." 'Id. The court also referred to evidence that Mr. Herbert had previously expressed to his wife that he would not want to be kept alive by machines. 'Id. at 1021, 195 Cal. Rptr. at 493.

139. 'Id.

140. 'Id. at 1022, 195 Cal. Rptr. at 493.

141. 'Id. at 1011, 195 Cal. Rptr. at 486. The court stated that "a murder prosecution is a poor way to design an ethical and moral code for doctors who are faced with decisions concerning the use of costly and extraordinary 'life support' equipment." 'Id.
some of the crucial issues involved. The most serious problem with the decisions made by the doctors and family members in this case was the unusually short length of time within which they made their decision to discontinue life-support systems. Within three days from the date of the cardiorespiratory arrest, Mr. Herbert was disconnected from his respirator, and two days later he was disconnected from intravenous feeding based on a determination by his physicians that he was in a persistent vegetative state. Significant medical authority and case law exist to indicate that the irreversibility of a coma cannot be determined within so short a time. Moreover, in the Barber case, there was no clearly documented diagnosis of irreversible coma which would meet the Los Angeles County Guidelines for Discontinuance of Cardiopulmonary Life-Support Systems Under Specified Circumstances to allow for disconnecting a respira-

142. See infra note 145.
143. 147 Cal. App. 3d at 1010, 195 Cal. Rptr. at 486.
144. Id. at 1010-11, 195 Cal. Rptr. at 486.
145. D. MEYERS, supra note 6, at 168-69 & n. 52; PRESIDENT'S COMMISSION: DEFINING DEATH, supra note 2, at 92-95, 98-99 (1981); A Definition of Irreversible Coma, Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, 205 J. A.M.A. 337 (1968). See also In re Colyer, 99 Wash. 2d at 144-45, 660 P.2d at 754-55, (Dore, J. dissenting). Justice Dore objected to 25 days as being an unacceptable time period for determining whether the patient in Colyer would have recovered brain functions. Id. at 145, 660 P.2d at 755. He claimed that other similar cases provide little legal support for withdrawing life-support mechanisms in such a short time. Id. at 144, 660 P.2d at 754 (citing Severns, 421 A.2d 1334; Saikewicz, 373 Mass. 728, 380 N.E.2d 417; In re Quinlan, 70 N.J. 10, 355 A.2d 647; In re Storar, 52 N.Y.2d 363, 38 N.Y.S.2d 266, 420 N.W.2d 64; Leach v. Akron General Medical Center, 68 Ohio Misc. 1, 22 Ohio Op. 3d 49, 426 N.E.2d 809). He concludes:

Leach allowed termination of life supporting mechanisms in 4 months; Severns in 5 months; the Quinlan case, after 1 year. The other two cases, Saikewicz and Storar, involved noncomatose individuals, both of whom were retarded. The majority opinion [in Colyer] represents the most liberal interpretation in the United States as to the length of time an incompetent must remain on a life supporting mechanism before it can be medically determined there is no reasonable possibility of the incompetent ever emerging from the present comatose condition to a cognitive sapient state.

Evidence presented to the trial court by the attending physicians has shown that Bertha Colyer was indeed alive, and a finding was made by the trial court to that effect. There do exist documented medical instances when fact patterns similar to the one at bar were present and the patient ultimately survived, although these cases are rare.

Id. at 144, 660 P.2d at 754.
tor. Thus, the Barber court has sanctioned not only controversial but precipitous medical actions, without substantial legal or medical support. In addition, there is no clear legal or medical consensus as to whether nourishment and hydration should be discontinued when the patient is in a persistent vegetative state. Certainly, as the Barber court found, the distinction made between withholding air and withholding food and water, may be based more on emotional symbolism than on rational differences. However, if nourishment is considered basic comfort care to ease the dying process, it may be required and, therefore, distinguished from the use of a respirator. Also, a difference exists as to the level of pain and suffering involved when distinguishing between the withdrawal of a respirator and the withdrawal of nourishment and hydration. When the respirator is withheld, little suffering or pain is involved. However, death from starvation and/or dehydration may take from several days to several weeks and may cause pain and suffering depending on the level of patient awareness and the medications provided. Assuming that in certain limited situations, where the patient is in a persistent vegetative state, withholding nutrition and hydration should be the accepted practice, the question that still remains is whether the physicians in Barber acted too quickly in removing the respirator.

146. D. MEYERS, supra note 6, at 54 (Cum. Supp. 1983). There was no written diagnosis of irreversible coma as required under the guidelines. Moreover, since Mr. Herbert's wife had filed a civil malpractice suit (cite omitted) and there was conflicting evidence as to what information was given to the family, the necessity for documentation avoids argument and uncertainty after the fact. Id.

147. See supra note 145.

148. See supra note 55. Also the California Hospital Association recognized this issue as controversial by contrasting the findings of the President's Commission with the Department of Health and Human Services' handicapped infant regulations. CALIFORNIA HOSPITAL ASSOCIATION, supra note 16, at 63.

