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Compulsory Medical Treatments: The State's Interest Re-evaluated

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Compulsory Medical Treatment: The State's Interest Re-evaluated

I. INTRODUCTION

Courts must often determine under what circumstances a competent adult may be forced to submit to medical treatment necessary to save his life. The question most frequently arises when doctors, hospital officials, and other interested parties seek a court order authorizing them to administer the treatment necessary. Due to the emergency situation associated with these cases, the court often must render its decision immediately. During these proceedings, the patient is rarely represented by counsel, or if he is, the attorney has had little time to prepare an adequate defense. Further, there generally is no standard of medical proof to determine whether the treatment is actually necessary to save the patient's life; thus, the doctor's allegations are accepted as accurate. Because of the urgency and the court's natural inclination to attempt to save the patient's life,[1] the patient's legal rights can be easily overlooked. The purpose of this Note is to examine the rights and interests involved in these situations and to suggest an appropriate legal standard for compelling medical treatment.

II. ORIGINS OF A PATIENT'S RIGHT TO DECLINE NECESSARY MEDICAL TREATMENT

Generally, every individual has a legal right to refuse medical treatment. This right originated in the common law and is incorporated in the constitutional rights of freedom of religion and privacy.

A. Common Law

Under the common law principle of the inviolability of the

1. For an interesting example of this see Powell v. Columbian Presbyterian Medical Center, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (Sup. Ct. 1965), where the patient had refused to consent to a blood transfusion and the court stated:

> How legalistic minded our society has become, and what an ultra-legalistic maze we have created to the extent that society and the individual have become enmeshed and paralyzed by its unrealistic entanglements!
>
> I was reminded of "The Fall" by Camus, and I knew that no release—no legalistic absolution—would absolve me or the court from responsibility if I, speaking for the court, answered "No" to the question "Am I my brother's keeper?" This woman wanted to live. I could not let her die!

Id. at 216, 267 N.Y.S.2d at 452.

body, all competent adults have a right to make their own medical decisions. Thus, a doctor may commit a battery if he treats a patient without proper consent;[2] and it is no defense that no harm was inflicted[3] or that the treatment proved beneficial.[4] However, in an emergency where a patient is unable to express his will, consent may be implied on the assumption that the patient would consent if he were able.[5] If the patient expressly rejects treatment prior to becoming incompetent, consent cannot subsequently be implied when the patient is dying.[6]

The principle which prohibits doctors from treating an objecting patient has recently been extended to prohibit courts from compelling a competent adult to submit to treatment. In *Erickson v. Dilgard*,[7] the court denied a doctor's application to administer a lifesaving blood transfusion to a competent adult patient who had consented to an operation but would not consent to the transfusion. The court recognized that a medical decision is always a question of judgment to be made by the patient. The court reasoned: "[I]t is the individual who is the subject of a medical decision who has the final say and that this must necessarily be so in a system of government which gives the greatest possible protection to the individual in the furtherance of his own desires."[8] Thus, it appears that *Erickson* is authority for the proposition that a competent adult can *never* be forced to submit to unwanted treatment.[9]

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2. *E.g.*, Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906); Mohr v. Williams, 95 Minn. 261, 104 N.W. 12 (1905); Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 105 N.E. 92 (1914); Rolater v. Strain, 39 Okla. 572, 137 Pac. 96 (1913). See generally McCoid, *A Reappraisal of Liability for Unauthorized Medical Treatment*, 41 MINN. L. REV. 381 (1957); Powell, *Consent to Operative Procedures*, 21 MD. L. REV. 189 (1961); Smith, *Antecedent Grounds of Liability in the Practice of Surgery*, 14 ROCKY MT. L. REV. 233 (1948).

3. See, *e.g.*, Donald v. Swann, 24 Ala. App. 463, 137 So. 178 (1931); Keister v. O'Neil, 59 Cal. App. 2d 428, 138 P.2d 723 (Dist. Ct. App. 1943); McCoid, *supra* note 2, at 403.

