

# Life and Death Choices after *Cruzan*: Case Law and Standards of Professional Conduct

LARRY GOSTIN and ROBERT F. WEIR

*American Society of Law & Medicine;*  
*University of Iowa College of Medicine*

**H**EALTH-CARE PROFESSIONALS OFTEN FEEL IMPELLED to initiate the complete range of modern medical procedures to sustain the lives of patients. A tragic consequence is that patients who lack decision-making capacity are sometimes given invasive treatment that is not consistent with their previous preferences, not wanted by their families, and not necessarily in their best interests.

The presumption favoring treatment is fueled by the perception of a technological imperative to preserve life, the practice of defensive medicine because of a perceived threat of civil, even criminal, liability for abating treatment, and a lack of clarity about who can make a proxy decision for nonautonomous patients and what standard of evidence is required for substitute judgments. The Supreme Court's decision in the case of Nancy Cruzan may encourage some health-care professionals to be less cooperative than they already are in abating treatment with nonautonomous patients, even when the treatment is contrary to a patient's best interests.

Our objective is to examine the law, ethics, and professional standards that survive *Cruzan*.<sup>1</sup> We will demonstrate that when health-care professionals abate treatment that is contrary to the patient's known

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<sup>1</sup> *Cruzan v. Director, Missouri Department of Health*, 110 S.Ct. 2841 (1990).

preferences or current best interests, they are acting both lawfully and in accordance with the highest ethical and professional standards.

We first explain and analyze the Supreme Court's decision in *Cruzan*. The ruling makes a review of state jurisprudence all the more important because the Supreme Court explicitly delegated to the "laboratory of the states" the determination whether to respect the rights of nonautonomous patients to die with dignity. We identify six areas addressed by existing case law. State courts have upheld the rights of autonomous patients to make their own treatment decisions; clarified the legal right to treatment refusal by patients lacking decision-making capacity; articulated the role and power of surrogate decision makers; discussed the medical conditions required before treatment may be abated, and the procedures whereby such medical determinations are to be made; considered and rejected possible distinctions between withholding and withdrawing care and between the types of treatment that may be refused; and weighed individual rights of self-determination against legitimate state interests.

We end with an analysis of policy options open to state legislatures and courts following *Cruzan*. We conclude that states should understand the reality of how patients express their views in uncomplicated statements to loved ones, how most patients have no desire to have their corporeal existence technologically maintained when they can no longer meaningfully interact with their environment, and how most patients want these decisions to be made by close family members or trusted friends rather than by the state.

## The Cruzan Case

At the time of the Supreme Court decision, Nancy Cruzan was in a persistent vegetative state (PVS), a condition in which a person exhibits motor reflexes, but evinces no indications of significant cognitive function (American Medical Association 1990). Nancy Cruzan's biological existence was being sustained by the provision of technological feeding and hydration. Hospital employees refused, without court approval, to honor her parents' request to withdraw artificial nutrition and hydration. Although Nancy Cruzan had confided in her close friends that she would not want to live should she face life as a "vegetable," the

Missouri Supreme Court held that the family could not assume the choice to abate treatment for an incompetent person in the absence of “clear and convincing” evidence of her wishes. The U.S. Supreme Court upheld Missouri’s decision to adopt a clear and convincing evidence standard. Subsequently, the Missouri courts found that, in fact, there was clear and convincing evidence of Nancy’s desire to be allowed to die. Technological nutrition and hydration were removed, and Nancy Cruzan died peacefully some ten days later.

*Cruzan* has been viewed as a ringing affirmation of the human right to self-determination for competent patients (*New York Times* 1990). The Supreme Court assumed, without expressly deciding, that autonomous patients have a constitutionally protected “liberty interest” in refusing unwanted medical treatment. The Court, however, provides uncertain protection for the rights of autonomous patients and virtually removes any constitutional protection once a person is declared incompetent.

The “liberty interest” to refuse treatment afforded to autonomous patients is of uncertain value in Supreme Court discourse. The Supreme Court did not adopt a heightened standard of constitutional review, known as “strict scrutiny.” Thus, the majority was careful not to suggest that competent patients have a fundamental right to refuse treatment. In constitutional parlance, a fundamental right will be protected unless the state interest is compelling.<sup>2</sup> A liberty interest, on the other hand, can be outweighed by state concerns, which sometimes appear weak or even abstract.

Human beings have a liberty interest in doing most things. The Supreme Court has liberally recognized liberty interests in many medically related areas. Yet, as the majority in *Cruzan* concedes, determining that a person has a liberty interest does not end the inquiry; whether a person’s constitutional rights have been violated is determined by balancing those liberty interests against relevant state interests.<sup>3</sup> The fact is that the modern Court often gives very little weight to a person’s right to liberty and will disregard it if the state can demonstrate any rational basis for its policy. This comes perilously close to the Court’s lowest standard of constitutional review—its “rational basis” test, which

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<sup>2</sup>E.g., *Skinner v. Oklahoma ex rel, Williamson*, 316 U.S. 535 (1942).

<sup>3</sup>*Youngberg v. Romeo*, 457 U.S. 307, 321 (1982); *Mills v. Rodgers*, 457 U.S. 291 (1982).

usually signals the Court's intention to favor the state's interests over those of the individual. Indeed, in many of the Supreme Court cases declaring a "liberty interest," the person deprived of liberty actually lost. Thus, the state appears to have a rational basis for depriving a person of a whole host of liberty interests: refusal of life-sustaining treatment ("preservation of life");<sup>4</sup> drug tests without probable cause ("national security"<sup>5</sup> or a "regulated industry");<sup>6</sup> antipsychotic medication (preventing the "danger" posed by mentally ill persons);<sup>7</sup> vaccines (promotion of the "public health");<sup>8</sup> or confinement in a mental hospital (need for "treatment").<sup>9</sup>

The *Cruzan* decision almost abandons any federal constitutional protection for incompetent patients. The Court held that a state is entitled, but not required, to insist that relatives prove by "clear and convincing" evidence that the patient, if competent, would have refused to be treated. The Court reasoned that the requirement of a clear and convincing standard of proof effectuated the state interests in preserving life and personal choice, preventing abuse by the surrogate, and ensuring accurate fact finding and reducing the risk of error.

The state interests used by the Court to justify denial of Nancy Cruzan's right to decline artificial feeding are hardly persuasive. The state interest in preserving the life of a person in PVS is purely theoretical. The state's authority to preserve "life" has become a magical concept, often driven by blind ideology rather than by any thoughtful appreciation of the unique characteristics of human life. When an individual has no meaningful interaction with her environment, no recognition of familiar persons or objects, nor any human feelings or experience of any kind, the state's interest in life is a mere abstraction.

To assert an interest in the outcome of a decision to abate life-sustaining treatment requires some demonstrable burden. All of the burden is borne by the family who suffers from the refusal of the law to allow a decision to dignify a natural death process. Whether the burden of continued life is measured by emotional suffering, by economic cost,<sup>10</sup> or by any other standard, it is not society, the medical

<sup>4</sup> *Cruzan v. Director, Missouri Department of Health*, op. cit.

<sup>5</sup> *National Treasury Employer Union v. Von Raab*, 109 S.Ct. 1384 (1989).

<sup>6</sup> *Skinner v. Railway Labor Executives Association*, 109 S.Ct. 1402 (1989).

<sup>7</sup> *Washington v. Harper*, 110 S.Ct. 1028 (1990).

<sup>8</sup> *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).

<sup>9</sup> *Parham v. J.R.*, 442 U.S. 584 (1979).

profession, or the state that has to pay the cost. The family must live with the consequences.

The right of a person in PVS to be allowed to die is now well grounded in biomedical ethics. What greater purpose could a moral right to liberty—or a constitutional right to privacy—achieve than to reject unwarranted state intrusion into such an intimate moment as death? The essence of the right to liberty (or privacy) is that the decision is deeply personal and critically important in the ordering of a patient's life. It is a decision that uniquely involves the individual, and where the outcome matters little to third parties—no one else is harmed by the decision, affected by it, or is properly interested. A family's decision to abate treatment of a loved one in PVS is supremely a private decision.

