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The State's Interest in the Preservation of Life: From *Quinlan* to *Cruzan*

PHILIP G. PETERS, JR.*

When Nancy Cruzan informed a friend that she would not want medical treatment if she could not live "at least halfway normally,"¹ she could hardly have imagined that a tragic automobile accident a year later would make her situation the focal point of a judicial debate over the nature and weight of the state's interest in the preservation of life. Yet, the dispute over whether to remove Nancy's gastrostomy feeding tube five years after the accident left her in a persistent vegetative state has had precisely that result.²

The state's interest in the preservation of life is the most elusive of the four state interests commonly acknowledged as a basis for requiring life-sustaining medical treatment against a patient's wishes.³ Although often described by courts and commentators as the most significant of the state interests,⁴ it has rarely served as an explicit rationale for mandating medical treatment. While courts continue to pay homage to the state's interest in life by balancing it against the patient's interests in the withholding of treatment, the balancing approach first promulgated in the landmark case of *Karen Quinlan*⁵ has proved to be an unstable compromise of the conflicting interests of patient and state. Instead, *Quinlan* was merely the first step in a widespread judicial reorientation of values. Doctrinal deference to the state's interest in life has shifted to respect for patient autonomy and well-being. In one factual context after another, the courts have concluded that the patient's interests outweigh those of the state.

Troubled by this treatment of the state's interest in life, an increasing number of judges have recently advocated greater deference to it. The state, they suggest, has

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1. This is the trial court's paraphrasing of the testimony. *In re Cruzan*, No. CV384-9P, slip op. at 6 (Jasper County Cir. Ct., Prob. Div. July 27, 1988). She made this statement in a "somewhat serious conversation" at age twenty-five. *Id.*

2. *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (en banc), cert. granted sub nom. *Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989).

3. The others are the state interests in preventing harm to third parties, protecting medical ethics, and preventing suicide. See *infra* text accompanying notes 39-41. The state's interest in preventing suicide is properly viewed as a component of the state's interest in the preservation of life, but courts typically treat it separately. See *infra* text following notes 41 & 379. The state interest in protecting third parties overlaps with the state interest in the preservation of life whenever legitimate extensions of withholding doctrine are opposed because they are believed likely to lead to future unethical extensions.

4. E.g., *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, 349, 486 A.2d 1209, 1223 (1985); PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 32 (1983) [hereinafter PRESIDENT'S COMMISSION].

5. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976). In *Quinlan*, the New Jersey Supreme Court offered a sophisticated formula for balancing these interests on a case-by-case basis. As patient prognosis dims and treatment burdens increase, reasoned the court, the state interest declines and patient interests grow. Eventually, the patient's interest outweighs the state's.

a stake in the patient's life and in the sanctity of all life that sometimes justifies treatment against a patient's wishes. In Massachusetts in 1986⁶ and Maine in 1987,⁷ judges advocating this view barely lost in 4-3 decisions. In the case of Nancy Cruzan, however, they finally held a majority. In *Cruzan v. Harmon*,⁸ Missouri reasserted the state's interest in the mesenation of life and fashioned a novel test for balancing this interest against those of the patient. In doing so, the Missouri Supreme Court became the only court in the past twenty years to give this much weight to the state's interest in the preservation of a patient's life and the only one to characterize this interest unambiguously as an interest in the maximization of life regardless of its quality.⁹ But the close votes in Massachusetts and Maine suggest that the Missouri Supreme Court will not be the last to do so.

The *Cruzan* case acquires additional significance when viewed as a part of an expanding matrix of legal doctrines which also exalt the state's interest in the preservation of life often characterizing this interest as one in the sanctity of life, over other values such as autonomy or well-being. These include statutory restrictions on abortion,¹⁰ judicial and statutory restrictions on recovery in wrongful life and wrongful birth actions,¹¹ judicially enforced treatment of pregnant women,¹² and statutory restrictions on the binding effect of living wills.¹³ Conceivably, courts and legislatures sympathetic to sanctity of life appeals in these other contexts will view *Cruzan* as a blueprint for the further extension of sanctity of life jurisprudence in the field of life-sustaining medical treatment.

Despite serious shortcomings in its analysis, the Missouri Supreme Court's disenchantment with current withholding doctrine is understandable in at least one important respect. While mainstream courts have confidently diminished the *weight* given to the state's interest, they have devoted remarkably little attention to its *meaning*. As a result of this silence, it is often difficult to tell whether mainstream courts have simply discounted this interest, as the Missouri Supreme Court suggested, or whether instead they have come to doubt that the values served by it, such as protection against error and abuse, require a balancing test like those advocated in *Quinlan* and *Cruzan*. Unfortunately, the judges urging greater deference to the state's interest in the preservation of life have done only slightly better. They have identified broad concerns such as protection of the vulnerable and preservation

6. *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986).

7. *In re Gardner*, 534 A.2d 947 (Me. 1987).

8. *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (en banc), cert. granted sub nom. *Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989).

9. Massachusetts used similar language but did not apply the language literally. See *infra* text accompanying notes 92-98.

10. E.g., Mo. REV. STAT. §§ 188.010-.220 (1986).

11. E.g., MINN. STAT. ANN. § 145.424 (West 1989); Mo. REV. STAT. § 188.130 (1986); S. D. CODIFIED LAWS ANN. § 21-55-2 (1987).

12. E.g., *In re A.C.*, 533 A.2d 611 (D.C. 1987), reh'g granted, 539 A.2d 203 (D.C. 1988) (en banc); *Jefferson v. Griffin Spalding County Hosp. Auth.*, 247 Ga. 86, 274 S.E.2d 457 (1981) (per curiam).

13. E.g., Mo. REV. STAT. §§ 459.010-.055 (1986); Gelfand, *Living Will Statutes: The First Decade*, 1987 Wis. L. REV. 737.

of the "sanctity of life," but they have not always explained how these broad policies relate to the balancing tests they advocate.

The courts need a more precise, less intuitive conception of the underlying goals served by the state's interest in the preservation of life if they are to tailor their withholding doctrine so that it best protects the state's various objectives without unduly impeding patient interests. Furthermore, precise identification of the specific goals served by this state interest seems a logical requirement for a reasoned resolution of the current disagreement over the weight to which it is entitled. To the extent that the patients' interests in withholding are constitutionally protected,¹⁴ this disentangling of the values and objectives underlying the state's interest is also an essential predicate to an evaluation of their constitutional sufficiency to support challenged judicial or legislative restrictions on the withholding of medical treatment.¹⁵

This Article discusses four possible values or purposes that may give the state an interest in the preservation of a patient's life. They are: (1) protecting patient wishes; (2) protecting patient welfare; (3) enforcing community beliefs about the inherent value or "sanctity" of life; and (4) fashioning a legal doctrine that is not susceptible to undesirable erosion (the "slippery slope" danger).¹⁶ This Article considers the kinds of limits on withholding that each of these policies might plausibly support, compares these limits to the judicial approaches taken in the refusal of treatment cases, and explores how apparent conflicts between these state goals and the interests of the patients might be resolved.

Because this Article focuses exclusively on the state's interests, however, it

14. Already, a number of courts have concluded that these patient interests are protected under the state and federal constitutions. *E.g.*, *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (Ariz. Ct. App. 1987); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); *In re Barry*, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983). By contrast, however, other courts are backing away from constitutional explanations for the patient's right to refuse medical treatment, preferring instead to rely upon the common law doctrine. *See, e.g.*, *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985). The Supreme Court may definitively decide this term in *Cruzan* whether the federal constitution protects these patient interests.

15. The Missouri Supreme Court concluded that it was. *Cruzan v. Harmon*, 760 S.W.2d 408, 418-19, 424 (Mo. 1988) (en banc), *cert. granted sub nom. Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989). The court called the state's interest on the facts of that case "immense" and "clear." *Id.* at 424. If the courts which acknowledge a constitutional privacy interest in appropriate medical treatment decisions borrow the test used in *Roe* to evaluate countervailing state interests, then the state will have to demonstrate both that its interest is compelling and that its restrictions are narrowly drawn to express only the legitimate state interests at stake. *Roe v. Wade*, 410 U.S. 113, 155 (1973). However, the test to be applied in privacy cases has not been uniformly stated, nor does it always appear to have been applied as stated. *See Schneider, State-Interest Analysis in Fourteenth Amendment "Privacy" Law: An Essay on the Constitutionalization of Social Issues*, 51 L. & CONTEMP. PROBS. 79, 82-86 (1988). It is even conceivable that the court could formulate some intermediate level of review similar to the one which may be used in some equal protection cases. *See Gunther, Foreword: In Search of Evolving Doctrine on a Changing Court: A Model for a Newer Equal Protection*, 86 HARV. L. REV. 1 (1972). For example, the court could defer to the state's characterization and assessment of its interests, but insist on a better "fit" between those interests and its laws than the rational basis test ordinarily requires. Alternatively, the court could decline to treat the patient's interests as a constant and instead use a graduated scale, requiring a greater showing of state interest as the suffering associated with the mandated treatment increases. This Article does not discuss the appropriate constitutional tests.

16. While this list is by no means exhaustive, it probably includes the most important policies at stake when the state seeks to justify the administration of medical treatment. For example, the state's interest in a productive return on its human resources will rarely play a major role in these cases. *See infra* notes 375, 464. The state may also have an interest in preserving the lives of *other* patients that dictates a choice *between* patients in allocating medical resources. That interest may support the *withholding* of treatment against the patient's interests and is beyond the scope of this Article.

necessarily isolates and considers only one portion of a complex problem involving the interests of patients, families, providers, and others. No comprehensive examination of the nature and weight of the patient's interests or those of other involved parties is attempted.¹⁷ Thus, no final conclusions about the ultimate shape of the patient's rights or about the constitutional stature of those rights are offered. Instead, this Article explores the nature, weight, and implications of the many meanings hidden beneath the state's multi-faceted interest in "the preservation of life."

I. JUDICIAL TREATMENT OF THE STATE'S INTEREST

Prior to the New Jersey Supreme Court's landmark decision in the case of Karen Quinlan,¹⁸ most refusal of treatment cases had involved patients who refused blood transfusions for religious reasons. While many courts authorized treatment against the patient's expressed or reputed wishes,¹⁹ only two seriously considered the state's interest in preserving the patient's life,²⁰ and only one expressly relied upon that interest in its decision.²¹ The others emphasized concerns about harm to fetuses or dependent minors,²² patient competency or equivocation,²³ medical ethics,²⁴ and the difficulties of making hurried judicial decisions about emergency treatment without adequate time for research or reflection.²⁵

In *John F. Kennedy Memorial Hospital v. Heston*,²⁶ however, the New Jersey Supreme Court emphasized the state's interest in the preservation of life, and unanimously affirmed a trial court order authorizing blood transfusions for an incompetent twenty-two-year-old Jehovah's Witness whose mother refused consent because of their faith. The court concluded that the state had an interest in sustaining life "hardly distinguishable from its interest in the case of suicide." Based on that

17. The Article does discuss the extent to which the interests of patients help to shape the interests of the state and it often offers suggestions for reconciling or balancing their respective interests.

18. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976).

19. *E.g.*, Application of President and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964); *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965); *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971); *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, cert. denied, 377 U.S. 985 (1964); *Powell v. Columbian Presbyterian Medical Center*, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (Sup. Ct. 1965); *Collins v. Davis*, 44 Misc. 2d 622, 254 N.Y.S.2d 666 (Sup. Ct. 1964). *Contra In re Osborne*, 294 A.2d 372 (D.C. 1972); *In re Brooks' Estate*, 32 Ill.2d 361, 205 N.E.2d 435 (1965); *Erickson v. Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962). *See also Holmes v. Silver Cross Hosp.*, 340 F. Supp. 125 (N.D. Ill. 1972) (civil rights action for unconsented blood transfusions); Annotation, *Power of Courts or Other Public Agencies, in the Absence of Statutory Authority, to Order Compulsory Medical Care for Adult*, 9 A.L.R.3d 1391 (1966).

20. *Heston*, 58 N.J. at 582, 279 A.2d at 673 (state's interest is "hardly distinguishable from its interest in the case of suicide"); *Georgetown College*, 331 F.2d at 1009 (suicide analogous but for "quibbles" about misfeasance and specific intent).

21. *Heston*, 58 N.J. at 583, 279 A.2d at 673.

22. *E.g.*, *Georgetown College*, 331 F.2d 1000; *Raleigh Fitkin*, 42 N.J. 421, 201 A.2d 537.

23. *E.g.*, *Georgetown College*, 331 F.2d 1000; *George*, 239 F. Supp. 752; *Powell*, 49 Misc. 2d 215, 267 N.Y.S.2d 450.

24. *E.g.*, *George*, 239 F. Supp. 752; *Heston*, 58 N.J. 576, 279 A.2d 670.

25. *E.g.*, *Georgetown College*, 331 F.2d 1000; *Heston*, 58 N.J. 576, 279 A.2d 670.

26. 58 N.J. 576, 279 A.2d 670 (mother refused consent based on religious beliefs of her now incompetent daughter).

interest and the interest of the hospital and staff in providing emergency treatment, the court affirmed the transfusion of blood.²⁷

A. *Quinlan and Its Aftermath: The Prevailing View*

In 1976, five years after it had decided *Heston*, the New Jersey Supreme Court handed down an opinion that dramatically reshaped judicial thinking about the withholding of treatment in general and about the state's interest in the preservation of life in particular. In *In re Quinlan*,²⁸ the court authorized the family of a twenty-two-year-old woman in a persistent vegetative state to disconnect the respirator that was believed to be keeping her alive.²⁹ In response to the suggestion that the state had an interest in "the preservation and sanctity of human life,"³⁰ the court crafted its oft-quoted formula for balancing this interest against the interests of the patient. Under that test, "the State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest."³¹ Because Karen Quinlan's prognosis was extremely poor and the bodily invasion great, her rights outweighed those of the state.³²

Professor Alexander Morgan Capron has suggested that the New Jersey Supreme Court's choice of a waxing and waning approach may have been borrowed from the analysis used by the United States Supreme Court in *Roe v. Wade*³³ to reconcile the pregnant mother's interests in bodily integrity and self-determination with the state's interest in the health of fetus and mother.³⁴ While this suggestion may have merit, an equally plausible explanation lies in the court's desire to distinguish the facts of *Quinlan* from the prior medical treatment cases in which courts had ordered treatment against the patient's wishes, including its own decision in *Heston*.³⁵ In language immediately preceding its statement of the balancing formula, the court distinguished these cases on the basis of their better patient prognosis and their greater invasiveness of treatment as follows:

The nature of Karen's care and the realistic chances of her recovery are quite unlike those of the patients discussed in many of the cases where treatments were ordered. In many of those cases the medical procedure required (usually a transfusion) constituted a minimal bodily invasion and the chances of recovery and return to functioning life were very good.³⁶

27. *Id.* at 581, 279 A.2d at 673. The facts of *Heston* also raised doubts about patient competency, but the court did not rely upon them.

28. 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

29. In fact, the respirator was removed and she survived until June 11, 1985. J. AREEN, P. KING, S. GOLDBERG & A. CAPRON, *LAW, SCIENCE AND MEDICINE* 283 (Supp. 1989).

30. *Quinlan*, 70 N.J. at 40, 355 A.2d at 663.

31. *Id.* at 41, 355 A.2d at 664. The court held that the patient's right to refuse medical treatment was protected by the constitutional right of privacy. *Id.* at 41, 355 A.2d at 663.

32. *Id.* at 41, 355 A.2d at 664.

33. 410 U.S. 113 (1973).

34. Capron, *Borrowed Lessons: The Role of Ethical Distinctions in Framing Law on Life-Sustaining Treatment*, 1984 ARIZ. ST. L.J. 647, 659.

35. *Quinlan*, 70 N.J. at 39, 355 A.2d at 663 (distinguishing *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971)).

36. *Quinlan*, 70 N.J. at 40-41, 355 A.2d at 664.

The choice of this prognosis-invasion formula, thus, may have had less to do with the abortion cases than with the court's tentative effort to distinguish factually the prior cases in which the state's authority to mandate treatment had been upheld.

The *Quinlan* balancing formula was vulnerable to the criticism that it inaccurately characterized the interests of both the state and individual. Professor Capron, for example, has persuasively suggested that the state's interest in protecting the lives of its citizens does not diminish merely because a person's prognosis is poor.³⁷ The state has just as much interest in protecting the terminal patient from errors or abuse as in protecting a patient with a promising prognosis. At the same time, the test is overprotective of competent patients insofar as it reduces a patient's power of self-determination when the prognosis is good.³⁸

But this criticism presupposes that the state's interest is simply to protect patient autonomy. The New Jersey Supreme Court apparently did not share this assumption. Its choice of criteria and its impetus for choosing them implied that the state's interest in the preservation of life also served other values. However, the court did not attempt to articulate those values or to explain how the values served by that state interest related to either prognosis or treatment burden. Thus, it did not explain whether its criteria were meant to measure the state's interest in protecting against suicide, as *Heston* had suggested, or whether the state's interest in the preservation of life reflected other values as well.

One year after *Quinlan*, the Massachusetts Supreme Court decided *Superintendent of Belchertown State School v. Saikewicz*.³⁹ That court distilled from *Quinlan* and the earlier cases four state interests applicable to life-saving treatment: (1) preserving life; (2) protecting innocent third parties; (3) preventing suicide; and (4) maintaining medical ethics.⁴⁰ The court deemed the state's interest in the preservation of life to be *most significant*.⁴¹ This taxonomy of state interests separated the state's interest in the preservation of life from the analogy to suicide which had fueled its role in *Heston* and presumably *Quinlan*.⁴² But the court never explained how the state's interest in life differed from the state's interest in suicide prevention. Quite possibly, the court had catalogued the four state interests without recognizing that the state's interest in the preservation of life acknowledged in *Quinlan* had its roots in *Heston* and that case's analogy to suicide. At any rate, the combined effect of *Quinlan* and

37. See Capron, *supra* note 34, at 657.

38. *Id.* at 657-58. In effect, the formula measures the extent of invasion of bodily integrity, but accords no separate standing to autonomy per se. The patient's interests in autonomy do not depend upon either the invasiveness of the procedure or the gravity of the prognosis. Thus, a cancer patient's autonomy interest in deciding for herself whether or not to accept chemotherapy is not weakened if she has a promising prognosis, nor does the interest of that patient in self-determination diminish merely because a treatment is minimally invasive. While the harmfulness and unconscionability of state intervention may be related to the invasiveness of the unwanted treatment, the patient nonetheless has a significant autonomy interest in every case.

39. 373 Mass. 728, 370 N.E.2d 417 (1977).

40. *Id.* at 741, 370 N.E.2d at 425.

41. *Id.* at 741-42, 370 N.E.2d at 425-26.

42. The court borrowed *Quinlan's* focus on curability (prognosis) to measure the state's interest in the preservation of life and, in a later case, borrowed the *Quinlan* balancing test itself. *Commissioner of Corrections v. Myers*, 379 Mass. 255, 399 N.E.2d 452 (1979).

Saikewicz was both to separate the state's interest in life from its interest in preventing suicide and also to elevate it to prominence.

Courts throughout the country eagerly embraced *Quinlan's* waxing and waning approach. Ironically, the widespread adoption of the *Quinlan* balancing test resulted in a much more prominent *doctrinal* role for the state's interest in the preservation of life than had existed prior to *Quinlan*. Because other courts quickly adopted both the *Saikewicz* taxonomy of state interests and the *Quinlan* formula for balancing the state's interest in life against the patient's privacy rights,⁴³ some scholars presumed that the state might now be able to compel relatively minor treatment for nonterminal patients, especially those who could be returned to good health.⁴⁴

In *practice*, however, the application of the *Quinlan* formula by the courts was much more deferential to patient interests than *Quinlan* had suggested. Despite the rhetorical and emotional appeal of the state's interest in the preservation of life and its purported preeminence, the courts could not bring themselves to mandate treatment that would violate a patient's wishes or, when patient wishes were unknown, to order treatment against a patient's best interests.⁴⁵ Prior to *Cruzan*, no state court of final resort had expressly mandated treatment on the grounds that the state's interest in the preservation of life outweighed a patient's interests in refusing medical treatment.⁴⁶ Instead, the patient's interests seemed always to outweigh the state's interest, regardless of the invasiveness of the procedure or the patient's prognosis. After *Quinlan*, this deference to patient interests was first extended to terminally ill patients, both competent⁴⁷ and incompetent,⁴⁸ and then to nonterminal patients, including many patients in vegetative states.⁴⁹ It was then extended to less and less invasive procedures.⁵⁰ In some cases, patients declined treatment that offered the prospect of return to relatively good health.⁵¹

43. *E.g.*, *Severns v. Wilmington Medical Center, Inc.*, 425 A.2d 156 (Del. Ch. 1980); *John F. Kennedy Memorial Hosp., Inc. v. Bludworth*, 452 So. 2d 921 (Fla. 1984); *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *approved*, 379 So. 2d 359 (Fla. 1980); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983); *see also* Pollock, *Life and Death Decisions: Who Makes Them and by What Standards?*, 41 RUTGERS L. REV. 505, 516 (1989).

44. *E.g.*, J. ROBERTSON, *THE RIGHTS OF THE CRITICALLY ILL* 59-60 (1983).

45. However, courts did not hesitate to order treatment for incompetents or minors over the objections of family or guardians when the judges believed treatment to be in the patient's best interests.

46. Arguably New York had implicitly done so. New York refused to permit withholding based only upon a patient's best interests, but had not relied explicitly on the state's interest in life. *In re Westchester County Med. Center*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988).

47. *Satz*, 362 So. 2d at 160.

48. *In re Barry*, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984) (vegetative, but believed terminal; respirator); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983) (vegetative patient on respirator).

49. *E.g.*, *In re Browning*, 543 So. 2d 258 (Fla. Dist. Ct. App. 1989) (nonterminal; gastrostomy tube); *Lane v. Candura*, 6 Mass. App. 377, 376 N.E.2d 1232 (1978) (nonterminal competent patient refusing amputation).

50. *See, e.g.*, *Rasmussen v. Fleming*, 154 Ariz. 200, 741 P.2d 674 (Ariz. Ct. App. 1987) (artificial feeding); *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986); *Wanzer, Federman, Adelstein, Cassel, Cassem, Cranford, Hook, Lo, Moertel, Safar, Stone, Van Eys, The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look*, 320 NEW ENG. J. MED. 844 (1989) [hereinafter *Wanzer*] (noting the progression to less burdensome treatments).

51. *E.g.*, *Public Health Trust of Dade County v. Wons*, 541 So. 2d 96 (Fla. 1989) (blood); *Commissioner of Corrections v. Myers*, 379 Mass. 255, 399 N.E.2d 452 (1979) (hemodialysis burden outweighs state interest in life, though not the additional state interest in orderly prison administration); *Lane*, 6 Mass. App. 377, 376 N.E.2d 1232 (amputation of gangrenous limb).

Despite continued judicial acknowledgement of this state interest,⁵² the courts certainly appeared to discount it heavily. Furthermore, its decline was not limited to cases where patients were still competent or had left clear instructions. Instead, the notion of patient autonomy was extended in practice to include incompetent patients whose wishes were either far from clear or simply unknown. *Quinlan* and subsequent cases concluded that the rights of these patients to appropriate treatment decisions should not be lost by their inability to exercise them. The courts then attempted to preserve those rights through doctrines like substituted judgment⁵³ and the delegation of decisionmaking to family or guardians.⁵⁴

Courts using the *Quinlan* balancing test made it clear that the treatment burden would have to be trivial and the prognosis for a return to good health excellent before the state's interest would prevail. One court gave the hypothetical example of oral medications for a curable patient.⁵⁵ After reading the cases, it is tempting to speculate that most courts would dismiss even that example as ill-advised dictum, thereby abandoning the *Quinlan* focus on prognosis and treatment burden altogether. Perhaps judicial unwillingness to enforce the test should not be surprising. Mainstream doctrine had severed the balancing test from its original suicide rationale and never explained its remaining purposes.

Perhaps for this reason a few courts simply declined to use the *Quinlan* balancing test at all.⁵⁶ In California, for example, courts acknowledged the state's interest in the preservation of life, but treated it as a constant which did not vary with the patient's prognosis and treatment burden. They then balanced this interest against those of the patient and deemed the patient's interests to be paramount.⁵⁷ Although the California Supreme Court has yet to decide a refusal of treatment case, the California intermediate appellate courts appear to view patient interests as superior to the state's interest regardless of prognosis, treatment burden, or patient motive.⁵⁸ Predictably, they have extended withholding doctrine farther than any other court. In the case of Elizabeth Bouvia, for example, they honored the request of a nonterminal cerebral palsy patient to withhold nasogastric feeding.⁵⁹

52. Professor Laurence Tribe suspects that courts may continue to acknowledge the state interest in order to anticipate and preclude extension of the right to die doctrine to active suicide. See L. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 1364, 1366-67 (2d ed. 1988).

53. *E.g.*, *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983).

54. *E.g.*, *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976); *Colyer*, 99 Wash. 2d 114, 660 P.2d 738.

55. *Myers*, 379 Mass. at 263, 399 N.E.2d at 456-57.

56. *E.g.*, *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 195, 209 Cal. Rptr. 220, 225 (1984); *In re Gardner*, 534 A.2d 947, 955 (Me. 1987). See also *In re Westchester County Medical Center*, 72 N.Y.2d 517, 534 N.Y.S.2d 886, 531 N.E.2d 607 (1988).

57. *Bartling*, 163 Cal. App. 3d at 195, 209 Cal. Rptr. at 225; *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1143-44, 225 Cal. Rptr. 297, 305 (1986); *In re Drabick*, 200 Cal. App. 3d 185, 209 n.25, 245 Cal. Rptr. 840, 855 n.25, *cert. denied*, 109 S. Ct. 399 (1988).

58. *Bartling*, 163 Cal. App. 3d at 195, 209 Cal. Rptr. at 225 (suggesting that a competent patient can refuse any treatment); *Bouvia*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (same).

59. *Bouvia*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297.

Rather surprisingly, New Jersey also appears to have forsaken its *Quinlan* test. In the first case since *Quinlan* to reach the state supreme court, that court reasoned that the patient's right to refuse medical treatment did not turn on the patient's quality of life.⁶⁰ Although the court did not mention *Quinlan* or its test by name, its conclusion in *In re Conroy*⁶¹ that patient rights did not wax and wane with patient prognosis was patently inconsistent with the *Quinlan* formula for balancing those patient interests against the interests of the state. In its place, the court directly considered the weight to be given to the state's interest in life. The court described this interest as "embracing two separate but related concerns: an interest in preserving the life of a particular patient, and an interest in preserving the sanctity of all life."⁶² Although the court characterized these interests as "certainly strong," it concluded that they were "indirect and abstract" in cases "that do not involve the protection of the actual or potential life of someone other than the decisionmaker."⁶³ Like the California courts, it concluded that the state's interest in the patient's *own life* would ordinarily be outweighed by "the patient's much stronger personal interest in directing the course of his own life."⁶⁴

In *Conroy*, the court also reassociated the state's interest in the preservation of life with its interest in preventing suicide, correctly viewing the latter as a part of the state's larger interest in life.⁶⁵ But it denied that this state interest was offended here. It rejected the analogy between suicide and the refusal of medical treatment, as all courts since *Quinlan* have done, on the grounds that medical conditions are not self-inflicted, that refusal of treatment merely allows the disease to take its "natural course" and that patients may not have a specific intent to die.⁶⁶ The court then expressly overruled *Heston* insofar as it suggested to the contrary.⁶⁷

Finally exorcising the ghost of *Heston*, the court also reinterpreted the factual and doctrinal basis for that case and the other early cases ordering treatment. No longer focusing on the salvageability of the patients in those cases, the court instead noted that each of the cases imposing treatment also involved patient equivocation or doubts about patient competence.⁶⁸ Thus it implicitly suggested that the state's legitimate concern with the preservation of life derived not from its suicide prevention policies per se, but from its desire to ensure "the patient's competency to

60. *In re Conroy*, 98 N.J. 321, 355, 486 A.2d 1209, 1226 (1985) ("[A] young, generally healthy person . . . has the same right to decline life-saving medical treatment as a competent elderly person who is terminally ill."). Although the New Jersey Supreme Court has decided several cases since *Conroy*, it has not yet tested its deference to patient autonomy in a case involving a young patient who rejects life-saving treatment, like a blood transfusion, that would return the patient to good health.

61. *Id.*

62. *Id.* at 349, 486 A.2d at 1223.

63. *Id.* at 349-50, 486 A.2d at 1223. The court cited cases involving abortion and treatment of infants over parental objections.

64. *Id.* at 350, 486 A.2d at 1223. In a subsequent case, the court said it would be "difficult to conceive of a case in which the state could have an interest strong enough to subordinate a patient's right to choose not to be sustained in a persistent vegetative state." *In re Peter*, 108 N.J. 365, 380, 529 A.2d 419, 427 (1987).

65. *Conroy*, 98 N.J. at 350, 486 A.2d at 1224.

66. *Id.* at 350-51, 486 A.2d at 1224.

67. *Id.* at 351, 486 A.2d at 1224.

68. *Id.* at 353-54, 486 A.2d at 1225-26. Other courts had similarly interpreted these cases. See, e.g., *Satz v. Perlmutter*, 362 So. 2d 160, 163 (Fla. Dist. Ct. App. 1978), approved, 379 So. 2d 359 (Fla. 1980).

make a rational and considered choice of treatment.”⁶⁹ This recasting of the state’s interest as an interest in protecting the quality of patient decisionmaking is also supported by the court’s conclusion that the value of life would be enhanced by respecting patient autonomy, not by thwarting it.⁷⁰

In addition to New Jersey, several other courts have used language that suggests an interpretation of the state’s interest in life which focuses on the quality of the patient’s decisionmaking process. Massachusetts, for example, suggested in *Saikewicz* that the state’s interest in preventing suicide lay in “the prevention of irrational self-destruction.”⁷¹ Another Massachusetts case suggested that the state’s interest in the preservation of life was greatest where “a decision to avoid treatment would be aberrational.”⁷² And several pre-*Quinlan* cases had explicitly suggested that the state’s role was to nurture and protect patient autonomy, rather than to restrict it.⁷³ A recent Maine case makes the same point.⁷⁴ Yet, no court has unequivocally committed itself to this narrow view of the state’s interest in the preservation of life. At the same time, however, they have left no doubts that a broader conception of this state interest is unlikely to be given substantial weight.

B. *The Minority View*

The movement towards increasing deference to patient interests life was not uniform, however. A few puzzling cases ordered blood transfusions against actual or probable patient wishes without much explanation.⁷⁵ And at least three jurisdictions gave serious consideration to ordering treatment in order to protect and advance the state’s interest in the preservation and sanctity of life. Missouri, of course, was one of these three.⁷⁶ Massachusetts and Maine also struggled with this issue. In these two states, advocates for a tougher application of the balancing test lost in 4-3 decisions.⁷⁷

69. *Conroy*, 98 N.J. at 353–54, 486 A.2d at 1225.

70. *Id.* at 350, 486 A.2d at 1223–24 (quoting Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 742, 370 N.E.2d 417, 426 (1977)).

71. *Saikewicz*, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11. Other states have echoed this view. *E.g.*, *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 196, 209 Cal. Rptr. 220, 226 (1984); *In re Lydia E. Hall Hosp. v. Cinque*, 116 Misc. 2d 477, 487, 455 N.Y.S.2d 706, 712 (Sup. Ct. 1982).

72. *In re Spring*, 8 Mass. App. 831, 845–46, 399 N.E.2d 493, 502 (1979), *rev’d on other grounds*, 380 Mass. 629, 405 N.E.2d 115 (1980), *quoted approvingly in Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 433 n.28, 497 N.E.2d 626, 635 n.28 (1986).

73. *In re Osborne*, 294 A.2d 372, 375 n.5 (D.C. 1972) (role of state is to insure maximum freedom of choice); *Erickson v. Dilgard*, 44 Misc. 2d 27, 28, 252 N.Y.S.2d 705, 706 (Sup. Ct. 1962) (autonomy appropriate in a system of government which gives the greatest possible protection to individual freedom).

74. *In re Gardner*, 534 A.2d 947, 955 (Me. 1987).

75. *University of Cincinnati Hosp. v. Edmond*, 30 Ohio Misc. 2d 1, 500 N.E.2d 299 (Com. Pl. 1986) (blood ordered in spite of incompetent patient’s “reputed” religious objections); *In re Estate of Dorone*, 349 Pa. Super. 59, 502 A.2d 1271 (1985) (blood ordered despite patient’s reported medic alert card rejecting blood), *aff’d*, 517 Pa. 3, 534 A.2d 452 (1987); *Crouse Irving Memorial Hosp. v. Paddock*, 127 Misc. 2d 101, 485 N.Y.S.2d 443 (Sup. Ct. 1985) (blood for caesarean section); *contra Public Health Trust of Dade County v. Wons*, 541 So. 2d 96 (Fla. 1989) (competent adult allowed to refuse blood); *Mercy Hosp. v. Jackson*, 62 Md. App. 409, 489 A.2d 1130 (1984) (same), *vacated*, 306 Md. 556, 510 A.2d 562 (1986) (moot).

