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LIFESAVING TREATMENT FOR UNWILLING PATIENTS

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I. INTRODUCTION

DOES anyone have the power to compel a hospital patient to have his life saved? If so, who? These distressing questions arise when a hospital patient, usually at the brink of death and unable to be removed from the hospital, refuses to authorize the attending physician to administer lifesaving treatment. Most frequently the refused treatment is the transfusion of whole blood, either because the need exists from hemorrhage or because it may arise in connection with major surgery. The patient's refusal is often based on the doctrine of Jehovah's Witnesses that the Bible forbids a Witness to give or receive whole blood.¹

Regardless of scriptural interpretation, it is widely and deeply felt by many persons—medical, religious, legal and lay of all sorts—that a person has “the right to die.” This phrase requires much qualification before it becomes an accurate statement of any professional group's doctrine, but it reflects the general view that since everyone dies sometime, exactly when a person dies (apart from suicide) is essentially in the hands of his Creator. Then if anyone is to interfere with the natural processes of disease and death, the person himself is the first, the most important, and perhaps the only party in interest. In the United States, where a person's first duty is not to serve the State, all persons having an interest in saving the hospitalized Jehovah's Witness's life stand well below the Witness himself; they are not so much primary parties in interest as quasi-intervenors in the Witness's arrangements with his God, seeking to create a dispute and then to draw it into litigation in a secular forum.

“Quasi” means “as if;” an as-if intervenor fictionalizes intervention to serve a purpose of justice which intervention literally does not fulfill. Quasi-intervenors properly bear a considerable burden in being permitted to enter a Witness's intrapersonal dispute, and, most awkward for all

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1. [A]bstain . . . from blood. . .” Acts 15:29. Other similar passages appear at Genesis 9:3-4, Leviticus 17:10-14, Deuteronomy 12:15-16, and elsewhere. See *In re Estate of Brooks*, 32 Ill. 2d 361, 362, 205 N.E.2d 435, 436-37 (1965), for a summary of Jehovah's Witness doctrine and authorities. See also Comment, *Unauthorized Rendition of Lifesaving Medical Treatment*, 53 Calif. L. Rev. 860 (1965); 77 Harv. L. Rev. 1539 (1964).

concerned, the quasi-intervenor must urge his standing without the benefit of leisurely judicial reflection. The quasi-intervenor must demand a quick decision on both his standing and the merits of compelling medical treatment, for whether the quasi-intervenor is the spouse of the patient, the attending physician and the hospital or some public guardian, the patient's life hangs in the balance, and procedural delay is apt to moot the compulsion issue by the patient's death—thereby raising potent, if secular issues, of liability and damages.

While the general issues of compulsory medical treatment are easily available for vigorous and circular discussion in the abstract surroundings of classroom, convention or cocktail party, it is difficult to arrange the issues in such an order that one can dispose of one issue before moving to the next—and to keep the dispositions stable in the light of later issues. Practical men of affairs like physicians, hospital administrators, and the legal and spiritual advisors of hospitals need to have a systematic means of deciding individual cases of refused lifesaving treatment. If the patient appears to be mentally competent to decide on transfusion or other treatment, then his refusal must be found disproportionately dangerous to the treatment and the hospital must decide that lifesaving treatment should be compelled; and only then are the hospital, the next of kin, and the State tested for the role of quasi-intervenor in the patient's case.

II. THE PATIENT'S COMPETENCE

A threshold issue must be settled before entering the discussion of quasi-intervention: the patient's mental competence to refuse treatment. The possibility of incompetency was carefully planted in Judge Wright's opinion in the most celebrated transfusion case, *Application of the President and Directors of Georgetown College, Inc.*² In this case, Judge Wright ordered transfusion after a bedside confrontation of the ulcer patient, her husband and the hospital personnel, but he did not explicitly rely on the fact of incompetency.³ If the patient is not mentally competent, whether because he is semi-conscious,⁴ psychotic, a minor,⁵ or under a court-

2. 331 F.2d 1000 (D.C. Cir.), rehearing denied, 331 F.2d 1010 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964) [hereinafter cited as *Georgetown Hospital Case*]. See also Annot., 9 A.L.R.3d 1391 (1966).

3. 331 F.2d at 1008. See also *United States v. George*, 239 F. Supp. 752, 753 (D. Conn. 1965).

