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# Notes and Comments

## Specific Intent, Substituted Judgment and Best Interests: A Nationwide Analysis of an Individual's Right to Die

The tremendous advancements in medical technology in the last several years have made it possible to sustain a person who has minimal brain functioning . . . . It is now possible to hold such persons on the threshold of death for an indeterminate period of time by utilizing extraordinary mechanical or other artificial means to sustain their vital bodily functions. The procedures used can be accurately described as a means of prolonging the dying process rather than a means of continuing life.<sup>1</sup>

Medical technology has effectively created a twilight zone of suspended animation where death commences while life, in some form, continues. Some patients, however, want no part of a life sustained only by medical technology. Instead, they prefer a plan of medical treatment that allows nature to take its course and permits them to die with dignity.<sup>2</sup>

As scientific advances make it possible for us to live longer than ever before, even when most of our physical and mental capacities have been irrevocably lost, patients and their families are increasingly asserting a right to die a natural death without undue dependence on medical technology or unnecessarily protracted agony — in short, a right to “die with dignity.”<sup>3</sup>

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1. *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So. 2d 921, 923 (Fla. 1984).
  2. *Rasmussen v. Fleming*, 154 Ariz. 207, 211, 741 P.2d 674, 678 (1987).
  3. *In re Conroy*, 98 N.J. 321, 343, 486 A.2d 1209, 1220 (1985).

## I. Introduction

These quotations underscore the sensitive and emotionally charged controversy as to whether, and under what circumstances, both competent and incompetent patients have the right to die, or as it is often termed, the right to refuse life-sustaining treatment.<sup>4</sup>

Wondrous advancements in biotechnology have blurred the once bright line delineating the realms of life and death<sup>5</sup> by permitting the maintenance of life beyond the point where the terminally ill or patients in a persistent vegetative state<sup>6</sup> may want to live. It has been said that

we are on the threshold of new terrain — the penumbra where death begins but life, in some form continues. We have been led to it by the medical miracles which now compel us to distinguish between 'death,' as we have known it, and death in which the body lives in some fashion but the brain (or a significant part of

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4. An interdisciplinary group of lawyers, doctors, theologians, and others, was established by Congress in 1978 to propose guidelines for implementing an individual's right to refuse medical treatment. They stated the problem this way: "Once someone realizes that the time and manner of death are substantially under the control of medical science, he or she wants to be protected against decisions that make death too easy and quick as well as from those that make it too agonizing and prolonged." PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL AND LEGAL ISSUES IN TREATMENT DECISIONS 23 (1983) [hereinafter PRESIDENT'S COMMISSION REPORT]; see also Johnson, *From Medicalization to Legalization to Politicization: O'Connor, Cruzan, and Refusal of Treatment in the 1990s*, 21 CONN. L. REV. 685 (1989); Peters, *The State's Interest in the Preservation of Life: From Quinlan to Cruzan*, 50 OHIO ST. L.J. 891 (1989).

5. *Rasmussen*, 154 Ariz. at 211, 741 P.2d at 678.

6. Dr. Fred Plum, Professor and Chairman of the Department of Neurology at Cornell University, first used the term "persistent vegetative state." *In re Jobes*, 108 N.J. 394, 403, 529 A.2d 434, 438 (1987). Dr. Plum first described such a patient as a "subject who remains with the capacity to maintain the vegetative parts of neurological function but who . . . no longer has any cognitive function." *In re Quinlan*, 70 N.J. 10, 24, 355 A.2d 647, 654, cert. denied sub nom. *Garger v. New Jersey*, 429 U.S. 922 (1976).

Dr. Plum's refined description, after writing several treatises and numerous articles on the condition, was noted in *In re Jobes*:

Vegetative state describes a body which is functioning entirely in terms of its internal controls. It maintains temperature. It maintains heart beat and pulmonary ventilation. It maintains digestive activity. It maintains reflex activity of muscles and nerves for low level conditioned responses. But there is no behavioral evidence of either self-awareness or awareness of the surroundings in a learned manner.

108 N.J. 394, 403, 529 A.2d 434, 438.

it) does not.<sup>7</sup>

Indeed, the constant injection of complex variables into the debate over the issue of care for the hopelessly or terminally ill has forced physicians, scientists, philosophers, theologians and, perhaps most importantly, legislators and judges, to reexamine and redefine the meaning of death. The traditional definition, a cessation of pulse and respiration,<sup>8</sup> no longer suffices.<sup>9</sup>

The legal discussion concerning whether an individual has a right to refuse life-sustaining medical treatment has largely focused on the basic tension between a patient's autonomy and the state's legitimate interest in the preservation of life.<sup>10</sup> However, the issue raises a litany of questions and conflicts in such diverse disciplines as medicine, law, and religion.<sup>11</sup> The quest to resolve this question has resulted in an interrelationship of these three disciplines that has often resulted in conflict.<sup>12</sup>

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7. *Severns v. Wilmington Medical Center*, 421 A.2d 1334, 1344 (Del. Sup. 1980); see also *Barber v. Superior Court for Los Angeles County*, 147 Cal. App. 3d 1006, 1014, 195 Cal. Rptr. 484, 488 (1983); *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1, 6 (1980) ("With the advance of medical technology the heart and lungs can be prevented from stopping and can be sustained on life support systems for indefinite periods. . . . [So, the question becomes w]hen does death occur — when the heart ceases or brain function ends?").

8. BLACK'S LAW DICTIONARY 488 (4th ed. 1968); see also *Evans v. Halterman*, 31 Ohio App. 175, 165 N.E. 869 (1928).

9. In response to this problem, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research recommended in 1981 the adoption of the Uniform Determination of Death Act (UDDA). Under its definition, an individual who has sustained either 1) irreversible cessation of circulatory and respiratory functions, or 2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards. 12 U.L.A. 338 (Supp. 1991).

10. The importance of the preservation of life is found in various documents that are an integral part of the history of the United States. The Declaration of Independence states as self-evident truths "that all men . . . are endowed by their Creator with certain unalienable rights, that among these are Life, Liberty and the pursuit of Happiness." In addition, the Fourteenth Amendment of the United States Constitution, although varying the theme of the Declaration, provides that no state shall "deprive any person of life, liberty, or property, without due process of law . . . ." U.S. CONST. amend. XIV. Lastly, many state constitutions explicitly recognize "certain natural and unalienable rights, among which are those of enjoying and defending life . . . ." N.J. CONST. art. I, para. 1.

11. *In re Conroy*, 98 N.J. 321, 344, 486 A.2d 1209, 1220 (1985) (the New Jersey Supreme Court acknowledged, "[n]o one person or profession has all the answers.").

12. See, e.g., *In re Quinlan*:

Medicine with its combination of advanced technology and professional ethics is both able and inclined to prolong biological life. Law with its felt obligation to

Until recently, medical decisions about prolonging life were relatively straightforward because of the limited options open to physicians and the few effective therapies from which to choose. However, physicians now have greater control over the time and nature of death due to advances in medical science, the fact that medical care is increasingly being provided to dying patients in institutional settings, and the increasing number of deaths caused by chronic, degenerative disease rather than communicable disease.<sup>13</sup>

Unfortunately, the development of new medical techniques has complicated the traditional duty of physicians to make every conceivable effort to prolong a patient's life.<sup>14</sup> Potentially therapeutic interventions to postpone the death of terminally ill patients have, at times, been undertaken regardless of the effect on the patient and contrary to the patient's best interests.<sup>15</sup> These medical techniques have resulted in a quality of life for the patient that "can range from marginally tolerable to positively miserable."<sup>16</sup> Physicians have been slow to acknowledge that in many cases the effect of certain therapies may not advance the patients' goals and values. Indeed, in many cases this delay results in "prolong[ing] suffering, [and] isolat[ing] the family from their loved one at a time when they may be close at hand or

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protect the life and freedom of the individual seeks to assure each person's right to live out his human life until its natural and inevitable conclusion. Theology with its acknowledgment of man's dissatisfaction with biological life as the ultimate source of joy . . . defends the sacredness of human life and defends it from all direct attacks. . . . Each must in some way acknowledge the other without denying its own competence.

70 N.J. 10, 32, 355 A.2d 647, 659 (quoting the position statement of Bishop Lawrence B. Casey reproduced in his amicus curiae brief for the case), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976).

13. See *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 737, 370 N.E.2d 417, 423 (1977); see also PRESIDENT'S COMMISSION REPORT, *supra* note 4, at 16-17.

14. *Saikewicz*, 373 Mass. at 737, 370 N.E.2d at 423 (such as the use of respirators to aid in breathing, gastronomic tubes to artificially provide nutrition and hydration, and chemotherapy to limit the effects of cancer).

15. *Id.*

16. *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 196, 245 Cal. Rptr. 840, 846 (1988) (quoting Ruark, Raffin & Stanford University Medical Center Committee on Ethics, *Special Article: Initiating and Withdrawing Life Support*, 318 NEW ENG. J. MED. 25, 25 (1988)).

result[ing] in economic ruin for the family.”<sup>17</sup> Thus, a direct conflict has arisen between the fundamental medical objectives of sustaining life and relieving suffering.<sup>18</sup>

Traditionally, the law has lagged behind the most advanced thinking in theology and medicine and has waited for theologians, physicians, and other moral leaders to create some common ground with regard to such a complex issue.<sup>19</sup> However, advances in medical science have given doctors a “range of options . . . to postpone death irrespective of the effect on the patient.”<sup>20</sup> Furthermore, societal changes in how and where people die, and the inability of physicians and theologians to forge a common ground due to the significant conceptual and ethical conflicts involved, have heightened public concern and forced legislators and judges to grapple with the sensitive issue of whether an individual has a right to die. Consequently, legislators and judges have been compelled to formulate new standards and procedures for measuring the conduct of persons involved in the care of either terminally ill or comatose patients.

Despite the absence of effective legislative guidance in this area, courts have attempted to deal with the issue. They have approached this acutely moral and emotional issue “with extreme caution and humility, mindful of the profound and overwhelming sense of responsibility”<sup>21</sup> that accompanies the life and death issues in these cases.

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17. *Saikewicz*, 373 Mass. at 737-38, 370 N.E.2d at 423 (quoting Lewis, *Machine Medicine and Its Relation to the Fatally Ill*, 206 J. A.M.A. 387, 387 (1968)).

18. PRESIDENT'S COMMISSION REPORT, *supra* note 4, at 15. A similar conflict exists in the area of theology; that is, the tension between the Judeo-Christian tradition of central respect and reverence for the sanctity and preservation of human life, and religion's “responsibility to assist man in the formation and pursuit of a correct conscience as to the acceptance of natural death when [medical] science has confirmed its inevitability beyond any hope other than that of preserving biological life in a merely vegetative state.” *In re Quinlan*, 70 N.J. 10, 32-33, 355 A.2d 647, 658-59 (quoting the position statement of Bishop Lawrence B. Casey reproduced in his amicus curiae brief for the case), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976). It should be noted that Bishop Casey resolved the theological dilemma for the Catholic Church by stating that the decision of the patient's father to discontinue the treatment being provided was a morally correct decision given the circumstances and the irreversible condition of the patient. *Id.*; see also *infra* notes 234-41 and accompanying text.

19. *Saikewicz*, 373 Mass. at 737, 370 N.E.2d at 423 (citing Burger, *The Law and Medical Advances*, 67 ANNALS INTERNAL MED. SUPP. 7, 15, 17 (1967)).

20. *Saikewicz*, 373 Mass. at 737, 370 N.E.2d at 423.

21. *Rasmussen v. Fleming*, 154 Ariz. 207, 211-12, 741 P.2d 674, 678-79 (1987).

The debate is extremely complex. It involves issues of constitutional law, individual rights, competing state interests, and other questions of biomedical and religious ethics. However, the courts generally have been able to compress these issues into several fundamental questions that take into account the competing considerations and conceptual conflicts.

First, is there any legal predicate to allow a competent patient the right to refuse medical treatment even if such a refusal will hasten death?<sup>22</sup> Second, if a right to refuse medical treatment exists, does it survive incompetency if the patient left written expressions of his wishes prior to becoming incompetent?<sup>23</sup> Third, are there legitimate state interests that should be balanced against the right of an individual to refuse medical treatment?<sup>24</sup> Fourth, what role should the judicial branch play in resolving disputes relating to the personal expression of an individual's right to die, and to what degree should judicial involvement be required in such cases?<sup>25</sup> Finally, the core question of the debate: given a protected right to refuse life-sustaining treatment and an appropriate surrogate decisionmaker to express, and therefore preserve, this right on behalf of an incompetent patient, what standards, requirements, and limitations should govern such a decision?<sup>26</sup> The state courts have wrestled with these issues during the last fifteen years.<sup>27</sup> However, results have been extremely diverse and inconsistent, reflecting the controversy and uncertainty which permeates this intense and personal issue.

This Comment has three basic objectives. After providing a background and foundation in section II, section III analyzes leading state court decisions involving a patient's right to refuse medical treatment. The major differences among states which have considered this issue are highlighted. Special emphasis is placed on the standards, requirements, and limitations which should govern a patient's right to refuse medical treatment.

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22. See *infra* notes 31-57 and accompanying text.

23. See *infra* notes 58-62 and accompanying text.

24. See *infra* notes 63-97 and accompanying text.

25. See *infra* notes 98-111 and accompanying text.

26. See *infra* notes 112-350 and accompanying text.

27. See *Cruzan v. Harmon*, 760 S.W.2d 408, 412 n.4 (Mo. 1988) (en banc) (listing fifty-four reported decisions between 1976 and 1988), *aff'd*, 110 S. Ct. 2841 (1990).

Section IV briefly reviews the case of *Cruzan v. Director, Missouri Department of Health*,<sup>28</sup> the first United States Supreme Court ruling on the validity of an individual's right to refuse medical treatment when that refusal will inevitably lead to death. This section also explores the effect, if any, this decision will have on other states.<sup>29</sup>

Finally, section V discusses the current statutory law governing an individual's right to refuse medical treatment and discusses the potential impact this "legislative guidance" will have on the courts and affected individuals.<sup>30</sup>

This Comment attempts to inform the reader why the issue of whether an individual has a protected right to refuse medical treatment is so complex. Given the diverse approaches by individual state courts and the lack of effective legislative guidance in this area, it is, and will remain, one of the most controversial constitutional issues in the United States. The proper place to begin the analysis is with the constitutional, philosophical, and conceptual framework underlying and supporting the right to refuse medical treatment.

## II. Theoretical Background

### A. Constitutional Right of Privacy

Although the United States Constitution does not explicitly mention a right of privacy, it is said to arise from penumbras of specific guarantees in the first, third, fourth, fifth, ninth and fourteenth amendments.<sup>31</sup> Although the boundaries of an individual right of privacy<sup>32</sup> have not been clearly defined by the United States Supreme Court, it appears well settled that "personal rights found in this guarantee of personal privacy must be limited to those which are 'fundamental' or 'implicit in the con-

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28. 110 S. Ct. 2841 (1990).

29. See *infra* notes 351-88 and accompanying text.

30. See *infra* notes 389-435 and accompanying text.

31. *Griswold v. Connecticut*, 381 U.S. 479, 484-85 (1965); see also *Roe v. Wade*, 410 U.S. 113, 152 (1973) ("[T]he [Supreme] Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution.").

32. *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) ("the right to be let alone — the most comprehensive of rights and the right most valued by civilized men.").



cept of ordered liberty' ”<sup>33</sup> or “deeply rooted in this Nation’s history and tradition.”<sup>34</sup>

As a result, the Court has recognized several areas of an individual’s private life that may be successfully protected from governmental intrusion absent a compelling state interest. These include child rearing and education,<sup>35</sup> abortion,<sup>36</sup> the use of contraception,<sup>37</sup> possession of obscene material in one’s home,<sup>38</sup> marriage,<sup>39</sup> familial relationships,<sup>40</sup> and procreation.<sup>41</sup> Conversely, other matters have been found to be subject to governmental intrusion.<sup>42</sup>

Prior to *Cruzan v. Director, Missouri Department of Health*, the United States Supreme Court had not ruled on whether the right of privacy encompassed the right of an individual to refuse medical treatment.<sup>43</sup> However, several state courts, taking into consideration the Court’s expansive view of substantive due process, have held that the constitutional right of privacy is broad enough to include the fundamental right of a competent patient “to chart his or her own medical treatment plan” and “to be free from unwanted infringements of bodily integrity, including medical treatment, in appropriate circumstances.”<sup>44</sup> In addition to holding that a competent patient’s

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33. *Paul v. Davis*, 424 U.S. 693, 713 (1976); see also *Palko v. Connecticut*, 302 U.S. 319, 325-26 (1937).

34. *Moore v. East Cleveland*, 431 U.S. 494, 503 (1977).

35. *Pierce v. Society of Sisters*, 268 U.S. 510 (1925).

36. *Roe v. Wade*, 410 U.S. 113, 153 (1973) (the right of privacy is a personal and individual right “broad enough to encompass a woman’s decision whether or not to terminate her pregnancy”). But see *Webster v. Reproductive Health Services*, 109 S. Ct. 3040 (1989) (limits on a woman’s right to obtain an abortion were upheld by the Court).

37. *Eisenstadt v. Baird*, 405 U.S. 438 (1972); see also *Carey v. Population Services Int’l*, 431 U.S. 678 (1977).

38. *Stanley v. Georgia*, 394 U.S. 557 (1969).

39. *Zablocki v. Redhail*, 434 U.S. 374 (1978).

40. *Moore v. East Cleveland*, 431 U.S. 494 (1977).

41. *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942).

42. See, e.g., *Bowers v. Hardwick*, 478 U.S. 186 (1986) (right of privacy does not encompass the right to engage in homosexual sodomy even in one’s own home); *State v. Murphy*, 117 Ariz. 57, 570 P.2d 1070 (1977) (federal constitutional right of privacy does not encompass the right to possess or ingest marijuana in one’s own home).

43. But see *Doe v. Bolton*, 410 U.S. 179, 213 (1973) (Douglas, J., concurring). “[T]he freedom to care for one’s health and person” is constitutionally protected. *Id.* (emphasis in original).

44. *Rasmussen v. Fleming*, 154 Ariz. 207, 214-15, 741 P.2d 674, 681-82 (1987); see also *Bouvia v. Superior Court (Glenchur)*, 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr.

right to refuse medical treatment falls within the constitutionally protected zone of privacy,<sup>45</sup> several state courts have also held that the right to refuse medical treatment is protected by their respective state constitutions.<sup>46</sup>

In sum, according to most state courts considering refusal of treatment cases prior to *Cruzan*, the United States Constitution, via a shadowy penumbra, and in some instances, state constitutions, provide for an individual right of privacy that encompasses and supports a competent patient's right to refuse medical treatment even if such a refusal will hasten the death of the patient.<sup>47</sup>

297, 301 (1986); *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 132, 482 A.2d 713, 717 (1984); *In re Severns*, 425 A.2d 156, 158 (Del. Ch. 1980); *Corbett v. D'Alessandro*, 487 So. 2d 368, 370 (Fla. Dist. Ct. App. 1986); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 739, 370 N.E.2d 417, 424 (1977); *Conservatorship of Torres*, 357 N.W.2d 332, 339-40 (Minn. 1984); *Cruzan v. Harmon*, 760 S.W.2d 408, 418 (Mo. 1988) (en banc), *aff'd*, 110 S. Ct. 2841 (1990); *In re Conroy*, 98 N.J. 321, 348, 486 A.2d 1209, 1222-23 (1985); *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1, 9, 426 N.E.2d 809, 813-14 (1980); *In re Colyer*, 99 Wash. 2d 114, 119-20, 660 P.2d 738, 741-42 (1983).

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An individual successfully can assert his or her constitutional right to privacy only against governmental acts and not against acts of a private defendant unless 'state action' exists. 'State action' is present when 'there is a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself.' We believe that the state's authority to license and regulate hospital, medical, dental and optometric service corporations, health care institutions, and physicians, surgeons and nurses, and its supervisory authority over the guardianship of incapacitated persons are factors that taken together are sufficient to establish state action [in the area of refusal of medical treatment . . . .

*Rasmussen*, 154 Ariz. at 215 n.9, 741 P.2d at 682 n.9 (citations omitted).

46. *Id.* at 215, 741 P.2d at 682 (pursuant to article 2, section 8 of the Arizona Constitution which expressly states that "[n]o person shall be disturbed in his private affairs, or his home invaded, without authority of law."); *see also Bouvia*, 179 Cal. App. 3d at 1137, 225 Cal. Rptr. at 301 (pursuant to article 1, section 1 of the California Constitution); *Guardianship of Browning*, 543 So. 2d 258, 267 (Fla. Dist. Ct. App. 1989) (pursuant to article 1, section 23 of the Florida Constitution); *In re Quinlan*, 70 N.J. 10, 40, 355 A.2d 647, 663 (pursuant to article 1, paragraph 1 of the New Jersey Constitution), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976); *Colyer*, 99 Wash. 2d at 120, 660 P.2d at 742 (pursuant to article 1, section 7 of the Washington Constitution).

47. *See In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987) (competent 37-year-old mother with a terminal illness had the right to the removal of her respirator although such a removal would hasten death); *Bouvia*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (competent 28-year-old quadriplegic, though not terminally ill, had the right to have removed a nasogastric feeding tube which was inserted against her will. In fact, the court commented that the right of a competent patient to refuse medical treatment is so basic

## B. Common Law Doctrine of Informed Consent

The right of self-determination and individual autonomy is deeply rooted in our Anglo-American tradition.<sup>48</sup> John Stuart Mill set forth his view of individual autonomy and personal liberty in this way:

[T]he only purpose for which power can be rightfully exercised over any member of a civilized community against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right. . . . The only part of the conduct of any one, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.<sup>49</sup>

The United States Supreme Court recognized an individual's right to be free from bodily invasion a century ago when it noted that, "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."<sup>50</sup> Judge Cardozo, prior to ascending to the Supreme Court, expressed this spirit of individual autonomy and freedom in the context of medical treatment when he stated that, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in

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and fundamental that "[i]ts exercise requires no one's approval. It is not merely one vote subject to being overridden by medical opinion."); *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984) (competent 70-year-old man, seriously ill, though not terminal, had the right to have his respirator and other life-support equipment removed, despite the fact that withdrawal of such devices would hasten his death); *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980) (competent 73-year-old man suffering from Lou Gehrig's disease had the right to seek removal of the respirator from his trachea).