76. *Cruzan v. Harman*, 760 S.W.2d 408 (Mo. 1988) (en banc), *cert. granted sub nom. Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989).

77. *In re Gardner*, 534 A.2d 947 (Me. 1987); *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986).

Their dissenting votes were easily overlooked at the time, but they foreshadowed the Missouri Supreme Court's opinion in *Cruzan*. The Massachusetts experience is especially interesting for two additional reasons. First, the Massachusetts courts made the most extended and self-conscious attempt actually to use the *Quinlan* formula in their decisions. Second, Massachusetts eventually modified the formula in a way borrowed by the Missouri Supreme Court in *Cruzan*.⁷⁸

Between the Massachusetts Supreme Court's decision in *Saikewicz* in 1977 and its 1986 decision in the case of Paul Brophy, Massachusetts courts at all levels implemented the *Quinlan* test in various contexts. Collectively, these cases emphasized the patient's life expectancy (quantity of life), his curability or prospects for return to good health (quality of life), and the magnitude of the bodily invasion. However, the Massachusetts courts, like others around the country, always concluded that treatment which violated the patient's wishes or was not in the patient's interests could be withheld. The treatment burden always outweighed the state's interest in life.⁷⁹ In chronological order, some of the treatments withheld included (1) amputation of the gangrenous leg of a seventy-seven-year-old (1978),⁸⁰ (2) hemodialysis for a patient with a relatively normal life expectancy (1979),⁸¹ (3) hemodialysis for a patient with end-stage kidney disease (1980),⁸² and (4) "no code" status for a newborn with cyanotic heart disease (1982).⁸³ In no case during that period did the courts base a treatment order upon the state's interest in the preservation of life alone,⁸⁴ although the Massachusetts Supreme Court did suggest that oral or intravenous administration of medications might be required of a healthy person.⁸⁵

In 1986, however, the Massachusetts Supreme Court faced a case that appeared to subject its adherence to the prognosis-invasion formula to a more difficult test. In

78. The Massachusetts courts first addressed these issues one year after *Quinlan*, in the case of Joseph Saikewicz. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977). Although the Massachusetts Supreme Court did not expressly adopt the *Quinlan* formula, it explicitly recognized the state's interest in the preservation of life and correlated the state's interest with patient prognosis. In particular, it emphasized, as *Quinlan* had, the distinction "between curing the ill and comforting and easing the dying." *Id.* at 738, 741-42, 370 N.E.2d at 423, 424-25 (quoting *In re Quinlan*, 70 N.J. 10, 47, 355 A.2d 647, 667 (1976)). Two years later, when the court completed its adoption of the *Quinlan* formula, it expressly balanced the state's interest (as measured by prognosis) against the patient's interest (as measured by treatment burden). Commissioner of Corrections v. Myers, 379 Mass. 255, 399 N.E.2d 452 (1979).

79. However, Massachusetts courts have ordered treatment of some minors over parental objections when treatment served the child's best interests. *E.g.*, Custody of a Minor, 375 Mass. 733, 379 N.E.2d 1053 (1978).

80. Lane v. Candura, 6 Mass. App. 377, 376 N.E.2d 1232 (1978) (amputation of gangrenous leg of 77-year-old woman constitutes an invasion that outweighs state's interest).

81. See Commissioner of Corrections v. Myers, 379 Mass. 255, 266, 399 N.E.2d 452, 458 (1979) (interest in preservation outweighed by patient's interests, but state's interest in orderly prison administration warranted treatment).

82. *In re Spring*, 380 Mass. 629, 641, 405 N.E.2d 115, 123 (1980) (state interest in hemodialysis of patient with end-stage kidney disease expected to live less than five years was even less than in *Myers*, because patient here had shorter life expectancy).

83. Custody of a Minor, 385 Mass. 697, 711, 434 N.E.2d 601, 609 (1982) (permitting "no code" of newborn with cyanotic heart disease and life expectancy of less than one year because only "manner of dying" at stake).

84. See, *e.g.*, *In re Dinnerstein*, 6 Mass. App. 466, 472-73, 380 N.E.2d 134, 138 (1978) (state's interest in the prolongation of life related to likelihood of cure and return to normal, functioning, integrated existence; prior cases ordering treatment involved hope of normal life). During that time period, an intermediate appellate court decided the case of Mary Heir, in which the court refused to authorize reinsertion of a feeding tube for a ninety-two-year-old woman with severe mental illness. *In re Heir*, 18 Mass. App. 200, 464 N.E.2d 959 (1984). This case has been severely criticized for its holding on the facts. It did not discuss the state-individual balance.

85. See *Myers*, 379 Mass. at 263, 399 N.E.2d at 457.

Brophy v. New England Sinai Hospital, Inc.,⁸⁶ the court was asked to authorize the withholding of artificial food and water through a gastrostomy tube from Paul Brophy, a patient in a persistent vegetative state. Brophy was not terminal and his treatment was relatively less invasive than those the court had previously considered. Before suffering the aneurism that had caused his condition, he had clearly expressed his desire not to receive medical treatment of this kind.⁸⁷ The court deferred to Brophy's past preferences. In doing so, its holding is consistent with the pattern in other jurisdictions of respecting patient wishes regardless of treatment burden or life expectancy.

But the court's 4-3 opinion revealed deep divisions in the court about the weight to be given to the state's interest in applying the balancing test and, in particular, about the role which the patient's quality of life ought to play in that test. The three dissenters believed the majority had given inadequate weight to the state's interest in life⁸⁸ by elevating patient autonomy over the state's interest even though the treatment was minimally invasive⁸⁹ and the patient had considerable life expectancy.⁹⁰ Under these circumstances, they feared that the majority had effectively authorized a suicidal preference for death.⁹¹ Thus, Massachusetts was only one vote short of overruling Brophy's previously expressed preference for nontreatment in order to protect the state's interest in life.

Equally significant was the *majority's* insistence that the state's interest in life did not depend upon the patient's quality of life.⁹² Because Brophy was not terminal and his treatment was relatively less invasive than those which the court had previously considered, the case for withholding treatment appeared to turn upon Brophy's vegetative status, just as it had with Karen Quinlan. As in *Quinlan*, the state's interest appeared to be reduced by the patient's poor prognosis for a return to a cognitive existence. Yet, the majority refused to concede that Brophy's quality of life was relevant to the interests of the state. If it desired to disavow any correlation between patient prognosis and the state's interests, the majority could have abandoned the waxing and waning approach entirely, as California and New Jersey had done. Instead, it modified the *Quinlan* balancing test in a way that purported to eliminate consideration of the patient's quality of life. In lieu of considering overall patient prognosis, including quality of life, the majority opinion repeatedly and pointedly described the state's interest in life exclusively in terms of the patient's quantity of life remaining.⁹³ The state, said the court in language later quoted

86. 398 Mass. 417, 497 N.E.2d 626 (1986).

87. *Id.* at 428 n.22, 497 N.E.2d at 632 n.22.

88. *Id.* at 443, 497 N.E.2d at 640 (Lynch, J., dissenting in part); *id.* at 451-53, 497 N.E.2d at 645-46 (O'Connor, J., dissenting in part).

89. *Id.* at 445, 497 N.E.2d at 641 (Lynch, J., dissenting in part).

90. *Id.* at 449, 497 N.E.2d at 645 (O'Connor, J., dissenting in part).

91. *Id.* at 442, 497 N.E.2d at 640 (Nolan, J., dissenting); *id.* at 447, 497 N.E.2d at 642-43 (Lynch, J., dissenting in part); *id.* at 452, 497 N.E.2d at 645 (O'Connor, J., dissenting in part).

92. *Id.* at 434, 497 N.E.2d at 635.

93. The court had suggested this emphasis on prolongation in the *Saikewicz* opinion. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 741-42, 370 N.E.2d 417, 425 (1977).

favorably in *Cruzan*, had an interest in "prolongation" of the patient's life.⁹⁴ In addition, the court protested that it would make no judgment about the "value," "quality," or "worth" of Brophy's life.⁹⁵ In so doing, it set the stage for *Cruzan*.

Yet, the Massachusetts majority did not put its doctrine into practice. Despite its purported focus on life expectancy, the court authorized the withholding of Brophy's treatment and, in doing so, left no doubt that the state's power to intervene was diminished not only by the burdens of Brophy's treatment, but also by the prospect of Brophy's degradation through maintenance of his "mere corporeal existence."⁹⁶ Balancing the state's interest in the preservation of life against the patient's interest in self-determination, the court concluded that his treatment, including not only the artificial feeding, but also the toilet care and other handling necessary for his care, was "intrusive as a matter of law"⁹⁷ and that the state's interest in his "mere corporeal existence" was insufficient to outweigh his interest in a death with dignity.⁹⁸ Thus, the poor quality of his life was clearly a factor in the holding, if not in the supporting doctrine.

As a result of the majority opinion's unsatisfactory struggle with the role of quality of life considerations, the current status of the prognosis-invasion test in Massachusetts is unclear.⁹⁹ On one hand, the actual holding in *Brophy* strongly suggests patient-oriented liberality in applying its balancing test. The majority did not specifically endorse New Jersey's views that autonomy is a constant whose weight is independent of the type of treatment involved and that autonomy generally outweighs the state's interest in the preservation of life, but its decision to permit the withholding of artificial feeding from a patient with a long life expectancy was correctly interpreted by the Missouri Supreme Court in *Cruzan* as significantly reducing the weight given to the state's interest.¹⁰⁰

On the other hand, the court's decision to measure the state's interest exclusively in terms of life expectancy superficially appears to be conservative. Its modification of the *Quinlan* test suggests that a patient's poor quality of life will no longer decrease the state's interest in mandating medical treatment. Theoretically, at least, the state

94. *Brophy*, 98 Mass. at 433, 497 N.E.2d at 635. See *infra* note 118 (quoting the court).

95. *Id.* at 434, 497 N.E.2d at 635.

96. *Id.*

97. *Id.* at 435, 497 N.E.2d at 636.

98. *Id.* at 434, 497 N.E.2d at 635. Judge Liacos' language in *Brophy* is ambiguous, but he appears to suggest that quality of life was relevant because it was relevant to the patient. To that extent, he is arguably deferring to autonomy rather than measuring the state's interest according to the patient's quality of life. But he also suggests that Brophy's poor condition strengthens his case for autonomy. If that is so, then quality of life does play a role in measuring the patient's interests against the state's interests. Merely switching its role from being a measure of prognosis (state interest) to a measure of patient interests does not materially change its usage.

99. In fact, the court also quotes language from the *Spring* opinion, which relates the state interest to both life expectancy and return to reasonable health. *Id.* at 433 n.28, 497 N.E.2d at 635 n.28.

100. *Cruzan v. Harmon*, 760 S.W.2d 408, 421-22 (Mo. 1988) (en banc), cert. granted sub nom. *Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989). Either of two possible interpretations supports this latter view: (1) arguably, Brophy's poor quality of life minimized the state's interest in life, notwithstanding the court's protestations to the contrary, so dramatically that relatively minor treatment burdens outweighed it; or (2) virtually all long-term treatments, including artificial feeding, will be deemed sufficiently invasive or burdensome to outweigh the state's interest, regardless of life expectancy. Conceivably, both of these patient-oriented interpretations reflect the views of the court.

retains a strong interest in ordering treatment so long as the patient's life expectancy is long. In fact, the dissenters in *Brophy* believed that honest application of this modified test required continued treatment in that case because Brophy's life expectancy was long and the treatment relatively noninvasive. Later, *Cruzan* borrowed the majority's language to support its conclusion that the state's interest in life should be measured solely by the possible duration of the patient's life.¹⁰¹

Maine, too, flirted with a tougher balancing test. In *In re Gardner*,¹⁰² the Maine Supreme Court's sole refusal of treatment case, a bare majority voted to respect the past preferences of a patient who was now in a persistent vegetative state and receiving artificial nutrition and hydration through a nasogastric tube.¹⁰³ However, three members of the court joined in a dissenting opinion that disputed the appropriate extent of Gardner's freedom to refuse medical treatment.¹⁰⁴ Writing for the dissenters, Justice Clifford acknowledged the state's interest in "the life of Joseph Gardner as an individual and in preserving life in general."¹⁰⁵ Finding the roots of that state interest in the instinct for self-preservation, the desire to protect society's "weakest and most vulnerable" members, and the abhorrence of suicide, the dissenters concluded that the state's interest in preserving life and preventing suicide ought to govern on the facts before the court.¹⁰⁶ Because Justice Clifford believed that nasogastric feeding was beneficial and minimally invasive to Gardner, he concluded that Gardner's past directives to withhold treatment were motivated by the desire to end a poor quality of life, not by the desire to avoid an invasive or detrimental treatment.¹⁰⁷ In Clifford's view, the majority had, therefore, established a precedent for granting third parties the right to end a patient's life because of its quality.¹⁰⁸ The dissenters viewed this precedent as unacceptably susceptible to abuse.

The Massachusetts and Maine dissenting opinions reveal a substantially stronger undercurrent of support for state intervention than a simple polling of holdings would suggest. Declining to subordinate the state's interest to autonomy, these jurists continue to recognize a broad state interest in mandating treatment. Fears about abuse of the vulnerable figured prominently in their opinions, as did abhorrence of a preference for death. Because they perceived a correlation between the refusal of minimally burdensome treatment and suicidal intent, they favored stricter application of a prognosis-invasion balancing test, perhaps modified to exclude quality of life

101. *Id.* at 419.

102. 534 A.2d 947 (Me. 1987). Florida may consider the issue soon. See *In re Browning*, 534 So. 2d 258 (Fla. Dist. Ct. App. 1989).

103. The majority expressed no doubts that Mr. Gardner's autonomy outweighed the state's interests in his care. *Gardner*, 534 A.2d at 950-52 (recognizing the central importance of self-determination), 955-56 (comparing the state interests). Significantly, it never acknowledged a state interest in life itself. It did note that Gardner's refusal of treatment was not suicide and would not involve the court in any quality of life assessments. *Id.* at 955. The court recognized a state interest in protecting dependent persons from abuse, but concluded that this interest was not implicated when the patient had competently expressed his wishes. *Id.*

104. *Id.* at 956.

105. *Id.* at 957.

106. *Id.* at 957-58.

107. *Id.* at 958.

108. *Id.*

considerations. However, they did not explain how strict application of the balancing tests would protect the vulnerable against abuse.

C. Cruzan's Interpretation of the State's Interest in Life

Unquestionably, the Massachusetts Supreme Court's debate over the proper application of the balancing test and the corresponding role of quality of life considerations resurfaced in the *Cruzan* opinion. But in Missouri, the advocates of a reinvigorated state interest held the bare majority. They borrowed the language of the *Brophy* majority but applied it as the dissenters would have. By a 4-3 vote, in *Cruzan* the Missouri Supreme Court questioned the emerging consensus about the dominance of patient rights and the insufficiency of the state's interest in preserving life.¹⁰⁹ Finding these precedents unconvincing, Judge Robertson's majority opinion refused to eat their "insane root."¹¹⁰ Instead, the majority held that Nancy Cruzan's gastrostomy tube could not be removed despite her irreversible, persistent vegetative state¹¹¹ because the state's interest in her life, as measured exclusively by her "relatively normal" life expectancy,¹¹² outweighed any interest Nancy might have in removal of the tube, as measured solely by the burden of continued feeding through the existing gastrostomy tube.¹¹³ It also held that the available evidence of Nancy's wishes was too unreliable to establish her informed consent to removal of the tube.¹¹⁴ With the regular members of the Supreme Court evenly divided, the deciding vote was cast by a special judge temporarily assigned to the court.¹¹⁵

1. Prolongation and Sanctity as Measures of the State's Interest

The *Cruzan* opinion is noteworthy in two principal respects. First, *Cruzan* was the first case since *Heston* to mandate treatment explicitly on the basis of the state's independent interest in the preservation of an adult patient's life, rather than upon the basis of the patient's wishes or best interests. Clearly, it attributed more weight to this interest than other courts had done. Second, *Cruzan* modified the test in which this

109. The Missouri Supreme Court reviewed and reversed a trial court declaratory judgment that Nancy Cruzan's artificial nutrition and hydration should be discontinued. The trial court had based its decision on its belief that Nancy's right to refuse treatment was constitutionally protected and that her "somewhat casual" conversation with her housemate, along with her lifestyle and her "other statements to family and friends suggest that she would not wish to continue her present existence without hope as it is." *In re Cruzan*, No. CV384-9P, slip op. at 4 (Jasper County Cir. Ct., Prob. Div. July 27, 1988). The court did not describe the contents of these conversations. A dissenter in the high court suggested that several witnesses talked of her lifestyle and, in particular, of her unwillingness to subject her family to the "torture they now endure." *Cruzan v. Harmon*, 760 S.W.2d 408, 443 (Mo. 1988) (en banc) (Higgins, J., dissenting), cert. granted sub nom. *Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989). The trial court described her as "a vivacious, active, outgoing, independent person who preferred to do for herself." *In re Cruzan*, slip op. at 4. While the trial court described the evidence on some other issues in the case as "clear and convincing," it did not describe the evidence of her preferences this way. *Id.* (medical evidence); *id.* at 6 (incapacity).

110. *Cruzan*, 760 S.W.2d at 413 n.5 (quoting from Shakespeare's *Macbeth*).

111. She had been maintained in that state for five years. *Id.* at 410-11.

112. *Id.* at 419.

113. *Id.* at 423-24, 426.

114. *Id.* at 424. The court stated that the evidence was insufficient to establish a "truly informed" refusal. It implicitly rejected a best interest analysis guided by her probable preferences, sometimes called "substituted judgment."

115. *Id.* at 442 (Welliver, J., dissenting).

state interest is balanced against the patient's interests in refusing treatment in order to eliminate quality of life considerations. Because the widely adopted *Quinlan* test balances the patient's overall prognosis against the treatment burden, it permits consideration of a patient's quality of life. In *Quinlan*, for example, the absence of any hope for a return to cognitive functioning diminished the state's interest in treatment. By contrast, the *Cruzan* test measures the state's interest solely by the patient's life expectancy.

In an opinion reminiscent of one of the dissenting opinions in *Brophy*,¹¹⁶ the court concluded that the state's interest in the preservation of life embraced two separate concerns: "an interest in the *prolongation* of the life of the individual patient and an interest in the *sanctity* of life itself."¹¹⁷ As the court seemed to believe that both concerns dictated the exclusion of quality of life considerations, quantity of life was left as the sole measure of the state's interest. The court principally relied on a lengthy quotation from *Brophy* that phrased the state's interest in terms of the patient's life expectancy.¹¹⁸

Judge Robertson then explained that "the state's concern with the *sanctity of life* rests on the principle that life is precious and worthy of preservation without regard to its quality."¹¹⁹ He expressed particular concern that the state "provide shelter for those who would choose to live—if able to choose—despite the inconvenience the choice might cause others."¹²⁰ In addition, he expressed fear that recognition of quality of life concerns would free the state to terminate the lives of "persons with all manner of handicaps."¹²¹ Finally, Robertson supported his conclusion that the state

116. It most closely resembled that of Judge O'Connor. He advocated a state interest measured by life expectancy without reference to quality or curability. *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 453, 497 N.E.2d 626, 646 (1986). Like Judge Robertson, he was concerned that the handicapped enjoy equal protection from the state. Like Robertson, he did not indicate how the violation of patient wishes would protect them.

117. *Cruzan*, 760 S.W.2d at 419 (emphasis added).

118. The concern for preservation of the life of the patient normally involves an *interest in the prolongation of life*. Thus, the State's interest in preserving life is very high when "human life [can] be saved where the affliction is curable." *Saikewicz*, . . . 370 N.E.2d at 425–26. That interest wanes when the underlying affliction is incurable and "would soon cause death regardless of any medical treatment." *Commissioner of Corrections v. Myers*, [379 Mass. 255] 399 N.E.2d 452, 452 (Mass.1979). *Saikewicz*, *supra*. The calculus 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."

Id.

119. *Id.* (emphasis added).

120. *Id.* His concern that quality of life considerations might lead to nontreatment based on social worth was evident even at the outset of the opinion. "The debate here is thus not between life and death," he explained. "We are asked to hold that *the cost of maintaining Nancy's present life is too great when weighed against the benefit that life conveys both to Nancy and her loved ones and that she must die.*" *Id.* at 412 (emphasis added).

121. *Id.* at 420 ("Were quality of life at issue, persons with all manner of handicaps might find the state seeking to terminate their lives.").

had a "strong predisposition in favor of preserving life"¹²² by citing Missouri's wrongful life,¹²³ abortion,¹²⁴ and living will¹²⁵ laws.

Despite Robertson's statement that the state's interest in life was "unqualified,"¹²⁶ however, *Cruzan* did not entirely accept the "sanctity of life" presumption that all lives, no matter how horrible, are worth living regardless of the cost. The court, instead, recognized that the patient might sometimes have overriding interests in refusing treatment. To identify those cases, it adopted a test that balances life expectancy against treatment burden.¹²⁷ Unfortunately, the court did not explain how the values it hoped to serve, such as protection of the vulnerable from social worth assessments, would be better served by its formula than by the *Quinlan* formula or by approaches more deferential to patient wishes. Nor did it explicitly consider the costs that its restrictive formula might impose on some patients with painful diseases or a clearly expressed preference for nontreatment.

122. *Id.* at 419.

123. In 1986, Missouri passed a statute denying a cause of action for either wrongful life or wrongful birth if based upon a claim that a "child would have been aborted." Mo. REV. STAT. § 188.130 (1986). Presumably, this statute reflects the same legislative beliefs about the sanctity of fetal life and the undesirability of abortion that are manifested in the state's restrictive abortion laws. In fact, this wrongful life statute is contained in the same chapter which regulates abortions.

124. Mo. REV. STAT. §§ 188.010–.220 (1986). These restrictions were integral to the United States Supreme Court's decision in *Reproductive Health Services v. Webster*, 109 S. Ct. 3040 (1989). The court noted that this chapter grants the "right to life" to all humans, including the unborn, and that the protection it extends to viable fetuses apply equally to fetuses whose viability depends upon artificial life support systems. The court noted that the statute defines viability to include the ability to survive indefinitely outside the womb both by natural "or artificial life support systems." *Cruzan*, 760 S.W.2d at 419 (emphasis in original). See also Mo. REV. STAT. §§ 188.015(7), .010 (1986). The court did not explain how concerns about fetal protection resembled the state's interests in the case before it, but perhaps protection of the vulnerable from social worth considerations constitutes the common denominator.

125. It noted that Missouri had substantially modified the Uniform Rights of the Terminally Ill Act (URITA) to "reflect this State's strong interest in life." *Cruzan*, 760 S.W.2d at 419. While URITA permits the withholding of "life-sustaining treatments," Missouri's statute describes these treatments as "death-prolonging procedure[s]." *Id.* at 419–20 (citing Mo. REV. STAT. § 459.010(3) (1986)). The difference might appear to be merely symbolic because URITA defines a "life-sustaining treatment" to be "any medical procedure or intervention that . . . will serve only to prolong the process of dying." URITA § 1(4). However, Missouri's statute does define the procedures differently. First, it applies only to procedures that "artificially" prolong dying. Mo. REV. STAT. § 459.010(3) (1986). Second, it also limits the procedures to those which cannot extend the patient's life more than a "short time," and unlike URITA, the Missouri statute specifically excludes medication, comfort measures, nutrition, and hydration. Mo. REV. STAT. § 459.010(3) (1986). While URITA is available to all patients who would die soon without treatment, the Missouri statute extends only to patients who will die "within a short time regardless of the application of medical procedures." Mo. REV. STAT. § 459.010(6) (1986) (emphasis added). While URITA achieves much the same effect by limiting its coverage to procedures which will merely "prolong the dying process" for patients who would die in the absence of treatment, it does not explicitly require that death be expected within a "short time" if treatment is rendered. Missouri also has included an additional statement expressing its opposition to mercy killing, euthanasia and "any affirmative or deliberate act or omission to shorten or end life." Mo. REV. STAT. § 459.055(5) (1986). The inconsistency of this broadly written provision with the basic functioning of the statute has been pointed out by others. Johnson, *The Death-Prolonging Procedures Act and Refusal of Treatment in Missouri*, 30 ST. LOUIS U.L.J. 805, 816 (1986) (second clause would nullify ability to withhold life-sustaining treatment). Relying on the policy it found to be implicit in these statutes, the court concluded that Missouri had a strong state interest in the preservation of life without reference to the quality of life preserved. *Cruzan*, 760 S.W.2d at 420 and accompanying text .

126. *Cruzan*, 760 S.W.2d at 420.

127. *Id.* at 420–22. It qualifies that presumption when the patient is terminal and the treatment invasive, but even then, I believe that the court would say that this formula was intended only to decide if the treatment was worth ceasing, not whether the patient's quality of life was worthwhile. The artificiality of this distinction is discussed at *infra* notes 345–64 and accompanying text.

2. Applying the Formula to Patients Whose Wishes Are Known

Although *Cruzan* involved an incompetent patient whose wishes were not established to the court's satisfaction, the court's balancing formula suggested serious restrictions on the autonomy of both currently competent patients and previously competent patients. At a minimum, *Cruzan* imposed more serious proof and formality requirements upon the exercise of patient autonomy than had any previous court, except the New York Court of Appeals.¹²⁸ In *Cruzan*, the court held that an effective patient directive would require all of the attributes of traditional informed consent and it opined that this might be impossible if the person were young and healthy because that person's preferences would be merely "hypothetical."¹²⁹

The opinion also strongly suggested that both the newly bolstered state interest in the preservation of life and the court's novel balancing of life expectancy against treatment burden would apply to patients who had competently expressed their wishes about medical treatment. Judge Robertson emphasized pointedly and repeatedly that any right of privacy or right to refuse medical treatment that Nancy Cruzan might have desired to exercise¹³⁰ was not absolute.¹³¹ Her interests in the control of her own medical treatment decisions would have to be weighed against the state's interest in the preservation of life.¹³² The court also stressed that both the common law right to refuse medical treatment and the possible constitutional right to privacy would have to be balanced against the state's interest in the prolongation and sanctity of life.¹³³ These statements suggest that Nancy Cruzan's rights would have been limited by the court's formula even if she had unequivocally attempted to exercise them.

The applicability of the court's balancing test is clouded somewhat by other language in the opinion that may limit its scope. Twice the court implied that Nancy's wishes would be relevant.¹³⁴ In addition, Judge Robertson's reported comments at a conference following the decision of the case indicated his willingness to defer to patient wishes.¹³⁵ Yet, two other factors suggest that the court's balancing test applies to autonomous patients. First, the court assigned to the state (not to Nancy) an interest in the prolongation of her life.¹³⁶ If, instead, the court had simply recognized the relevance of Nancy's life expectancy to a determination of her own best interests in the absence of clear instructions from her, then it might be reasonable to assume that

128. *In re Westchester County Medical Center*, 72 N.Y.2d 517, 534 N.Y.S.2d 886, 531 N.E.2d 607 (1988).

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

130. The court expressed doubt about the existence of a "right" in someone who could not exercise it. *Id.* It also doubted that the constitutional right of privacy extended to medical treatment decisions, at least for the withholding of food and water. *Id.* at 418. The court was also unconvinced of the authority of a guardian to exercise any such right on the patient's behalf. *Id.* at 424. Even if the right were delegable, the court believed that its delegation would require formalities to protect the waiver of the right to life. *Id.* at 425.

131. *Id.* at 419, 421-22.

132. *Id.* at 419.

133. *Id.* at 419, 421-22.

134. *Id.* at 424, 426. In addition, the court reserved ruling on the possibility that a competent patient could have a common law right to refuse treatment that is broader than the state's restrictive living will statute. However, the court expressly relied upon the restrictions in that statute limiting its application to terminal patients and prohibiting suicide and euthanasia, as evidence of the state's "policy strongly favoring life." *Id.* at 419.

135. Koenig, *Coma Patients Spur Right-To-Die Debate*, St. Louis Post Dispatch, Apr. 16, 1989, at 3D, col. 1.

136. *Cruzan*, 760 S.W.2d at 419.

competent patients could use a different formula for determining their own interests. But if the interest in their lives belongs to the state, then the state presumably can limit their freedom to refuse life-sustaining treatment whenever their life expectancy is long in relation to the burden of their treatment. Second, the court expressly cited two recent cases respecting the wishes of competent, nonterminal patients to refuse life-sustaining treatment as evidence that other courts had improperly discounted the state's interest in the preservation of life.¹³⁷ Robertson concluded that routine deference to patients' wishes, regardless of life expectancy or treatment burden, was inappropriate because it would lead to the approval of suicide.¹³⁸

All of these factors indicate that the *Cruzan* balancing formula governs the treatment of patients who have competently communicated their preferences, at least to the extent that these expressions fall outside of the state's living will statute.

Because of the court's fundamental disagreement with mainstream doctrine about the nature of the state's interest, its opinion goes far beyond the issues that had to be reached to decide this case on its facts. The court could, for example, have concluded that the evidence of Nancy's desires was insufficient to justify withdrawal of the gastrostomy tube on that basis and that the burdens of Nancy's continued existence with the gastrostomy tube in place were insufficient to justify the conclusion that withdrawal of treatment would advance her best interests, or it could have concluded that nutrition and hydration are, indeed, different from other medical treatments.¹³⁹ Either of these options might have comported with the court's conservative approach to the subject. If it had chosen one of these narrower bases for its opinion, its holding would have been noteworthy, but the court would have left its larger disagreements with mainstream analysis for a case requiring that the larger issues be decided. Instead, the court took issue with mainstream analysis at virtually every step. In particular, it revived and recast the state's interest in the preservation of life. In so doing, it strongly suggested that the interests of all patients, both competent and incompetent,¹⁴⁰ must be balanced against the state's interests in the prolongation and the sanctity of life.¹⁴¹

137. *Id.* at 421 (citing *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987)). Judge Robertson also appeared to view these cases as evidence that other courts have inflated the strength of the *patient's* interest in refusing treatment.

138. *Cruzan*, 760 S.W.2d at 421-22 (quoting L. TRIBE, *supra* note 52, at 1366-67).

139. However, the court did not insist that food and nutrition be treated differently. *Cruzan v. Harmon*, 760 S.W.2d 408, 423-24 (Mo. 1988) (en banc), *cert. granted sub nom. Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989). Nevertheless, it is hard to shake the sense that the outcome of the case was influenced by this issue and that the court might have treated it differently if resolution of this issue were believed necessary to decide the case.

140. The extension of *Cruzan* to competent or previously competent patients would result in rules that are even more restrictive in some respects than the living will statute upon which the court relied. First, the statute does not govern the treatment of currently competent patients. Second, the statute permits previously competent patients to direct the withholding of *any* treatment without regard to treatment burden *except* nutrition, hydration, and procedures to provide comfort or alleviate pain. MO. REV. STAT. § 459.010(3) (1986).

At the very least, this conflict suggests that the court misread the policy of the state as expressed in the statute. The legislature clearly recognized and deferred to the desires of terminal patients to refuse any treatment except those listed. While the statute's restriction to terminal patients does support the court's belief that the state's interest in overriding the patient's wishes lessens as prognosis dims, the statute also clearly states an intention not to limit the rights of patients who are still competent to make their own decisions. MO. REV. STAT. § 459.055(2) (1986).

141. To be sure, the subsequent appointment of a new permanent justice with a swing vote leaves this issue in doubt

D. *The State's Interest After Cruzan*

Judicial sentiments about the state's interest in life have undergone a fascinating evolution over the past twenty years. In 1976, the patient-oriented decision in *Quinlan* ironically ascribed new prominence to the state's interest in life. Surprisingly, other courts eagerly acknowledged this prominence, but it quickly subsided as the courts put the *Quinlan* balancing test into practice. Regrettably, however, neither the rise nor the fall of the weight assigned to this state interest provoked detailed judicial exploration of the possible underlying values. While language in a few of the cases hints at specific concerns, such as irrational decisionmaking,¹⁴² abuse of vulnerable patients, suicide prevention, and disrespect for the intrinsic value of life, the courts rarely explored at length how these different concerns might justify the test they had selected to measure the state's interest. While virtually all courts have continued to "balance" the state's interests against those of the patient, thereby reserving the freedom to intervene in an appropriate case, they have given little indication of what that case would be or why the state should intervene.

The three recent 4-3 decisions have raised once again the question of the *weight* associated with this state interest and the appropriate *test* by which to implement it. Yet, precise identification of the specific *policies* served by this state's interest should precede the effort to decide the weight that it deserves or the task of shaping suitable legal standards. Before the courts determine the weight to assign to the state's interest in life, they must identify the subsidiary policies which they believe it serves and the weight to which these policies are entitled. Precise identification is also necessary to determine the kinds of cases in which these policies are most threatened and the appropriate legal safeguards necessary to protect the state's goals without unnecessarily impeding patient interests.¹⁴³ To the extent that constitutionally protected privacy rights are at stake, searching inquiry is not only sound jurisprudence but also a constitutional mandate.¹⁴⁴ Instead, mainstream courts have balanced a rather inchoate conception of the state's interest against the more concrete interests of the patient on a case-by-case basis and generally found the state's interest to be the weaker of the two. In searching for just outcomes, they have spent little time on grand theory, but the recent divided opinions demonstrate the need for more extended judicial examination of the separate components of the state's interest in the preservation of life.