No one doubts the validity of the state interests in preventing abuse by a surrogate, and ensuring accurate fact finding. But these interests are not reasonably achieved by requiring clear and convincing evidence of the incompetent patient's prior wishes. Some review process, perhaps by a hospital ethics committee, to ensure a reliable prognosis of PVS and that the family is properly motivated may be appropriate. The state can reasonably ensure that surrogates do not abuse their authority, not by removing their power of substitute judgment as occurred in *Cruzan*, but by ensuring that they are not unduly motivated by economic or other personal benefit.

Nor does a clear and convincing standard best ensure accurate fact finding. Justice Brennan's dissent in *Cruzan* explains the markedly asymmetrical evidentiary burden of the Missouri rule. All of the burden rests on the incompetent patient and her family to prove unequivocally that she would not want to be treated. The proxy must adduce specific statements by the patient that foresaw the precise technological shackles she now endures. The state, on the other hand, need not submit any proof to support a finding that the patient would want to continue treatment.

The Supreme Court has removed an entire class of people from the protection of the federal Constitution. The Court accepted a high evi-

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<sup>10</sup> The Supreme Court, however, was careful to observe that in Nancy Cruzan's case the state was paying for the costs of her continued treatment. The Court did not indicate that it would have altered its decisions if the family were bearing the financial burden.

dentiary standard that only a few previously foresighted nonautonomous patients will be able to meet. The *Cruzan* opinion does not constitutionally protect the never-autonomous (e.g., the severely mentally retarded and young children who cannot express any view); the once-autonomous who failed to express a view about their future treatment; and the once-autonomous who expressed views insufficiently exact to meet the rigorous clear and convincing evidence standard.

The Supreme Court held it to be permissible to adopt a standard of proof that is so exacting as to burden unconscionably the right of an incompetent patient to avoid unwanted medical technology. But it is critical to understand that Missouri and New York<sup>10a</sup> are the only states to have adopted a clear and convincing standard specifically for feeding tubes. (Maine and Illinois have also applied this standard, in a more general way, to a patient's expressed refusal of life-sustaining treatment.) *Cruzan* does not change the law outside of these four states. State supreme courts resoundingly uphold the legality of abating life-sustaining treatment when the treatment is contrary to the earlier preferences or current best interests of patients. *Cruzan* will not have a direct impact on the statutory law in the 42 jurisdictions that have enacted natural-death acts; and it will not alter the case law in the 29 jurisdictions that have addressed the legal right of autonomous and nonautonomous patients to refuse medical treatment.

We will now examine what this body of case law says about ethical standards and legal liability. We then examine the future impact of *Cruzan* on the law, policy, and ethics of making life-and-death choices.

## Rights of Autonomous and Nonautonomous Patients to Have Treatment Abated

### 1. *Autonomous Refusals to Be Treated*

The judicial philosophy favoring the abatement of treatment has been amply demonstrated. The principle that every autonomous individual has a right to determine what will be done to his or her body, which courts have continually affirmed, has two distinct legal bases. The first,

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<sup>10a</sup>The New York Health Care Agents and Proxy Law of 1990 overturns the state judicial determination requiring clear and convincing evidence by allowing appointed proxies to make substitute decisions.

recognized in virtually all jurisdictions to consider the issue, is the common-law right of informed refusal, a corollary to the right of informed consent.<sup>11</sup> The second basis is the constitutional right of privacy or self-determination.

The vast majority of courts have interpreted the U.S. and state constitutions as conferring a privacy right to refuse medical treatment.<sup>12</sup> The modern Supreme Court, however, is reluctant to expand the privacy doctrine beyond reproductive decision making.<sup>13</sup> The *Cruzan* decision preferred liberty over privacy rights not merely because of the conservative ideology that constitutional rights should be limited to those stated in the text of the constitution and that the federal courts should, wherever possible, defer to the states.<sup>14</sup> The privacy doctrine has also been closely associated with strict-scrutiny analysis, and the Court did not want to confer a fundamental right to refuse treatment.

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<sup>11</sup> *Cruzan v. Director, Missouri Department of Health*, op. cit.; *in re Jane Doe*, 16 Phila. 229 (Pa. Ct. Com. Pl. 1987); *John F. Kennedy Memorial Hospital, Inc. v. Bludworth*, 452 So.2d 921 (Fla. Sup. Ct. 1984); *Rasmussen v. Flemming*, 154 Ariz. 207, 741 P.2d 674 (1987); *in re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied sub. nom.; *Garger v. New Jersey*, 429 U.S. 922 (1976); *in re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *in re Eichner (in re Storar)*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981); *in re Colyer*, 99 Wash.2d 114, 660 P.2d 738 (1983); *Tune v. Walter Reed Army Medical Hospital*, 602 F.Supp. 1452 (D.D.C. 1985); *in re Gardner*, 534 A.2d 947 (Me. 1986); *McConnell v. Beverly Enterprises*, 209 Conn. 692 (1989); *in re Culham*, No.87-340537-AZ (Mich.Cir.Ct. Oakland County Dec. 15, 1987) (Breck, J.), in *Right-to-Die Court Decisions*, Society for the Right to Die, Inc., 1988, v.2:MI-1; *in re Rodas*, No.86PR139 (Colo.Dist.Ct. Mesa County Jan. 22, 1987, as modified, April 3, 1987) (Buss, J.), in *Right-to-Die Court Decisions*, Society for the Right to Die, 1988, v.2:CO-1; *in re Torres*, 357 N.W.2d 332 (Minn. 1984); *in re Severns*, 425 A.2d 156 (Del.Ch. 1980).

<sup>12</sup> *In re Jane Doe*, op. cit.; *John F. Kennedy Memorial Hospital, Inc. v. Bludworth*, op. cit.; *in re Guardianship of Grant*, 109 Wash 2d 545, 747 P.2d 445 (1987), modified 757 P.2d 534 (Wash. July 15, 1988); *Rasmussen v. Flemming*, op. cit.; *Brophy v. New England Sinai Hospital, Inc.*, 398 Mass. 417, 497 N.E. 2d 626 (1986); *in re Conroy*, op. cit.; *McConnell v. Beverly Enterprises*, op. cit.; *in re Culham*, op. cit.; *Gray v. Romeo*, 697 F.Supp. 580 (D.R.I. 1988); *in re Bayer*, No. 4131 (N.D. Burleigh County Ct. Feb. 5 and Dec. 11, 1987) (Riskedahl, J.), in *Right-to-Die Court Decisions*, Society for the Right to Die, Inc., 1988, v.2:ND-1.

<sup>13</sup> *Bowers v. Hardwick*, 106 S.Ct. 2841 (1986).

<sup>14</sup> *Webster v. Reproductive Health Services*, 1989 WL 70950 (U.S. July 3, 1989) (No.88-605).

*Cruzan* preserves the differences between individual state jurisdictions rather than creating a uniform national policy. Privacy rights conferred by individual state constitutions<sup>15</sup> should be unaffected.

The right to refuse life support has been recognized in competent patients with terminal illnesses, for example, in a series of cases involving patients in the final stages of amyotrophic lateral sclerosis,<sup>16</sup> or with fatal malignancies of the brain,<sup>17</sup> lungs,<sup>18</sup> or pericardium.<sup>19</sup> The common-law right to discontinue treatment also extends to patients who are not terminally ill, but are making intentional decisions to end a life that has no personal meaning. The court in *Bouvia* held that the patient's decision to forgo medical treatment "is a moral and philosophical decision that, being a competent adult, is hers alone."<sup>20</sup>

## 2. Determining Competency and Respecting the Rights of Incompetent Patients

The primary difficulty for the medical profession and the courts does not concern the treatment decisions of autonomous (or competent) patients. Rather, the difficulty arises in determining the appropriate course when a critically ill patient has never been autonomous or has not expressed an ascertainable view about treatment while autonomous. Still, the right to refuse medical intervention has been extended by

<sup>15</sup> *In re Jane Doe*, op. cit.; *Rasmussen v. Flemming*, op. cit.; *Brophy v. New England Sinai Hospital*, op. cit.; *in re Conroy*, op. cit.; *in re Guardianship of Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *McConnell v. Beverly Enterprises*, op. cit.; *in re Culham*, op. cit.; *in re Bayer*, op. cit.

