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MINORS, MEDICAL TREATMENT, AND INTERSPOUSAL DISAGREEMENT: SHOULD SOLOMON SPLIT THE CHILD?

INTRODUCTION

Recently, the Illinois Supreme Court confronted the unique issue of whether two minor twins could be compelled, absent the consent of their natural mother, to donate bone marrow for the benefit of their dying half-brother.¹ The noncustodial, biological father of these twins asked their mother, the custodial parent, to consent to an operation designed to save the life of his son, a child completely unrelated to the natural mother.² After the twins' mother refused, the father petitioned the court to allow the twins to participate in this procedure. The Illinois Supreme Court, affirming the trial court's decision, found this procedure was not in the twins' best interests and denied the father's petition.³ Although this case of first impression generated a new rule of law applicable under similar factual conditions, its disposition ultimately rested on established legal principles.⁴ This conclusion, however, does not diminish the legal significance of this case, which is found in the unresolved issue that it forces us to consider.

A central feature in the Illinois case of Curran v. Bosze was the disagreement between two natural parents over a proposed course of medical treatment for their children.⁵ The court's resolution of the dispute, however, was colored by the nature of the marital relationship. In the Curran case, the parents had contractually established the parameters of their respective parental interests and responsibilities, and, as such, the mother had the right to the exclusion of the father to consent to the children's medical care.⁶ The court, therefore, did not have the opportunity to address the more complex scenario.

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¹. Curran v. Bosze, 566 N.E.2d 1319 (Ill. 1990); see infra notes 11-24 and accompanying text (discussing the case in full).
². Curran, 566 N.E.2d at 1321.
³. Id. at 1345.
⁴. The decision was premised on the application of an Illinois statute that authorizes limitation of the custodial parent's authority where its exercise is clearly not in the child's best interest. Ill. Rev. Stat. ch. 40, para. 608(a) (1989). The trial court, however, focused more significantly on constitutional issues and explicitly held that this request would violate the twins' right to bodily integrity and self-determination. Curran v. Bosze, No. 87 M1 4599, slip op. at 4-5 (Ill. Cir. Ct. July 18, 1990), aff'd, 566 N.E.2d 1319 (Ill. 1990). Thus, while the Illinois Supreme Court affirmed the trial court's holding, the basis for its conclusion differed from that of the trial court.
⁵. The twins were asked to undergo a medical procedure. However, the purpose of the procedure was to provide therapeutic benefit for a third child and not the twins themselves. Curran, 566 N.E.2d at 1321.
⁶. See infra note 13 and accompanying text (referring to the text of the agreement).
suggested by the facts of this case. Specifically, Curran v. Bosze\(^7\) begs the question of how to resolve parental disputes over the medical treatment decisions for minors where both parents are equally situated with respect to the right of consent. While, at first glance, this situation may appear to be the product of an overactive legal imagination, two courts in the past several years have been faced with this dilemma.\(^8\) The purpose of this Comment is to address the sensitive issues that arise in these situations and provide guidance for their efficient resolution.

The Background section begins with a discussion of the three known cases involving disputes between parents over the medical treatment decisions for their children.\(^9\) This section also explores the relevant principles of constitu-

7. Curran, 566 N.E.2d at 1321.
9. It is appropriate to emphasize that this Comment focuses solely on intrafamilial disputes. There are other forms of disputes that concern medical treatment decision-making for minors, but these disputes are typically between parent and state or parent and child. See generally In re Eric B., 235 Cal. Rptr. 22 (Cal. Ct. App. 1987) (holding that the juvenile court could order a dependent minor to undergo periodic medical monitoring to detect the possible recurrence of cancer although parents objected on religious grounds); In re Phillip B., 156 Cal. Rptr. 48 (Cal. Ct. App. 1979) (holding that the trial court could deny petitioner’s request that the child be declared a dependent of the court for the purpose of ordering heart surgery when the parents objected and the surgery was risky), cert. denied, 445 U.S. 949 (1980); Newmark v. Williams, 588 A.2d 1108 (Del. 1991) (holding that the child was not neglected when parents refused on religious grounds to consent to chemotherapy that was painful, risky, and posed only a 40% chance of success); In re L.H.R., 321 S.E.2d 716 (Ga. 1984) (identifying circumstances under which parents or legal guardians of a terminally ill infant may exercise the infant’s right to terminate treatment without prior judicial approval); Custody of a Minor, 379 N.E.2d 1053 (Mass. 1978) (holding that the court could take custody away from parents who refused to consent to chemotherapy treatment for their child where treatment posed minimal risk to the child and offered hope for a cure for otherwise fatal leukemia); In re Green, 292 A.2d 387 (Pa. 1972) (holding that when a child’s life is not endangered, the state cannot outweigh a parent’s refusal to consent to treatment); Robert Bennett, Allocation of Child Medical Care Decision-Making Authority: A Suggested Interest Analysis, 62 VA. L. REV. 285 (1976) (reviewing the roles of minors, parents, doctors, and the state in medical decision-making for children); Linda S. Ewald, Medical Decision Making for Children: An Analysis of Competing Interests, 25 ST. LOUIS U. L.J. 689 (1982) (examining the sources of the various rights and interests involved in medical decision-making for children); Joseph Goldstein, Medical Care for the Child at Risk: On State Supervision of Parental Autonomy, 86 YALE L.J. 645 (1977) (exploring the role and limits of the law in protecting children from parental exploitation in the provision or denial of medical care); Eve T. Horwitz, Note, Of Love and Laetrile: Medical Decision Making in a Child’s Best Interests, 5 AM. J.L. & MED. 271 (1979) (recommending that the state be required to prove by clear and convincing evidence that the parents’ choice of medical treatment would harm the child before the best interests test is applied); Katherine A. Miller, Comment, Court-Ordered Medical Treatment for Minors: An Alternative Approach To Protect the Child’s Best Interests, 7 WHITTIER L. REV. 827 (1985) (focusing on the difficulties of court-ordered medical treatment and suggesting flexible judgments derived from expert testimony and substituted judgment); G. Emmett Raitt, Jr., Note, The Minor’s Right To Consent to Medical Treatment: A Corollary of the Constitutional Right to Privacy, 48 S. CAL. L. REV. 1417 (1975) (arguing that a child’s constitutional right of access to medical treatment must be given value when weighed against parental interests in caring for and control-
TIONAL AND FAMILY LAW AND THEN IDENTIFIES THE COMPETING INTERESTS INHERENT IN INTERPARENtal DISPUTES OVER MEDICAL TREATMENT DECISIONS. NEXT, THIS COMMENT DISCUSSES THE TWO DIFFERENT STANDARDS USED IN SURROGATE DECISION-MAKING FOR LEGALLY INCOMPETENT INDIVIDUALS, INCLUDING MINORS. THIS COMMENT ANALYZES THE "SUBSTITUTED JUDGMENT" DOCTRINE AND THE "BEST INTERESTS" APPROACH TO DETERMINE WHICH STANDARD IS APPROPRIATE FOR CASES INVOLVING MINORS. IN ADDITION, A DISCUSSION OF THE APPOINTMENT AND RESPONSIBILITY OF A SURROGATE DECISION-MAKER AND GUARDIAN AD LITEM IS INCLUDED SINCE THESE PERSONS ARE OFTEN EMPowered TO MAKE TREATMENT DECISIONS FOR INCOMPETENT INDIVIDUALS.

THE ANALYSIS COMPONENT OF THIS COMMENT IS DIVIDED INTO TWO DISTINCT SEGMENTS. THE FIRST SECTION FocusES ON THE THREE MAJOR CASES IN AN EFFORT TO SUGGEST THE DESIRED LEGAL CONCLUSIONS IN THIS DIFFICULT ARENA. THIS SECTION DEMONSTRATES THAT WHEN PARENTS DISAGREE OVER THE MEDICAL TREATMENT DECISIONS FOR THEIR CHILDREN, THEIR STRONG INTERESTS IN PARENTAL AUTONOMY CANCEL EACH OTHER OUT OF THE EQUATION. AS A RESULT, THE SOLE INQUIRY CONCERNS THE BEST INTERESTS OF THE PARTICULAR CHILD, AND ANY RESOLUTION OF THE DISPUTE MUST ENGENDER THIS PRINCIPLE. WHILE THE ULTIMATE DECISION MAY BE DIFFICULT, IT NEVERTHELESS MUST BE MADE.

THE SECOND PRONG OF THE ANALYSIS CONCENTRATES ON THE PROCESS THROUGH WHICH THESE DECISIONS ARE MADE. IMPLICIT IN THIS PROCEDURAL ANALYSIS ARE EFFORTS TO INSURE THAT THE RESPECTIVE RIGHTS OF ALL PARTIES INVOLVED ARE PRESERVED TO THE GREATEST EXTENT POSSIBLE. IT MUST BE REITERATED, HOWEVER, THAT THE MINOR'S INTERESTS REMAIN THE PARAMOUNT CONCERN. IT IS, AFTER ALL, HIS OR HER PHYSICAL AND EMOTIONAL HEALTH THAT HANGS IN THE BALANCE. IN THESE SITUATIONS, THIS COMMENT REVEALS, AN INDEPENDENT GUARDIAN AD LITEM SHOULD BE APPOINTED TO REPRESENT THE CHILD IN ANY PROCEEDING, FORMAL OR INFORMAL. ALSO, INSTITUTIONAL ETHICS COMMITTEES SHOULD BE INVOLVED, NOT ONLY TO ASSIST IN EFFECTING THE BEST INTERESTS CALCULUS AND TO REPRESENT THE INTERESTS OF THE MEDICAL PROFESSION, BUT ALSO TO SERVE AS A FORUM FOR INFORMAL ARBITRATION. THIS SUGGESTION PROMOTES THE MORE PERVASIVE NEED TO RESOLVE THESE DISPUTES WITHOUT RESORT TO THE ADVERSARIAL PROCESS.

I. BACKGROUND

A. Curran v. Bosze

Bosze was the biological father of the twins, but he and Nancy had neither been married nor cohabitated. After Nancy sought and received a legal determination of paternity, the two parties entered into a parentage order, which defined the respective parent-child relationships. Under the terms of this order, Nancy received the "sole care, custody, control and educational responsibility of the minor children." Tamas also had three other children. However, these children were not biologically related to Nancy. One of these children was Jean Pierre, a twelve-year-old boy who was at the center of this dispute. In 1988, Jean Pierre was diagnosed with a rare form of leukemia known as acute undifferentiated leukemia. After unsuccessful attempts to locate a compatible bone marrow donor within his family, Tamas asked Nancy's permission to allow the twins to undergo a blood test to see whether they were compatible donors. If the test results were positive, Tamas further asked that the twins be allowed to donate bone marrow to save Jean Pierre's life. Nancy consulted with various individuals, including family members, parents of bone marrow donors, donors themselves, and a pediatrician. After concluding there was an intolerable risk inherent in the procedure, Nancy refused to give consent for either the blood test or the bone marrow harvesting procedure. In response, Tamas petitioned the Circuit Court of Cook County, Illinois, to override Nancy's refusal and compel the twins to submit to the procedures against Nancy's wishes. The trial court refused to grant Tamas' request, finding that such an order would violate the twins' constitutional right to privacy. Tamas then filed an emergency motion for direct appeal to the Illinois Supreme Court. The court, however, remanded the case so that a guardian ad litem could be appointed to represent the twins. After hearing extensive testimony from both parents, numerous physicians, and former donors, the trial court reaffirmed its original decision and Tamas appealed.

Tamas Bosze argued that the trial court erred by not employing the substituted judgment doctrine in determining whether the twins should submit to

13. The parentage order also provided:
   In all matters of importance relating to the health, welfare and education of the children, Mother shall consult and confer with Father, with a view toward adopting and following a harmonious policy. Mother shall advise Father of which school the children will attend and both parents shall be given full access to the school records of the children.
   Id. at 1321.
14. This disease is also known as mixed lineage leukemia and is very difficult to treat. Id.
15. Bone marrow donation, like other forms of organ donation, requires significant biological similarities between donor and recipient. These similarities are the factors that establish compatibility. If the requisite compatibility is missing, the donor will likely reject the donated organ. Id. at 1333. Compatibility can be determined through blood testing procedures. Id. at 1321.
the procedure. Ms. Curran and the guardian ad litem, however, argued that this doctrine was unavailable in a case involving minors who had never been competent to consent to the treatment. As such, Ms. Curran maintained that the best interests standard should govern the resolution of the dispute. The court, recognizing that the substituted judgment doctrine governs surrogate decision-making for incompetent individuals, nevertheless held that this doctrine was unavailable in the case at bar. Because it was not possible to establish the intent of the children through clear and convincing evidence, the court found the correct approach focused on the best interests of the children.

In resolving this dispute, the court initially referred to the parentage order granting Nancy Curran sole custody and control over her children. While noting that Mr. Bosze had standing to challenge Nancy's exercise of parental authority, the court determined pursuant to state statute that the limitation of this authority was appropriate only where its unfettered exercise would clearly be contrary to the best interests of the child. Noting that this case was one of first impression, the court proceeded to identify three factors necessary for determining whether donating bone marrow to a sibling would be in a child's best interests:

First, the parent who consents on behalf of the child must be informed of the risks and benefits inherent in the bone marrow harvesting procedure to the child. Second, there must be emotional support available to the child from the person or persons who take care of the child . . . . Third, there must be an existing, close relationship between the donor and recipient [that

18. Mr. Bosze argued that two recent Illinois Supreme Court decisions mandated the use of the substituted judgment doctrine. See In re Estate of Greenspan, 558 N.E.2d 1194 (III. 1990); In re Estate of Longeway, 549 N.E.2d 292 (III. 1989). Both cases involved adult patients who were incompetent to consent for medical treatment. At issue was whether the right to refuse nutrition and hydration could be exercised. In Greenspan, the later Illinois Supreme Court decision on this issue, the court held that surrogate decision-makers, through the doctrine of substituted judgment, could exercise this right on behalf of the incompetent individual where it was possible to determine the incompetent's intent by clear and convincing evidence. Greenspan, 558 N.E.2d at 1202. As such, Mr. Bosze and the guardian ad litem for Jean Pierre argued that the court should inquire into the decision the twins would have made had they been competent to do so. Curran, 566 N.E.2d at 1322.