II. PROTECTING PATIENTS' WISHES

Of the various possible components of the state's interest in the preservation of life, the least controversial is the state's legitimate desire to protect patients against

until the next case reaches the court. At that time, the court could reconsider the language in *Cruzan* which suggests that its balancing formula applies to both competent and incompetent patients.

142. See 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).

143. As one judge observed in 1989, "[a] more precise list would assist the decisionmaker in this difficult process." *In re Browning*, 543 So. 2d 258, 266 n.11 (Fla. Dist. Ct. App. 1989).

144. *Wisconsin v. Yoder*, 406 U.S. 205, 221 (1972).

error and abuse. Courts typically describe their concern about accurately ascertaining patient interests as a desire to protect society's most vulnerable members from abuse.¹⁴⁵ In *Cruzan*, for example, Judge Robertson stated this concern as follows: "Any substantive principle of law which we adopt must also provide shelter for those who would choose to live—if able to choose—despite the inconvenience that choice might cause others."¹⁴⁶ He concluded his opinion by stating his preference "to err on the side of life, respecting the rights of incompetent persons who may wish to live despite a severely diminished quality of life."¹⁴⁷

Regrettably, these expressions of legitimate concern rarely differentiate between the interests of patients who have competently expressed their own preferences and the interests of patients who have not done so.¹⁴⁸ Unquestionably, the state's interest in protecting patients against error and abuse in medical decisionmaking processes extends to both classes of patients. But the kinds of restrictions warranted to avoid error and abuse when patient wishes are known are likely to be different from those which can be justified when they are not. Thus, this Part discusses the state's interest in protecting against error and abuse in ascertaining the patient's wishes and Part III discusses the state's interest in protecting against error and abuse in determining the treatment decision which will serve the patient's best interests.

However, the temptation to treat patients' wishes and their objective best interests as completely distinct interests has serious risks of its own. As the two are closely related, separate consideration will often overlook important information about the patient's interests. Accordingly, both Parts II and III emphasize the interconnectedness of welfare and wishes.

A. *The State's Interest in Safeguarding Patient Wishes*

1. *The State's Objectives*

Without doubt, the state possesses an interest "in preserving the lives of those who want to live."¹⁴⁹ In part, this derives from the state's interest in preserving and protecting life. And in part it derives from the state's strong interest in protecting patient autonomy.¹⁵⁰ The state's combined interests in protecting the patient's life and

145. Chief Justice McKusick of the Maine Supreme Court concluded that "the most important state interest that will arise where a patient is incompetent at the time life-sustaining procedures are to be removed is the interest in protecting from abuse those persons no longer able to care for themselves." *In re Gardner*, 534 A.2d 947, 955 (Me. 1987). Likewise Judge O'Connor, one of the dissenters in *Brophy*, objected to the termination of Brophy's nutrition and hydration because doing so threatened society's protection of "its weakest and most vulnerable members." *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 453, 497 N.E.2d 626, 646 (1986).

146. *Cruzan v. Harmon*, 760 S.W.2d 408, 419 (Mo. 1988) (en banc), cert. granted sub nom. *Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989).

147. *Id.* at 427.

148. Chief Justice McKusick of Maine is a notable exception. *In re Gardner*, 534 A.2d 947, 955 (Me. 1987).

149. Note, *The Refusal of Life-Saving Medical Treatment vs. The State's Interest in the Preservation of Life: A Clarification of the Interests at Stake*, 58 WASH. U.L.Q. 85, 103 (1980). The state's explicit concern with the lives of its citizens is at least as old as the Declaration of Independence. *Id.* at 103 n.96.

150. The Declaration of Independence expressly confirms both of these governmental roles. See G. WILLS, *INVENTING AMERICA: JEFFERSON'S DECLARATION OF INDEPENDENCE* 374 (1978). Two of the early cases refusing to order medical treatment emphasized this government's role in protecting autonomy. *In re Osborne*, 294 A.2d 372 (D.C. 1972);

liberty justify the enactment of laws designed to ensure that reasonable efforts are made to ascertain accurately a competent patient's current wishes and an incompetent patient's past preferences. The state's interest in protecting patients' wishes against error or abuse legitimately extends not only to the accurate ascertainment and implementation of their wishes but also, in appropriate circumstances, to the protection of patients against uninformed, incompetent, or involuntary decisions about life-saving medical care.¹⁵¹ Several courts have suggested that the state's interest in protecting patients against incompetent refusals constitutes the heart of its interest in the preservation of life.¹⁵² In this respect, the state's interest in protecting patients' lives and nurturing their autonomy furthers the same policies underlying the informed consent doctrine.¹⁵³ This state interest also resembles state supervision of important personal decisions in other areas of life, such as those regulated by the statute of frauds,¹⁵⁴ the statute of wills,¹⁵⁵ and adoption laws.¹⁵⁶ At its root, this state interest is derivative and protective of the patient's wishes, rather than in opposition to them.

For presently competent patients, safeguards to protect patient autonomy may take a variety of concrete forms. For example, courts could hold bedside hearings or view videotape depositions to ensure accurate understanding of the patient's wishes. Not surprisingly, many trial courts already have done so.¹⁵⁷ Bedside hearings for patients who are unable to attend court, in particular, offer advantages for assessing patient competency, detecting undue influence,¹⁵⁸ and asking follow-up questions to assess the adequacy of the patient's information and seriousness of purpose.

The case of Kathleen Farrell, a thirty-seven-year-old woman with Lou Gehrig's disease, gives some further examples of measures which might be taken to protect the consent process. In that case, the New Jersey Supreme Court insisted that two nonattending physicians verify Ms. Farrell's competency and access to medical

Erickson v. Dilgard, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962). When a patient desires treatment, both of the state's interests overlap, but when the patient declines treatment, only his liberty interests are directly at stake. Nevertheless, as several courts have noted, the value of life itself is enhanced not by thwarting patient autonomy, but by respecting it. *E.g.*, Public Health Trust v. Wons, 541 So. 2d 96, 100-01 (Fla. 1986) (Ehrlich, J., concurring); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 742, 370 N.E.2d 417, 426 (1977); *In re Conroy*, 98 N.J. 321, 350-51, 486 A.2d 1209, 1223-24 (1985).

151. Because these measures could interfere with patient wishes, they are paternalistic. However, measures designed to insure a voluntary, competent, and informed consent constitute a weak form of paternalism undertaken to protect the quality of a patient's autonomy. *See* T. BEAUCHAMP & J. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 174-79 (2d ed. 1983).

152. *See supra* text accompanying notes 68-74.

153. *See In re Farrell*, 108 N.J. 335, 347-48, 529 A.2d 404, 410 (1987).

154. *E.g.*, OKLA. STAT. ANN. tit. 12A, § 2-201 (West 1963); 13 PA. CONS. STAT. ANN. § 2201 (Purdon 1984); WIS. STAT. ANN. § 241.02 (West 1987).

155. *E.g.*, OKLA. STAT. ANN. tit. 84, §§ 41-146 (West Supp. 1989); 20 PA. CONS. STAT. ANN. §§ 2501-20 (Purdon Supp. 1989); WIS. STAT. ANN. §§ 853.01-.62 (West Supp. 1988).

156. *E.g.*, OKLA. STAT. ANN. tit. 10, §§ 55-60.23 (West 1987); WIS. STAT. ANN. §§ 48.81-.95 (West Supp. 1988).

157. *E.g.*, *Farrell*, 108 N.J. at 345-46, 529 A.2d at 409 (home); *In re Requena*, 213 N.J. Super. 475, 479, 517 A.2d 886, 888 (Ch. Div.) (hospital), *aff'd*, 213 N.J. Super. 443, 517 A.2d 869 (App. Div. 1986); *In re O'Brien*, 135 Misc. 2d 1076, 1078-79, 517 N.Y.S.2d 346, 347-48 (Sup. Ct. 1986) (hospital); *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 190, 209 Cal. Rptr. 220, 222 (1984) (videotape); *In re Visbeck*, 210 N.J. Super. 527, 532, 535-37, 510 A.2d 125, 127, 129-30 (Ch. Div. 1986) (hospital).

158. The patient's dependency on others may make her vulnerable to undue influence. *See* J. ROBERTSON, *supra* note 44, at 49.

information.¹⁵⁹ In addition, Kathleen Farrell had already undergone psychological counseling to ensure that she was not clinically depressed.¹⁶⁰ Finally, the court hinted that an explicit waiting period before effectuating patient requests might be warranted to protect against hasty, unconsidered decisions. However, the court concluded that a formal waiting period was unnecessary under the procedures adopted in *Farrell*, because the consultation requirement would itself delay the withholding of treatment long enough to avoid a hasty decision.¹⁶¹

Concerns similar to those raised in *Farrell* probably explain the short waiting periods found in some living will statutes.¹⁶² A waiting period provides time for both reflection and confirmation of diagnosis. Time for reflection is especially important if withholding will quickly lead to incompetency or unconsciousness, thereby precluding reconsideration after withholding commences. It is also likely to be valuable when the patient's decision immediately follows a catastrophic accident or the sudden onset of an illness.¹⁶³ Counseling, too, might be warranted on a case-by-case basis for patients who vacillate¹⁶⁴ or have otherwise demonstrated that they are using the treatment crisis to appeal for help, to solve a family dispute, or deal with some other problem.¹⁶⁵

The task of protecting patient preferences presents special problems when the patient is no longer competent. Because the proof will often consist of third-party recollections of past conversations with the patient, rather than the patient's contemporaneous testimony, providers and courts must evaluate the reliability of these recollections.¹⁶⁶ This task becomes especially difficult if the witnesses themselves have strong personal beliefs about the suitability of treatment or if they have a personal interest in the decision. In addition, previously expressed preferences are often general or abstract, thereby posing interpretive problems in applying them to a current decision about future treatment.¹⁶⁷ As Professor Rebecca Dresser notes, these statements may also lack the thoughtful exchange between patient, family, and

159. *Farrell*, 108 N.J. at 356, 529 A.2d at 415. It based this requirement on the absence of neutral witnesses for patients being cared for at home. *Id.* at 355, 529 A.2d at 414. The court denied, however, that patients would be more vulnerable to abuse at home than in an institution.

160. *Id.* at 346, 529 A.2d at 409. The psychologist not only concluded that Farrell's decision to disconnect her respirator was informed, voluntary, and competent, but also that her decision was serious. *Id.* The case for requiring an expert evaluation of patient competency is fairly strong. Although it could delay effectuation of the patient's wishes, it would permit the verification of competency and provide a short period of time for reflection. By comparison, the case for requiring psychiatric counseling prior to a binding decision to refuse life-saving treatment is considerably weaker. A counseling requirement could delay withholding substantially, and even pose a danger of subtle coercion. Its desirability would turn on evidence that marginally competent patients would benefit from it when assessing the long-term implications of their condition.

161. *Id.* at 357, 529 A.2d at 415; see also *In re Colyer*, 99 Wash. 2d 114, 135 n.8, 660 P.2d 738, 750 n.8 (1983) (requirement of prognosis committee review obviated the need for a waiting period).

162. Gelfand, *supra* note 13, at 763.

163. *Farrell*, 108 N.J. at 357, 529 A.2d at 415.

164. *Lane v. Candura*, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978).

165. See Jackson & Youngner, *Patient Autonomy and 'Death with Dignity': Some Clinical Caveats*, 301 *NEW ENG. J. MED.* 404 (1979).

166. In one case, opponents of withholding introduced expert testimony to challenge the reliability of these recollections due to the passage of time. *In re Jobes*, 108 N.J. 394, 411 n.7, 529 A.2d 434, 442 n.7 (1987).

167. Dresser, *Life, Death and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 *ARIZ. L. REV.* 373, 376 (1986).

provider that often helps competent patients discern the health care implications of their personal values and goals.¹⁶⁸ Furthermore, when the patient's previous expressions are remote in time or predate the onset of illness or accident, the patient's preferences may have changed during the interim.¹⁶⁹ As one observer has noted:

[P]ersons' ideas about the quality of life change drastically as they age, especially in the last years of their lives. The twenty-one-year-old who wants to be shot rather than suffer the imagined ignominy of a nursing home is only too grateful to accept the nursing home bed and warm meals when he turns eighty-five. A living will or a frank conversation with one's physician even at age fifty-five would rarely reflect what one's wishes would be at seventy.¹⁷⁰

Even if the patients' preferences have not changed during the interim, statements predating their current illness are likely to be more general and are surely more hypothetical than they are after illness sets in.¹⁷¹ Finally, their past statements may have presumed the use of medical technologies that are no longer necessary.¹⁷²

Thus, the task of accurately ascertaining the patient's past preferences is often quite difficult. Factfinders can rarely eliminate all doubt about how the patient would choose if able to do so now.¹⁷³ That increases the risk of error and the room for abuse.¹⁷⁴ At the same time, however, the current inability of the incompetent patient to provide us with better information about his wishes means that unrealistic proof or formality requirements will thwart the wishes of incompetent patients more often than they would those of presently competent patients.¹⁷⁵ Because of these factors, the task of monitoring error and at the same time protecting patient preferences is especially difficult.

Courts have considered a number of precautions for treatment decisions involving incompetent patients. Preferring to err on the side of life, they typically place the burden of proof upon the party requesting that treatment be withheld and require that the evidence be clear and convincing.¹⁷⁶ The probative value of past statements then turns upon their specificity, thoughtfulness, longevity, consistency and remoteness, and also upon the patient's maturity and health.¹⁷⁷ New Jersey also

168. *Id.*

169. See *In re Westchester County Medical Center*, 72 N.Y.2d 517, 531, 534 N.Y.S.2d 886, 892, 531 N.E.2d 607, 613 (1988) (requiring evidence of strength and durability of commitment that makes a change of heart unlikely).

170. N. CANTOR, LEGAL FRONTIERS OF DEATH AND DYING 64 (1987); see also *In re Estate of Dorone*, 349 Pa. Super. 59, 502 A.2d 1271 (1985) (noting the role of the instinct for self-preservation).

171. See *infra* text accompanying notes 203-17, 275-310.

172. See *Westchester*, 72 N.Y.2d at 530, 534 N.Y.S.2d at 892, 531 N.E.2d at 613 (1988); Dresser, *supra* note 167, at 376.

173. See *In re Jobes*, 108 N.J. 394, 434, 529 A.2d 434, 455 (1987) (Handler, J., concurring).

174. See J. ROBERTSON, *supra* note 44, at 49.

175. Competent patients facing a one-time emergency treatment decision, such as a blood transfusion, are an exception.

176. *E.g.*, *In re Storar*, 52 N.Y.2d 363, 378-79, 438 N.Y.S.2d 266, 274, 420 N.E.2d 64, 72, *cert. denied*, 454 U.S. 858 (1981) (rejecting a beyond reasonable doubt standard); *In re Peter*, 108 N.J. 365, 379, 529 A.2d 419, 425-26 (1987); *McConnell v. Beverly Enter.*—Conn., 209 Conn. 692, 710-11, 553 A.2d 596, 605 (1989). *Contra In re Drabick*, 200 Cal. App. 3d 185, 211, 245 Cal. Rptr. 840, 856, *cert. denied*, 109 S. Ct. 399 (1988); *In re Ingram*, 102 Wash. 2d 827, 842, 689 P.2d 1363, 1371 (1984).

177. *In re Conroy*, 98 N.J. 321, 362, 486 A.2d 1209, 1230 (1985); *In re Jobes*, 108 N.J. 394, 412, 529 A.2d 434, 443 (1987). The patient's previous actions under comparable circumstances would also be relevant. *Conroy*, 98 N.J. at

requires a second medical opinion about competency, prognosis, and treatment. New Jersey sometimes requires a consultation with a hospital ethics committee or state ombudsman, depending upon the patient's condition and location.¹⁷⁸ Some other jurisdictions impose similar consultation or review requirements.¹⁷⁹

2. The Costs of Intervention

The understandable desire to ensure the quality of patient decisionmaking must be tempered, however, by the recognition that undue proceduralization will deny many patients their freedom to decline treatment.¹⁸⁰ Even procedures enacted and implemented in good faith could have this effect, especially if they require or are likely to send the parties to court.¹⁸¹ Too often in the past, patients have endured unwanted treatment until their death while waiting for their cases to be decided.¹⁸² Cognizant of the dangers of overprotection, many courts have made a special effort to establish procedures that eliminate, as much as possible, the need to resort to the courts. For example, Washington permits declaratory judgment actions to help resolve doubtful treatment issues before they are mooted by treatment or death.¹⁸³ For the same reason, Massachusetts wisely rejected a suggestion that proof beyond a reasonable doubt be required.¹⁸⁴ New York has refused to impose formalities similar to those required in living will statutes.¹⁸⁵

Undue proceduralization is especially likely to harm two categories of patients: competent patients who need emergency treatment and all previously competent patients.¹⁸⁶ In emergencies, onerous procedural requirements could guarantee that the wishes of competent patients who seek to decline a one-time emergency treatment, such as a blood transfusion, are ignored. The wishes of previously competent patients

363, 486 A.2d at 1230. By contrast, casual or spontaneous remarks would be less reliable. *Jobes*, 108 N.J. at 412, 529 A.2d at 443.

178. See, e.g., *Conroy*, 98 N.J. 321, 486 A.2d 1209 (procedures for terminal patients in nursing homes); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976) (procedures for vegetative patients in hospitals); *Peter*, 108 N.J. 365, 529 A.2d 419 (procedure for vegetative patients in nursing homes); *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987) (second medical opinion for competent patients at home). Perhaps a waiting period to confirm a hopeless prognosis should also be considered. See *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983) (Dore, J., dissenting) (25 days insufficient); *Farrell*, 108 N.J. at 357, 529 A.2d at 415 (requirement of independent medical opinions results in sufficient delay).

179. E.g., *Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (review by hospital prognosis committee required).

180. *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1985) (Handler, J., concurring) (discussing *Conroy*'s requirement that an ombudsman be consulted in nursing home cases).

181. See *Farrell*, 108 N.J. at 357, 529 A.2d at 415 (requiring judicial review only in the event of conflict because judicial intervention would deny too many patients the ability to exercise their rights); *Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (noting delay and chill on resolve of guardians to assert the rights of their wards).

182. *Farrell*, 108 N.J. at 357, 529 A.2d at 415 (collecting cases).

183. *Colyer*, 99 Wash. 2d at 136-37, 660 P.2d at 750-51.

184. *Custody of a Minor*, 385 Mass. 697, 434 N.E.2d 601 (1982) (could cause undue pain and loss of dignity).

185. *In re Westchester County Medical Center*, 72 N.Y.2d 517, 531-32, 534 N.Y.S.2d 886, 892-93, 531 N.E.2d 607, 613-14 (1988).

186. The degree of risk to liberty will turn upon the patient's medical circumstances as well as upon the nature of the legal restriction. For example, if long-term treatment is temporarily continued, patients who are likely to remain competent long enough to comply with any necessary formalities will suffer a less permanent violation of their autonomy than will patients who face a one-time emergency treatment decision, such as a surgery-related blood transfusion. Blanket delay or formality requirements could cost this second group of patients an irreversible and complete frustration of their liberty interests.

are also especially vulnerable because these patients can neither remedy the shortcomings in their proof nor fight to ensure that their past wishes will be respected.¹⁸⁷

In addition, the controversial statutes passed to regulate abortions plainly demonstrate that purportedly protective state regulations may sometimes camouflage quite antagonistic motives.¹⁸⁸ Even when they are enacted in good faith, they may enable health care providers or trial judges who are uncomfortable with a patient preference for death to thwart patient autonomy. Courts and legislatures contemplating protective measures such as mandatory waiting periods or psychiatric evaluations should, therefore, consider carefully the likelihood that they will produce abusive overtreatment. In the past, the real threat to patient autonomy has been overaggressive treatment, not an undue readiness to withhold treatment against patient wishes.¹⁸⁹

3. *Balancing Protection Against Interference*

Both the state and the patient share an interest in protecting the quality of patient autonomy and, at the same time, in avoiding counterproductive proceduralization. This balancing process should not be misconceived as a balancing of conflicting interests of the patient and the state. Instead, it is a balancing of their shared interests in protecting patient autonomy from error and abuse, on one hand, against their shared interests in avoiding undue interference with that autonomy, on the other. To the extent that the state's interest in medical treatment cases arises out of its desire to protect the quality of patient autonomy, its interests mirror those of the patient. An overprotective rule, therefore, is no more in the state's interest than it is in the patient's, just as an underprotective law is no more in the patients' interests than it is in the state's.

Resolution of this tension between protection and interference requires a balancing, but not the kind suggested in *Quinlan* and *Cruzan*.¹⁹⁰ It does not involve a balancing of either the state's interests against the patient's interests or of prognosis against treatment burden. Instead, courts and legislatures considering restrictions on withholding should balance the burdens which proposed safeguards will impose on patient liberty against the risk that avoidable error and abuse will occur in the absence of safeguards. Because of the certainty that any further proceduralization will lead to some unwanted treatment, lawmakers should not impose additional restrictions unless

187. Procedures which might not deter a competent patient from persisting with a demand that treatment be discontinued may be more likely to deter family and providers from insisting upon effectuation of patient wishes, particularly if judicial action is necessary.

188. See, e.g., *Thornburgh v. American College of Obst. & Gyn.*, 476 U.S. 747 (1986); *Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983).

189. *Wanzer*, *supra* note 50, at 845.

190. In *Conroy*, the New Jersey Supreme Court noted the problem of error: "To err either way—to keep a person alive under circumstances under which he would rather have been allowed to die, or to allow that person to die when he would have chosen to cling to life—would be deeply unfortunate." *In re Conroy*, 98 N.J. 321, 343, 486 A.2d 1209, 1220 (1985). In *Farrell*, the court recognized the task of balancing protection against restriction. *In re Farrell*, 108 N.J. 335, 358, 529 A.2d 404, 416 (1987).

they have legitimate reason to believe that abuse or error is a problem, that existing procedures to detect and correct error and abuse, both within the affected health care institutions¹⁹¹ and in the courts, are inadequate, and that the added procedures will avoid the danger.¹⁹²

As the dangers of error or abuse may vary with the patient's current competence, health-care setting, finances, and family situation, so too may the need for safeguards.¹⁹³ Restrictions should be narrowly tailored to address those specific needs because the state's interest in protecting patient wishes will justify only the least restrictive measures necessary to avoid the feared abuse. Otherwise the restrictions will unduly thwart the very autonomy interests they are intended to protect. Indeed, a precise "fit" between means and ends will be a prerequisite to surviving constitutional scrutiny.¹⁹⁴

While the balancing of protection against interference provides no brighter lines than the *Quinlan* and *Cruzan* tests, it focuses analysis on the appropriate issues. Two examples will help illustrate its operation. In cases involving Jehovah's Witnesses in need of emergency blood transfusions, for example, the threat to patient autonomy interests from heavy proof or verification requirements is quite high. The administration of unwanted treatment will be complete and irreversible by the time the patient returns to consciousness and can verify her "reputed" beliefs. Thus, courts should permit withholding based on reliable evidence, like medic alert cards, even though there is always some slight risk of error.¹⁹⁵ Conversely, the temporary treatment of a chronically ill person reasonably suspected to be suicidal, like Elizabeth Bouvia, would be warranted to permit further evaluation and confirmation of her competency and diagnosis. The risks of impaired competence or inadequate information in cases like hers are high and patients like Bouvia will typically have future opportunities to decline unwanted life-saving treatment once their competency is confirmed. Nevertheless, involuntary treatment should involve only the shortest delay and the least intrusive procedures necessary to verify her competency while stabilizing her condition and preserving her opportunity to make her own choices in the future.¹⁹⁶

191. New Jersey, for example, has imposed extra procedures for patients in nursing homes. *Conroy*, 98 N.J. 321, 486 A.2d 1209.

192. There may also be a more subtle state interest involved here, but it too fails to support interference with patient choice. Perhaps a corollary of our community obligation to protect the patient from error and abuse is his obligation to let us try to help. But this interest would justify only the weak paternalistic measures of the sort described above. It would not support mandatory treatment once competence and reflection were assured, nor would it support measures designed to interfere with that choice.

193. New Jersey, more than any other state, has attempted to design procedures to fit the patient's competency, diagnosis, and health-care setting. Compare *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987) (patient in persistent vegetative state in nursing home) with *Conroy*, 98 N.J. 321, 486 A.2d 1209 (conscious in nursing home); compare *id.* (nursing home) with *Farrell*, 108 N.J. 335, 529 A.2d 404 (home) and *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976) (hospital); compare *Farrell* (competent) with *Conroy* (incompetent).

194. See *supra* note 15.

195. *Contra In re Estate of Dorone*, 349 Pa. Super. 59, 502 A.2d 1271 (1985), *aff'd*, 517 Pa. 3, 534 A.2d 452 (1987).

196. See Comment, *Suicidal Competence and the Patient's Right to Refuse Lifesaving Treatment*, 75 CALIF. L. REV. 707, 754 (1987) [hereinafter *Suicidal Competence*].

4. *Evaluating the Quinlan and Cruzan Balancing Tests*

Neither the *Quinlan* nor the *Cruzan* balancing tests appropriately reflect the state's interest in avoiding error or abuse in ascertaining patient wishes. With respect to this specific state interest, the balancing tests are both underprotective and overrestrictive. The tests are underprotective because the state has an equal interest in protecting both terminal and curable patients against violation of their wishes. At the same time, the balancing tests overly restrict patients who have long life expectancies or face noninvasive treatments because these tests would deprive these patients of choice even if their competent wishes can be clearly proven. To the extent that error and abuse constitute the underlying concern, the state's interest in preserving life does not justify treatment of those patients against their wishes once the quality of their consent has been verified.¹⁹⁷ Treatment based on the *Quinlan* or *Cruzan* balancing tests would only "protect" these patients against themselves. Quite simply, the waxing and waning formulas do not accurately reflect the appropriate role of the state in protecting patients against error and abuse in the ascertainment of their wishes.¹⁹⁸

Because the *Quinlan* and *Cruzan* tests focus on the patient's condition and his treatment, rather than on the risk of error, they misstate the circumstances in which state restrictions are appropriate to protect against error and abuse. This poor fit helps to explain why most courts have acknowledged the state's interest in the preservation of life, but have refused to enforce it by way of the balancing tests.

The Florida Supreme Court dramatically made this point in a case involving Abe Perlmutter,¹⁹⁹ a competent man with Lou Gehrig's disease (amyotrophic lateral sclerosis) who wanted his respirator removed. The court adopted the language of a lower appellate court that had described the respective interests as follows:

It is all very convenient to insist on continuing Mr. Perlmutter's life so that there can be no question of foul play. . . . However, it is quite another matter to do so at the patient's sole expense and against his competent will, thus inflicting never ending physical torture on his body until the inevitable, but artificially suspended, moment of death.²⁰⁰

To the extent that error and abuse are feared, courts should avoid the temptation to characterize the issue as a debate over the *weight* to be given to the state's interest and instead should consider the *kinds* of doctrinal protection which might serve this interest. The *Quinlan* and *Cruzan* balancing tests, no matter how "strictly" enforced, are a poor tool for effectuating this state interest. The dangers of framing the debate as a question of how much weight to afford the state's interest in the preservation of life are that strict enforcement of the *Quinlan* or *Cruzan* tests will inappropriately restrict patient autonomy and also that an emphasis on these tests will divert attention

197. *In re Gardner*, 534 A.2d 947, 953 (Me. 1987).

198. While both the *Quinlan* and *Cruzan* tests may have been shaped by unstated concerns about suicide, neither court expressly relied on these concerns to defend the tests. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976); *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (en banc), cert. granted sub nom. *Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989).

199. *Satz v. Perlmutter*, 379 So. 2d 359 (Fla. 1980), aff'g 362 So. 2d 160 (Fla. Dist. Ct. App. 1978).

200. *Satz*, 362 So. 2d at 164.

away from more appropriate ways of protecting the state's interests in avoiding error and abuse. Lawmakers concerned with error and abuse would do better to identify societal contexts in which error or abuse are most likely to occur. Then they can explore how best to protect patients in these settings without sacrificing patient autonomy or well-being. For example, evidence that isolated, aged adults had been the victims of abusive treatment decisions might warrant greater supervision of nursing homes or better social services for elderly persons living alone. Such legislation might include assistance to help senior citizens memorialize their preferences about future treatment or select their surrogates in advance. Measures of this kind are more likely to address the problems of the vulnerable, including the danger of abusive medical decisions, than reinvigoration of a balancing test which mandates treatment regardless of the patient's wishes.

5. *Quality of Life Considerations*

Direct consideration of the safeguards necessary to protect patient wishes has an additional advantage over the *Quinlan* test which should appeal to courts that dislike judicial assessments of the quality or worth of the patient's life. When safeguards are evaluated by their net impact on patient autonomy, their validity in a particular case does not turn on the patient's quality of life. Unlike the *Quinlan* test, the state's interest turns not on the patient's prognosis but on its reason to suspect error and abuse. Its interest in restricting withholding is proportional to the danger, not to the patient's prognosis alone. The autonomy of every patient receives equal protection, regardless of current health, age, or disability. By replacing the *Quinlan* balancing test with direct consideration of the restrictions necessary to avoid error and abuse, courts not only will fashion more appropriate rules for protecting patients, but they also will avoid the need to base treatment decisions for autonomous patients on their quality of life.²⁰¹

However, quality of life considerations would not be eliminated altogether. Because a patient who is competent, informed, and acting freely is likely to consider his prognosis, including his expected quality of life, a patient's decision to forego treatment, when his expected quality of life is promising, may justify initial suspicion that his decision stems from inadequate information, coercion, or incompetence, or that it has not been accurately ascertained.²⁰² In this limited evidentiary sense, the focus of the *Quinlan* balancing test on the patients' prognosis and treatment burden correlates loosely with suspicions about the quality of patient autonomy. But the relevance of prognosis and treatment burden should not be overstated. They merely signal the need for greater scrutiny. They do not alter the derivative nature of the state's interest. Contrary to the dictates of the *Quinlan* test, the state's interest in

201. The *Cruzan* and *Brophy* tests also purport to eliminate quality of life considerations. But they do not accurately identify cases in which error or abuse require safeguards or suggest the form those safeguards should take.

202. See *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 433 n.28, 497 N.E.2d 626, 635 n.28 (1986) (noting that the state's interest in life is greatest when refusal appears to be "aberrational"); *In re Conroy*, 98 N.J. 321, 355, 486 A.2d 1209, 1226 (1985) (patient may be influenced by his prognosis).

avoiding error and abuse will not support continued intervention once the patient's informed refusal is verified, regardless of the prognosis or treatment burden.

B. *The Balance Between Protection and Interference: Judicial Treatment of Unclear Past Preferences*

The tension between the desire to err on the side of life in ascertaining wishes, on the one hand, and the desire to respect patients' wishes, on the other, is most starkly presented whenever the evidence of patients' past preferences leaves room for doubt. Respect for the patient's life and liberty dictates a serious effort to glean the patient's probable wishes from the available evidence. But as the evidence becomes weaker and our confidence in it declines, the state's interest in avoiding erroneous withholding of treatment appears to gain strength. At some point, the evidence becomes so untrustworthy that it ought not govern the treatment decision, even if the court ordinarily prefers to respect past preferences.²⁰³

The courts have handled this issue in various ways. The most conservative jurisdictions, New York and Missouri, require clear and convincing evidence of an informed refusal before a patient's past wishes may be considered.²⁰⁴ New York ignores evidence that fails to meet this standard. Absent clear evidence of patient wishes, all life-saving treatments must be administered in New York because New York will not permit third parties to decide whether treatment is in the patient's best interests.²⁰⁵ Missouri also ignores evidence that is not clear and convincing. It apparently relies, instead, upon the *Cruzan* balancing test to dictate the treatment decision.²⁰⁶

The Missouri Supreme Court provided an indication of how rigorously an informed refusal standard might be applied. After Judge Robertson concluded that the right of autonomy reflected in the doctrine of informed consent logically ought to include the right of informed refusal,²⁰⁷ he also concluded that the capacity, voluntariness, and information requirements for informed consent should govern informed refusal as well.²⁰⁸ As informed consent ordinarily requires "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,"²⁰⁹ he concluded that patient preferences expressed in advance of the

203. Some scholars doubt the wisdom of respecting past preferences. See *infra* text accompanying notes 275–310.

204. Once proven, patient wishes may be entitled to substantial deference in New York. *In re Westchester County Medical Center*, 72 N.Y.2d 517, 534 N.Y.S.2d 886, 531 N.E.2d 607 (1988). In Missouri, however, even clearly proven wishes may be limited by the state's interest in the preservation of life. *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (en banc), cert. granted sub nom. *Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989).