4. See authority cited *supra* note 3.

5. Jackovach v. Yocom, 212 Iowa 914, 237 N.W. 444 (1931); King v. Carney, 85 Okla. 62, 204 Pac. 270 (1922). See Powell, *supra* note 2, at 199; 42 KY. L.J. 98 (1953); 4 U.C.L.A.L. REV. 627 (1957); *cf.* Rogers v. Sells, 178 Okla. 103, 61 P.2d 1018 (1936) (dicta).

6. Powell, *supra* note 2, at 197, 199.

7. 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962).

8. *Id.* at 28, 252 N.Y.S.2d at 706.

9. However, the *Erickson* case can also be read as holding that treatment can be compelled if it is absolutely certain the patient will die, as then there would be no question of judgment.

B. CONSTITUTIONAL RIGHT TO FREEDOM OF RELIGION

Commonly the guarantee of free exercise of religion[10] is asserted by the patient to avoid medical treatment.[11] While one's freedom to believe is absolute,[12] this freedom is subject to certain limitations when it is transmitted into actions.[13] The basic limitation is the existence of a compelling public interest which conflicts with the individual's private interest.[14] Thus, the Supreme Court has upheld statutes that prohibit polygamous marriages as advocated by Mormons[15] and statutes that prohibit children of Jehovah's Witnesses from selling religious magazines in the street.[16]

At least one party has successfully invoked this constitutional guarantee to avoid compulsory medical treatment. In *In re Brooks' Estate*,[17] a seriously ill Jehovah's Witness voluntarily sought treatment, but refused to consent to transfusions believed necessary to save her life.[18] The appellate court re-

10. See Kurland, *Of Church and State and the Supreme Court*, 29 U. CHI. L. REV. 1 (1961).

11. See Application of President & Directors of Georgetown College, 331 F.2d 1000, *rehearing denied*, 331 F.2d 1010 (1964), *cert. denied*, 377 U.S. 978 (1965); *In re* Brooks' Estate, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964). These cases concern Jehovah's Witnesses who have refused to consent to blood transfusions because of absolute scriptural proscriptions against "eating blood." See How, *Religion, Medicine & Law*, 3 CAN. B.J. 365, 368 (1960). While this prohibition is absolute, judicial decisions are made easier because patients often will not physically resist treatment if it is forced upon them; they merely refuse to consent. The patients evidently believe if the transfusion is forced upon them the responsibility is shifted to the court and they are absolved. Although the Biblical prohibition against blood transfusions seems absolute, each individual should be free to interpret his own religion. Thus, the patient's religious beliefs may not be infringed by the court's ordering treatment. The cases should be of little value as precedent where the patient believes that the prohibitions are absolute.

12. Prince v. Massachusetts, 321 U.S. 158 (1944); Cantwell v. Connecticut, 310 U.S. 296 (1940).

13. *Ibid.*

14. See Sherbert v. Verner, 374 U.S. 398, 406 (1962). The court in *In re* Brooks' Estate, 32 Ill. 2d 361, 205 N.E.2d 435 (1965), used the older test of requiring an overt act that presented a "clear and present danger" to society. See 44 TEXAS L. REV. 190, 191 (1965). Due to the tenor of the *Brooks* opinion, it seems likely that the court would have reached the same result using the compelling state interest test.

15. Reynolds v. United States, 98 U.S. 145 (1878).

16. Prince v. Massachusetts, 321 U.S. 158 (1944).

17. 32 Ill. 2d 361, 205 N.E.2d 435 (1965).

18. Although the appeal came after the transfusions were given, the court allowed it on the basis of presenting an issue of substantial

versed an order authorizing the administration of the transfusion on the ground that the authorization constituted an unconstitutional interference with the patient's freedom of religion.

C. The Constitutional Right to Privacy

Additional support for the right to refuse medical treatment may be provided by the constitutional right of privacy. In establishing the constitutional right of marital privacy, the Supreme Court, in *Griswold v. Connecticut*,[19] demonstrated a willingness to protect the right to be let alone.[20] While the scope of *Griswold* is unclear,[21] it seems likely that the "zones of privacy" will encompass the individual's freedom from compulsory medical treatment. Although the Court did not articulate the standard to be applied, Mr. Justice Goldberg's concurring opinion hinted that the balancing approach would be used.[22]

Logically, it is difficult to distinguish the arguments supporting the judical protection of inviolability of the body and those advanced in support of the constitutional right of privacy. Clearly both concepts are rooted in the American traditions of individual freedom and an abhorrence of the state's unreasonable intrusion in private relations.[23] In establishing an appropriate standard with respect to privacy and compulsory medical treatment, consideration should be given to the standard applied in the freedom of religion area. A person who refuses medical treatment on philosophical or moral grounds should have his right as vigorously protected as a person who refuses on religious grounds.