4. *Collins v. Davis*, 44 Misc. 2d 622, 254 N.Y.S.2d 666 (Sup. Ct. 1964) (surgery not specified).

5. *In re Clark*, 90 Ohio L. Abs. 21, 185 N.E.2d 128 (Lucas County C.P. 1962); *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537 (1964), cert. denied, 377 U.S. 985 (1964) (unborn child).

created guardianship,⁶ the established machinery will be set in motion for appointing some competent person to decide the treatment question in spite of the patient's apparent objections.⁷ The refusal of routine life-saving treatment should not be taken as per se evidence of mental incompetency,⁸ though it may be difficult to decide competency in a given case, and any person (except a judge) who decides both wrongly and negligently that the patient is not competent may be liable for provable damages.

Something like incompetency per se would explain the intervention which has been permitted to the State where a competent adult's death from refused treatment would leave his or her children pro tanto unsupported. The dying spouses had minor children in two cases⁹ and the child was still in utero in another,¹⁰ but the children were grown and gone in two others.¹¹ Surely the State has a duty to save the life or health of a child who is threatened by parental neglect,¹² but whether this duty extends so far as saving the parent's life against his will is a matching of policies which has never been squarely decided, though it has been mentioned as something more than a makeweight where the children were minors. At best the State's interest in preserving two spouses to care for their children instead of one seems attenuated; one wonders if it would be a stronger interest if a sole surviving parent's life were at stake, so that public guardianship of the minors became an imminent reality.

III. JUSTICIABILITY AND STANDING IN GENERAL

Assuming the mental competency of the refusing patient, any person who goes into court to compel the patient to accept treatment faces serious difficulties in legal concepts. The quasi-intervenor has problems

6. *In re Nemser*, 51 Misc. 2d 616, 273 N.Y.S.2d 624 (Sup. Ct. 1966) (even for the special and limited purpose of determining mental competency to consent to an amputation).

7. It would seem exceedingly remote that such a representative would decide against treatment, but this happened in *In re Nemser*, *Id.*

8. The patient was explicitly found competent in *Erickson v. Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962).

9. *Georgetown Hospital Case*, 331 F.2d 1000, 1006 (D.C. Cir. 1964) (one seven-months infant); *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965) (four children); treatment was compelled in both cases. See 41 Wash. L. Rev. 124 (1966).

10. *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537 (1964).

11. *In re Estate of Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); *In re Nemser*, 51 Misc. 2d 616, 273 N.Y.S.2d 624 (Sup. Ct. 1966) (orders to compel treatment were denied in the latter case and held erroneous in the former).

12. See the discussion and cases cited in the *Georgetown Hospital Case*, 331 F.2d 1000, 1007-08 (D.C. Cir. 1964).

both in the "justiciability" of the issue of compulsory treatment and in his "standing" to ask to represent the patient and probably consent to treatment for him. Standing and justiciability are often used interchangeably, and the terms need not always be differentiated.¹³ But the terms can be distinguished when the occasion demands, and the compelled blood transfusion cases demand the distinction: whether intervention will be allowed or not is a justiciability question, as two judges of the District of Columbia Circuit thought.¹⁴ However, whether a particular quasi-intervenor has the necessary interest is a standing question, and this is a novel point.

In determining whether a party has standing to sue, the court asks this question: Does the party have a direct and perceptible interest which he is entitled to require the court to enforce?¹⁵ In cases and controversies brought in federal courts, standing to sue is closely related to the justiciability of issues, but in state courts, where justiciability may receive broader treatment, such statements as that "every action shall be prosecuted in the name of the real party in interest"¹⁶ put more stress on standing. In a state court of general jurisdiction, a thoroughly justiciable issue can go unadjudicated, if the real parties in interest decline to try it and no would-be intervenor has the requisite standing. This idea, moreover, can be applied to the patient who refuses medical treatment.

Non-justiciability is easier to describe than justiciability: a dispute may be too abstract, premature or moot,¹⁷ or the parties may not be truly adverse, or a judicial order in the cause may not be enforceable.¹⁸ The

13. "The requirement of standing is often used to describe the constitutional limitation on the jurisdiction of this Court to 'cases' and 'controversies.'" *Barrows v. Jackson*, 346 U.S. 249, 255 (1953).

14. *Georgetown Hospital Case*, 331 F.2d 1010, 1015 (D.C. Cir. 1964) (dissenting opinion).