<sup>16</sup> *In re Jane Doe*, op. cit.; *in re Culham*, op. cit.; *Satz v. Perlmutter*, 362 So.2d 160 (Fla.Ct.App. 1978), aff'd, 379 So.2d 359 (Fla. 1980); *in re Farrell*, 108 N.J. 335, A.2d 404 (1987).

<sup>17</sup> *Hazelton [sic] v. Powhatan Nursing Home, Inc.*, No.CH-98287 (Va.Cir.Ct. Fairfax County Aug. 29, 1986), order signed (Sept. 2, 1986), (Fortkort, J.), appeal denied, Record No. 860814 (Va. Sept. 2, 1986), 6 Va.Cir.Ct. Op. 414 (Aspen 1987).

<sup>18</sup> *Bartling v. Superior Court*, 163 Cal. App.3d 1127, 209 Cal. Rptr. 220 (Ct.App.1984).

<sup>19</sup> *Tune v. Walter Reed Army Medical Hospital*, op. cit.

<sup>20</sup> *Bouvia v. Superior Court (Glenchur)*, 179 Cal.App.3d 1127, 225 Cal. Rptr. 297 (Ct.App. 1986), review denied (Cal. July 28, 1988), cert. denied, 109 S.Ct. 399 (1988). See also *Georgia v. McAfee*, 385 S.E.2d 651 (Ga. Sup.Ct. Nov. 21, 1989).



virtually every court from autonomous individuals to those who have become nonautonomous<sup>21</sup> and to those who have always been nonautonomous.<sup>22</sup> Simply because a person has lost his or her autonomy does not mean he or she loses his or her individual rights, too.

The threshold question in these cases is how to determine if a patient is capable of making the decision to refuse or abate life-sustaining treatment. The lack of such decision-making capacity "is not a medical or psychiatric diagnostic category," but occurs instead when "a patient lacks sufficient ability to understand a situation and to make a choice in the light of that understanding."<sup>23</sup> The President's Commission (1983) stated that decision-making capacity "is not a medical or psychiatric category; it rests on a judgment . . . that a patient lacks sufficient ability to understand a situation and to make a choice in the light of that understanding." The patient's decision is to be respected "even though that decision in all likelihood will lead shortly to her death."<sup>24</sup>

### 3. Identifying the Surrogate

The courts, therefore, respect the rights to self-determination and privacy of nonautonomous patients as well as patients retaining decision-making capacity. But if a nonautonomous patient has no voice, who will articulate his or her interests? The courts have traditionally allowed a surrogate to stand in the place of such a patient. Courts have affirmed the indispensable role of the patient's surrogate because non-

<sup>21</sup> *John F. Kennedy Memorial Hospital, Inc. v. Bludworth*, op. cit.; *Rasmussen v. Flemming*, op. cit.; *Brophy v. New England Sinai Hospital, Inc.*, op. cit.; *in re Quinlan*, op. cit.; *in re Eichner (in re Storar)*, op. cit.; *in re Colyer*, op. cit.; *McConnell v. Beverly Enterprises*, op. cit.; *in re Torres*, op. cit.; *in re Severns*, op. cit.; *Gray v. Romeo*, op. cit.; *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 22 Ohio Ops.3d 49, 426 N.E.2d 809 (Com.Pl. 1980); *in re Conservatorship of Drabick*, 200 Cal. App.3d 185, 245 Cal. Rptr. 840 (Cal.Ct.App. 1988), review denied (Cal. July 28, 1988), cert. denied, 109 S.Ct. 399 (1988); *in re Guardianship of Browning*, 568 So.2d 4 (Fla. Sup. Ct. 1990).

<sup>22</sup> *In re Guardianship of Grant*, op. cit.; *Superintendent of Belchertown State School v. Saikewicz*, op. cit.; *in re Eichner (in re Storar)*, op. cit.

<sup>23</sup> *In re Application of Brooks (Leguerrier)* (N.Y.Sup.Ct. Albany County June 10, 1987) (Conway, J.), in *Right-to-Die Court Decisions*, Society for the Right to Die, Inc., 1988, v.2:NY-4.

<sup>24</sup> *Lane v. Candura*, 6 Mass. App. Ct. 377, 376 N.E. 2d 1232 (1978).

autonomous patients cannot exercise the right personally to choose their medical treatment.

Without a surrogate, a nonautonomous patient's right to accept or refuse medical treatment becomes meaningless. With a surrogate, a nonautonomous patient may exercise the right to choose between alternative treatments,<sup>25</sup> refuse a specific type of treatment,<sup>26</sup> or refuse several forms of life-sustaining treatment.<sup>27</sup> Even when the choice of the patient's spouse, adult child, parents, other family members, a guardian ad litem, or the court is not the patient's own choice, "it is a genuine choice nevertheless—one designed to further the same interests she might pursue had she the ability to decide herself."<sup>28</sup>

Physicians, nurses, and hospital administrators involved in managing cases of nonautonomous patients are often unsure regarding the selection of a surrogate. Some physicians make decisions to continue or abate life-sustaining treatment unilaterally. This alternative is problematic (except in emergency situations) in that it both deprives the patient of his or her right of refusal, and exposes the physician to potential civil liability for acting without proper consent.<sup>29</sup> The job of the surrogate is to consider the medical-treatment choices in the light of the patient's value system (if that is ascertainable), and to ensure that the treatment recommendation is viewed as an option, and not simply implemented as a physician's order

Some courts have developed a serial or lexical ordering of decision makers. The *Rasmussen* court upheld the right of a guardian to withhold treatment for an incompetent nursing-home patient in a chronic vegetative state. The court put forth a priority list of authorized decision makers: a person designated by the patient in writing; the patient's spouse; an adult child or the majority of the adult children; the patient's parents; the nearest living relative; or a judicially appointed guardian (if necessary).<sup>30</sup>

In the following sections we review the state of the law on surrogate decision making. Thereafter, we support the case for a presumption in

<sup>25</sup> *In re Guardianship of Ingram*, 689 P.2d 1363 (Wash. 1984).

<sup>26</sup> *Brophy v. New England Sinai Hospital, Inc.*, op. cit.; *in re Quinlan*, op. cit.

<sup>27</sup> *In re Guardianship of Hamlin*, op. cit.; *in re Severns*, op. cit.

<sup>28</sup> *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987).

<sup>29</sup> *Leach v. Akron General Medical Center*, op. cit.

<sup>30</sup> *Rasmussen v. Flemming*, op. cit.

favor of families unless the patient has personally selected a proxy in writing, or unless a close personal friend of the patient is in a better position to make a responsible decision consistent with the patient's previous values or current best interests.

*Advance Directives Appointing a Surrogate.* Some patients have personally selected a relative or close friend as a proxy for medical decision-making purposes prior to becoming nonautonomous. Planning for the possibility of being unable to make treatment decisions themselves, they appointed one or more persons in writing to make future decisions on their behalf. Two different forms of advance directives are available, which reflect the person's value system and life situation.

The first form of advance directive available to the residents of most jurisdictions is a statutory advance directive. Beginning with California in 1976, at least 41 states and the District of Columbia now have natural-death acts that provide a specific legal mechanism for citizens to exercise their legal right to refuse life-sustaining treatment.