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public interest. See Wallace v. Labrenz, 411 Ill. 618, 102 N.E.2d 769 (1952), *cert. denied*, 344 U.S. 824.

19. 381 U.S. 479 (1965) (anticontraceptive statute an invasion of marital privacy).

20. The Court declared this right existed not in any one of the Bill of Rights amendments, but in the penumbra of several of them. In Olmstead v. United States, 277 U.S. 438 (1928), Justice Brandeis in a dissenting opinion declared the existence of a similar right—"the right to be left alone." *Id.* at 471. See generally *Symposium on the Griswold Case and the Right of Privacy*, 64 Mich. L. Rev. 197 (1965).

21. It has been suggested that the right was left open-ended. Dixon, *The Griswold Penumbra*, 64 Mich. L. Rev. 205 (1965).

22. See Griswold v. United States, 381 U.S. 479, 486 (1965); Emerson, *Nine Justices in Search of a Doctrine*, 64 Mich. L. Rev. 230, 232-33 (1965).

A distinction must be drawn between the common law right of privacy and the constitutional right of privacy. The latter relates to state interference rather than interference by an individual.

23. See Griswold v. United States, 381 U.S. 479 (1965); Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962).

As a practical matter, however, consistent results may not be reached in every case. A compelling public interest in the area of privacy does not necessarily qualify as such in the area of religion since different rights are being protected. Further, the right of privacy is a newly recognized right and may well be applied conservatively; thus, little in the way of a public interest will be necessary to allow lawful invasions of privacy.

If the standard associated with freedom of religion is not applied, the standard suggested in *Sherbert v. Verner*,[24] which requires something more than a rational relationship to a colorable public interest, would be the best rule to avoid completely emasculating the right of privacy.

III. LIMITATIONS ON A PATIENT'S ABILITY TO DECLINE MEDICAL TREATMENT

A. The State Police Power

The state has the power to protect the lives of its citizens from interference by others. Under this police power concept the state may regulate its internal affairs for the protection and promotion of general health, safety, morals, and welfare of its citizens even where it proves to be inconvenient or offensive to a particular individual.[25] Even certain fundamental rights which an individual considers dear must yield if the interests of society as a whole demand the contrary.

There are numerous examples of such a compelling state interest in the realm of compulsory medical treatment. In *Sadlock v. Board of Education*,[26] it was argued that compulsory vaccination violated the rights of religious freedom and personal liberty. However, the court upheld a school board resolution making vaccination mandatory for admission to school because it was within the state's police power to prescribe reasonable methods to combat disease. Similarly, to prevent disease, a state can pass a statute requiring purification of sewage and public water supply,[27] authorize a court to appoint a guardian for unvaccinated minors, and vaccinate them,[28] and authorize

24. 374 U.S. 398, 406 (1962).

25. See Halter v. Nebraska, 205 U.S. 34 (1906).

26. 137 N.J.L. 85, 58 A.2d 218 (1948); *accord*, Jacobson v. Massachusetts, 197 U.S. 11 (1904). *But see* Kolbeck v. Kramer, 84 N.J. Super. 569, 202 A.2d 889 (Super. Ct. 1964).

27. State Bd. of Health v. City of Greenville, 86 Ohio St. 1, 98 N.E. 1019 (1912).

28. Cude v. State, 237 Ark. 927, 377 S.W.2d 816 (1964) (children not admitted to school without vaccination).

the health department to quarantine a person suspected of having venereal disease.[29] Further, a state university can deny admission to a student who refuses to submit to an x-ray examination for the detection of a tubercular infection.[30]

This line of cases has been cited as authority for the state's power to force a nonconsenting adult to submit to medical treatment. It should be noted, however, that none of the courts in these cases actually compelled treatment of an individual; rather, they sanctioned imposition of criminal penalties or deprivation of social or political privileges as the alternative to refusing treatment.