205. *Westchester*, 72 N.Y.2d 517, 534 N.Y.S.2d 886, 531 N.E.2d 607. The court emphasized the possibility that the patient may have changed his mind and the danger that the statements were made without the resolve that should be brought to bear on the issue. Thus, it required evidence of a firm and stated commitment about treatment under circumstances like those at issue sufficient to indicate that a change of heart was unlikely. *Id.* at 530–31, 534 N.Y.S.2d at 892, 531 N.E.2d at 613.

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

207. *Id.* (relying on *Conroy*). Without consent, the physician has committed a battery. *Id.* at 416–17.

208. *Id.* at 417 (citing *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985)).

209. *Id.* (quoting 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)).

onset of disease are not adequately informed. He stated that "it is *definitionally impossible* for a person to make an informed decision—either to consent or to refuse—under *hypothetical* circumstances; under such circumstances, neither the benefits nor the risks of treatment can be properly weighed or fully appreciated."²¹⁰

Although other courts had made the analogy to informed consent before, and even acknowledged the relevance of remoteness and specificity to the probative value of the past statements,²¹¹ none had carried its implications as far. Applying this standard to the facts before the court and refusing to consider evidence of Nancy Cruzan's lifestyle and values, Judge Robertson concluded that the "statements attributable"²¹² to Nancy Cruzan were "unreliable for the purpose of determining her intent."²¹³ Judge Robertson's skepticism about the propriety of basing decisions on the patient's prior "hypothetical" statements has far-reaching implications. If it were applied literally in future cases, it would jeopardize virtually all advanced directives that did not comply with a living will statute. And if the logic of this viewpoint were fully accepted, the wisdom of the living will statutes would itself be questioned.

Although the degree of Judge Robertson's skepticism about respecting "hypothetical" past preferences is unprecedented in the courts, with the possible exception of New York, it is not entirely unexpected. Professor Laurence Tribe, for example, concludes that "treatment decisions which are based on preferences expressed *prior* to the onset of . . . disability may strain the concept of self-determination beyond coherence."²¹⁴ He continues by stating that "it is hard to be confident that a person who does not experience a disability will be able to predict accurately the decision he would make if he actually were suffering the disability."²¹⁵ Nonetheless, Tribe concludes that these past preferences are probably the best approximation of what the patient would have decided after illness.²¹⁶ Robertson, however, suggests that they are irrelevant.²¹⁷

210. *Cruzan*, 760 S.W.2d at 417 (emphasis added). The court also quotes *Conroy* favorably for the conclusion that "it is naive to pretend that the right to self-determination serves as the basis for substituted decisionmaking." *Id.* at 415. For further discussion of the autonomy roots of substituted decisionmaking, see *infra* text accompanying notes 316–19.

211. *E.g.*, *In re Westchester County Medical Center*, 72 N.Y.2d 517, 531 N.E.2d 607 534 N.Y.S.2d 886, (1988) (observing that patients may change their minds); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

212. *Cruzan*, 760 S.W.2d at 424.

213. *Id.* He based his conclusion on the casual and general nature of her comments as well as their remoteness in time and circumstances.

214. L. TRIBE, *supra* note 52, at 1599 n.29 (emphasis in original).

215. *Id.*

216. *Id.*

217. Judge Robertson also mistakenly equated the patient's right to information, as embodied in the tort doctrine of informed consent, with the patient's underlying right to decline unwanted care. The patient's right to decline treatment does not depend on the adequacy of his information. Competent patients may, for religious or more eccentric reasons, refuse to hear the relevant facts about a recommended surgery. Even if they could be forced to sit through disclosure, they could not be forced to listen. Yet, the surgery may not be performed against their wishes, even if it would save their lives. The informed consent (and refusal) doctrine was not developed to limit patient autonomy, but to protect it. It imposes an obligation upon health care providers, not a restriction upon patients. While physicians must attempt to provide their patients with the information necessary to make their decision, it is up to patients how, or even whether, to process this information. The right to information should not be confused with the underlying right to refuse medical treatment.

This distinction between the right itself and the corollary ideal of a fully informed decision is crucial in evaluating the advanced directives of previously competent patients. If they were still competent, we would insist that their physicians offer them full information about the alternative treatment options. But these patients are no longer competent.

In contrast to New York and Missouri, many other jurisdictions use all of the available evidence. Reliance upon a patient's past preferences, lifestyle, and values, even when they fall short of informed refusal, is commonly called "substituted judgment."²¹⁸ Not surprisingly, both courts²¹⁹ and legislatures²²⁰ have widely endorsed substituted judgment as a means of respecting the interests of patients who are currently unable to express their wishes. Although its usage is not uniform, the doctrine generally requires a court to determine, as best it can, what the patient would want if competent to make the decision himself.²²¹ To determine this, some courts, like those in Massachusetts, consider all relevant evidence, including information about the benefits and burdens offered by treatment and also any available evidence of patient values and preferences. The effort to ascertain and respect patient preferences, therefore, blends seamlessly into a patient-centered, best interests analysis.

New Jersey has taken an intermediate position. In the three-tiered analysis enunciated in *Conroy*, past preferences govern conclusively only if they are clearly and convincingly established.²²² When the evidence is trustworthy but not clear and convincing, this evidence of the patient's subjective wishes must be combined with evidence of the patient's objective interests. Treatment may only be withheld if it is clear that the burdens of continued life with treatment outweigh the benefits of that life. The final tier of this progression governs decisions that must be made in the absence of any trustworthy evidence of the patient's wishes. Revealing its uneasiness with objective interest analysis, the court authorized the withholding of life-sustaining medical care from these patients only when the patient is terminal and the administration of treatment would be inhumane.²²³

New Jersey's three-tier classification is more structured and more cautious than the blending approach in Massachusetts. In Massachusetts, borderline subjective evidence could conceivably combine with and reinforce borderline evidence of objective best interests to suggest rather clearly the appropriate treatment decision. In

Thus, we already have the only information that we will be able to obtain about their wishes. Unlike currently competent patients, we cannot insist upon a better disclosure and an improved patient decision. *See Cruzan*, 760 S.W.2d at 417.

218. *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); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983); N. CANTOR, *supra* note 170, at 64; J. ROBERTSON, *supra* note 44, at 51.

219. *See infra* note 221.

220. *E.g.*, Gelfand, *supra* note 13, at 791. *See* TEX. REV. CIV. STAT. ANN. art. 4590(h), § 4C (Vernon Supp. 1989) (do what patient would desire).

221. *See, e.g.*, *In re Spring*, 380 Mass. 629, 634, 405 N.E.2d 115, 119 (1980); *Conroy*, 98 N.J. at 360, 486 A.2d at 1229; *In re Jobes*, 108 N.J. 394, 415, 529 A.2d 434, 444; *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417; Dresser, *supra* note 167, at 377. The doctrine is sometimes extended to include the decisionmaker's attempt to put herself in the shoes of a patient whose past wishes are unknown. *Saikewicz*, 373 Mass. at 751, 370 N.E.2d at 430-31. But John Robertson correctly suggests that is less confusing to describe this as patient-centered interest analysis. J. ROBERTSON, *supra* note 44, at 51. The discussion in this section refers only to the narrower conception of substituted judgment in which the decisionmaker relies on the past preferences, values, or personality of a previously competent patient.

222. *Conroy*, 98 N.J. at 360, 486 A.2d at 1229.

223. The eligible patients are those with less than a year to live who will suffer severe pain. *Conroy*, 98 N.J. at 363, 486 A.2d at 1231. Its exclusive focus on pain for best interest assessments is overly restrictive. Annas, *When Procedures Limit Rights: From Quinlan to Conroy*, HASTINGS CENTER REP. 1985, at 24, 26. Apr. These requirements do not apply to patients who are comatose or vegetative. *In re Peter*, 108 N.J. 365, 374-75, 529 A.2d 419, 424 (1987); *In re Jobes*, 108 N.J. 394, 443, 529 A.2d 434, 443 (1987).

New Jersey, however, no treatment may be withheld unless one category of evidence or the other is clear and convincing. Thus, the two jurisdictions set quite different thresholds at which blending will authorize nontreatment, but both approaches share a fundamental similarity. Both use all of the available evidence to permit withholding when the subjective evidence alone would not otherwise satisfy the court.

This full use of all the available evidence better reconciles the patients' interests in autonomy and well-being with the state's interest in avoiding error and abuse than the compartmentalization required in New York and Missouri. Aggregation of the evidence maximizes respect for the patient by considering all trustworthy evidence of how the patient would have decided.²²⁴ It also better advances the interests of these patients in making a medical decision which maximizes their welfare.²²⁵ When proxies make treatment decisions in the absence of clear directives, they must inevitably make value judgments about the desirability of further treatment under the patient's current circumstances.²²⁶ When the proxy considers the patient's past preferences, values, and conduct, the proxy's judgments are more likely to reflect the patient's values, thus advancing the patient's interests as the patient would have perceived them. As will be discussed further below, no bright line identifies the point when autonomy-based respect for past preferences turns into patient-centered best interest analysis.²²⁷ Trustworthy, but inconclusive, evidence of patient wishes stands in the transition zone and raises both autonomy and welfare considerations. Simultaneous consideration of all subjective and objective evidence reflects this interrelationship between the patients' interests in control over their future medical care and their interest in treatment decisions that advance their welfare. As a result, a blending test better accommodates patient interests than an approach which separately examines consent and welfare.

Use of the combined objective and subjective evidence accomplishes this without unduly increasing the risk of error. It does not bind the decisionmaker to automatic reliance on scanty evidence of the patient's preferences. The weight of this evidence is still determined by such factors as its remoteness, thoughtfulness, completeness, specificity, and consistency.²²⁸ Yet, blending maximizes the chances of advancing the patient's interests by drawing upon the combined probative value of both objective and subjective proof. For example, a tentative decision that the withholding of treatment would be in a patient's current interests is more confidently implemented if the available evidence indicates that the patient would have agreed. The same reinforcement can occur when the available evidence suggests that a patient

224. See N. CANTOR, *supra* note 170, at 64 (the effort is dictated by respect for autonomy); PRESIDENT'S COMMISSION, *supra* note 4, at 136.

225. While New York refuses to permit proxies to make best interest decisions, preferring instead to mandate treatment in the absence of clear directives, and Missouri apparently uses its own balancing test to decide these cases, many, perhaps most, other jurisdictions use a patient-oriented best interests standard when evidence of a patient's wishes is unavailable to protect that patient's welfare. See *infra* notes 241, 331.

226. See *infra* text accompanying notes 261-64 (discussing the subjectivity of best interest analysis).

227. See *infra* text following note 318 (discussing the transition from clear wishes to unclear wishes and general values).

228. See *supra* text accompanying note 177.

would have refused treatment and the objective evidence strongly confirms the rationality of that choice. Combined consideration can also reinforce preliminary conclusions in favor of treatment, such as borderline findings that the patient would have wanted treatment or that treatment would advance the patient's interests. The two kinds of evidence can, therefore, be mutually reinforcing in a way that minimizes the risk of error and maximizes the prospect that the patient's interests will be served.

The same treatment decision might not result if the two categories of proof were considered separately. In that event, the practice of erring on the side of life might first dictate disregard of evidence about patient preferences that is not clear and convincing. The preference for treatment would then support continued treatment in the absence of clear and convincing evidence that treatment impairs the patient's interests. Yet, each category of evidence may suggest that withholding would better serve the patient's interests and the two together may be sufficiently reliable to justify a decision to withhold treatment. Failure to consider all of the evidence simultaneously, therefore, can increase the risk of error.²²⁹ Thus, the state's interest in accurate ascertainment of patient wishes supports blending, rather than separate evaluation of the subjective evidence. At most, the presumption in favor of life justifies a sliding scale requiring greater evidence of objective benefit as the evidence of subjective intent to refuse treatment weakens.

However, the temptation to overprotect the patient through analogies to informed consent and tough burdens of proof may be difficult to resist as it follows predictably from several factors. First, the law loves classification. As a result, subjective evidence of patient wishes is habitually examined separately from the evidence of patient interests. The apparent assumption is that this approach offers patients maximum protection. As discussed above, however, that compartmentalization actually weakens the reliability of the decisionmaking process and is biased toward unnecessary treatment against patient interests.

Second, "judges show caring with legal procedures."²³⁰ Their desire to protect patients is vital to a safe society, but the propriety of using procedural restrictions to manifest that concern should not be taken for granted. In some instances, those restrictions are likely to cause more harm than they prevent.²³¹

Finally, substituted judgment has its own disadvantages which may explain some judicial resistance to combining objective and subjective evidence. Proxy decisionmakers often must attempt to deduce a treatment decision from behavior and comments not directly intended for that purpose. Extrapolating a treatment decision

229. Simultaneously considering both subjective and objective evidence has advantages even when the evidence of patient wishes indicates a treatment decision contrary to that suggested by the decisionmaker's perception of the patient's current interests. Simultaneous consideration permits the decisionmaker to compare the relative reliability of both categories of evidence. See *infra* text following note 318 for a further discussion of the conflict between patient wishes and welfare under these circumstances.

230. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375, 436 (1988).

231. The *Conroy* trial court acknowledged this: "Of course, once we human beings start making choices we start making mistakes. It is inevitable that we will allow some people to die when we could have and should have prolonged their lives. But we cannot let this fear of error force us into abdicating our basic human responsibility to make choices." *In re Conroy*, 188 N.J. Super. 523, 529, 457 A.2d 1232, 1236, *rev'd*, 190 N.J. Super. 453, 464 A.2d 303 (1983), *rev'd*, 98 N.J. 321, 486 A.2d 1209 (1985).

from this evidence often is difficult, even if information about the patient's current interests is considered as well. Because the decisionmaker inevitably possesses a greater degree of discretion in making these decisions than he does when a clear advanced directive has been given, the potential for error or abuse is accentuated. Therefore, these cases may warrant greater supervision by the state.

But these risks do not dictate that trustworthy evidence of patient wishes be totally disregarded. Because of the material differences between presently competent and previously competent patients, insistence on clear and convincing proof of an incompetent patient's informed refusal is inappropriate. Unlike competent patients, presently incompetent patients cannot remedy the shortcomings in proof. They cannot reconfirm their wishes after a waiting period or counseling. They cannot rephrase their wishes more precisely or formally. To ask as much is to demand foresight humans do not possess.²³² Nor can they reconfirm their continued adherence to remote statements. To ask as much is to conclude in advance that virtually all past preferences, including many specifically intended to direct future medical care, will be disregarded. Ordinary people do not communicate their wishes in a manner designed to convince skeptical judges. They discuss their beliefs casually and spontaneously.²³³ To ignore this evidence, as Missouri and New York do, will too often subject the patient to unwanted treatment and unnecessary harm.²³⁴

While wrongfully shortening a patient's life is a more serious error than wrongfully treating the patient, Nancy Rhoden correctly notes that "we must not forget that continued treatment can cause pain to patients who feel pain, can bring anguish to those capable of emotional suffering, and can violate the prior wishes of those who feel neither."²³⁵ While conservative courts correctly insist that decision-

232. See *In re Westchester County Medical Center*, 72 N.Y.2d 517, 534 N.Y.S.2d 886, 531 N.E.2d 607 (1988) (Simons, J., dissenting).

233. See *id.* at 551, 534 N.Y.S.2d at 905, 531 N.E.2d at 626 (Simons, J., dissenting); Rhoden, *supra* note 230, at 392 n.75. See also *In re Jobs*, 108 N.J. 394, 529 A.2d 434 (1987).

234. The disadvantages of overemphasizing the analogy to informed consent probably helps explain why so few living will statutes share Judge Robertson's skepticism about "hypothetical" advanced directives. In 1988, only the Oklahoma and California living will statutes had provisions distinguishing between advanced directives executed *after diagnosis* of a terminal illness (binding on future health care) from those executed *before diagnosis* (merely advisory). Gelfand, *supra* note 13, at 765 (citing CAL. HEALTH & SAFETY CODE § 7191(b) (West Supp. 1976)); *id.* at 770, 794 n.254 (citing OKLA. STAT. ANN. tit. 63, § 3107(B)-(C) (West 1985, 1987)). California's statute also requires that living wills be renewed every five years. CAL. HEALTH & SAFETY CODE § 7189.5 (West Supp. 1989). At one time, the Wisconsin, Idaho, and Georgia statutes also provided for periodic renewal, but all of these provisions were deleted in 1986. Gelfand, *supra* note 13, at 765. No other state has enacted either an expiration period or a distinction between prediagnosis and postdiagnosis directives. Instead, the great majority of states have been satisfied with the protection provided by their revocation provisions for patients whose feelings do change with the passage of time. See *id.* at 766. Ordinarily, these provisions permit revocation without the formalities required for execution. *Id.* For example, they need not be witnessed or in writing. In some states, the patient need not be competent to revoke a living will. As Professor Gelfand notes, this presents the problem that an incompetent patient can revoke, but not effectuate, a living will. *Id.*

Legislatures could consider Professor Gelfand's suggestion that documents over 10 years old become advisory unless renewed. *Id.* at 768 n.125. But his suggestion would produce a substantial amount of uncertainty and litigation which seems unlikely to change any outcomes. Because the current revocation rules seem adequate to handle cases of changed intent, there is no good reason to restrict or diminish the effect of advanced directives by patients who are not ill at the time they express their wishes. Professor Gelfand has also proposed that the courts have authority, similar to *cy pres*, to modify living wills based upon unforeseeable circumstances which dictate that the document not be followed. *Id.* at 794 n.254.

235. Rhoden, *supra* note 230, at 436. Professor Rhoden correctly notes that procedures seeking to eliminate all

making standards be designed to minimize error,²³⁶ that goal is better reconciled with patient autonomy and welfare by simultaneously considering all of the available subjective and objective evidence than by strictly enforcing an “informed refusal” standard.

Unless a court completely rules out the use of objective evidence of a patient’s best interests, as New York has done,²³⁷ the difficult question is not whether to blend, but what standards of proof to impose on the consolidated evidence and upon whom to impose them. At one end, New Jersey requires not only that the combined evidence be clear and convincing, but also that the objective evidence be independently clear and convincing. Most other courts require only that the combined evidence be clear and convincing proof. But few really insist upon it. Insistence on this stringent proof requirement would discriminate against incompetent patients by regularly mandating treatment that was unwanted. Thus most courts in practice require a more traditional showing and defer substantially to the assessments of family members or guardians personally familiar with the patient. These proxies are likely to understand the patient’s values and preferences in ways too subtle for “clear and convincing” articulation in court. Some courts have never imposed this difficult burden of proof at all.²³⁸ Thus, Professor Rhoden has even suggested that the burden of proof be shifted to those who challenge a family’s treatment decision.²³⁹

The choice of a standard along the continuum between Rhoden and New Jersey depends largely on the confidence placed in decisionmaking by family members and guardians. The less likely the perceived danger of error or abuse by these decisionmakers, the greater the net harm from strict proof or procedural requirements and the stronger the case for approving the best judgment which the proxy decisionmaker can make from the combined evidence. Whatever the standard chosen, it should permit consolidation or blending of the objective and subjective evidence.

III. PROTECTING PATIENT WELFARE

A second component of the state’s interest in the preservation of life is its interest in advancing and protecting the *welfare* of its citizens. Founded on the

wrongful terminations will create many more wrongful continuations. *Id.* at 434–36. She proposes a legal presumption in favor of the choice of a close family member. *Id.* at 437.

236. In analyzing this tension between avoiding erroneous withholding and respecting patient wishes, conservative courts have emphasized the patient’s right to life and insisted that waiver of that right meet standards suitable to the waiver of important personal interests. For example, Judge Robertson discusses the waiver of other constitutional rights. *Cruzan v. Harmon*, 760 S.W.2d 408, 425 (Mo. 1988) (en banc), *cert. granted sub nom. Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989) (discussing delegation of exercise to third parties); *In re Westchester County Medical Center*, 72 N.Y.2d 517, 530, 534 N.Y.S.2d 886, 892, 531 N.E.2d 607, 613 (1988).

237. Rhoden, *supra* note 230, at 375–77.

238. *See supra* note 176 (cases imposing clear and convincing burden of proof). Courts declining to impose this burden include California and Washington. *In re Drabick*, 200 Cal. App. 3d 185, 211, 245 Cal. Rptr. 840, 856, *cert. denied*, 109 S. Ct. 399 (1988); *In re Ingram*, 102 Wash. 2d 827, 842, 689 P.2d 1363, 1371 (1984) While *Colyer* required clear and convincing evidence of prognosis in the case of a vegetative patient, *Ingram* did not impose this burden of proof on a proxy’s decision that nontreatment would serve the patient’s interests.

239. Rhoden, *supra* note 230, at 437. Joseph Goldstein reached similar conclusions some time ago. *See* Goldstein, *Medical Care for the Child at Risk: On State Supervention of Parental Autonomy*, 86 YALE L.J. 645 (1977).

principle of beneficence,²⁴⁰ this state interest has special poignancy when a patient's life is at stake. The state's interest in protecting patient well-being constitutes a second reason why the state may have an interest in preserving the lives of seriously ill patients. It justifies measures to protect patients from death due to error or abuse in the ascertainment of their interests.

The strongest cases for state intervention to protect patient welfare involve patients who are currently incompetent and whose past preferences are unknown. The state's responsibility to protect incompetent individuals is embodied in the *parens patriae* doctrine and has been applied to incompetent patients needing medical treatment.²⁴¹ But the state's interest in protecting patient welfare is not necessarily limited to incompetent patients whose wishes are unknown. The principle of beneficence arguably justifies treating patients against their past or present wishes if doing so is perceived by the decisionmaker to be in the patients' overall, long-term best interests.²⁴²

To the extent that the state interest in life incorporated in the *Quinlan* and *Cruzan* balancing tests reflects a paternalistic desire to protect patient welfare, the legitimacy of these tests depends on two considerations: (1) the adequacy of the state's interest in patient welfare as a basis for requiring treatment when the patient's wishes can be ascertained, and (2) the suitability of the *Quinlan* and *Cruzan* balancing formulas as barometers of patient welfare.

A. Conflicts Between Autonomy and Welfare

As the *Cruzan* opinion suggests, in recent years courts have routinely subordinated the state's interest in the preservation of life to the patient's interests in autonomy. In doing so, they have implicitly elevated autonomy over an "objective" third-party assessment of the patient's best interests. Living will statutes reflect the same deference to autonomy, at least under the circumstances covered by the various state statutes. Neither the case law nor the statutes generally permit deviation from the patient's instructions on the basis of the patient's interests.

But this consensus is relatively recent. The pre-*Quinlan* cases reveal much less

240. Ethicists have long recognized a principle of beneficence that obligates health care providers to protect and advance a patient's well-being. T. BEAUCHAMP & J. CHILDRESS, *supra* note 151, at 143; Dresser, *supra* note 167, at 383. The Hippocratic tradition obliges the physician to benefit the sick and protect them from their own indulgences. J. CHILDRESS, WHO SHOULD DECIDE: PATERNALISM IN HEALTH CARE 39-43 (1982). In addition, the physicians' instincts for intervention are fueled by their training to fight disease and death. To a great extent, our society continues to foster this paternalism. As Willard Gaylin has observed, patients commonly abandon themselves to their doctors and, in so doing, have given paternalism greater respectability in the medical setting than it enjoys in other places. Gaylin, *Who Speaks for the Child*, in WHO SPEAKS FOR THE CHILD: THE PROBLEMS OF PROXY CONSENT 3, 21 (W. Gaylin & R. Macklin eds. 1982). Paternalism, noted James Childress "is not merely assumed, it is assigned." J. CHILDRESS, *supra*, at 46. Health care providers will often be tempted to meet patient's needs as the providers perceive them even if the patient disagrees. The principle of beneficence supports and explains their desire to intervene. *Id.* at vii-viii.

241. *In re Conroy*, 98 N.J. 321, 364-65, 486 A.2d 1209, 1231 (1985); *In re Storar*, 52 N.Y.2d 363, 381, 438 N.Y.S.2d 266, 275, 420 N.E.2d 64, 73, *cert. denied*, 454 U.S. 858 (1981). Although there is disagreement about the best method of ascertaining and protecting an incompetent patient's best interests, a substantial consensus supports the effort to do so when the patient's past preferences are unknown. *E.g.*, *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983); *Conroy*, 98 N.J. 321, 486 A.2d 1209. Only New York expressly refuses to engage in best interests analysis. *In re Westchester County Medical Center*, 72 N.Y.2d 517, 534 N.Y.S.2d 886, 531 N.E.2d 607 (1988).

242. See J. CHILDRESS, *supra* note 240, at vii-viii, 39-43.

unanimity. On one side are the courts that refused to order treatment and explicitly subordinated state paternalism to autonomy.²⁴³ A few even characterized the state's proper role in our system of government as the protection of patient choice.²⁴⁴ In contrast to this view, however, the cases mandating treatment strongly suggested a judicial willingness to mandate life-saving treatment, especially when a single medical intervention, like a blood transfusion, seemed very likely to produce a cure. These courts looked desperately for a basis to intervene. While they sometimes based intervention on the state's interest in preserving medical ethics²⁴⁵ and protecting minor children,²⁴⁶ these additional rationales often seem like convenient supplements for a decision that would have been made in any event. Trial courts were understandably reluctant to let a curable person die, especially if the trial judge lacked time to research and reflect upon his decision.²⁴⁷ Concerns about patient competency and equivocation clearly surface in many of these cases, but it is hard to shake the sense that these concerns were partly fueled by doubts that refusal served the patient's interests and by a belief that the courts ought to protect those interests.

Yet, no court expressly relied on this paternalistic rationale. While the *Quinlan* balancing test seems implicitly to reflect the state's interest in patient welfare, it, too, was formulated without explicit reliance on a patient welfare rationale. Perhaps this omission should not be surprising. A patient welfare rationale would be inconsistent with the notions of autonomy and bodily integrity underlying the informed consent doctrine. Nevertheless, it is tempting to speculate that the *Quinlan* test owes some of its broad initial appeal to its intuitive correlation with objective patient welfare. Under the *Quinlan* test, the state's interest in mandating treatment diminishes as patient prognosis declines and treatment burden increases. Most competent and rational patients would consider these same factors to decide whether the treatment would be worthwhile. Because their interests in treatment will wax and wane with their overall prognosis and the burden of treatment, so too will the state's benevolent interest. As a result, the state's interest in protecting patient welfare (unlike the state's interest in protecting patient autonomy) may be well served by a waxing and waning approach such as the *Quinlan* test.²⁴⁸

Indeed, after *Quinlan*, most observers believed that patients who were terminal and suffering had more liberty to refuse treatment under the *Quinlan* balancing tests

243. *E.g.*, *In re Osborne*, 294 A.2d 372 (D.C. 1972); *Erickson v. Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (Sup. Ct. 1962).

244. *Osborne*, 294 A.2d at 375 n.5; *Erickson*, 44 Misc. 2d at 28, 252 N.Y.S.2d at 706.

245. *United States v. George*, 239 F. Supp. 752, 754 (D. Conn. 1965).

246. *E.g.*, *Application of President of Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964).

247. Most of the cases reveal the concerns of trial judges about the need to make life-or-death decisions in emergency circumstances.

248. See Capron, *supra* note 34, at 659. A potential shortcoming of this test as a proxy for the best interests of competent patients is its failure to take explicit account of the harm caused by violating their wishes. That problem could be cured either by interpreting the test to include the violation of autonomy as a burden associated with treatment or by weighting the scales more heavily against the state when patient autonomy is involved. Thus, prognosis would have to be better or treatment burden lesser to justify treatment of a competent person against his wishes than treatment of an incompetent patient whose wishes are unknown.

than patients who were salvageable.²⁴⁹ Of course, subsequent applications of the test rebutted that assumption; instead, courts routinely permitted all patients to refuse medical treatment. But even now, most courts refuse to concede an unqualified right to decline medical treatment. Instead they typically retain a balancing test, often the *Quinlan* test, thereby reserving the flexibility to permit intervention in an extreme case. Massachusetts, for example, suggested that a person with a curable condition might not be able to refuse oral medications.²⁵⁰ Another example of this temptation to limit deference to patient wishes is found in at least one restrictive living will statute, which gives providers discretion to treat a patient against his expressed preferences if they have "serious reason therefor consistent with the best interest" of the patient.²⁵¹ More recently, the temptation to make a paternalistic assessment of the patient's interests reappears in a few cases like *In re Estate of Dorone*,²⁵² where the trial court ordered blood transfusions for a Jehovah's Witness whose medic alert card reputedly gave contrary instructions. And even in jurisdictions which doctrinally preclude paternalistic intervention, the exercise of fact-finding discretion on issues like patient competence and proof of past preferences is surely influenced by beliefs about the patient's current interests.²⁵³

These examples collectively illustrate the persistent urge to overrule patient wishes regarding life-sustaining treatment when they seem clearly wrong or irrational from the decisionmaker's point of view.²⁵⁴ This urge may reflect a number of underlying concerns. First, there is more reason to doubt the patient's competence and informed consent when the treatment decision seems illogical. Objective welfare may, thus, serve as a tentative gauge of the quality of patient autonomy. As discussed in Part II, this evidence justifies greater scrutiny of some patient decisions and even the use of weak paternalistic measures such as psychiatric evaluation or cooling off periods to ensure patient competence, seriousness, access to information, and free will. The objective of these measures is to confirm that withholding actually does reflect the patient's competent assessment of her own interests. These measures, therefore, serve as a bridge between the state's interest in correct ascertainment of patient wishes and its interest in patient welfare.²⁵⁵ In fact, the two concerns may be hard to separate in individual cases.

249. N. CANTOR, *supra* note 170, at 1-4, 16, 44; J. ROBERTSON, *supra* note 44, at 34-35. The AMA took a similar stance. Rachels, *Active and Passive Euthanasia*, 292 NEW ENG. J. MED. 78, 78 (1975). The AMA sanctioned nontreatment of terminal patients facing extraordinary treatment.

250. *Commissioner of Corrections v. Myers*, 379 Mass. 255, 399 N.E.2d 452 (1979). After *Brophy*, the court may no longer adhere to this view. *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986). Even before *Brophy*, Massachusetts seemed unclear of the rationale for its rule. In *Lane*, for example, it suggested that the wisdom of the patient's choice was not at issue. *Lane v. Candura*, 6 Mass. App. Ct. 377, 383, 376 N.E.2d 1232, 1236 (1978).

251. MO. REV. STAT. §§ 459.025, .045(1) (1986).

252. 349 Pa. Super. 59, 502 A.2d 1271 (1985). Other cases include *Crouse-Irving Memorial Hosp. v. Paddock*, 127 Misc. 2d 101, 485 N.Y.S.2d 443 (Sup. Ct. 1985) and *University of Cincinnati Hosp. v. Edmond*, 30 Ohio Misc. 2d 1, 506 N.E.2d 299 (C.P. 1986).

253. See *In re Westchester County Medical Center*, 72 N.Y.2d 517, 538, 531 N.E.2d 607, 618, 534 N.Y.S.2d 886, 897 (1988) (Hancock, J., concurring).

254. See also *supra* note 71 (cases restricting state's interest in suicide to irrational preference for death).

255. See J. CHILDRESS, *supra* note 240, at 167.

But once concerns about patient autonomy have been resolved, continued intervention requires a different rationale.²⁵⁶ Any further intervention will thwart patient autonomy, not protect it. Yet, the *Quinlan* and *Cruzan* balancing tests clearly dictate treatment in some cases, even if patient preferences are clearly established.²⁵⁷ As a result, the tests seem to presuppose some additional state interest. One possibility is a beneficent state interest in patient welfare. This interest would support intervention to oppose “illogical,” though competent, refusals of treatment.²⁵⁸ Another is a state interest in opposing self-destructive or suicidal acts, sometimes associated with the state’s interest in the “sanctity of life.” This Part considers the state’s interest in patient welfare. The state’s interest in the sanctity of life is considered in Part IV.

1. *The Preference for Autonomy*

The unwillingness of any courts which have recently ordered treatment to admit that they are elevating well-being over autonomy or to rely expressly on well-being as a justification for intervention certainly supports the conclusion that even these courts view intervention to protect patients against themselves as doctrinally, if not emotionally, inappropriate. In law and ethics, autonomy has gained stature over the past few decades while at the same time support for paternalistic supervision of individual choice has eroded.²⁵⁹ The current judicial and legislative trend assigning a priority to autonomy over well-being probably has two principle explanations. First, the patient is believed to be the best judge of his own interests. For this reason, the supposed conflict between autonomy and well-being may be false. Second, our

256. A preference for death can be rational, especially in patients affected by a debilitating disease, in the sense that the patient is competent and that her calculus is within reason. See J. ROBERTSON, *supra* note 44, at 28. Conceivably, some patients, like suicidal individuals, may be overemphasizing short-term problems and discounting long-term possibilities. If so, they may someday realize their misjudgments and thank us for our intervention, thereby ratifying our interference with their autonomy. But the ratification defense of paternalistic intervention has two shortcomings. First, its probabilistic and speculative nature would permit widespread abuse by providers and courts who simply disagree with the patient and prefer aggressive treatment. Second, in presently competent patients, the possibility of patient ratification can be adequately addressed by delay or short-term counseling requirements. A patient who continues to refuse treatment after counseling is unlikely to thank us for requiring further treatment. Without strict time limits, the ratification argument could serve as an illegitimate proxy for a more deep-seated desire to force the patient to accept a third-party’s assessment of her interests. Long-term intervention of this nature presents the risk of coercion to change a patient’s deep-seated values, rather than an effort to return her to an emotional equilibrium. Yet, autonomy would have little meaning if its exercise were conditioned on the acceptance of majority values. See *In re Gardner*, 534 A.2d 947, 955 (Me. 1987).