15. *Massachusetts v. Mellon*, 262 U.S. 447 (1923).

16. Fed. R. Civ. P. 17(a).

17. In spite of the patient's recovering his health as mooted a transfusion order, Illinois has ruled that these cases are non-justiciable, chiefly for reasons of free exercise of religion. *In re Estate of Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965). See also *People ex rel. Wallace v. Labrenz*, 411 Ill. 618, 104 N.E.2d 769, cert. denied, 344 U.S. 824 (1952) (infant). New Jersey has ruled that mootness is no bar to finding judicial power to order transfusion of a mother to save a child in utero, *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537 (1964), cert. denied, 377 U.S. 985 (1962) (the mother left the hospital by the time the case was argued), or to preserve the life of a child with congenital heart malformation, *State v. Perricone*, 37 N.J. 463, 181 A.2d 751 (1962), cert. denied, 371 U.S. 890 (1964) (the child had died before argument). The District of Columbia Circuit is split on whether the patient's recovery moots the issue or not. *Georgetown Hospital Case*, 331 F.2d 1000 (D.C. Cir.), rehearing denied, 331 F.2d 1010 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964). See 39 N.Y.U.L. Rev. 706 (1964).

18. See the summary in Mr. Justice Douglas' separate opinion in *Public Affairs Associates, Inc. v. Rickover*, 369 U.S. 111, 114 (1962).

inward dispute of a Jehovah's Witness does not fit conveniently into any of these categories, and while for later argument one must assume that the dispute is justiciable, indeed it may not be. Between a dying patient and his conscience, the blood-transfusion issue is neither abstract nor premature, though to the patient the issue is properly justiciable in a forum spiritual rather than temporal. The patient sees no adverseness between his position and his scriptural interpretations; and while a judicial order to transfuse the patient will be enforced, its enforceability subsumes the preceding defects of justiciability in a most circular manner.

Here the connection between justiciability and standing must be acknowledged again; for practical purposes of litigation, no issue of justiciability can come before the court unless some party has standing to raise it. Nevertheless, may it not be usefully determined in the abstract that some disputes are not justiciable no matter who brings them up? In the blood transfusion situation, an abstract determination of non-justiciability would thus cause immediate dismissal of any application by a quasi-intervenor, or at least of some classes of applications. Such a rule would dispose of enough difficult cases, chiefly those of dying but competent adults, to be worth having. Only Illinois has so ruled to date.¹⁹

Assuming, however, that it is impracticable or unwise to dispose of the standing question in the abstract, by saying that no person can be a quasi-intervenor in the non-justiciable question of the competent adult's right to refuse medical treatment, it becomes necessary to define and classify the possible quasi-intervenors and to arrange the classes in an order to suggested eligibility, before advancing an opinion on whether any quasi-intervenor's interests merit giving him standing.

IV. THE STANDING OF HOSPITALS

The person or institution having physical custody of the non-ambulatory patient feels acutely the embarrassment of his refusing lifesaving treatment. If the custodian is a spouse or relative, either he is sympathetic to the patient's wishes and leaves the patient alone, raising no question of competency or lifesaving treatment, or he is unsympathetic or frightened and usually feels impelled to have the patient placed in the custody of a hospital. While physicians make the medical judgments, it is the hospital that houses the patient; the hospital must bear the consequences of action or inaction.²⁰

19. *In re Estate of Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965) (mootness through recovering health held to be no impediment to decision).

20. Hospitals are usually the moving parties in judicial proceedings, either as business organizations, *Georgetown Hospital Case*, 331 F.2d 1000 (D.C. Cir.), rehearing denied, 331 F.2d 1010 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964); *Raleigh Fitkin-Paul Morgan Memorial*

There is much to be said for giving the hospital as custodian a free hand to save its patients' lives when the staff physicians think that life-saving is possible. The physicians' rule, *primum non nocere*, first do no harm, will of course mean that by soliciting hospitalization the patient implicitly gives up his choice between ordinary means of lifesaving treatment and probable death or his power to tell the physician to employ a procedure that is unnecessarily dangerous—as by consenting to stomach or heart surgery but refusing standby blood transfusion.²¹ The hospital's lifesaving power need not unduly shrink the patient's power to premise ordinary treatment and surgery upon his consent.²² Nor will hospitals understand that they have the power of unlimited lifesaving of human vegetables; extraordinary care of indefinite duration for terminal patients is a commitment of hospital and medical resources not likely to be made over the patient's objection. The line that separates ordinary lifesaving treatment for patients who will get well from extraordinary life-extending treatment for patients who will not get well may shift with medical experience. Nevertheless, drawing the line is a commonplace decision for medical staffs, and the cases in which hospitals are eager to compel medical treatment, on good medical advice, are likely to remain the easy cases in the technology of saving useful lives.