48. See, e.g., Mill, *On Liberty*, reprinted in *THREE ESSAYS* 5 (1975).

49. *Id.* at 15.

50. *Union Pacific Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891).

damages.”<sup>51</sup>

Protection of this common law right to be free from non-consensual bodily invasions is at the core of what has become known as the doctrine of informed consent. This doctrine “arose in recognition of the value society places on a person’s autonomy and as the primary vehicle by which a person can protect the integrity of his body.”<sup>52</sup> Under this doctrine,

the patient must have the capacity to reason and make judgments, the decision must be made voluntarily and without coercion, and the patient must have a clear understanding of the risks and benefits of the proposed treatment alternatives or nontreatment, along with a full understanding of the nature of the disease and the prognosis.<sup>53</sup>

Although emergency situations require different rules, “[i]n general, the more intense and personal the consequences of a choice and the less direct or significant the impact of that choice upon others, the more compelling the claim to autonomy in the making of a given decision.”<sup>54</sup>

In view of the individual’s right to be free from unwanted bodily invasions and the requirement that physicians inform patients of all material facts and risks relating to their condition, the informed consent doctrine would be rendered useless if, “after receiving all information necessary to make an informed decision, the patient is forced to choose only from alternative methods of treatment and precluded from foregoing all treatment whatsoever.”<sup>55</sup> Many state courts have expanded the concept to include the right of a competent patient to withhold consent and refuse treatment even if such treatment involves life-sustaining procedures.<sup>56</sup> Freedom of choice, which underlies the

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51. *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914); see also *Cobbs v. Grant*, 8 Cal. 3d 229, 242, 104 Cal. Rptr. 505, 513, 502 P.2d 1, 9 (1972).

52. *Cruzan*, 760 S.W.2d at 417.

53. *Wanzer, Adelstein, Cranford, Federman, Hook, Moertel, Safar, Stone, Taussig & Van Eys, The Physician's Responsibility Toward Hopelessly Ill Patients*, 310 NEW ENG. J. MED. 955, 957 (1984).

54. *Shultz, From Informed Consent to Patient Choice: A New Protected Interest*, 95 YALE L.J. 219, 220 (1985).

55. *Rasmussen v. Fleming*, 154 Ariz. 207, 216, 741 P.2d 674, 683 (1987).

56. State courts which have held that a competent patient's right to refuse medical treatment is both a constitutional right and a common law right (pursuant to the doc-

common law right to be free from non-consensual physical invasions, "must include the possibility of alternative treatment or no treatment at all" and, therefore, according to many states, "encompasses the right [of competent patients] to refuse life sustaining treatment in certain circumstances."<sup>57</sup>

### C. *Incompetency and the Right to Refuse Life-Sustaining Treatment*

Beyond examining whether a particular state recognizes a competent patient's right to refuse life sustaining treatment pursuant to a constitutional right of privacy, the common law doctrine of informed consent, or both, it must be determined whether such a right survives the incompetency of the patient, even in circumstances where the patient left no clear indication of his intent prior to becoming incompetent.

Typically, only an individual can assert his common law or

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trine of informed consent) include Arizona (*Rasmussen*, 154 Ariz. at 216, 741 P.2d at 683), California (*Bouvia v. Superior Court* (Glenchur), 179 Cal. App. 3d 1127, 1134, 225 Cal. Rptr. 297, 300 (1986) ("It follows that such a [competent] patient has the right to refuse any medical treatment, even that which may save or prolong her life." (emphasis in original))), Connecticut (*Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 132, 482 A.2d 713, 718 (1984)), Massachusetts (*Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 431, 497 N.E.2d, 626, 633 (1986)), Minnesota (*Conservatorship of Torres*, 357 N.W.2d 332, 339-40 (Minn. 1984) (although the court recognized the common law right, it premised its holding on the constitutional and statutory right)), Missouri (*Cruzan v. Harmon*, 760 S.W.2d 408, 417 (Mo. 1988) (en banc), *aff'd*, 110 S. Ct. 2841 (1990)), New Jersey (*In re Farrell*, 108 N.J. 335, 348, 529 A.2d 404, 410 (1987)), and Washington (*In re Colyer*, 99 Wash. 2d 114, 121-22, 660 P.2d 738, 743 (1983)).

State courts which have expressly limited a competent patient's right to refuse life-sustaining treatment to the common law doctrine of informed consent (and have not recognized such a right pursuant to a constitutional right of privacy) include Illinois (*Estate of Longeway*, 133 Ill. 2d 33, 45, 549 N.E.2d 292, 297 (1989)), Maine (*In re Gardner*, 534 A.2d 947, 951 (Me. 1987)), and New York (*In re Storar* and *In re Eichner v. Dillon*, 52 N.Y.2d 363, 376-77, 420 N.E.2d 64, 70, 438 N.Y.S.2d 266, 272-273, *cert. denied*, 454 U.S. 858 (1981)).

Some state legislatures, when enacting legislation in this area, have also recognized the right to control one's own medical treatment and declared it to be fundamental. *See, e.g., CAL. HEALTH AND SAFETY CODE* § 7186 (West 1990) (the findings and declarations underlying California's Natural Death Act mandate an individual's fundamental right to have life-sustaining procedures withheld or withdrawn in instances of a terminal condition); *WASH. REV. CODE* § 7.70.050 (Supp. 1990).

57. *Colyer*, 99 Wash. 2d at 122, 660 P.2d at 743; *see also Gardner*, 534 A.2d at 951 ("An individual's right to control his medical care is not lessened when the treatment at issue involves life sustaining medical procedures.").

constitutional rights.<sup>58</sup> Because of the fundamental nature of the individual's right to be free of non-consensual invasion of one's bodily integrity,<sup>59</sup> however, state courts have logically concluded that "to deny the exercise [of the right] because the patient is unconscious would be to deny the right."<sup>60</sup>

The New York Supreme Court expressed the justification for such a conclusion this way:

We . . . conclude that by standards of logic, morality and medicine the terminally ill should be treated equally, whether competent or incompetent. Can it be doubted that the "value of human dignity extends to both"? What possible societal policy objective is vindicated or furthered by treating the two groups of terminally ill *differently*? What is gained by granting such a fundamental right only to those who, though terminally ill, have not suffered brain damage and coma in the last stages of the dying process? The very notion raises the spectra of constitutional infirmity when measured against the Supreme Court's recognition that incompetents must be afforded all their due process rights; indeed any State scheme which irrationally denies to the terminally ill competent patient is plainly subject to constitutional attack.<sup>61</sup>

In sum, state courts considering the issue have concluded that an individual's protected right to refuse life-sustaining medical treatment, whether based on the United States Constitution, a state constitution, or common law, survives the incompetency of the individual despite any failure to express his wishes regarding medical treatment prior to becoming incompetent.<sup>62</sup>

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58. See, e.g., *Bell v. Planning & Zoning Comm'n*, 174 Conn. 493, 391 A.2d 154 (1978).

59. See, e.g., *In re Peter*, 108 N.J. 365, 372, 529 A.2d 419, 423 (1987) ("All patients, competent or incompetent, with some limited cognitive ability or in a persistent vegetative state, terminally ill or not terminally ill, are entitled to choose whether or not they want life-sustaining medical treatment.").

60. *Severns v. Wilmington Medical Center*, 421 A.2d 1334, 1347 (Del. 1980).

61. *Rasmussen v. Fleming*, 154 Ariz. 207, 219, 741 P.2d 674, 686 (1987) (quoting *Eichner v. Dillon*, 73 A.D.2d 431, 464-65, 426 N.Y.S.2d 517, 542-43 (1980) (emphasis in original, citations omitted), *modified on other grounds sub nom. 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)).

62. See *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 745-46, 370 N.E.2d 417, 427-28 (1977):

[W]e recognize a general right in all persons to refuse medical treatment in appro-

### D. *The Four Countervailing State Interests*

As with any other individual right protected by either the Constitution or common law, the right to refuse medical treatment by either a competent or incompetent patient is not absolute.<sup>63</sup> It is well settled that the state has an interest in four areas: 1) preserving life; 2) protecting the interests of innocent third parties; 3) preventing suicide; and 4) maintaining the ethical integrity of the medical profession.<sup>64</sup>

The state's interest in preserving life is generally considered the most significant of the four.<sup>65</sup> The importance of this interest is justified since it "embrac[es] two separate but related concerns: an interest in preserving the life of the particular patient,

appropriate circumstances. The recognition of that right must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both. . . . To protect the incompetent person within its power, the State must recognize the dignity and worth of such a person and afford to that person the same panoply of rights and choices it recognizes in competent persons.

*Id.* at 745-46, 370 N.E.2d at 427-28; *see also* *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 207-08, 245 Cal. Rptr. 840, 854-55 (1988) (the court based its conclusion primarily on the California Supreme Court case of *Conservatorship of Valerie N.*, 40 Cal. 3d 143, 219 Cal. Rptr. 387, 707 P.2d 760 (1985), in which the court expressly held that a severely retarded and incompetent individual, had the same fundamental rights as a competent person in the area of procreative choice despite any statutory prohibitions to the contrary); *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 133, 482 A.2d 713, 718 (1984); *Severns*, 421 A.2d at 1347; *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So. 2d 921, 923 (Fla. 1984); *In re Conroy*, 98 N.J. 321, 359, 486 A.2d 1209, 1229 (1985); *Quinlan*, 70 N.J. at 41, 355 A.2d at 664 ("If a putative decision by Karen to permit this non-cognitive, vegetative existence to terminate by natural forces is regarded as a valuable incident of her right of privacy . . . then it should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice."); *In re Colyer*, 99 Wash. 2d 114, 123, 660 P.2d 738, 744 (1983).

63. *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1, 9 (1980). ("On one side of the scale, this court must place a constitutionally protected right; on the other, any potential interest, either societal or legal, that the state might wish to protect.").

64. *See, e.g., Rasmussen v. Fleming*, 154 Ariz. 207, 216, 741 P.2d 674, 683 (1987); *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 195, 209 Cal. Rptr. 220, 225 (1984); *Foody v. Manchester Memorial Hospital*, 40 Conn. Supp. 127, 132-34, 482 A.2d 713, 718 (1984); *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 741, 370 N.E.2d 417, 425 (1977); *In re Conroy*, 98 N.J. 321, 348-49, 486 A.2d 1209, 1223 (1985); *Leach*, 68 Ohio Misc. at 9; *In re Colyer*, 99 Wash. 2d 114, 122, 660 P.2d 738, 743 (1983).

65. *See, e.g., Saikewicz*, 373 Mass. at 740, 370 N.E.2d at 425; *Conroy*, 98 N.J. at 349, 486 A.2d at 1223; *PRESIDENT'S COMMISSION REPORT*, *supra* note 4, at 32.

and an interest in preserving the sanctity of life.”<sup>66</sup> The second state interest involves the protection of innocent third parties, specifically minor children, from emotional or financial damage resulting from an individual’s choice to refuse life sustaining treatment.<sup>67</sup> The third state interest, the prevention of suicide, is self-explanatory.<sup>68</sup> The fourth state interest, safeguarding the integrity of the medical profession, involves both the review of modern medical practices and professional attitudes towards refusal of treatment scenarios and the ability of hospitals and physicians to effectively treat patients.<sup>69</sup>

Despite the considerable magnitude and legitimacy of these four state interests, state courts have not found them to be compelling or substantial enough to outweigh the right to refuse life-sustaining medical treatment.<sup>70</sup> This statement, of course, begs the question of how the state courts have universally justified such a conclusion.<sup>71</sup>

Although the state interest in the preservation of life is most significant, such an interest must be balanced against the individual’s interest in refusing to endure the tremendous cost of prolonging life.<sup>72</sup> State court decisions generally view the pa-

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66. *Conroy*, 98 N.J. at 349, 486 A.2d at 1223; see also *Rasmussen*, 154 Ariz. at 216, 741 P.2d at 683.

67. *Saikewicz*, 373 Mass. at 742, 370 N.E.2d at 426; see also *Conroy*, 98 N.J. at 353, 486 A.2d at 1225 (“When the patient’s exercise of his free choice could adversely and directly affect the health, safety, or security of others. . .”).

68. See *infra* notes 87-90 and accompanying text.

69. *Leach*, 68 Ohio Misc. at 10.

70. See, e.g., *Rasmussen*, 154 Ariz. at 216-18, 741 P.2d at 683-85; *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 132-34, 482 A.2d at 713, 718-20 (1984); *In re Severns*, 425 A.2d 156, 158-59 (Del. Ch. 1980); *Estate of Longeway*, 133 Ill. 2d 33, 48, 549 N.E.2d 292, 299 (1989); *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 432-40, 497 N.E.2d 626, 634-39 (1986); *Conservatorship of Torres*, 357 N.W.2d 332, 339 (Minn. 1984); *Conroy*, 98 N.J. at 348-55, 486 A.2d at 1223-25; *Leach*, 68 Ohio Misc. at 9-10.

71. Subordination of state interests has not been so universal when other circumstances surrounded an individual’s choice to refuse medical treatment. This is true particularly in the area of blood transfusions. See, e.g., *In re President & Directors of Georgetown College*, 331 F.2d 1000 (D.C. Cir.) (state interest in preventing the abandonment of a child outweighed mother’s religious objection to receiving a blood transfusion) *cert. denied*, 377 U.S. 978 (1964); *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971) (patient’s express refusal of a blood transfusion, based on religious beliefs, was outweighed by the state’s interest in preserving life).

72. *Saikewicz*, 373 Mass. at 742, 370 N.E.2d at 425; see also *Foody*, 40 Conn. Supp. at 134, 482 A.2d at 718.



tient's prognosis<sup>73</sup> as being determinative of the state interest, while the nature of the treatment (i.e., usefulness, benefits, and intrusiveness of the treatment) typically frames the patient's interest.<sup>74</sup> Consequently, the general rule balancing these interests, first utilized by the *Quinlan* court, is that the state's interest in the preservation of life "weakens and the individual's right of privacy grows as the degree of bodily invasion [associated with the treatment in question] increases and the prognosis dims."<sup>75</sup>

In other words, the state's interest in preserving life is extreme when "the affliction is curable,"<sup>76</sup> but the interest ebbs and the balance shifts when the issue is not "whether, but when, for how long, and at what cost to the individual that life may be briefly extended."<sup>77</sup> As a result of this analysis, courts have effectively removed this significant state interest as an obstacle to the expression of a patient's right to refuse life-sustaining treatment, either personally or through a surrogate. This result seems appropriate, since the circumstances typically reflect a terminally ill or persistent vegetative patient with a prognosis of no recovery and potential medical treatment that involves a high degree of bodily invasion<sup>78</sup> that will prolong life at an extreme and traumatic cost to the patient.<sup>79</sup>

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73. See generally Note, *The "Terminal Condition" Condition in Virginia's Natural Death Act*, 73 VA. L. REV. 749, 771 (1987) (contrasting *Quinlan's* "prognosis based approach" with the approach of particular state statutes that view the patient's life expectancy as determinative of the state interest within this balance).

74. *Foody*, 40 Conn. Supp. at 134, 482 A.2d at 718-19.

75. *In re Quinlan*, 70 N.J. 10, 41, 355 A.2d 647, 664 cert. denied sub nom. *Garger v. New Jersey*, 429 U.S. 922 (1976).

76. *Saikewicz*, 373 Mass. at 742, 370 N.E.2d at 425-26.

77. *Id.*; see also *In re Spring*, 8 Mass. App. Ct. 831, 399 N.E.2d 493 (1979), rev'd on other grounds, 380 Mass. 629, 405 N.E.2d 115 (1980):

The general State interest in the preservation of life — most weighty where the patient, properly treated, can return to reasonable health, without great suffering, and a decision to avoid treatment would be aberrational — carries far less weight where the patient is approaching the end of his normal life span, where his afflictions are incapacitating, and where the best that medicine can offer is an extension of suffering.

*Id.* at 845-46, 399 N.E.2d at 502.

78. *Foody*, 40 Conn. Supp. at 135, 482 A.2d at 719 (examples include "around the clock nursing care, drugs to control brain seizures, the assistance of a respirator, a lung cleaning suction catheter and a nasogastric feeding tube.").

79. See, e.g., *Saikewicz*, 373 Mass. at 731-33, 370 N.E.2d at 420-22; *Brophy*, 398 Mass. at 421-27, 497 N.E.2d at 628-31; *Foody*, 40 Conn. Supp. at 135, 482 A.2d at 719; *Severns*, 425 A.2d at 157; *Leach*, 68 Ohio Misc. at 3; *Longeway*, 133 Ill. 2d at 36, 549

The second state interest considered is the protection of innocent third persons, which in the context of refusal of treatment cases typically involves children.<sup>80</sup> Courts have lessened the weight of this interest with respect to the patient's right to refuse life-sustaining medical treatment, when his condition is terminal or persistently vegetative, in three ways. First, and perhaps easiest for the court, is the situation when the patient has no children who might suffer materially or emotionally from the patient's decision to withdraw life-sustaining equipment. In these circumstances, the interest of third parties is minimal, at best, and does not outweigh the patient's right.<sup>81</sup>

Second, is the situation when the spouse and children of a patient, as well as a litany of friends and relatives, join in asking the court for a discontinuation of the life-support systems given the patient's irreversible condition and desire to exercise her right to refuse such treatment. As in the first instance, the interest of other third parties in such a situation is minimal or does not exist and is outweighed by the patient's right.<sup>82</sup>

Last, is the situation when a patient wishing to exercise his right to refuse life-sustaining medical treatment has children as well as a spouse who do not expressly join in asking the court to discontinue life-support systems. Nevertheless, the state's interest in protecting innocent third parties still does not outweigh the patient's interest. For example, in *In re Farrell*,<sup>83</sup> where a terminally ill, competent, thirty-seven-year-old wife and mother of two teenage sons wished to remove her life support systems and "die with dignity," the court distinguished this case from one in which a parent could be forced to accept treatment, as for example, in the area of blood transfusions, because recovery was

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N.E.2d at 293; *Colyer*, 99 Wash. 2d at 116, 660 P.2d at 740.

80. See, e.g., *In re President & Directors of Georgetown College*, 331 F.2d 1000, 1008 (D.C. Cir.) (blood transfusion ordered to save the life of a mother, despite her religious beliefs to the contrary, given the state interest in preventing the abandonment of her child, and the mother's "responsibility to the community to care for her infant") cert. denied, 377 U.S. 978 (1964); *Holmes v. Silver Cross Hosp.*, 340 F. Supp. 125 (N.D. Ill. 1972) (overruling a father's refusal to undergo a blood transfusion to save his life since his refusal would devastate his dependents); *John F. Kennedy Memorial Hosp. v. Hesston*, 58 N.J. 576, 279 A.2d 670 (1971) (blood transfusion ordered for a pregnant woman).

81. See, e.g., *Foody*, 40 Conn. Supp. at 137-38, 482 A.2d at 720.

82. See, e.g., *Leach*, 68 Ohio Misc. at 9-10.

83. 108 N.J. 335, 529 A.2d 404 (1987); see also *supra* note 47.

feasible and the security of the surviving children was threatened.<sup>84</sup> The *Farrell* court instead found that Mrs. Farrell had considered her children's interests when deciding to withdraw her respirator, and that her husband's capacity to care for the children in her absence was "unquestioned."<sup>85</sup> Therefore, the court held that the state interest in the protection of innocent third persons was not sufficient to override her right to decide.<sup>86</sup>

The third state interest in the prevention of suicide has generally received little discussion by the courts. In short, a patient's decision to cease life-sustaining medical treatment does not constitute suicide.<sup>87</sup> This conclusion is true because:

- (1) in refusing treatment the patient may not have the specific intent to die, and (2) even if he did, to the extent that the cause of death was from natural causes the patient did not set the death-producing agent in motion with the intent of causing his own death.<sup>88</sup>

Patients who choose to forego life-sustaining treatment typically do not have a specific intent to die, but fervently wish to live only if they can do so without medical technology, surgery, drugs, or prolonged suffering.<sup>89</sup> In essence, "[r]efusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of self-inflicted injury."<sup>90</sup>

A final state interest which is often offered as a potential limitation on an individual's right to refuse medical treatment, is that of safeguarding the integrity of the medical profession. Although the view that medical ethics do not require medical intervention at all costs has only recently gained wide support,

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84. *Farrell*, 108 N.J. at 352, 529 A.2d at 413.

85. *Id.*

86. *Id.*

87. *Quinlan*, 70 N.J. at 51-52 & n.9, 355 A.2d at 670 & n.9.

88. *Saikewicz*, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11; see also *Colyer*, 99 Wash. 2d at 123, 660 P.2d at 743; Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 FORDHAM L. REV. 1, 17-18 (1975).

89. See *Satz v. Perlmutter*, 362 So. 2d 160, 162-63 (Fla. Dist. Ct. App. 1978) ("The testimony of Mr. Perlmutter . . . is that he really wants to live, but [to] do so, God and Mother Nature willing, under his own power.") *aff'd*, 379 So. 2d 359 (Fla. 1980).

90. *Conroy*, 98 N.J. at 351, 486 A.2d at 1224.

as long ago as 1624 Francis Bacon wrote, "I esteem it to the office of a physician not only to restore health, but to mitigate pain and dolours; and not only when such mitigation may conduce to recovery, but when it may serve to make a fair and easy passage."<sup>91</sup>

This view is now the official position of the American Medical Association, which in 1986 stated:

The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his family or legal representative if the patient is incompetent to act in his own behalf, should prevail.

. . . .