The second form of advance directive is a durable power of attorney, a procedure that designates a decision maker in the event of the patient's loss of autonomy. Under a "durable" power, unlike an ordinary power, the surrogate can make decisions for the patient after he or she loses the capacity to make such decisions personally. All 50 states and the District of Columbia have durable-power statutes, and some commentators believe that durable powers implicitly apply to health-care decisions even though most are silent on the question. Some 27 jurisdictions have recognized the use of durable powers to refuse life-sustaining treatment by statute or by interpretation (Areen and Hartog 1990; Society for the Right to Die 1990).

The constitutional significance of designated proxies received a considerable boost in *Cruzan*. The majority of the Supreme Court suggested it might constitutionally require states to give legal effect to the decisions of a surrogate decision maker who was duly appointed by the patient. Justice O'Connor, recognizing that states may fail to honor a patient's intent to refuse medical treatment, said that this failure could be avoided if the state was constitutionally required to uphold the patient's appointment of a proxy to make health-care decisions on her behalf.

*Courts as Surrogates.* The issue becomes more difficult when the individual has designated no trusted surrogate. Debate centers on the appropriate role of the courts. Although a few courts have required ju-

dicial involvement in a limited range of cases (e.g., technological feeding cases),<sup>31</sup> most courts strive to eliminate the need for prior judicial approval by developing guidelines for the decision-making process.<sup>32</sup> In *Saikewicz* the Massachusetts Supreme Judicial Court wrote that such "difficult and awesome" decisions should be subject to the "detached but passionate investigation" characteristic of court deliberation.<sup>33</sup> Since then, however, that court has acknowledged the importance of family and physicians in the decision, urging judicial review only in highly limited circumstances. The court *in re Spring* stated clearly that "[o]ur opinions should not be taken to establish any requirement of prior judicial approval that would not otherwise exist."<sup>34</sup>

The judicial system is too expensive, time-consuming, and cumbersome for dealing with the sensitive and personal decision to refuse treatment. Judicial intervention may take too long, infringing the very rights to privacy and autonomy that courts seek to protect. "Too many patients have died before their right to reject treatment was vindicated in court."<sup>35</sup>

Judicial review of treatment decisions, therefore, is generally not appropriate. Only unusual circumstances, such as some irreconcilable conflict among physicians, other health professionals, and/or family members would warrant judicial intervention. Even where there is no consensus on abating treatment, or where there is no obvious family member to act as a surrogate, the better use of courts is only to appoint a legal guardian empowered to choose for a nonautonomous patient.<sup>36</sup> Once a guardian is appointed, "the courts need not be involved in the substantive decision to refuse life-sustaining treatment."<sup>37</sup> "Decision

<sup>31</sup> *In re Colyer*, op. cit.; *Long v. Star of Florida*, 1990 Fla. LEXIS 1368; *in re Greenspan*, 1990 Ill. LEXIS 82; *in re Estate of Longway*, 133 Ill. 2d 33, 549 N.E.2d 292 (1989); *in re Estate of Greenspan*, 558 N.E. 2d 1194 (Ill. Sup. Ct., July 9, 1990).

<sup>32</sup> *In re Jobes*, op. cit.; *John F. Kennedy Memorial Hospital, Inc. v. Bludworth*, op. cit.; *in re Guardianship of Hamlin*, op. cit.; *in re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980); *in re Dinnerstein*, 380 N.E. 2d 134 (Ct. App. Mass. 1978); *in re Guardianship of Browning*, op. cit.

<sup>33</sup> *Superintendent of Belchertown State School v. Saikewicz*, op. cit.

<sup>34</sup> *In re Spring*, op. cit.

<sup>35</sup> *In re Farrell*, op. cit.

<sup>36</sup> *In re Conroy*, op. cit.; *in re Quinlan*, op. cit.; *Superintendent of Belchertown State School v. Saikewicz*, op. cit.; *in re Eichner (in re Storar)*, op. cit.; *in re Spring*, op. cit.

<sup>37</sup> *In re Colyer*, op. cit.

making within health care should be controlled primarily within the patient–doctor–family relationship.”<sup>38</sup>

*Families as Surrogates.* As the foregoing discussion shows, both courts<sup>39</sup> and commentators (Dyck 1987; President’s Commission 1983; Rhoden 1988; Ruark et al. 1988; Weir 1989) have frequently argued that the locus of decisions to abate treatment should be in the family. The law has traditionally respected “the private realm of family life which the state cannot enter.”<sup>40</sup> The New Jersey Supreme Court concluded that “this tradition of respect and confidence in the family should ground our approach to the treatment of the sick.”<sup>41</sup> Public opinion also supports this intuitive preference for families (*Cleveland Plain Dealer* 1985; *New York Times* 1986a,b; President’s Commission 1983).

In the Cruzan case, Justice Brennan queried, “Is there any reason to suppose that a state is more likely to make the choice that the patient would have made than someone who knew the patient intimately? To ask the question is to answer it.”<sup>42</sup> We concur. Many reasons exist as to why one or more family members should be the patient’s surrogate (except in cases where the most knowledgeable surrogate is a lifetime partner, as in the case of a gay couple or other close friend) (Rhoden 1988; Steinbrook et al. 1986; Weir 1989). First, even for the autonomous patient, family members are usually a source of advice and feedback regarding medical decisions. They “commonly act as advocates for patients in the hospital, looking out for comfort, care and best interests.”<sup>43</sup> Second, a patient may well have conveyed his or her personal views about being kept alive in the intimate setting of the family. The family is the place the patient is most likely to have expressed such views over a span of years, where both the evolution and consistency of his or her thinking is most likely to be documented.

Third, where a patient’s specific views concerning his or her condition are not ascertainable, a family is usually in the best position to approxi-

<sup>38</sup> *In re Quinlan*, op. cit.

<sup>39</sup> *Barber v. Superior Court*, op. cit.; *in re Jobes*, op. cit.; *John F. Kennedy Memorial Hospital, Inc. v. Bludworth*, op. cit.; *in re Colyer*, op. cit.; *in re Torres*, op. cit.; *Leach v. Akron General Medical Center*, op. cit.

<sup>40</sup> *Prince v. Mass.*, 321 U.S. 158, 64 S.Ct. 438, 88 L.Ed. 645 (1944).

<sup>41</sup> *In re Farrell*, op. cit.

<sup>42</sup> *Cruzan v. Director, Missouri Department of Health*, Brennan, J. dissenting.

<sup>43</sup> *In re Jobes*, op. cit.

mate the likely choices of a patient who was previously autonomous. Family members may be most familiar with the patient's personal and religious values concerning dying and death, or regarding the miracles of modern medicine. Fourth, families are usually bound by love and caring, and want to maximize all the patient's interests in continued life where there is meaningful human experience, or the dignity of a peaceful death. Most important, families have to live with the consequences of these decisions. Families continue to visit and grieve over the sight of a loved one who is physically alive but unable to interact. Physicians, ethics committees, and courts, however, go on to the next case.

#### *4. Safeguarding against Abuse: Procedures and Criteria for Decisions to Abate Treatment*

Reliance upon families to decide whether to abate treatment, to be sure, entails risk. They hardly come to these determinations with dispassion and objectivity. The feeling that the patient is suffering may be in part a projection of the relative's own suffering at watching his or her loved one severely incapacitated, or stripped of dignity. A relative's view that a patient cannot meaningfully engage in life experiences may be tempered by the sadness of how much he or she used to enjoy life. Families might abuse their right to choose when a choice is based on self-interest, particularly when it involves the expense of further treatment, or when an additional crisis taxes the family support structure.

The contrary argument is that the patient does not want his or her family to endure either the suffering or costs associated with the continued treatment; that is, the patient wants what is best for the whole family, too. "An individual who is part of a closely knit family would doubtless take into account the impact his acceptance or refusal of treatment would likely have on his family. . . . In any choice between proposed treatments which entail grossly different expenditures of time or money by the incompetent's family, it would be appropriate to consider whether a factor in the incompetent's decision would have been the desire to minimize the burden on his family."<sup>44</sup>

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<sup>44</sup> *In re Jobes*, op. cit.