257. The extreme cases could arguably have been perceived as so likely to involve incompetence as to make case-by-case adjudication unworthwhile or unreliable. But no court used this rationale to defend an *irrefutable* presumption.

258. While beneficence is probably the most significant justification for protecting competent patients from their own errors in judgment, other related explanations are also possible. For example, society may have an independent interest in avoiding the waste of its human resources. This possible explanation for intervention reflects a broader utilitarian orientation than the principle of beneficence as I have described it. In addition, some advocates of intervention may doubt human moral authority to abandon a life worth living, not merely because it wastes social assets but because it reflects a disrespect for the sanctity of life. This objection has obvious roots in a principle rejecting the intentional hastening of death under any circumstances. Here, however, it is limited to the acquiescence in death when life is objectively worthwhile. For a further discussion of these moral objections, see *infra* Part IV.

259. Wanzer, *supra* note 50, at 844 (noting public acceptance of patient choice); *In re Jobes*, 108 N.J. 394, 418 n.11, 529 A.2d 434, 446 n.11 (1987) (same). The spread of living will statutes suggests this as well.

society endorses notions of individualism that elevate autonomy over well-being in the hierarchy of values.²⁶⁰

Well-being is a subjective state. The value placed on extended life under adverse medical conditions is an intimately personal and subjective decision. Concepts such as dignity and privacy have very different meanings for different individuals.²⁶¹ In addition, a patient's faith may influence his acquiescence in or resistance to disease.²⁶² Often, there will be no consensus about the value of life or the burden of treatment in a vegetative state, with advanced deteriorative disease or in other similarly catastrophic circumstances.²⁶³ Deferring to the patient's own wishes and values is more appropriate than imposing highly contested judicial or social values.²⁶⁴ Not only is forced treatment itself likely to impair the patient's subjective interests, but the continuation of treatment over her objections imposes additional injury by disrespecting her wishes. Because these decisions are subjective, the state's interest in protecting patient well-being will tend to merge with the state's interest in protecting patient preferences.

A recent Florida case clearly exemplifies the injuries that may follow from court-ordered treatment.²⁶⁵ In that case, a competent patient had been administered blood against her wishes. On appeal, the Chief Justice of the Florida Supreme Court rebuffed the suggestion of some members of the court that the blood transfusions were justified because they would return her to a normal life. "Receiving a blood transfusion is a serious sin for someone of her faith," he correctly observed. "After the transfusion she must live with the knowledge of that sin, and, because she has a recurring condition, she must also live with the knowledge that should she again become critically ill, she may again be forced to receive blood."²⁶⁶ She must live with the knowledge that her spiritual life has been endangered. For her, the risk of death was preferable.

Deference to patient wishes not only advances patient interests, but it also respects the dignity and worth of the patient.²⁶⁷ Marjorie Shultz points out that "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."²⁶⁸ Because patient autonomy is

260. See J. CHILDRESS, *supra* note 240, at 73.

261. Dresser, *supra* note 167, at 387; Jennings, *The Limits of Moral Objectivity*, HASTINGS CENTER REP., JAN./FEB. 1989, at 19, 20.

262. See Application of President and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964).

263. See L. TRIBE, *supra* note 52, at 1369; *Jobes*, 108 N.J. at 440, 529 A.2d at 458 (Handler, J., dissenting).

264. Several recent judicial opinions have explicitly recognized the subjective nature of medical decisionmaking. A recent Maine case, for example, noted that the patient had done his own balancing of values. *In re Gardner*, 534 A.2d 947, 955 (Me. 1987). "That personal weighing of values," said the court, "is the essence of self-determination." *Id.* And in Elizabeth Bouvia's case, the appellate court concluded that her decision to forego medical treatment raised moral and philosophical questions best left to her. *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1142-43, 225 Cal. Rptr. 297, 304-05 (1986).

265. *Public Health Trust of Dade County v. Wons*, 541 So. 2d 96 (Fla. 1989).

266. *Id.* at 100 (Ehrlich, J., concurring).

267. See J. CHILDRESS, *supra* note 240, at 55-73; PRESIDENT'S COMMISSION, *supra* note 4, at 26 (autonomy has both instrumental and intrinsic value).

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

particularly appropriate in the medical setting, no court has explicitly justified the imposition of unwanted treatment on a patient-welfare rationale.

As a result, it is not surprising that New Jersey has abandoned the emphasis on curability that was apparent in *Quinlan*.²⁶⁹ Likewise, New York has suggested that unconsented treatment will justify civil damage awards even if the treatment is beneficial or necessary to preserve life.²⁷⁰ Despite the natural and commendable temptation to intervene when patients are feared to be making a mistake, most courts recognize that the state will better respect patients' lives and protect patient interests by respecting their competent wishes. The majority of courts have properly concluded that the value of life is harmed more by denying a competent patient the right of choice than by respecting his decision to refuse treatment.²⁷¹ Put differently, they have elevated the state's interest in protecting patient autonomy over its interest in advancing the patient's objective well-being.

Two final implications of the state's interest in patient welfare deserve mention. First, this state interest is two-edged. It also would support the *withholding* of medical treatment from competent patients who desire treatment whenever the fact finder concludes that treatment is *not* in the patient's interests.²⁷² Although mandating life-saving treatment is obviously different from denying it, the principle of advancing patient welfare would equally support both kinds of interference with patient choice if the patient is not deemed the best judge of his own interests. Deference to autonomy, by contrast, protects the wishes of those who prefer to receive all treatments which they can afford that are likely to extend their lives.²⁷³

Second, judicial intervention based upon patient welfare inevitably obliges the court to assess the patient's quality of life. Thus, any effort to reinvigorate the state's interest in the preservation of life using a patient welfare rationale would pose a serious problem for the judges most inclined to breathe new vigor into this state interest. Only patients whose welfare requires continued treatment would be "protected" under a welfare-based view of the state's interest in life. Both *Brophy* and *Cruzan* tried to sidestep this quality of life problem by excising the patient's quality of life from direct consideration. As will be discussed below, however, this purported solution causes more harm than it avoids. Deference to patient autonomy, on the other hand, has the advantage of delegating these value judgments whenever possible to the patients.

Collectively, these characteristics of the state's interest in patient welfare cast

269. In *Quinlan*, the court distinguished *Heston* on the basis of the patient's prognosis and treatment burden. In *Conroy*, it reinterpreted *Heston* and the other early cases ordering medical treatment, emphasizing concerns about competence or equivocation. See *supra* notes 65-70 and accompanying text.

270. *In re Storar*, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273, *cert. denied*, 454 U.S. 858 (1981).

271. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 742, 370 N.E.2d 417, 426 (1977); *In re Gardner*, 534 A.2d 947, 955 (Me. 1987); *In re Conroy*, 98 N.J. 321, 347-48, 486 A.2d 1209, 1223-24 (1985); *Public Health Trust of Dade County v. Wons*, 541 So. 2d 96, 100 (Fla. 1989) (Ehrlich, J., concurring).

272. Cf. *Annas*, *supra* note 223, at 25 (suggesting more latitude to withhold painful treatment contrary to patient wishes than to order treatment over patient objections).

273. See *In re Conroy*, 98 N.J. 321, 366-67, 486 A.2d 1209, 1232 (1985) (patient wishes govern even if treatment seems inhumane).

grave doubt on the suitability of treating a competent patient against his wishes.²⁷⁴ The case against paternalistic treatment is strongest for patients who are currently competent. Competent patients can assess their contemporaneous interests better than anyone else. They can be provided with complete and current information about their prognosis and the treatment options. They can make their wishes as specific and formal as necessary to satisfy providers or courts. Some cases may even permit time for psychiatric evaluation of competency and for reflection. Thus, these decisions are likely to reflect the patients' subjective interests. At the same time, their current competence means that they will consciously suffer the violation of autonomy if treatment is rendered against their wishes.

The case for respecting *past* preferences, however, is much different. Given the differences between the circumstances of presently competent patients and those of previously competent patients, the discounting or even disregarding of *past* preferences may be more tolerable than the disregard of *current* patient preferences. That is the subject of the succeeding sections.

2. Clear Past Preferences

Even if respect for patient autonomy warrants deference to the wishes of currently competent patients, it does not necessarily dictate adherence to the past preferences of patients who are no longer competent. As the President's Commission observed, "[a]n advanced directive does not . . . provide self-determination in the sense of active moral agency by the patient on his or her own behalf."²⁷⁵ At the time of actual decision, these patients are incompetent and unable to participate actively in a decisionmaking dialogue with their health care providers and family.²⁷⁶ At a minimum, this absence of contemporaneous choice presents the dangers posed by "hypothetical" advanced directives, discussed above, and raises questions about the patient's intent to govern the particular treatment decision to be made. The less clearly applicable and informed the patient's last wishes, the less powerful the case for using them, rather than the patient's current interests, to make the treatment decision.

274. Several other kinds of state regulation serve as possible analogies for state intervention to protect citizen safety. Examples include seatbelt and helmet laws, suicide prevention and intervention programs, controlled substances laws, pharmaceutical regulation, and laws requiring aerial nets or barring snake-handling. See, e.g., Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 *FORDHAM L. REV.* 1, 7 (1975); Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 *RUTGERS L. REV.* 228, 246-49 (1973); Note, *supra* note 149, at 86. Space does not permit a detailed exploration of these laws, but most appear distinguishable in one of several respects. Some involve burdens to third parties, others raise suspicions of undue influence (snake-handling), incompetence (suicide), or powerlessness to protect oneself (drug laws and other consumer protection statutes). None involve invasions of bodily integrity similar to involuntary treatment and many only prohibit conduct, rather than mandate it. In addition, these other settings do not seem to provide the opportunity for convenient case-by-case consideration of individual wishes similar to that provided in patient treatment contexts.

The prohibition of slavery, even with the prior consent of the enslaved, is another possible analogy warranting more extended discussion. The prohibition against voluntary slavery is a very complex issue which seems likely to rest upon several factors not equally relevant to refusal of medical treatment such as the probability of coercion, the probability of future suffering and regret, and the evil societal effects of permitting commerce in humans.

275. PRESIDENT'S COMMISSION, *supra* note 4, at 137.

276. *Id.*

These objections play a role in the debate over the kind of proof which should be adduced before past preferences govern the treatment decision. That issue has already been considered in Part II. But the absence of contemporaneous choice also invites a more fundamental objection to respecting past preferences. Even if a patient's last competent instructions were recent, serious, clear, voluntary, informed, and followed the onset of the disease, thereby presumably satisfying the strictest informed refusal standard, they still reflect the preferences of the *competent* patient. The values and interests of that patient may differ from those of the currently *incompetent* and, presumably, more seriously ill patient. For this reason, Rebecca Dresser suggests that society should seek to advance the patient's current interests rather than the patient's past exercise of autonomy. Loss of competency, she suggests, may directly alter the things that make life worthwhile. Incompetent patients, she notes, may still experience pain and pleasure, but they may now lack the capacity to value ideas they cherished when competent, such as autonomy and dignity,²⁷⁷ or to sense their violation.²⁷⁸ These values matter to competent persons, but not incompetent ones, she suggests. Since incompetent patients are unable to reflect upon the changes in their condition and rethink their previously expressed treatment preferences to reflect their current interests,²⁷⁹ their past expressions may not reflect their current interests.

Dresser contends that the true appeal of past preferences is their embodiment of the concerns of the competent decisionmakers.²⁸⁰ To impute these values to incompetent patients, as cases like *Quinlan* have done, elevates the values and interests of competent people, like family members and judges, over the actual current interests of the incompetent patient. Imputing these values to them is "fundamentally dishonest,"²⁸¹ she contends, and may result in treatment decisions that burden, rather than benefit, the patient.²⁸² For these reasons, Dresser's proposal constitutes one possible explanation of Judge Clifford's puzzling suggestion in a recent Maine case that treatment against a patient's wishes shows a humane and caring society.²⁸³

Relying upon the moral philosopher Derek Parfit,²⁸⁴ Dresser also suggests an additional reason why adherence to past preferences is inappropriate. She contends that the competent person who expressed those preferences is in fact a different person from the currently incompetent and incapacitated patient.²⁸⁵ Her suggestion that the current incompetent patient is a different person from the former competent

277. Dresser, *supra* note 167, at 381.

278. *Id.* at 385.

279. However, in a few states living wills can be "revoked" by incompetent patients. Gelfand, *supra* note 13, at 766; Dresser, *supra* note 167, at 382 n.47. Missouri is one of these states. MO. REV. STAT. § 459.020(1) (1986).

280. Dresser, *supra* note 167, at 389.

281. *Id.*

282. *Id.* at 381.

283. *In re Gardner*, 534 A.2d 947, 957 (Me. 1987) (Clifford, J., dissenting).

284. D. PARFIT, REASONS AND PERSONS (1984). Parfit bases identity on the degree of connectedness and continuity of psychological features.

285. Dresser, *supra* note 167, at 379-81.

patient raises some difficult philosophical questions about the nature of self.²⁸⁶ However, it is not essential to resolve those questions to appreciate her argument that the condition of the incompetent, seriously ill patient has changed so greatly that it is unfair to govern current treatment of the incompetent patient by that patient's former value choices. In her view, respect for past preferences holds patients hostage to past experiences which innocently, perhaps inevitably, miscalculate their current interests. This argument calls into question not only the use of a patient's previous casual statements about medical treatment, such as those at issue in *Cruzan* and *Quinlan*, but also more formal directives like living wills. Even preferences expressed after the onset of disease might be questioned because, by hypothesis, they predate incompetency. Thus, this argument for superseding past preferences is more radical than Judge Robertson's objection to hypothetical directives.

Dresser prefers a best interest analysis that takes account of the patient's current capacities and identifies the kinds of pain and pleasure that the patient actually experiences.²⁸⁷ For example, this perspective might dictate the resuscitation of a patient who currently enjoys simple pleasures such as eating and being in the company of others despite her past instructions to the contrary. Conversely, it might dictate the withholding of future burdensome treatments despite a prior request that all available treatments be administered.²⁸⁸

We see loose analogies in the debate over surrogate parenthood. One of the arguments for permitting a surrogate to keep her collaboratively conceived children is that the surrogate's circumstances following childbirth are so different from her circumstances at the time of her preconception promise that she ought not be held to her promise. Similarly, divorces are often explained as the result of one or both spouses becoming "different people" from the ones who made the marriage vows. The case for similarly releasing patients from their past statements is even easier because no third parties have detrimentally relied upon the patient's past expressions of preference.

Dresser's position is vulnerable to several rebuttals. First, to focus exclusively on current interests would unwisely separate incompetent patients from their history. Because of the subjective nature of these treatment choices, the decisionmaker also would lose the best available evidence of the patient's current interests. In addition, disregard of past preferences would afford too little weight to the autonomy interests that survive a patient's incompetency. Finally, respect for past preferences, regardless of our current assessment of a patient's best interests, is most consistent with our general distaste for paternalism in the context of medical decisionmaking.

In a recent article, Nancy Rhoden criticized Dresser's present-oriented perspective of the patient for "viewing a person only in a highly restrictive slice of time."²⁸⁹ Drawing from the work of Ronald Dworkin, she concluded that "we need

286. Parfit's views on this issue are presaged by those of Hume and Locke. Rhoden, *supra* note 230, at 412 n.156.

287. Dresser, *supra* note 167, at 383-84.

288. *Id.* at 381-82.

289. Rhoden, *supra* note 230, at 415.

not view the patient's present as if his past never occurred."²⁹⁰ Instead, we should take the view that past directives express "the relevant values of the patient, viewed as someone with a past."²⁹¹ Viewing the patient this way, we should ask how the person who is now incompetent would, when competent, "have imagined herself after incompetency."²⁹² Thus, the incompetent patient's opinions are relevant, even if they cannot be said to demonstrate the incompetent patient's wishes, if any.²⁹³

Rhoden correctly notes the incompatibility of the notion of different selves with our commonly held views of people.²⁹⁴ In our society, each person is viewed as a single individual throughout her life. Certainly, the need for continuity and predictability in human relations dictates this view as a general rule. It also accords with our senses, notwithstanding our inability to prove empirically the existence of "self."²⁹⁵ Rhoden rightly suggests that these deeply held beliefs deserve some weight.²⁹⁶ Nevertheless, these beliefs do not prove themselves. And regardless of the wisdom, perhaps even inevitability, of viewing each person as a single historical individual in ordinary affairs, the importance of the stakes in the unique context of life-sustaining medical treatment justifies closer scrutiny of this view. The absence of cognizable third-party reliance frees us to ask whether the patient's change in circumstances is so great that it would be a disservice to act upon the patient's prior expressions of intent.

The most important reason for respecting past preferences is that they are the best available measure of the patient's current interests. Family members and courts forced to make a treatment decision on behalf of the patient are no better able to place themselves in the shoes of the vegetative or incompetent and gravely ill patient than the patient himself.²⁹⁷ For patients who retained competence for some time following the onset of affliction, the case for respecting past preferences is especially clear. The only advantage offered by a contemporaneous proxy decisionmaker is access to postincompetency data about the patient's condition and treatment options. This additional information is certainly relevant, but it is not dispositive. A value judgment must still be made and it is most appropriate to use the patient's own values to evaluate his current interests. Although we cannot eliminate the possibility that the patient would have changed his mind if he had experienced his current predicament while competent (if that is possible), his past prediction seems the best approximation of what his decision would be now.²⁹⁸ Moreover, the conscious but incompetent patient may still be able to understand that his past preferences are being violated.

290. *Id.* (citing Dworkin, *Autonomy and the Demented Self*, 64 MILBANK Q. 4, 14 (Supp. II 1986)).

291. *Id.*

292. *Id.*

293. *Id.* at 418. Rhoden articulates her view as follows:

[A]n entirely present-oriented view is a bad way to view even persons who left no living will; it is unlikely that they would want to be viewed just as a body that can experience only physical sensations. . . . Considering the patient only in the immediate present divides the patient from her past, her history, her values, and her relationships—from all those things that make her human.

Id.

294. *Id.* at 413–14.

295. *See id.* at 414 n.166 (explaining the seeds of the philosophical debate).

296. *Id.* at 414–15.

297. Some commentators question this conclusion. *See Dresser, supra* note 167, at 389 n.91.

298. *See* L. TRIBE, *supra* note 52, at 1599 n.29. On the other hand, third-party decisionmakers making a

Thus, proxies can seldom be confident that ignoring past preferences will really advance the patients' interests.

Respecting patients' preferences also pays homage to patients' individual dignity.²⁹⁹ Even Dresser acknowledges that the formerly competent patient's exercise of autonomy gives rise to an autonomy interest that continues to deserve respect even after incompetence. But she would, for the reasons already stated, assign less weight to a patient's interest in directing a *future* treatment than to a currently competent patient's interest in making *contemporaneous* treatment decisions.³⁰⁰ She questions the readiness of both courts and legislatures to defer reflexively to patient autonomy interests.³⁰¹ These practices, she contends, are flawed because they rest on the premise that respect for incompetent patients is best obtained by treating them like competent patients.³⁰² She then expresses doubts about the priority of past autonomy when pitted against the patient's interest in current well-being.³⁰³ Her views find support in the provisions of some living will statutes that permit revocation without regard to competency,³⁰⁴ or permit physicians to override living wills if the physicians have "serious reason therefore consistent with the best interest[s] of the declarant."³⁰⁵ But these views constitute a decided minority. The better view respects past as well as present preferences.

The judicial consensus to respect past preferences probably draws its most compelling justification from the emerging consensus that patients ought to be able to control their future fates. Evidenced by the movement toward living will statutes, this consensus reflects a reciprocal social compact to respect one another's wishes after incompetency.³⁰⁶ It may also reflect a contractarian conviction that a healthy person unaware of what illness or accident might befall him would want this control over future medical treatment.³⁰⁷ That person might prefer respect for his conscious wishes over respect for his objective well-being.

contemporaneous decision could possibly be more empathetic to the patient's current interests than the patient herself was, especially if the patient was healthy at the time of her directives. This could occur if the patient was frightened or disdainful of the prospect of illness and handicap, while the proxy is not similarly biased. I am not convinced that this view is well-founded.

299. A competent patient's interests concerning autonomy may extend beyond the patient's incompetency, even though the patient can neither continue to exercise autonomy nor recognize any violation of past preferences by health care providers. As analogies, Rhoden suggests that a duty, such as marital fidelity, may be breached even though the victim never learns of it. Likewise, a duty may be breached even if the time of performance follows the promisee's absence or death. She uses these analogies to suggest that respect for the patient who was once competent dictates respect for her past directives. This approach sidesteps the discontinuity objection by relating the duty back to the competent person. The idea of relating back the duty has intuitive appeal. Unlike the dead promisees, these patients will in fact experience the consequences of breach, even if not cognitively aware of it. Rhoden, *supra* note 230, at 416-18.

300. Dresser, *supra* note 167, at 394.

301. Dresser, *supra* note 167, at 374-75, 382 n.48. Although statutes governing wills and organ donation show similar respect for the former patient, they are distinguishable because they do not threaten the interests of the incompetent testator or donor in any manner comparable to a mistaken directive about health care. *But see* N. CANTOR, *supra* note 170, at 65.

302. Dresser, *supra* note 167, at 373.

303. *Id.* at 381.

304. *Id.* at 382 n.47; *see, e.g.*, TEX. REV. CIV. STAT. ANN. art. 4590h, § 4(a) (Vernon Supp. 1989); MO. REV. STAT. § 459.020(1) (1986).

305. MO. REV. STAT. §§ 459.025, 459.045(1)-(2) (1986).

306. *See supra* note 259 (public support for patient choice).

307. Perhaps the moral significance of this compact can be minimized by viewing it as a compact among healthy

The compact reflects at least two underlying ideas. First, the compact lets patients maximize their own utility. Patients who value control over future treatment and who attempt to exercise it are performing a long-term interest-maximizing calculus that takes into consideration the value of exercising self-determination while competent.³⁰⁸ They may greatly value this liberty at a time when medical technology threatens to deprive them of control over their bodies for unprecedented periods of time.³⁰⁹ Second, this social compact reflects deeply held doubts about the bias of the health care and judicial systems for aggressive treatment. The current living will statutes were motivated by the concern that proxies were unwilling or unable to cease treatment in appropriate cases. Given our doubts about third-party willingness to terminate treatment based upon our best interests, we prefer a doctrine of mutual respect for prior preferences. Thus, we collectively permit ourselves to assess individually the desirability of future medical treatment. Each of us remains free to leave his future fate in the hands of others. But those who do not wish to do so, despite the limits on their ability to know their future circumstances, are promised respect for their own choice. Purely objective patient-oriented interest analysis is an inadequate substitute. Its connotations of objectivity and certainty are overstated and it sacrifices too much of the patient's individuality. The ability of patients to control their own care should not cease the moment they become incompetent.³¹⁰

3. Unclear Past Preferences

The less clear the patient's past preferences, however, the more reasonable it is to rely instead upon the decisionmaker's assessment of the patient's best interests.³¹¹ But the choice between autonomy and welfare is not an all-or-nothing matter. As discussed above, the patient's interests in an appropriate medical decision are more likely to be served by simultaneous consideration of the objective evidence of the

people who unduly value their current autonomy, and fear the loss of control over their lives in the future as a result of medical technology. Healthy people may underestimate the value of life for the seriously ill. Even if this perception is true, a matter of serious doubt to me, it does not diminish the importance of self-determination to the contractors.

308. See N. CANTOR, *supra* note 170, at 65 (patients benefit from the knowledge that their wishes will be respected).

309. This view is subject to the criticism that patients who have exercised their autonomy while competent will lose none of the satisfaction associated with their exercise of autonomy if their past wishes are later ignored and their current interests are advanced. In essence, they can have their cake and eat it too. But that criticism would not support disrespect for patient wishes in the future because it would deprive all future patients of the satisfaction associated with the power to directly control their bodies.

Is this view vulnerable to the criticism that it sacrifices the interests of the patients who would actually benefit from treatment for the benefit of others who desire the satisfaction of feeling in control of their lives? No, because the patient who would "benefit" from treatment has already benefited from the exercise of autonomy and she has chosen the latter benefit over the possibility of the former.

310. Cf. *Holmes v. Silver Cross Hosp.*, 340 F.Supp. 125 (N.D. Ill. 1972) (competent patient who refused blood transfusions lapsed into unconsciousness and the hospital then obtained a trial court order authorizing a transfusion). A final justification for deference to past preferences is that it encourages individual thought and initiative. An additional disadvantage is that it could convey a silent message to people, especially the elderly, to sacrifice themselves for their families or society. The magnitude of this risk is difficult to gauge, but the infrequent use of living wills suggests that it is not a significant danger at this time.

311. The probative value of evidence of a patient's past preferences will turn upon factors such as remoteness in time, seriousness, repetition, and specificity. See *supra* text accompanying note 177.

patient's physical interests and the subjective evidence of his past preferences than by treating the two kinds of evidence separately.³¹² As the treatment decision is inevitably subjective, evidence of patient values, preferences, and behaviors should be used as much as possible.

When the objective and subjective evidence suggest the same decision, simultaneous consideration protects the interests of patients and the state in minimizing errors. It does so without forcing the state to choose between its interests in liberty and welfare. When the two categories provide conflicting clues, however, the outcome most consistent with the state's interests is more difficult to determine. Assuming that the state ranks autonomy above welfare, clear evidence of patient wishes should govern. But when the evidence of patient intent is borderline, the traditional preference to err on the side of life would probably lead most courts to order treatment when the subjective evidence conflicts with the objective evidence.

There is, however, another way of resolving the cases when borderline subjective evidence conflicts with the objective evidence. Proxies can compare the probative force of the two categories of evidence and use the more reliable evidence. This would result in a sliding scale in which greater evidence of intent to refuse treatment is required, the more that treatment seems objectively beneficial. Conceivably, this sort of comparison explains the few cases, like *In re Dorone*, in which courts have demanded airtight proof of refusal. If so, the *Dorone* case is a regrettable example of the use of this sliding scale as the patient's medic alert card appeared to constitute an adequate basis for withholding treatment. However, when subjective evidence is less clear, the choice between wishes and welfare can reasonably be based on the relative reliability of the evidence, thus maximizing the likelihood of advancing patient interests. Only when both categories are equally reliable will courts have to choose between them either by ranking autonomy and welfare or by erring on the side of treatment. And when neither category provides trustworthy evidence, the presumption in favor of treatment should govern.

In many cases, like those involving vegetative patients, the actual burdens or benefits to the patient of further treatment cannot be demonstrated. In a sense, the objective evidence is neutral. Here, any trustworthy evidence of wishes will constitute the most accurate source of guidance available. Under those circumstances, nontreatment may well be appropriate. The case of Nancy Cruzan is illustrative. Because of the absence of direct instructions from Nancy and the difficulty of confirming either the benefits or the burdens of her current life, her case is an extremely difficult one.³¹³ . But Nancy had stated several times that she did not wish

312. See *supra* text accompanying notes 224–28.

313. Nancy Cruzan's case would be extraordinarily difficult to decide under any standard. The evidence of her preferences was far from conclusive. Our current knowledge of the benefits and burdens of her life is conjectural at best. Although the holding in *Cruzan* was unprecedented and, in my view, unfortunate, it was not unfathomable or even unexpected. Cases such as Nancy Cruzan's require the resolution of some of the most troubling issues in withholding doctrine. For vegetative patients, the foremost of these is a reconsideration of society's obligations toward a patient who can experience neither burdens nor benefits. Can these lives be considered pointless and, if so, should treatment decision turn on the interests of family or society? See, e.g., *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1021, 195 Cal. Rptr. 484, 493 (1983) (family burden relevant); PRESIDENT'S COMMISSION, *supra* note 4, at 135 (same). In addition, this

to be kept alive if she were a “vegetable.” She told her friend that if she “couldn’t do for herself things even halfway, let alone not at all, she wouldn’t want to live that way and she hoped that her family would know that.” She once told her sister, in the context of her grandmother’s death, that “death is sometimes not the worst situation you can be in” when compared to being “sent to the point of death and then stabilized” without hope of “ever really getting better.”³¹⁴ These comments were apparently consistent with her lifestyle and independent nature. These factors had led her friends, family, and the guardian *ad litem* to believe that she would not wish to continue receiving treatment in a hopelessly vegetative existence.³¹⁵ Despite its casual nature, it also convinced the trial court. Although the available evidence of her wishes only makes the case slightly less difficult than it would be without it, the difference is dispositive. Based on that trustworthy evidence, the trial court reasonably authorized the discontinuation of her artificial nutrition and hydration.

4. *Autonomy and Unclear Preferences*

One possible objection to combining unclear preferences with objective evidence is that this blending overstates the role of autonomy. The New Jersey Supreme Court stated: “[I]n the absence of adequate proof of the patient’s wishes, it is naive to pretend that the right of self-determination serves as the basis for substitute decision-making.”³¹⁶ Some critics feel this pretense could even threaten genuine autonomy by establishing a precedent for delegating exercise of one’s personal autonomy to another person without explicit instructions or permission from the right-holder.³¹⁷ It may “allow the truly involuntary to be declared voluntary.”³¹⁸ In this way, misuse of autonomy phraseology could disguise and justify decisions that actually harm the patient’s welfare by basing harmful nontreatment on a false autonomy. Arguably, the state interest in patient welfare, therefore, supports its refusal to consider incomplete statements of past preferences or evidence about the patient’s lifestyle and values.

These objections are serious and to some extent legitimate. At worst, these objections question the honesty of courts which draw upon the normative power of autonomy to justify the delegation of decisionmaking power to third parties. At a

case requires consideration of the possibly special nature of artificial nutrition and hydration. Cases like hers also raise especially clearly the issue of distributive justice in the allocation of health care resources. In time, courts and legislatures will surely consider whether patients like Nancy Cruzan should be treated indefinitely if doing so leaves fewer funds to fight other threats to life like AIDS or infant mortality. See PRESIDENT’S COMMISSION, *supra* note 4, at 95–100; T. BEAUCHAMP & J. CHILDRESS, *supra* note 151, at 183–217. Regrettably, the Missouri Supreme Court lost the opportunity to help solve these riddles.

314. All of these quotations from the trial transcript were taken from Ms. Cruzan’s brief to the Supreme Court. Brief for Petitioners at 5–6, *Cruzan v. Director, Mo. Dept. of Health* (Sept. 1, 1989) (No. 88-1503).

315. *Cruzan v. Harmon*, 760 S.W.2d 408, 411 (Mo. 1988) (en banc), *cert. granted sub nom. Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989).

316. *In re Conroy*, 98 N.J. 321, 364, 486 A.2d 1209, 1231 (1985).

317. See *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 443, 497 N.E.2d 626, 643 (1986) (Lynch, J., dissenting in part) (partnership masquerading as autonomy). One extremely liberal court struggled unsatisfactorily with this dilemma. *In re Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (fearing the precedent of informal waivers of constitutional rights, the court instead entrusted the guardian with a virtually unfettered discretion to do a best interest assessment), *cert. denied*, 109 S. Ct. 399 (1988).

318. *Cruzan*, 760 S.W.2d at 426 (quoting Price & Burt, *Sterilization, State Action and the Concept of Consent*, PSYCHOLOGY REV. 58 (1975)).

minimum, they dictate the use of more precise language, like that used in New Jersey, to disclose the blending of objective and subjective evidence that is inherent in substituted judgment.

But these objections also understate the role of self-determination in substituted judgment. Substituted judgment does represent an effort to let the patient determine the treatment. It attempts to confer upon the patient a *post hoc* or counterfactual autonomy. As we cannot clearly and convincingly ascertain what the patient did want, we ask if it is possible to deduce what he *would have wanted* had he been asked. Unlike proxy decisionmaking for the patient who has never been competent, substituted judgment for previously competent patients is not simply a patient-centered best interests assessment. It does not simply seek to discover what the reasonable patient in this patient's shoes would want now, if able to tell us. Instead it asks what the formerly competent patient would have wanted, *if asked while competent*. Thus, it uses the patient's *past* values, preferences, and actions in an effort to let the probable choices of the previously competent patient control the current medical decision.

It is too cynical to dismiss the practice of phrasing the task in terms of the patient's wishes as merely an attempt to disguise the controversial task of best interests analysis in the less controversial trappings of autonomy, although this is surely part of the explanation. Nor can it be fully explained as an inadvertent by-product of analogizing the decisionmaking process in cases involving incompetent patients to those involving competent patients, although that, too, is part of the explanation. Rather, this phrasing captures the legitimate objective of the decisionmaker. It acknowledges the desirability of respecting a patient's values, of respecting his putative wishes, and of giving him some control over his future treatments by extrapolating from his values when he has left no express instructions. This conception of autonomy is undoubtedly expansive and may even stretch the term itself beyond its proper moorings, but the underlying idea that substituted judgment shows special respect for the patient is sound. Failure to recognize the special significance of this effort to let the patient "control" the medical decision would improperly trivialize the normative importance of the patient's prior values. If this is not "autonomy," it is certainly a close cousin that is entitled to respect.