19. Curran and the guardian ad litem for the twins maintained that it was impossible to discern the future intent of three-and-one-half-year-old twins and, as such, the best interests approach was required. Curran, 566 N.E.2d at 1322.

20. Id. at 1326.

21. Id. at 1320. The Illinois Parentage Act enables parents to establish such contractual relations. ILL. REV. STAT. ch. 40, para. 2506 (1989).

22. ILL. REV. STAT. ch. 40, para. 608(a) (1989). Paragraph 608(a) provides:

Except as otherwise agreed by the parties in writing at the time of the custody judgment or as otherwise ordered by the court, the custodian may determine the child's upbringing including but not limited to, his education, health care and religious training, unless the court, after a hearing, finds, upon motion by the noncustodial parent, that the absence of a specific limitation of the custodian's authority would clearly be contrary to the best interests of the child.
creates a corresponding psychological benefit.\textsuperscript{58}

After finding the second and third prongs of the analysis were not met, the court held that it was not in the twins’ best interests to undergo this procedure.\textsuperscript{54} Consequently, the court denied Mr. Bosze’s petition.

\section*{B. Soloveichik v. Soloveichik}

In January of 1989, the Circuit Court of Cook County, Illinois, was faced with another unique and difficult case.\textsuperscript{55} Miriam and Moshe Soloveichik were the parents of a twelve-year-old boy, Yisroel, who was dying as a result of a brain tumor. The disease had left him in a severely debilitated state, described as nonresponsive. In simple terms, Yisroel was unable to move his limbs or shoulders, had limited control over his facial muscles, and could not communicate.\textsuperscript{56} Moreover, Yisroel was drifting in and out of a vegetative state. His prognosis for survival was equally dim. His physician believed that Yisroel was likely to die soon. Although Yisroel had received extensive medical care for approximately two years, these efforts had proven ineffective in stemming the physical and mental deterioration caused by his disease.\textsuperscript{27}

Unfortunately, another situation compounded the already tragic nature of these circumstances. Yisroel’s parents, who were married and living together, could not agree on the appropriate course of therapy. Moshe, Yisroel’s father, wanted his son to have an operation to internalize the external shunt that served to drain the fluid accumulating in his brain as a result of the tumor.\textsuperscript{58} Miriam, Yisroel’s mother, felt any further surgical procedures would only prolong the dying process and subject Yisroel to more needless pain and suffering, both mental and physical.\textsuperscript{59} Moreover, the hospital’s medical staff believed the proposed surgery was medically inappropriate and could produce more harm than good.\textsuperscript{30} After Moshe arranged for Yisroel’s transfer to a hospital that would perform the operation, Miriam initiated an action in which both parents eventually sought a declaration of limited parental rights. Specifically, each parent wanted the unilateral authority to grant or refuse consent for Yisroel’s medical treatment to the exclusion of the other.\textsuperscript{31} In addition, both the father

\begin{itemize}
\item \textsuperscript{23} Curran, 566 N.E.2d at 1343.
\item \textsuperscript{24} Specifically, the court found that Ms. Curran, by virtue of her refusal to consent to the procedure, would not be able to provide the requisite emotional support. \textit{Id.} at 1344. In addition, the court noted the relationship between the siblings was too distant to supply the psychological benefit necessary to authorize this procedure. \textit{Id.}
\item \textsuperscript{25} Soloveichik v. Soloveichik, No. 89 CH 215 (Ill. Cir. Ct. Jan. 19, 1989).
\item \textsuperscript{26} Affidavit of Dr. Kenneth Boyer at 2, Soloveichik v. Soloveichik, No. 89 CH 215 (Ill. Cir. Ct. Jan. 19, 1989).
\item \textsuperscript{27} \textit{Id.}
\item \textsuperscript{28} Verified Complaint for Declaratory Judgment, Injunctive and Other Relief at 3, \textit{Soloveichik} (No. 89 CH 215).
\item \textsuperscript{29} \textit{Id.} at 6.
\item \textsuperscript{30} \textit{Id.} at 3, 5.
\item \textsuperscript{31} Soloveichik v. Soloveichik, No. 89 CH 215, slip op. at 7 (Ill. Cir. Ct. Jan. 19, 1989).
\end{itemize}
as well as the hospital, which was named as a party-defendant to the action, requested an independent guardian be appointed to make any future treatment decisions for Yisroel.\(^3\)

\textit{Soloveichik} is distinguishable from \textit{Curran}, although both involved parental disagreements over medical treatment decisions. In \textit{Curran} there was a parentage order defining the respective interests of the parents. By contrast, the \textit{Soloveichik} case involved two parents, both legally vested with the authority to consent to their child's therapy, who were seemingly enmeshed in an unresolvable conflict over this decision. As such, the court was faced with the task of extinguishing one parent's right to consent, albeit to a limited extent, in favor of the other parent. Complicating this task was the fact that both parents were found to be caring, loving, and responsible persons dedicated to the welfare of their child.\(^3\) The court resolved this dispute by awarding Miriam with a limited guardianship for the purpose of making medical treatment decisions.\(^4\)

In arriving at this conclusion, the court first noted that under Illinois law, minors under the age of fourteen were not permitted to make life-sustaining-treatment decisions.\(^5\) The court held that these situations required clear and convincing evidence of the minor's intent, even if the minor were found to be legally competent.\(^6\) In \textit{Soloveichik}, the court found this standard was not satisfied. Because Yisroel's wishes were not a factor in the decision, the court proceeded to employ the best interests analysis to decide whether further surgery was mandated. Adopting a version of a test used by the Supreme Court of New York County in \textit{In re Beth Israel Medical Center},\(^7\) the court articulated twelve factors to consider in the best interests calculus:\(^8\)

With respect to whether the burdens to a particular patient from prolongation of life 'markedly outweigh' the benefits, the following factors should be considered:

1) the age of the patient; 2) the life expectancy with or without the procedure contemplated; 3) the degree of present and future pain or suffering with or without the procedure; 4) the extent of the patient's physical and mental disability and degree of helplessness; 5) statements, if any, made by the patient which directly or impliedly manifest his views on life prolonging measures; 6) the quality of the patient's life with or without the procedure, i.e., the extent, if any, of pleasure, emotional enjoyment, or intellectual satisfaction that the patient will obtain from prolonged life; 7) the risks to life from the procedure contemplated as well as its adverse side effects and de-

\(^{32.}\) \textit{Id.}

\(^{33.}\) The court found it unnecessary to appoint a guardian ad litem because both parents had displayed "extraordinary conduct" toward their child. \textit{Id.} Thus, the court did not feel the appointment of a guardian would serve Yisroel's best interests. \textit{Id.} at 20.

\(^{34.}\) \textit{Id.} at 20.

\(^{35.}\) \textit{Cf.} ILL. REV. STAT. ch. 111, para. 4501, § 1 (1989) (delineating exceptions to the rule).

\(^{36.}\) \textit{Soloveichik}, slip op. at 9.

\(^{37.}\) 519 N.Y.S.2d 511 (Sup. Ct. 1987).

\(^{38.}\) \textit{Soloveichik}, slip op. at 14.
gree of invasiveness; 8) religious or ethical beliefs of the patient; 9) views of those close to him; 10) views of the physician; 11) the type of care which will be required if life is prolonged as contrasted with what will actually be available to him; 12) whether there are any overriding state parens patriae interests in sustaining life (e.g. preventing suicide, integrity of the medical profession or protection of innocent third parties, such as children).39

Considering most of these factors, the Soloveichik court determined that the benefits of the proposed surgery were markedly outweighed by its burdens, even though this decision could hasten the dying process.40 Because Miriam's wishes were in accord with the judicial assessment of Yisroel's best interests, she was awarded the limited guardianship to the exclusion of Moshe.41

C. In re Jane Doe

Jane Doe was a thirteen-year-old child who had always suffered from limited mental growth and ability.42 In May of 1991, Jane was admitted to the hospital after experiencing persistent swallowing difficulties and periodic choking episodes. Two weeks later, her condition deteriorated and she was placed on mechanical ventilation. In early July, 1991, Jane Doe lapsed into a state of unconsciousness. While the hospital's physicians were not sure of her exact condition, they concluded:

[Jane suffered from a] neurological degenerative disorder . . . with substantial atrophy of the brain and no reasonable possibility of a 'meaningful recovery' due to the fact that substantial portions of her brain are irreversibly damaged, including the areas which control her cognitive functions, her ability to eat, swallow and breathe. . . . Jane Doe has no self-awareness, self-control, capacity to relate to others or capacity to communicate or control her existence.43

Jane's physician further stated that he was not sure whether she felt pain from the life-support that she received, but opined that her death was imminent without technological efforts.44

Because Jane had no hope for a "meaningful recovery," her treating physician as well as the hospital bioethics committee felt Jane's continued treat-

39. Beth Israel Medical Ctr., 519 N.Y.S.2d at 517 (textual structure of quotation altered). It should be noted that the court in Soloveichik expressly refused to adopt the sixth factor. Soloveichik, slip op. at 14. The court felt it was inappropriate to consider this variable because it would require a "quality of life" determination. Id.

40. Soloveichik, slip op. at 14.

41. Id. at 20.


43. Id., slip op. at 4. When asked the meaning of "no hope for 'meaningful recovery,'" Jane Doe's physician responded, "The child may recover to the extent that she may again be able to respond to deep pain, but there is no hope for recovery past that point." Id. at 3 n.1.

44. Id. at 4.
ment, including life-support, was both inhumane and medically abusive. Accordingly, the committee recommended both the issuance of a "Do Not Resuscitate" ("DNR") order and the discontinuation of all extraordinary life-sustaining medical procedures. These recommendations were presented to Jane's parents, but they did not agree on the course of her treatment. Jane's mother felt the DNR order was appropriate. She was, however, ambivalent on the issue of whether life-support should be discontinued. Jane's father, on the other hand, vigorously opposed both recommendations. In fact, he indicated that every possible medical intervention should be used to keep Jane alive.

In response to this dispute, the hospital petitioned the Superior Court of Fulton County, Georgia, for a declaratory judgment allowing the mother alone to consent to the DNR order. In addition, the hospital requested an order permitting a termination of all artificial and extraordinary means of life-support at the direction of its physicians.

In denying both of the hospital's requests, the court identified and balanced several constitutional precepts that operated in this unique set of circumstances. First, because parents are presumed to act in the best interests of their children, the court found that parents are endowed with broad decision-making authority. Moreover, the court stated:

[P]arental rights [are] fundamental and entitled to the utmost protection of the law, they are fully vested in each individual parent, not shared as a parental unit. The mother and father are each entitled to the full spectrum of parental rights. The mother's rights with regard to the child are no greater than the father's . . . and vice versa.

As a direct result of each parent's fundamental right to act on behalf of his or her children, the court also ruled that the state could not interfere with the exercise of these rights absent extreme circumstances, such as abuse or neglect. Finally the court noted that under both state and federal constitutions there is a presumption in favor of life competing with the above-mentioned interests and that this presumption is reflected in the laws protecting the health and welfare of all individuals, especially society's most vulnerable members. In reaching its decision in this context, the court held that this constitutional guarantee must be recognized.

Balancing these factors, the court determined that Jane Doe must be kept alive and that a DNR order was inappropriate. Because the parents could not agree, the court found that granting Jane's mother exclusive authority to make health care decisions would both violate her father's fundamental rights

45. Id. at 6.
46. Id. at 7.
47. Id.
48. Id. at 12; see infra notes 65-82 and accompanying text (discussing parental rights issues).
49. In re Jane Doe, slip op. at 16.
50. Id. at 14.
51. Id. at 18.
52. Id. at 18-19.
as a parent and contravene the integrity of the family unit.\textsuperscript{63} In addition, the court concluded that Jane Doe's continued treatment did not constitute abuse and, as such, the state could not constitutionally interfere with the medical decision-making process.\textsuperscript{64} In the face of disagreement and medical uncertainty, the court determined the balance must be tipped in favor of Jane's right to life. Thus, until the parents reached accord, the court found it impermissible either to trample on their individual fundamental rights as parents or to interfere with Jane's continued existence.

The problems caused by parents who disagree are unique and, as such, are deserving of special attention. Before it is possible to determine the best way to resolve these disputes, however, it is essential to identify the nature and scope of the competing interests at stake in these controversies. These relevant interests are the subject of the next section.

\textbf{D. Competing Interests—Children, Parents, and the State}

In considering disputes over the medical treatment decisions for minors, there are several sets of competing interests that come into play.\textsuperscript{65} Specifically, three parties have important stakes in the outcome of the dispute.\textsuperscript{66} These parties are the minor child, his or her parents, and the state. All of these interests must be considered in attempting to resolve the disputes.\textsuperscript{67} The court's role is to effect the balancing process so that the least intrusive solution can be achieved. An examination of each of these competing interests follows.

\textbf{1. Minors}

Minors do not possess the full panoply of constitutional and common law rights that adults enjoy.\textsuperscript{68} For example, minors are not allowed to vote, drink

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\textsuperscript{53} Id. at 21.

\textsuperscript{54} Id. at 15.