The lack of emotional distance, the intertwining of the patient's life with that of the deciding family members, and shared financial resources are not sufficient reasons to take away the rights of a family to choose. In fact, it is this closeness of both condition and consequence that gives the family the strongest moral claim to make such a choice. Most people believe that passion and closeness help relatives make decisions consistent with a patient's best interests, and seldom lead to abuse.

Yet courts have properly identified a process and criteria that surrogates must use. Such procedures and criteria ought not be designed to transform a personal, moral choice into a legal judgment made in an adversarial battleground. Rather, they ought to provide a consistent process and clear standards for abating treatment. By establishing criteria and procedures for surrogate decision making, the courts can continue to leave the choice where it belongs, in the family, but provide clear parameters and safeguards against abuse.

*A Process for Surrogate Decision Making.* Courts often rely on a second opinion or consensus before giving effect to decisions to abate treatment. In *Quinlan*, Karen Quinlan's guardian, family, and attending physicians had to concur that there was no reasonable possibility of the young woman's recovering from her comatose state. A physician could receive immunity from liability only after a hospital committee or other medical consultative body agreed with the prognosis.

Laying down procedures to affirm family decision making, thereby supplanting any need for judicial intervention, has been a continuing theme of state supreme courts. New Jersey's highest court, for example, has generally required the concurrence of two independent medical specialists either to confirm that the patient is competent to refuse treatment, or that the patient is in a persistent vegetative state.<sup>45</sup> In cases involving incompetent nursing-home patients with severe and permanent mental and physical impairment and limited life expectancy, the court also requires notification of, and concurrence by, the state ombudsman in the decision to abate treatment.<sup>46</sup>

More important, courts have made clear that no civil or criminal liability would be incurred by any person who with good-faith reliance on

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<sup>45</sup> *In re Jobs*, op. cit. See also *in re Guardianship of Hamlin*, op. cit., overruling *in re Colyer*, op. cit.

<sup>46</sup> *In re Conroy*, op. cit.; *in re Peter*, 108 N.J. 365, 529 A.2d 419 (1987).

procedures established by the court abated life-sustaining treatment.<sup>47</sup> Health-care professionals, however, must also follow the standard of care set by their peers. It is well settled that a decision to abate treatment taken in careful consultation with family members and medical colleagues is within the bounds of professional and ethical practice (American Dietetic Association 1987; American Medical Association 1986; American Nurses Association 1988; Gostin 1986; President's Commission 1983).

*Standards for Surrogate Decision Making.* Just as important as the procedure to be followed are the substantive criteria that must guide treatment choices. Ideally the patient, prior to the loss of autonomy, made his or her explicit wishes known, and the surrogate simply acts as executor of these wishes. This task is easiest when the individual has put his or her wishes in writing.

In the absence of documentation, courts search for evidence of the patient's previously expressed desires. Courts have considered oral directions to family members, friends, or health-care providers, reactions of the patient to medical treatment administered to others, the individual's religious beliefs, and the patient's previous pattern of behavior concerning his or her own medical care. Where it is impossible to ascertain what the patient would have chosen, most courts allow the patient's guardian, family, and physicians to attempt a good-faith determination of the best interests of the patient. The New Jersey Supreme Court defined a "pure-objective test" in *Conroy*, where severe unavoidable pain was the principal factor. Responding to the dissent's criticism of *Conroy* that a "decision to focus exclusively on pain as the sole criterion ignores and devalues other important ideals regarding life and death," the Washington Supreme Court in *Grant* introduced a number of factors, including the individual's level of functioning, loss of dignity, life expectancy, and medical prognosis, as well as the risks and benefits of the treatment options open to the patient.

*Prognosis Required for Decision Abating Treatment.* An autonomous patient has the right to abate treatment irrespective of his or her medical condition or prognosis. Once the treatment choices of an autonomous patient are clear, the patient's life expectancy and the bal-

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<sup>47</sup> *In re Jobes*, op. cit.; *John F. Kennedy Memorial Hospital v. Bludworth*, op. cit.



ance between burdens and benefits do not carry as much legal weight as those choices do. These decisions are considered of such a uniquely personal nature that the patient's right to self-determination simply overrides any countervailing state interest in preserving life.<sup>48</sup>

The New Jersey courts have extended this nearly absolute right of self-determination to nonautonomous patients whenever there is evidence that the patient, while autonomous, would have declined treatment. This right of self-determination "is applicable in every surrogate-refusal-of-treatment case, regardless of the patient's medical condition or life expectancy."<sup>49</sup>

Courts, however, understandably look carefully at the patient's medical condition or prognosis before sanctioning surrogate decisions for nonautonomous patients who have not expressed a clear position of abating treatment. The clearest cases involved patients who are terminally ill—those who have a "life expectancy [of] no more than a year."<sup>50</sup>

Courts also recognize the right of nonautonomous patients who are not terminally ill to refuse care.<sup>51</sup> Courts have upheld numerous decisions to abate treatment for patients in a persistent vegetative state (PVS).<sup>52</sup> Patients in PVS may live for 30 years or more while attached to life-sustaining equipment.<sup>53</sup> Yet, the court held that life support could be removed because "there is no reasonable possibility of [the patient] . . . ever emerging from . . . [the] present comatose condition to a cognitive, sapient state."<sup>54</sup> The "absence of a terminal illness may serve to reinforce the decision to discontinue life-sustaining treatment because of the potentially long and indefinite period that a young person without a terminal illness may continue to live in a vegetative condition deriving no benefit other than mere existence from the life-sustaining treatment, but suffering the continued indignities and dehumanization created by his or her helplessness."<sup>55</sup>

<sup>48</sup> *In re Peter*, 108 N.J. 365, 529 A.2d 419.

<sup>49</sup> *In re Peter*, op. cit.

<sup>50</sup> *In re Dinnerstein*, op. cit. *Brophy v. New England Sinai Hospital, Inc.*, op. cit.; *in re Peter*, op. cit.; *in re Beth Israel Medical Center (Weinstein)*, op. cit.

<sup>51</sup> *Delio v. Westchester County Medical Center*, op. cit.

<sup>52</sup> See, e.g., *Rasmussen v. Flemming*, op. cit.; *in re Conservatorship of Drabick*, op. cit.

<sup>53</sup> *Brophy v. New England Sinai Hospital, Inc.*, op. cit.

<sup>54</sup> *In re Quinlan*, op. cit.

<sup>55</sup> *Delio v. Westchester County Medical Center*, op. cit.

Few courts have yet to grapple with the charged issue of abating treatment for nonvegetative, nonterminally ill patients. These include a potentially much larger, highly vulnerable, population of those with severe forms of dementia, mental illness, and mental retardation. Such severe chronic conditions can cause intolerable physical and mental anguish and can seriously diminish any meaningful interaction with the human environment. Severe physical and experiential deficits may legitimately justify abating treatment in some cases.

Chronically ill patients, however, can also experience joy and contentment (Dresser and Robertson 1989). Their position is especially vulnerable because of the financial cost of their care. Decisions to ration medical and nursing resources, while seldom explicitly articulated, can too easily influence judgments to abate treatment. Worse, certain types of life-prolonging treatment such as technological feedings may be continued, while others that are critical to a meaningful or even comfortable existence are too costly to be maintained.

The next generation of court decisions will have to venture beyond the now well-accepted boundaries of brain death, terminal illness, and the persistent vegetative state in defining when treatment can be abated. Still to be definitively decided are the numerous, and more difficult, cases involving seriously debilitated nonautonomous nursing-home residents, AIDS patients, and others who retain some alertness, however limited.