B. Parens Patriae

It is generally recognized that the state as *parens patriae*[31] has the power of guardianship over minors and incompetents.[32] *Parens patriae* stems from the state's self-imposed duty to protect the welfare of these classes of individuals.[33] The courts have occasionally employed this power to order actual medical treatment. Thus, in *In re Vasco*,[34] a two year old child suffering from a probably malignant eye disease was provided with a necessary operation by order of the court over the parents' refusal to consent. The court held that the child was entitled to the protection of the law, and that where the parents arbitrarily[35] failed to provide proper medical treatment the court could order the necessary treatment. In *Mitchell v. Davis*,[36] where a seriously ill child was given only prayers as treatment, the court ordered temporary custody of the child to be given to the juvenile officials who would provide the necessary treat-

29. *Ex parte* Kilbane, 32 Ohio Op. 530, 67 N.E.2d 22 (C.P. 1945); see Peterson v. Widule, 157 Wis. 641, 147 N.W. 966 (1914) (mandatory venereal disease test for marriage license was constitutional).

30. State v. Armstrong, 39 Wash. 2d 860, 239 P.2d 545 (1952).

31. See Annot., 30 A.L.R.2d 1138 (1953). Parents have a strong natural interest in the custody and control of their children. This includes supervision and physical well-being. However, the courts have agreed the state has an overriding interest and can interfere where the child's life or health is in danger.

32. See, *e.g.*, *In re* Turner, 94 Kan. 115, 145 Pac. 871 (1915); McIntosh v. Dell, 86 Okla. 1, 205 Pac. 917 (1922). See generally Foote, Levy & Sander, Cases on Family Law 367-94 (1966).

33. See 64 Mich. L. Rev. 554, at 555 (1966).

34. 238 App. Div. 128, 263 N.Y. Supp. 552 (1933).

35. There is some question whether it was *arbitrarily* refused. The court recognized that medical science was not exact, and that there was only a 50% chance of cure. *Id.* at 130, 263 N.Y. Supp. at 555.

36. 205 S.W.2d 812 (Tex. Civ. App. 1947).

ment. Other courts have invoked the power of *parens patriae* in ordering surgical care for a child suffering from a limb deformity[37] and in authorizing blood transfusions to a child where his life was in danger.[38] When the parents refused consent because of their religious convictions, one court appointed a guardian for an unborn child so a necessary blood transfusion could be given to the child upon birth.[39]

However, this power has limitations. For example, the amputation of a twelve year old child's severely deformed arm was not ordered where the parents' objection was based on a fear of the possible failure of the operation.[40] In reaching its decision, the court seemed particularly impressed by the risk of death inherent in the operation. Thus, the court will not order treatment for a child when the treatment is dangerous to life or there is a significant difference of opinion as to the efficacy of the proposed treatment.[41] In these cases, the parents' decision will be controlling.

Two recent decisions extend *parens patriae* to compulsory treatment of nonconsenting adults. In *Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson*,[42] a pregnant woman refused to consent to blood transfusions prior to giving birth because of her religious beliefs. The plaintiff hospital, seeking a court order to allow it to give the transfusion, argued that the mother was likely to hemorrhage and that there was a strong possibility that both mother and child would die as a result. In reversing the lower court's decision, it was held that the state has an

37. *In re* Rotkowitz, 175 Misc. 948, 25 N.Y.S.2d 624 (Dom. Rel. Ct. 1941) (psychological injury caused by social rejection).

38. *E.g.*, Wallace v. Labrenz, 411 Ill. 618, 104 N.E.2d 769 (1952); Morrison v. State, 252 S.W.2d 97 (Mo. 1952); State v. Perricone, 37 N.J. 463, 181 A.2d 751 (1962), *cert. denied*, 371 U.S. 890 (1962). In these cases the parents refused to grant consent to the blood transfusions for religious reasons. In *Perricone*, without the transfusion the child would have died or suffered neurological disability.

39. Hoener v. Bertinato, 67 N.J. Super. 517, 171 A.2d 140 (Juv. & Dom. Rel. Ct. 1961). Previous to this action, the same parents had one child who survived because of a similar order, and another who died because there was no order.