\textsuperscript{55} While this Comment focuses on disputes between natural parents, other forms of disputes are possible, specifically parent-state and parent-child. For a discussion of these issues, see generally Ewald, supra note 9; Goldstein, supra note 9; Horwitz, supra note 9; Andrew Kleinfeld, The Balance of Power Among Infants, Their Parents and the State, 4 Fam. L.Q. 319 (1970); Stuart J. Baskin, Comment, State Intrusion into Family Affairs: Justification and Limitations, 26 Stan. L. Rev. 1353 (1974); Miller, supra note 9; Raitt, supra note 9; Elizabeth J. Sher, Comment, Choosing for Children: Adjudicating Medical Care Disputes Between Parents and the State, 58 N.Y.U. L. Rev. 157 (1983).

\textsuperscript{56} There is an additional party with a vested interest in the outcome of the dispute. Because the disagreement involves medical treatment, the medical profession is necessarily drawn into the controversy. While the state is normally entrusted with safeguarding the integrity of the profession, the self-regulating characteristics of the profession empower health care providers to oversee the protection of their interests. In these situations, health care providers can supply valuable information as well as define the ethical limits placed on their conduct.

\textsuperscript{57} See Prince v. Massachusetts, 321 U.S. 158, 165 (1944) (commenting on the conflict between the parental interest in household authority and child rearing and the state's interest in the welfare of children).

\textsuperscript{58} Developments in the Law—The Constitution and the Family, 93 Harv. L. Rev. 1156, 1358 (1980) [hereinafter Developments in the Law]. The commentator notes:
alcohol, drive a car below a certain age, or enter into binding contracts. The reasoning underlying these restrictions lies in the presumption that minors, by virtue of their age and inexperience, are not as capable as adults either to understand the risks and consequences of their actions or to exercise sound judgment in making important decisions.\(^5\) This same reasoning also applies to the context of medical decision-making and, as such, minors normally cannot give valid consent for these procedures.\(^6\) As will be shown, other parties, usually the parents, are entrusted to make the important decisions necessary to the health and welfare of the child.

Despite these limitations on the minor’s exercise of personal autonomy, minors do possess certain rights that are afforded judicial protection.\(^6\) As the Supreme Court noted in *Planned Parenthood v. Danforth*,\(^6\) “Constitutional rights do not mature and come into being magically when one obtains some state defined age of majority.”\(^6\) One of these rights is the right to privacy, which encompasses the right to bodily integrity and self-determination.\(^6\) Al-

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It is important to distinguish the two reasons why a child may not be entitled to the full constitutional protection that an adult would receive under similar circumstances. First, a child may possess a constitutional right of lesser magnitude than an adult possesses. This might be the case if the values animating a given constitutional provision were not as applicable to children as adults. Second, the state may be able to assert interests to support its treatment of children that it could not assert with respect to adults. This would be the case if the state’s treatment of children fell within its police power or *parens patriae* power while the treatment of identically situated adults did not come within either category.


\(^{60}\) 60. There are, however, a number of exceptions to this general rule. One exception involves emergency situations in which the parent is unavailable to consent. *William L. Prosser & W. Page Keeton, Law of Torts* § 18, at 117-18 (5th ed. 1984). There are other exceptions to this rule as well. Certain jurisdictions allow minors to consent for specific kinds of treatment, such as abortion, venereal disease, and alcoholism. *See* H.L. v. Matheson, 450 U.S. 398 (1981) (abortion); Bellotti v. Baird, 443 U.S. 622 (1979) (abortion); *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976) (abortion); *see also* Ewald, *supra* note 9, at 701 (discussing statutes that allow children to consent to treatment for venereal disease, drug addiction, and pregnancy). In addition, emancipated and mature minors have the ability to consent to all forms of medical treatment. *Id.* at 701-04. For the purpose of this Comment, both the emancipated and the mature minor are important to the application of the substituted judgment doctrine. *See infra* notes 175-78 and accompanying text (discussing the emancipated and mature minor doctrines).


\(^{62}\) 62. 428 U.S. 52, 70 (1976) (discussing the right of a mature minor to consent to an abortion).

\(^{63}\) Id. at 74.

\(^{64}\) 64. *See* *Roe v. Wade*, 410 U.S. 113 (1973). The *Roe* decision followed a line of cases establishing the contours of the right to privacy. Implicit in *Roe* is recognition of the right to bodily integrity and personal autonomy. The right of privacy in the abortion context was extended to minors in *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976) (holding that parents do not pos-
though the exercise of this right is often delegated to a third party, the requirement of third party consent indicates that a protected interest both exists and is protected by the third party. As such, barring emergency circumstances, minors cannot be compelled to undergo medical treatment in the absence of valid consent. Problems can arise, however, as to the appropriate source of this requisite consent, and it is in these situations that a tension can exist between the other two parties: the parents and the state.

2. Parents

The traditional source of consent in matters concerning the medical treatment of minors has been the child's parents.65 Parents have long been entrusted with the responsibility of making all decisions necessary for raising their children.66 In fact, the right of parents to make these decisions free from unwarranted state intrusion enjoys constitutional protection.67 As the Supreme Court stated in Parham v. J.R., "Our constitutional system long ago rejected any notion that a child is 'the mere creature of the state' and, on the contrary, asserted that parents generally 'have the right, coupled with the high duty, to recognize and prepare [their children] for additional obligations.'"68 Consequently, parents possess a fundamental liberty interest in the care, custody, and management of their children that is protected by the Fourteenth Amendment to the United States Constitution.69 This interest is known as the right to privacy in matters of the family and is afforded the same degree of protection

65. See Parham v. J.R., 442 U.S. 584, 602 (1979) ("Our jurisprudence historically has reflected Western civilization concepts of the family as a unit with broad parental authority over minor children."); Bellotti, 443 U.S. at 638 ("[W]e cannot ignore that... deeply rooted in our Nation's history and tradition is the belief that the parental role implies a substantial measure of authority over one's children. Indeed, 'constitutional interpretation has consistently recognized that the parents' claim to authority in their own household to direct the rearing of their children is basic in the structure of our society.'" (quoting Ginsberg v. New York, 390 U.S. 629, 639 (1968))); Wisconsin v. Yoder, 406 U.S. 205 (1972) ("The history and culture of Western Civilization reflects a strong tradition of parental concern for the nurture and upbringing of their children.").


68. Parham, 442 U.S. at 602 (quoting Pierce, 268 U.S. at 535).

69. In re Phillip B., 92 Cal. App. 3d 796, 801 (1979) (citing United States v. Orito, 413 U.S. 139, 142 (1973)); see also Prince v. Massachusetts, 321 U.S. 158, 166 (1944) ("It is cardinal with us that the custody, care, and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.").
as all other recognized fundamental rights.70

Two basic presumptions are implicit in the rule guaranteeing the right to family privacy in child rearing. First, parents are in the best position to assess the needs of their children.71 This is primarily due to the unique and intimate nature of the parent-child relationship. Parents are involved in the day-to-day events that shape the child's existence as well as ready the child for independent life. Also, "Parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions."72 Finally, parents are constantly imparting a personal system of values upon the child and are better able to insure that the child's needs will be met with respect to this set of ethics.73

The second presumption inherent in the right to family privacy is that parents act in their child's best interests.74 Vast experience has shown that parents tend to act in manners consistent with the child's welfare.75 The "natural bonds of affection lead parents to act in the best interests of their children."76

70. When examining cases involving state interference with fundamental rights, including the right to privacy in family matters, courts apply a strict scrutiny analysis that requires both a compelling state interest as well as a narrowly tailored means-ends fit in order for the regulation to pass constitutional muster. Roe v. Wade, 410 U.S. 113, 155 (1973) ("Where certain 'fundamental rights' are involved, the Court has held that regulation limiting these rights may be justified only by a 'compelling state interest' . . . and that legislative enactments must be narrowly drawn to express only the legitimate state interests at stake."); see also Zablocki v. Redhail, 434 U.S. 374 (1978) (same); Griswold v. Connecticut, 381 U.S. 479 (1965) (same).

71. See Developments in the Law, supra note 58, at 1353-54 ("The parental right of control also serves the child's interests because parents typically possess a sensitivity to the child's personality and needs that the state cannot match, and because the closeness of the familial relationship provides strong assurances that parents will use their special knowledge of the child to act in his best interests." (emphasis added)); see also Goldstein, supra note 9, at 650 ("[The legal system] does not have the capacity to deal on an individual basis with the consequences of its decisions or to act with the deliberate speed required by a child's sense of time and essential to his well being."); Horwitz, supra note 9, at 280 ("Parents have both a common law right and a duty to act as proxies for their children . . . . Parents are given these proxy rights because society views them as more capable of making reasoned choices for children than the children themselves.").


73. There are many different values and approaches that individuals bring to the task of parenting. Accordingly, inherent in the right to family privacy is the concept that there is no one "right" way to raise children. As such, parents are and must be given latitude as they raise their children. Note, Mental Hospitalization of Children and the Limits on Parental Authority, 88 Yale L.J. 186, 198-202 (1978); see also Goldstein, supra note 9, at 648-51 ("The law presumes the capacity and recognizes the authority of adults to parent their children in accord with their own individual beliefs, preferences, and lifestyles . . . [and not with] some particular religious or scientific ideal."); Sher, supra note 55, at 170-76 (discussing the basis of parents' fundamental interest in raising their children); Developments in the Law, supra note 58, at 1214 ("No societal consensus exists as to the best way to raise children; even if such a consensus existed, however, the state's parens patriae interest in protecting the well-being of children would still compel a presumption that parents are better qualified than the state to promote the child's best interests.").

74. Parham, 442 U.S. at 602. The Parham Court explicitly referred to this concept as a legal presumption. Id.

75. Id.

76. Id. (citing 1 William Blackstone, Commentaries *447; 2 James Kent, Commentaries
As a result of confidence in the nurturing character that parents bring to the task of raising their children, parents are afforded broad discretion in the decisions they make for their offspring. This latitude not only guarantees the right to family privacy but also helps to maintain stability in the home environment.

While the parents enjoy substantial freedom in this regard, there are limits to parental authority. Unfortunately, not all parents consistently act in the best interests of their children. There are times when some parents, by virtue of their beliefs or inadequacies, act in ways that can and do compromise the health and welfare of their children. One example can be found in the context of Jehovah's Witnesses. Due to their religious beliefs, people who practice

ON AMERICAN LAW *198).

77. This broad discretion is not absolute. For example, parents do not have the discretion to abuse and neglect their children. This discretion, however, recognizes that parents make mistakes as well as subject their children to risks. The question then becomes where the discretionary privilege should end and the supervision of parental authority should begin. The author does not profess to know the answer to this question, but, out of respect for the fundamental right of family privacy, he believes it necessary to err on the side of parental discretion. See generally Judith Areen, Intervention Between Parent and Child: A Reappraisal of the State's Role in Child Neglect and Abuse Cases, 63 GEO. L.J. 887 (1975) (discussing the competing interests of the child, the parents, and the state in the context of neglect cases); Douglas J. Besharov, "Doing Something" About Child Abuse: The Need To Narrow the Grounds for State Intervention, 8 HARV. J.L. & PUB. POL'Y 539 (1985) (discussing state intervention in child abuse cases); Goldstein, supra note 9, at 619 (exploring the modes of protecting children and parents from excessive state intervention in abuse cases).

78. Parham, 442 U.S. at 603 ("Nonetheless, we have recognized that a state is not without constitutional control over parental discretion in dealing with children when their physical or mental health is jeopardized.").

79. See Washington v. King County Hosp., 278 F. Supp. 488 (W.D. Wash. 1967) (finding the child neglected due to parents' refusal to allow life-saving medical treatment), aff'd per curiam, 390 U.S. 598 (1968); People ex rel. Wallace v. Labrenz, 104 N.E.2d 769 (Ill. 1952) (terminating parental consent rights after parents refused to allow child to undergo necessary blood transfusions), cert. denied, 344 U.S. 824 (1952); Morrison v. State, 252 S.W.2d 97 (Mo. Ct. App. 1952) (holding that a child was neglected when the parents refused to consent to a life-saving blood transfusion on religious grounds); State v. Perricone, 181 A.2d 751 (N.J. 1962) (finding that a special guardian should be appointed for a child when the parents refused to consent to a blood transfusion for the child because of religious beliefs), cert. denied, 371 U.S. 890 (1962); Application of Brooklyn Hosp., 258 N.Y.S.2d 621 (Sup. Ct. 1965) (ruling that parents' right to consent to medical treatment should be removed when parents do not consent to life-saving treatment). The reasoning behind these holdings has been eloquently expressed in Prince v. Massachusetts, 321 U.S. 158 (1944), a case involving a Jehovah's Witness who violated the child labor laws by allowing her young niece to distribute religious pamphlets. "Parents may be free to become martyrs themselves. But it does not follow they are free in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves." Id. at 170. Parents' consent, or lack thereof, also has been overridden in cases where they chose unorthodox medical treatment over accepted medical practices for their children. See, e.g., Custody of a Minor, 379 N.E.2d 1053 (Mass. 1978) (overriding the parents' refusal to treat an otherwise fatal form of leukemia with chemotherapy). But see In re Hofbauer, 393 N.E.2d 1009 (N.Y. 1979) (holding that parents acted reasonably when rejecting the recommendation of chemotherapy treatment because they placed the child under the care of a licensed physician who advocated metabolic therapy).
this faith cannot accept blood transfusions. As a result, these parents will not consent to certain medical procedures, even when the procedure is necessary to save the life of their child. Courts have consistently overridden the parents' religious objections in these cases on the ground that life, not premature, avoidable death, is in the child's best interest.\textsuperscript{80}

There are other examples that may involve conflict of interest or gross disregard for the basic necessities of life, such as food, clothing, shelter, and education. In these situations, courts have abridged the right to family privacy and allowed the state—the other actor with vested interests—to intervene and protect the child.\textsuperscript{81} It must be stressed, however, that the fact "[t]hat some parents may at times be acting against the interests of their children... creates a basis for caution, [but it] is hardly a reason to discard wholesale those pages of human experience that teach that parents generally do act in the child's best interest."\textsuperscript{82} This statement reaffirms the notion that parents have a fundamental right to direct the upbringing of their children. The following section demonstrates, however, that in those situations where parents compromise the health and welfare of their children, it is the state that asserts its power and assumes the role of parent.