### *5. What Types of Treatment May Be Terminated?*

Once the nonautonomous patient's right to refuse treatment is accepted, courts see no moral or legal difference between withholding and withdrawing life support, and generally draw no distinctions among the various forms of treatment. Physicians may believe that withholding treatment is permissible because omissions are not punishable under law, whereas withdrawing treatment is morally questionable and legally suspect since the act of withdrawal might be interpreted as a causative factor in the patient's death. In a unanimous voice, courts have rejected this approach. As the *Conroy* court observed, "Whether necessary treatment is withheld at the outset or withdrawn later on, the consequence—the patient's death—is the same."<sup>56</sup>

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<sup>56</sup>*In re Conroy*, op. cit.

Instead, courts examine the physician's respect for the desires of the patient and the level of care administered. A rule forbidding physicians from discontinuing a treatment that could have been withheld initially will discourage doctors from attempting certain types of care and force them prematurely to allow a patient to die. Physicians must be free to exercise their best professional judgment, especially when facing the sensitive question of whether to administer treatment.

Courts have declared that any life-sustaining treatment may be withheld or withdrawn at the surrogate's request. This has been applied to cases involving ventilators<sup>57</sup> and extended to justify the withdrawal of chemotherapy,<sup>58</sup> blood transfusions,<sup>59</sup> cardiopulmonary resuscitation,<sup>60</sup> hemodialysis,<sup>61</sup> and amputation.<sup>62</sup>

*Nutrition and Hydration.* One of the most controversial forms of abating treatment involves removing technologically administered nutrition and hydration (American Nurses' Association 1988).<sup>63</sup> Such decisions to terminate treatment are frequently intended to end a life that is "over." The provision of nutrition and hydration has a particularly intimate association with the nursing function of nurturance and care. Former Surgeon General C. Everett Koop, in another context, said that nourishment in all cases is "the bottom line" and that removal of sustenance is medical neglect per se. Other commentators concur that technological nourishment constitutes routine nursing care to satisfy basic human survival (Rosner 1987).

Despite the emotional significance of technological nutrition and hydration, the President's Commission (1983), the American Medical Association (1986), the American Nurses' Association (1988), and the American Dietetic Association (1987) state that withholding nutrition and fluids in accordance with a patient's wishes or best interests does

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<sup>57</sup> *In re Eichner*, op. cit.; *Tune v. Walter Reed Army Medical Hospital*, op. cit.; *Satz v. Perlmutter*, 362 So. 2d 160 (Fla.Ct.App. 1978), aff'd, 379 So.2d 359 (Fla. 1980); *in re Farrell*, op. cit.; *Bartling v. Superior Court*, op. cit.

<sup>58</sup> *Superintendent of Belchertown State School v. Saikewicz*, op. cit.

<sup>59</sup> *In re Osborne*, 294 A.2d 372 (D.C. 1972); *in re Brown*, 478 So.2d 1033 (Miss. 1985).

<sup>60</sup> *In re Dinnerstein*, op. cit.

<sup>61</sup> *In re Spring*, op. cit.

<sup>62</sup> *Lane v. Candura*, op. cit.; *in re Beth Israel Medical Center (Weinstein)*, op. cit.

<sup>63</sup> *Barber v. Superior Court*, op. cit.; *in re Jobes*, op. cit.; *Brophy v. New England Sinai Hospital, Inc.*, op. cit.; *in re Conroy*, op. cit.; *in re Gardner*, op. cit.; *in re Severns*, op. cit.; *in re Conservatorship of Drabick*, op. cit.; *Evans v. Bellevue Hospital (Wirth)*, op. cit.

not in itself constitute unethical medical behavior (Robertson 1989). Many commentators perceive no moral difference between abating nutrition and hydration and abating other forms of life-sustaining treatment (Lo and Dornbrand 1984).

Justice O'Connor in *Cruzan* agreed with four dissenters that "artificial feeding cannot readily be distinguished from other forms of medical treatment." "An individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water" is constitutionally protected. Her concurring opinion may well encourage future law suits challenging, on equal-protection grounds, statutes that distinguish between artificial feeding and other forms of treatment (Annas 1990). Technological nutrition and hydration are medical treatments that are not morally or legally distinguishable from other forms of life-sustaining treatment.<sup>64</sup> The only state courts not to accept this conclusion are the Missouri court in *Cruzan* and the Washington court in *Grant*.<sup>65</sup>

## 6. State Interests

Judicial affirmation of the right to privacy for nonautonomous patients is not without limits. An individual's right to refuse life support must be balanced against competing state interests. Life support may be removed only if the patient's rights override the four state interests first identified in *Saikewicz* in the preservation of life, protection of innocent third parties, prevention of suicide, and maintenance of the ethical integrity of the medical profession.<sup>66</sup>

The state interest in the preservation of life weakens and eventually succumbs to the individual's right of privacy as the bodily invasion by the treatment increases and the patient's prognosis dims.<sup>67</sup> The state's interest in life encompasses a broader interest than mere corporeal exist-

<sup>64</sup> *Barber v. Superior Court*, op. cit.; *Rasmussen v. Flemming*, op. cit.; *Brophy v. New England Sinai Hospital, Inc.*, op. cit.; *in re Conroy*, op. cit.; *in re Eichner*, op. cit.; *in re Gardner*, op. cit.; *McConnell v. Beverly Enterprises*, op. cit.; *in re Rodas*, op. cit.; *Gray v. Romeo*, op. cit.; *Delio v. Westchester County Medical Center*, op. cit.; *Childs v. Abramovice (Morrison)*, op. cit.

<sup>65</sup> *Cruzan v. Director, Missouri Department of Health*, op. cit.; *in re Guardianship of Grant*, op. cit.

<sup>66</sup> *Superintendent of Belchertown State School v. Saikewicz*, op. cit.

<sup>67</sup> *In re Quinlan*, op. cit.

tence. . . . The burden of maintaining the corporeal existence can degrade the very humanity it was meant to serve.”<sup>68</sup>

The request to remove life support also cannot be equated with an intent to die and therefore does not conflict with the state’s interest in preventing suicide. The withdrawal of life-sustaining treatment does not constitute attempted suicide, as the decision is usually based on a wish to be free of medical intervention rather than a specific intent to die. Death results, if at all, from the underlying medical condition.<sup>69</sup>

The state interest in the ethical integrity of the medical profession is, fortunately, usually consistent with the patient’s right to refuse treatment. Some physicians may equate a high standard of care with the ability to treat patients with every means available—to provide the most care possible. Courts, however, have concluded that patients may choose to discontinue intervention and end life when all that is left of it are the most basic bodily functions. Out of respect for this right, “the prevailing medical ethical standards . . . do not require medical intervention at all costs.”<sup>70</sup> Not only is deferral to a patient’s wishes on the part of physicians permissible, but it may even be expected or required under evolving standards of ethical (Hastings Center 1987) and professional care (New York State Task Force for Life and the Law 1987).

The protection of innocent third parties, such as a near-term fetus or a dependent child, is the state interest that sometimes prevails over the patient’s right to self-determination in at least a few cases. Yet *in re A.C.*<sup>71</sup> the U.S. Court of Appeals for the D.C. Circuit held that a woman has a constitutional right to refuse treatment even if it may imminently threaten her fetus. Many commentators have taken the same view (Field 1989; Rhoden 1987). Courts, however, do not always respect the choice of a woman in the late stages of pregnancy to refuse treatment (such as a Cesarean section) if it would unnecessarily imperil the fetus.<sup>72</sup>

Courts seldom find the interests of dependent children who are not physically threatened sufficient to override the patient’s right to privacy.

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<sup>68</sup> *Brophy v. New England Sinai Hospital, Inc.*, op. cit.

<sup>69</sup> *In re Conroy*, op. cit.

<sup>70</sup> *Delio v. Westchester County Medical Center*, op. cit.

<sup>71</sup> *In re A.C.*, 573 A.2d 1235 (1990).

<sup>72</sup> *Jefferson v. Griffin Spalding County Hospital Authority*, 247 Ga. 86, 274 S.E.2d 459 (1981).