Still, courts should not treat reliance on these prior values as if they were deferring to a traditional exercise of autonomy. Characterizing the decision in the language of autonomy is comforting for obvious reasons, but it can deflect attention from the surrogate's discretion in reaching a decision most compatible with the patient's past values and preferences. Introduction of illegitimate factors then becomes too easy. While courts should acknowledge the special status of patient preferences and values, even those which do not rise to the level required by the doctrine of informed consent as traditionally applied, they should also acknowledge that evidence of this less dispositive character justifies greater state supervision because of the state interest in avoiding error or abuse.³¹⁹

319. See *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 445, 497 N.E.2d 626, 641 (1986) (Lynch, J., dissenting in part) (extra scrutiny needed with substituted judgment).

In addition, the weight given to this evidence probably ought to reflect the extent to which the patients' previous statements indicate an *intention* to control their future medical care. Evidence of intention is relevant because it suggests a desire to bind future decisionmakers, rather than leave the treatment decision in their hands. A person's intention to direct future treatment also suggests more strongly the seriousness and durability of the preferences than would more casual comments about the attributes of a life worth living. Most probative will be statements specifically requesting that a particular treatment be discontinued. Next would be a patient's past decisions about her own medical treatment. Less dispositive will be expressions of opinion about the wisdom of medical treatment rendered to others. And least decisive are general statements or patterns of behavior that are not consciously intended to communicate any directions about future medical care.

Although the probative force of this evidence will vary from case to case, all of the evidence is relevant because it maximizes the role of the patient's beliefs in the transition from a subjective to an objective assessment of interests. Regardless of its label, this evidence is entitled to the special stature that most courts afford it. Its use advances the state's interests in correctly ascertaining patient wishes and welfare.

B. *Ascertaining the Patient's Best Interests*

Whenever the court or health-care decisionmaker cannot take complete guidance from the patient's past preferences, the patient's objective best interests will play a role in the treatment decisions. When evidence of patient wishes is available, but insufficient, this objective evidence can be used to supplement the subjective evidence. And when the patient has never been competent or has left no trustworthy evidence of her wishes, the objective evidence constitutes the sole source of guidance about the patient's welfare. In these cases, the state, like the patients themselves, has an interest in protecting patients against error and abuse in ascertaining their best interests. Here, judicial concerns about abuse of the weak and vulnerable members of society seem especially apropos.

1. *Protection Against Error and Abuse*

Although there is substantial consensus about the desirability of ascertaining and protecting the patient's best interests, considerably more dispute exists about suitable ways to minimize the dangers of error and abuse inherent in this analysis. The real burdens and benefits of life in extremely debilitating circumstances are often beyond our ability to know confidently or comprehend fully.³²⁰ Often, there will be no objective consensus on the value to the patient of further treatment.³²¹ Even though good faith best interest assessments by family or friends who have had a close relationship with the patient seem more likely to advance the patient's interests than any available alternative, the subjectivity of the process means that the decisionmakers will often be unable to demonstrate the objective benefits of their decision in a

320. See Brody, *In the Best Interests of . . .*, HASTINGS CENTER REP., Dec. 1988, at 37.

321. See *supra* text accompanying notes 261-66.

clear and convincing manner. That dilemma understandably makes subjective evidence of the patient's preferences and values especially useful. But where adequate information about patient preferences is unavailable, the proxy decision-maker's task is extremely difficult and involves a great deal of discretion. Critics like Judge Robertson seem especially concerned that this discretion will be used to withhold treatment from persons whose lives are inconvenient to others in society. At worst, this discretion calls into question our authority to withhold life-saving medical treatment in the absence of adequate information about the patient's wishes.³²² At a minimum, it challenges the state to erect substantive and procedural standards that will minimize error and merit social confidence.³²³

These concerns may account for New York's refusal to permit any judicial best interest analysis whatsoever.³²⁴ New York's approach insulates courts and health-care providers from the task of playing God. "[N]o person or court," said the New York Court of Appeals, "should substitute its judgment as to what would be an acceptable quality of life for another."³²⁵ But the flat rejection of best interest analysis is certain to cause great harm. The irrebuttable presumption that all lives are worth living will condemn many patients to unnecessary treatment, suffering, indignity, or pointless existence. Refusal to examine a patient's interests in treatment is not a hands-off policy. It is a mandate for forcible treatment. The civil and criminal laws effectively compel providers and family to administer life-sustaining treatment for institutionalized patients unless special consideration is given to medical treatment decisions.³²⁶ The responsibility for this unnecessary impairment of patient interests rests with the lawmakers who reject best interests analysis.³²⁷

The evidence of abuse by families and guardians is insufficient to warrant this exclusion of best interest analysis altogether.³²⁸ In fact, overtreatment seems to have posed a greater threat to protection of patients in the past than undertreatment.³²⁹ At the same time, science continually offers new ways to extend life, often without also offering hope of relief from the underlying disease. This technology should be used

322. See, e.g., *In re Jobes*, 108 N.J. 394, 429–32, 529 A.2d 434, 452–53 (1987) (Handler, J., concurring).

323. *Id.* at 437–38, 529 A.2d at 456–57 (Handler, J., concurring). Perhaps the best way to advance both the patient's interests and those of the state is to permit patients to select their own surrogate decisionmakers. Many states already permit this. Patients can then select persons who share the same values with respect to medical treatment, including agreement on such matters as the role of family burden and use of social resources. Issues like these may be important to the patient, but many courts will be reluctant to impute them to the patient in a best interest analysis. As a result, the decision of a personally selected health care decisionmaker seems more likely to reflect the patient's perspective than the decisions of courts or providers. But for patients who have left no living will nor authorized a medical decisionmaker, the state's interest in protecting the patient's life against inappropriate medical decisions supports measures designed to safeguard against error and abuse in the ascertainment of patient interests.

324. *In re Westchester County Medical Center*, 72 N.Y.2d 517, 530, 531 N.E.2d 607, 613, 534 N.Y.S.2d 886, 892 (1988); *In re Storar*, 55 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981). A Florida appellate court recently concluded that best interest analysis was an inappropriate remedy for a constitutional right. *In re Browning*, 543 So. 2d 258 (Fla. Dist. Ct. App. 1989); but see *In re Barry*, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984) ("substituted judgment" for vegetative infant permitted).

325. *Westchester*, 72 N.Y.2d at 530, 531 N.E.2d at 613, 534 N.Y.S.2d at 892.

326. See *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (quashing criminal charges).

327. *In re Jobes*, 108 N.J. 394, 428, 529 A.2d 434, 452 (1987) (Handler, J., concurring).

328. See *In re Browning*, 543 So. 2d 258 (Fla. Dist. Ct. App. 1989) (insufficient evidence of abuse to require judicial review of guardian's decision).

329. Wanzer, *supra* note 50; Rhoden, *supra* note 230, at 419–29.

only when it serves the interests of the patients, not when it sentences them to further suffering. New York's response, therefore, represents a regrettable paralysis rather than a constructive effort to address the difficulties associated with best interest analysis.³³⁰

Most courts and commentators wisely acknowledge that life-saving treatment should not be rendered if it will not serve the patient's interests.³³¹ But substantial disagreement exists over the specific criteria to be used with incompetent patients for deciding whether treatment is worthwhile. To some extent this disagreement turns on serious differences of opinion over the likelihood of abusive decisions by family and guardians.

The disagreement is reflected in the various substantive tests that have been adopted to govern and monitor the exercise of decisionmaking power. At least one jurisdiction permits trial courts and other proxy decisionmakers to apply a general benefit-burden calculus.³³² But some critics doubt the feasibility of preventing error or abuse with general criteria.³³³ In particular, they fear that the worth of the patient *to others* may permeate the decisionmaking process.³³⁴ For this reason, decisionmakers have sometimes limited nontreatment to cases in which the patient's interests are clearest. In New Jersey, for example, decisionmakers who believe that nontreatment would serve the patient's interests must find either trustworthy evidence of the patient's desire to refuse this treatment or else evidence that the patient is terminal and facing "recurring, unavoidable and severe pain."³³⁵ Similarly, the 1984 federal Child Abuse Amendments³³⁶ and the subsequent child abuse regulations³³⁷ limit withholding to cases in which the child is irreversibly comatose, the treatment would be futile in terms of survival, or the treatment would be inhumane under the circumstances.³³⁸ Under these regulations, nutrition, hydration, and medication may never be withheld.³³⁹ Several state legislatures have similarly attempted to fashion a

330. See *In re Conroy*, 190 N.J. Super. 453, 464 A.2d 303 (App. Div. 1983).

331. See, e.g., *supra* note 241 (collecting cases); Pollock, *supra* note 43, at 523. Even many conservative commentators—some with a "sanctity of life" or "vitalist" perspective—appear to have come to this conclusion in the most compelling cases. See, e.g., P. RAMSEY, *ETHICS AT THE EDGE OF LIFE* 191–93 (Tay-Sachs), 212–16 (Lesch-Nyhan disease and anencephaly) (1978); but see Destro, *Quality of Life Ethics and Constitutional Jurisprudence: The Demise of Natural Rights and Equal Protection for the Disabled and Incompetent*, 2 J. CONTEMP. HEALTH L. & POL'Y 71, 111, 124 n.241 (1986).

332. E.g., *Barber v Superior Ct.*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (proportionality test).

333. E.g., R. SHERLOCK, *PRESERVING LIFE: PUBLIC POLICY AND A LIFE NOT WORTH LIVING* 83, 170 (1987).

334. The debate has been fueled by abusive "Baby Doe" cases where children with Down's Syndrome or mild spina bifida were denied life-saving treatment. Weir, *Pediatric Ethics Committees: Ethical Advisers or Legal Watchdogs?*, 15 L. MED. & HEALTH CARE 99, 105 (1987).

335. *In re Conroy*, 98 N.J. 321, 366, 486 A.2d 1209, 1232 (1985). A notable exception is made for comatose and vegetative patients. *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987). The court may be having second thoughts about these requirements. *Id.* at 376 n.5, 529 A.2d at 425 n.5.

336. 42 U.S.C. §§ 5101–07 (1982 & Supp. V 1987) (Child Abuse Prevention and Treatment Act). For a trenchant criticism of the narrow discretion afforded to parents and providers under the various Baby Doe laws, see Weir, *supra* note 334, at 108 (citing babies with trisomy 18 or trisomy 13).

337. 45 C.F.R. § 1340 (1988).

338. 45 C.F.R. § 1341.15(b) (1988). By permitting medical treatment to be withheld where it would "merely prolong dying" or otherwise "be futile in terms of the survival of the infant," the law permits quality of life decisions at the margin. Weir, *supra* note 334, at 103; N. CANTOR, *supra* note 170, at 178.

339. 42 U.S.C. § 5102(3) (Supp. II 1984); 45 C.F.R. § 1341 (1988). Several living will statutes are similarly restricted. Gelfand, *supra* note 13, at 757.

narrow list of proper cases for withholding treatment.³⁴⁰ Some commentators have suggested the analysis would be further improved by eliminating considerations such as dignity and humiliation which may not be appreciated or experienced by the incompetent patient.³⁴¹

In addition, the courts have devoted considerable attention to the decisionmaking process. Some courts have delegated the decisionmaking to persons most likely to know and share the patient's values and to use their discretion in good faith.³⁴² Others have required prior judicial approval. Some have required independent confirmation of diagnosis or consultation with others well versed in medical ethics. New Jersey also tailors the procedural requirements to the patient's institutional setting. And some courts have chosen to impose a stringent burden of proof.

Each of these approaches has its own advantages and disadvantages. Because procedural rigidity and overrestrictive substantive tests of a patient's best interests will lead to many medical treatment decisions that impair, rather than advance, patient interests, lawmakers considering which procedural or substantive safeguards to adopt must balance the risks of erroneously terminating treatment against the risk that unduly restrictive procedures will force harmful or pointless treatments on the very patients the state is trying to protect. As with the state's interest in avoiding error or abuse in the ascertainment of patient wishes, the state's interest in patient welfare is derivative of and protective of the patient's best interests. Both the patient and the state, accordingly, have a shared interest in an accurate assessment of the risks and a precise tailoring of legal protections to respond to those risks without being overbroad.

2. Evaluating the *Quinlan* and *Cruzan* Tests

Both the *Quinlan* and *Cruzan* tests overlook the state's interest in *procedural* safeguards. In this respect, they understate the state's interest in protecting the welfare of incompetent patients. They merely impose *substantive* tests to govern the treatment decision. As a substantive test, however, the *Quinlan* test better approximates the patient's overall interests than the *Cruzan* test. While the *Cruzan* test incorporates substantive restrictions apparently designed to protect patients against abuse, its formula for doing so is far too restrictive.

Ideally, decisions protecting patient welfare would consider all factors relevant to the patient's overall interests in the medical treatment decision. They would take into consideration the patient's physical and mental condition and the impact of those facts on the net value of treatment *to the patient*. A sound best interest analysis would, therefore, consider the burdens and benefits of the patient's life with treatment and compare it to the burdens and benefits of life without. The *Quinlan* prognosis-

340. As of 1983, "nineteen states had considered new legislation . . . and seven of the states had enacted statutes intended to prevent the occurrence of any more 'Baby Doe' cases." Weir, *supra* note 334, at 105; Feldman and Murray, *State Legislation and the Handicapped Newborn: A Moral and Political Dilemma*, 12 L. MED. & HEALTH CARE 156, 156 (1984).

341. See Dresser, *supra* note 167, at 383-84.

342. Cf. *supra* note 239 (commentators advocating this approach).

invasion formula performs this function fairly well.³⁴³ The patient's future prognosis roughly gauges the benefits expected from treatment and the treatment burden roughly gauges the costs. This formula is flexible enough to consider the burdens to the patient both from her disease (prognosis) and from her treatment.³⁴⁴

While the *Quinlan* formula is a reasonable measure of patient welfare if it is properly construed, the *Cruzan* formula is not. In an effort to strip the formula of "quality of life" concerns, the court also stripped the formula of coherence. Length of life is entitled to consideration, but quality of life is not. Burden of treatment may be considered, but burden of illness apparently may not. The resulting formula may occasionally reflect an incompetent patient's current interests in treatment, but often will not. As a result, the formula can only be defended as a suitable measure of patient welfare if its restrictions are necessary to prevent intolerable error and abuse by proxy decisionmakers.

3. *The Role of Quality of Life*

The Missouri Supreme Court's modification of the *Quinlan* formula to remove quality of life considerations had been suggested in *Brophy*, but not actually implemented. The *Cruzan* formula permits consideration of the burden of the treatment itself and of the patient's life expectancy, but it does not permit consideration of the patient's physical or mental condition—his quality of life.³⁴⁵ This attempt to eliminate quality of life considerations is even more restrictive than New Jersey's requirement that cognitive patients must be suffering pain before treatment is withheld. While New Jersey permits consideration of the pain and discomfort of *both* the patient's disease and the proposed treatment, Missouri considers only the pain of treatment.

Judge Robertson apparently excluded quality of life considerations because he feared the abandonment of patients whose quality of life makes them inconvenient or useless.³⁴⁶ His reasoning appears to confuse the danger that decisionmakers will withhold treatment based on the patient's value *to society* with the merits of permitting decisionmakers to consider the benefits of life *to the patient*. But he may have feared that social value considerations would soon permeate the decisionmaking process.³⁴⁷ Even so, *Cruzan*'s exclusion of quality of life considerations is regrettable for two reasons. First, quality of life considerations are essential to a fair assessment of the patient's actual interests. Second, the *Cruzan* formula actually permits some

343. As the test does not explicitly account for the value to the patient of her autonomy, the test would require modifications to perform well as a measure of the interests of a patient who has expressed her preferences. See *supra* notes 38, 248.

344. While the court delegated to *Quinlan*'s guardians the duty to weigh these factors and make an assessment of her interests, it clearly authorized the consideration of all relevant factors, including considerations which are commonly called "quality of life."

345. It also separates the state's interest in life expectancy from the patient's interest in treatment. In this respect, it differs from *Quinlan*.

346. *Cruzan v. Harmon*, 760 S.W.2d 408, 419–20 (Mo. 1988) (en banc), cert. granted sub nom. *Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989).

347. He may also have been influenced by a sanctity-of-life belief that all life is intrinsically worthwhile. That possibility is explored in Part IV.

quality of life considerations to influence the medical treatment decision, while it arbitrarily excludes others.

A patient's physical and mental condition is clearly relevant to his overall interests. Competent patients demonstrate that point every day by refusing treatment. Equal respect for incompetent patients dictates that the impact of their disease on their interests be considered, not excluded. It has occasionally been suggested, however, that equal protection of handicapped persons dictates disregard of their quality of life.³⁴⁸ Thus, a treatment decision for a Downs Syndrome baby who requires surgery to repair an esophageal defect arguably should be made without regard to the child's retardation. Under this view, the child should receive the same treatment that an otherwise normal baby would receive. While this conclusion is correct on the facts, it is doctrinally unsound, as illustrated in the case of Joseph Saikewicz.³⁴⁹ Saikewicz was a severely retarded man whose life might have been extended by chemotherapy. Despite evidence that most competent patients opted to undergo chemotherapy, the court concluded that chemotherapy would not serve Saikewicz's best interests.³⁵⁰ The court reasoned that chemotherapy would be more burdensome for Saikewicz than it would be for a competent patient because Saikewicz probably would have to be restrained during its administration. In addition, his inability to understand the purpose of the treatment would prevent him from taking comfort in the possibility of remission. While *Saikewicz* was an extremely difficult case and could easily have been decided differently, the court correctly attempted to evaluate the burdens and benefits of treatment for the actual patient before the court and not a hypothetical patient with "normal" mental or physical attributes. Equal protection for Joseph Saikewicz required no less.

The equal protection objection to considering quality of life breaks down further when the disabling condition itself dictates the need for treatment. It makes no sense to ask whether a child with Tay-Sachs disease would want medical treatment if healthy and competent. If healthy and competent, the child would not need the treatment. Equal treatment for disabled patients does not mean treating them as if they had no handicap. It means making the same good faith effort to assess their actual needs that would be made for a healthier person.³⁵¹

As with all discrimination cases, the important task is to ensure that those patient attributes which make the patient vulnerable to discrimination are only used when genuinely relevant. Biases or preconceptions about the value of life to these patients should not be permitted to distort the process of ascertaining their best interests. Thus, the cases in which esophageal repairs were withheld from retarded children are troubling not because the patient's quality of life may have been considered, but because the decisionmakers incorrectly concluded that death would be preferable to

348. See Destro, *supra* note 331, at 96-99, 118; T. BEAUCHAMP & J. CHILDRESS, *supra* note 151, at 133.

349. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977).

350. The court used a patient-centered best interests analysis that it called "substituted judgment." *Id.* at 752, 370 N.E.2d at 431.

351. See J. ROBERTSON, *supra* note 44, at 87 (Baby Doe cases should be decided on the patient's net interests, despite the financial and emotional burden imposed by the patients).

living with Downs Syndrome. Although concerns about equal protection certainly justify supervision of the decisionmaking process to ensure that quality of life considerations are not misused, as they were in these cases, they do not justify the exclusion of quality of life considerations in proper cases.

Properly used, quality of life considerations promote equal treatment, rather than threaten it.³⁵² As a result, no court, except the New York Court of Appeals, has totally precluded the consideration of quality of life factors.³⁵³ Even the relatively conservative Child Abuse Amendments make some concessions to the patient's quality of life.³⁵⁴ Because both logic and kindness support full consideration of the patient's circumstances, jurists who cannot bring themselves to admit that they have considered quality of life have often been unable to ignore it in practice.³⁵⁵ For example, Judge Liacos disclaimed the use of quality of life considerations in *Brophy*, even as he relied on them in balancing the state's interests against Mr. Brophy's. And in a recent New Jersey case, involving a woman in a persistent vegetative state,³⁵⁶ Judge Pollock objected to the use of quality of life considerations, instead basing nontreatment on his conclusion that treatment was merely forestalling her inevitable death. But given the patient's long life expectancy in that case, his conclusion was implicitly based on her future quality of life.

Even Missouri has implicitly permitted some quality of life evaluations by its willingness to base a treatment decision on the degree of discomfort associated with a medical treatment.³⁵⁷ The determination of whether a painful treatment is worthwhile inevitably requires consideration of the value of extended life to the patient. A painful treatment is only harmful if the additional life expectancy that it offers is not worth the pain or burden of the treatment. To make this assessment, the decisionmaker must calculate the net value of continued life with the treatment and compare it with the net value of a shorter life without the treatment. This requires consideration of the patient's quality and quantity of life under the two alternatives.

Thus, the determination of whether a given treatment is worthwhile necessarily requires consideration of the patient's quality of life. Yet, the *Cruzan* formula denies equal recognition to quality of life considerations arising out of the patient's disease, rather than the burdensomeness of the treatment. Continued life may be no less insufferable for these patients than for patients whose disease symptoms are more benign, but whose treatment is horribly burdensome. In both cases, a shorter life without the treatments may be preferable to the longer life offered by aggressive

352. The Missouri Supreme Court expressed concern that other patients might be more susceptible to abuse than Nancy Cruzan because they would lack her supportive family. 760 S.W.2d 408, 412 (Mo. 1988) (en banc), cert. granted sub nom. Cruzan v. Director, Mo. Dept. of Health, 109 S. Ct. 3240 (1989). Yet, it made no attempt to limit its restrictions to those cases.

353. *In re Westchester County Medical Center*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988).

354. See *supra* text accompanying notes 336–38.

355. *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986).

356. *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987).

357. *Cruzan v. Harmon*, 760 S.W.2d 408, 422–24 (Mo. 1988) (en banc), cert. granted sub nom. Cruzan v. Director, Mo. Dept. of Health, 109 S. Ct. 3240 (1989).

therapy.³⁵⁸ Fair treatment, therefore, requires that the overall burdens of continued treatment be considered in both cases.³⁵⁹

Because the *Cruzan* formula denies many patients a full consideration of their overall interests, it can only be defended as a product of the state's interest in protecting patient welfare if the distinction between treatment burden and disease burden is the least restrictive way to prevent erroneous or abusive withholding of treatment from patients with debilitating diseases.³⁶⁰ Advocates of the distinction might contend, for example, that it wisely precludes consideration of those patient attributes most likely to be abused if "quality of life" considerations were openly permitted, such as retardation, senility, and physical disability.³⁶¹ But it achieves that prophylactic objective by condemning all patients with painful or debilitating diseases and significant life expectancies to nonbeneficial treatment whenever the treatment itself is not oppressive.

Accordingly, the crucial factual question for lawmakers is whether patients with painful or debilitating disease are so vulnerable to error and abuse that it is better to treat all of them, regardless of their individual circumstances, than to undertake a case-by-case assessment of their best interests. As I do not believe that the experience of patients in jurisdictions with more liberal tests indicates a sufficient risk of abuse, I find the *Cruzan* formula far too restrictive. Furthermore, lawmakers who are less sanguine than I about the decisionmaking process would better serve the patients whom they are trying to protect if they fashioned safeguards more narrowly tailored to the cases with greatest risk of abuse, thereby reducing the instances in which "protective" measures force nonbeneficial treatment. For example, these lawmakers might consider greater supervision of those categories of patients who can be identified as especially vulnerable to error or abuse, such as patients who have no close family or friends to assess their interests or patients in some institutional settings. Or they might promulgate decisionmaking criteria intended to circumscribe the discretion of proxy decisionmakers more narrowly in these high risk cases.³⁶² While there are reasons to doubt that even measures of this sort are necessary, they would represent a more appropriate response to the dangers than the *Cruzan* formula.

358. Even Ramsey conceded that aggressive treatment that will only prolong the dying process may be forgone when the patient is suffering irremedial pain. P. RAMSEY, *supra* note 331, at 191-93, 212-16 (1978) (suffering from Tay-Sachs, and Leach-Nyhan disease and anencephaly, respectively). See R. SHERLOCK, *supra* note 333, at 100, 103.

359. Whether dignitary injuries associated with the disease should be considered as well as the physical and emotional burden turns on whether the patient has previously expressed objections to the treatment, or if not, the likelihood that the patient can currently experience indignities such as humiliation.

360. It has also been defended as a desirable defense against "slippery slope" extension of the law permitting the passive withholding of treatment to include active euthanasia. That subject is discussed below in Part V. It may also be defended as a way of enforcing the state's opposition to a preference for death. That subject is discussed in Part IV.

361. The court was clearly concerned to protect patients more vulnerable than Nancy Cruzan, perhaps at the cost of sacrificing her interests. See *Cruzan*, 760 S.W.2d at 426. "The State's interest is in the preservation of life, not only Nancy's life, but also the lives of persons similarly situated and yet without the support of a loving family." *Id.* "[W]e choose to err on the side of life, respecting the rights of incompetent persons who may wish to live despite a severely diminished quality of life." *Id.* at 427.

362. Similarly, they might scrutinize these cases for conflicts of interests or require confirmation of the patient's diagnosis.

4. *The Case of Nancy Cruzan*

Significantly, Judge Robertson never suggested that his formula represented an attempt to fashion a suitable test of Nancy Cruzan's overall interests. He focused instead on the state's oft-ignored interest in life. As a result, he attributed to the *state*, not to Nancy, an interest in her life.³⁶³ In fact, he never explicitly discussed Nancy's overall interests in the treatment decision before the court.³⁶⁴ As a result, it is tempting to speculate that his balancing test was designed to advance state interests separate from its interest in protecting and advancing Nancy's wishes and welfare. Certainly, other possible bases for the state's interest in the preservation of life exist and they may provide alternative explanations for the court's rejection of quality of life considerations. For example, some critics believe that quality of life considerations should be avoided because they constitute the first step toward involuntary euthanasia. Others view refusal of treatment based on a poor quality of life as akin to suicide. Both of these concerns may have played a role in the formulation of the *Cruzan* test. These concerns are the subjects of Parts IV and V.

IV. THE STATE'S INTEREST IN THE SANCTITY OF LIFE

The state also may claim that its interest in the preservation of life serves policies that are independent of patients' wishes or welfare and sometimes in conflict with them. A few courts appear to have recognized this dichotomy by observing that the state's interest in the preservation of life extends not only to preservation of the patient's own life but also to protection of the "sanctity of all life."³⁶⁵ At least two plausible reasons explain why a society might conclude that it is wrong to let a patient die even if decisionmakers can satisfactorily determine that treatment does not advance the patient's interests. First, refusals based on a preference for death may violate society's ethical or religious beliefs about the sanctity or intrinsic value of life.³⁶⁶ Second, even if allowing patients to die is ethically proper, widely implementing this practice may intolerably threaten the sanctity of life by eroding social and legal barriers to other killing, such as suicide, voluntary active euthanasia, and even involuntary euthanasia.³⁶⁷ This Part considers the possible state interest in the sanctity or intrinsic value of life. Part V examines the "slippery slope" problem.

363. *Cruzan*, 760 S.W. 2d at 424. ("Given the fact that Nancy is alive and that the burdens of her treatment are not excessive for her, we do not believe her right to refuse treatment, whether that right proceeds from a constitutional right of privacy or a common law right to refuse treatment, outweighs the immense, clear fact of life in which the state maintains a vital interest.")

364. Interestingly, neither did the brief of the Attorney General.

365. *E.g.*, *In re Conroy*, 98 N.J. 321, 349, 486 A.2d 1209, 1223 (1985); *see also In re Gardner*, 534 A.2d 947, 957 (Me. 1987) (Clifford, J., dissenting).

366. *See Wanzer*, *supra* note 50, at 849; *Brophy v. New England Sinai Hosp., Inc.* 398 Mass. 417, 453, 497 N.E.2d 626, 646 (1986) (O'Connor, J., concurring in part and dissenting in part) (Brophy's suicidal intent inconsistent "with this nation's traditional and fitting reverence for human life").

367. *Cruzan v. Harmon*, 760 S.W.2d 408, 420 (Mo. 1988) (en banc), *cert. granted sub nom. Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989).

A. *The Sanctity of Life in Refusal of Treatment Cases*

For some people, especially those with a deep faith in God, life itself may have an intrinsic value that makes intentionally ending it morally wrong, at least in the absence of an equally compelling moral excuse.³⁶⁸ This view may reflect a belief that all humans, like Job, have a responsibility to live out their lives and that they lack the authority or the capacity to judge either the value of their own lives or the value of the lives of their wards. Undoubtedly, very similar concerns have contributed to the substantial unanimity with which courts have rejected wrongful life actions. Arguably, they also help explain why many living will statutes are restricted to the terminally ill.³⁶⁹

Most importantly, this moral mandate partly explains the past criminality of suicide.³⁷⁰ At common law, suicide was *malum in se*, like murder, an offense against God and nature.³⁷¹ Self-destruction was unnatural because it was contrary to the instinct for self-preservation.³⁷² Suicide offended God because it breached God's proscription "Thou shalt not kill."³⁷³ It usurped God's right to end life.³⁷⁴ Suicide also cheapened life by treating it as alienable.³⁷⁵ While suicide itself is no longer criminal, the courts have uniformly acknowledged a continuing state interest in preventing suicide. In addition, state criminal laws continue to prohibit assisted suicide and mercy killing, regardless of the decedent's consent or the killer's motives.³⁷⁶ These expressions of state policy provide plausible support for the view that the state has an interest in the intrinsic value of life which would support its interference with attempts by patients or their surrogates to implement a preference for death.

For some modern judges, the state's interest in resisting suicidal self-destruction is implicated by a patient's refusal of medical treatment whenever a patient with a long life expectancy declines a minimally invasive treatment.³⁷⁷ Their objections to

368. See, e.g., T. BEAUCHAMP & J. CHILDRESS, *supra* note 151, at 95; Wanzer, *supra* note 50, at 849; Blake, *State Interests in Terminating Medical Treatment*, HASTINGS CENTER REP., May/June 1989 at 5, 8, Callahan, *Can We Return Death to Disease?*, HASTINGS CENTER REP., Jan./Feb. 1989, at 4; Koop, *The Challenge of Definition*, HASTINGS CENTER REP., Jan./Feb. 1989, at 1, 2 (describing this view). Beauchamp and Childress conclude that there is a prima facie right to commit suicide, but that justification to intervene may exist in some cases. T. BEAUCHAMP & J. CHILDRESS, *supra* note 151, at 99.

369. This contention is unpersuasive. See *infra* note 425.

370. See *infra* text accompanying notes 371-76.

371. Hales v. Petit, 75 Eng. Rep. 387 (C.B. 1562); Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 FORDHAM L. REV. 1, 16 & n.69 (1975); N. CANTOR, *supra* note 170, at 46 (offense against God, nature, and instinct); *Suicidal Competence*, *supra* note 196, at 745 (common law offense to God and society); Note, *supra* note 149, at 103 & n.97, 104 (against God, man, and public welfare).

372. Hales, 75 Eng. Rep. at 400.

373. *Id.* at 400; Note, *supra* note 149, at 104 n.105 (citing Augustine).

374. Note, *supra* note 149, at 104.

375. It also set an evil example to other susceptible members of society. Byrn, *supra* note 274, at 20-22. It also deprived the king of the subject's service. Hales, 75 Eng. Rep. at 400; Byrn, *supra* note 274, at 21. And it challenges the benevolent role of the state. Byrn, *supra* note 274, at 21.

376. W. LAFAYE & A. SCOTT, CRIMINAL LAW § 7.8, at 651-52, § 5.11, at 477-78, § 3.6, at 228 (2d ed. 1986).

377. Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 442, 443, 448, 497 N.E.2d 626, 640, 643 (1986) (dissenting opinions of Nolan, Lynch, and O'Connor); *In re Gardner*, 534 A.2d 947, 956-58 (Me. 1987) (Clifford, J., dissenting); John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670 (1971); Application of President & Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964); see also Cruzan

nontreatment in these cases may reflect some of the same moral objections to self-destruction as those expressed about suicide. Undoubtedly, they also reflect, as suicide prevention practices do, concerns about patient competence and welfare. But the context in which the references to suicide are made do not suggest an entirely paternalistic explanation. Judge Nolan, a dissenter in *Brophy*, was most frank. In his view, withholding treatment from Paul Brophy in deference to his wishes constituted suicide and was “self-destruction and . . . intrinsically evil.”³⁷⁸ Other judges have been less specific about the reasons why they object to nontreatment in the cases which most resemble suicide. Often, they seem to assume that the suicide analogy speaks for itself.