Even if death is not imminent but a patient's coma [or terminal illness] is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, *it is not unethical to discontinue all means of life prolonging medical treatment.*<sup>92</sup>

In addition to demonstrating that refusal of treatment cases involving comatose or terminally ill patients will not "bring into disrepute the ethical integrity of the medical profession,"<sup>93</sup> the profession has abandoned the mostly symbolic and ethical distinction between life-sustaining or prolonging procedures that provide oxygen (respirators) or waste disposal (dialysis machines or catheters) and procedures that involve the artificial provision of nutrition and hydration such as the insertion of nasogastric tubes.<sup>94</sup>

91. F. Bacon, *New Atlantis* quoted in Mannes, *Euthanasia vs. The Right to Life*, 27 BAYLOR L. REV. 68, 69 (1975).

92. American Medical Association Council on Ethics & Judicial Affairs, *Withholding or Withdrawing Life-Prolonging Medical Treatment*, Opinion 2.18 (March 15, 1986) (emphasis added); see also *Bartling*, 163 Cal. App. 3d at 196, 209 Cal. Rptr. at 225; *Saikewicz*, 373 Mass. at 743-44, 370 N.E.2d at 426-27 ("Recognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores; such a doctrine does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the State's interest in protecting the same."); *Colyer*, 99 Wash. 2d at 123, 660 P.2d at 744.

93. *Rasmussen*, 154 Ariz. at 218, 741 P.2d at 685.

94. See American Medical Association Opinion 2.18, *supra* note 92. "[A]rtificially or technologically supplied respiration, nutrition or hydration" is equivalent to other forms of life-sustaining or prolonging medical treatment for the purposes of defining the right

State courts have also agreed that although there is a certain amount of emotional symbolism attached to the provision of nutrition and hydration, "there is no legal difference between a mechanical device that allows a person to breathe artificially and a mechanical device that artificially allows a person nourishment."<sup>95</sup> As a result, both the courts and the medical profession have recognized that the provision of artificial nutrition and hydration should be treated as any other medical treatment when the patient is irreversibly ill. These institutions have further recognized that the termination of such procedures does not impugn the integrity of the medical profession since termination "does not deprive the patient of life; rather, the inability of the patient to chew or swallow, as a result of his illness, is viewed as the ultimate agent of death."<sup>96</sup>

In sum, state courts have found the state's interest in maintaining the ethical integrity of the medical profession to be insufficient to deny the patient's wishes in treatment situations where he is either terminally ill or in a persistent vegetative state. In light of the position of the medical profession, which finds the expression of such a right completely consistent with the current state of medical ethics, the patient's right to refuse or withdraw any life-support system, whether it be a respirator

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of the patient to reject or accept such bodily invasions. *Id.*

95. *Gray v. Romeo*, 697 F. Supp. 580, 587 (D.R.I. 1988); see also *Estate of Longeway*, 133 Ill. 2d 33, 41-42, 549 N.E.2d 292, 295-96; *In re Gardner*, 534 A.2d 947, 954-55 (Me. 1987); *Corbett v. D'Alessandro*, 487 So. 2d 368, 371 (Fla. Dist. Ct. App. 1986); PRESIDENT'S COMMISSION REPORT, *supra* note 4, at 190.

Similarly, the state courts have abandoned the traditional distinction between ordinary and extraordinary medical treatment, which had been dispositive of whether to discontinue life-sustaining measures in refusal of treatment cases, since "while there is medical recognition of the right of a sapient and sentient patient to refuse extraordinary treatment, when a patient is in an apparently non-reversible vegetative state . . . the distinction between ordinary and extraordinary medical treatment becomes blurred . . . ." *Severns*, 425 A.2d at 159; see also *Foody*, 40 Conn. Supp. at 135-37, 482 A.2d at 719-20; *Conroy*, 98 N.J. at 369-74, 486 A.2d at 1233-37 (rejection of categorical distinctions between actively hastening death by terminating treatment and passively allowing someone to die of a disease, between ordinary and extraordinary treatment, and between treatment by artificial feeding and other forms of life-sustaining procedures); PRESIDENT'S COMMISSION REPORT, *supra* note 4, at 82-87 (in the past, this distinction was used to distinguish obligatory (or ordinary) from optional (or extraordinary) care).

96. *Longeway*, 133 Ill. 2d at 42, 549 N.E.2d at 296; see also *Brophy*, 398 Mass. at 439, 497 N.E.2d at 638; *Delio v. Westchester County Medical Center*, 129 A.D.2d 1, 23-24, 516 N.Y.S.2d 677, 691-92 (2d Dep't 1987).

or a nasogastric tube, is extremely compelling.<sup>97</sup>

### E. *The Role of the Judicial Branch*

An appropriate inquiry at this point, and one that has sparked a debate of its own between judges and commentators alike, is what role courts should play in situations involving the expression of a right to refuse life-sustaining treatment and to what extent judicial involvement should be required in such cases.

The seminal right to die case, *In re Quinlan*,<sup>98</sup> entrusted to the patient's guardian, family, attending physicians, and a hospital "ethics committee" the decision of whether to continue artificial life support in future situations.<sup>99</sup> The court felt there was no legitimate reason to remove such a complex decision from the control of the medical profession and held that "a practice of applying to a court to confirm such decisions would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome."<sup>100</sup>

One year later, however, the Massachusetts Supreme Judicial Court in *Superintendent of Belchertown State School v. Saikewicz*,<sup>101</sup> viewed the role of the court quite differently. The court expressly rejected the *Quinlan* approach and took "a dim view of any attempt to shift the ultimate decision-making responsibility" away from the courts to any other group held out

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97. The ethical integrity of the medical profession has been further ensured by the state courts not requiring any medical facility or its staff to act contrary to their particular moral or ethical principles when irreversibly ill patients are involved. As a result, courts have required the patient to be transferred to a different facility, or a new physician to be appointed to carry out the patient's choice, if the current staff or physician cannot. See *Brophy*, 398 Mass. at 439-41, 497 N.E.2d at 638-39. But see *Elbaum v. Grace Plaza of Great Neck*, 148 A.D.2d 244, 544 N.Y.S.2d 840 (1989) (nursing care facility would be required to remove the gastrointestinal tube providing nutrition and hydration to a 63-year-old patient in an irreversible, persistent vegetative state, in accordance with her prior statements, if a suitable facility that would accede to her wishes could not be found within ten days).

98. 70 N.J. 10, 355 A.2d 647 (1976), cert. denied sub nom. *Garger v. New Jersey*, 429 U.S. 922 (1976).

99. *Quinlan*, 70 N.J. at 55, 355 A.2d at 671.

100. *Id.* at 50, 355 A.2d at 669.

101. 373 Mass. 728, 370 N.E.2d 417 (1977).

to represent the "morality and conscience of our society."<sup>102</sup> Furthermore, the *Saikewicz* court, quite definitively, treated judicial resolution of whether potentially life-prolonging treatment should be withheld from an incompetent patient as a nondelegable duty of the courts, since such a life and death determination "require[s] the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created."<sup>103</sup>

The immediate reaction to the *Saikewicz* view was anything but friendly.<sup>104</sup> In fact, the majority of recent cases that speak to this issue still support the *Quinlan* approach of judicial noninvolvement when at all possible.<sup>105</sup> In essence, the *Quinlan* view advocates judicial involvement in decisions where the removal of life-sustaining treatment is an issue only because of a dispute between the interested parties.<sup>106</sup>

Despite the general disapproval of the *Saikewicz* view by commentators and courts, this view has perhaps gained new vitality with the recent decision of the Illinois Supreme Court in *Estate of Longeway*.<sup>107</sup> While recognizing that some would consider court intervention objectionable, and that the medical profession would perhaps resent it, the *Longeway* court supported the *Saikewicz* view for three substantial reasons: 1) the state's strong public policy of preserving the sanctity of life, which is

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102. *Id.* at 758-59, 370 N.E.2d at 434.

103. *Id.* at 759, 370 N.E.2d at 435.

104. See, e.g., Curran, *The Saikewicz Decision*, 298 NEW ENG. J. MED. 499 (1978); Relman, *The Saikewicz Decision: Judges as Physicians*, 298 NEW ENG. J. MED. 508 (1978). But see Baron, *Medical Paternalism and the Rule of Law: A Reply to Dr. Relman*, 4 AM. J. L. & MED. 337 (1978) (judicial intervention is the only mechanism to guarantee due process to the incompetent patient).

105. See, e.g., *Rasmussen*, 154 Ariz. at 223-24, 741 P.2d at 690-91 (although the court did recognize that a minimal amount of judicial involvement is inescapable where guardianship is sought and/or an incompetency hearing is necessary); *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 203, 245 Cal. Rptr. 840, 850-51 (1988); *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So. 2d 921, 925-26 (Fla. 1984) (pursuant to particular parameters within which a surrogate decisionmaker must operate, prior court approval for termination of life-support systems is too burdensome since, in general, such a decision should be made within the patient-doctor-family relationship); *In re L.H.R.*, 253 Ga. 439, 442-45, 321 S.E.2d 716, 720-21 (1984); *In re Colyer*, 99 Wash. 2d 114, 136, 660 P.2d 738, 750 (1983).

106. *Rasmussen*, 154 Ariz. at 224, 741 P.2d at 691; see also *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

107. 133 Ill. 2d 33, 549 N.E.2d 292 (1989).

preserved in refusal of treatment cases through the complex determination of a patient's intent prior to incompetence; 2) court intervention is necessary to ensure against the remote possibility of greed tainting the judgment of the surrogate decisionmaker; and 3) the *parens patriae* power of the court, which enables it to protect the estate and person of incompetents.<sup>108</sup>

As an epilogue to this debate over the degree of judicial involvement necessary to the resolution of refusal of life-sustaining treatment cases and as a prologue to the heart of this analysis (i.e., a discussion of the two tests utilized by the courts in handling these situations), the apparent conclusion is that the *Quinlan* approach to judicial involvement is theoretically and perhaps, philosophically correct, while practically, the *Saikewicz* and *Longeway* approach necessarily must be followed. Although the judiciary may wish to remain detached from such personal decisions as an individual's right to remove life sustaining medical treatment and leave such a determination primarily to the individual, family and attending physicians, this wish is impracticable. As long as ineffective statutory remedies exist, different evidentiary burdens are required to demonstrate a patient's intent, objective factors are required to be measured, and legal, moral, and ethical disputes arise between the interested parties in individual cases,<sup>109</sup> the judicial branch must be the ultimate

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108. *Id.* at 51-53, 549 N.E.2d at 300-01.

109. Even the *Quinlan* approach, as modified by later decisions, see *supra* note 105, recognizes that the judicial branch must get involved when there is a dispute between the interested parties as to whether or not medical treatment should be withheld to provide an equitable solution. Practically speaking, this situation almost always occurs since a dispute usually arises between the surrogate decisionmaker and/or the family, and the state, via the physicians or the guardian ad litem. The state must always assert its interest in preserving life and is typically reluctant to give up such an interest without a court mandate.

The guardian ad litem is appointed by the court to represent the interests of the incapacitated person when the person has no counsel and, typically, when the physicians or health care facility agree with the guardian's request to withhold medical treatment from the incompetent patient. The guardian ad litem performs both procedural and substantive duties and, in general, is required to discover all facts relevant to the medical treatment of the patient in an attempt to ensure that the guardian's request to remove life-sustaining treatment from the incompetent patient is, indeed, the best course of action for the patient. Such a role on behalf of the incompetent patient necessarily implies an adversarial relationship with the surrogate decisionmaker and is an additional reason why, even under the *Quinlan* approach, courts are needed to resolve such matters. See generally *Rasmussen*, 154 Ariz. at 222-23, 741 P.2d at 689-90; *Colyer*, 99 Wash. 2d at



arbitrator. Otherwise, the family of the patient may have no other recourse to protect the right of the patient to "die with dignity."

## F. Summary

All states considering this issue have agreed that an individual right to refuse life-sustaining medical treatment does exist and is protected pursuant to the common law, the federal or state constitution or in some instances, all three. Additionally, the states have agreed that such a right extends to both competent and incompetent patients but is subject to the four countervailing state interests discussed above. This underlying framework brings us to the heart of the debate permeating right to die scenarios. Faced with an incompetent patient who is either terminally ill or in a persistent vegetative state, how can a surrogate decisionmaker<sup>110</sup> preserve the patient's protected right to

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133-34, 660 P.2d at 748-49.

110. Whether the selection of a surrogate decisionmaker requires court proceedings is an issue that has not been expressly faced by many courts. In *In re Quinlan*, the New Jersey Supreme Court upheld the appointment of Karen Quinlan's father as her guardian, but did not explicitly rule on whether the surrogate always needed to be court appointed. 70 N.J. 10, 355 A.2d 647 (1976), cert. denied sub nom. Garger v. New Jersey, 429 U.S. 922 (1976). In *Superintendent of Belchertown State School v. Saikewicz*, the Massachusetts Supreme Judicial Court held that, in general, a court-designated guardian should be named as a surrogate for a patient who lacks judicial capacity. 373 Mass. 728, 370 N.E.2d 417 (1977). But see *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So. 2d 921, 926 (Fla. 1984) (provided certain prerequisites are satisfied, a judicially appointed guardian is not required if there are close family members willing to exercise the patient's right to refuse life-sustaining medical treatment); *In re Browning*, 543 So. 2d 258, 270 (Fla. Dist. Ct. App. 1986) (legal guardian is not essential to make life-sustaining medical decisions despite the court's advocacy due to the great amount of responsibility involved), *aff'd*, 568 So. 2d 4 (Fla. 1990).

As a practical matter, regardless of whether the appointment of a surrogate decisionmaker by the court is mandatory when the family does not seek it, in almost all of the refusal of medical treatment cases, a close family member has been appointed by the court at the request of the family member, to be the guardian or conservator and, hence, the surrogate decisionmaker for the incompetent patient. See, e.g., *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 189, 245 Cal. Rptr. 840, 841 (1988) (brother); *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 128, 482 A.2d 713, 715 (1984) (father); *Estate of Longeway*, 133 Ill. 2d 33, 36, 549 N.E.2d 292, 293 (1989) (daughter); *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 419, 497 N.E.2d 626, 629 (1986) (wife). But see *Browning*, 543 So. 2d at 262 (the court appointed the incompetent patient's second cousin as the guardian and surrogate decisionmaker because this was her closest living relative); *Rasmussen v. Fleming*, 154 Ariz. 207, 219-20, 741 P.2d 674, 686-87 (1987) (the court appointed the public fiduciary as the incompetent patient's guardian and surrogate decisionmaker). Court appointment of a guardian or conservator is impliedly necessary

refuse life-sustaining medical treatment and what standards, requirements, and limitations, must be followed to preserve both the autonomy of the patient and the interests of the state?

Because of its personal nature, the state courts have approached this issue with great reluctance. Nevertheless, given the lack of express legislative guidance in this area and the public need for guidelines in making such life and death determinations, the state courts have not shirked their responsibility to provide guidance. Accordingly, these courts have developed two different approaches and three standards to deal with the protection and expression of an incompetent individual's right to refuse life-sustaining treatment. These approaches balance the numerous competing interests involved and attempt to provide equitable solutions to this complex problem until the legislature "streamline[s], tailor[s], or overrule[s] the procedures . . . to the extent that no constitutional doctrine is abrogated."<sup>111</sup> These approaches have been labeled the "substituted judgment" approach and the "best interests" approach.

### III. State Court Decisions

#### A. *Substituted Judgment and Best Interests*

Both the substituted judgment approach and the best interests approach for surrogate decisionmaking on behalf of incompetent patients are driven by the two traditional values that guide decisionmaking for competent patients: promoting patient welfare and respecting patient self-determination.<sup>112</sup>

The substituted judgment doctrine requires the court or a surrogate decisionmaker to "don the mental mantle of the in-

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by states that utilize the best interests approach for surrogate decisionmaking. The support for such an approach is derived from the guardian appointment section of the probate code of a particular state; that is, to utilize such an approach normally requires the appointment of a guardian or conservator as a prerequisite. See *infra* notes 301-50 and accompanying text. But see *In re Hamlin*, 102 Wash. 2d 810, 818, 689 P.2d 1372, 1377 (1984) (court appointment of a guardian is not necessary if the incompetent patient's immediate family, after consultation with the medical prognosis committee, agrees that the patient's best interests would be served by the removal of life-sustaining medical treatment).

111. *Longeway*, 133 Ill. 2d at 53, 549 N.E.2d at 301.

112. PRESIDENT'S COMMISSION REPORT, *supra* note 4, at 132.

competent"<sup>113</sup> and to "substitute itself [or himself] as nearly as may be for the incompetent, and to act upon the same motives and considerations as would have moved [the patient]."<sup>114</sup> The doctrine had its origin 175 years ago in England when it was applied to authorize a gift from the estate of an incompetent person.<sup>115</sup> More recently the doctrine has been broadened to provide guardians with the authorization to consent to certain medical treatments on behalf of the ward.<sup>116</sup> By analogy, the state courts have used the doctrine to allow guardians to refuse certain medical treatments on behalf of the ward even if such a refusal will hasten the patient's death.

Within refusal of treatment scenarios, the doctrine of substituted judgment calls upon the surrogate decisionmaker to establish, with as much accuracy as possible, what decision a competent patient would have made with regard to the refusal of life-sustaining medical treatment.<sup>117</sup> Employing this approach as a way to preserve the incompetent patient's right of refusal is purely subjective in nature, and requires the surrogate to determine first whether or not the patient, prior to becoming incompetent, demonstrated an explicit intent to refuse certain types of medical treatment in specific situations.<sup>118</sup> Where no express intent is evident, the surrogate, guided by the personal value system of the patient, must attempt to identify how the patient would have approached the decision had he been competent; thus

even if no prior specific statements were made, in the context of the individual's entire mental life, including his or her philosophi-

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113. *In re Carson*, 39 Misc. 2d 544, 545, 241 N.Y.S.2d 288, 289 (N.Y. Sup. Ct. 1962).

114. *City Bank Farmers Trust Co. v. McGowan*, 323 U.S. 594, 599 (1945).

115. *Ex parte Whitbread in re Hinde*, a Lunatic, 35 Eng. Rep. 878 (1816); see also *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 751-52, 370 N.E.2d 417, 431 (1977).

116. See, e.g., *Strunk v. Strunk* 445 S.W.2d 145 (Ky. Ct. App. 1969) (renal transplant); *Guardianship of Moe*, 385 Mass. 555, 432 N.E.2d 712 (1982) (sterilization); *Guardianship of Roe*, 383 Mass. 415, 421 N.E.2d 40 (1981) (forcible administration of antipsychotic drugs).

117. PRESIDENT'S COMMISSION REPORT, *supra* note 4, at 132.

118. New York, Maine, and Missouri refuse to allow the surrogate to go beyond this determination in refusal of life-sustaining treatment cases. This rule, which will be elaborated on in the next section, has become known as the specific subjective intent rule. See *infra* notes 123-70 and accompanying text.

cal, religious and moral views, life goals, values about the purpose of life and the way it should be lived, and attitudes toward sickness, medical procedures, suffering and death, that individual's likely treatment/nontreatment preferences can be discovered. Family members are most familiar with this entire life context.<sup>119</sup>

In circumstances where the patient has never been competent or has failed to indicate preference while competent, the surrogate decisionmaker must make a decision for the patient regarding the removal of life-sustaining treatment according to the best interests approach. This requires the surrogate to take into consideration more "objective, societally shared criteria."<sup>120</sup> Under this standard, the surrogate decisionmaker determines what medical treatment would be in the best interests of the incompetent patient by reviewing criteria such as relief of suffering, the preservation or restoration of functioning, and the quality as well as the duration of life.<sup>121</sup> In addition, the best interests approach requires the surrogate to consider other objective facts, such as the incompetent patient's age, level of consciousness, medical condition, isolation, and restrictions on physical freedom. This analysis promotes an accurate determination of a patient's best interests with regard to the refusal of life-sustaining treatment that "will encompass consideration of the satisfaction of present desires, the opportunities for future satisfactions, and the possibility of developing or regaining the capacity for self-determination."<sup>122</sup>

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119. Newman, *Treatment Refusals for the Critically Ill: Proposed Rules for the Family, the Physician and the State*, 3 N.Y.L. SCH. HUM. RTS. ANN. 47 (1985).

It should be noted that although the scope of this comment focuses primarily on surrogate decisionmaking with regard to refusal of life-sustaining treatment for incompetent, adult patients, the doctrine of substituted judgment has also been applied to newborn infants whose brains were irreversibly damaged at birth and were, consequently, in persistent vegetative states; in each instance, the court concluded that the interests of the terminally ill infant outweighed the interests of the state and that the parents of the child, via substituted judgment, could validly assert a privacy interest on behalf of the infant and authorize the removal of life-sustaining and support treatment. See *In re P.V.W.*, 424 So. 2d 1015 (La. 1982); *In re L.H.R.*, 253 Ga. 439, 321 S.E.2d 716 (1984); *Guardianship of Barry*, 445 So. 2d 365 (Fla. 1984).

120. PRESIDENT'S COMMISSION REPORT, *supra* note 4, at 135.

121. *Id.* at 135. By "quality of life" the reference is to "the value that the continuation of life has for the patient," and not "the value that others find in the continuation of the patient's life . . ." *Id.* at 135, n.43.

122. *Id.* at 135.

## B. *The Substituted Judgment States*

### 1. *New York*

The New York Court of Appeals first confronted the "right to die" issue in *In re Storar* and *In re Eichner v. Dillon*,<sup>123</sup> a consolidation of two cases. *Eichner* involved Brother Fox, an eighty-three-year-old member of the Society of Mary, who was being maintained by a respirator in a permanent vegetative state.<sup>124</sup> The local director of the society, Father Eichner, after being appointed committee (or guardian) of the patient's person and property, applied to have the respirator removed.<sup>125</sup> His petition was based on the reasonable likelihood that Brother Fox would never awake from the vegetative coma and evidence that, prior to becoming incompetent, the patient had made it known through discussions relating to Catholic moral principles that he would not want to be sustained by a respirator in such circumstances.<sup>126</sup> Although the court did not expressly recognize the use of the substituted judgment doctrine in Brother Fox's situation,<sup>127</sup> it granted Father Eichner's application to remove the respirator on behalf of the patient because clear and convincing evidence<sup>128</sup> of the patient's wishes was presented.<sup>129</sup> The court indicated that the proof presented was "compelling" because Brother Fox had

carefully reflected on the subject, expressed his views and con-

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123. 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981), *cert. denied*, 454 U.S. 858 (1981).