Dependent children receive little psychological benefit in having the life of a gravely ill parent prolonged needlessly. The most difficult cases involve Jehovah's Witnesses who could live a full life if they consented to a blood transfusion. Even here most,<sup>73</sup> but not all,<sup>74</sup> courts have upheld the right of an autonomous adult to refuse a transfusion, even when the patient is the parent of a minor child.

*Transferring Patients to Effectuate Their Wishes.* Does the ethical, professional, and legal obligation to comply with the preferences of the patient or the requests of the patient's surrogate prevent a health-care facility or physician from transferring or discharging a patient? Because of their religious or moral beliefs, some health-care facilities and physicians have policies in place to oppose abating treatment. Compelling facilities or physicians to abate treatment, they argue, would undermine the integrity of the medical profession (Miles, Singer, and Siegler 1989).

It may, of course, be possible to transfer the patient to another facility willing to remove life support and preside over the last moments of life. Some courts have allowed the option of transfer, provided it is not "unduly burdensome"<sup>75</sup> (Gostin 1986). In *Bayer*, the North Dakota appeals court upheld the family's right to refuse continued feedings, but then put the burden on the family to find someone who would comply with the court order. The family approached over 200 physicians, and finally, after five months, was forced to take the patient home under the care of a hospice program.<sup>76</sup> The family refused to pay for the five months of interim care, and instead filed a second lawsuit against the noncompliant facility for damages related to the long delay and unauthorized administration of treatment.<sup>77</sup>

For some families, care of dying patients at home is a manageable task and provides a close final bond with the dying patient. For others,

<sup>73</sup> *Fosmire v. Nicoleau*, 75 N.Y. 2d 218, 551 N.E. 2d 77 (Ct. Appeals 1990); *in re Osborne*, op. cit.; *in re Melideo*, 88 Misc.2d 974, 390 N.Y.S.2d 523 (N.Y. Sup. Ct. 1976).

<sup>74</sup> *In re Winthrop Univ. Hospital*, 128 Misc.2d 804, 490 N.Y.S.2d 996 (N.Y. Sup. Ct. 1985); *John F. Kennedy Memorial Hospital v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971).

<sup>75</sup> *Brophy v. New England Sinai Hospital, Inc.*, op. cit.; *Gray v. Romeo*, op. cit.; *in re Bayer*, op. cit.; *Delio v. Westchester County Medical Center*, op. cit.; *Childs v. Abramovitch (Morrison)*, op. cit.

<sup>76</sup> *In re Bayer*, op. cit.

<sup>77</sup> *In re Bayer*, op. cit.

however, it presents an unconscionable physical and mental burden. Death caused by the withdrawal of fluids can be especially difficult to manage, because of the perception of pain, discomfort, and change of appearance in the patient. Care of dying patients can also be expensive and require specialized skills, such as the administration of pain-relieving medication. Family members may themselves be frail or elderly, making the physical task an impossible one. "If the right to self-determination is to have any meaning at all, it must be paramount to the interests of the patient's hospital and doctors."<sup>78</sup>

### Remote Risk of Liability for Decisions to Abate Treatment

In addition to having ethical concerns, many physicians also fear civil or criminal liability for terminating life support. The majority of cases come to court because the physicians involved are anxious about what the *Quinlan* court called "the brooding presence of such possible liability."<sup>79</sup> Yet the courts have responded clearly and reassuringly. Every court of final decision has found physicians free of civil or criminal liability for abating life-sustaining treatment.

Courts have consistently favored physicians, acting in good faith, who carry out the right of patient self-determination (Glantz 1988). Courts offer a number of justifications.<sup>80</sup> Some view the constitutional right of privacy as protection from civil or criminal prosecution.<sup>81</sup> Many reason that the patient's death is caused by the underlying medical condition, so that the removal of life support does not constitute an act of homicide.<sup>82</sup> Others posit that a good-faith decision by a physician that a particular treatment has a disproportionate balance of burden to benefit for a patient cannot be a battery and is therefore protected from civil liability.<sup>83</sup> Physicians' concerns can also be allayed by stressing that the removal of life-sustaining treatment, when either

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<sup>78</sup> *Bartling v. Superior Court*, op. cit.

<sup>79</sup> *In re Quinlan*, op. cit.

<sup>80</sup> E.g. *Barber v. Superior Court*, op. cit.

<sup>81</sup> *In re Quinlan*, op. cit.; *in re Colyer*, op. cit.

<sup>82</sup> *In re Quinlan*, op. cit.; *in re Colyer*, op. cit.

<sup>83</sup> *John F. Kennedy Memorial Hospital, Inc. v. Bludworth*, op. cit.; *in re Spring*, op. cit.

wanted by the patient or judged to be in the patient's best interests, is consistent with the ethics of responsible medical practice.<sup>84</sup>

Aided by the judicial guidelines and procedures discussed above, physicians can usually discontinue life-sustaining measures without threat of liability. Given the proliferation of judicial opinion that morally responsible medical decisions made in good faith are immune from liability, and given the absence of any case where civil damages or criminal sanctions have been imposed, the medical community can and should no longer hide behind the law as a justification for refusing appropriate requests to abate life-sustaining treatment. Indeed, probably a greater risk of liability exists in cases where physicians continue treatment against the wishes of the patient or the patient's surrogate.

Physicians who do not honor their patient's wishes to refuse treatment may face charges of negligence, battery, or intentional infliction of emotional distress.<sup>85</sup> In addition, many states expressly provide for civil liability or professional sanctions for physicians who choose not to heed requests made by patients in connection with natural death acts. Alaska, for example, calls for denial of compensation as well as a civil penalty of up to \$1,000 plus actual costs of the failure to comply with the declaration (*Biolaw* 1987).

Four cases of nonautonomous patients should give health-care providers cause for concern about legal liability for failing to respect the wishes of patients or their surrogates. The *Leach* court suggested that civil liability be imposed on a physician unwilling to cooperate with the right to refuse treatment. Mr. Leach requested that his wife, who was in PVS, be removed from a ventilator, but his request was rejected by the attending physician. His attending physician then withdrew from the case, and over 30 physicians were reportedly contacted before one was found who would comply with a court order to terminate life support. Mr. Leach and his adult children filed an action for damages against the attending physician and the hospital for their futile and unwanted efforts to prolong Mrs. Leach's life. The court of appeals held that the unconsented, nonemergency treatment given Mrs. Leach repre-

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<sup>84</sup> *John F. Kennedy Memorial Hospital v. Bludworth*, op. cit.; *Brophy v. New England Sinai Hospital, Inc.*, op. cit.; *Superintendent of Belchertown State School v. Saikewicz*, op. cit.; *in re Spring*, op. cit.

<sup>85</sup> *In re Bayer*, op. cit.; *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914); *Leach v. Shapiro*, 13 Ohio App.3d 393, 469 N.E.2d 1047 (Ct.App. 1984).



sented a battery for which the physicians and hospital could be liable in damages.<sup>86</sup>

New Jersey's highest court decided in *Strachan* that a hospital could be sued for damages when it refused to remove a brain-dead patient from life support.<sup>87</sup> Physicians had refused for three days to remove life support and sign a death certificate for Jeffrey Strachan, despite the urgings of his parents. The case is paradigmatic in that the wrongful delay appeared to be a result of the lack of an institutional protocol for the termination of life support, rather than due to any individual maliciousness. Although the case involved a brain-dead patient, the decision nevertheless represents a historic shift, beginning with a declaration of the right to make treatment-abatement decisions and progressing to the actual establishment of a tort remedy for failure to honor the wishes of a family.