Disentangling the state’s interest in the sanctity or intrinsic value of life from other policies served by the state’s interest in the preservation of life is difficult, and, perhaps, a little unfair. The phrase “sanctity of life” itself has many possible meanings. At its core lies the idea that all life is equally valuable and worthy of respect regardless of age, handicap, race, or other attribute. In this respect, it constitutes a widely shared liberal ideal, demanding protection of the vulnerable against error and abuse. Accordingly, “sanctity of life” advocates who have objected to the use of “quality of life” considerations sometimes base their objections on a fear that surrogates will abuse their discretion, thereby discriminating against the best interests of the aged, senile, or handicapped, a topic discussed above. In addition, they fear that withholding a minimally burdensome treatment on the grounds that life has lost its value will open the door to practices they believe are intolerable, such as nontreatment based on a person’s social worth, nontreatment in violation of a person’s wishes (involuntary euthanasia), and active measures to hasten the death of seriously ill patients (assisted suicide of competent patients and active euthanasia of incompetents). That subject is considered in Part V. But sanctity of life objections often run deeper than fears of error or extension. Some sanctity of life advocates also believe that the sanctity of life ideal precludes a patient’s assessment that his own life is not worth continuing or a surrogate’s assessment that death would serve a patient’s best interests. Under this view, a preference for death is itself morally wrong and the state may legitimately refuse to condone it. Even though this viewpoint may be interwoven with concerns about abuse and extension, it seems appropriate to consider the moral objection in isolation from its related concerns.

1. *Judicial Treatment of the State’s Interest in the Intrinsic Value of Life*

Early in the development of withholding doctrine, the courts separated the state’s interest in suicide prevention from its interest in the preservation of life. This separation was largely an historical accident caused by the *Saikewicz* taxonomy of

v. Harmon, 760 S.W.2d 408, 422 (Mo. 1988) (en banc) (noting that an unrestricted right to refuse medical treatment will lead to the approval of suicide), cert. granted sub nom. Cruzan v. Director, Mo. Dept. of Health, 109 S. Ct. 3240 (1989); *In re Browning*, 543 So. 2d 258, 270 (Fla. Dist. Ct. App. 1989) (“In such cases, the act intuitively seems close to suicide.”).

378. *Brophy*, 398 Mass. at 442, 497 N.E.2d at 640 (Nolan, J., dissenting). Judicial acquiescence in it, in his view, constituted “anti-life secular humanism” and “modern paganism.”

state interests. Recently, a few courts have recognized correctly that the state's interest in preventing suicide constitutes one aspect of the state's larger interest in the preservation of life.³⁷⁹ But traditionally the courts have considered the state's interest in suicide separately. They have then distinguished refusals of treatment from traditional suicide on the grounds that the patient lacks a specific intent to die³⁸⁰ and that the underlying injuries are not self-inflicted.³⁸¹ But the similarities between refusal of life-sustaining medical treatment and suicide are often more substantial than the majority opinions have conceded.

The cases that immediately followed *Quinlan* did not raise the issue of suicidal intention or euthanasia as dramatically as the more recent ones involving artificial food and water. Unlike the recent cases, most of the early withholding cases following *Quinlan* were relatively tolerable for sanctity of life advocates. These cases typically involved terminally ill patients whose treatments, such as artificial respiration, dialysis, and chemotherapy, were relatively invasive and burdensome.³⁸² In some, the patient's short life expectancy may have mooted concerns about injury to the state's interest in life.³⁸³ In others, the burdens of treatment apparently provided a morally acceptable justification for refusing treatment. In addition, most patients refusing burdensome treatment may actually have wished to live, but only on their own terms, without the burdens and suffering imposed by advanced technology.³⁸⁴ Thus, a substantial consensus, which included the Catholic Church, arose supporting the withholding of "extraordinary" measures from terminal patients.³⁸⁵

Even in these relatively easy cases, however, it was a bit disingenuous to state flatly that the patients desired to live, but not while on the machines. Although this characterization probably expressed both the patient's dilemma and her justification, it never entirely accurately described her intentions. At the very least, all these patients preferred the likelihood, sometimes the certainty, of an earlier death to a longer life with continued treatment.³⁸⁶ Similarly, surrogates who made decisions on behalf of incompetent patients were, at least in part, deciding that death was best for the patient. The more swift and certain the patient's probable death upon discontinu-

379. *In re Conroy*, 98 N.J. 321, 355, 486 A.2d 1209, 1226 (1985); *Severns v. Wilmington Medical Center, Inc.*, 425 A.2d 156, 158 (Del. Ch. 1980).

380. See *infra* text accompanying note 389.

381. See *infra* text accompanying notes 443-52.

382. *Wanzer*, *supra* note 50, at 844; e.g., *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976); *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), approved, 379 So. 2d 359 (Fla. 1980); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977). See also N. CANTOR, *supra* note 170, at 1-20; J. ROBERTSON, *supra* note 44, at 34-35 (courts less likely to find adequate state interest).

383. E.g., *In re Sanders*, 129 Misc. 2d 45, 492 N.Y.S.2d 510 (Sup. Ct. 1985) (trial court notes that the patient is not choosing life over death because he is already terminal); *Custody of a Minor*, 385 Mass. 697, 712, 434 N.E.2d 601, 606 (1982) (question is the manner of death, not a choice between life and death); *In re Requena*, 213 N.J. Super. 475, 484, 517 A.2d 886, 891 (Ch. Div.) ("surrender to the dying process"), *aff'd*, 213 N.J. Super. 443, 517 A.2d 869 (App. Div. 1986).

384. *In re Conroy*, 98 N.J. 321, 351, 486 A.2d 1209, 1224 (1985); *Satz*, 362 So. 2d at 162-63.

385. See N. CANTOR, *supra* note 170, at 48.

386. And some of these patients may actually have preferred death to disability. For example, some persons declining amputation may be more motivated by a preference not to be handicapped than by the fear of surgery. N. CANTOR, *supra* note 170, at 22.

ance and the less painful the treatment,³⁸⁷ the more that refusal resembled suicide and the more that the surrogate decisionmaker's request for discontinuance or withholding resembled assisted suicide or euthanasia. Nevertheless, the majority opinions uniformly insisted that death was merely foreseeable and not intended.³⁸⁸

The next generation of cases made the distinction between nontreatment on the one hand, and suicide or assisted suicide on the other, much more difficult to sustain. In some of those cases, like Paul Brophy's and Nancy Cruzan's, the patient's life expectancy was long and the burden of treatment was relatively small.³⁸⁹ As a result, the resemblance to traditional suicide increased.³⁹⁰ In these cases, patient directives to withhold treatment seemed to reflect a belief that life under the circumstances was not worth living. In this respect, the objectives of the patient resembled those of the ordinary suicidal person.³⁹¹ Still, courts declined to mandate treatment. Some continued to insist that the patients lacked the requisite intent.³⁹² Others stopped distinguishing suicide on this ground, thereby implicitly conceding the issue,³⁹³ but continued to distinguish refusal of treatment from suicide on the alternative ground that disease, not man, caused death. They refused to acknowledge or to consider the independent relevance of suicidal intent.

A few courts, however, did address the issue of suicidal intent. In *Quinlan*, for

387. *See id.* at 31 (the law presumes that people intend the natural consequences of their actions). The probabilistic nature of some treatments, such as chemotherapy, make many refusals resemble the kind of personal risk assessment made daily in decisions whether to ride motorcycles or sail hang-gliders. In those cases, the likelihood of a shorter life does not sufficiently resemble suicidal intent to be objectionable.

388. *E.g., Satz*, 362 So. 2d at 162–63; *In re Colyer*, 99 Wash. 2d 114, 123, 660 P.2d 738, 743 (1983); Byrn, *supra* note 274, at 18; *cf. PRESIDENT'S COMMISSION, supra* note 4, at 77–82 (discussing the distinction). The difficulty of separating a preference for death from a simple desire to avoid burdensome treatment is illustrated by the facts of a blood transfusion case in which the patient hoped to live without the blood, but preferred life in the promised land to life on earth with the blood. *In re Osborne*, 294 A.2d 372, 373–74 (D.C. 1972); *see also PRESIDENT'S COMMISSION, supra* note 4, at 78 (sometimes difficult to determine when a consequence ought to be treated as intended).

389. Many of the other cases involving artificial nutrition and hydration could probably be interpreted similarly, even though the proof will rarely be so evident as in Elizabeth Bouvia's case. *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986). Kathleen Farrell said, "I'm tired of suffering [from Lou Gehrig's disease]," to explain her desire to be removed from her respirator. *In re Farrell*, 108 N.J. 335, 346, 529 A.2d 404, 409 (1987). Disavowing Karen Quinlan's care, Paul Brophy said, "I don't ever want to be on a life-support system. No way do I want to live like that; it is not living." *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 428 n.22, 497 N.E.2d 626, 632 n.22 (1986). He commented, "When your ticket is punched, it's punched." Regarding a bad burn victim whom he rescued, he said, "If I'm ever like that, just shoot me, pull the plug." The dissenters pointed this out. *Id.* at 442, 497 N.E.2d at 640 (Nolan, J.); *id.* at 446, 497 N.E.2d at 642 (Lynch, J.); *id.* at 450, 497 N.E.2d at 644 (O'Connor, J.).

390. *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (en banc), *cert. granted sub nom. Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989). The analogy to suicide generally surfaces in cases where nonterminal patients decline a minimally invasive treatment. The early cases involved refusal of blood transfusions. Application of President and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964); *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971). The more recent cases raising this issue have involved the discontinuation of artificial nutrition and hydration for patients in a persistent vegetative state. *E.g., In re Gardner*, 534 A.2d 947 (Me. 1987); *Brophy*, 398 Mass. 417, 497 N.E.2d 626; *see also Cruzan*, 760 S.W.2d 408; *In re Browning*, 543 So. 2d 258 (Fla. Dist. Ct. App. 1989) (nonterminal, near vegetative state).

391. When, in the absence of patient directions, the surrogate makes his own determination that withholding of a minimally burdensome treatment better comports with the patient's interests, he too is implicitly expressing an opinion that the patient's life is not worth continuing in its current condition. His decision to withhold or discontinue treatment, thus, constitutes a form of passive euthanasia.

392. *E.g., Bouvia*, 179 Cal. App. 3d at 1144–45, 225 Cal. Rptr. at 305–06; *Delio v. Westchester County Medical Center*, 129 A.D.2d 1, 24, 516 N.Y.S.2d 677, 692 (1987).

393. *E.g., Rasmussen v. Fleming*, 154 Ariz. 200, 207, 741 P.2d 674, 681 (Ct. App. 1986); *Gardner*, 534 A.2d at 955–56; *Brophy*, 398 Mass. at 439, 497 N.E. 2d at 638.

example, the court left no doubt that the exercise of a patient's right to refuse treatment should not and would not expose the patient or those who assisted the patient to suicide, assisted suicide, or homicide charges because the patient was exercising a constitutional right.³⁹⁴ The holding, therefore, appeared to insulate even patients with a preference for death. But the significance of the court's language was clouded somewhat by the balancing test also enunciated by the court. The *Quinlan* test itself appeared to limit patient rights in cases most likely to involve suicidal intent.

Other courts have cast doubt on the significance of suicidal intent by suggesting that the state's interest in preventing suicide applies only to irrational self-destruction, implying that competent refusal of treatment falls outside the state's interest.³⁹⁵ Few, however, have been so explicit as the California courts. In the case of Elizabeth Bouvia, a California court clearly stated that Bouvia's motive was irrelevant.³⁹⁶

In summary, no court has expressly mandated treatment on the grounds that the refusal in question resembled suicide. A few have either implicitly or expressly suggested that suicidal intention would be irrelevant. But most simply refuse to acknowledge or discuss its presence.

2. Preservation of Life

Even though the courts have uniformly denied that withholding or refusal of treatment impairs the state's interest in *preventing suicide*, they might nonetheless have satisfied conservative critics if they had shown a willingness to protect the state's interest in the *preservation of life*, an interest which most courts have treated as doctrinally distinct. The *Quinlan* balancing test seemed potentially well suited to that task for it implied an overriding state interest whenever patient prognosis was good and treatment burden minimal. In theory, at least, it authorized intervention in cases most clearly suggesting suicidal intent.

Yet, no court has ordered treatment using the *Quinlan* test, not even an emergency blood transfusion or artificial nutrition and hydration. When forced to decide in cases like that of Paul Brophy, the courts have been unwilling to recognize a sufficient state interest to justify treatment. In all likelihood, the *Quinlan* balancing test has failed to operate as a vehicle for enforcing the state's interest in the intrinsic value of life because mainstream courts considered the state's interest in the sanctity of life to be less weighty than the countervailing patient interests. When put to the test, they are unwilling to use the *Quinlan* test to balance the scales. In *Conroy*, for example, the court described the state's interest in the sanctity of life as "indirect and abstract" as long as the patient was only making decisions about his own life.³⁹⁷ This sentiment is also implicit in the refusal by most courts to acknowledge the existence of suicidal intent in any refusal of treatment case. Given the disfavor with

394. *In re Quinlan*, 70 N.J. 10, 52, 355 A.2d 647, 670, cert. denied, 429 U.S. 922 (1976).

395. See *supra* note 68 and accompanying text.

396. *Bouvia*, 179 Cal. App. 3d at 1145, 225 Cal. Rptr. at 306; *Suicidal Competence*, *supra* note 196, at 708-09.

397. *In re Conroy*, 98 N.J. 321, 350, 486 A.2d 1209, 1223 (1985).

which the courts appear to view the state's interest in the intrinsic value of life, judicial refusal to use the *Quinlan* test as a means of identifying proscribed motives is anything but surprising.

Critics, by contrast, never lost sight of the relationship between suicidal intent and the *Quinlan* test. But they discovered that the *Quinlan* formula, even if literally applied, was less protective of the state's interest in preventing suicide than it appeared. Although many of the early cases had emphasized the imminence of death and the burden of treatment, an emphasis consistent with a sanctity of life perspective, the actual terms of the *Quinlan* test were not so narrowly circumscribed. That test based the state's interest on patient prognosis, not patient life expectancy. As a result, the state's interest declined even if the patient had a long life expectancy so long as the patient's condition and prospects were sufficiently bleak. In fact, Karen Quinlan's own case had turned in part on the likelihood that she would never recover her cognitive abilities.³⁹⁸ Therefore, the state's interest in overriding patient wishes decreased under the *Quinlan* formula as the patient's prospective quality of life declined.

Perhaps this attribute of the *Quinlan* test would not have generated any dissent if the courts had still insisted that the treatment itself be relatively burdensome in order to outweigh the state's interest in the sanctity of life. But in the eyes of the dissenters in Maine and Massachusetts and the majority in Missouri, the mainstream courts had failed to do so. In particular, these judges felt that artificial feeding was not a sufficiently burdensome treatment to override the state's interest in the lives of patients with long life expectancies. In their eyes, a patient requesting that food and water be withheld was motivated by a desire to end life because it was not worth living, not by a desire to avoid a burdensome treatment. Under these circumstances, they found the resemblance to suicidal intention intolerable.

The modification of the *Quinlan* test proposed in *Brophy* and implemented in *Cruzan* was the logical product of their objections.³⁹⁹ As modified, the test measured the state's interest solely in terms of life expectancy and the patient's justification solely in terms of treatment burden. Poor prognosis no longer weakened the state's interest in overriding patient wishes.⁴⁰⁰

But the case for using the *Cruzan* formula as a way of enforcing the state's interest in the intrinsic value of life depends upon two important assumptions. First, it assumes that the state has a significant interest in prolonging a patient's life against that patient's interests. Second, it presupposes that the burden of disease is never an adequate justification for acquiescing in death, even though the burdens of treatment can sometimes justify a refusal to accept treatment. These assumptions are considered in the next two sections.

398. *Quinlan*, 70 N.J. 10, 355 A.2d 647.

399. As discussed above, there are additional explanations for the excision of quality of life concerns. See *supra* notes 117-27, 345-62 and accompanying text.

400. While Judge Robertson's choice of criteria was also influenced by his desire to protect incompetent patients from abusive medical decisions, he certainly thought that a balancing test limited to life expectancy and treatment burden would prevent extension of the doctrine to suicides, as indeed it would. *Cruzan v. Harmon*, 760 S.W.2d 403, 422 (Mo. 1988) (en banc), cert. granted *sub nom.* *Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989).

B. *The Distinction Between Burdensome Treatment and Burdensome Disease*

Under the *Cruzan* formula, the state's interest in the intrinsic value of life is not limited by the patient's quality of life, but it is offset by the burdensomeness of the patient's *treatment*. No similar offset is permitted when patients wish to refuse a minimally burdensome treatment because their *disease* is painful, debilitating, or demoralizing. Burdensome treatment, therefore, excuses refusal of treatment while burdensome disease does not.

This distinction between burdensome treatments (which may be refused) and burdensome diseases (which must be treated) is reminiscent of the principle of double effect and its differentiation between desired effects and undesired but foreseeable consequences.⁴⁰¹ That principle, which is part of Roman Catholic tradition, justifies an act that would otherwise be morally objectionable if the actor's primary intention is to accomplish another morally justifiable act of equal or greater moral weight.⁴⁰² The killing of a fetus to save the life of the mother is an example of conduct justified under this principle.⁴⁰³ In the context of medical treatment, it has been used, for example, to justify the administration of pain killers to relieve severe agony, even though they may shorten the patient's life.⁴⁰⁴ While intentionally shortening the patient's life might ordinarily be wrong, the "primary" objective here is to alleviate pain, not to end life. That objective is proper. Because avoiding pain is the objective of treatment in these cases and treatment is not being used as a means to shorten the patient's life, the treatment is morally permissible even though it has the undesired but foreseeable result of hastening death. In this fashion, the principle of double effect purportedly rationalizes this decision without explicitly evaluating the quality or worth of the patient's life or conceding that the intentional ending of life is proper.⁴⁰⁵

The *Cruzan* formula may reflect a similar point of view. Whenever a treatment is refused or withheld because it is particularly invasive, the principal objective of nontreatment can be described as avoiding the infliction of an inhumane treatment burden. As with the administration of life-shortening pain killers, the patient's earlier death may be characterized as an "unintended" by-product. Thus, withholding may

401. See PRESIDENT'S COMMISSION, *supra* note 4, at 77-82 (rejecting the distinction).

402. Eike-Henner W. Kluge describes the principle as follows:

The principle itself is that if one act has two consequences, the one good and the other evil, where both consequences are inevitable outcomes of the initial act itself, then the act is morally acceptable (and, presumably, the bad result morally excusable) if these four conditions are met:

(1) Considered in and by itself, the act is not morally objectionable.

(2) The agent's intention in performing the act is directed towards the good to be achieved only and does not include the bad result as a desideratum.

(3) The bad result is merely the inevitable concomitant and not a means to the good result or a condition of it.

(4) There are grave reasons for engaging in the act itself such that failure to perform the act would result in at least as bad a state of affairs as the bad effect of the performance of the act.

Kluge, *The Ethics of Deliberate Death*, reprinted in J. AREEN, P. KING, S. GOLDBERG & A. CAPRON, LAW, SCIENCE AND MEDICINE 1107-08 (1984) [hereinafter J. AREEN]. See also PRESIDENT'S COMMISSION, *supra* note 4, at 80 n.110 (defining the elements of double effect).

403. Kluge, *supra* note 402, at 1107.

404. *Id.* at 1109; see also Wanzer, *supra* note 50, at 846-47 (discussing physician obligations to alleviate pain). Painkillers can induce respiratory depression or result in pneumonia. PRESIDENT'S COMMISSION, *supra* note 4, at 77 n.100.

405. Implicitly, of course, it assumes that the patient is better served by a shorter, comfortable life than by a longer, painful one.

be justified even if intentionally shortening life is otherwise objectionable. By contrast, withholding a nonburdensome treatment from a patient whose disease is causing great debilitation or agony could probably not be justified under this principle.⁴⁰⁶ Here, avoiding the pain of treatment would not be the end. Instead, ending life would be the desired objective and ending treatment would be a means to that end.⁴⁰⁷ Ending nonburdensome, life-sustaining treatment would, therefore, be an unjustifiable means to achieve an improper end. Treatment burden would, thus, constitute an excuse for hastening death, while disease burden would not.

Yet, the similarities between the patient with a painful disease and the one with a painful treatment seem more important than the differences. In each case, the patient desires to end pain by ending treatment. In both, ending treatment will hasten death, a result that the patients know and prefer to continued treatment. The law ordinarily “holds people to be equally responsible for all the reasonably foreseeable results of their actions and not just for those results that they acknowledge having intended to achieve.”⁴⁰⁸ If the burdens of remaining alive can justify acquiescence in death, they would seem to excuse both classes of patients.⁴⁰⁹ The distinction between burden of treatment and burden of disease, therefore, unfairly tolerates death in one instance but not the other.⁴¹⁰

The distinction between treatment and disease may conceivably be defended on another basis. When the state mandates a treatment against the patient’s wishes or interests, it not only violates the patient’s liberty and welfare interests, but it violates his bodily integrity. The state probably needs greater justification to force very invasive medical treatments than to require less invasive medical treatments. Even if the state’s interests in life would otherwise outweigh the patient’s interests in liberty and welfare, the bodily invasion necessary to treat the patient’s condition may sometimes shock the conscience. Under these circumstances, the invasiveness of treatment could define the proper limits of government authority to mandate medical care. Minimally burdensome treatments would raise no problem of intrusiveness under this analysis, even if the disease being treated was causing excruciating pain. Put differently, the state may have less authority to inflict pain than to force a person to endure it. As a result, treatment burden is arguably a useful measure of the patient’s challenge to the state’s interest in life.

However, this bodily integrity analysis is unsuitable as a basis for the distinction

406. See *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 442, 497 N.E.2d 626, 640 (1986) (Nolan, J., dissenting) (double effect would not sanction withheld nutrition from Paul Brophy).

407. Perhaps the principle could be extended to this case by characterizing the primary goal as the alleviation or shortening of pain, not death. But this extension is not very convincing so long as the elimination of pain is to be achieved by intentionally shortening the patient’s life.

408. PRESIDENT’S COMMISSION, *supra* note 4, at 78; N. CANTOR, *supra* note 170, at 31.

409. Cf. PRESIDENT’S COMMISSION, *supra* note 4, at 62, 80 (decision whether to administer painkillers that may shorten life should reflect net benefit to the patient). At least one critic has suggested that the principle of double effect is really an appeal to utility. Kluge, *supra* note 402, at 1109. If so, it is a flawed utility approach for the reasons suggested in the text. Its principal appeal may be that it disguises the utility analysis, thereby minimizing social awareness of the utility maximizing process.

410. Below, I will consider the possibility that erosion of social values regarding killing could be additionally threatened if we permit withholding where the “primary” goal is death. See *infra* Part V.

between treatment and disease burdens because it assumes without explanation that the state's interest in life would otherwise outweigh the patient's interests in appropriate medical care. Yet, even when the bodily intrusions are relatively minor, patients retain a significant interest in self-determination and in medical care that reflects their best interests. These interests are not accurately measured by treatment burden alone.⁴¹¹ Patients have an obvious interest in self-determination, regardless of treatment burden, and an interest in avoiding treatments that may prolong a life of horrible discomfort and despair even if that suffering is caused by a disease rather than by the treatment. The autonomy and welfare interests of the patient with a painful or dehumanizing disease are as great as those of the patient refusing burdensome life-saving treatment. Either patient's "excuse" for refusing treatment is equally weighty. Thus, the interests of patients with burdensome diseases ought to be reflected in any balancing formula adopted to measure the interests of patients and the state. As the *Cruzan* test ignores these interests, it is badly flawed. As between the *Quinlan* and *Cruzan* tests, therefore, the *Quinlan* formulation is preferable because it considers a patient's overall prognosis, not just the treatment burden.

C. Sanctity of Life as a Basis for Mandating Treatment

The courts have shown little inclination to enforce the state's interest in the intrinsic value of life using either balancing test, not even to order blood transfusions for patients who could return to good health.⁴¹² Implicitly, mainstream courts have concluded that a patient's possible preference for death is not objectionable if the patient is merely declining treatment, or at least not sufficiently objectionable to warrant forcible treatment. They have made it clear that the state's interest in life for its own sake no longer carries sufficient weight to require an "excuse" before patient interests will govern. The patient's interests always constitute sufficient justification for refusal.

Unfortunately, too few courts have acknowledged that patients and their surrogates are now being authorized to determine whether life is worth living.⁴¹³ While the *Bouvia* court expressly stated that motive was irrelevant, few courts have been so honest. Perhaps the courts have not been explicit about this because they fear that explicit tolerance of a preference for death will weaken the policies against suicide and assisted suicide. But the resulting hypocrisy has its own costs. By treating the suicide analogy as an all-or-nothing comparison and rejecting it completely, courts forsake the opportunity to consider whether some suicide prevention practices might appropriately be borrowed for cases where refusals most resemble suicide. In this way, courts could protect patients against incompetent or ill-considered refusals. Some patients, after all, may need help as much as they need liberty. Furthermore,

411. Mahoney, *The Right of Privacy and the Right to Die*, 5 MIDWEST MED. ETHICS 22, 24 (1989).

412. A few courts have ordered transfusions since *Quinlan*, but none have relied upon the state's interest in the intrinsic value of life or the *Quinlan* balancing test.

413. Some tried to have it both ways, denying the suicide analogy, but confirming that patient interests would govern even if the analogy was sound.

by unnecessarily ignoring the obvious similarities to suicide, the courts needlessly cast doubt on the soundness of their holdings.

Instead, the courts should explicitly acknowledge their conclusion that the state's interest in the sanctity of life—in the belief that all lives are worth living—yields to the patient's interests in self-determination and, when patients' wishes are unknown, to patient interests in medical decisions that serve patients' best interests. Courts should acknowledge that they have implicitly recognized new defenses to the criminal laws governing homicide and suicide insofar as they apply to the withholding of medical treatment. At least in this context, consent is now a defense.⁴¹⁴ Likewise, withholding based on a patient's best interests is excused.⁴¹⁵ Put differently, there is no longer a duty to treat under these circumstances.⁴¹⁶

Once these changes in traditional doctrine were frankly admitted, they would then be more exposed to public debate, but that is as it should be. Most people in our society would probably disagree with the normative assumption that preferring death is inherently wrong, cowardly, or irrational, at least after exhausting the kinds of safeguards suggested in Parts II and III.⁴¹⁷ Even those unwilling to rule out the possibility of a state interest in thwarting rational preferences for death would probably agree with the judicial consensus that this interest is less weighty than patient autonomy or well-being. Unless this interest in the sanctity of life is elevated over the interests of the patient in appropriate medical treatment, the use of the *Quinlan* or *Cruzan* balancing tests to effectuate this policy cannot be supported.

The sanctity of life rationale also erroneously assumes that the criminal and civil power of the state should be used to enforce this state interest. This assumption is difficult to justify in the absence of tangible harm to the patient or others from nontreatment. Medical treatment decisions involve an intimate zone of personal privacy. State intrusion into that zone inescapably requires forcible invasion of the patient's body. Restraints may even be necessary.⁴¹⁸ Patients who are conscious will also suffer the humiliation and anger of the violation of their wishes. In short, involuntary treatment can cause serious harm. Even if society views treatment as *morally* obligatory, the undesirable consequences of *legally* enforcing that moral judgment make involuntary treatment inappropriate.⁴¹⁹

And to the extent that the patient's interests are constitutionally protected, there is good reason to doubt that a community's moral objections to rational self-

414. Cf. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (exercise of a constitutional right is a defense to criminal charges), cert. denied, 429 U.S. 922 (1976).

415. It is basically a new application of the necessity defense. Under that defense, a violation is justified if compliance with the law would have done even more harm. See W. LAFAVE & A. SCOTT, *supra* note 376, § 5.4, at 441-42.

416. Absence of a duty is a simpler way to maintain the distinction between active and passive killing without the need to recognize new homicide defenses, at least if discontinuation is treated as an "omission." See *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1022, 195 Cal. Rptr. 484, 493 (1983).

417. See *Cantor*, *supra* note 274, at 245-46; see also PRESIDENT'S COMMISSION, *supra* note 4, at 32 (state interest usually "attenuated").

418. See *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984) (hands tied to bed).

419. For this reason, the state role in this field is also distinguished from its enforcement of other victimless crimes, such as defaming the dead.

destruction would constitute an adequate state interest.⁴²⁰ Reliance on these moral objections to justify interference with patient interests would also raise the possibility of undue church-state entanglement.⁴²¹

At most, strong moral objections to nontreatment might conceivably justify the state's refusal to encourage, support, or fund patients who are refusing treatment.⁴²² They do not justify coercive treatment. Nor do they justify more subtle and less honest means of interference with patient care, such as the implementation of legal doctrines like unrealistic informed consent requirements which are biased against patient autonomy.

The naked state interest in the intrinsic value of life is, therefore, too attenuated to support mandatory, nonbeneficial treatment.⁴²³ To the contrary, respect for life is better demonstrated by treating only patients who desire treatment or who will benefit from it. Forced treatment elevates respect for the abstract idea of life over the respect for the living persons themselves. It treats the patients as inanimate objects who cannot be harmed or degraded.⁴²⁴ Fortunately, most courts reject this view and are unwilling to enforce this state interest when forced to decide whether to require treatment, notwithstanding their purported adherence to a balancing test.⁴²⁵ "We cannot," said the California court of appeals that decided the case of Elizabeth Bouvia, "conceive it to be the policy of this state to inflict such an ordeal upon anyone."⁴²⁶

V. SLIPPERY SLOPES

The state's interest in the preservation of life extends, of course, beyond the individual patient whose treatment is at issue. It also encompasses future individuals whose lives would be threatened if withholding doctrine created a social or legal climate conducive to intolerable conduct, such as involuntary euthanasia. Thus, slippery slope concerns constitute another possible explanation of judicial statements

420. However, these views may suffice under a rational basis test. See *Bowers v. Hardwick*, 478 U.S. 186, 196 (1986).

421. Cf. *Webster v. Reproductive Health Servs.*, 109 S. Ct. 3040, 3082-85 (1989) (Stevens, J., concurring in part and dissenting in part) (conclusion that life begins at conception endorses a theological position without secular purpose).

422. See *Harris v. McRae*, 448 U.S. 297 (1980). Interestingly, legislatures sympathetic to patient wishes have specifically ensured that refusal of treatment does not constitute suicide for purposes of life insurance coverage. *E.g.*, Mo. REV. STAT. § 459.050 (1986).

423. See PRESIDENT'S COMMISSION, *supra* note 4, at 32.

424. Annas, *Predatory Prediction and Mindless Mimicry: The Case of Mary O'Connor*, HASTINGS CENTER REP., Dec. 1988, at 31, 32-33.

425. The mainstream judicial view may, however, be criticized as being inconsistent with the many living will statutes that apply only to terminal patients. These statutes could be construed as creating a limited exception to the pre-existing laws governing suicide and homicide in cases of terminally ill patients. These statutes often expressly state that they are not intended to sanction suicide. But conclusions about legislative intent are difficult to draw because the impetus for these statutes was the difficulty experienced by the terminally ill in ending death-prolonging treatments. J. ROBERTSON, *supra* note 44, at 102. It seems likely that the statutes were intended to insure protection for the wishes of these patients and not to restrict the rights of other patients. In fact, many of the statutes expressly indicate that they are cumulative of common law rights, thereby refuting the suggestion that they reflect a policy of restricting autonomy to the circumstances governed by the living will statutes. Mo. REV. STAT. § 459.055 (1986). More explicit legislation will be necessary before firm conclusions about legislative policy can be reached.

426. *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1144, 225 Cal. Rptr. 297, 305 (1986).

that the state's interest in the preservation of life extends not only to protecting the individual patient, but also to preserving "the sanctity of all life."⁴²⁷

Slippery slope arguments in this field take two distinct forms. First, some courts and commentators suggest that liberal tolerance for the withholding of treatment in circumstances that resemble suicide logically dictates judicial approval of suicide itself. Thus, they doubt that the distinction between active killing and passively letting someone die can be defended. Second, some critics of liberal withholding doctrine fear that it will so familiarize society with the intentional hastening of death that ethically inappropriate extensions will be tolerated, such as the withholding of treatment because the patient has little social worth.

A. *Prevention of Suicide*

The analogy to suicide is clearest when a patient refuses life-sustaining medical treatment that is routine and minimally invasive by any standard and that offers the prospect of a good recovery. Under these circumstances, Professor Tribe correctly notes that "the state's acquiescence in the person's choice to refuse treatment appears not substantially different from state sanction of suicide."⁴²⁸ Suicidal intention may also be present when the patient's prospects are less promising, as where a patient suffering a deteriorative disease instructs providers not to provide artificial food and nutrition or when a patient declines amputation of a gangrenous limb because he prefers death to disability. The dissenters in Maine and Massachusetts vigorously and persuasively exposed this similarity in cases involving the artificial feeding of vegetative patients.

The failure of current doctrine to acknowledge a special state interest in cases where suicidal intention is most apparent invites the criticism that it logically dictates judicial approval of active suicide by competent adults.⁴²⁹ And because current doctrine permits third parties to assist patients who prefer to die by removing or withholding unwanted treatments, it may constitute a step toward judicial approval of assisted suicide and active, voluntary euthanasia upon patients who wish or wished to die but are now physically unable to commit suicide.⁴³⁰

427. *In re Conroy*, 98 N.J. 321, 349, 486 A.2d 1209, 1223 (1985).