40. *In re* Hudson, 13 Wash. 2d 673, 126 P.2d 765 (1942); *cf. In re* Frank, 41 Wash. 2d 294, 248 P.2d 553 (1952). In the *Frank* case, the parents refused to have a child's speech impediment corrected. However, this refusal was not sufficient to justify the conclusion that the child was a dependent child. Such a conclusion would authorize a court to award custody of the child to someone who would have the impediment corrected.

41. See Morrison v. State, 252 S.W.2d 97 (Mo. 1952).

42. 42 N.J. 421, 201 A.2d 537, *cert. denied*, 377 U.S. 985 (1964).

interest in protecting unborn children and that this interest justifies ordering unwanted transfusions where it is the only alternative available to save the child's life. However, the court expressly limited its holding by stating that it had not reached the question of whether a competent adult may be compelled to submit to medical treatment solely to save his own life because under the instant facts the lives of the parent and child were so "intertwined and unseparable."[43]

In *Application of President and Directors of Georgetown College*,[44] where the mother of a seven month old child voluntarily entered the hospital but would not consent to transfusions necessary to save her life because of her religious convictions, an emergency order was granted authorizing the transfusions. The court reasoned that because the patient was *in extremis* and *non compos mentis* she was no more able to competently make decisions than a child. The court also pointed out that the patient has a responsibility to the community to care for her child, and the state, as *parens patriae*, can not tolerate parental conduct which constitutes child abandonment, particularly "this most ultimate of voluntary abandonments."[45] The conclusion suggested by this case is that the state can order treatment where the adult patient is either incompetent or has dependents to whom he has a responsibility of care.

Arguably, *Georgetown* is subject to the criticism of extending the *parens patriae* concept beyond its intended limits. While the concept does extend to incompetents, to allow a court to order treatment where an objecting patient is *non compos mentis* because of his illness may prove dangerous. If the patient has not previously objected, a court could wait until he is sufficiently incapacitated and then base the determination to authorize treatment on incompetency. Should this be done, the

43. *Id.* at 423, 201 A.2d at 538.

44. 331 F.2d 1000, *rehearing denied*, 331 F.2d 1010 (1964), *cert. denied*, 377 U.S. 978 (1965). In *Georgetown*, the federal judge who heard the case purported not to decide the issue on the merits, but rather he issued the order only to maintain the status quo—to prevent mootness by the patient's death before full consideration. However, the dissent states that the status quo was not achieved because the issue was mooted by the recovery of the patient. 331 F.2d at 1011. It is clear that the status quo cannot be maintained in these cases. It is relevant to note that no decision has been had on the merits of this case and it should be of little value as precedent.

45. *Id.* at 1008. The reason for the incompetency is of little import. See, *e.g.*, Porter v. Hall, 34 Ariz. 308, 271 Pac. 411 (1928); *In re* Wann's Estate, 176 Pa. Super. 498, 108 A.2d 820 (1954); 9 UTAH L. REV. 161, 169 (1964).

court has effectively circumvented the patient's right to refuse treatment. This right should be protected even after the patient can no longer assert it.[46] Also, there is a danger that any decision by the patient which is inconsistent with the general mores of society could be evidence of incompetency. Thus, a patient could be declared incompetent merely because treatment was refused.[47] Such action would be a totally irresponsible use of *parens patriae.*

Two other criticisms of the *Georgetown* decision may be advanced. First, while the court correctly found a public interest sufficient to justify ordering medical treatment—the parent's responsibility to care for his children—the court was incorrect in basing its decision on the *parens patriae* concept. The purpose of *parens patriae* is to provide a vehicle for the court to physically protect the child and not to protect a parent so he can in turn provide for his child. Second, the court's "ultimate abandonment" argument[48] seemingly overlooked the existence of the remaining parent who presumably can care for the child.[49] More importantly, rather than abandoning the child, it can be argued that the parents are providing the child with an important moral lesson—the value one should place upon his principles and religious convictions.