In the *Bayer* case, the family of Jane Bayer refused to pay for five months of unconsented treatment for her while she was in PVS. The family brought a suit against a North Dakota facility for damages related to unauthorized administration of treatment.<sup>88</sup>

In New York, a trial court ruled in the *Jean Elbaum* case that a nursing home could not collect its fees of over \$100,000 for the continued technological feeding of the PVS patient against her surrogate's wishes.<sup>89</sup>

This important shift in judicial opinion indicates that physicians and hospitals may now incur risks of legal liability or loss of fees for aggressively treating critically and terminally ill patients contrary to the wishes of the patients or their surrogates. All physicians are acutely aware of their legal risks when they fail—either through negligence or intention—to provide sufficient treatment for their patients. Physicians now need to recognize that they also have legal risks when they overtreat their critically ill patients, especially when the treatment is not wanted by an autonomous patient or is contrary to the best interests of a nonautonomous patient.

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<sup>86</sup> *Leach v. Shapiro*, op. cit.

<sup>87</sup> *Strachan v. John F. Kennedy Memorial Hospital*, 209 N.J. Super. 300, 507 A.2d 718 (App.Div. 1986), aff'd in part, rev'd in part, 109 N.J. 523, 538 A.2d 346 (1988).

<sup>88</sup> *In re Bayer*, op. cit.

<sup>89</sup> *Elbaum v. Grace Plaza of Great Neck*, No.2920 (N.Y.Sup.Ct.App.Div. Aug. 2, 1989).

## Life-and-Death Choices after Cruzan

The *Cruzan* decision shows how far out of touch the Supreme Court has become with regard to how people think and behave. The overwhelming majority of people do not anticipate the circumstances of their death with the exactness required under a clear and convincing evidence standard and do not plan their lives by creating formal legal instruments (McCrary and Botkin 1989; Emanuel and Emanuel 1989). Even if a person dwells on the remote possibility of loss of cognition, she may not marshal the formal evidence of her preferences or may not be sufficiently precise in enunciating the exact medical circumstances under which treatment should be abated.<sup>90</sup> When a person tells a family member or close friend that she does not want her life sustained artificially, she is “express[ing] her wishes in the only terms familiar to her, and . . . as clearly as a lay person should be asked to express them.”<sup>91</sup>

What is more important, the Court creates a presumption that a person would want technological support to sustain an unconscious, nonpurposeful life. Exactly the opposite presumption is warranted. When asked, very few people would choose to be kept physically alive when all conscious life is over.

Finally, the Court reasons that because *some* family members are improperly motivated, *all* family members may be precluded from making substitute decisions in the absence of a durable power or other legally sufficient evidence of intent. Again, most people prefer close relatives or friends who know them well to make proxy decisions. Patients certainly do not wish to have their family’s hands tied because they neglected to execute the proper legal instrument.

The insistence on “clear and convincing evidence” imposes a particular burden on persons without sufficient education or means. Legal formalities in drafting adequate advance directives, or complying with statutory requirements can be complicated and vary from state to state. Those who are poor, illiterate, or have inadequate access to legal or other advice simply will be foreclosed from exercising their rights.

Fulfillment of the wish to experience a natural and dignified death cannot realistically be achieved through the legal formalism envisioned

<sup>90</sup> *Cruzan v. Director, Missouri Department of Health*, op. cit.

<sup>91</sup> *In re O'Connor*, 72 N.Y.2d 517, 551 (1988) (Simons, J., dissenting).

by the Supreme Court. The question then becomes, How best can policy makers ensure that people will be treated more in accordance with both their advance preferences and current best interests when they are dying?

One obvious method of ensuring that a person's wishes are respected after *Cruzan* is to provide assistance to enable her to comply with state evidentiary requirements in writing a power of attorney and/or an advance directive. State agencies could publish and distribute simple advance directive forms. Alternatively, states could fund charitable or community organizations to provide forms and advice in completing them.

The literature reveals numerous instances where advance directives are not respected by health-care providers, either because they are unaware of an advance directive or cannot reliably ascertain whether it is authentic (Schucking 1985). Local governments can devise imaginative solutions to this problem. A "portable advance directive" provides a good model. Under this concept a network would be formed whereby all emergency, law-enforcement, health-care, and nursing facilities in a geographical area could be apprised of the availability and contents of an advance directive. This could be accomplished through a database or simply by requiring municipal and private services to notify each other of the existence of an advance directive. Confidentiality would have to be ensured. A "portable advance directive" would inform service providers of the availability and authenticity of a patient's previously expressed wishes.

Some states may still fail to recognize the constitutional importance of advance directives. We can expect to see future federal court cases under the constitutional theory that durable powers of attorney have binding force even in restrictive states like Missouri. Justice O'Connor's concurrence opens the door to the argument that durable powers give patients a constitutional right to have the decisions of their proxies respected.

While states should make every effort to encourage persons to prepare advance directives, the greater challenge is to devise legal mechanisms to respect patient choices with a minimum of legal formality. State legislatures have a number of policy options. First, the state could establish a low threshold of proof. A person's desire to have treatment abated could be demonstrated by a preponderance of evidence (i.e., the balance of evidence)—not merely by legal instrument, but by in-

formal communication. This could include discussions with family and friends containing such common expressions as "I would not want to live as a vegetable"; known religious or other beliefs consistent with the view that they would not wish to use medical technology to prolong their lives; or statements to health-care professionals about treatment options at the end of life.

Second, states could create a presumption favoring substitute decisions by family members. By relying primarily on family evaluation of a patient's statements and values, states could at once avoid the burden of a lengthy process of judicial review, and designate the proxy decision maker most likely to be intimately familiar with the patient. Only in cases where the family has a conflict of interest or is divided itself would an alternative process of evaluation be necessary. The New York Health Care Agents and Proxy Law of 1990, for example, overturns the state judicial determination requiring clear and convincing evidence by allowing appointed proxies to exercise substituted judgements.

Third, states could enact laws that require health-care facilities to inform patients of the right to make an advance directive and to record their treatment preferences. Reasonable opportunities for persons to reflect on treatment alternatives arise when they are admitted to a hospital, nursing home, or hospice, or even when they apply for health insurance, Medicaid, or Medicare. States might choose one or most of these occasions to require health-care providers to discuss treatment alternatives and note the patient's preferences.

The federal Patient Self-Determination Act, enacted within the Omnibus Budget Reconciliation Act of 1990, provides a good illustration of a "routine offering" requirement.<sup>92</sup> The Act requires health-care providers, as a condition of the receipt of Medicare or Medicaid dollars, to provide written information at the time of admission about the patient's rights under state law to accept or refuse medical treatment and to formulate advance directives. Health-care providers will be responsible for documenting in each person's medical record whether she has executed an advance directive. States are required to develop a written description of state law on advance directives, and health-care providers must undertake public education programs for staff and the community on the subject of advance directives.

A wide chasm exists between people's desires to express their wishes

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<sup>92</sup>The implementation date of the Act is December 1, 1991.

and their failure to draft written advance directives (Danforth 1990). The most probable reason is that people are simply not asked. "Routine offering" statutes will ensure that, long after *Cruzan* has been forgotten by most citizens, patients will be informed of their rights and provided assistance in exercising them.

Experience dictates that even considerable efforts to encourage patients to plan for their deaths are not always successful. Many people, for example, die without leaving a will. When a person dies intestate, the state provides arrangements for the distribution of property consistent with most people's belief system. The same policy would be reasonable in cases where individuals do not leave prior instructions about final care. In the absence of known preferences, the state should assume that individuals would wish to be treated in their best interests and would trust their families to make decisions on their behalf. Decisions to abate treatment, therefore, could be made by loved ones where it best serves the patient's interests.

Life-and-death choices across the country could sink to the low level where people must deliberately marshal their legal evidence in the fear that their government will fail to respect their wishes and privacy. Alternatively, states can enact creative laws to encourage meaningful dialogue with family and physicians on final care, assist people in making clear and simple statements of their preferences, and adopt legal presumptions about the closeness of family life that best reflect the value system and behavior of most Americans.

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*Address correspondence to:* Larry Gostin, J.D., Office of the Executive Director, American Society of Law & Medicine, 765 Commonwealth Avenue, 16th Floor, Boston, MA 02215.