So far the hospital has been regarded as an actor in medicine, rather than being a participant in legal proceedings. Need the hospital's role of quasi-intervenor receive judicial approval?

In the *Georgetown Hospital* case²³ a Judge of the United States Court of Appeals ordered a blood transfusion, which was administered by the hospital staff with lifesaving results, but the entire court en banc agreed only to decline to rehear the case. Two judges thought that since no complaint had been filed, no appealable issue was before the court. Five judges thought that since the patient had recovered her health, the issue was moot. And two judges thought that there was no justiciable case or controversy. The result is a series of separate opinions on a non-case

Hosp. v. Anderson, 43 N.J. 421, 201 A.2d 537 (1964); In re Clark, 90 Ohio L. Abs. 21, 185 N.E.2d 128 (Lucas County C.P. 1962), by their administrators, State v. Perricone, 37 N.J. 463, 181 A.2d 751 (1962) (sup't of hospital); Collins v. Davis, 44 Misc. 2d 622, 254 N.Y.S.2d 666 (Sup. Ct. 1964) (sup't of county hospital); Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962) (sup't of county hospital), or by another representative of the hospital, United States v. George, 239 F. Supp. 752 (D. Conn. 1965) (United States Attorney on behalf of a Veterans Administration hospital).

21. See State v. Perricone, 37 N.J. 463, 181 A.2d 751 (1962); Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962).

22. See Comment, Unauthorized Rendition of Lifesaving Medical Treatment, 53 Calif. L. Rev. 860, 862-65 (1965).

23. 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964).

having no authoritative force approving or disapproving hospital-sought compelled transfusions in the District of Columbia. Another case of compelled transfusion²⁴ concerned a pregnant woman; it invoked the power of the State of New Jersey on behalf of the incompetent and unborn infant to preserve its life by saving its mother's. Beyond that, while the law declared clearly favored an injunction to transfuse if the medical need arose, the issue was mooted by the mother's leaving the hospital. In two other cases hospitals sought and secured court orders compelling blood transfusions, the transfusions were administered, and the opinions have not been undercut. In one case the patient was in a Veterans Administration hospital, and so the hospital used a United States Attorney to apply for the temporary restraining order under which the patient was transfused;²⁵ in the other case the patient was in a private hospital, which was joined by the plaintiff husband as a nominal defendant.²⁶ In summary, whether a hospital really needs judicial approval for compulsory transfusions or not, four cases say that it can get it.

Even though the discussion here is concerned primarily with legal duties, liabilities, and procedures, it would be unrealistic to overlook the ethical and institutional concerns of the hospital in wanting to administer ordinary lifesaving treatment to all its patients. A hospital is not the patient's servant, subject to his orders. The hospital shares the physician's independence of judgment and responsibility for action, and to let a patient die runs counter to the reason for the hospital's existence.²⁷ Furthermore, Georgetown Hospital is a religious institution, and the Ethical and Religious Directives for Catholic Hospitals²⁸ provide explicitly that "the failure to supply the *ordinary means* of preserving life is equivalent to euthanasia,"²⁹ and "[e]uthanasia [mercy killing] in all its forms is forbidden."³⁰ Hence, to withhold blood transfusions is a moral wrong on the part of the decision-makers in a Catholic hospital, regardless of what the patient wants done. And a non-religious hospital breaches its ethical commitment to lifesaving in letting a patient die when he could

24. *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537 (1964); 33 *Fordham L. Rev.* 80 (1964).

25. *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965).

26. *Powell v. Columbian Presbyterian Medical Center*, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (Sup. Ct. 1965).

27. This argument impressed the District Judge in *United States v. George*, 239 F. Supp. 752, 754 (D. Conn. 1965), but not Circuit Judge Burger in the *Georgetown Hospital Case*, 331 F.2d 1010, 1015-18 (D.C. Cir. 1964).