C. Other Public Interests

Other public interests may be suggested to buttress the court's decision to order treatment. The argument for protection of dependent children could be extended to other dependent relatives. However, this is not a sufficiently compelling interest because those people should be able to care for themselves. Even weaker is the argument that the state may have an interest in allowing a doctor to perform his duties to the best of his abilities. This interest evidently is the benefit gained through the raising of public confidence in the medical profession, or the belief that the over-all performance of the medical

46. See 9 Utah L. Rev. 161, 169 (1964).

47. See 113 U. Pa. L. Rev. 290, 294 (1964). The author of this article suggests this is what actually happened in *Georgetown* because there is little in the record to demonstrate incompetence. This argument may have more weight where the person offers no reason for his refusal.

48. States can interfere when a parent abandons his child. See State v. Sandford, 99 Me. 441, 59 Atl. 597 (1905); Palmer v. State, 223 Md. 341, 64 A.2d 467 (1960).

49. See Lane v. Commonwealth, 371 S.W.2d 16 (Ky. Ct. App. 1963); 113 U. Pa. L. Rev. 290, 294 (1964).

profession will be higher if each doctor is allowed to do his utmost for every patient.[50] However, this interest of society is not sufficient to outweigh society's interest in allowing an individual freedom of choice in such matters.

D. INTEREST IN PROTECTING THE INDIVIDUAL FROM HIMSELF

Where there is no other public interest present, the state may nevertheless argue that it has sufficient interest in each individual to protect him from himself, and authorize unwanted medical treatment on that basis. This interest is based upon the belief that each citizen makes a valuable contribution to society. This proposition has not yet been advanced, and indeed it should not be, for this interest is not sufficient to outweigh the individual's right to refuse treatment.

There is, however, authority that could be used as precedent for a court to protect a person from his own improvident decisions. For example, while it would seem to be a matter of personal concern, courts have uniformly upheld legislation authorizing fluoridation of water.[51] However, this line of cases is clearly distinguishable. In *Dowell v. City of Tulsa*,[52] the city's inclusion of fluoride was held not to be medical treatment.[53] Further, one commentator has suggested that the treatment is not forced upon the individual for his own well-being, but rather is intended for the benefit of the vast majority of the community who do not object.[54] Also, a person objecting to the fluoridation has a number of reasonable alternatives available such as using bottled water. In effect, the interference is just not sufficient to constitute a violation of a person's legal rights.

Cases which uphold statutes prohibiting the use of poisonous snakes in religious ceremonies[55] further illustrate the state's

50. See 64 MICH. L. REV. 554 (1966).

51. See, *e.g.*, De Aryan v. Butler, 119 Cal. App. 2d 674, 260 P.2d 98 (1953), *cert. denied*, 347 U.S. 1012 (1954); Dowell v. City of Tulsa, 273 P.2d 859 (Okla. 1954), *cert. denied*, 348 U.S. 912 (1954); Kraus v. City of Cleveland, 76 Ohio L. Abs. 214, 121 N.E.2d 311 (Ct. App. 1954). See generally 3 ST. LOUIS U.L.J. 284 (1954).

52. 273 P.2d 859 (Okla. 1954).

53. *Id.* at 864.

54. See 9 UTAH L. REV. 160, 165 (1964).

55. Lawson v. Commonwealth, 291 Ky. 437, 164 S.W.2d 972 (1942); State v. Massey, 229 N.C. 734, 51 S.E.2d 179, *appeal dismissed sub nom.*, Bunn v. North Carolina, 336 U.S. 942 (1949); Harden v. State, 188 Tenn. 17, 216 S.W.2d 708 (1948). *But cf.* State v. Woody, 61 Cal. 2d 716, 394 P.2d 813 (1964) (insufficient state interest to prohibit use of peyote in religious ceremony).

ability to protect an individual from himself, although these cases are also distinguishable. While the primary danger is to those handling the snakes, who presumably do not want protection, there is some risk to spectators and to the general public if the snakes were to escape. However, it can be argued that the intent of these statutes is to protect those other than the handler and absolute prohibition is not necessary because the handlers could be required to perform in an escape proof glass cage.[56] Clearly the answer is that these statutes are the most reasonable way to protect the public and were not intended to protect only those in actual contact with the snakes.