124. *Id.* at 369, 420 N.E.2d at 66, 438 N.Y.S.2d at 268.

125. *Id.* at 372, 420 N.E.2d at 68, 438 N.Y.S.2d at 270.

126. *Id.*

127. "[T]hat issue [whether, in case of incompetency, a decision to discontinue life-sustaining medical treatment may be made by someone other than the patient] is not presented in this case because here Brother Fox made the decision for himself before he became incompetent." *Id.* at 378, 420 N.E.2d at 72, 438 N.Y.S.2d at 274; *see also infra* note 151.

128. The clear and convincing evidence standard is the highest standard applicable to civil cases and is typically required where particularly important personal interests are at stake. *Addington v. Texas*, 441 U.S. 418, 424 (1979). This standard serves to "impress the factfinder with the importance of the decision," *id.* at 427, and it "forbids relief whenever the evidence is loose, equivocal or contradictory." *Backer Management Corp. v. Acme Quilting Co.*, 46 N.Y.2d 211, 220, 385 N.E.2d 1062, 1066, 413 N.Y.S.2d 135, 139 (1978) (quoting *Southard v. Curley*, 134 N.Y. 148, 151, 31 N.E. 330, 331 (1892)).

129. *Storar*, 52 N.Y.2d at 379, 420 N.E.2d at 72, 438 N.Y.S.2d at 274.

cluded not to have his life prolonged by medical means if there were no hope of recovery . . . . These were obviously solemn pronouncements and not casual remarks made at some social gathering, nor can it be said that he was too young to realize or feel the consequences of his statements.<sup>130</sup>

The *Storar* matter involved a fifty-two-year-old retarded man who had terminal cancer of the bladder.<sup>131</sup> His closest relative was his seventy-seven-year-old mother who, after being advised by physicians that the disease would be fatal, even after exhausting all medical and surgical alternatives, applied for an order from the court prohibiting further blood transfusions.<sup>132</sup> Her primary purpose was to maintain her son's comfort.<sup>133</sup>

The court, noting the absence of proof similar to that presented in the *Eichner* matter, denied the mother's application.<sup>134</sup> The court explained that because the patient had never been competent to make an express, informed decision about medical treatment, it would be impossible for anyone to determine, subject to a clear and convincing standard, whether he would have wanted potentially life-prolonging treatment were he competent.<sup>135</sup> In perhaps an ominous statement of things to come, the court stated that, despite understanding the despair and religious beliefs of the patient's mother, it could not "allow an incompetent patient to bleed to death because someone, even someone as close as a parent or sibling, feels that this is best for one with an incurable disease."<sup>136</sup>

In the most recent New York right to die case, *In re West-*

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130. *Id.* at 379-80, 420 N.E.2d at 72, 438 N.Y.S.2d at 274.

131. *Id.* at 373, 420 N.E.2d at 66, 438 N.Y.S.2d at 270.

132. *Id.* at 373, 420 N.E.2d at 69, 438 N.Y.S.2d at 271.

133. *Id.*

134. *Id.* at 380, 420 N.E.2d at 72, 438 N.Y.S.2d at 274-75.

135. *Storar*, 52 N.Y.2d at 380, 420 N.E.2d at 72, 438 N.Y.S.2d at 275.

136. *Storar*, 52 N.Y.2d at 382, 420 N.E.2d at 73, 438 N.Y.S.2d at 275-76; *see also* *Delio v. Westchester Medical County Center*, 129 A.D.2d 1, 26, 516 N.Y.S.2d 677, 693 (2d Dep't 1987) (the Appellate Division, utilizing the articulated standard in *Eichner/Storar*, and noting the distinctions between the two situations, held that by clear and convincing evidence, a 33-year-old patient in a chronic vegetative state with no hope of recovery had "made a solemn, intelligent determination while competent that he would refuse to be maintained in a chronic vegetative state with nutrition and hydration" and that, therefore, discontinuing such medical treatment, pursuant to the application of his wife as conservator, who was entitled to act in accordance with his prior clearly expressed wishes, was proper).

chester County Medical Center,<sup>137</sup> the Court of Appeals generated a great deal of controversy<sup>138</sup> by clarifying the vague, restrictive boundaries alluded to in *Storar* and further limiting the right of an individual to exercise the right to refuse life sustaining treatment through a surrogate decisionmaker. Mary O'Connor, the patient, was a seventy-seven-year-old widow who had become mentally incompetent, as a result of several strokes, and was unable to ingest food or drink without artificial assistance.<sup>139</sup> When the hospital and physicians attending Mrs. O'Connor determined that a nasogastric tube should be inserted to provide her with greater nourishment, her two daughters objected.<sup>140</sup> As a result, the hospital sought a court order seeking authorization to insert the tube.<sup>141</sup> Her daughters countered that to do so would be against their mother's request expressed prior to becoming incompetent that she did not want her life prolonged by artificial means if she was unable to care for herself.<sup>142</sup>

To determine whether there was clear and convincing evidence of the patient's intent to reject life-sustaining treatment the facts of this case required the court to analyze more closely the standard utilized in the *Storar/Eichner* decision.<sup>143</sup> Refining this standard, the court explained that the heavy burden of clear and convincing evidence would be satisfied only when "the patient held a firm and settled commitment to the termination of life supports"<sup>144</sup> prior to becoming incompetent, and the persistence and seriousness of the patient's statements suggested to the trier of fact that the individual's beliefs were strong and the commitment to those beliefs was durable and not subject to recent change.<sup>145</sup>

The court stated that although the best situation would be one in which the patient had expressed his intent in writing

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137. 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988) [hereinafter cited as *O'Connor*].

138. See, e.g., Gindes, *Judicial Postponement of Death Recognition: The Tragic Case of Mary O'Connor*, 15 AM. J.L. & MED. 301 (1989).

139. *O'Connor*, 72 N.Y.2d at 522, 531 N.E.2d at 609, 534 N.Y.S.2d at 887.

140. *Id.* at 524, 531 N.E.2d at 609, 534 N.Y.S.2d at 888.

141. *Id.*

142. *Id.*

143. *Id.* at 530, 531 N.E.2d at 613, 534 N.Y.S.2d at 892.

144. *Id.* at 531, 531 N.E.2d at 613, 534 N.Y.S.2d at 892.

145. *Id.*

prior to becoming incompetent, requiring a written statement in every case would be unrealistic.<sup>146</sup> Consequently, oral expressions, similar to the type present in *Eichner*, could satisfy the difficult standard articulated.<sup>147</sup> However, the court held that Mrs. O'Connor's oral statements about her desire to decline life-sustaining treatment, despite being repeated over a number of years to several people, were not sufficient to meet the clear and convincing evidence standard of express intent because they were made in reaction to the "unsettling experience of seeing or hearing of another's unnecessarily prolonged death"<sup>148</sup> or because she refused to be a burden on anyone in her old age.<sup>149</sup> In sum, according to the majority, nothing in the record suggested that Mrs. O'Connor's statements relating to life-sustaining treatment were "transform[ed] . . . from the type of comments that are often made casually into the type of statements that demonstrate a seriousness of purpose."<sup>150</sup> Therefore, the court was unable to grant her daughters' petition to block the hospital from administering artificial nutrition and hydration.<sup>151</sup>

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146. *Id.*

147. *Id.* at 531-32, 531 N.E.2d at 614, 534 N.Y.S.2d at 893.

148. *Id.* at 532, 531 N.E.2d at 614, 534 N.Y.S.2d at 893.

149. *Id.* ("If such statements were routinely held to be clear and convincing proof of a general intent to decline all medical treatment once incompetency sets in, few nursing home patients would ever receive life sustaining medical treatment in the future.").

150. *Id.*

151. *Id.* The court expressly rejected the "so-called 'substituted judgment' approach" utilized by other states relying solely on the personal decision of the patient, if expressed. *Id.* at 530, 531 N.E.2d at 613, 534 N.Y.S.2d at 892. However, the difference between the two approaches is purely semantic. The approach used simply reflects a stricter standard under the substituted judgment umbrella. After all, the concurrence in *O'Connor* acknowledges that "[w]hat the rule literally demands is an impossibility: a factual determination of the incompetent patient's actual desire at the time of the decision. . . . There is simply no way of excluding the possibility that the patient has had a change of mind so that her past statements do not indicate her present wishes." *Id.* at 536, 531 N.E.2d at 616, 534 N.Y.S.2d at 895-96 (Hancock, J., concurring); see also *Estate of Longeway*, 133 Ill. 2d 33, 50, 549 N.E.2d 292, 300 (1989). As a result, while the court stresses its "fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another," *O'Connor*, at 530, 531 N.E.2d at 613, 534 N.Y.S.2d at 892, in essence, the tougher standard merely limits a potential surrogate decisionmaker to exercising a patient's right to refuse life-sustaining treatment if, and only if, clear and convincing evidence of the patient's express intent are present, pursuant to the guidelines articulated in the *O'Connor* decision. See also *In re Gardner*, 534 A.2d 947, 950 (Me. 1987).



## 2. *Maine*

The Supreme Judicial Court of Maine considered the right to die issue in *In re Gardner*.<sup>152</sup> This case involved a twenty-three-year-old patient in a chronic and persistent vegetative state resulting from injuries to his head sustained when he fell from the back of a moving pickup truck.<sup>153</sup> The patient had no hope of ever regaining normal body functions, had lost his ability to ingest food or drink by normal means, and was being kept alive solely through the artificial administration of nutrition and hydration via a nasogastric tube.<sup>154</sup> Although no one family member was ever appointed as the patient's guardian and surrogate, all of his family and close friends urged the court to terminate the nutrition and hydration given the patient's express intent, prior to becoming incompetent, "that he not be maintained on the nasogastric tube . . . ."<sup>155</sup>

The court, while rejecting the use of the substituted judgment doctrine in this case<sup>156</sup> given facts and circumstances similar to the New York *Eichner* case,<sup>157</sup> held that the patient had "clearly and convincingly in advance of treatment expressed his decision not to be maintained by life sustaining procedures in a persistent vegetative state . . . ."<sup>158</sup> Therefore, based on statements he had made to both his girlfriend and a close friend, the court ordered that the nutrition and hydration being administered to the patient be terminated in accordance with the wishes of his family and close friends.<sup>159</sup>

## 3. *Missouri*

In *Cruzan v. Harmon*,<sup>160</sup> the Supreme Court of Missouri confronted the issues surrounding an individual's right to refuse life-sustaining treatment for the first time.<sup>161</sup> The case involved

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152. 534 A.2d 947 (Me. 1987).

153. *Id.* at 949.

154. *Id.*

155. *Id.*

156. *Id.* at 950; *see also supra* note 151.

157. *Gardner*, 534 A.2d at 952-53.

158. *Id.* at 953.

159. *Id.*

160. 760 S.W.2d 408 (Mo. 1988) (en banc), *aff'd*, 110 S. Ct. 2841 (1990).

161. For a discussion of the United States Supreme Court affirmance, *see infra*

Nancy Cruzan, a thirty-year-old woman who lay in a persistent vegetative state in a Missouri state hospital, after a car accident which left her dependent on a surgically implanted gastrostomy tube for her nutrition and hydration<sup>162</sup> and "oblivious to her environment except for reflexive responses to sound and perhaps painful stimuli."<sup>163</sup> In light of what was characterized as a "'somewhat serious conversation' [with her roommate] that if sick or injured [Nancy] would not want to continue her life unless she could live 'halfway normally' ",<sup>164</sup> her parents requested that the court authorize the hospital to terminate artificial nutrition and hydration for Nancy.<sup>165</sup>

After a comprehensive review of some of the other leading state cases in this area,<sup>166</sup> as well as a balancing of the relevant state interests against the interests of the patient,<sup>167</sup> the court found that Nancy's statements prior to becoming incompetent were informally expressed reactions that did not demonstrate clear and convincing proof of her intent to refuse life-sustaining treatment if in a persistent vegetative state.<sup>168</sup> As a result, the court held that despite the substantial emotional burden on Nancy's loved ones and given the state's strong interest in preserving life, "the evidence offered at trial as to Nancy's wishes is inherently unreliable and thus insufficient to support the co-guardians' claim to exercise substituted judgment on Nancy's behalf."<sup>169</sup>

New York, Maine, and Missouri have been labeled the specific subjective intent states because a surrogate decisionmaker can only exercise a decision to refuse life-sustaining treatment on behalf of an incompetent patient if clear and convincing evidence of the patient's *express intent* with regard to such a decision is manifested prior to becoming incompetent.<sup>170</sup> As a result, oral statements of the kind described in *O'Connor* and *Cruzan*

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notes 351-88 and accompanying text.

162. *Cruzan*, 760 S.W.2d at 411.

163. *Id.*

164. *Id.*

165. *Id.*

166. *Id.* at 412-16.

167. *Id.* at 419-22.

168. *Id.* at 424.

169. *Id.* at 426.

170. See *supra* note 151.

are not enough to satisfy the strict standard of specific subjective intent required by these states to allow a surrogate to preserve the incompetent patient's right to refuse life-sustaining medical treatment. The importance of this distinction will become glaringly evident as the cases in the remaining substituted judgment states are discussed.

#### 4. *Connecticut*

In *Foody v. Manchester Memorial Hospital*,<sup>171</sup> forty-two-year-old Sandra Foody was in a vegetative state and unable to breathe without the assistance of artificial devices intended to regulate her respiration and pulse.<sup>172</sup> Her medical history revealed that for the last twenty-four years she had been suffering from multiple sclerosis which became progressively worse and culminated with her developing respiratory arrest and degenerating into a permanent and irreversible vegetative state.<sup>173</sup> Her father, as her conservator, petitioned the court to authorize the discontinuance of the artificial means being used to sustain her life.<sup>174</sup>

After determining the existence of a right on the part of the incompetent patient to refuse life-sustaining medical treatment,<sup>175</sup> the court held that the primary method to express and preserve that right would be "to determine with as much accuracy as possible the wants and needs of the incompetent individual, not necessarily what may conform to what the majority deem wise or prudent,"<sup>176</sup> or, in other words, through application of the subjective substituted judgment standard. The court then explained that although Sandra Foody had never explicitly set forth her views as to whether she would want to be kept alive in her present circumstances, "[a]n expression of intent while competent [was] not essential"<sup>177</sup> to applying the doctrine of substituted judgment because the choice of her surrogate decisionmaker could "be based upon knowledge of the individual

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171. 40 Conn. Supp. 127, 482 A.2d 713 (1984).

172. *Id.* at 128-29, 482 A.2d at 716-17.

173. *Id.*

174. *Id.* at 128, 131-32, 482 A.2d at 715, 717.

175. *Id.* at 132-33, 482 A.2d at 717-18.

176. *Id.* at 138, 482 A.2d at 720.

177. *Id.* at 138-39, 482 A.2d at 721.

gleaned from a family relationship" or other subjective criteria.<sup>178</sup>

Consequently, the court articulated three conditions which would serve as prerequisites to future surrogates acting as the patient's substitute decisionmaker with regard to the continuation of life-sustaining treatment: 1) the incompetent patient's condition must be permanent and irreversible without any reasonable probability that the patient would ever return to normal; 2) the patient's attending physician, along with two other consulting physicians, must concur as to the irreversible condition of the patient; and 3) there must be a concerned family member or members who will agree to serve in good faith as the patient's surrogate decisionmaker.<sup>179</sup>

Given the satisfaction of these three conditions and the evidence that Sandra Foody, although not doing so expressly, had resigned herself to her affliction and the inevitable consequences which did not appear to include life on a respirator, the court granted her father's petition to remove the devices artificially sustaining her life.<sup>180</sup>

### 5. Delaware

*In re Severns*<sup>181</sup> involved a fifty-five-year-old woman who was in a coma after suffering severe injuries in an automobile accident. Almost a year after the accident, her husband petitioned the court to be appointed her guardian for the purpose of exercising her right not to be subjected to extraordinary medical means such as a respirator to sustain her breathing and an intravenous tube to provide her with nutrition and hydration.<sup>182</sup>

The evidence indicated that the patient had informed her husband that in circumstances similar to those in question she

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178. *Id.* at 139, 482 A.2d at 721.

179. *Id.* at 140, 482 A.2d at 721.

180. *Id.* The most recent Connecticut right to die case, *McConnell v. Beverly Enterprises-Connecticut*, 209 Conn. 692, 553 A.2d 596 (1989), will be discussed below in the context of statutory law. This is the only recorded case to affirmatively utilize a statute, the Removal of Life Support Systems Act, CONN. GEN. STAT. §§ 19a-570 to 575 (Supp. 1990). See *infra* notes 389-435 and accompanying text.

181. 425 A.2d 156 (Del. Ch. 1980).

182. *Id.* at 157-58.

did not wish to be kept alive.<sup>183</sup> Evidence of her intent was apparent from her membership in the Delaware Euthanasia Education Council and her desire to execute a living will memorializing her intent to die with dignity, which evidently was never completed due to the reluctance of her husband to execute one as well.<sup>184</sup> As a result of this subjective evidence demonstrating Mrs. Severn's intent, the court, applying the substituted judgment doctrine, granted her husband's request to assert her right to decline life-sustaining treatment.<sup>185</sup>

## 6. *Florida*

In *John F. Kennedy Memorial Hospital v. Bludworth*,<sup>186</sup> the Florida Supreme Court had the opportunity to articulate guidelines as to when artificial life-sustaining procedures may be terminated in the case of comatose, terminally ill patients. The patient in question, Francis Landy, had suffered permanent brain damage, was terminally ill, and was being kept alive solely by artificial means.<sup>187</sup> The patient's wife, after being appointed guardian, requested that all life-support systems be discontinued and delivered a living will executed by the patient in 1975 explaining his desire not to be kept alive by artificial means such as a respirator.<sup>188</sup>

The court, after emphasizing the value of a patient's right to refuse particular life-sustaining treatments, whether competent or incompetent,<sup>189</sup> held, pursuant to the doctrine of substituted judgment, that the right of an irreversibly comatose or terminally ill patient may be exercised on the patient's behalf by close family members, preferably a spouse, adult children, parents, or legal guardians.<sup>190</sup> As a prerequisite however, the primary attending physician must certify, with the concurrence of two other physicians, "that the patient is in a permanent vegetative state and that there is no reasonable prospect that the pa-

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183. *Id.* at 158.

184. *Id.*

185. *Id.* at 161.

186. 452 So. 2d 921 (Fla. 1984).

187. *Id.* at 922.

188. *Id.*

189. *Id.* at 924.

190. *Id.* at 926.

tient will regain cognitive brain function and that his existence is being sustained only through the use of extraordinary life sustaining measures"<sup>191</sup> which include respirators and other artificial support systems.<sup>192</sup>

In this case, the prerequisite was met and the court granted the request of the guardian to terminate the life support systems since it was what she believed her husband, if competent, would have requested under the same circumstances.<sup>193</sup> The court reasoned that the living will left by the patient, while not the exclusive means of demonstrating the intent of the patient, was "persuasive evidence" of the patient's intent for the purpose of substituted judgment analysis, and "should be given great weight" by surrogate decisionmakers who exercise the right to refuse life-sustaining treatment on behalf of an incompetent patient.<sup>194</sup>

*Guardianship of Browning*<sup>195</sup> gave the Florida District Court of Appeal an opportunity to refine and elaborate on the *Bludworth* criteria.<sup>196</sup> The patient in this case, Estelle Browning, had suffered a massive stroke in 1986 which caused permanent and irreversible brain damage and required her to have a gastrostomy to allow food and water to be administered directly

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191. *Id.*

192. *Id.*

193. *Id.*

194. *Id.* In *Corbett v. D'Alessandro*, the Right to Decline Life-Prolonging Procedures Act, passed by the Florida legislature partially in response to the *Bludworth* case, was not applicable since the 75 year-old patient in a persistent vegetative state had not left any written declaration of her intent prior to becoming incompetent and the "provision of sustenance" was not a life prolonging procedure for purposes of the statute. 487 So. 2d 368, 370 (Fla. Dist. Ct. App. 1986). The court concluded that the patient's guardian, her husband, could exercise the patient's constitutional right on her behalf to remove the nasogastric tube providing nutrition and hydration pursuant to the doctrine of substituted judgment and the limitations and prerequisites articulated in *Bludworth*. *Id.* at 371-72.

195. 543 So. 2d 258 (Fla. Dist. Ct. App. 1989), *aff'd*, 568 So. 2d 4 (Fla. 1990).

196. It also gave the court a further opportunity to demonstrate the ineffectiveness of the Florida Life-Prolonging Procedures Act in a manner similar to the *Corbett* case, *supra* note 191. The court explained that the statute was inapplicable in this case despite the existence of a living will since "the provision of sustenance" is not a life-prolonging procedure for purposes of the statute and the patient in question did not fit the rigid, statutory definition of "terminal condition" which required the death of the patient to be "imminent." *Browning*, 543 So. 2d at 264-65.

through the stomach.<sup>197</sup> Two years after the stroke, the patient's guardian, her second cousin, filed a petition to terminate artificial life-support including nutrition and hydration and produced a living will executed by the patient, as well as testimony from the patient's neighbors supporting the claim that the patient never wished to be sustained by artificial means.<sup>198</sup>

The court first held that the restrictions of the Florida Life-Prolonging Procedures Act<sup>199</sup> precluded a statutory remedy to aid the patient and guardian.<sup>200</sup> It then reasoned that the guardian, as the surrogate decisionmaker, would still be able to preserve the constitutionally protected right to refuse life-sustaining treatment which is not eliminated or reduced due to the lack of a statutory right, according to the substituted judgment doctrine and a reformulation of the *Bludworth* criteria.<sup>201</sup>

The court stated that when the surrogate decisionmaker chooses to forego life-sustaining treatment on behalf of the incompetent patient, adequate and up-to-date evidence must be available on four issues:

- (1) Is the patient suffering from a medical condition which would permit the patient, if competent, to forego life sustaining medical treatment?
- (2) Is there any reasonable probability that the patient will regain competency so that this right could be self-exercised by the patient?
- (3) Is the patient's personal decision on this subject sufficiently clear that the guardian can make a substituted judgment?
- (4) Is the patient's right to forego medical treatment outweighed by state interests . . . ?<sup>202</sup>

The first two questions go to the medical condition and prognosis of the patient. Similar to the *Bludworth* requirement, it must be certified by three physicians via affidavit, deposition, or sworn statement that the patient is incompetent and in an irreversible condition with no hope of recovery.<sup>203</sup> In conjunction

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197. *Browning*, 543 So. 2d at 261.