149. 147 Cal. App. 3d at 1016, 195 Cal. Rptr. at 490.


151. Id. at 63 (Cum. Supp. 1983). When death results from the withdrawal of the respirator, the patient becomes unconscious several minutes after withdrawal and suffers brain death shortly afterwards. Id.

152. Id.

153. Id.
B. Resolution

1. Statutory Resolution

Resolution of some of the termination of life-support issues for patients in a persistent vegetative state, could be accomplished by statute. For example, the Los Angeles County Guidelines for Discontinuance of Cardiopulmonary Life-Support Systems Under Specified Circumstances could be adopted or a minimum time frame could be established before a respirator is disconnected. However, revisions in statutory law often can not keep pace with the ongoing medical and technological advances that consistently present new legal and ethical issues. Moreover, statutes while helpful, are an unsatisfactory way to resolve issues where medical uncertainty still exists and further ethical discussion is necessary. For example, in cases concerning the withdrawal of nutrition or the determination of the patient’s best interests, it would be difficult for a statute to address all of the individual variations present in a particular case. However, a statute could require health care facilities to establish ethics committees for resolution of those issues which cannot be addressed directly by statute.

2. Ethics Committees

Because of the lack of medical and legal consensus, the most promising approach to resolving decisions regarding the withdrawal of life-support systems appears to be the Quinlan concept of an ethics committee. A committee allows the responsibility of judgment to be shared in cases where no guidelines have been established and the proposition is controversial, such as the withdrawal of nutrition and hydration. The ethics committee approach allows for a case-by-case evaluation to take into account the differences that impact and affect each decision.

Although ethics committees are recommended by the California Hospital Association to assist with decisionmaking,154

154. CALIFORNIA HOSPITAL ASSOCIATION, supra note 16, at 66(d)-66(e). Ethics committees would serve to perform such functions as assisting in the formulation of hospital policies pertaining to withholding and withdrawing life-sustaining treatment, serving as a resource to those involved in biomedical and ethical decisions, and providing a forum for
they are not found in most hospitals. Less than 20% of the acute care hospitals in the United States had ethics committees in 1982. One of the largest problems facing the formation of ethics committees is physician resistance. There is a fear among some physicians that the physician-patient relationship will be destroyed or a committee will dictate rules on what is a private matter. However, an ethics committee can be structured to provide guidance, not to be the ultimate arbiter. The purpose of a committee is to spell out those values that constitute the context in which individual prudence must operate. Although this approach, depending on the structure and specific function of the committee, may remove some autonomy from the treating physicians and family, its advantages can be likened to the value of multi-judge courts in resolving difficult questions of law on appeal.

Another major objection to ethics committees is the lack of clinical knowledge of committee members. There is a concern that members with a non-clinical background will not be able to understand sufficiently the medical details upon which medical judgment is based. Although there is substance to this objection, it should function as a challenge rather than as an obstacle. Medical personnel must have the ability to translate, while non-clinical members must familiarize themselves with medical terminology. This is meant to insure the patient’s best interest to be viewed as a broad human judgment, rather than simply a scientific discussion about biomedical ethical issues. Id.

155. Jonsen, A.R., What is Extraordinary Life Support? Medical Staff Conference, University of California, San Francisco, 141 West J. Med. 358, 362 (Sept. 1984). The University of San Francisco has had an ethics committee for seven years. Id. The committee is composed of seven doctors, two nurses, a chaplin, an attorney, and a professor of ethics in medicine, and unanimous decisions are reached on all cases. Even when it has no referrals, the ethics committee meets monthly to address policy questions. Information as to the University of San Francisco's ethics committee was provided by a telephone interview with Albert R. Jonsen, Professor of Ethics in Medicine and Chief, Division of Biomedical Ethics, Department of Medicine, University of California, San Francisco on November 26, 1984.


157. Id. at 153.

158. 90 N.J. at 50, 355 A.2d at 669.

159. McCormick, supra note 156, at 154.

160. Id. at 153.

161. Id.
While an ethics committee can complicate the decision making process by merely multiplying the number of opinions as to appropriate treatment, the availability of a vehicle for consultation is desirable. The committee need not be involved for the majority of cases. However, whenever disagreement or uncertainty exist, the involvement of such an ethics committee is of value. The hospital itself could specify the types of cases which would come under the ethics committee review.

Besides using an ethics committee for cases where there is medical uncertainty, an ethics committee is best suited to take into account a variety of economic considerations. For example, government has limited resources. Competing demands are made on these resources and medical need is only one of those forces seeking the maximum allocation from the available sources. Economic factors cannot be ignored when resources are scarce and an alternate allocation of the resources and personnel might benefit other patients more. On the other hand, since Medicare and Medicaid payments are set, regardless of length of time or treatment provided, there may be a need for ethics committees to constrain inappropriate financial considerations regarding treatment decisions that have little relationship to the patient’s best interests.