The increasingly infrequent legislation which makes suicide or attempted suicide a crime[57] might also be thought of as an example of the state seeking to protect an individual from himself. Because of the concern with preserving the life of an individual, it has been suggested that the suicide statutes provide an analogy for compelling medical treatment.[58] However, it is probable that the suicide statutes were passed not so much to protect the individual from himself as to prevent the disruptive effect which suicide has on society. Furthermore, there is a basis for distinction on the underlying facts. Because most people who attempt suicide are temporarily incompetent and irrational,[59] there appears to be no value in allowing such an individual a freedom of choice.

If the refusal of medical treatment necessary to sustain life is thought to violate the suicide statutes, it could provide the courts with a legal handle sufficient to justify its interference. Actually, refusal of treatment is not attempted suicide because death is not the primary objective; rather, it is a possible consequence. Suicide requires a specific, intentional action which is not satisfied by a passive refusal of treatment.[60] Intent does include situations where a result is not substantially certain.[61]

56. 9 UTAH L. REV. 160, 165 n.27 (1964).

57. There are only six states which now have suicide statutes. PERKINS, CRIMINAL LAW 67-68 (1957).

58. Cawley, *Criminal Liability in Faith Healing*, 39 MINN. L. REV. 48, 68 (1954); 3 FORDHAM L. REV. 513 (1965); 26 MONT. L. REV. 95 (1965); 44 TEXAS L. REV. 190 (1965); 9 UTAH L. REV. 160 (1964). However, this theory was rejected in Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962).

59. See DUBLIN, SUICIDE 144 (1963); PERKINS, *op. cit. supra* note 57.

60. Although the refusal of medical treatment may be enough action to infer an intention to die, this should be negated by the fact that the patient voluntarily came to the hospital seeking aid. See 33 FORDHAM L. REV. 513, 516 (1965); 26 MONT. L. REV. 95 (1965).

61. See generally 33 FORDHAM L. REV. 513 (1965).

However, there would be intent in this context only where it is certain the patient will die. Thus it is unlikely that suicide legislation provides a specific ground to compel treatment.[62]

IV. THE STANDARD

While it could be argued that the *Dilgard* case is authority for the proposition that a competent adult may never be forced to submit to medical treatment, the most reasonable approach to an individual's right to refuse medical treatment is to impose certain limitations on that right. Before considering the standard for ordering medical treatment, two other problems must be examined. First, some uniform standard of medical proof must be established. The issue of compulsory treatment should only be reached after the medical diagnosis is found to be sound.[63] In determining whether the judgment is sound, the opinion of the doctors seeking authorization should be carefully scrutinized in view of their involvment. Ideally, impartial expert testimony should be taken, but this may be impractical in most cases due to the emergency nature of the problem. However, this may be solved by requiring the judge to seek affidavits from competent doctors independent of the proceeding. If it is clear that the patient will die without the treatment, the problems of finding a state interest may be reached. However, where it is not certain the patient will die, or where the necessary treatment involves a high degree of risk, or is of questionable medical value, the decision should be left to the patient. Second, a person must be competent to be permitted to refuse treatment. In emergency situations where the patient who refuses treatment is incompetent, his decision should only be respected when he has expressed his refusal prior to the emergency. In all circumstances the patient is entitled to an honest, objective appraisal of his competency.

A competent adult who will die if certain treatment is not administered, should have a right to refuse medical treatment.

62. *Contra*, Perr, *Suicide Responsibilities of Hospital and Psychiatrist*, 9 CLEV.-MAR. L. REV. 427, 433 (1960); 33 FORDHAM L. REV. 513 (1965); *cf.* Crawley, *Criminal Liability in Faith Healing*, 39 MINN. L. REV. 48, 68 (1954). It has been suggested that the interests of the individual may be outweighed by the interests of society if the individual's talents or skills are of immense benefit to society. 64 MICH. L. REV. 554, 556 (1966). However, it is questionable whether any amount of benefit is more valuable than the individual's freedom of choice.

63. Courts must use this power sparingly. Otherwise, the danger of the courts being brought in to re-examine every medical decision may arise. 9 UTAH L. REV. 160, 167 (1964).

That rule should be qualified only where there is a substantially compelling public interest in conflict with his right. The ultimate test of a compelling public interest is where a third person who is incapable of protecting himself will be directly and adversely affected if the patient dies.