3. \textit{The State}

The state has several identifiable interests that arise in matters regarding the medical treatment decisions for children. First and foremost, the state has a strong interest in the preservation of human life.\textsuperscript{83} A clear example of this policy can be found in the statutes that criminalize murder and assisted suicide.\textsuperscript{84} As a result, whenever the actions of an individual threaten this essential value, the state is permitted to intervene and protect its compelling interest in the sanctity of human life. Recently, however, the United States Supreme Court recognized that the state's interest in preserving life can be subordi-
nated to the free exercise of a competent individual's right to bodily integrity and self-determination, at least in the context of refusing life-sustaining medical treatment. This holding expressly does not apply to incompetent individuals for whom clear and convincing evidence of their intent has not been demonstrated, including minors. In this situation, the state's interests in preserving life remains intact and is buttressed by an additional state interest that arises in the context of incompetent individuals.

The state also has an important interest in protecting innocent parties who are unable to protect themselves. This group includes all incompetent individuals, the mentally infirm, and minors. Children are unique because they rarely possess, by virtue of their inexperience, the ability to protect themselves from harm. Accordingly, when their welfare is compromised by those entrusted with the responsibility for their care, the state has the power, as parens

85. Cruzan v. Missouri Dep't of Health, 110 S. Ct. 2841 (1990). As a result of an automobile accident, Nancy Cruzan, twenty-six years old at the time, suffered severe injuries and lapsed into a persistent vegetative state. After it was determined that Nancy would not regain her cognitive faculties, her parents, as guardians, sought a court order to remove the artificial nutrition and hydration that were keeping her alive. The Supreme Court of Missouri denied the request, holding that, absent clear and convincing evidence of Nancy's wishes concerning life-sustaining treatment, her parents did not have the authority to consent to the withdrawal. Id. at 2846.

The United States Supreme Court affirmed the decision. Id. at 2856. Initially, the Court queried whether an individual had the right to refuse treatment, even where the treatment was necessary to preserve the life of the individual. Answering in the affirmative, the Court noted that this right was a "logical corollary" of the doctrine of informed consent. Id. at 2847. Specifically, the Court found that the right to consent to treatment included the right to refuse treatment, and this right was grounded in principles of self-determination. In addition, the Court reviewed a litany of case law addressing "termination of treatment" issues and found that the right to refuse treatment was guaranteed to both competent and incompetent individuals. Id. at 2847-51. However, because incompetent individuals are unable to give or withhold the requisite consent, the question remained as to when and under what circumstance the previously expressed or implied desires of these individuals could be given legal weight.

In resolving this dilemma, the Court endorsed the doctrine of substituted judgment as a vehicle through which the rights of incompetent individuals could be respected. Before this doctrine could be invoked, however, the Court held that the state may require the standard of clear and convincing evidence for persons seeking to refuse or terminate treatment on behalf of an incompetent individual. In support of its holding, the Court cited several state interests, including the preservation of life, the protection of individuals unable to act on their own behalf, the prevention of suicide, and preserving the integrity of the medical profession, which justified imposition of the higher evidentiary standard. The Court, reviewing the testimony presented at trial, held that the lower court did not err in concluding this standard was not satisfied. Id. at 2855.

86. Id. at 2855.

87. See Carey v. Population Servs. Int'l, 431 U.S. 678 (1977) (discussing the state's partial power over minors); Prince v. Massachusetts, 321 U.S. 158 (1944) (discussing the state's interest in protecting the welfare of children); Longeway, 549 N.E.2d at 301 (holding that the state has an interest in protecting incompetents); Siemieniec, 512 N.E.2d at 691 (explaining the government's interest in protecting children); Saikewicz, 370 N.E.2d at 426 (discussing the state's interest in protecting children from the potentially harmful decisions of their parents).

88. Saikewicz, 370 N.E.2d at 426.

89. Parham v. J.R., 442 U.S. 584, 603 (1979) (stating that children are unable to make sound judgments about their health).
patriae,\textsuperscript{90} to intervene on behalf of the child.\textsuperscript{91} This doctrine permits the state to usurp the role of the parent in these situations.\textsuperscript{92} This, however, should not be the state's prerogative; it should be the state's duty.\textsuperscript{93}

There are two other state interests stemming from its role as the guardian of the health and welfare of society at large. First, there is the goal of ensuring that society will continue to be productive and self-perpetuating.\textsuperscript{94} "A democratic society rests, for its continuance, upon the healthy, well-rounded growth of young people into full maturity as citizens, with all that implies."\textsuperscript{95} The state is entitled to take the necessary steps to attain this goal by insuring that its children are free from harm. This will enable future adults both to contribute to society and to help it thrive. Another interest centers around the efficient allocation of limited societal resources.\textsuperscript{96} By preserving the health and welfare of minors, the state can prevent these children from becoming its wards, a process that drains precious dollars from the budget which could be put to other more productive uses.\textsuperscript{97} A viable and functioning economy, then, is a permissible goal for the state to pursue because it preserves the interests of the entire society.

The final state interest that arises in the context of medical treatment decisions for minors is found in the need to protect the ethical integrity of the medical profession.\textsuperscript{98} While the medical profession can and should be viewed


\textsuperscript{91} Custody of a Minor, 379 N.E.2d 1053 (Mass. 1978). "On a proper showing that parental conduct threatens a child's well-being, the interests of the State and of the individual child may mandate intervention." \textit{Id.} at 1063.

\textsuperscript{92} Curtis, \textit{supra} note 90, at 895 (delineating those circumstances when the state is allowed to intervene on behalf of the child).

\textsuperscript{93} Horwitz, \textit{supra} note 9, at 282-83. One court framed the nature of the state's responsibility as follows:

The child is a citizen of the State. While he "belongs" to his parents, he belongs also to his State. Their rights in him entail many duties. Likewise the fact [that] the child belongs to the State imposes upon the State many duties. Chief among them is the duty to protect his right to live and to grow up with a sound mind in a sound body, and to brook no interference with that right by any person or organization. \textit{In re} Clark, 185 N.E.2d 128, 132 (Ohio Ct. C.P. 1962). \textit{But see} DeShaney v. Winnebago County, 489 U.S. 189 (1988) (holding that the state possesses no affirmative duty under the Federal Constitution to protect individuals from harm).

\textsuperscript{94} Prince v. Massachusetts, 321 U.S. 158, 168 (1944).

\textsuperscript{95} \textit{Id.}

\textsuperscript{96} Parham v. J.R., 442 U.S. 584, 605 (1979) (asserting that the state has an interest in giving free health care only to those with a genuine need).

\textsuperscript{97} Zablocki v. Redhail, 434 U.S. 374, 394 (1978) (Stewart, J., concurring).

\textsuperscript{98} \textit{See} Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 426 (Mass.
as a separate actor with values and interests of its own, the state also shares
these interests and is an effective vehicle through which they can be asserted.
When parents make or refuse to make treatment decisions that contravene the
established ethical principles of the medical profession, the state can take steps
to insure that those values are not jeopardized. The success of the medical
profession depends on maintaining the public's confidence that physicians will
conduct themselves pursuant to those established principles. Allowing parents
to abridge these professional interests could destroy the crucial trust inherent
in the patient-physician relationship and, as a result, undermine the functioning
of the profession. Because the physician plays a critical role in preserving
society's health and welfare, the state has an important interest in protecting
the integrity of that role.

The primary vehicles through which the state asserts its parens patriae
power for the benefit of minors are child abuse and neglect statutes. All
states have this type of legislation, which authorizes intervention by the state
upon a finding that the child has suffered from abuse or neglect. In the
context of medical treatment, the Illinois legislature defines a neglected child
as one whose parents have failed to provide the child with any and all treat-
ment necessary to that child's well-being. Once this finding is made, the
court can appoint a guardian to represent the legal interests of the
child. Once appointed, the guardian is entrusted to determine the course of action
that best serves the child's interests, and is empowered to make the decisions
necessary to achieve this result.

It should be noted that a finding of neglect will not issue in all situations
where parents opt to withhold medical treatment. There is debate as to
whether the courts should intervene when the child's life is not threatened by
parental inaction. There are also cases involving parents who refuse to con-

102. Ill. Rev. Stat. ch. 100 1/2, para. 11-5 (Supp. 1991); see infra notes 111-24 and accompa-
nying text (discussing the procedures and standards used for appointing guardians).
103. One of the most interesting and controversial examples of this point is in the area of
withholding treatment from defective newborns. For a thorough discussion of the issues involved,
see Richard C. Sparks, Bioethics and the Handicapped Newborn (1988); Robert Weir,
Selective Nontreatment of Handicapped Newborns (1984); Ethical Issues at the Out-
set of Life (William B. Weil & Martin Benjamin eds., 1987); Larry Gosin, A Moment in
Human Development: Legal Protection, Ethical Standards and Social Policy in the Selective
104. Compare, e.g., In re Seiferth, 127 N.E.2d 80 (N.Y. 1955) (refusing to intervene and order
surgical repair of child's cleft palate and harelip) and In re Green, 292 A.2d 387 (Pa. 1972)
(refusing to intervene and order surgery for a child who suffered from a severe form of scoliosis)
and In re Hudson, 126 P.2d 765 (Wash. 1942) (refusing to intervene and order the surgical
removal of a deformed arm) with In re Kawarth, 199 N.W.2d 147 (Iowa 1972) (ordering surgical
removal of tonsils over parents' objection) and In re Sampson, 278 N.E.2d (N.Y. 1972) (ordering
plastic surgery over mother's religious objections).
sent to medical treatment on religious grounds.\textsuperscript{106} In these situations, a tension exists between the state’s interest in the welfare of the child and the parent’s right to freedom of religion as guaranteed by the First Amendment.\textsuperscript{106} Also, where the refusal to consent is based on accepted medical advice, as is the case with severely defective newborns and dying children with no hope of any meaningful recovery, the courts will not find the child neglected.\textsuperscript{107} By contrast, there may be situations in which the parents consent to a particular treatment, but the courts override this consent because the treatment is not in the child’s best interest.\textsuperscript{108} This is most common where the chosen therapy is intended to benefit a third party, such as situations involving experimental treatment and organ donation.\textsuperscript{109} While the state enjoys a vested interest in safeguarding the health and welfare of minors, the contours of this interest undergo consistent development on a case-by-case basis. Unique situations do arise, and the nature of the competing interests can only be determined with reference to those particular circumstances.

\textbf{E. The Role of the Courts}

When disputes arise over medical treatment decisions for minors, either between the state and the parents or among the parents themselves, the courts are often called upon to resolve these conflicts. This is not an enviable task. The endeavor requires the sensitive balancing of competing interests, and often no clear-cut answers are available. Compounding the difficulties inherent in this process are the urgency of the proceedings and the tragic reality surrounding the case of a sick or dying child. In resolving these disputes, while considering all competing interests, the courts must focus primarily on the minor’s interests.\textsuperscript{110} After all, the minor is the person who is most affected by the outcome of the proceeding.

Two elements in this judicial process are worthy of mention. The first concerns the appointment and role of the surrogate decision-maker/guardian and

\begin{footnotesize}
\begin{itemize}
    \item \textsuperscript{105} See \textit{supra} note 79 and accompanying text (discussing cases involving Jehovah’s Witnesses who refuse to accept blood transfusions).
    \item \textsuperscript{106} U.S. Const. amend I. Specifically, it is the Free Exercise Clause of the First Amendment that is implicated in these situations.
    \item \textsuperscript{107} See Soloveichik v. Soloveichik, No. 89 CH 215, slip op. at 3 (Ill. Cir. Ct. Jan. 19, 1989).
    \item \textsuperscript{108} See \textit{In re} Richardson, 284 So. 2d 185 (La. 1973) (denying the parents’ request that one of their children be allowed to donate his kidney for the benefit of his sister); Charles H. Baron, \textit{Live Organ and Tissue Transplants from Minor Donors in Massachusetts}, 55 B.U. L. Rev. 159 (1975) (discussing the legal problem of parental consent for minors who wish to donate their organs); William J. Curran, \textit{A Problem of Consent: Kidney Transplantation in Minors}, 34 N.Y.U. L. Rev. 891 (1959) (discussing briefly three Massachusetts cases that required the consent of minor organ donors to be obtained prior to the procedure).
    \item \textsuperscript{109} \textit{In re} Richardson, 284 So. 2d at 187.
    \item \textsuperscript{110} Custody of a Minor, 379 N.E.2d 1053, 1063 (Mass. 1979) (discussing the paramount importance of the minor’s interests); Robert Bennett, \textit{Allocation of Child Medical Care Decision-Making Authority: A Suggested Interest Analysis}, 62 Va. L. Rev. 285, 307-08 (1976); Miller, \textit{supra} note 9, at 838.
\end{itemize}
\end{footnotesize}
the guardian ad litem. These individuals can play distinct roles, and it is the latter person who assumes greater importance in disputes over medical treatment decisions. The second consideration involves the appropriate standard of analysis to be employed by the court in resolving the dispute. There are two approaches commonly used to make medical decisions for legally incompetent individuals: the substituted judgment doctrine and the best interests test. Each of these standards is appropriate in certain defined sets of circumstances. This section examines both of these considerations as they pertain to judicial resolution of disputes over medical treatment decisions.

1. The Surrogate Parent and the Guardian ad Litem

A third party can play two different roles when representing the interests of a minor. One role is the surrogate parent or, in the alternative, the general guardian. This person is charged with the "general care and control of the person and estate of the ward." As the definition implies, there is a sense of permanency in the position, and the general guardian, in the case of incompetent minors, assumes a parental role. As such, the general guardian is entrusted with all the rights and duties possessed by a natural parent, including the right to grant or withhold consent for medical treatment. This relationship usually lasts until the minor reaches the age of majority or attains an emancipated status.