28. Published by the Catholic Hospital Ass'n of the United States and Canada (2d ed. 1955).

29. *Id.* at 5, Rule 22.

30. *Id.* at 5, Rule 21.

easily be saved. Hospitals simply do not lend their facilities to this kind of behavior, quite apart from whether the criminal law might regard the patient's conduct as suicide.

Whether the hospital's inner compulsion toward lifesaving is ethical or religious in the senses used here, hospitals' announced concern is likely to be legal liability—not because a hospital stands to lose liberty or property in saving a patient's life against his will, as long as it does not bungle the job, but because hospitals usually are not articulate in ethics and religion, and because raising the threat of being sued unifies a constellation of vague laymen's fears about The Law into a widely appreciated specter. Hence the lawyers and the judges get the unwanted job of deciding whether to transfuse or not. As one trial judge commented despairingly, after ordering a transfusion: "How legalistic minded our society has become . . . !"³¹

V. THE STANDING OF THE NEXT OF KIN

A hospital receives little of legal value when either a competent patient or his next of kin signs a paper purporting to relieve the hospital of liability for not administering refused treatment.³² The patient himself, in waiving liability of the hospital and its attending physicians by signing a paper so stating, cannot "release" a claim, such as an action for negligence, because such a release-in-advance would be unenforceable,³³ and because no claim has yet arisen. The waiver is not "consent" to treatment, either. Quite the contrary, it evidences lack of consent to the treatment proposed. As a non-consent, then, waiver must operate legally very much like an express assumption of risk, and it would presumably be regarded judicially much like a contract not to sue in consideration of the promise not to transfuse.

If the patient waives his anticipated lawsuit in return for an unencumbered conscience, what is the function of having the next of kin sign also? The next of kin, whether spouse, parent, child or some more remote relative, is not ipso facto the patient's legal guardian.³⁴ This rule of law

31. Markowitz, J., in *Powell v. Columbian Presbyterian Medical Center*, 49 Misc. 2d 215, 216, 267 N.Y.S.2d 450, 452 (Sup. Ct. 1965). See also his extended remarks on the same subject, though declining to order an amputation, in *In re Nemser*, 51 Misc. 2d 616, 620-25, 273 N.Y.S.2d 624, 628-32 (Sup. Ct. 1966).

32. Such papers were mentioned in the *Georgetown Hospital Case*, 331 F.2d 1010, 1015-16 (D.C. Cir.), rehearing denied, 331 F.2d 1010 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964) ("waiver" proposed by patient and husband but not signed); *United States v. George*, 239 F. Supp. 752, 753 (D. Conn. 1965) ("release" signed); *In re Estate of Brooks*, 32 Ill. 2d 361, 362, 205 N.E.2d 435, 437 (1965) ("release" signed).

33. See *Tunkl v. Regents of the Univ. of Calif.*, 32 Cal. Rptr. 33, 383 P.2d 441 (1963).

34. When time permits, the usual procedure is for the next of kin to ask the court to appoint a guardian ad litem, as was done in *People ex rel. Wallace v. Labrenz*, 411 Ill. 618, 104 N.E.2d 769 (1952) (infant); *State v. Perricone*, 37 N.J. 463, 181 A.2d 751 (1962)

impairs the capacity of the next of kin to do acts which legally bind the presumably competent patient, and even a legal guardian cannot automatically elect medical treatment in the best interest of the ward patient over the patient's previously competent and express refusal to treatment. Apparently the signing of the waiver by the next of kin has only evidentiary value in case of a lawsuit based upon non-waiver by the patient. The signed form³⁵ enables the hospital first to argue that the patient's refusal of treatment was competent, but second, if that fails, the hospital can argue that the next of kin knew the patient's wish for non-treatment while he was competent. In either defense the next of kin would be witnesses to what was on the patient's mind, and the hospital hopes that the next of kin would neither sign a waiver lightly nor repudiate it easily.

