Editorial

The *Spring* Case and the Importance of Interdisciplinary Dialogue

by Ronald E. Cranford, M.D.

After reviewing the article by Attorneys Dunn and Ator in this issue of MEDICOLEGAL NEWS, I have a few comments for consideration. It seems clear that the authors are advocating a stronger role for the courts in these decisions — if not in the routine judicial review of these cases, then at least in the formulation of legally binding guidelines. Given that state legislatures have been hesitant to consider these controversial matters and will probably continue to be hesitant in the near future, and that the medical profession has also been reluctant to address these questions meaningfully, the authors' views are certainly defensible and may be one of the most acceptable ways to move in our imperfect society. Hopefully, court decisions such as *Saikewicz*,[1] *Spring*,[2] and *Eichner*,[3] *amicus curiae* briefs like those filed by the Illinois Association of Hospital Attorneys and the American Society of Law & Medicine in the *Spring* case, and aggressive views such as those expressed by these authors, will provoke the medical profession and the legislatures into action, if only to counter the views currently being expressed by the courts in these landmark decisions.

This article has all the more convinced me that we need to establish some mechanism for dealing with these problems in an interdisciplinary way. For example, courts need guidance and advice from physicians regarding the mental condition of patients like Earle Spring and their degree of competency. It is not at all unusual for demented patients to have moments of apparent lucidity and yet to be quite demented and clearly incompetent (both medically and legally) the vast majority of the time. It is, frequently, extraordinarily difficult to know exactly what the patient wants and how much he is truly aware of his condition.

Terms such as "competency," "mental impairment," and "senility" need to be clarified so that the courts and others can reach meaningful decisions on the appropriate course of treatment in these cases. For example, not only is Karen Ann Quinlan not brain dead, she is not even in a coma, if we use the correct medical meaning of that term. Coma has been characterized "operationally as sleeplike, unarousable unresponsiveness, without evidence of psychological awareness of self or environment."[4] Actually, Ms. Quinlan is demented, just like Earle Spring; the only difference is one of degree, not type.

As I understand Mr. Spring's condition, he was severely demented; that is, there was a severe (but not total) impairment of cognitive functioning. Ms. Quinlan, in contrast, is "completely" or "totally" demented; there is *no* cognitive functioning whatsoever. *Quinlan*-type cases are "easier" than *Spring*-type situations because there is never any question that such patients are incompetent and unable to express their wishes. If we attempt to decide as they would have decided — the substituted judgment test rightly criticized by Mr. Dunn and Ms. Ator — we must rely upon previously expressed wishes or those of parents or a guardian *ad litem*. With people like Mr. Spring, however, the question is more confused: Should we rely upon statements made during "moments of lucidity," no matter what the ward says, as indicative of what the ward truly wants? If "senility" is used to mean any change — mental or physical — that occurs in the elderly, then this term cannot be equated with mental incompetency. But senility is often used more specifically to refer to the impairment of mental functioning which often arises in the elderly, an extraordinarily common problem and one which will become more frequent as longevity increases in the general population. In medical terms, however, *senile dementia* is only one, albeit the most common, cause of the impairment of mental functioning in the elderly. Physicians and lawyers need to understand each others' language if they are to interact meaningfully on these issues; the uncritical use of the term "senility" is just one example of this problem of poor communication.

The authors' views on the determination of competency seem to require an elaborate procedure that will only serve to prolong these decisions. We already have numerous examples of how "fast" the courts have moved in these cases, but I'm sure that Mr. Dunn and Ms. Ator feel that this is necessary to protect the rights of the presumed incompetent.

Their comments on existing criminal law and the irrelevancy of motive to criminal liability illustrate the antiquity of the criminal statutes and reinforce the fear of physicians regarding potential criminal liability (admittedly negligible when carefully analyzed). Sooner or later, the criminal statutes will have to be revised and updated, or other legislation will have to be enacted to cope with these dilemmas.

Although I do not always agree with Mr. Dunn's views on these issues (the role of the family, for example), he and Ms. Ator are performing a valuable service to society with contributions like this article. Unlike so many others, they are willing to take positions and propose solutions, and they are to be commended for that.

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References

1. *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977).

2. In re *Spring*, 405 N.E.2d 115 (Mass. 1980).

3. *Eichner v. Dillon*, 426 N.Y.S.2d 517 (Sup. Ct., App. Div., 1980).

4. Bates, D., *et al.*, *A Prospective Study of Nontraumatic Coma: Methods and Results in 310 Patients*, ANNALS OF NEUROLOGY 2(3):211-20 (September 1977) at 211. *See also* Cranford, R.E., Smith, H.L., *Some Critical Distinctions Between Brain Death and the Persistent Vegetative State*, ETHICS IN SCIENCE & MEDICINE 6:199-209 (1979).