The courts have the authority to appoint a general guardian in a variety of circumstances. The Illinois Probate Act, for example, specifies that the court can create this relationship on its own motion, on the motion of a reputable citizen, or "whenever it appears necessary or convenient." This power encompasses the situation in which a child is found to be abused or neglected and can extend to cases where a conflict of interest exists between parent and child. Since the guardian assumes the role of parent when the child is a minor, custody is usually granted to the general guardian. While guardians serve

111. For the purposes of this Comment, the surrogate decision-maker and guardian ad litem are different actors. It should be noted that a licensed attorney, appointed as guardian ad litem, can serve in both of these capacities. See infra notes 114-24 and accompanying text (discussing various forms of surrogate decision-making).

112. The reason behind this conclusion is that the guardian ad litem is the person who represents the child in judicial proceedings. It is in these proceedings that best interests and substituted judgment determinations are made.

113. See infra sections I.E.2.b and I.E.2.c, notes 139-65 and accompanying text (discussing and analyzing, in turn, the substituted judgment doctrine and the best interests test).


115. ILL. REV. STAT. ch. 110 1/2, para. 11-13 (1989).

116. Once the minor attains the age of majority, the policy justification underlying the guardianship disappears. The individual is now presumed to be able to take care of himself or herself and, as such, needs no additional supervision. It should be noted that a showing of parental fitness can also result in the restoration of parental custody. Id. para. 11-5(d).

117. Id. para. 11-5(a).

118. Id. para. 11-13(a).
an essential function in our society by preserving the welfare of incompetent individuals, guardians do not play a role in the disputes between parents over medical treatment decisions unless, through prior court appointment, the guardian himself or herself is a party to the dispute.

The other type of guardian whose role is critical in these disputes is the guardian ad litem. Unlike the general guardian, the guardian ad litem is a special guardian who possesses limited powers and duties with respect to the child. The primary function served by this person can best be described as a legal representative for the child who has the responsibility to both advocate and safeguard the interests of the child during legal proceedings. This not only includes situations in which the minor is a party to the suit, but also where the child's interests are the subject of the proceedings. In most cases, the guardian ad litem is an attorney who directly represents the child in court. In the event this person is not an attorney, he or she is directly responsible for obtaining counsel to serve in this capacity. Moreover, when a child is involved in the proceedings, the court has a duty to insure the appointment of a guardian ad litem. By serving as the minor's voice, the guardian ad litem has the opportunity to prevent the subordination of the minor's interest to those of the other parties involved.

It is important to reemphasize the need for a guardian ad litem when dealing with disputed medical treatment decisions. These decisions directly affect the health and welfare of the child, especially when made in life-and-death situations. While the court may find that one of the parties to the dispute—the parent(s) or the state—is acting consistently with the child's best interests, this is not always the case. For example, while parents may disagree over a treatment decision, the dispute may actually be the byproduct of other marital tensions. In addition, the stress, depression, and anger that inevitably accom-
pany tragedy can cloud the judgment of even the most caring and responsible parents. The state, on the other hand, may be underinformed. This is possible considering the overburdened and underfinanced condition of most social service agencies. In light of these realities, the guardian ad litem can provide the court with objective facts that can only serve to guide the court in making a well-informed decision. The following section explores the two standards used in making decisions for incompetent individuals.

2. Standards of Review

a. The right to bodily integrity and self-determination

As long ago as 1891, the United States Supreme Court recognized the right of all citizens to bodily integrity and self-determination.125 "No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person free from all restraint or interference of others, unless by clear and unquestionable authority of law."126 This right is also embodied in the constitutional right of privacy that recognizes a zone in which people are free from unwarranted intrusion in the exercise of their guaranteed freedoms.127 Included in this zone of privacy is the right to decide what one can or cannot do with his or her own body. The Illinois constitution expressly recognizes this right to bodily integrity and self-determination.128

Implicit in this right of personal inviolability is the concept of informed consent.129 In the words of Justice Cardozo, "Every 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

125. Union Pac. Ry. v. Botsford, 141 U.S. 250, 251 (1891). Self-determination also can be defined as personal autonomy. These two terms are used interchangeably for the purposes of this Comment. See also Cruzan v. Missouri Dep't of Pub. Health, 110 S. Ct. 2841, 2846 (1990) (observing the Court's past recognition of the right of "possession and control of his own person, free from all restraint or interference of others"); In re Estate of Longeway, 549 N.E.2d 292, 297 (Ill. 1989) (same).

126. Botsford, 141 U.S. at 251.

127. Griswold v. Connecticut, 381 U.S. 479 (1965). In Griswold, the first in a series of cases charting the contours of the fundamental right to privacy, the Court held that a Connecticut statute banning the dissemination of birth control information was unconstitutional. The Court held that freedom in matters involving procreation was implicit in the concept of ordered liberty and, as such, there could be no state intrusion into this zone of privacy absent a compelling interest. Id. at 485; see also Roe v. Wade, 410 U.S. 113 (1973) (recognizing the right to seek an abortion as inherent in the right to privacy); Eisenstadt v. Baird, 405 U.S. 438 (1972) (recognizing that the right of privacy extends to married and unmarried persons alike); In re Estate of Longeway, 549 N.E.2d 292, 296 (Ill. 1989) (reiterating a constitutional right to privacy as guaranteed by the penumbra of the Bill of Rights); Family Life League v. Department of Public Aid, 493 N.E.2d 1054 (Ill. 1986) (same).

128. Ill. Const. art. 1, § 6 ("The people shall have the right to be secure in their persons . . . against . . . invasions of privacy . . . .").

129. Cruzan, 110 S. Ct. at 2846-47 (stating that consent is required to maintain the right of personal inviolability); Longeway, 549 N.E.2d at 297 (same).
commits an assault, for which he is liable in damages.” Informed consent is therefore required before any medical procedure can be performed, barring certain limited exceptions. This principle requires the physician to divulge any and all information to the patient that is necessary to make an informed and intelligent treatment decision. This not only includes the benefits and risks of the proposed course of therapy, but also any reasonable and available treatment alternatives. As a result, informed consent directly empowers the individual to control his or her own destiny and, in doing so, preserves the right of bodily integrity and self-determination.

The above-quoted passage from Justice Cardozo, however, signals that there are limitations to the doctrine of informed consent. By specifying “adult years and sound mind,” he recognized that both minors and the mentally infirm are not capable of exercising this right. This does not mean these individuals do not possess protected interests. Rather, this implies that someone other than the incompetent individual must assert this right in order for consent to be valid.

There are two standards by which courts make decisions for incompetent individuals: the substituted judgment doctrine and the best interests test. While these approaches are quite different, they embody the common goal of

133. Canterbury, 464 F.2d at 772.
135. Saikewicz, 370 N.E.2d at 431.
helping a court decide for those who cannot decide for themselves. The manner in which this process is effected, however, is where these approaches part company. While both doctrines preserve the individual’s right to bodily integrity, only the substituted judgment doctrine furthers the right to self-determination. Thus, this approach is preferred. There are situations in which substituted judgment is not applicable and, therefore, a court fashions its decision based on the best interests of the individual. In Curran, each parent argued for the use of a different standard. While it is not clear that the choice of either approach would be outcome-determinative, in this case it is certainly possible. As a result, it is essential to determine which standard applies in any given set of circumstances. To this end, a discussion of each standard follows.

b. The substituted judgment doctrine

When a court is faced with making decisions for incompetent individuals, one available route to achieve this end is the substituted judgment doctrine. This principle allows the court to make choices for the incompetent by determining what the individual would have chosen had he or she been competent to do so at the time of the decision. Although this doctrine originated in a case involving an allowance petition from the estate of a mental incompetent, it is now commonly used in the medical treatment context, usually where termination of treatment is at issue. When this doctrine is applied, it allows the court to give a voice to the individual, who, by virtue of his or her incompetence, can no longer articulate a preference in a legally cognizable fashion.

Underlying the substituted judgment doctrine is respect for the incompetent individual’s right to self-determination. Accordingly, the loss of the ability to choose for oneself no longer involves the loss of rights guaranteed to all other citizens. This principle, then, protects an incompetent’s right to bodily

137. See infra section I.E.2.b (discussing the principles behind the substituted judgment doctrine).
141. Curran, 566 N.E.2d at 1322; Saikewicz, 370 N.E.2d at 431.
142. See, e.g., Curran, 566 N.E.2d at 1322; Saikewicz, 370 N.E.2d at 431.
143. Cruzan, 110 S. Ct. at 2848 (“[T]he right of self-determination should not be lost merely because an individual is unable to sense a violation of it.”); see also Saikewicz, 370 N.E.2d at 427 (recognizing that incompetent persons have the same rights as competent persons “because the value of human dignity extends to both”).
144. See Cruzan, 110 S. Ct. at 2848; see also in re Guardianship of Roe, 421 N.E.2d 40, 51 (Mass. 1981) (“To deny [this right] to persons who are incapable of exercising it personally is to degrade those whose disabilities make them wholly reliant on other, more fortunate, individuals.”).
integrity and self-determination by giving effect to that which this person would actually have chosen in a given set of circumstances. Thus, it is not really the court that is making the decision. Rather, it is the incompetent individual who decides.

There are two ways in which the court can employ the substituted judgment doctrine to arrive at the decision the incompetent individual would have made. The first is narrow in scope and is known as the subjective standard. Using this approach, the court will look to the clearly expressed intent of the individual regarding the medical treatment at issue. For example, in the termination-of-treatment context, a living will or power of attorney for health care can provide this evidence. These documents explicitly delineate the individual's wishes in certain defined circumstances. Specific oral communications also satisfy the subjective standard.

The second method that is followed by a number of jurisdictions, including Illinois, is the limited-objective standard. These courts will permit the use of substituted judgment in cases lacking a clear expression of intent by the incompetent individual. In employing this standard, the court will look to other trustworthy evidence that helps to paint a picture of the individual's personal value system, "including his or her philosophical, religious, and

145. See cases cited supra note 139 (discussing the judiciary’s role in consent decisions for incompetent individuals).
146. In re Moe, 432 N.E.2d 712, 720 (Mass. 1982) (“The court dons the ‘mental mantle of the incompetent’ and substitutes itself as nearly as possible for the individual in the decision making process.”).
147. Cruzan, 110 S. Ct. at 2848.
148. Id.

A living will enables an individual to declare in writing the precise form or forms of medical treatment that will be administered or withheld in the event the individual is no longer able to participate in his or her own health care decisions. See, e.g., Illinois Living Will Act, ILL. REV. STAT. ch. 110 1/2, para. 701 (Supp. 1991). A power of attorney for health care, on the other hand, enables the individual to delegate decision-making authority to an agent who, in the exercise of this authority, acts in conformity with the individual’s values and expressed preference. See, e.g., Illinois Powers of Attorney for Health Care Act, ILL. REV. STAT. ch. 110 1/2, para. 804 (Supp. 1991). It should be noted, however, that the power of attorney for health care supersedes the operation of a living will as long as the designated agent is available to make the necessary health care decisions. Id. para. 804-11. Additionally, Illinois has recently enacted a new statute dealing with surrogate decision-making in the health care context. Illinois Health Care Surrogate Act, P.A. No. 87-749 (1991). The Act’s express purpose is to “define the circumstances under which private decisions by patients with decisional capacity and by surrogate decision makers on behalf of patients lacking decisional capacity to terminate life-sustaining treatment may be made without judicial involvement of any kind.” Id. While this act is without force in situations covered by a valid living will or power of health-care attorney, it nevertheless fills the gaps left by those documents, which may be otherwise limited or nonexistent.

150. Cruzan, 110 S. Ct. at 2849; In re Estate of Longeway, 549 N.E.2d 292, 299 (Ill. 1989); see also In re Conroy, 486 A.2d 1209, 1231-33 (N.J. 1988) (permitting evidence indicating that an incompetent patient would have forgone medical treatment). But see In re Westchester County Medical Ctr. ex rel. O’Connor, 531 N.E.2d 607 (N.Y. 1988) (requiring clear and convincing evidence of an individual’s intent).
151. Cruzan, 110 S. Ct. at 2849.
moral views, life goals, values about the purpose of life and the way it should be lived, and attitudes toward sickness, medical procedures, suffering and death. These factors taken as a whole can guide the judge in ascertaining what the individual would have done had he or she been competent to decide.

A common thread running through both approaches to the substituted judgment doctrine is the intent of the individual. At all times, the court seeks to reconstruct this intent in deciding for the incompetent. The doctrine preserves individual autonomy because it both mandates a search for this intent and respects this intent once it has been revealed. However, it is not always possible to determine an individual's intent. Situations exist in which either the incompetent individual has never been competent or trustworthy evidence is not available to establish the individual's intent and preferences. This may or may not be the case in situations involving minors. When these circumstances do arise, however, the justification for utilizing the substituted judgment doctrine collapses, and a different standard is required.

c. The best interests test

The best interests approach is the other method by which courts make treatment decisions for incompetent individuals. Under this approach, a court does not determine what the person would have wanted had he or she been competent to decide. Rather, the court decides for the individual based on which course of action it believes is in his or her best interest. The power to make such decisions stems from the power of the court to act as parens patriae for those unable to care or to choose for themselves.

The origin of the best interests test can be traced to the resolution of child custody disputes where courts endeavored to determine which parent could best serve the child's physical and psychological welfare. In making such determinations, the court would look to a variety of objective facts and charac-


153. See Rasmussen v. Fleming, 741 P.2d 674 (Ariz. 1987); In re Drabick, 245 Cal. Rptr. 840 (Cal. 1988); In re Torres, 357 N.W.2d 332 (Minn. 1984); In re Jobes, 529 A.2d 434 (N.J. 1987); In re Hamlin, 689 P.2d 1372 (Wash. 1984).