198. *Id.* at 262.

199. *See supra* note 196.

200. *Id.*

201. *Browning*, 543 So. 2d at 265-66.

202. *Id.* at 271.

203. *Id.* at 272.

with the third question, the court confirmed the adoption of the substituted judgment doctrine by the *Bludworth* court in these cases.<sup>204</sup> It further elaborated that the guardian makes the decision regarding life sustaining treatment including the provision of artificial sustenance, on the patient's behalf not only based on the express intent of the patient in the form of a living will, if apparent, but also "based . . . upon [any] relevant evidence concerning the personal decision which the patient, if competent, would make"<sup>205</sup> including oral statements and religious beliefs and to the extent that such evidence is clear and convincing.<sup>206</sup>

### 7. *Illinois*

In the case of *Estate of Longeway*,<sup>207</sup> the patient was incompetent having sustained serious brain damage as the result of several massive strokes. Although she was not technically in a persistent vegetative state, the damage was so extensive that the physicians concluded that she would never regain consciousness.<sup>208</sup> The patient's guardian, her daughter, petitioned the court to order the withdrawal of the artificially administered nutrition and hydration sustaining her mother, and alleged that on several occasions the patient had indicated that she did not wish to be kept alive artificially.<sup>209</sup>

The Illinois Supreme Court, subject to particular prerequisites, adopted the doctrine of substituted judgment as controlling in situations where a surrogate decisionmaker requests to exercise the right of an incompetent patient to refuse life-sustaining treatment.<sup>210</sup> First, the incompetent patient must be ter-

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204. *Id.* at 272-73. The court explained:

We emphasize that this doctrine does not allow the guardian to truly substitute the guardian's judgment for that of the patient. The guardian makes the decision which the evidence establishes the patient would have made under these circumstances. The guardian makes the decision which the patient would have made even if that decision is different than the decision which the guardian would make for himself or herself.

*Id.*

205. *Id.* at 273.

206. *Id.* at 272-73.

207. 133 Ill. 2d 33, 549 N.E.2d 292 (1989).

208. *Id.* at 36, 549 N.E.2d at 293.

209. *Id.*

210. *Id.* at 49, 549 N.E.2d at 299.



minally ill within the definition provided in the Illinois Living Will Act.<sup>211</sup> The patient's condition must be incurable and irreversible, where death is imminent and the application of death-delaying procedures serve only to prolong the dying process.<sup>212</sup> Second, the incompetent patient must be diagnosed by the attending physician, and at least two other consulting physicians, as irreversibly comatose or in a persistent vegetative state.<sup>213</sup> Third, the patient's right to refuse life-sustaining treatment, including the artificial administration of nutrition and hydration, must outweigh the interests of the state, as it normally does.<sup>214</sup> Last, the court explained that employing the doctrine of substituted judgment requires the surrogate to first determine if the patient had expressed explicit intent regarding such a decision prior to becoming incompetent or, where no clear intent is evident, to be guided by the patient's personal value system.<sup>215</sup> Furthermore, the court expressly rejected the theory utilized by the specific subjective intent states<sup>216</sup> by stating that "although actual, specific express intent would be helpful and compelling, the same is not necessary for the exercise of substituted judgment by a surrogate."<sup>217</sup>

As a result, given the lack of express intent in this case, the court held that the patient's guardian could substitute her judgment for that of the patient's based upon other, more generalized evidence of the patient's wishes provided that they satisfied the clear and convincing proof standard.<sup>218</sup> The court remanded the case back to the lower court in accordance with the criteria articulated emphasizing that "[o]n remand, the court should not hesitate to admit any reliable and relevant evidence if it will aid in judging [the patient's] intent."<sup>219</sup>

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211. ILL. REV. STAT. ch. 110 ½, para. 702(h) (Supp. 1990).

212. *Longeway*, 133 Ill. 2d at 47, 549 N.E.2d at 298.

213. *Id.*

214. *Id.* at 48, 549 N.E.2d at 299.

215. *Id.* at 49, 549 N.E.2d at 299; *see also supra* note 119 and accompanying text.

216. *See supra* notes 123-70 and accompanying text.

217. *Longeway*, 133 Ill. 2d at 50, 549 N.E.2d at 300.

218. *Id.* at 50-51, 549 N.E.2d at 300.

219. *Id.* at 51, 549 N.E.2d at 300 (emphasis added); *see also* Estate of Greenspan, 137 Ill. 2d 1, 558 N.E.2d 1194 (1990) (after rejecting the application of the Illinois Living Will Act, ILL. REV. STAT. ch. 110 ½, para. 702(h) (Supp. 1990), because the patient did not express his intent in writing, the Illinois Supreme Court confirmed the *Longeway*

## 8. Massachusetts

In *Superintendent of Belchertown State School v. Saikewicz*,<sup>220</sup> perhaps the second seminal case in the area after *Quinlan*, the patient was a sixty-seven-year-old mentally retarded and incompetent man with leukemia.<sup>221</sup> He had lived in state institutions for most of his life and had no family willing to decide whether to administer chemotherapy to cure the terminal disease.<sup>222</sup>

Despite the absence of a family member to act as guardian, the court "don[ed] the mental mantle of the incompetent,"<sup>223</sup> according to the doctrine of substituted judgment, to determine subjectively, with as much accuracy as possible, the wants, needs, interests, and preferences of the incompetent patient in deciding whether to provide chemotherapy.<sup>224</sup> The court explained:

In short, the decision in cases such as this should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person. . . . [T]he question is, do the facts on the record support the proposition that [the patient] himself would have made the decision under the standard set forth?<sup>225</sup>

Consequently, the court, by identifying the six factors weighing against the administration of chemotherapy utilized by the probate judge,<sup>226</sup> was satisfied that a decision to withhold

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criteria for a surrogate to exercise the right to refuse life-sustaining treatment, including the artificial provision of sustenance, on behalf of a 76-year-old incompetent patient in an irreversible and persistent vegetative state who had orally expressed his desire not to be sustained by artificial means to his wife, his daughters, his employees, and his rabbi).

220. 373 Mass. 728, 370 N.E.2d 417 (1977).

221. *Id.* at 731, 370 N.E.2d at 420.

222. *Id.*

223. *Id.* at 752, 370 N.E.2d at 431 (quoting *In re Carson*, 39 Misc. 2d 544, 545, 241 N.Y.S.2d 288, 289 (1962)).

224. *Id.* at 750, 370 N.E.2d at 430.

225. *Id.* at 752-53, 370 N.E.2d at 431.

226. *Id.* at 753-54, 370 N.E.2d at 432 (the six factors include the age of the patient, the probable side effects of the treatment, the low chance of producing remission, the certainty that treatment would cause immediate suffering, the patient's inability to cooperate with the treatment, and the quality of life possible for the patient even if the treat-

the chemotherapy treatment from the incompetent patient was based on a regard for the patient's actual interests and preferences and that the facts supported such a determination.<sup>227</sup>

Almost ten years later, in *Brophy v. New England Sinai Hospital, Inc.*,<sup>228</sup> the Massachusetts Supreme Judicial Court had another opportunity to apply the doctrine of substituted judgment as applied to refusal of treatment scenarios. The patient, after suffering a brain aneurysm, was in a persistent vegetative state with a substantially less than one percent chance of ever recovering cognitive function and was artificially maintained through a gastrostomy tube which provided nutrition and hydration.<sup>229</sup> The patient's wife, and guardian, petitioned the court to order the removal of the tube after the physician and hospital refused to do so.<sup>230</sup>

After reviewing the substituted judgment standard of *Saikewicz*, the court "found on the basis of ample evidence which no one disputes, that [the patient's] . . . judgment would be to decline the provision of food and water and to terminate his life."<sup>231</sup> The court relied on the findings of the lower court judge who considered six various factors: the patient's expressed preferences to several family members, his religious convictions and their relation to refusal of treatment, the impact on his family, the probability of adverse side effects, the prognosis, with and without further treatment, and his present and future incompetency.<sup>232</sup> Consequently, after finding that the state's interests would not override such a judgment, the court granted the guardian's petition to withhold nutrition and hydration from the patient since the primary goal of "determin[ing] with as much accuracy as possible the wants and needs of the individual involved"<sup>233</sup> had been achieved.

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ment brought about remission (but not to the extent that the value of life is equated with the quality of life)).

227. *Id.* at 754-55, 370 N.E.2d at 432.

228. 398 Mass. 417, 497 N.E.2d 626 (1986).

229. *Id.* at 421, 497 N.E.2d at 628.

230. *Id.* at 422, 497 N.E.2d at 628.

231. *Id.* at 427, 497 N.E.2d at 631.

232. *Id.*

233. *Id.* at 433, 497 N.E.2d at 634-35 (quoting *Saikewicz*, 373 Mass. at 750, 370 N.E.2d at 430).

### 9. New Jersey

The seminal and perhaps most publicized right to die case is *In re Quinlan*.<sup>234</sup> In the case, Karen Ann Quinlan, then age twenty-one, stopped breathing for at least two fifteen-minute periods for reasons not clearly explained.<sup>235</sup> Consequently, the once-healthy girl suffered severe brain damage to the extent that she was characterized by physicians as being in a persistent vegetative state without any possibility of ever regaining cognitive function or awareness of her surroundings.<sup>236</sup> Karen's father, as her guardian, petitioned the court for judicial authority to order the disconnection of the respirator, without which the physicians believed she could not survive.<sup>237</sup>

Given the extreme importance of this decision, the New Jersey Supreme Court's articulation of the doctrine of substituted judgment and of the legal standards that were to be applied by the surrogate decisionmaker in making the decision, is worthy of repetition:

If a putative decision by Karen to permit this non-cognitive, vegetative existence to terminate by natural forces is regarded as a valuable incident of her right of privacy, as we believe it to be, then it should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice. The only practical way to prevent destruction of the right is *to permit the guardian and family of Karen to render their best judgment, subject to the qualifications hereinafter stated, as to whether she would exercise it in these circumstances*. If their conclusion is in the affirmative this decision should be accepted by a society the overwhelming majority of whose members would, we think, in similar circumstances, exercise such a choice in the same way for themselves or for those closest to them.<sup>238</sup>

As a result, a unanimous court held that Karen's father, as guardian, could exercise his daughter's right of privacy by authorizing removal of the life-support systems<sup>239</sup> subject to cer-

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234. 70 N.J. 10, 355 A.2d 647, cert. denied sub nom. Garger v. New Jersey, 429 U.S. 922 (1976).

235. *Id.* at 10, 23, 355 A.2d at 647, 654.

236. *Id.* at 24, 26, 355 A.2d at 654-55.

237. *Id.* at 29-30, 355 A.2d at 657.

238. *Id.* at 41-42, 355 A.2d at 664 (emphasis added).

239. *Id.*

tain specified qualifications.<sup>240</sup>

The case of *In re Conroy*,<sup>241</sup> almost ten years after *Quinlan*, presented the New Jersey Supreme Court an opportunity to build on the principles established in *Quinlan*, when it considered whether a nasogastric feeding tube could be removed from an eighty-four-year-old incompetent nursing home resident suffering irreversible mental and ultimately fatal physical ailments.<sup>242</sup> The guardian, petitioning the court to remove the nasogastric tube, was a nephew who had known Claire Conroy for over fifty years, visited her approximately once a week for four or five years prior to her being admitted into the nursing home, and testified that, given her fear and avoidance of physicians in the past, she would not have wanted the nasogastric tube to be inserted in the first place.<sup>243</sup>

The court, prior to articulating its holding and rationale, stressed that the situation involving Mrs. Conroy was different from that of *Quinlan*.<sup>244</sup> Mrs. Conroy was not in a persistent vegetative state but was awake and conscious although burdened with significantly diminished capacity and a relatively short life expectancy.<sup>245</sup> Given that proviso, the court proceeded to set up an analytical framework that would, in the future, govern surro-

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240. *Id.* at 55, 355 A.2d at 671-72. Specifically, the court held that: upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital "Ethics Committee" or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive sapient state, the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital or others.

*Id.* at 55, 355 A.2d at 672.

241. 98 N.J. 321, 486 A.2d 1209 (1985).

242. *Id.* at 335, 486 A.2d at 1216.

243. *Id.* at 339-40, 486 A.2d at 1218.

244. *Quinlan*, 70 N.J. at 54 n.10, 355 A.2d at 671 n.10 (The court left open the question whether the principles it enunciated might be applicable to incompetent patients in "other types of terminal medical situations . . . not necessarily involving the hopeless loss of cognitive or sapient life.").

245. *Conroy*, 98 N.J. at 359, 486 A.2d at 1228-29; see also *id.* at 342 n.1, 486 A.2d at 1219 n.1 (analytic framework established by the court is restricted to elderly, nursing home residents with shortened life expectancies).

gate decisionmakers attempting to exercise the right to refuse life-sustaining treatment on behalf of incompetent nursing home residents with limited life expectancies.<sup>246</sup>

First, pursuant to a subjective standard of substituted judgment, the court held that life sustaining treatment may be withheld "when it is clear [and convincing] that the particular patient would have refused the treatment under the circumstances involved."<sup>247</sup> The court explained that the types of evidence that are appropriate in determining what course of treatment the patient would have wished to pursue included written documents such as a living will or other written directives, reactions that the patient voiced regarding medical treatment administered to others, inferences from a person's religious beliefs, or a consistent pattern of conduct with respect to the patient's prior decisions about medical care.<sup>248</sup> The court further commented that the probative value of the different types of evidence presented in a given case would vary depending on the remoteness, consistency, thoughtfulness, and specificity of the prior statements or actions, as well as medical evidence establishing "that the patient fits within the Claire Conroy pattern."<sup>249</sup>

Second, in what is a preview to the theory underlying the best interests standard,<sup>250</sup> the court formulated two objective tests that, if satisfied, would authorize a guardian to refuse life-sustaining medical treatment on behalf of an incompetent nursing home patient with a limited life expectancy.<sup>251</sup> The first, the limited-objective test, allows life-sustaining treatment to be withheld from a patient "when there is some trustworthy evidence that the patient would have refused the treatment, and

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246. *Id.* at 360-67, 486 A.2d at 1229-33.

247. *Id.* at 360, 486 A.2d at 1229.

248. *Id.* at 361-62, 486 A.2d at 1229-30. The court also acknowledged an error it made in the *Quinlan* case when it chose to disregard evidence of statements made to friends by Karen regarding artificial prolongation of the lives of others who were terminally ill since "[s]uch evidence is certainly relevant to shed light on whether the patient would have consented to the treatment if competent to make the decision." *Id.* at 362, 486 A.2d at 1230.

249. *Id.* at 362-63, 486 A.2d at 1230-31.

250. *See infra* notes 301-50 and accompanying text.

251. *Conroy*, 98 N.J. at 364, 486 A.2d at 1231 ("We hesitate . . . to foreclose the possibility of humane actions, which may involve termination of life sustaining treatment, for persons who never clearly expressed their desires about life sustaining treatment but who are now suffering a prolonged and painful death.").

the decision-maker is satisfied that it is clear that the burdens of the patient's continued life with the treatment outweigh the benefits of that life for him."<sup>252</sup> The first prong of the test would be satisfied by evidence that, in terms of the subjective test, would be too vague or casual to constitute clear proof of the patient's intent, yet might be sufficient to satisfy this test. The second prong would be satisfied by medical evidence making it apparent that the treatment in question would not provide the patient with any net benefit but would merely prolong suffering.<sup>253</sup>

Under the pure-objective test, trustworthy evidence that the patient would have declined the life-sustaining treatment can be completely absent.<sup>254</sup> Yet, such treatment can be refused on behalf of an incompetent patient if the net burdens of the patient's life with the treatment clearly outweigh the benefits that the patient derives from life and the administration of life-sustaining treatment would produce severe and unavoidable pain to the extent that continued treatment would be inhumane.<sup>255</sup> Under this test, subjective evidence of the patient's wishes with regard to life-sustaining medical treatment is unnecessary.<sup>256</sup> Under both of the objective tests, it seems that the burdens of treatment are strictly limited to physical pain and suffering, since the court expressly refused to consider broader quality of life considerations.<sup>257</sup>

Because of the particular vulnerability of elderly nursing home patients, the court also set up a procedural framework, to be followed by a surrogate decisionmaker wishing to refuse life-sustaining treatment on behalf of an incompetent nursing home patient.<sup>258</sup>

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252. *Id.* at 365, 486 A.2d at 1232.

253. *Id.* at 365-66, 486 A.2d at 1232.

254. *Id.* at 366, 486 A.2d at 1232.

255. *Id.*

256. *Id.*

257. *Id.* at 365-67, 486 A.2d at 1232-33.

258. *Id.* at 383-85, 486 A.2d at 1241-42. The Ombudsman has responsibility for institutionalized New Jersey residents 60 years of age and older. This procedural framework includes 1) judicial determination of incompetency according to a clear and convincing standard and designation of a guardian; 2) notification of the Ombudsman of any potential refusal of life-sustaining treatment which could be considered a potential case of abuse; 3) investigation by the Ombudsman including a prognosis of the patient's med-

The *Conroy* court's holding was restricted to incompetent nursing home patients with life expectancies of less than a year. The companion cases of *In re Peter*<sup>259</sup> and *In re Jobes*<sup>260</sup> allowed the New Jersey Supreme Court to fill the gap created by the failure of the *Conroy* court to address the status of patients like Karen Quinlan who were in a persistent vegetative state but had life expectancies of more than a year.

In *Peter*, the patient was a sixty-five-year-old nursing home patient in a persistent vegetative state with no hope of recovery, yet had a life expectancy of more than one year.<sup>261</sup> The patient's guardian, Eberhard Johannig, following the procedural framework outlined in *Conroy*,<sup>262</sup> wrote a letter to the Ombudsman requesting that he approve the removal of the nasogastric tube that provided Ms. Peter with nutrition and hydration.<sup>263</sup> Despite the Ombudsman's belief that the patient would not have wanted to continue being attached to a nasogastric tube, he refused to grant her guardian's request because the patient's life expectancy was greater than a year.<sup>264</sup>

On appeal, the court explained that "[b]y definition such patients, like Ms. Peter, do not experience any of the benefits or burdens that the *Conroy* balancing tests are intended or able to appraise. Therefore, *we hold that these tests* [while applicable to patients like *Conroy*] *should not be applied to patients in the persistent vegetative state.*"<sup>265</sup> After reiterating the *Quinlan* standard,<sup>266</sup> the court held that it also was not applicable in Ms. Peter's case since, via a durable power of attorney authorizing her guardian to make all medical decisions on her behalf, she had left clear and convincing evidence of her desire not to be

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ical condition by two independent physicians; and 4) concurrence among the guardian, attending physician, and Ombudsman that one of the three tests has been satisfied.

259. 108 N.J. 365, 529 A.2d 419 (1987).

260. 108 N.J. 394, 529 A.2d 434 (1987).

261. *Peter*, 108 N.J. at 370, 529 A.2d at 421-22.

262. *See supra* note 258.

263. *Peter*, 108 N.J. at 371, 529 A.2d at 422.

264. *Id.* at 371-72, 529 A.2d at 422.

265. *Id.* at 376-77, 529 A.2d at 425 (emphasis added).

266. *Quinlan*, 70 N.J. at 41, 355 A.2d at 664 (according to substituted judgment doctrine, the guardian and family of the patient are to "render their best judgment" as to what medical decision regarding life-sustaining treatment the patient would want them to make).



sustained in her present condition. Hence, the court decided to apply the *Conroy* subjective test to Ms. Peter's situation and granted her guardian's petition to remove the nasogastric tube.<sup>267</sup>

*Peter* stands for the proposition that the *Conroy* subjective test is applicable in every refusal of life sustaining medical treatment case involving a surrogate decisionmaker, regardless of the patient's medical condition or life expectancy. Thus, life-sustaining treatment may be removed by the surrogate on the patient's behalf when there is clear and convincing proof, in the form of express intent, that if the patient were competent, treatment would be declined.<sup>268</sup>

It appeared from reading *Peter* that New Jersey was abandoning the substituted judgment doctrine utilized in *Quinlan* in favor of a stricter version of the doctrine and a consequently higher evidentiary burden, according to the specific subjective intent rule followed most prominently by New York.<sup>269</sup> A later case, *Jobes*, revealed that this was not so.

In *Jobes*, the patient was a thirty-one-year-old woman who, while receiving treatment for injuries caused in a car accident, sustained severe loss of oxygen and blood flow to her brain, resulting in massive and irreversible brain damage and causing her to exist in a persistent vegetative state.<sup>270</sup> The patient's husband and guardian filed suit seeking removal of the life-sustaining food nutrition system, or jejunostomy tube, from his comatose wife. Noting that several neurological specialists agreed that the

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267. *Peter*, 108 N.J. at 378-79, 529 A.2d at 426-27. In comparing the *Quinlan* standard and the *Conroy* subjective test it appears that the latter test is more stringent than the former and bears a similar resemblance to the specific subjective intent approach discussed earlier. See *supra* notes 123-70 and accompanying text. Only clear and convincing evidence of the patient's express intent, for example, in the form of a living will or a durable power of attorney, as in *Peter*, will be sufficient for a surrogate to refuse life-sustaining treatment on behalf of an incompetent patient. See Moore, "Two Steps Forward, One Step Back": An Analysis of New Jersey's Latest "Right-To-Die" Decisions, 19 RUTGERS L.J. 955, 983-84 (1988).