Oftentimes the next of kin do not want lifesaving treatment if the patient refuses it. Husbands and wives often share the same views, and neither the husband in the *Georgetown Hospital* case³⁶ nor the wives in *United States v. George*³⁷ and *Collins v. Davis*³⁸ would authorize lifesaving treatment as next of kin. And so in all three cases the treatment—transfusion in the first two, surgery in the third—was administered under court orders obtained by hospitals; the courts evidently prefer lifesaving intervention by hospitals to the life-risking wishes of patients and their next of kin. But husbands and wives also disagree sometimes, and in one case the husband sued his wife and her hospital in order to force a blood transfusion; the judge obliged the husband.³⁹ One wonders what shred of legal value attaches to waivers when the next of kin disagree among themselves. Such an intra-familial quarrel, as much as doubts of the wisdom of surgery, apparently moved a New York trial judge to throw a dispute among three sons over amputating their mother's ankle out of his court—and back to the hospital, of course.⁴⁰

(infant); In re Nemser, 51 Misc. 2d 616, 273 N.Y.S.2d 624 (Sup. Ct. 1966) (80-year-old in diabetic confusion). See 43 N.C.L. Rev. 450, 453-55 (1965).

35. The American Medical Association's booklet, *Medicolegal Forms* (1961), suggests this text: "Refusal to Permit Blood Transfusion": "I (We) request that no blood or blood derivatives be administered to [name] during this hospitalization, notwithstanding that such treatment may be deemed necessary in the opinion of the attending physician or his assistants to preserve life or promote recovery. I (We) release the attending physician, his assistants, the hospital and its personnel from any responsibility whatever for any untoward results due to my (our) refusal to permit the use of blood or its derivatives." *Id.* at Form 36.

36. 331 F.2d 1000, 1006-07 (D.C. Cir.), rehearing denied, 331 F.2d 1010 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964).

37. 239 F. Supp. 752, 753 (D. Conn. 1965).

38. 44 Misc. 2d 622, 254 N.Y.S.2d 666 (Sup. Ct. 1964).

39. *Powell v. Columbian Presbyterian Medical Center*, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (Sup. Ct. 1965).

40. In re Nemser, 51 Misc. 2d 616, 273 N.Y.S.2d 624 (Sup. Ct. 1966). See also *United*

VI. THE STANDING OF THE STATE

Does the State—a city, county, or state government, or the United States in some circumstances—presently have such an interest in preserving the lives of its citizens as to stop their dying prematurely? The State's intervention as *parens patriae* of incompetents still lies outside the discussion.⁴¹ Here the question is whether, as in *In re Estate of Brooks*,⁴² State power operating through a public or an *ad hoc* guardian should be invoked in order to transfuse the competent patient against his will; Illinois stands thus far alone in saying No.

Ultimately the question of State power is one of professional judgment in the exercise of political authority. Just as a lawyer knows how to tie up a testator's property for about a hundred years but often decides not to do so, and a surgeon knows how to improve the function of an arthritic hip joint but thinks on balance that the patient will get along as well without surgery, the State probably has the parental power to compel the ordinary means of lifesaving medical treatment to be administered, but the State may be better advised not to use the power, at least for the time being. Labor is not in such short supply, the problem is not of such common occurrence, and the American citizen's duty is not so singly to serve his State, that individual decisions to decline lifesaving medical treatment need to be overruled. It is possible if strained⁴³ to frame this attitude in terms of the patient's free exercise of religion, but free exercise is usually understood to permit thought and expression rather than antisocial actions. One doubts that free exercise is constitutionally protected as being more in the mind than in the musculature when the consequence of belief in declining blood transfusion is as surely death as the prohibited action of slashing an artery. And even if free exercise is a satisfactory ground, it is too narrow to allow non-religious persons who simply hate medicines and hospitals to fend off the State, though it works as an explanation for all the cases raised to date.⁴⁴

States v. George, 239 F. Supp. 752, 753 (D. Conn. 1965), where the husband-patient and his wife, both Jehovah's Witnesses, refused transfusion, but the husband's mother, who was not a Witness, favored transfusion.

41. See the cases cited in Judge Wright's opinion in the Georgetown Hospital Case, 331 F.2d 1000, 1007 (D.C. Cir.), rehearing denied, 331 F.2d 1010 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964). As to infants, see *In re Clark*, 90 Ohio L. Abs. 21, 185 N.E.2d 128 (Lucas County C.P. 1962). See also 14 Syracuse L. Rev. 84 (1962); 10 Villanova L. Rev. 140 (1964).

42. 32 Ill. 2d 361, 205 N.E.2d 435 (1965).

43. *Id.* at 370-73, 205 N.E.2d at 440-42; see the exhaustive Note, 42 Indiana L.J. 386 (1967).