154. Longeway, 549 N.E.2d at 299 ("Under the best interests test, a surrogate decision maker chooses for the incompetent patient which medical procedures would be in the patient's best interests. The criteria used include 'relief from suffering, preservation or restoration of functioning, and quality and extent of sustained life.'" (quoting Rasmussen, 741 P.2d at 689)); see also Stewart Pollock, Life and Death Decisions: Who Makes Them and by What Standard?, 41 RUTGERS L. REV. 505, 520 (1985) ("The best interests test involves consideration of objective facts such as the patient's age, level of consciousness, condition, and isolation, together with the restrictions on his or her physical freedom. Also to be considered are the invasiveness of the treatment and the pain, if any, experienced by the patient.").

155. Pollock, supra note 154, at 521.

teristics concerning each parent in order to guide its judgment. Although this approach is still utilized in the child custody context, it is also used for making medical treatment decisions for incompetent individuals. In such circumstances, the court will look to objective criteria to determine whether the burdens of a proposed course of treatment outweigh the benefits. Some of these factors include the patient's age, life expectancy with or without the procedure, present and future pain and suffering, risks and side effects of the procedure, and the extent of the patient's disability and helplessness. In an effort to evaluate these factors in an objective manner, the court assumes the perspective of the reasonable person. This helps to insure that the subjective values and preferences of the parents, relatives, and other surrogate decision-makers do not enter into the best interests calculus.

Although the substituted judgment doctrine is the preferred standard because it preserves the incompetent individual's right to personal autonomy, the best interests test is frequently used in cases involving children. Even those courts that profess to employ substituted judgment for a minor's medical treatment decisions actually use the best interests standard. In Strunk v. Strunk, the Kentucky Supreme Court was faced with a petition requesting that a twenty-seven-year-old lifelong incompetent be allowed to donate bone marrow to save his dying brother. The court expressly stated that the substituted judgment doctrine controlled, but the opinion was full of language concerning the balancing of benefits and burdens. Such language indicates that the court did not decide on the grounds of the incompetent person's intent, but rather on which choice would best serve the incompetent's well-being.

157. Some of these factors include "maturity and judgment, mental stability, ability to provide access to schools, moral character, ability to provide continuing involvement in the community, financial sufficiency, and sense of responsibility for the child." Charlow, supra note 156, at 268.
159. Id.
160. Pollock, supra note 154, at 522.
161. See Curran v. Bosze, 566 N.E.2d 1319, 1326 (Ill. 1990); see also Brief of Guardian ad Litem for Allison and Jimmy Curran at 26, Curran v. Bosze, 566 N.E.2d 1319 (Ill. 1990) (No. 70501) ("[N]o rational basis for a substituted judgment decision exists for infants and life-long incompetents because they have had no opportunity to gain and then express their views on any of the types of life experiences required, first to form any value judgments and second, for a surrogate truly to 'don the [ir] mental mantle.'" (alteration in cited source)).
162. Curran, 566 N.E.2d at 1331. The court embarked on a case-by-case analysis of several opinions regarding organ transplantation from both minors and life-long incompetents to other people, including siblings, in order to show that these courts have consistently applied a best interests analysis even where purporting to use the substituted judgment doctrine. See id. at 1326-31 (interpreting Hart v. Brown, 289 A.2d 386 (Conn. 1972); Strunk v. Strunk, 445 S.W.2d 145 (Ky. 1969); In re Richardson, 284 So. 2d 185 (La. 1973); Little v. Little, 576 S.W.2d 493 (Tex. 1979); In re Pescinski, 226 N.W.2d 180 (Wis. 1975)).
163. 445 S.W.2d 145 (Ky. 1969).
164. See id. at 146-48.
165. Id.; see also Pollock, supra note 154, at 525-30. Pollock noticed a trend in courts' decisions to use the label "substituted judgment" when, in reality, the courts were applying a best interests analysis. Pollock cautions the reader to "look beneath the label." Id. at 525.
Moreover, this result is reasonable in light of the fact that when the court assumes the role of parent, it should guide its decision-making process by the standard to which it holds parents, that is, the best interests approach.

In sum, the best interests doctrine applies in cases where the individual has never been competent or has never adequately expressed his or her intent regarding medical treatment decisions. Cases involving children fall into this category. Although this approach may not directly preserve the incompetent person's right to self-determination, by requiring an evaluation of objective criteria it avoids the pitfalls of interjecting the subjective preferences of the surrogate into the decision-making process. To this extent, the best interests analysis does not readily permit the result that the substituted judgment doctrine was designed to prevent.

II. Analysis

While it is not possible to determine how often disputes arise between parents over the medical treatment decisions for their children, the examples provided in this Comment indicate that these situations do arise. In many cases there are likely to be urgent circumstances that are compounded by the tragic nature of the situation. Decisions need to be made quickly; however, the decision-making process is not easy. As shown above, there are several actors involved in these disputes, all of whom have vested interests in the outcome. In providing guidance for the resolution of these disputes, this section focuses on two distinct components of the decision-making process. First, a substantive approach is used to suggest the proper method for balancing the competing interests. Second, a procedural approach delineates how these competing interests, in light of the substantive formula, can best be respected. At all times, it should be emphasized, the interests of the minor must remain the paramount concern.

A. The Substantive Approach

As indicated, there are several sets of competing interests implicated in these types of disputes. The purpose of this section is to suggest a formula through which these interests can be balanced in order to arrive at the desired conclusion. Before this formula can be identified, it is appropriate to summarize these various interests. The minor has the right to bodily integrity and, in certain defined circumstances, the right to self-determination. Because the

166. The author has found only three cases involving disputes between parents over medical treatment decisions for their children. There may be other such decisions, however, but they are likely to be unreported. There are two reasons for this conclusion. First, in emergency cases, once the decision is made, the basis for the dispute disappears and the case becomes moot. Second, parental differences may be subject to resolution at various points prior to the appeals process. Hence, the majority of these types of cases may never make it past the trial court.

167. See supra notes 55-109 and accompanying text (analyzing the competing interests of children, parents, and the state that factor into decisions over medical treatment).

168. See supra notes 125-38 and accompanying text (discussing the United States Supreme
minor normally cannot exercise these rights, others are entrusted to perform this task. First and foremost, the parents are the individuals who possess this responsibility and, as such, they are entitled to make those decisions that their child is incapable of making. In doing so, parents have the constitutional right to be free from state interference. Moreover, this right to family privacy, as noted by the Jane Doe court, is vested in each individual parent, and not shared by the parental unit. When parents are delinquent in the exercise of their right, the state, as parens patriae, is entitled to intervene to preserve the minor's interests. Typically, the vehicles through which the state assumes the role of parent are child abuse and neglect statutes. Although these principles appear reasonably straightforward, parental disagreement distorts their application. When this occurs, the central force in the decision-making process is disabled, and, as a result, a decision-making vacuum is created. Therefore, the challenge involves defeating this state of inertia and arriving at a decision.

The key to resolving these disputes is twofold. First, the individual who is to make the decision must be identified. Second, the standard by which the decision is to be made must be defined. Answering the first question can be accomplished through a process of elimination.

Under normal circumstances, parents make medical treatment decisions for their children. Both parents possess this right and, absent some form of incapacity or contractual relationship to the contrary, one parent is not entitled to exercise this right to the exclusion of the other. When disagreement prevents parents from acting on behalf of their children, the respective parental rights must cancel each other out of the balancing equation. There are two principal reasons for this conclusion. First, while disputes over medical treatment decisions affect parental rights, there is a third party whose interests are also affected. This individual is the child. Because the focus of the dispute concerns a medical treatment decision, the child's welfare must be the primary consideration. When disagreement disables parents' ability to act, this inaction threatens the child's welfare. As a result, the parents must be written out of the equation.

Court's recognition of every person's right to bodily integrity and self-determination).

169. See supra notes 65-82 and accompanying text (tracing the traditional right held by parents to make decisions concerning the medical treatment of their minor children).


171. Id.

172. In re L.H.R., 321 S.E.2d 716, 722 (Ga. 1984) (“In the case of suspected neglect or abuse or when the parent assumes a stance which in any way endangers the child, the parent’s right to speak for the child may be lost.”); President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forgo Life-Sustaining Treatment 216 (1983) (“When a decision consistent with the child’s interests is not reached, the health care provider should seek to have a court appoint a surrogate in place of the parents, on the grounds that the parents are incapacitated to make the decision, unable to agree, unconcerned for the infant’s well-being, or acting out of an interest that conflicts with the child’s.”) (emphasis added)) [hereinafter President's Commission].
Parental rights are fundamental but not sacrosanct. When parents fail to provide their children with necessary medical care, their constitutional rights can be compromised and even terminated. The source of the parental failure to provide necessary medical care should not make a difference. The end result is the same. Thus, whether it is irresponsibility or inaction stemming from disagreement, the child's welfare is still threatened. In order to insure that the child's interests are protected, the threat must be removed. While stripping parents of their right to make these decisions is not a desirable solution, it is the only way to guarantee the preservation of the child's welfare.

The second reason for removing the parents from the balancing equation can be found in the parental relationship itself. When faced with the reality of a very sick child, parents may be presented with several treatment options, including nontreatment. Depending on the parents' respective values, each might believe a specific treatment regimen is best for the child. However, the treatment choices can be mutually exclusive. For example, in Soloveichik v. Soloveichik, one parent wanted additional surgery whereas the other wanted only palliative care. In these situations, each parent is attempting to do what is best for the child, and both parents have an equal right to make this decision. Without addressing the merits of the particular treatment options, it is clear that a decision needs to be made. If one parent is given the right to make the decision to the exclusion of the other, the latter's fundamental rights have been violated. In addition, the integrity of the family unit is likely to be damaged by giving one parent absolute control over the destiny of the child. Removing the parents from the equation treats both parents equally with respect to their constitutional rights and may serve to provide stability to a strained family environment.

Under most circumstances, the child who is the subject of the dispute is not competent, either legally or physically, to make the necessary treatment decision. For example, in the specific cases discussed earlier in this Comment, two of the children suffered extended bouts of unconsciousness and were unable to communicate their wishes. In Curran v. Bosze, the twins were only three and one-half years old and were clearly unable to either form or express their intent concerning the bone marrow procedure. This result is likely to be common in cases involving children who are very sick. As such, a surrogate decision-maker is required to choose on behalf of these children.

There may, however, be cases in which the child is capable of deciding for himself or herself. Several states have recognized exceptions to the general rule that children are not competent to consent for their medical care. These exceptions are known as the emancipated minor doctrine and the mature mi-
Under these doctrines, there are certain defined situations in which minors have the right to consent to medical treatment. While a more extensive discussion of these issues is beyond the scope of this Comment, it should be mentioned that these rules are premised on the idea that, by virtue of their age and experience, certain adolescent minors may possess the requisite maturity and intelligence to make important decisions. These children are often able to understand the nature and risks of medical treatment and, as a result of their maturity, are entitled to exercise their autonomy. When the case involves a mature or emancipated minor, the search for a surrogate decision-maker should cease. At this point, the minor’s decision regarding the proposed treatment options should be the final word on the matter.

As indicated, when parents are derelict in their duties, the state, as parens patriae, has the right and responsibility to intervene and protect the child. Inherent in the state’s authority to take control of the child is the power to make decisions on behalf of the child. Although the state has a vested interest in the health and welfare of its children, it is not the most desirable surrogate to make difficult medical treatment decisions. These decisions not only involve complex medical issues but also may raise unique and significant ethical considerations. As a result, these cases require individualized attention over an extended period of time. While the state may be adept at providing basic services for abused and neglected minors, such as removing them to welfare facilities or foster homes, it is ill-equipped to serve as a parent for the purpose of medical treatment decision-making. Social service agencies are generally

175. See Ill. Rev. Stat. ch. 40, paras. 2201-2211 (1989). See generally Bennett, supra note 9, at 288-94 (discussing the mature minor doctrine and several other exceptions to the common law general rule mandating parental consent); Ewald, supra note 9, at 700-05 (tracing the minor’s role in medical decision-making in the context of specific treatment, emancipation, maturity, and judicial intervention).

176. These situations may be divided into a number of categories. First, there are certain medical conditions for which minors can consent to treatment, including venereal disease, substance abuse, and pregnancy. Ewald, supra note 9, at 701. Second, certain statutes may prescribe an age at which minors can consent. See, e.g., Mont. Code Ann. § 41-1-402(a) (1991) (high school graduate); Or. Rev. Stat. § 109.640 (1989) (fifteen or older); Pa. Stat. Ann. tit. 35, § 10101 (1977) (high school graduate). Third, there are certain characteristics, such as marriage, living away from home, financial independence, and military service, that qualify the minor as emancipated. In these situations, the minor may consent. See, e.g., Cal. Civ. Code Ann. § 62 (Deering Supp. 1982). Finally, certain statutes authorize any minor who can prove the requisite maturity and intelligence to make his or her own health care decisions. See, e.g., Miss. Code Ann. § 41-41-3(h) (1981) (requiring that minor be of “sufficient intelligence to understand and appreciate the consequences of the proposed surgical or medical treatment or procedures, for himself”).

177. Ewald, supra note 9, at 701, 703.

178. Id.

179. See supra notes 87-97 and accompanying text (noting the state’s important interest in protecting parties unable to protect themselves and recognizing the state’s power to intervene on behalf of children in certain circumstances).

180. This is true primarily because the nature of any particular condition or disease can be in constant flux depending on the disease itself or the type of treatment provided. As the situation evolves, so does the decision-making process itself.
underfinanced and overburdened, and these characteristics are not conducive to sensitive and efficient decision-making in this context. Thus, the state should not be considered as a viable surrogate for making these decisions.