268. *Peter*, 108 N.J. at 377-78, 529 A.2d at 425; procedurally, the guardian must still apply to the Ombudsman and follow the other requirements provided for in *Conroy* (see *supra* note 258), except there is no longer a need to apply to the court for formal designation of a guardian unless the patient has not already appointed such a decisionmaker. *Id.* at 383-84, 529 A.2d at 429.

269. See *supra* note 267.

270. *Jobes*, 108 N.J. at 401-03, 529 A.2d at 437-38.

patient was in a persistent vegetative state,<sup>271</sup> the petition alleged that Mrs. Jobses would decline artificial feeding if competent to decide,<sup>272</sup> and that it was in her best interests to do so.<sup>273</sup>

The New Jersey Supreme Court immediately recognized the novelty and importance of the question at hand. This case, unlike *Conroy* and *Peter*, required the court "to develop the guidelines and procedures under which life-sustaining medical treatment may be withdrawn from a non-elderly nursing home patient in a persistent vegetative state who, prior to her incompetency, failed to express adequately her attitude toward such treatment."<sup>274</sup> After describing the type of evidence that typically establishes a person's medical preferences under the "subjective test" utilized in *Conroy* and *Peter*,<sup>275</sup> the court explained that the statements about life-sustaining medical treatment attributed to the patient were "remote, general, spontaneous and made in casual circumstances" and "closely track the examples of evidence that we have explicitly characterized [in the past] as unreliable."<sup>276</sup> As a result, instead of foreclosing the possibility of any relief due to the lack of clear and convincing proof of the patient's express attitude toward life-sustaining medical treatment (as New York, Maine, and Missouri courts have done), the

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271. *Id.* at 403-06, 529 A.2d at 438-42.

272. *Id.* at 409-11, 529 A.2d at 442. In addition to testimony from Mrs. Jobses' closest friends, her cousin, and clergyman intending to prove that, if she were competent, Mrs. Jobses would not want to be sustained through artificial feeding, her husband testified that, if competent, his wife would "definitely" choose to terminate the life-sustaining treatment given certain statements she had made to him in 1976-77 that she would not want to be kept alive under Karen Quinlan's circumstances. *Id.*

273. *Id.* at 400, 529 A.2d at 437.

274. *Id.* at 399, 529 A.2d at 436.

275. *Id.* at 411-12, 529 A.2d at 443; see also *supra* note 267. The standard under this "subjective test" is strikingly similar to the strict standard required by the specific-subjective intent rule and mandates, according to a clear and convincing degree of evidence, that the probative value of prior statements offered to demonstrate a patient's desire to refuse life-sustaining treatment depends on their specificity, remoteness, consistency, thoughtfulness, and maturity of the person at the time the statements were made. *Id.*

276. *Id.* at 412, 529 A.2d at 443; see also *Conroy*, 98 N.J. at 362-63, 486 A.2d at 1230 (negating probative value of "an off-hand remark about not wanting to live under certain circumstances made by a person when young and in the peak of health"); *Conroy*, 98 N.J. at 366, 486 A.2d at 1232 ("informally expressed reactions to other people's medical condition and treatment" are not clear and convincing proof of a patient's intent to refuse life-sustaining treatment).

*Jobes* court returned to the *Quinlan* holding<sup>277</sup> for guidance in solving this unique problem.<sup>278</sup>

After reviewing the *Quinlan* holding,<sup>279</sup> the court confirmed that it should continue to defer to the substituted judgment of close and loving family members as surrogate decisionmakers<sup>280</sup> when decisions about life-sustaining medical treatment must be made for irreversibly vegetative patients, who had not clearly expressed their medical preferences prior to becoming incompetent.<sup>281</sup> Consequently, the court held that, given the trustworthy evidence of Mrs. *Jobes*' personal inclinations against life-sustaining medical treatment, it was entirely proper to allow her husband as surrogate decisionmaker to refuse the artificial administration of nutrition and hydration on her behalf.<sup>282</sup> The procedural guidelines effectuated in *Quinlan*<sup>283</sup> were applicable because they seemed to be "functioning in the setting for which [they were] intended."<sup>284</sup>

New Jersey, in coming full circle from *Quinlan* to *Jobes*, has clearly been the most dynamic state in the area of right to die determinations.<sup>285</sup> *Quinlan* and *Jobes* stand for the proposition

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277. See *supra* note 266.

278. *Jobes*, 108 N.J. at 413, 529 A.2d at 443.

279. *Id.* at 413-16, 529 A.2d at 443-46; see also *supra* notes 234-39 and accompanying text.

280. *Id.* at 414, 529 A.2d at 444 (the court, as in *Quinlan*, suggested that such a decision would be governed by considering the patient's prior reactions and statements to medical issues as well as the patient's personal value system, with particular reference to the patient's relevant philosophical, theological, and ethical values).

281. *Id.* at 417, 529 A.2d at 445-46.

282. *Id.* at 419, 529 A.2d at 447.

283. *Id.* at 421, 529 A.2d at 448; see also *supra* note 239.

284. *Jobes*, 108 N.J. at 421, 529 A.2d at 448.

285. Just recently, the New Jersey legislature enacted the Declaration of Death Act. Act of April 8, 1991, ch. 90, 1991 N.J. Laws Sen. No. 1208. This Act authorizes physicians to declare a patient dead if "circulatory and respiratory functions [are] maintained solely by artificial means, and . . . has sustained irreversible cessation of all functions of the entire brain, including the brain stem . . ." *Id.* § 3. However, before doing so, the physician must use reasonable efforts to determine whether a declaration of death would contradict the personal religious beliefs of the patient as communicated by family members or close associates of the patient. *Id.* § 5. If the declaration of death would violate the patient's beliefs, the physician may not declare death solely on the basis of neurological criteria. *Id.* While the statute will obviously be subject to judicial interpretation, it could circumvent New Jersey case law to some extent because, it appears to reflect legislative adoption of a modified subjective substituted judgment standard. Thus, the statute appears to defer to close family members or other appropriate surrogate deci-

that surrogate decisionmakers, according to the substituted judgment doctrine, can make decisions regarding life-sustaining medical treatment on behalf of incompetent patients who have not clearly expressed their medical preferences by taking into consideration all relevant evidence, specific or remote, shedding light on the decision the patient would have made if competent.

The *Conroy* holding articulates a substituted judgment/best interests, subjective/objective analytical framework applicable to surrogate decisionmakers seeking to refuse medical treatment on behalf of incompetent nursing home patients who are elderly and have life expectancies of one year or less. *Peter* utilizes the subjective test of *Conroy* in a manner very similar to that of the specific subjective intent states. It provides guidelines for surrogate decisionmakers seeking to refuse medical treatment on behalf of an incompetent patient, regardless of the patient's medical condition or life expectancy, provided the patient has left clear and convincing evidence of the desire to refuse such treatment prior to becoming incompetent.

#### 10. Ohio

In *Leach v. Akron General Medical Center*,<sup>286</sup> the patient, Edna Leach, was a seventy-year-old woman suffering from a degenerative and terminal muscle disease that forced her to be sustained by a respirator, a nasogastric tube, and a catheter.<sup>287</sup> Given her incompetent and chronic vegetative state, her husband instituted an action to discontinue all life support systems, claiming that would be consistent with her desire if she were competent to express it.<sup>288</sup>

The patient's husband introduced evidence of numerous conversations that she had with him and other family members and friends. The most compelling conversation took place only two days before Mrs. Leach entered the hospital, when she expressed her wish to die rather than to be placed on life-support

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sionmakers' knowledge of the patient's personal value system regarding decisions about life-sustaining medical treatment. More importantly, the statutory mechanism does not require written evidence of the patient's wish to cease life-sustaining treatment. See *infra* notes 409-35 and accompanying text.

286. 68 Ohio Misc. 1 (1980).

287. *Id.* at 3.

288. *Id.* at 3-4.

systems.<sup>289</sup> In addition to the evidence of Mrs. Leach's intent not to be sustained by artificial means, three neurologists testified that she had suffered irreversible brain damage and that it was highly unlikely she would ever regain consciousness.<sup>290</sup>

After succinctly stating the issue involved,<sup>291</sup> the Ohio Court of Common Pleas adopted the doctrine of substituted judgment, holding that a surrogate decisionmaker could choose to refuse life-sustaining treatment on behalf of an incompetent patient when there is clear and convincing evidence of the patient's intent to refuse such treatment under similar circumstances.<sup>292</sup> Consequently, pursuant to the testimony of the neurologists and the clear and convincing proof of Mrs. Leach's intent to refuse life sustaining treatment in such circumstances, the court granted the patient's husband's request to remove the life support systems.<sup>293</sup>

### 11. *Summary: Substituted Judgment States*

The basic doctrine of substituted judgment is subjective and mandates that the surrogate decisionmaker, with as much accuracy as possible, make the decision the incompetent patient would make if competent.<sup>294</sup> While most of the states seem to be in agreement concerning the doctrine itself,<sup>295</sup> a subtle yet critical difference is apparent regarding the quality and type of evidence necessary to allow a surrogate to refuse life-sustaining treatment on behalf of an incompetent patient.

The three specific subjective intent states, New York, Maine, and Missouri, require that clear and convincing evidence of the patient's *express intent* with regard to such treatment be produced before allowing a withdrawal of the treatment; without such evidence, an incompetent patient in one of these states is precluded from having a surrogate exercise her right to refuse

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289. *Id.* at 4.

290. *Id.* at 4-5.

291. *Id.* at 6 ("The basic question is how long will society require Mrs. Leach and others similarly situated to remain on the threshold of certain death suspended and sustained there by artificial life supports.").

292. *Id.* at 12.

293. *Id.*

294. See *supra* notes 113-19 and accompanying text.

295. But see *supra* note 151.

treatment.<sup>296</sup> In the other states applying the substituted judgment doctrine, a refusal of life sustaining treatment is validated when clear and convincing evidence of a patient's intent is evident regardless of whether it is express, founded on the personal value system of the patient,<sup>297</sup> or determined from casual statements made by the patient while competent.<sup>298</sup>

Thus, the New York Court of Appeals in *O'Connor* and the Missouri Supreme Court in *Cruzan* prevented the surrogate decisionmakers from refusing life sustaining medical treatment on behalf of their respective patients despite evidence of the patient's intent<sup>299</sup> that, in other states, would have been sufficient to allow such a decision even though the evidence was not express.<sup>300</sup>

### C. The Best Interests States

#### 1. Arizona

In *Rasmussen v. Fleming*,<sup>301</sup> Mildred Rasmussen suffered three strokes in addition to a degenerative neural muscular disease after being admitted to a nursing home at the age of sixty-four. As a result, she was unable to receive fluids and nourishment without the aid of a nasogastric tube.<sup>302</sup>

Given the patient's inability to function cognitively, and physicians' testimony that she was in a chronic vegetative state from which she would never recover, the public fiduciary commenced a proceeding to be appointed guardian. The fiduciary sought consent to remove the nasogastric tube on the patient's behalf and asserted the patient's right to refuse medical treatment with regard to "do not resuscitate" ("DNR") and "do not hospitalize" ("DNH") notations on her medical chart.<sup>303</sup> Al-

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296. See *supra* notes 123-70 and accompanying text.

297. See *supra* note 112 and accompanying text.

298. See *supra* notes 171-293 and accompanying text.

299. See *supra* notes 148-51 & 164-69 and accompanying text.

300. See, e.g., *Estate of Longeway*, 133 Ill. 2d 33, 50-51, 549 N.E.2d 292, 300 (1989).

301. 154 Ariz. 207, 741 P.2d 674 (1987).

302. *Id.* at 212, 741 P.2d at 679.

303. *Id.* at 212-13, 741 P.2d at 679-80.

Although by the time this proceeding reached the Supreme Court of Arizona Mrs. Rasmussen had died, rendering the proceeding moot, the court in its discretion decided to address the difficult issues at hand given the underlying and significant public impor-

though the patient's immediate family was notified of the proceeding, they did not play an active role in the determination of her treatment.<sup>304</sup>

After explaining that the Medical Treatment Decision Act of 1985<sup>305</sup> did not provide Mrs. Rasmussen with a statutory right to refuse life-sustaining medical treatment,<sup>306</sup> the court held that she was not precluded from a remedy in light of both a constitutional and a common law right to refuse such treatment.<sup>307</sup> The court first reviewed the statute outlining the general duties and powers of the guardian.<sup>308</sup> This statute provides in relevant part, "[a] guardian may give any consents or approvals that may be necessary to enable the ward to receive medical or other professional care, counsel, treatment or service."<sup>309</sup>

Despite the arguments of the state the court held that the statutory right to consent to the delivery of medical care must include at least implicitly, the right to consent to the delivery of no medical care.<sup>310</sup> Furthermore, as supported by the statute, the court adopted the best interests standard to guide the guardian, or surrogate decisionmaker, in making a decision with regard to the refusal of life-sustaining treatment.<sup>311</sup> Under this standard, the decisionmaker assesses what medical treatment would be in the best interests of the patient based on several

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tance of the case. *Id.* at 213-14, 741 P.2d at 680-81.

Other state jurisdictions, in similar fashion, have also declined to rely on the mootness doctrine following the death of the patient to avoid resolving the critical issues surrounding an individual's right to refuse medical treatment. *See, e.g.,* *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984); *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So. 2d 921; *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *Guardianship of Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

304. *Rasmussen*, 154 Ariz. at 212, 741 P.2d at 679.

305. ARIZ. REV. STAT. ANN. §§ 36-3201 to 36-3210 (1986).

306. *Rasmussen*, 154 Ariz. at 214-15, 741 P.2d at 681-82 (the patient lacked this right under the act because she failed to execute the required written declaration and was not suffering from a terminal condition as required by the statute).

307. *Id.* at 215, 741 P.2d at 681-82.

308. *Id.* at 220, 741 P.2d at 687.

309. ARIZ. REV. STAT. ANN. § 14-5312(A)(3) (1975).

310. *Rasmussen*, 154 Ariz. at 221, 741 P.2d at 688 ("To hold otherwise would . . . reduce the guardian's control over medical treatment to little more than a mechanistic rubberstamp for the wishes of the medical treatment team."); *see infra* notes 316, 321 & 334 and accompanying text.

311. *Rasmussen*, 154 Ariz. at 222, 741 P.2d at 689.

objective criteria, which include the "satisfaction of present desires, the opportunities for future satisfactions and the possibility of developing or regaining the capacity for self-determination."<sup>312</sup>

Given the authority of the guardian as well as the appropriate standard to guide the decision, the court held that the patient's best interests would be served by removing the nasogastric tube and retaining the "DNR" and "DNH" orders on her medical chart. This decision was based on the patient's inability to interact with her environment, and the fact that medical treatment would have provided minimal benefits and would only have postponed the patient's death rather than improved her life.<sup>313</sup>

## 2. California

In *Conservatorship of Drabick*,<sup>314</sup> forty-four-year-old William Drabick, suffered a severe head injury in an automobile accident placing him in a persistent vegetative state.<sup>315</sup> The patient's brother, after being appointed as conservator, sought a court order allowing him to remove the nasogastric tube sustaining his brother's life, claiming that such a removal was in his brother's best interests.<sup>316</sup>

After rejecting the doctrine of substituted judgment<sup>317</sup> and the application of California's Natural Death Act,<sup>318</sup> the court looked to the probate code to determine the powers vested in the conservator in situations involving the refusal of life-sus-

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312. *Id.* (quoting PRESIDENT'S COMMISSION REPORT, *supra* note 4, at 135); see also *supra* notes 120-122 and accompanying text.

313. *Id.*

314. 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988).

315. *Id.* at 190, 245 Cal. Rptr. at 842.

316. *Id.* at 189, 245 Cal. Rptr. at 841. The conservator also offered evidence, based on numerous and explicit conversations that his brother had had with his paramour, that he would not want to be kept alive in his present state and that he would want his physician to remove the nasogastric tubes providing him with food and water despite the fact that such a removal would cause his death. *Id.* at 191-92, 245 Cal. Rptr. at 843.

317. *Id.* at 200, 245 Cal. Rptr. at 849.

318. CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1991). The California Natural Death Act was inapplicable because after his accident the patient was unable to execute a binding directive to physicians regarding health. *Drabick*, 200 Cal App. 3d at 214-15, 245 Cal. Rptr. at 858-59.



taining treatment.<sup>319</sup> This provides that, "the conservator has the exclusive authority to give consent for . . . medical treatment to be performed on the conservatee as the conservator in good faith based on medical advice determines to be necessary . . ."<sup>320</sup>

The court, satisfied with the application of the probate statute to this situation, explained that, by implication, the statute gives the conservator the power to withhold or withdraw medical treatment.<sup>321</sup> It held that its only determination was whether or not such a power was exercised on behalf of the incompetent patient in "good faith" based upon medical advice or, pursuant to a best interest standard.<sup>322</sup> The court remarked that allowing the patient's brother, as conservator in this instance, to exercise vicariously his brother's right to refuse life-sustaining medical treatment according to a best interests standard, protected the individual and preserved his constitutional rights.<sup>323</sup>

Consequently, the court held that the conservator's good faith decision in this context, according to a best interests standard, required the consideration of medical advice regarding the patient's prognosis and any other information relevant to the patient's best interests, including any written directives or statements made by the patient.<sup>324</sup> The court cautioned, however, that the conservator need not prove the patient's desire to withdraw medical treatment by a clear and convincing standard and that any statements, formal or informal, of the patient would only be one factor in demonstrating that the conservator had considered the patient's best interests objectively and in good faith.<sup>325</sup>

### 3. *Minnesota*

In *Conservatorship of Torres*,<sup>326</sup> the patient had suffered massive and irreversible brain damage due to a lack of oxygen

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319. *Id.* at 200, 245 Cal. Rptr. at 849.

320. CAL. PROB. CODE § 2355(a) (1981).

321. *Drabick*, 200 Cal. App. 3d at 201, 245 Cal. Rptr. at 849; *see also supra* note 310 and accompanying text and *see also infra* notes 334 & 347 and accompanying text.

322. *Drabick*, 200 Cal. App. 3d at 204, 245 Cal. Rptr. at 852.

323. *Id.* at 209, 245 Cal. Rptr. at 855.

324. *Id.* at 217-18, 245 Cal. Rptr. at 861.

325. *Id.* at 212, 217-18, 245 Cal. Rptr. at 857, 861.

326. 357 N.W.2d 332 (Minn. 1984).

caused by cardiopulmonary arrest and had, subsequently, been placed on a respirator.<sup>327</sup> A conservator, whose relation to the patient is unknown, was appointed to represent the patient.<sup>328</sup> Shortly after the appointment, the conservator requested a court hearing to determine the appropriate medical treatment for the patient.<sup>329</sup>

The court first looked to the applicable statutory authority codifying the powers of the conservator in the area of medical decision making for the conservatee.<sup>330</sup> The statute provides that, "the duties and powers . . . which the court may grant to a conservator of the person include, *but are not limited to*: . . . (4)(a) The power to give any *necessary consent* to enable the . . . conservatee to receive *necessary* medical or other professional care, counsel, treatment or service . . . ."<sup>331</sup>

Despite arguments that the language of the statute limited the power of the conservator,<sup>332</sup> the court found that the statute mandated greater authority for the conservator than just the power to consent to medical care.<sup>333</sup> As a result, the court held that "if the [patient's] best interests are no longer served by the maintenance of life supports, the probate court may empower the conservator [and surrogate decisionmaker] to order their removal despite the absence of a specific provision in [the applicable statute]."<sup>334</sup>

After determining that a conservator had the authority to refuse life-sustaining medical treatment on behalf of an incompetent patient, the court rejected three specific arguments contrary to the application of this authority in the case of Mr. Torres.<sup>335</sup> First, the court held that the decision of the conserva-

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327. *Id.* at 334.

328. *Id.*

329. *Id.* at 334-35. The only known living relatives of the patient were a cousin, who testified at the hearing, and an aunt, who lived in Texas and was unable to attend the hearing due to her age and health. She did, however, send a letter expressing her belief that her nephew would not want to be sustained by mechanical devices (this letter was never considered by the court as evidence). *Id.* at 336.

330. *Id.* at 337.

331. *Id.* (Quoting MINN. STAT. § 525.56(3) (1982)(emphasis in original)).

332. *Id.* at 337.

333. *Id.*

334. *Id.*; see also *supra* notes 310 & 321 and accompanying text and see *infra* note 347 and accompanying text.

335. *Torres*, 357 N.W.2d at 340-41.

tor to remove the respirator in this particular case was made according to the best interests of the patient in light of the fact that prolonging the patient's life without hope of recovery, as corroborated by attending physicians,<sup>336</sup> was contrary to society's concern for the right of an individual to die with dignity.<sup>337</sup> Second, the court dismissed the challenge to the conservator's authority on due process grounds, explaining that a full evidentiary hearing was held on the recommended care for Mr. Torres, full and complete notice was given to all concerned, and all interested parties were represented at the hearing.<sup>338</sup> Lastly, the court summarily rejected the argument that the decision to remove the patient's respirator was affirmed by the trial court based on speculative evidence, because the record did not support a finding that the trial court had abused its discretion.<sup>339</sup>

#### 4. *Washington*

In *In re Welfare of Colyer*,<sup>340</sup> the patient was a seventy-year-old woman in a persistent vegetative state and unable to breathe without the aid of a respirator.<sup>341</sup> Her husband requested that she be removed from the life-support systems maintaining her and allowed to "pass through this life with dignity,"<sup>342</sup> given her condition and grim prognosis for any sort of meaningful existence.

The Supreme Court of Washington rejected the applicability of Washington's Natural Death Act<sup>343</sup> since the patient left no written directive of her wishes regarding life-sustaining medical treatment.<sup>344</sup> The court reviewed the applicable guardianship

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336. *Id.* at 335-36.

337. *Id.* at 340; see *supra* notes 120-22 and accompanying text.

338. *Id.* at 340.