44. See 77 Harv. L. Rev. 1539, 1545 (1964).

VII. CONCLUSION

It is doubly a pity that the courts have become involved in the deciding of compelled lifesaving medical treatment, firstly because quick decisions on hard questions are not delivered very adeptly by the judicial process, and secondly because the quasi-intervenors, whoever they are, ask the courts for legal relief which they cannot really have—the immunity from being sued.

Here the last of the commonplace reasons for courts to decline cases for non-justiciability comes into operation, the unenforceability of whatever relief the court adjudges to the plaintiff. When a Jehovah's Witness declares that it is no sin for him meekly to accept a blood transfusion ordered by a court of competent jurisdiction,⁴⁵ it is not for any court to declare that the Witness is immune from the damnation he feared before the order was made. When a hospital transfuses a patient under a court order, how much more than an advisory opinion can the order ever be? If the patient sues for battery, does the clerk of court refuse to accept the complaint? Of course not; the hospital and its staff have no immunity to suit, even though the judge may summarily find for defendants as soon as they produce the court order to transfuse. And if the court-ordered procedure is bungled or if some unordered and unconsented-to procedure is employed, what then of the order? It is revealed as a declaratory judgment of scope limited to matters not in suit, offering the defendant hospital and staff no defense, let alone immunity to suit.

This is not as bad as it may sound to the hospital and staff. Administrators and physicians will simply have to live without the hope of legal immunity; they can go on getting intelligent consent to treatment from the great majority of patients, listening to refusals of treatment from a very few, making up their minds to treat or not to treat as a technical-ethical question, letting the lawyers worry about the legal consequences of their actions after they act.

The quarrel of Jehovah's Witnesses seems to be with the courts as representatives of government power, not with the hospitals as payers of damage judgments. While the medical emergencies producing court-ordered transfusions have been genuine, the legal proceedings have been test cases having for their ultimate destination the Supreme Court of the United States. The Supreme Court, however, has thus far declined to review any such case,⁴⁶ and no damage suit for negligence or battery has been brought by a transfused Jehovah's Witness, probably because of the

45. See *United States v. George*, 239 F. Supp. 752, 753 (D. Conn. 1965).

46. Certiorari has been denied in *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 377 U.S. 985 (1964); *Georgetown Hospital Case*, 377 U.S. 978 (1964); *State v. Perricone*, 371 U.S. 890 (1962); *People ex rel. Wallace v. Labrenz*, 344 U.S. 824 (1952).

difficulty of framing the desired constitutional issues by that means.⁴⁷ This difficulty should continue to protect hospitals from suit.

Assuming, however, that an ex-patient can find a basis for asserting hospital liability, the damages potentially recoverable for non-transfusion are much greater than for transfusion done with the requisite care. It is hard to visualize a jury awarding more than nominal damages for battery⁴⁸ to a live Jehovah's Witness, but not at all difficult to imagine a wrongful death award for negligently failing to employ the usual means of lifesaving care if a hospital guessed wrong about competency to refuse treatment. As for criminal sanctions, such as assault and battery for transfusing without consent, these seem unlikely to attract the notice of prosecuting attorneys, let alone juries, though they are theoretically possible; and most hospital staff members would probably prefer this trifling risk to that of refusing transfusion and thereby becoming accessory to suicide,⁴⁹ whether that is a crime or not.⁵⁰

The social institutions which provide hospitals—medicine, religion and government—all protect the physician and hospital from legal harm in saving useful lives easily within the reach of medical technology. Hospital medical staffs and administrators should realize this and take courage to act accordingly in favor of life; and persons who from religious beliefs or dislike of hospitals seek to tie the lifesavers' hands should stay out of hospitals when their time has come. But there is no immunity from the test cases that Jehovah's Witnesses will go on raising, cases in which the patients, the hospitals and the courts are the victims, and only the law reviews find earthly reward.

47. See the speculation in 77 Harv. L. Rev. 1539, 1541 n.7 (1964).

48. In a battery action the justification of emergency would be a defense for the hospital, though it does not seem to have been employed in these circumstances. See 45 B.U.L. Rev. 125, 127 n.13 (1965).

49. There is much doubt that a declaratory judgment could impede criminal prosecution in any case. See 77 Harv. L. Rev. 1539, 1543 (1964).

50. See 33 Fordham L. Rev. 513 (1965).