The last potential source of surrogate decision-making authority is a guardian for the child. Depending upon the type of guardianship, that individual either manages the day-to-day affairs of the minor ward or represents the ward in legal proceedings. While the general guardian undertakes the former task, the guardian ad litem is a licensed attorney who can serve in both capacities. Once appointed, the general guardian is given control over the ward's person and is empowered to make those decisions necessary for the ward's well-being, including those which relate to medical treatment. Because the general guardian's role is essentially akin to that of a parent, the opportunity exists to develop a close relationship. Through this relationship, the general guardian is capable of providing the individualized attention which is necessary for making the difficult decisions which affect the ward's health and welfare. As a result, the guardian should be viewed as an important player in resolving these disputes.

In the context of interparental disputes over medical treatment decisions, the preferred form of guardianship should be a guardian ad litem. This individual, through appointment as a minor's general guardian, can not only make the general decisions necessary to safeguard the health and welfare of the child but also can represent the child in proceedings that test the propriety of the decisions. Because these decisions are likely to be challenged by one or both parents, it is critical that the individual entrusted to act on behalf of the child is able to advocate this position under emergency circumstances. Moreover, application of the substituted judgment doctrine and best interests test is subject to judicial oversight and, consequently, the person making decisions under either standard should be fluent in the nature and scope of these doctrines. By combining the roles of guardian and counsel, the guardian ad litem is in the best position to insure that the child's interests are not only recognized but also protected.

The second prong of the substantive analysis concerns the appropriate standard by which surrogate decision-making is effected. As indicated, there are two standards that can be employed to make decisions for incompetent individuals: the substituted judgment doctrine and the best interests test. The choice of a standard depends on whether the incompetent individual was formerly competent to make decisions concerning his or her medical care and, if so, whether it is possible to discern the incompetent's prior intent concerning these decisions. If the individual was competent and his or her intent can be

181. See supra section I.E.1, notes 110-24 and accompanying text (discussing judicial appointment of a surrogate parent or guardian ad litem and the role of this party in disputes over medical treatment).

182. See supra sections I.E.2.b and I.E.2.c, notes 136-65 and accompanying text (analyzing in detail the components and application of these competing approaches).

183. See supra sections I.E.2.b and I.E.2.c, notes 136-65 and accompanying text.
established by clear and convincing evidence, the constitutional respect for bodily integrity and self-determination mandates the use of substituted judgment. Where the individual has never been competent or the intent cannot be determined, the best interests approach controls. These same principles apply in cases involving minors whose medical treatment has been interrupted by parental dispute.

In those cases involving emancipated or mature minors who have been or remain competent to consent for medical treatment, the appropriate standard for surrogate decision-making is the substituted judgment doctrine. Once it has been established that the minor has the requisite maturity and intelligence to make these decisions, it is imperative to attempt to discern the minor's wishes concerning medical treatment. Perhaps the minor is capable of expressing this intent. If so, no further inquiry is required. If the minor was formerly competent but, as a result of his or her infirmity, can no longer express this intent, a guardian ad litem should be appointed to both identify and advocate the minor's wishes. In this situation, the guardian ad litem serves solely as a voice for a child who can no longer speak. As long as the mature or emancipated minor's right to bodily integrity and self-determination is intact, efforts to decide for this individual must respect this right. The substituted judgment doctrine is the only vehicle through which this can be accomplished.

The answer is different, however, in cases involving minors who, by virtue of their age or illness, have never been competent to make these decisions. In such cases, the minor does not possess a protected interest in directing his or her care and must rely on a surrogate to make the necessary decisions. Under these circumstances, the surrogate must base the decision on the course of treatment that is in the best interests of the minor. Although the best interests calculus is not always easy to effect, there are numerous factors that can be considered to determine the path of greatest benefit and least harm. Occasionally, in the context of medical care, the best interests approach may favor nontreatment of the minor. Although this is a difficult decision to make, especially where nontreatment hastens the dying process, it nevertheless must be made. While it may appear paradoxical to equate best interests with death, the prospect of continued life with intractable pain and suffering may not always be justified.

There may not be a concrete method to precisely define the best interests test. There are, however, several characteristics deserving of mention. First, the test must be fact-specific and should focus on any and all relevant infor-

184. See supra sections I.E.2.b and I.E.2.c, notes 136-65 and accompanying text.
185. See supra sections I.E.2.b and I.E.2.c, notes 136-65 and accompanying text.
186. See supra text accompanying notes 37-38 (detailing the twelve-factor test to be applied in the best interests calculus).
187. This may be the case where there is no hope for meaningful recovery and prolonged life entails a great deal of pain and suffering.
188. But see In re Beth Israel Medical Ctr., 519 N.Y.S.2d 511 (Sup. Ct. 1987) (outlining the twelve factors to consider in conducting this analysis).
In terms of information, more is better. Second, in striving to determine the best interests of the individual, the analysis must focus on creating the greatest differential between benefit and harm. Once this balance is struck, it is possible to identify the course of treatment that respects the best interests of the individual. Finally, hard decisions should not be avoided. While life itself is a presumptive good, there are situations in which continued life is inhumane. The use of medical technology to sustain life at all costs may constitute medical abuse, degrade the integrity of the individual and the medical profession, and serve only to perpetuate an otherwise torturous dying process both for the patient and his or her loved ones. Thus, the best interests approach must incorporate the “quality of life” not “sanctity of life” philosophy.  

In sum, the substantive analysis can best be illustrated through the use of a flowchart. Starting from the point at which the parents disagree, the first inquiry concerns the identity of the decision-maker. Because the parents are written out of the equation, the choice involves either the child or the guardian ad litem. If the child is competent, the result is straightforward. The child’s wishes must be respected. If the child is not competent, a guardian ad litem must be appointed to represent the interests of the minor. First, the guardian must ask whether the child was formerly competent to express an intent concerning medical treatment. If the child was formerly competent, the guardian, as surrogate, must strive to determine the child’s previous intent and serve as his or her voice through the doctrine of substituted judgment. If either the child was not formerly competent or intent cannot be discerned, the guardian must act for the child in a manner consistent with his or her best interests. Following this substantive approach will insure that the minor’s interests remain the paramount concern in resolving these disputes.

B. The Procedural Framework

While the substantive component of the analysis properly focused on the health and welfare of the minor, there are several procedural aspects in this dispute resolution that should not be overlooked. Because there are additional interests and considerations inherent in these disputes, focusing on the process of decision-making can help to insure these considerations are not ignored. Specifically, there are two interests that must be addressed. First, the parents have an interest in making medical treatment decisions. If the process can be adjusted to help the parents avoid losing their decision-making rights, these...
steps should be taken. Parents have, after all, a significant interest in the outcome of the dispute. Second, there is a pressing need to keep these disputes from going to court. The adversarial process is not conducive to the efficient and sensitive resolution of these dilemmas. As will be shown, the use of hospital-based (institutional) ethics committees can respect both of these considerations as well as serve as a forum for informal arbitration.

In designing a framework to resolve disputes between parents who disagree over the medical treatment decisions for their children, the institutional ethics committee is a valuable tool. Affiliated with hospitals and other health care facilities, these committees can play two valuable roles in dispute resolution. First, they can provide a forum for informal arbitration so that parents can attempt to reconcile their differences before resorting to the adversarial process. In addition, these committees can serve in an advisory capacity to the courts that may be faced with difficult ethical and legal choices. Before these functions can be analyzed, however, the nature and structure of these committees must be identified.

The past two decades have seen the emergence and rise of the institutional ethics committee as an integral part of the health care facility. As medical technology continues to evolve and greater emphasis is placed on patient rights and participation in the medical decision-making process, physicians are increasingly faced with difficult questions concerning the provision of medical services. The withdrawal of life-sustaining treatment, the use of experimental therapies and protocols, and the use of fetal surgery are but a few of the numerous areas in which these questions arise. In response to both physicians’ and society’s need for a more structured approach to these ethical quagmires, many hospitals have established ethics committees that promote discus-
sion of the pertinent issues relating to the care of particular patients. In a nutshell:

An institutional ethics committee is a "multi-disciplinary group of health care professionals within a health care institution that has been specifically established to address the ethical dilemmas that occur within that institution. At the present time, these dilemmas frequently concern the treatment or non-treatment of patients who lack decision-making capabilities". Comprised of physicians, nurses, therapists, clergy, social workers and attorneys who represent a variety of disciplines, interests and points of view, these committees are uniquely situated to provide guidance to physicians, families and guardians when ethical dilemmas arise.

As such, these committees provide a unique opportunity not only for sharing values and information, but also for resolving disputes that arise in the provision of medical care. Therein lies their true value.

In the context of this Comment, the institutional ethics committee can play a vital role by serving as a forum for informal arbitration. They not only can help to resolve disputes before they become irreconcilable, but they also provide a vehicle through which parents can continue to participate in the decision-making process. When parents are confronted with a sick or dying child, it is understandable that they experience stress and emotional trauma. Moreover, these emotional reactions can create an impasse that prevents them from agreeing on the desired course of treatment. Ethics committees can provide a forum in which parents are offered support as well as an opportunity to air their differences. The committee also can advise the parents of the available treatment options against the backdrop of relevant medical and ethical information. "Most importantly, ethics committees achieve these benefits 'while assuring that decisions involving the life and death of incompetent patients will serve their best interests.'" Viewed in this light, these committees offer a much less adversarial environment than a courtroom proceeding. It is pre-

196. See President's Commission, supra note 172, at 161 (1983).
197. In re Torres, 357 N.W.2d 332, 335 n.2 (Minn. 1984) (quoting Ronald E. Cranford & A. Edward Doudera, The Emergence of Institutional Ethics Committees, 12 Law Med. & Health Care 13 (1984)). It should be noted that the composition of members is not limited to the various professional disciplines within the health care sector. Such an omission would undermine the overall purpose of the committee, which is to entertain the most wide-ranging set of values and opinions in reaching a conclusion. Meisel, supra note 190, at 483. As a result, it is recommended that lay persons in the community in which the health care facility is located are included in the process. Id. In addition, it is desirable for the parents and the guardian ad litem, if appointed, to be present as well. This also serves the requirement that the committee is representative of all interested parties.
198. See In re Jobes, 529 A.2d 434, 464 (N.J. 1987) (Pollock, J., concurring) (noting the supportive role these committees play in the decision-making process); see also In re Farrel, 529 A.2d 404, 418 (N.J. 1987) (O'Hern, J., concurring) ("[S]uch a committee might have provided aid and counsel to a physician and family facing such a decision.").
199. In re Farrel, 529 A.2d at 418 (O'Hern, J., concurring).
cisely within this setting that the free flow of ideas and values is promoted. This, in turn, can contribute to the efficient and sensitive resolution of the dispute. As a result, resort should first be made to ethics committees to attempt to resolve the dispute.201

Informal arbitration also prevents these disputes from going to court.202 Due to the emotional and complex nature of these conflicts as well as the myriad personal values and rights involved, courts are not well-equipped to resolve these matters. There are often no clear-cut answers available, and, considering that these disputes must be resolved quickly, it is neither realistic nor fair to assume that courts can respond efficiently case after case. Thus, it is best to leave the resolution of the dispute to the parties involved. The parents must live with the consequences of the decision and, as a result, they should be the persons to make it. Moreover, allowing the parents the chance at informal arbitration can promote harmony in the familial relationship and help to preserve the constitutional right of family privacy.203 In sum, an institutional ethics committee would provide the ideal forum for resolving these disputes before resort to the judicial process and the designation of a surrogate decision-maker.

There will be instances, however, where these attempts at informal arbitration fail. This does not mean that the role of the ethics committee has ended. Rather, these groups can provide a valuable function in the resolution of these conflicts.204 Through extensive discourse concerning the care of a particular patient, the committee can generate information that can assist both the

201. Id. (Pollock, J., concurring). “Termination of treatment cases involve not only legal and medical, but also, ethical judgments. As an aid to physicians and families, hospitals and other health care facilities, such as nursing homes, should give serious consideration to making available the services of ethicists and institutional ethics committees.” Id. (Pollock, J., concurring). The use of ethics committees would also stem the urge to resort immediately to the courts, a trend that the judiciary is reluctant to condone. “[A] practice of applying to the court to confirm such a decision would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession’s field of competence, but because it would be impermissibly cumbersome.” In re Quinlan, 355 A.2d 647, 649 (N.J.), cert. denied, 429 U.S. 922 (1976). “The current practice of members of the medical profession and their associated hospitals [is to shift] the burden of their responsibilities to the courts, to determine, in effect, whether doctors should proceed with certain medical procedures.” In re Nemser, 273 N.Y.S.2d 624, 629 (Sup. Ct. 1966).

202. See Meisel, supra note 190, at 477 (discussing the use of institutional ethics committees as an integral part of the medical treatment decision-making process).

203. See supra notes 65-82 and accompanying text (analyzing the parents’ rights as well as their role in their child’s medical treatment).

204. “[T]he findings and advice of such groups . . . ordinarily would be of great assistance to a probate judge faced with such a difficult decision . . . [and] it [is] desirable for a judge to consider such views wherever available and useful to the court.” Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 434 (Mass. 1977); see also In re Jobes, 529 A.2d 434, 464 (N.J. 1987) (Pollock, J., concurring) (“Patient care advisory committees . . . have been authorized by the Maryland Legislature effective as of July 1, 1987 . . . . On request of a ‘petitioner’, a term that includes among others, a physician and a family member, . . . an advisory committee ‘shall offer advice in cases involving individuals with life-threatening conditions.’” (quoting Md. Health-Gen. Code Ann. §§ 19-370 to 19-374 (Supp. 1986)).
guardian ad litem and the judge in his or her analysis of the issues.\textsuperscript{205} Although the courts have resisted the notion that ethics committees should serve as a substitute for judicial review,\textsuperscript{206} they have likewise acknowledged the desirable role these committees can play as an adjunct to judicial review.\textsuperscript{207} This belief reflects the judiciary's awareness of its own inexperience in the complex world of medicine and bioethics and recognizes the need for expert consultation in these situations. It also supports the idea that, while judges are less well-equipped than parents, guardians, or health care providers to make these decisions, the likelihood of legal consequences indicate that the decision should be supervised by a more politically accountable body. To blindly entrust these decisions to the private community has dangerous consequences.\textsuperscript{208} Nevertheless, ethics committees can assist guardians and the judiciary in resolving these disputes, and this participation should be encouraged.