339. *Id.* at 341.

340. 99 Wash. 2d 114, 660 P.2d 738 (1983).

341. *Id.* at 116, 660 P.2d at 740.

342. *Id.* at 116-17, 660 P.2d at 740.

343. WASH. REV. CODE § 70.122 (Supp. 1991).

344. *Colyer*, 99 Wash. 2d at 118, 660 P.2d at 741; see also *Guardianship of Grant*, 109 Wash. 2d 545, 553, 747 P.2d 445, 449 (1986) (the Act only mandates competent adults to execute directives authorizing the refusal of life sustaining treatment and, therefore, was inapplicable to the patient since she had been declared incompetent at 14); *Guardianship of Hamlin*, 102 Wash. 2d 810, 816, 689 P.2d 1372, 1376 (1984) (the Act is not the exclusive method for withholding life-sustaining treatment when no valid di-

statute,<sup>345</sup> which provided that a guardian had the power "to care or maintain the incompetent or disabled person, assert his or her rights and best interests and provide timely, informed consent to necessary medical procedures."<sup>346</sup> Finally, the court held that since consent to medical treatment was expressly required by the statute, the refusal of life-sustaining medical treatment could also be asserted by the guardian pursuant to the best interests standard.<sup>347</sup>

In addition to adopting the best interests standard for surrogate decisionmaking, the court established procedural guidelines to follow in future cases. These guidelines include: 1) the unanimous concurrence by a prognosis committee that the patient's condition is terminal with no reasonable probability of returning to a cognitive state; 2) court appointment of a guardian and a guardian ad litem to represent the best interests of the incompetent; and 3) exercise of the patient's right to refuse life sustaining treatment if, in the guardian's best judgment, it is in the patient's best interests to do so.<sup>348</sup>

Although the court affirmed the decision of the trial court to discontinue the life-support systems of the incompetent patient, it shunned general judicial involvement in every substantive decision to withhold medical treatment.<sup>349</sup> The court recognized that, given the procedural guidelines established, and the possibility of disagreement between family members or physicians, there would be instances requiring the detached opinion and inquiry of the judiciary.<sup>350</sup>

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rective is executed by the patient prior to becoming incompetent).

345. *Colyer*, 99 Wash. 2d at 129, 660 P.2d at 746.

346. WASH. REV. CODE § 11.92.040(3) (1987).

347. *Colyer*, 99 Wash. 2d at 131, 660 P.2d at 747; *see also supra* notes 310, 321 & 333 and accompanying text.

348. *Colyer*, 99 Wash. 2d at 137, 660 P.2d at 751 (decision up to the attending physicians and at least two other physicians).

349. *Id.* at 136-37, 660 P.2d at 750; *see also supra* notes 98-109 and accompanying text.

350. *Colyer*, 99 Wash. 2d at 136-37, 660 P.2d at 750-51; *see also* Guardianship of Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984). The *Hamlin* court affirmed the best interests standard of *Colyer*, but modified the procedural guidelines established by holding (contrary to the implication in *Colyer*) that the appointment of a guardian is not required in all situations. If the incompetent patient's family, after consultation with the prognosis committee, agrees with the conclusion that the best interests of the patient would be advanced by withdrawing life sustaining treatment, judicial appointment of a

IV. The *Cruzan* Case

In *Cruzan v. Director, Missouri Department of Health*,<sup>351</sup> the United States Supreme Court first addressed whether an individual's right to die was a fundamental right protected by the United States Constitution — even if the individual was incompetent and unable to express it personally. While this case is important in this respect, the Court restricted itself to reviewing an extremely narrow question.<sup>352</sup> This question was whether the Constitution prohibited the state of Missouri from establishing a procedural safeguard requiring clear and convincing evidence of an incompetent patient's express wishes to refuse life-sustaining treatment before allowing a surrogate decisionmaker to refuse such treatment on behalf of the patient.<sup>353</sup>

A. *Justice Rehnquist's Majority Opinion*

After reviewing the facts and procedural history of the case<sup>354</sup> and undertaking a review of the case law and different approaches utilized by individual states,<sup>355</sup> the Court came to several conclusions. Contrary to past state court holdings,<sup>356</sup> it recognized that the due process clause of the fourteenth amendment, by direct inference, rather than via the shadowy penumbra of the generalized right of privacy,<sup>357</sup> confers a liberty interest in refusing unwanted medical treatment on competent and incompetent patients even in the instance of life-saving nutri-

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guardian is not required. Conversely, if the patient has always been incompetent and there is no available family, a guardian must be judicially appointed to carry out the mandate of the best interests standard. *Id.* According to the guidelines of *Colyer* as modified by *Hamlin*, the court extended its rationale in those cases dealing with the removal of a respirator to instances where the life sustaining medical treatment in question is the artificial administration of nutrition and hydration through a nasogastric tube. *Id.*

351. 110 S. Ct. 2841 (1990).

352. *Id.* at 2851 (quoting *Twin City Bank v. Nebeker*, 167 U.S. 196, 202 (1897)) (when deciding "a question of such magnitude and importance . . . it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject.").

353. *Id.* at 2851.

354. *Id.* at 2845-46; see also *supra* notes 156-61 and accompanying text.

355. *Cruzan*, 110 S. Ct. at 2846-51.

356. See *supra* notes 31-47 and accompanying text.

357. *Cruzan*, 110 S. Ct. at 2851 n.1.

tion and hydration.<sup>358</sup>

Second, given the valid liberty interest in question, the Court addressed the issue of whether Missouri could establish constitutional, procedural safeguards to ensure that a surrogate conforms as closely as possible to the expressed wishes of the patient.<sup>359</sup> Affirming the decision of the Missouri Supreme Court,<sup>360</sup> it held that Missouri, or any state, "may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state."<sup>361</sup>

While acknowledging that substituted judgment states allow more general proof of an incompetent patient's decision to satisfy the clear and convincing standard necessary for the surrogate to act,<sup>362</sup> the Court explained that the due process clause did not require adherence to this approach by all states absent substantial proof of the patient's views.<sup>363</sup> The Court further explained that it was not constitutional error for the Missouri Supreme Court to impose heightened evidentiary requirements on the surrogate seeking to terminate treatment in the form of express patient intent, nor was it incorrect to find that the evidence presented in the case to reflect this intent<sup>364</sup> was insufficient to overcome this standard.<sup>365</sup> In sum, although the right to refuse medical treatment was held to be constitutionally sound, Missouri, or any state, can, within the bounds of the fourteenth amendment, safeguard the personal elements associated with such a right by requiring the surrogate decisionmaker to defer to the expressed wishes of the incompetent patient before allowing such a decision to be made.<sup>366</sup>

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358. *Id.* at 2851.

359. *Id.* at 2852.

360. *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (en banc). For a discussion of the Missouri Supreme Court decision see *supra* notes 156-66 and accompanying text.

361. *Cruzan*, 110 S. Ct. at 2854; see also *supra* notes 144-45 and accompanying text.

362. *Cruzan*, 110 S. Ct. at 2854-55.

363. *Id.* at 2855. The Court also acknowledged that if such a lesser standard were required by the Constitution, or utilized by Missouri, the "loving and caring" parents of the patient would have surely qualified to exercise their daughter's right to refuse the artificial nutrition and hydration sustaining her. *Id.*

364. See *supra* text accompanying note 164.

365. *Cruzan*, 110 S. Ct. at 2855.

366. *Id.* at 2855-56; see also *supra* notes 122-55 and accompanying text.

Subsequent to the unsuccessful outcome in the Supreme Court, Nancy Cruzan's par-

## B. *The Concurring Opinions of Justice O'Connor and Justice Scalia*

While agreeing with the holding of the majority, Justice O'Connor pointed out that while it was constitutionally permissible for Missouri to formulate a strict method to safeguard an incompetent individual's liberty interest in refusing medical treatment, such a holding did not preclude other states from adopting other, less stringent approaches.<sup>367</sup> Justice O'Connor further explained that the holding of the majority only decided "that one State's practice does not violate the Constitution; the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the 'laboratory' of the States."<sup>368</sup>

Justice Scalia, also concurring with the majority opinion, made two separate points. First, he explained that "the federal courts have no business"<sup>369</sup> in deciding right to die cases because such decisions are more properly left up to the states through their elected representatives.<sup>370</sup> Given the silence of the Constitution on this issue, Justice Scalia urged individual state legislatures, as state supreme courts have,<sup>371</sup> to decide what measures should be taken in preserving the life of an incompetent patient as there is no requirement that the Court "inject itself into every field of human activity."<sup>372</sup> Second, citing the legitimate state interest in preventing suicide, he scrutinized the family's three attempts at distinguishing the patient's case from ordinary sui-

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ents returned to the original trial court on November 1, 1990 with new evidence in an attempt to surpass the strict standard of Missouri affirmed by the Court. Smolowe, *Bringing an End to Limbo*, TIME, December 24, 1990 at 64. After hearing three witnesses who recounted specific conversations in which Nancy stated that she would not want to live "like a vegetable," probate judge Charles Teel, Jr. reaffirmed his 1988 decision and ruled that there was "clear and convincing evidence" that Nancy would not want to continue living in a persistent vegetative state. *Id.*; see also Pierce, *Many Issues Remain Unresolved in Wake of Cruzan*, INTERNAL MEDICINE, February 1-14, 1991 at 2 [hereinafter cited as Pierce]. Since the Missouri Attorney General promised to abide by the ruling, the gastrostomy tube that had kept Nancy alive for seven years was removed on December 14, 1990 and she died on December 26. Pierce, *supra*; Smolowe, *supra*.

367. *Cruzan*, 110 S. Ct. at 2858-59.

368. *Id.* at 2859.

369. *Id.* (Scalia, J., concurring).

370. *Id.*

371. See *infra* notes 383-85 and accompanying text.

372. *Cruzan*, 110 S. Ct. at 2863 (Scalia, J., concurring).

cide and concluded that none of the three sufficed.<sup>373</sup>

### C. Justice Brennan's Dissenting Opinion

Justice Brennan had two major disputes with the opinion of the majority. First, unlike the majority, which classified the right to refuse unwanted medical treatment simply as a general liberty interest within the bounds of the due process clause, he characterized the right as fundamental and deeply rooted according to the substantive due process and right of privacy theories supporting other fundamental, personal rights.<sup>374</sup> Given his belief in the fundamental nature of the right to refuse medical treatment, Justice Brennan explained that any requirement significantly interfering with the exercise of such a right cannot be upheld absent a compelling state interest.<sup>375</sup>

As a result, he urged that the Missouri decision be reversed due to the "improperly biased procedural obstacles imposed by the Missouri Supreme Court [that] impermissibly burden" the fundamental right to refuse unwanted artificial nutrition and hydration.<sup>376</sup> While acknowledging that no personal right is absolute, no matter how fundamental, Justice Brennan claimed that the state would gain nothing by overruling the decision of the patient.<sup>377</sup> Consequently, although the state had legitimate interests at stake, Missouri could only "constitutionally impose those procedural requirements that serve to enhance the accuracy of a determination" of the patient's wishes.<sup>378</sup> The Missouri "safeguard," he pointed out, overstepped this boundary by discounting evidence of the patient's intent and desires,<sup>379</sup> imposing a heightened evidentiary burden that, in essence, is nothing less than "an obstacle to the exercise of a fundamental right . . .

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373. *Id.* at 2860-62. The three attempts were "(1) that she is permanently incapacitated and in pain; (2) that she would bring on her death not by any affirmative act but by merely declining treatment that provides nourishment; and (3) that preventing her from effectuating her presumed wish to die requires violation of her bodily integrity." *Id.* at 2860.

374. *Id.* at 2865 (Brennan, J., dissenting); see also *supra* notes 31-42 and accompanying text.

375. *Cruzan*, 110 S. Ct. at 2865 (Brennan, J., dissenting).

376. *Id.* at 2864.

377. *Id.* at 2869-70.

378. *Id.* at 2871.

379. *Id.* at 2874 nn.19-20.



evin[ing] a disdain for Nancy Cruzan's own right to choose."<sup>380</sup>

Although not disputing the fact that the states remain free to articulate various procedural safeguards to protect the interests of incompetent patients, Justice Brennan explained that these protections are not limitless and, within the framework of the Constitution, must be reliable in discovering the intent of the patient yet flexible enough to avoid prejudice with regard to the patient's decision.<sup>381</sup> In conclusion, he asserted that Missouri's strict evidentiary standard failed to pass this test and, therefore, should be held unconstitutional because, unlike the vast majority of the states, Missouri "fashioned a rule that lessens the likelihood of accurate determinations"<sup>382</sup> and displaced "Nancy's own assessment of the processes associated with dying."<sup>383</sup>

#### D. *Evaluation of Cruzan*

It is apparent that the *Cruzan* holding will have a minimal effect on the right to die and further appears to be an attempt at maintaining the status quo. From one perspective the decision is a critical one since the Supreme Court, for the first time, held that the right to refuse medical treatment is a right protected within the general liberty interest of the fourteenth amendment. Significantly, however, the Court refused to characterize the right as a fundamental privacy right, which allowed it to easily affirm Missouri's strict evidentiary requirement as constitutionally permissible.

The rationale underlying the *Cruzan* holding parallels the reasoning supporting the Court's most recent abortion decision

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380. *Id.* at 2872-73 & 2876.

381. *Id.* at 2876.

382. *Id.*

383. *Id.* at 2878; see also *Cruzan*, 110 S. Ct. at 2878 (Stevens, J., dissenting). "Missouri's regulation [requirement of clear and convincing evidence of an incompetent patient's express intent] is an unreasonable intrusion upon traditionally private matters encompassed within the liberty protected by the Due Process Clause" since it places the fate of Nancy Cruzan in the hands of the state legislature instead of those of her family. *Id.* at 2882. To avoid such "a distressing misunderstanding of the importance of individual liberty" he asserts that the state should defer to the decision that gives appropriate respect to Nancy Cruzan's best interest which, in this case, is to allow her parents to exercise, on her behalf, her constitutional right to refuse life-sustaining medical treatment. *Id.* at 2883.

in *Webster v. Reproductive Health Services*<sup>384</sup> and further reflects the general indifference of the Rehnquist Court in protecting an individual's personal rights against burdensome state regulation. In *Webster*, while affirming tenuously the fundamental right to an abortion, the Court held that several regulations restricting this right were valid exercises of state authority and signaled that even greater state restrictions would be permissible. Similarly, in *Cruzan*, while holding that the right to refuse medical treatment was legitimate and valid, though not fundamental, the Court permitted Missouri to restrict that right and impose strict evidentiary burdens on surrogate decisionmakers seeking to exercise the right on behalf of an incompetent patient.<sup>385</sup>

In sum, the Court's holding in *Cruzan* will have little, if any, impact on the manner in which individual state legislatures and courts address the right to die issue. Unfortunately, this translates into a personal medical decision ultimately depending on the state in which the patient is living. Consequently, unless state legislatures take the initiative to change the existing landscape with effective legislation, the three diverse approaches now utilized by state courts will continue to be the standards applied: the specific subjective intent standard according to substituted judgment theory, as affirmed by the *Cruzan* majority,<sup>386</sup> the subjective standard pursuant to substituted judgment theory, as advocated by Justice Brennan,<sup>387</sup> and the objective, best interests standard, as suggested by Justice Stevens.<sup>388</sup>

#### V. Statutory Law and an Individual's Right to Die

As demonstrated, by adopting different approaches based on either common law or constitutional rights, state courts have not ignored their responsibility to resolve disputes involving a surrogate decisionmaker's attempt to exercise the right to refuse life-sustaining medical treatment on behalf of an incompetent patient. However, given the moral, ethical, social, medical, and

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384. 109 S. Ct. 3040 (1989).

385. See *supra* notes 354-66 and accompanying text.

386. See *supra* notes 123-70 and accompanying text.

387. See *supra* notes 171-293 and accompanying text.

388. See *supra* notes 301-50 and accompanying text.

legal considerations involved, courts nonetheless have consistently maintained that refusal of treatment situations "are not well-suited for resolution in adversarial judicial proceedings" and should instead be addressed via state legislation.<sup>389</sup>

The following passage articulates the rationale underlying the courts' continued plea for legislative involvement in the sensitive area of right to die:

Legislatures are also considered to be better suited than courts to set guidelines in this area. Legislatures may be better able to balance the interests involved in determining whether to permit termination of care, and they have the power to make laws and regulations for the protection of the public health and welfare. In addition, the delicate ethical considerations involved in making a "right to die" decision may require a legislative determination, as the legislature has the job of weighing and understanding social interaction. Finally, it is argued that legislatures directly represent the people and are thus best able to determine social policy.<sup>390</sup>

In essence, the state courts, while outlining procedures to resolve refusal of treatment disputes, have asserted that the "legislature is free to streamline, tailor or overrule" these judicially created approaches "to the extent that no constitutional doctrine is abrogated."<sup>391</sup> In response to the calls of state courts to provide some legislative guidance in the right to die area, state legislatures have enacted two types of statutes: durable power of attorney statutes, which allow persons to designate surrogates to make medical treatment decisions in the event of incompetency,<sup>392</sup> and natural death or living will acts, which au-

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389. *Rasmussen v. Fleming*, 154 Ariz. 207, 225, 741 P.2d 674, 692 (1987).

390. *Brown, Therefore, Choose Death*, 10 HUM. RTS. J. 39, 44 (1982); accord *Satz v. Perlmutter*, 379 So. 2d 359 (Fla. 1980):

It is the type [of] issue which is more suitably addressed in the legislative forum, where fact finding can be less confined and the viewpoints of all interested institutions and disciplines can be presented and synthesized. In this manner only can the subject be dealt with comprehensively and the interests of all institutions and individuals be properly accommodated.

*Id.* at 360; see also *In re Conroy*, 98 N.J. 321, 343-46, 486 A.2d 1209, 1220-21 (1985); *Guardianship of Hamlin*, 102 Wash. 2d 810, 822, 689 P.2d 1372, 1379 (1984).

391. *Estate of Longeway*, 133 Ill. 2d 33, 53, 549 N.E.2d 292, 301 (1989).

392. See, e.g., ALASKA STAT. §§ 13.26.335, 13.26.344(l) (Supp. 1989); CAL. CIV. CODE § 2500 (Supp. 1990); D.C. CODE ANN. § 21-2205 (1989); IDAHO CODE § 39-4505 (Supp. 1989); ILL. REV. STAT. ch. 110 ½, para. 804-1 to 804-12 (Supp. 1988); KAN. STAT. ANN. § 58-625

thorize persons to specify the type of care they do or do not want in written directives left prior to becoming incompetent.<sup>393</sup>

While the practical wisdom underlying the enactment of such statutes is unquestioned, and while it is perhaps socially wise to encourage people to furnish written instructions regarding health care in the form of a living will or durable power of attorney, the simple fact is that these statutes have not aided the courts because they are seldom used by the general populace.<sup>394</sup> Right to die organizations have received a flood of inquiries regarding living wills.<sup>395</sup> Even after the highly publicized *Cruzan* decision, the numbers still reflect that given the low probability of becoming irreversibly vegetative, many individuals do not feel an urgency to execute formal evidence of their

(Supp. 1989); ME. REV. STAT. ANN. tit. 18-A, § 5-501 (Supp. 1989); NEV. REV. STAT. § 449.800 (Supp. 1989); N.Y. PUB. HEALTH LAW §§ 2980-94 (McKinney 1990); OHIO REV. CODE ANN. § 1337.12 (Anderson Supp. 1989); OR. REV. STAT. § 127.510 (1989); PA. STAT. ANN. tit. 20, § 5603(h) (Purdon Supp. 1989); R.I. GEN. LAWS §§ 23-4.10-1 (1989); TEX. REV. CIV. STAT. ANN. art. 4590h-1 (Vernon Supp. 1990); VT. STAT. ANN. tit. 14, § 3451 (1989).

393. See, e.g., ARIZ. REV. STAT. ANN. §§ 36-3201 to 36-3210 (1986); ARK. STAT. ANN. § 20-17-202 (Supp. 1989); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1990); DEL. CODE ANN. tit. 16, § 2502 (1983); FLA. STAT. §§ 765.01-.15 (1987); IDAHO CODE § 39-4504 (Supp. 1989); ILL. REV. STAT. ch. 110 ½, para. 702(h) (Supp. 1987); IND. CODE § 16-8-11-14(g)(2) (1988); IOWA CODE § 144A.7(1)(a) (1989); LA. CIV. CODE ANN. art. 40:1299.58.1, 40:1299.58.3(C) (West Supp. 1990); MINN. STAT. § 145B.01 (Supp. 1989); MO. REV. STAT. § 459.010 (1986); TEXAS HEALTH & SAFETY CODE ANN. § 672.003(d) (Vernon Supp. 1990); UTAH CODE ANN. §§ 75-2-1105 to 75-2-1106 (Supp. 1989); VA. CODE ANN. § 54.1-2981 (1988); WASH. REV. CODE § 70.122 (1979); WYO. STAT. § 35-22-102 (1988).

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Surveys show that the overwhelming majority of Americans have not executed such written instructions. See Emmanuel & Emmanuel, *The Medical Directive: A New Comprehensive Advance Care Document*, 261 J. A.M.A. 3288 (1989) (only 9% of Americans execute advance directives about how they would wish treatment decisions to be handled if they became incompetent); *American Medical Association Surveys of Physician and Public Opinion on Health Care Issues* 29-30 (1988) (only 15% of those surveyed had executed living wills . . .).

*Cruzan v. Director of Mo. Dep't of Health*, 110 S. Ct. 2841, 2875 n.21 (1990) (Brennan, J., dissenting); see also OFFICE OF TECHNOLOGY ASSESSMENT, CONGRESS OF THE UNITED STATES, INSTITUTIONAL PROTOCOLS FOR DECISIONS ABOUT LIFE-SUSTAINING TREATMENTS 23 n.2 (1988) (1986 Oregon study found that although adults in 82% of homes had heard about living wills, only 23% of adults in homes with persons over 65 and 16% of other adults had prepared one).