162. Id. at 154.
163. D. MEYERS, supra note 6, at 444-45.
164. Id. at 445.
165. D. MEYERS, supra note 6, at 174.
166. Id.
167. The prosecution at the preliminary hearing in the Barber case had tried to show that the defendants and the hospital benefitted financially from Mr. Herbert’s demise. However, the municipal court judge ruled that evidence on the financial state of the hospital and its arrangements with its doctors is irrelevant in determining whether sufficient evidence of murder existed for a trial. L.A. Times, supra note 50, at 1, 6. See also McCormick, supra note 156, at 152, for a discussion of the emergence of economic considerations in operating health care facilities for profit and in the use of salaried employee physicians.

Not only can economic factors influence a physician’s opinion regarding the discontinuation of life-support systems, but these factors can also affect the family. The overwhelming cost of medical care can influence the decisions of the family regarding the prolongation of intensive treatments for those family members who are in a persistent vegetative state. See President’s Commission: Deciding to Forego Life-Sustaining Treatment, supra note 3, at 185 n.35.
Thus, the concept of shared judgment in decision making allows for consideration of all of these factors (medical, ethical, economic, and legal), with more detached investigation, than if left solely to the treating physicians and the family. For example, while responsibility is diffused for an obviously difficult decision where the ethical and medical dimensions are complex, this diffusion can allow a more truly informed and less self-protective prognosis and treatment or non-treatment recommendation to be made. Moreover, in the absence of statutory law in this area, this approach places the treating physicians in a better position if subsequent litigation occurs.

The ethics committee, composed of lay persons and medical personnel, provides a broader prospective than a prognosis board. However, the prognosis board is an alternative that does increase participation in decision making. Because of the seriousness of a decision to withdraw life-support systems, the value of a multidisciplinary approach of an ethics committee which takes into account legal and ethical perspectives, in addition to the medical perspectives which are considered by a prognosis board, seems to have more advantages than a prognosis board.

Either an ethics committee or a prognosis board would have provided support for the physicians in the Barber case, since withdrawal of all life-support systems, including intravenous feeding devises, after five days is not a universally accepted medical practice. The only necessity for judicial intervention would be in cases where there is a disagreement by the ethics committee or prognosis board as to treatment procedures. The Colyer court adequately outlined the situations requiring judicial intervention in the decision to withdraw life-support systems. Even the Quinlan court, which held that as a general procedure judicial intervention is unnecessary, found that

168. D. Meyers, supra note 6, at 444.
169. As long as the concern over civil and criminal liability exists, a recommendation from an ethics committee can confirm the diagnosis made by the physician, the appropriateness of discontinuing further treatment as proposed, and that such action is consistent with accepted medical practice. Thus, the physician is insulated from a malpractice claim. Also, a decision that is sometimes viewed with fear or suspicion receives more social acceptability. D. Meyers, supra note 6, at 383 & n.9.
170. See generally D. Meyers, supra note 6, at 382; California Hospital Association, supra note 16, at 36.
171. 99 Wash. 2d at 137, 660 P.2d at 751. See supra text accompanying notes 84-88.
"[t]his is not to say that in the case of an otherwise justifiable controversy access to the courts would be foreclosed; we speak rather of a general practice and procedure." Although the Barber court cited Quinlan to find judicial intervention unnecessary, the Barber court apparently ignored this specific exception which was found in Quinlan. Consequently, not only the interests of the patient, but also the interests of the treating physician in avoiding civil and criminal liability, require the use of an ethics committee, or in the alternative, court approval, to provide additional input regarding judgment in the frontier areas of medical decisionmaking, such as withdrawal of nutrition and hydration, or a determination as to the irreversibility of a coma.

V. CONCLUSION

The Barber court has taken a major step in establishing California legal standards for the withdrawal of life-support treatment from patients in a persistent vegetative state. This decision arose due to a lack of adequate legislative or medical guidelines in this area. To apply the Barber holding may be to encourage precipitous withdrawal of nutrition and hydration, as well as respirators, for patients who in fact have a chance of recovery or whose chances of recovery have been inadequately assessed. In addition, even with the Barber decision, the physician may still risk civil or criminal liability.

The better alternative is for the legal and medical professions to encourage the legislature to bypass Barber and revise existing statutes or establish procedural guidelines responsive to the needs of the patient in a persistent vegetative state. The statute or guidelines must address the issues of: (1) decision making for those patients who have not previously expressed their wishes concerning the extent of care, (2) withdrawal of nutrition and hydration, and (3) when court intervention is appropriate. Moreover, a statute or guidelines must require the use of ethics committees to insure maximum protection of each indi-

172. 90 N.J. at 50, 355 A.2d at 669.
173. See Barber, 147 Cal. App. 3d at 1022, 195 Cal. Rptr. at 493, where the court apparently did not see that any justiciable controversy was involved in this particular situation.
174. See supra note 16.
individual's rights and be responsive to technological changes. Finally, it is necessary that the statute or guidelines make an adequate statement exonerating the physician from criminal liability.

Sheila Brutoco*

* Golden Gate School of Law, Class of 1986.