In addition to the above-mentioned considerations, there is also the issue concerning the guardian ad litem.\textsuperscript{209} While this individual was previously discussed in the context of the substantive approach, the guardian ad litem also must be mentioned in the context of procedure. The purpose of the guardian ad litem is to safeguard the rights and interests of the minor by representing that child, as counsel, in any proceedings in which the child is involved.\textsuperscript{210} This role is especially critical when the health and welfare of the minor will be directly affected by the outcome of the dispute. This situation is common in the context of medical treatment decisions, and the result can be of life-and-death proportions.

Since the minor is directly affected by the outcome of the proceedings, it only seems reasonable that he or she should have the benefit of counsel.\textsuperscript{211}

\textsuperscript{205} This is primarily the result of the multidisciplinary character of these committees. It is inevitable that when so many viewpoints are brought together, a wealth of information will be generated. In addition, the discussion will naturally be confined to the relevant issues:

Perhaps the most important benefit of ethics committees, indeed the characteristic without which the courts might be less enthusiastic about them as a substitute for judicial review, is the belief that ethics committees will identify and counsel against decisions that are substantively impermissible or that are based on improper motivations.

\textsuperscript{206} \textit{E.g.}, Saikewicz, 370 N.E.2d at 434 ("We take a dim view of any attempt to shift the ultimate decision-making responsibility away from the duly established courts of proper jurisdiction to any committee, panel or group, ad hoc or permanent.").

\textsuperscript{207} \textit{See}, \textit{e.g.}, \textit{id}.

\textsuperscript{208} \textit{See} Andrew L. Merritt, The Tort Liability of Hospital Ethics Committees, 60 S. CAL. L. REV. 1239 (1987) (discussing the liability of hospital ethics committees).

\textsuperscript{209} \textit{See supra} section I.E.1, notes 114-23 and accompanying text (discussing at length the guardian ad litem's role in representing the child's interests in proceedings affecting the child's welfare).

\textsuperscript{210} \textit{See supra} notes 119-23 and accompanying text.

\textsuperscript{211} \textit{See generally} James K. Genden, \textit{Separate Legal Representation for Children: Protecting the Rights and Interests of Minors in Judicial Proceedings}, 11 HARV. C.R.-C.L. L. REV. 565 (1976) (analyzing the circumstances when appointment of a child advocate may be valuable and the difficulties surrounding the use of lawyers for children); Martin Guggenheim, The Right To
This will insure that the minor's interests and not the interests of the other parties to the suit will remain the focus of the proceedings. Moreover, the fact that the result may be the same with or without the presence of the guardian ad litem is irrelevant. There is always the possibility that this individual might make a difference, and in these situations it is necessary to err on the side of the minor's protected interests. Although the guardian ad litem's role may be minor and merely involve assisting the judge in effecting the best interests calculus, this role is important enough to justify appointment of a guardian ad litem. Appointing a guardian ad litem can only serve to bring new and independent information to the judge's attention and perhaps result in a more objective conclusion.\footnote{In all cases involving disputes over the medical treatment decisions for minors, a guardian ad litem should be appointed to represent the minor during the proceedings.}

By focusing on procedural issues in addition to substantive analysis, it is possible to examine ways in which the decision-making process can be improved. Emphasis on informal arbitration can provide a valuable service. By forcing the parents to discuss their differences under controlled and well-informed conditions, disputes can potentially be resolved before resort to the judicial process is necessary.\footnote{Perhaps all that is required is communication. If the end result avoids the appointment and use of a surrogate decision-maker, the means that accomplish this result should be encouraged. The key, then, to resolving these disputes is frank and earnest discussion. The ethics committee and the guardian ad litem can promote the communicative process and, in turn, can help to keep the medical decision-making for children where it belongs: with the parents.}

C. Curran, Soloveichik, and Jane Doe

At this point, it is appropriate to issue a report card for the three known cases involving disputes between parents over the medical treatment decisions for their children.\footnote{By examining the disposition of these cases in light of the benefits of ethics committees as an adjunct to judicial review.}

above-mentioned principles, it is possible to see how the results of these cases can improve the future resolution of these disputes.

1. Curran v. Bosze

While Curran\(^{215}\) can literally be viewed as a dispute between two natural parents over a medical treatment decision, its precedential value for future cases is quite limited. Due to the unique fact situation in Curran, this case can be distinguished on its face. Nancy Curran had complete decision-making authority to the exclusion of Tamas Bosze.\(^{216}\) Thus, while the two parents disagreed, only Ms. Curran's opinion on this matter was dispositive. Absent a showing that Ms. Curran's refusal of consent for the bone marrow procedure was not in the best interests of her children, neither Mr. Bosze nor the court could interfere with this decision.\(^{217}\) While opportunities may exist to criticize the reasoning behind the court's holding,\(^{218}\) the end result was correct. As such, Curran v. Bosze does not provide much guidance for resolving actual disputes between parents who have equal decision-making power with respect to their children.\(^{219}\)

2. Soloveichik v. Soloveichik

On the other hand, Soloveichik v. Soloveichik\(^{220}\) presents the exact scenario addressed by this Comment. Miriam and Moshe Soloveichik were husband and wife and each had the equal right to make decisions for their child.\(^{221}\) After they could not agree on Yisroel's medical treatment, both sought declarations of limited guardianship to the exclusion of the other for the purpose of managing Yisroel's care.\(^{222}\) In resolving this dispute, the judge conducted an independent best interests analysis and determined that Miriam's request was more consistent with Yisroel's welfare.\(^{223}\) Consequently, he awarded her a limited guardianship to make Yisroel's medical treatment decisions.\(^{224}\)

There are both positive and negative aspects to this decision. On the positive side, the judge correctly adopted and applied a version of the best interests test designed to quantify the benefits and burdens of a proposed course of treat-
In doing so, the judge was able to effect a solution that maximized the ratio between benefit and harm. Second, the focus of the inquiry centered exclusively on Yisroel’s interests. This approach insured that the individual whose interests were most adversely affected by the decision was adequately considered during the proceeding. Finally, the judge was not afraid to make a difficult decision. By awarding Miriam the limited guardianship, the judge implicitly sanctioned a course of therapy that did not prolong Yisroel’s dying process. The judge realized that, under the circumstances, continued life did not maximize the ratio between benefit and burden. Although the judge was not in an enviable position, he was able to efficiently and sensitively weigh the interests and quickly arrive at a solution.

There are a few steps, however, that should have been observed. While the result of this case may have been the same whether or not these procedural suggestions were followed, there is no measurable degree of certainty in this conclusion. First, the judge should have appointed a guardian ad litem either to make decisions on behalf of Yisroel or to help the judge in effecting the best interests test. This individual can provide objective and independent information when weighing the risks and benefits of a proposed course of treatment. Moreover, because the guardian ad litem is appointed to represent the child, the potential that conflicts of interests will infect the proceedings is reduced. Second, there were no attempts to use the hospital’s internal ethics committee for the purpose of informal arbitration. While this step may not have resolved the parental disagreement, there is a chance it would have been successful. Because informal arbitration offers an opportunity to resolve the dispute between parents outside of the adversarial process, it should be utilized whenever possible.

3. In re Jane Doe

The case of In re Jane Doe also involved a dispute between two parents equally situated with respect to medical decision-making. In Jane Doe, the mother wanted a Do Not Resuscitate (“DNR”) order issued for her daughter and was ambivalent on the issue of whether the extraordinary life-sustaining treatment should be discontinued. The father, on the other hand, adamantly

225. See supra note 39 and accompanying text (presenting the multi-factor analysis used by the Soloveichik court to evaluate the child’s best interests).
226. Specifically, the judge found that additional surgery would not yield any additional benefit and would contribute to Yisroel’s pain and suffering. Soloveichik, No. 89 Ch 215, slip op. at 19. Hence, the option of no additional surgery, which did not decrease the harm/benefit ratio, was the only acceptable option.
227. See supra section I.E.1, notes 114-24 and accompanying text (reviewing the respective roles of the guardian ad litem and the surrogate guardian).
228. See supra section I.B., notes 190-201 and accompanying text (discussing the procedural framework for resolving medical treatment disputes between parents).
230. Id., slip op. at 7.
opposed both of these options and wanted everything done to keep his daughter alive.\textsuperscript{231} The court, focusing almost exclusively on the rights of both parents to make medical treatment decisions for their children, refused to intervene on behalf of the mother or the hospital.\textsuperscript{232} As a result, Jane Doe languished in a semiconscious state with no hope for meaningful recovery, kept alive by the "virtues" of medical technology.\textsuperscript{233}

Unfortunately, there are significant problems with this decision. By focusing on the fundamental rights of the parents, the court ignored the subject of the dispute. There were no efforts to independently determine whether Jane Doe's continued and technologically assisted life was in her best interests. The court simply held, absent a showing of abuse or neglect, it did not have the power to intervene in the dispute and favor one parent over the other. There are two implicit errors in this holding. First, the court refused to recognize the concept of medical abuse. Several parties, including the hospital, the ethics committee, Jane Doe's physicians, and her mother, believed the continued use of extraordinary measures was inhumane because it merely prolonged the painful process of dying.\textsuperscript{234} The court, disregarding this argument, concluded that the inherent uncertainties in medical science mitigated the unanimous medical opinion that there was no hope for meaningful recovery.\textsuperscript{235} This conclusion was neither realistic nor practical.\textsuperscript{236} A judge is trained in the law, not medicine. Because the question of meaningful recovery is a medical question, a judge should defer to the unanimous opinion of medical experts. In addition, there are few, if any, absolute certainties in this world. Therefore, if absolute certainty were required before actions are justified, even those involving life and death, the fruits of technological and social progress could not be enjoyed. While medicine may not be an exact science, knowledge and technology have provided the medical community with trustworthy indicia of probabilities. To ignore such probability in the face of unanimous expert opinion only serves to fetter the provision of competent and humane services.

Next, by refusing to intervene and resolve this dispute under the guise of treating both parents equally, the court actually favored the father's request to the exclusion of the mother. This approach clearly does not respect the inter-

\begin{itemize}
\item\textsuperscript{231} \textit{Id.}
\item\textsuperscript{232} \textit{Id.} at 18.
\item\textsuperscript{233} As a postscript, Jane Doe died eight days after the conclusion of the proceedings. During this period of time, she was resuscitated twice. The third attempt failed. Telephone Interview with Susan Devitt, Attorney, Alston & Bird (Mar. 2, 1992). Ms. Devitt represented the hospital in the Jane Doe litigation.
\item\textsuperscript{234} \textit{In re} Jane Doe, Civ. No. D-93064, slip op. at 8.
\item\textsuperscript{235} \textit{Id.} at 19.
\item\textsuperscript{236} Although uncertainty exists in the practice of medicine, uncertainty needs to be assessed in terms of probabilities and possibilities. There is a difference in saying an event is probable as opposed to possible. The former implies likelihood whereas the latter implies chance. \textit{Mere} possibility, especially where remote, should not, in and of itself, justify action or inaction. Here, there was a remote possibility, based on the inherent uncertainty in medical science, that Jane Doe would achieve some degree of meaningful recovery. This chance for a miracle, however, should not have assumed such a central role in the proceedings.
\end{itemize}
ests of both parents. Moreover, it does not justify the failure to examine the best interests of the child. If the court were truly concerned with treating both parents equally, it would have disregarded their wishes equally and searched for a solution that best respected the interests of Jane Doe. The court's refusal to intervene should not be viewed any differently from the parents' inability to act. Nothing was accomplished, and, as a result, Jane Doe's suffering continued.

Although a guardian ad litem was appointed to represent Jane Doe, this individual was rendered ineffective by the court's approach to these issues. Because the court focused almost exclusively on parental rights, the appointment of the guardian appeared to involve more style than substance. Finally, there were no attempts to utilize the ethics committee as a forum for informal arbitration. Considering the court's refusal to accept the recommendations of the committee, however, this is not surprising. This result is not consistent with the deference paid to the parental rights by the court. As indicated, the ethics committee provides parents with a forum in which to work out their differences and still retain decision-making authority over their children. The Jane Doe court simply refused to intervene in the dispute and, as a result, left the parents in the same position as they were when they walked in the front door of the courthouse. The court's respect for the parents' rights not only failed to accomplish the desired goal but also violated the interests of Jane Doe.

CONCLUSION

Disputes between parents over the medical treatment decisions for their sick children involve primarily moral and medical issues. While this Comment focuses on the appropriate legal resolution of these disputes, it must be emphasized that resort to the legal process should only occur when all other attempts fail. This process is unduly burdensome and its actors are not well-equipped to resolve these highly personal dilemmas, which necessarily occur under time constraints and during periods of emotional duress. Through efforts to keep these disputes where they belong, it is possible to assure the participation of those individuals most affected by these decisions as well as to respect the diversity of values that provide the foundation of a democratic society.

Unfortunately, some of these disputes are going to find their way into the judicial process. In light of this fact, this Comment attempts to outline a method through which disputes can be resolved in an efficient and sensitive manner. Hopefully, when these situations arise in the future, all the involved

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237. See supra note 49 and accompanying text (noting that each parent as an individual is vested with fundamental parental rights).

238. See supra note 54 and accompanying text (discussing the In re Jane Doe court's determination to displace a parental decision).

239. See supra notes 191-203 and accompanying text (presenting a suggested procedural framework and other aspects involved in resolving medical treatment disputes between parents).
parties will be able to do more than struggle through on an ad hoc basis. If that is the case, this Comment serves its purpose.

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