395. See Friedrich, *A Limited Right to Die*, TIME, July 9, 1990, at 59; Pierce, *supra* note 366, at 17.

health care preferences.<sup>396</sup>

As one California appellate court observed, "[t]he lack of generalized public awareness of the statutory scheme and the typically human characteristics of procrastination and reluctance to contemplate the need for such arrangements however makes this a tool which will all too often go unused by those who might desire it."<sup>397</sup>

Several state courts have confirmed this rationale given their rejection and nonapplication of natural death acts the absence of a written directive or failure of the statute to cover a patient's specific situation;<sup>398</sup> a review of two particular examples will emphasize the point. In *Corbett v. D'Alessandro*,<sup>399</sup> the court explained that the statutory right created by the Florida Right to Decline Life-Prolonging Procedures Act<sup>400</sup> could not be applied to a guardian's request to withdraw artificial nutrition and hydration from a seventy-five-year-old woman in a persistent vegetative state.<sup>401</sup> The court reasoned that the patient had not left any written declaration of her intent prior to becoming incompetent and the "provision of sustenance" was not a life-prolonging procedure for the purposes of the statute.<sup>402</sup> Similarly, in *Rasmussen v. Fleming*,<sup>403</sup> the Arizona Supreme Court explained that the Arizona Medical Treatment Decision Act<sup>404</sup> did not provide the patient with a statutory right to refuse life-

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396. *Cruzan*, 110 S. Ct. at 2875 (Brennan, J., dissenting).

397. *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1015, 194 Cal. Rptr. 484, 489 (1983); see also *In re Westchester County Medical Center*, 72 N.Y.2d 517, 551, 531 N.E.2d 607, 626, 534 N.Y.S.2d 886, 905 (1988) (Simons, J., dissenting) (When a person relates to family or friends that she does not want her life to be 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. To require more is unrealistic, and for all practical purposes, it precludes the rights of patients to forego life-sustaining treatment.").

398. See *supra* notes 194, 196, 219, 306, 318 & 344 and accompanying text.

399. 487 So. 2d 368 (Fla. Dist. Ct. App. 1986).

400. FLA. STAT. §§ 765.01-.15 (1987).

401. *Corbett*, 487 So. 2d at 370.

402. *Id.*; see *supra* note 194; see also *Guardianship of Browning*, 543 So. 2d 258, 264-65 (Fla. Dist. Ct. App. 1989) (The Act was inapplicable to the patient's situation despite the existence of a living will since "the provision of sustenance" is not a life-prolonging procedure for purposes of the statute and the patient in question did not fit the rigid, statutory definition of "terminal condition," which required the death of the patient to be "imminent."), *aff'd*, 568 So. 2d 4 (Fla. 1990).

403. 154 Ariz. 2d 207, 741 P.2d 674 (1987).

404. ARIZ. REV. STAT. ANN. §§ 36-3201 to 36-3210 (1986).

sustaining medical treatment because she failed to execute the required written declaration and was not suffering from a "terminal condition" as defined by the statute.<sup>405</sup>

Despite the rejection of these living will statutes, state courts have not held that these statutes are the exclusive remedy for patients and, therefore, preclude the exercise of any constitutional or common law rights of patients simply because the statute is not applicable to them.<sup>406</sup> Fortunately for the patients and surrogate decisionmakers, such a judicial stance translates into courts analyzing the request to refuse life-sustaining treatment according to one of the three standards discussed above since the absence of a statutory remedy "does not affect the otherwise existing constitutional [or common law] rights of persons in a permanent vegetative state with no reasonable prospect of regaining cognitive brain function to forego the use of artificial life sustaining measures."<sup>407</sup>

It is apparent that statutes requiring written evidence of patient intent, either by living will or health care durable power of attorney, are theoretically sound and perhaps indicative of legislative intent or public policy. However, these statutes do not provide practical solutions to refusal of treatment scenarios, given general ignorance of the existence of such remedies, procrastination on the part of the average person, and narrow application to actual patient situations.<sup>408</sup> North Carolina, Oregon,

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405. See *supra* note 306 and accompanying text.

406. See, e.g., *Corbett*, 487 So. 2d at 370 (Fla. Dist. Ct. App. 1986). Evidence that the Florida Act was not intended to encompass the entire spectrum of instances in which a patient's privacy rights could be exercised was found in § 765.15 of the statute itself (that is, the statute is "cumulative to the existing law . . . and do[es] not impair any existing rights . . . a patient . . . may have . . . under the common law or statutes of the state."). *Id.*; see also *In re Browning*, 543 So. 2d 258, 265 (Fla. Dist. Ct. App. 1986); *Guardianship of Hamlin*, 102 Wash. 2d 810, 816, 689 P.2d 1372, 1376 (1984); *Guardianship of Grant*, 109 Wash. 2d 545, 553, 747 P.2d 445, 449 (1986).

407. *Corbett*, 487 So. 2d at 370-71.

408. Starting in December, 1991, the Patient Self-Determination Act will require health care facilities receiving federal funds to maintain written policies about patient decision making and to advise patients of their rights to make health care decisions using advance directives such as living wills and durable powers of attorney for health care. 42 U.S.C. § 1395cc(a)(1) (1990). More specifically, such facilities must note in patient records whether the patient has made an advance directive, ensure compliance with advance directives in accordance with state law, and provide staff and community education about advance directives. 42 U.S.C. § 1396a(a) (1990); *Pierce*, *supra* note 366, at 17.

Virginia, and Connecticut, have had the foresight to recognize this and have enacted natural death legislation that specifically provides for withdrawal of life-sustaining treatment for patients who have not executed a written, natural death directive and are diagnosed as comatose with no reasonable possibility of returning to a cognitive sapient state.<sup>409</sup>

The Connecticut Removal of Life Support Systems Act<sup>410</sup> is perhaps the most important of these statutes because it is the only statute of the four thus far to be used affirmatively by a state court confronted with a refusal of life-sustaining treatment situation.<sup>411</sup> In *McConnell v. Beverly Enterprises-Connecticut*,<sup>412</sup> the Supreme Court of Connecticut was confronted with a husband and children seeking an injunction to remove a gastrostomy tube through which the patient received life-sustaining nutrition and hydration.<sup>413</sup> The patient, the fifty-seven-year-old wife of the plaintiff and mother of the three coplaintiffs, was in a persistent vegetative state with no prospect of improvement.<sup>414</sup> The record of the trial court revealed that the patient, because of her professional experience and training as a nurse, had expressly and repeatedly informed her family and coworkers that if she were ever incapacitated, she would not want to be kept alive by artificial means.<sup>415</sup>

Prior to *McConnell*, the only other Connecticut case to squarely address the right to die issue was *Foody v. Manchester Memorial Hospital*,<sup>416</sup> in which the court held that the primary method for a surrogate decisionmaker to express an incompetent

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409. CONN. GEN. STAT. §§ 19a-570 to 19a-575 (Supp. 1990); N.C. GEN. STAT. § 90-322 (Cum. Supp. 1979); OR. REV. STAT. § 127.640 (1989); VA. CODE ANN. § 54.1-2986 (1986); see also New Jersey Declaration of Death Act of April 8, 1991, ch. 90, 1991 N.J. Laws Sen. No. 1208 (after using reasonable efforts to determine the personal religious beliefs of the patient, as communicated by the family or other close associates, a physician may declare the patient dead according to neurological criteria if such a declaration will not violate those beliefs; this appears to be legislative adoption of a modified subjective substituted judgment standard not requiring written directions by the patient); see *supra* note 285.

410. CONN. GEN. STAT. §§ 19a-570 to 19a-575 (Supp. 1990).

411. See *supra* note 180.

412. 209 Conn. 692, 553 A.2d 596 (1989).

413. *Id.* at 695, 553 A.2d at 598.

414. *Id.* at 696, 553 A.2d at 598.

415. *Id.* at 696, 553 A.2d at 598-99.

416. 40 Conn. Supp. 127, 482 A.2d 713 (1984).

patient's constitutional and common law right to refuse life-sustaining treatment was through application of the subjective substituted judgment standard.<sup>417</sup> In *McConnell*, the court impliedly recognized that the statutory mechanism provided by the legislature, given their knowledge of both a constitutional right of privacy and a common law right of self-determination, would streamline or perhaps overrule the judicially created substituted judgment standard of *Foody*.<sup>418</sup>

The Connecticut Supreme Court, in light of the fact that many state courts confronted with upholding a terminally ill patient's right to refuse treatment

have urged legislatures to enact guidelines for appropriate private decisionmaking in these heart-rending dilemmas: . . . [The court explained] [w]hen the [Connecticut state] legislature has attempted to respond to this urgent request for statutory assistance, we have an obligation to pursue the applicability of statutory criteria before resorting to an exploration of residual common law [or constitutional] rights, if any such rights indeed remain. We must therefore decide whether a reasonable construction of our act ever permits the removal of a gastrostomy tube [providing artificial nutrition and hydration].<sup>419</sup>

Other state courts making the same inquiries with regard to similar statutory mechanisms, have been forced to resort to common law or constitutional remedies for the guardian and patient according to one of the three available standards due to the inapplicability of the statute.<sup>420</sup> However, the Connecticut Supreme Court was able to utilize it as a remedy for Mrs. McConnell because of the construction and flexibility of the Connecticut Act. The court found that the legislature approached the issue by establishing three guiding principles.<sup>421</sup> First, if a patient is not in a terminal condition, as defined by

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417. See *supra* notes 171-80 and accompanying text.

418. *McConnell*, 209 Conn. at 698-99, 553 A.2d at 600; see also *id.* at 697 n.2, 553 A.2d at 599 n.2 ("Although the trial court decided that judgment for the plaintiffs was, in the alternative [to a statutory remedy], also warranted on a theory of substituted judgment, it is not necessary for us to review that holding in the circumstances of the present case.").

419. *Id.* at 703, 553 A.2d at 602; see also *supra* notes 388-90 and accompanying text.

420. See *supra* notes 398-407 and accompanying text.

421. *McConnell*, 209 Conn. at 703, 553 A.2d at 602.



the statute,<sup>422</sup> "beneficial medical treatment and nutrition and hydration must be provided."<sup>423</sup> Second, if a patient is in a terminal condition, life-sustaining treatment may be removed in the exercise of the physician's best medical judgment given the informed consent of the guardian and the expressed wishes of the patient.<sup>424</sup> Finally, any removal of life-sustaining treatment must be done in a manner consistent with providing "comfort, care and pain alleviation" for the patient.<sup>425</sup>

The court noted, however, that these three guidelines were unclear as to the issue of removal of a gastrostomy tube, especially given the exclusion of the provision of nutrition and hydration from the definition of "life-support system" in § 19a-570(1) of the Act.<sup>426</sup> Despite the possibility that the statute would not be applicable given this exclusion, the court stretched the construction of the statute and held that, in giving effect to every section of the Act, it "implicitly contemplates the possible removal from a terminally ill patient of artificial technology in the form of a device such as a gastrostomy tube, but it does not, under any circumstances, permit the withholding of normal nutritional aids such as a spoon or straw."<sup>427</sup> In other words, to implement the Act's "beneficent purpose of providing functional guidelines for the exercise of common law and constitutional rights,"<sup>428</sup> the court found a distinction between artificial and normal administration of nutrition and hydration which permitted the withdrawal of a gastrostomy tube.<sup>429</sup>

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422. CONN. GEN. STAT. § 19a-570(3) (Supp. 1990) ("[t]he final stage of an incurable or irreversible medical condition which, in the opinion of the attending physician, will result in death").

423. *McConnell*, 209 Conn. at 703, 553 A.2d at 602; CONN. GEN. STAT. § 19a-571 (Supp. 1990).

424. *McConnell*, 209 Conn. at 703, 553 A.2d at 602; CONN. GEN. STAT. § 19a-571 (Supp. 1990).

425. *McConnell*, 209 Conn. at 703, 553 A.2d at 602; CONN. GEN. STAT. § 19a-573 (Supp. 1990).

426. *McConnell*, 209 Conn. at 704, 553 A.2d at 602.

427. *Id.* at 705, 553 A.2d at 603; but see *id.* at 711, 553 A.2d at 606 (Healey, J., concurring) (The so-called "middle construction" of the statutory scheme, while consistent with the plaintiffs' claims for relief, "involves a flawed process of statutory construction.").

428. *Id.* at 705, 553 A.2d at 603.

429. *Id.*; see also *id.* at 705, n.12, 553 A.2d at 603, n.12 ("We note that the statute could have been drafted to require expressly that hydration and nutrition be made avail-

The court then applied the facts of Mrs. McConnell's situation to its interpretation and construction of the Act. First, the court held that, pursuant to § 19a-570(3), the patient was in a "terminal condition" as deemed by her attending physician.<sup>430</sup> Second, the court noted that the patient's family brought the action in question and, therefore, held that their consent to removal of the tube from the patient, as required by § 19a-571(3), was satisfied.<sup>431</sup> Last, the court affirmed the trial court's finding that the attending physician, in making his decision to remove the feeding tube, used his best medical judgment and considered the expressed wishes of the patient through her guardian and family as required by §§ 19a-571(1), 19a-571(4).<sup>432</sup> The court explained that the evidence presented was clear and convincing of the patient's desire not to have her life prolonged if an injury ever left her in a vegetative state.<sup>433</sup> As a result, while perhaps stretching the plain meaning of the statute,<sup>434</sup> the court granted the family's petition to remove the gastrostomy tube from Mrs. McDonnell based solely on the statutory right created by the Removal of Life Support Systems Act (which simply appears to be a codified modification of substituted judgment), and notably did so without a written directive from the patient memorializing her wishes.<sup>435</sup>

## VI. Conclusion

The exercise of an individual's right to refuse life-sustaining treatment by a surrogate decisionmaker will continue to be a controversial area of constitutional and health law for two major reasons: the absence of effective legislation in the area and the

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able even through artificial devices." The court then makes reference to the Missouri living will act reviewed in *Cruzan*, Mo. REV. STAT. § 459.010(3) (1986), that was inapplicable not only because no written directive was left by the patient but because the statute specifically provided that "any procedure to provide nutrition and hydration" was not included in the definition of "death-prolonging procedure." (emphasis added)).

430. *McConnell*, 209 Conn. at 707-08, 553 A.2d at 604 (The court also noted that the conclusion of the attending physician in this regard, after consultation with the family, should be "unimpeded by courts, other medical experts or ethicists.").

431. *Id.* at 708, 553 A.2d at 604.

432. *Id.*

433. *Id.* at 708-09, 553 A.2d at 604-05.

434. See *supra* note 427 and accompanying text.

435. *McConnell*, 209 Conn. at 710, 553 A.2d at 605.

diverse approaches utilized by the state courts in confronting the issue that, in some instances, preclude a guardian from exercising the right. In light of the minimal impact of *Cruzan* on existing state court decisions, it appears that only state legislatures or state courts can take the initiative to perhaps lessen the existing controversy by taking approaches that truly reflect a balancing of a patient's autonomy and the legitimate state interests involved.

The state legislature, as the voice of the people, with a general mandate of weighing and understanding social interaction for the protection of the public health and welfare, must be the body that directly confronts the many legal, medical, and ethical issues associated with an individual's right to refuse life-sustaining treatment. State courts have consistently called for such legislative action in recognizing that the determination of such sensitive issues belongs not in the adversarial setting of a court, but in the fact-finding and viewpoint-synthesizing atmosphere of the legislative forum.

The enactment of living will and durable power of attorney statutes, which enable people to memorialize their desires with regard to health care and life-sustaining treatment, is wise from a public policy perspective. However, such statutes should only be considered a first step in protecting an individual's autonomy. The absence of a statutory right which does not require written instructions, in states such as New York and Missouri, precludes guardians from expressing the rights of an incompetent patient and at the very least demonstrates a failure on the part of the state legislatures to protect adequately the rights of the vast majority of people who are simply unaware of the existence or the need to execute documents outlining their wishes regarding life-sustaining treatment.

It is clear that the state legislatures of North Carolina, Oregon, Virginia, and Connecticut, had the foresight to recognize the need for such legislation by creating statutory rights for incompetent patients who fail to leave any written instructions of their intent to refuse medical treatment.<sup>436</sup> The Connecticut statute, the Removal of Life Support Systems Act,<sup>437</sup> is perhaps

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436. See *supra* note 409.

437. See *supra* note 410.

the most important of the four given its affirmative application in the *McConnell* case.<sup>438</sup> Therefore, it should serve as a model for other state legislatures to enact similar statutes. The Connecticut Act, which presumably symbolizes the social policy of the people of the state as expressed through their representatives, balances the many competing interests involved and codifies under what circumstances and according to what guidelines life-sustaining treatment can be withdrawn from an incompetent patient who left no written instructions.

In that sense, statutes of this sort accomplish several objectives that many state legislatures should take note of if concerned with lessening the controversy surrounding the right to die. First, they allow state courts to abandon judicially created remedies and standards in favor of legislative remedies. Second, the statutory rights created represent the voice of the people who, given the personal nature of the issue, are the patients and families most effected by the outcome of the dilemmas involved. Last, and perhaps most important, based on the flexible application of the Connecticut statute in *McConnell*, they accurately demonstrate respect for both the autonomy of the individual, and the legitimate state interest in preserving life.

In light of the probability that the legislative landscape will remain the same and state legislatures will not enact Connecticut-type statutes, the responsibility to develop a flexible approach to the right to die issue will continue to rest with the state courts. In the absence of effective legislation in the area, state courts have developed two standards and three judicially created approaches in attempting to resolve the problems presented by a surrogate decisionmaker wishing to express the right of an incompetent patient to refuse life-sustaining treatment: substituted judgment (including the specific subjective intent rule and the subjective standard) and best interests.

These approaches, with the possible exception of the specific subjective intent rule, have allowed patients to express through their surrogate decisionmaker their right to refuse life-sustaining treatment. It is apparent that, in the abstract, these different approaches should not be viewed strictly as mutually exclusive alternatives, but rather as part of a straight-line con-

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438. See *supra* notes 410-35 and accompanying text.

tinuum which would leave open the possibility of applying any of the approaches depending on the patient's situation. Such a theory is not unique given the implication of the language in several cases,<sup>439</sup> the view of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research,<sup>440</sup> and at least one recent commentary on the subject.<sup>441</sup>

In essence, application of such a theory would allow state courts, as evidence of an incompetent patient's subjective intent becomes less and less reliable (or in some instances non-existent), to transform their analysis from the subjective, via substituted judgment, to the objective, according to the best interests approach. The theory would not preclude any incompetent patients from expressing their rights with regard to medical treatment through their guardians simply because no evidence of their intent is evident.<sup>442</sup> Furthermore, and perhaps most impor-

439. *Rasmussen v. Fleming*, 154 Ariz. 207, 221-22, 741 P.2d 674, 688-89 (1987); *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 139-40, 482 A.2d 713, 720-21 (1984); *Estate of Longeway*, 133 Ill. 2d 33, 49, 549 N.E.2d 292, 299 (1989) ("While not passing on the viability of the best interests theory in Illinois, we decline to adopt it in this case because we believe the record demonstrates the relevancy of the substituted judgment theory."); *In re Conroy*, 98 N.J. 321, 364, 486 A.2d 1209, 1231 (1985):

[I]n the absence of adequate proof of the patient's wishes, it is naive to pretend that the right to self-determination serves as a basis for substituted decision-making. . . . We hesitate, however, to foreclose the possibility of humane actions, which may involve termination of life-sustaining treatment, for persons who never clearly expressed their desires about life-sustaining treatment but who are now suffering a prolonged and painful death.

*Id.*

440. PRESIDENT'S COMMISSION REPORT, *supra* note 4, at 5. The decisions of surrogates should, when possible, attempt to replicate the ones that the patient would make if capable of doing so. When lack of evidence about the patient's wishes precludes this, decisions by surrogates should seek to protect the patient's best interests. *Id.* at 136. "The substituted judgment standard can be used only if a patient was once capable of developing views relevant to the matter at hand; further, there must be reliable evidence of those views." *Id.* The Commission recommends using the best interests approach when the patient's likely decision, needed to apply the substituted judgment approach, is unknown. *Id.* at 136.

441. Pollock, *Life and Death Decisions: Who Makes Them and By What Standards*, 41 RUTGERS L. REV. 505, 518-21 (1989).

442. For a detailed discussion of the specific subjective intent rule as applied by the courts of New York, Maine, and Missouri, and affirmed in *Cruzan*, see *supra* notes 123-70 and accompanying text & notes 354-66 and accompanying text. This author agrees with Justice Brennan's dissent in *Cruzan*, see *supra* notes 374-83 and accompanying text, and feels that further application of such a restrictive approach is diametrically

tantly, application of such a theory mandating the viability of both substituted judgment and best interests in any refusal of treatment case accomplishes the two major objectives of courts when confronted with cases in this area. First, given the array of options available to a court and the surrogate decisionmaker, the theory's flexibility adequately protects an individual's autonomy and right of self-determination with regard to medical treatment. Second, given the requirements and standards that still need to be satisfied even under the most objective best interests analysis, the theory would still leave the courts enough space to preserve the state's legitimate interest in preserving life by ensuring that an incompetent patient's right to refuse life-sustaining medical treatment will not be expressed for ill motives or pecuniary gain.

In conclusion, absent effective legislation or a flexible judicial approach, the cases that reach the courts involving an incompetent individual's right to refuse life-sustaining treatment will continue to generate inconsistent holdings depending on the state in question. Therefore, they will continue to cause controversy and confusion in what is an extremely personal and sensitive issue. Two ways to resolve the right to die controversy include the enactment of effective legislative action and creative judicial approaches that will demonstrate balance and respect for both the individual and the state. Such legislative action should include the enactment of statutes outlining standards and limitations for expression of an incompetent patient's right to die by a surrogate without requiring written evidence of a patient's intent. Additionally, such judicial creativity should include the application of a theory to refusal of treatment cases that leaves open the possibility of using whichever of the two established approaches is appropriate under the circumstances.

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opposed to this continuum theory given its sole effect of precluding, and therefore burdening, the expression of a patient's rights solely due to a lack of specific intent.

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