428. L. TRIBE, *supra* note 52, at 1367.

429. *Cruzan v. Harmon*, 760 S.W.2d 408, 415-16 (Mo. 1988) (en banc), *cert. granted sub nom. Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989); *In re Gardner*, 534 A.2d 947, 958 (Me. 1987) (Clifford, J., dissenting); *Brophy v. New England Sinai Hosp., Inc.* 398 Mass. 417, 442, 497 N.E.2d 626, 640 (1986) (Nolan, J., dissenting); *id.* at 447, 497 N.E.2d at 642 (Lynch, J., dissenting in part); *id.* at 450, 497 N.E.2d at 644 (O'Connor, J., dissenting in part). In this discussion, active suicide includes self-destructive acts like the administration of poison. I also take it to mean "acts" of omission such as fasting in order to die. *See, e.g.*, *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 582, 279 A.2d 670, 673 (1971); *Brophy*, 398 Mass. at 446-48, 497 N.E.2d at 642-43 (Lynch, J., dissenting in part); *Delio v. Westchester County Medical Center*, 129 A.D.2d 1, 24 n.8, 516 N.Y.S.2d 677, 692 n.8 (1987); *In re Caulk*, 125 N.H. 226, 480 A.2d 93 (1984) (fasting prisoner). Fasting is "passive" but it is unlike refusal of medical treatment because it does not combine with illness to cause death. Thus, fasting does not neatly fit the active-passive distinction. Instead, it resembles suicide, rather than refusal of treatment, because disease is not a cause of death. *See* N. CANTOR, *supra* note 170, at 28-29 (fasting not letting nature take its course).

430. *See, e.g.*, Koop & Grant, *The "Small Beginnings" of Euthanasia: Examining the Erosion in Legal Prohibitions Against Mercy-Killing*, 2 J. L. ETHICS & PUB. POL'Y 585, 595 (1986); Brief of Mo. Citizens for Life, at 43, *Cruzan*, 760 S.W.2d 408 (No. 70813) [hereinafter Citizens for Life Brief] (lethal injections are next).

The distinction between suicide and withholding of treatment is vulnerable to criticism from two quite different viewpoints. Opponents of withholding, like the dissenters in Maine and Massachusetts, object to the satisfaction of the patient's desire to die in either case because of the presence of suicidal intention in each. They object to the conclusion, particularly by surrogates, that a person would be better off dead. They fear that failure to enforce the state's interest in the sanctity of life out of deference to patient interests dictates similar deference when active suicide cases arise. Thus, they would ban both active suicide and suicidal refusals of treatment.⁴³¹

The conservative critics of mainstream withholding doctrine have improbable allies in their argument that current doctrine logically suggests tolerance of suicide. The advocates of greater tolerance of active suicide and active euthanasia join in the conclusion of conservative jurists that withholding is often a form of suicide. They differ only in their ultimate conclusion that both should be tolerated rather than both prohibited.⁴³² Consider Elizabeth Bouvia's two encounters with the courts.⁴³³ In both cases, she had a similar interest in relief from pain and from the indignities associated with her increasing dependency. To many, it may seem arbitrary and unfair to accommodate her wishes in one case and not another.⁴³⁴ Does it make sense, they might ask, to permit a burn victim who fears a life of disability to refuse life-saving grafts or surgery, but to deny him access to the instruments of self-destruction if he initially agrees to the grafts and they leave him more disabled than his doctors predicted?

Indeed, attempted suicide is no longer illegal in the great majority of jurisdictions.⁴³⁵ A few opinions in withholding cases have even suggested that the state's interest in prevention is limited to "irrational" suicides.⁴³⁶ On the other hand, it is far from clear that decriminalization reflects any legislative sentiments about the authority of the state to prevent suicides. The task of deducing public policy is made more difficult by the continued encouragement of suicide prevention⁴³⁷ and the criminalization of assistance by third parties.⁴³⁸

Despite the opportunity to use this current uncertainty as a vehicle for reconsidering the state interest in preventing suicide, most courts have chosen instead to distinguish suicide from the refusal of medical treatment. Mainstream courts have uniformly rejected the contention that they are sanctioning a form of suicide. They have distinguished suicide from refusal of treatment on the grounds that patients who refuse treatment die from natural causes and lack a specific intention to die. Yet,

431. See Koop, *supra* note 368, at 2.

432. See, e.g., Rachels, *supra* note 249; PRESIDENT'S COMMISSION, *supra* note 4, at 29-30.

433. Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986).

434. At least one court has apparently permitted a competent 85-year-old patient to fast in order to hasten death. J. AREEN, *supra* note 402, at 1125.

435. Cantor, *supra* note 274, at 254-55; J. ROBERTSON, *supra* note 44, at 28.

436. See *supra* note 69 and accompanying text.

437. See Byrn, *supra* note 274, at 16 (privilege to use reasonable force to prevent suicide); *Suicidal Competence*, *supra* note 196, at 735, 745-46 (temporary civil commitment; privilege to use reasonable force to prevent).

438. See N. CANTOR, *supra* note 170, at 5-10 (consent is no defense); J. ROBERTSON, *supra* note 44, at 29, 68 (active euthanasia never legal); *Suicidal Competence*, *supra* note 196, at 735, 745-46; see also Barber v. Superior Court, 147 Cal. App. 3d 1006, 1012, 195 Cal. Rptr. 484, 487 (1983) (euthanasia not excusable).

neither of these distinctions survives close scrutiny. To this extent, the critics of the distinction between active and passive death are correct. There are important similarities between suicide and refusal of treatment that most courts have either denied or ignored.

Still, toleration of a virtually unrestricted right to refuse medical treatment does not necessarily dictate similar tolerance of active suicide and euthanasia. It is possible that the factual differences between refusal of treatment and traditional suicide will support different treatment for reasons not yet fully articulated by the courts.⁴³⁹ Even if they do not, courts should not impose medical treatment against patient interests in order to preserve state authority to prevent active suicide. The better conclusion to draw is that the policies supporting suicide prevention may be narrower than many courts have supposed.

1. *The Mainstream Judicial Distinctions*

Virtually all majority opinions, *Cruzan* being one exception,⁴⁴⁰ have pointedly distinguished traditional suicide from the refusal of medical treatment. They have relied principally upon two theories to make the distinction. First, they suggest that disease, not the conduct of the patient, is the cause of death in medical treatment cases. Second, courts doubt that patients refusing medical treatment have the specific intent to die. Both of these distinctions have serious weaknesses. As discussed above,⁴⁴¹ some patients may indeed be motivated by a desire to die. In some cases, death is so certain and the preference for it so clear that the analogy to suicidal intent is compelling.⁴⁴² Yet, the courts have already demonstrated that they will either deny or ignore the presence of specific intent even when that intent is patently clear. In these cases, judicial contentions that the patient lacks the requisite intent is better viewed as a euphemistic way of stating the underlying conclusion that a preference for earlier death is permissible in refusal of treatment cases. What is missing is an explanation of why this preference is more tolerable here than in the case of active suicide. The absence of this explanation invites criticism that toleration of suicidal intent here presages toleration of traditional suicide as well.

Perhaps the courts feel that an adequate explanation is provided by the causal distinction between suicide and refusal of treatment. Courts insist that illness, not refusal of treatment, is the cause of death in the withholding cases.⁴⁴³ Often, they express this belief by stating that treatment would only “prolong dying.”⁴⁴⁴ In cases

439. See *infra* notes 454–74 and accompanying text.

440. Another is *Barber*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (emphasizing the absence of a duty on the part of providers to act and leaving untouched the trial court’s findings on causation and malice).

441. See *supra* notes 379–93 and accompanying text.

442. While most courts have retained a nominal balancing test that theoretically could be used to mandate treatment in these cases, thus far they have not demonstrated any interest in doing so. Whether they will do so in the clearest cases is still unknown.

443. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 738, 743 n.11, 370 N.E. 2d 417, 423, 426 n.11 (1977).

444. See, e.g., *In re Gardner*, 534 A.2d 947, 956 (Me. 1987) (“only prolong the ultimate moment of his death”; “natural dying process”); *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So. 2d 921, 924 (Fla. 1984) (“how long and at what cost the dying process should be prolonged”); *Custody of a Minor*, 385 Mass. 697, 711, 434 N.E.2d 601,

where death is imminent, this description aptly reflects the state's minimal interest in extending the patient's life against her wishes. But often, especially when patients are in persistent vegetative states,⁴⁴⁵ this description is at best inaccurate and at worst misleading.

The courts also emphasize that withholding merely lets nature take its course, while suicide actively accelerates death.⁴⁴⁶ Refusal of treatment, said the New Jersey Supreme Court in *Conroy*, is an exercise of self-determination, not self-infliction.⁴⁴⁷ There are two related threads to this argument. In one respect, it draws upon the act-omission distinction by suggesting a morally relevant distinction between taking affirmative action to hasten death and acquiescing in death which could be avoided or delayed.⁴⁴⁸ The second underpinning for this distinction between suicide and refusal of treatment is the distinction between human conduct that is the sole immediate cause of death, such as a suicidal gunshot, and human conduct that operates in conjunction with disease to cause death, such as the refusal of medical treatment. This distinction between sole causes and concurrent causes explains how the courts can treat fasting by a healthy person as a form of suicide but not an ill person's refusal of artificial nutrition.⁴⁴⁹ It also helps to explain how the active disconnection of medical apparatus, like a respirator, can be characterized as an "omission."⁴⁵⁰ While removal of apparatus is an "act," it acts only in conjunction with the underlying disease to cause death, unlike a gunshot or poison. By contrast, most suicides are both active and the sole immediate cause of death.⁴⁵¹

But the legal and ethical significance of these distinguishing factual characteristics is not self-evident, even though courts and commentators have often assumed as much. For example, a physician's negligent or intentional failure to treat a patient can be a legal cause of death even though the culpable conduct is an omission and even though that omission merely lets nature take its course.⁴⁵² If, by contrast, withholding treatment at a patient's request is not a legal cause of death under the

609 (1982) ("manner of dying" at stake); *In re L.H.R.*, 253 Ga. 439, 445, 321 S.E.2d 716, 722 (1984) ("prolonging her death rather than her life"); PRESIDENT'S COMMISSION, *supra* note 4, at 65.

445. See, e.g., *Gardner*, 534 A.2d at 956 ("only prolong the ultimate moment of his death"; "natural dying process"); *L.H.R.*, 253 Ga. at 445, 321 S.E.2d at 722 ("prolonging her death rather than her life").

446. See, e.g., *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1144-45, 225 Cal. Rptr. 297, 305-06 (1986) (natural causes); *In re Colyer*, 99 Wash. 2d 114, 123, 660 P.2d 738, 743 (1983) (natural causes); Byrn, *supra* note 274, at 18 (death-producing agent not set in motion by patient).

447. *In re Conroy*, 98 N.J. 321, 359, 486 A.2d 1209, 1229 (1985). Interestingly, the same court had called refusal of treatment a form of "self-destruction" in *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 578, 580-82, 279 A.2d 670, 672-73 (1971). A number of courts have drawn the same contrast. E.g., *McConnell v. Beverly Enter.*—Conn., 209 Conn. 692, 701, 553 A.2d 596, 601 (1979); *Gardner*, 534 A.2d at 955; *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978), *approved*, 379 So. 2d 359 (Fla. 1980).

448. Cf. PRESIDENT'S COMMISSION, *supra* note 4, at 54.

449. See *supra* note 429.

450. E.g., *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1017, 195 Cal. Rptr. 484, 490 (1983). This characterization permitted the court to excuse the conduct of the providers in that case. First, the court concluded that the criminal law penalized failures to act only when the responsible individual had a duty to act. It then reasoned that the providers had no duty to act against the patient's best interests.

451. Suicides, of course, also have underlying "causes" such as depression, but these causes will not ordinarily lead to death without action by the sufferer.

452. Actions which accelerate the death of a terminally ill patient are legal causes of death. PRESIDENT'S COMMISSION, *supra* note 4, at 70 (omission as cause); Capron, *supra* note 34, at 651 (natural cause does not preclude responsibility).

suicide and homicide laws, the real explanation cannot be found in causation doctrine. Instead, the causation distinction used by the courts serves as a proxy for an unstated and implicit conclusion that intentionally causing death under these circumstances is justified. That justification must be found outside causation doctrine in judicial beliefs about respecting patient wishes and avoiding patient suffering. Because these justifications may apply similarly to active suicide, they may not support a distinction between active suicide and the refusal of medical treatment.

Because the distinctions based on causation and specific intention are unconvincing, the similarities between refusal of treatment and active suicide or homicide are more substantial in many cases than the courts have acknowledged. If the factual differences between the two are morally relevant in a way that the law should recognize, courts must identify other reasons why patient decisions that effectuate a preference for an earlier death are more tolerable when the patient is declining medical treatment than when he takes poison. They should not continue to conclude that the two contexts are materially different without explaining why the differences outweigh the similarities.⁴⁵³ If the distinction between refusing treatment and suicide is legitimate, it must find other roots. Otherwise, the claim that liberal withholding doctrine logically requires greater toleration of suicide is correct.

2. Other Rationales for Distinguishing Refusal and Suicide

The necessity for a fresh examination of the policies behind the state's interest in preventing suicide does not necessarily dictate judicial or legislative approval of active suicide. Even though the distinctions used by the courts so far are more conclusory than explanatory, other more persuasive reasons for distinguishing between the two contexts may exist. There are several possible reasons for distinguishing between passive acquiescence in a disease process and active acceleration of death.⁴⁵⁴ Only a brief review of them is possible here.

Doubts about a suicidal patient's competency and about his true desires constitute the most important justification for more active intervention in suicide attempts.⁴⁵⁵ These concerns may be more serious when persons attempt suicide than

453. Nevertheless, causation distinctions have proven equally tempting to critics of withholding. Judge Robertson, for example, clearly believed that the withholding of minimally burdensome treatments such as artificial food and water was causally different from withholding burdensome treatment. He described the Cruzan family's desire as a request to *make* her die, rather than to *let* her die. *Cruzan v. Harmon*, 708 S.W.2d 408, 412, 422 (Mo. 1988) (en banc) ("to make Nancy die"; "to cause death"), *cert. granted sub nom. Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989); see also Destro, *supra* note 331, at 126 (not the disease that kills when nutrition is withheld); *Right to Die*, U. MICH. L. QUADRANGLE NOTES, Fall 1988, at 7 (reporting the comments of Professor Kamisar). But nontreatment is no more and no less a cause of death in these cases than it is when a person declines chemotherapy or a major invasive surgery that would add time to his life. See N. CANTOR, *supra* note 170, at 39 (withholding respirator suffocates as much as withholding nutrition starves). In all of these cases, both the disease and the refusal of treatment combine to hasten death. Causation analysis will not support a distinction between them.

454. An excellent debate that further develops these issues took place between Glanville Williams and Yale Kamisar. See G. WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* (1957); Kamisar, *Some Non-Religious Views Against Proposed Mercy-Killing Legislation*, 42 MINN. L. REV. 969 (1958); Williams, *Mercy-Killing Legislation—A Rejoinder*, 43 MINN. L. REV. 1 (1958).

455. See Cantor, *supra* note 274, at 256–57; *Suicidal Competence*, *supra* note 196, at 732, 746–53. Several recent

when they decline medical treatment. The percentage of suicide attempts associated with clinically significant emotional distress may be sufficient to warrant, at the very least, a strong presumption of incompetency. Likewise, many suicide attempts may be pleas for help, not for death. And because suicide attempts typically risk immediate unconsciousness and death, unlike many refusal of treatment decisions, they do not provide time for reflection or reconsideration.⁴⁵⁶ In addition, suicide attempts typically require emergency treatment by providers who lack knowledge of the patient's competency and wishes. For all of these reasons, routine suicide prevention may be justified in order to insure an adequate decisionmaking process.⁴⁵⁷ These considerations support temporary intervention in suicide attempts just as they would support similar interventions in medical treatment cases when reasons to doubt the quality of patient autonomy exist. However, this rationale would not support long-term interference with the few competent and persistent suicidal patients or prosecution of their accomplices.

Another possible explanation for the distinction lies in the value judgment that humans have less obligation to fight disease than to endure an otherwise healthy but agonizing existence. This viewpoint is a close cousin of the suggestion that patients have a greater obligation to fight a painful disease than to accept a painful treatment. In both cases, proper respect for the intrinsic value of life arguably compels persons to accept their fates, even though it does not compel them to maximize their life expectancies by accepting treatment.⁴⁵⁸ Active suicide, in this view, disvalues human life by its aggression against life and its suggestion that life is "property which may be destroyed or alienated at the will of the 'owner.'" ⁴⁵⁹ This fatalistic distinction is unconvincing for two reasons. First, it assumes that a preference for death is evil. Second, a patient's refusal of medical treatment is no more or less "fated" than shooting himself in the head.⁴⁶⁰ Both the patient's refusal of treatment and the suicidal individual's self-inflicted injuries challenge the idea that life is always worth living. Both dispute the obligation to endure an intolerable life. Apparently, conservative judges share this view, for they seek to restrict both traditional suicide and suicidal refusals of treatment. They are not comfortable allowing passive refusals and then drawing the line at active suicide.

A slightly different defense of the distinction can be made by focusing on the propriety of government intervention, rather than upon the morality of the patient's choice. Government intervention to force medical treatment requires an invasion of bodily integrity. No similar invasion occurs when the state merely deprives the

decisions in medical treatment cases have suggested that the state's interest is in preventing *irrational* suicide. See *supra* note 71.

456. See Cantor, *supra* note 274, at 261.

457. See N. CANTOR, *supra* note 170, at 34.

458. See Byrn, *supra* note 274, at 21 (suggesting that refusal of treatment, unlike suicide, constitutes "deference to the vagaries of life").

459. *Id.* at 20.

460. Other commentators also have found the distinction unconvincing. *E.g.*, Cantor, *supra* note 274, at 255 n.133 (citing several others).

individual of the freedom to actively invade his own body to cause his own death.⁴⁶¹ Arguably, a lesser showing of state interest should be required to support laws against suicide, assisted suicide, and mercy killing. However, this defense of the state's authority to regulate active killing assumes that the state's interest in opposing active suicide is sufficient to justify the lesser intrusions necessary to prevent those competent suicides. Yet, an individual suffering a painful and debilitating disease may have a great interest in active suicide. Both his autonomy and his suffering are at stake. Under these circumstances, the sufficiency of the state's countervailing interest cannot be assumed. Furthermore, the difference in intrusiveness will often be fleeting. Once the patient attempts suicide, state intervention to thwart the suicide attempt will often require forcible treatment and bodily restraints. As a result, arguments for greater state authority to prevent suicide than to mandate medical treatment do not find persuasive support in the kinds of governmental action necessary to enforce the state's interest.

However, other factual differences between suicide and refusal of treatment may give rise to practical consequences warranting a difference in treatment. For example, suicide may be more likely to cause imitation by individuals of dubious competence.⁴⁶² In addition, suicides may be more likely to impose burdens on society because of the emergency procedures instituted to respond to suicide attempts. In the case of suicidal patients with terminal disease, some commentators have also suggested that the availability of analgesics and other comfort measures reduces the need to hasten death still further by active euthanasia or suicide.⁴⁶³ Suicide is also more likely to deprive society of valuable human resources than refusal of medical treatment.⁴⁶⁴ And while tolerance of suicide may or may not increase the risks of error and abuse, it magnifies substantially the number of cases in which error is possible.⁴⁶⁵ Furthermore, the violent nature of active suicide may increase the risk that judicial legal tolerance would somehow jaded society to active killing in other contexts, such as capital punishment, involuntary euthanasia, or war. Conceivably, these differences justify prohibition of active suicide.⁴⁶⁶

More troubling than the prospect of increased tolerance for active suicide is the possibility that refusal of treatment doctrine will be extended to permit active

461. Cf. *Public Health Trust of Dade County v. Wons*, 541 So. 2d 96 (Fla. 1989) (noting the difference between compelling behavior offensive to religious principles, such as blood transfusions, and prohibiting conduct motivated by religious principles, such as snake handling); L. TRIBE, *supra* note 52, at 1372 n.6 (safety laws that require active participation of individual or directly impinge on the body may warrant greater scrutiny).

462. Byrn, *supra* note 274, at 22; Cantor, *supra* note 274, at 242, 257.

463. Cantor, Quinlan, *Privacy, and the Handling of Incompetent Dying Patients*, 30 *RUTGERS L. REV.* 243, 266 (1977); PRESIDENT'S COMMISSION, *supra* note 4, at 72.

464. See Cantor, *supra* note 274, at 242-43, 245-46; Note, *supra* note 149, at 108; *Suicidal Competence*, *supra* note 196, at 730, 744 (patients who refuse treatment not likely to produce tangible social benefits). Cantor notes that effectuation of this state interest would require the evaluation of the social worth of each affected individual, a task he finds unseemly and unrealistic in the context of medical treatment. Cantor, *supra* note 274, at 242-43.

465. See Beauchamp, *A Reply to Rachels on Active and Passive Euthanasia in Ethical Issues in Death and Dying*, reprinted in J. AREEN, *supra* note 402, at 1104-07.

466. In a refusal of treatment case, furthermore, the difficulty of confidently ascertaining whether the patient who refuses medical treatment has a desire to die may also counsel against mandating an unwanted and possibly harmful treatment. See Byrn, *supra* note 274, at 23.

euthanasia.⁴⁶⁷ The case for distinguishing active euthanasia from passive euthanasia is considerably stronger than the case for distinguishing suicide from refusal of treatment. In addition to the reasons given for treating suicide different than refusal of treatment, the special dangers associated with the role of third parties makes toleration of active euthanasia considerably more problematic. First, the patient's request for active assistance in dying is a quite different demand upon his caretakers than a request to be let alone.⁴⁶⁸ The right to demand assistance that is recognized in some refusal of treatment cases would be an intolerable imposition upon the consciences of caretakers when extended to active killing. Even if a willing accomplice can be found, the risk of abuse may be more grave if those accomplices are permitted to cause actively the patient's death.⁴⁶⁹ The risks would be especially great if the patient's past preferences were unclear and the decisionmakers were making a substituted judgment or best interests assessment.⁴⁷⁰ Social toleration of active euthanasia by health care providers could also impair patient trust in their providers and damage the self-image and devotion of those providers.⁴⁷¹

Furthermore, the symbolic effect on social values of sanctioning actively "killing" patients may be far more dramatic than the effect of simply withholding treatment from these patients.⁴⁷² With active euthanasia, man alone, not in combination with disease, causes the death of another human being.⁴⁷³ Toleration of this sole causative role in the death of another blameless individual has no precedent in our law and culture. It, therefore, could pose a qualitatively greater threat to erode our taboos against killing and our respect for human life than nontreatment of the seriously ill.⁴⁷⁴

In addition, there is always the danger that an activity which is permitted will some day be mandated, once society becomes acclimated to it. It is easy to overstate the speculative nature of this danger. Nevertheless, to the extent that this concern has merit, the limitation of intentional killing to the withholding of medical treatment serves to limit the potential cases of mandated euthanasia to those where nature itself provides a cause of death.

Collectively, these differences may support a distinction between active killing and the withholding of medical treatment, particularly when third-party assistance is involved. Each of these contentions is speculative and each has its own problems. Serious consideration of them would require a separate article. While these concerns

467. Current treatment doctrine permits a patient's caretakers to participate in the patient's refusal of treatment. They may discontinue or disconnect life-sustaining treatment at a patient's request. In addition, they may decline to initiate treatment that they would otherwise be required to provide.

468. See Wanzer, *supra* note 50, at 848; J. CHILDRESS, *supra* note 240, at 178.

469. PRESIDENT'S COMMISSION, *supra* note 4, at 79-80; J. CHILDRESS, *supra* note 240, at 179.

470. See L. TRIBE, *supra* note 52, at 1370.

471. See PRESIDENT'S COMMISSION, *supra* note 4, at 79; J. CHILDRESS, *supra* note 240, at 179.

472. See, e.g., Kamisar, *supra* note 454, at 978-1013; PRESIDENT'S COMMISSION, *supra* note 4, at 30. Perhaps for this reason, the district attorney in one important New York case suggested that the patient's interests should yield to the state's interests in prohibiting one person to cause the death of another. *In re Storar*, 52 N.Y.2d 363, 377-78, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273, *cert. denied*, 454 U.S. 858 (1981).

473. Cf. Beauchamp, *supra* note 465, at 1104.

474. *Id.*; J. CHILDRESS, *supra* note 240, at 179.

are not entirely convincing, they certainly warrant great caution in the extension of the right to refuse medical treatment into a broader right to die. The propriety of taking that step and the adequacy of the state interests opposing it must remain for determination in the specific factual context in which it arises. The important point for purposes of assessing the state's interest in unwanted medical treatment is that liberal deference to patient wishes and interests by no means preordains equal tolerance for active suicide, assisted suicide, or active euthanasia. The factual differences between withholding treatment, on the one hand, and suicide or active euthanasia, on the other, may justify some differences in treatment.

3. *Tolerating Suicide and Active Euthanasia*

In any event, the case for state interference with suicide and active euthanasia must be decided on its own merits. It would be wrong to deny autonomy to suffering patients merely because the insights revealed in their cases suggest possible limits on the state's interest in preventing suicide and assisted suicide.⁴⁷⁵ To the extent that refusal of treatment and suicide are similar, sound development of withholding doctrine will help to produce sounder suicide policies. That consequence is not one to be feared. So long as withholding doctrine is itself sound, courts ought not be afraid to acknowledge the extent to which the searching scrutiny given to withholding doctrine has yielded insights about the state's interest in preventing suicide as well.⁴⁷⁶ The important question is whether withholding doctrine is itself ethically and legally sound.

Conceivably, however, close examination of the state's interest in preventing suicide could help prevent oversights in refusal of treatment cases by revealing values or policies that have been overlooked by the courts. Judicial refusal to acknowledge the similarities certainly makes this a plausible concern. But the fear is unfounded in fact. The principal policy currently supporting the prevention of suicide is a desire to protect the incompetent and confused. Concerns about competency justify only limited, temporary interference with patients declining treatment. Other possible concerns, such as the danger of setting an example which will be imitated by vulnerable individuals or the waste of societal resources,⁴⁷⁷ have dubious weight and, at any rate, simply do not appear to play a significant role in the refusal of treatment context.⁴⁷⁸ Other policies include sanctity of life objections to a preference for death and slippery slope concerns about the toleration of intentional killing. The former

475. See *supra* note 69 (cases suggesting that the state interest is limited to irrational suicide).

476. Despite the protestations of judges, their refusal in refusal of treatment cases to give teeth to the balancing tests in the face of a preference for death does suggest an unstated judicial readiness to reconsider suicide policies should that issue be raised directly. If so, the claim of conservative critics is at least partially correct. That possibility is clouded by judicial insistence that the factual differences between refusal and suicide are legally relevant.

477. See *supra* notes 462–64 and accompanying text.

478. Possible harm to third parties, including family members, is another possible state interest in preventing suicide. *Suicidal Competence*, *supra* note 196, at 745. This state interest is contingent upon risk to third parties and would not support the conclusion that either suicide or refusal is wrong in itself. Nor does it turn upon prognosis or treatment. As a result, the balancing tests are not appropriate vehicles for effectuating this interest. In refusal of treatment cases, the courts have acknowledged that this is a separate state interest in requiring medical treatment.

were considered in Part IV and the latter will be considered next. None of them justify the conclusion that current withholding doctrine is unsound.

B. *Social Consequences*

Some courts and commentators fear that ethically appropriate extensions of the right to refuse medical treatment could lead to other extensions of the doctrine that are not similarly justified.⁴⁷⁹ Some have even speculated that liberal withholding doctrine could domesticate the intentional killing of others in a way that affects society's feelings about homicide, capital punishment, and war.⁴⁸⁰ But the most common and disturbing contention is that liberal withholding doctrine could lead to wholesale elimination of the senile, retarded, and handicapped because of the burden they impose on society.⁴⁸¹ Fears of this kind provide yet another possible explanation of Judge Clifford's paradoxical suggestion that a humane and caring nation would sometimes treat a patient against her wishes.⁴⁸² Disrespect for her interests may be the price to be paid for the protection of more important interests—in this case, the lives of future patients.⁴⁸³

Professor Yale Kamisar cites the current case law permitting the withholding of nutrition and hydration as an example of this kind of slippery slope progression.⁴⁸⁴ He claims that these cases could never have been decided if the courts had been asked to proceed directly to the nutrition and hydration cases. But by deciding cases like *Quinlan* first, the courts have acclimated society to the withholding of treatment in a way that has made society more receptive to the extensions of withholding doctrine to include nutrition and hydration.⁴⁸⁵

479. See PRESIDENT'S COMMISSION, *supra* note 4, at 29–31.

480. *E.g.*, Note, *supra* note 149, at 106 n.113 (homicide); Beauchamp, *supra* note 465.

481. *See, e.g.*, *Cruzan v. Harmon*, 760 S.W.2d 408, 420 (Mo. 1988) (en banc), *cert. granted sub nom. Cruzan v. Director, Mo. Dept. of Health*, 109 S. Ct. 3240 (1989); *In re Gardner*, 534 A.2d 947, 955 (Me. 1987); *Citizens for Life Brief*, *supra* note 430, at 43–48; *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 453, 497 N.E.2d 626, 646 (1986) (O'Connor, J., concurring in part and dissenting in part); Kamisar, *supra* note 454, at 1014–41. The slippery slope arguments are related to criticisms that current doctrine provides too much room for error and abuse, but they are even more disturbing because they suggest that the implementation of current doctrine will weaken societal opposition to that abuse.

482. *Gardner*, 534 A.2d at 957–58 (Clifford, J., dissenting).

483. *Koop & Grant*, *supra* note 430, at 607; Kamisar, *supra* note 454, at 1041–42; *see also* Note, *supra* note 149, at 106 (balancing the risks to future patients against the harm of unwanted treatment only in cases involving incompetent patients). This is, therefore, a state interest in the lives of other individuals, rather than a state interest in the patient herself. Courts have ordinarily treated threats to third parties as a separate basis for intervention by the state. Despite the orthodox separation of these interests, any discussion of the state's interest in preserving the life of the patient would be incomplete without consideration of the social consequences which could follow from a restrictive conception of the state's interest in the patient's own life.

484. *Right to Die*, *supra* note 453, at 7–8. A recent article in the *New England Journal of Medicine* describes the progression as follows:

Some of the practices that were controversial five years ago in the case of the dying patient have become accepted and routine. Do-not-resuscitate (DNR) orders, nonexistent only a few years ago, are now commonplace. Many physicians and ethicists now agree that there is little difference between nasogastric or intravenous hydrations and other life-sustaining measures. They have concluded, therefore, that it is ethical to withdraw nutrition and hydration from certain dying, hopelessly ill, or permanently unconscious patients.

Wanzer, *supra* note 50, at 844. The authors of that article then proceed to break still more ground by concluding that “it is not immoral for a physician to assist in the rational suicide of a terminally ill person.” *Id.* at 848.

485. *Right to Die*, *supra* note 453, at 7. “Because of the enormous publicity generated by the underlying *Quinlan* case, we quickly grew accustomed to the idea of turning off a respirator—and psychologically ready for the next phase.

Because of the apocryphal imagery associated with these slippery slope arguments, particularly the common comparisons to Nazi Germany,⁴⁸⁶ they invite a cynical response. But the dangers are too serious to treat lightly. Well-intentioned deference to nontreatment decisions conceivably could reshape the social climate in a way that makes previously unthinkable conduct thinkable. Withholding doctrine certainly constitutes highly public precedent for the conclusion that a person would be better off dead. And it permits surrogates to make this decision when the patient's wishes are unknown. Thus, it serves as precedent for the intentional killing of another blameless person. The long-term impact of this doctrine on our taboos against killing and on our commitment to caring for the seriously ill is a matter of serious concern.

Because this kind of slippery slope argument relies on speculation about the actual impact of proposed practices on future values, however, it is particularly difficult either to prove or to refute as a factual matter. As a result, the arguments themselves may be susceptible to abuse.⁴⁸⁷ Too readily accepted, they lead toward an unthinking acceptance of the status quo and the prohibition of some conduct that is acknowledged to be ethically acceptable.⁴⁸⁸ Lawmakers, therefore, ought to demand evidence that the pressures in this society to take unjustified action are likely to prove irresistible.

Three distinctions central to withholding may serve as possible fences to prevent descent down a slippery slope. These are the distinctions between (1) voluntary and involuntary termination, (2) patient-oriented interest assessment and social worth evaluation, and (3) letting patients die and actively killing them. Critics typically fear that several or all of these distinctions will be abandoned if still further fences are not erected. Thus, they have suggested that some limits be placed on patient autonomy, as by excluding nutrition and hydration from patient control, or by giving the state's interest more weight in the *Quinlan* balancing test. Alternatively, the right to refuse treatment could be restricted to terminal patients, as the *Cruzan* test tends to do, or to patients who have actually expressed a preference, as New York does. Thus far, most courts have refused to impose these additional restrictions on the substantive rights of patients. Instead, they have imposed more limited procedural safeguards designed to protect the decisionmaking process. And they have trusted their own ability and that of the public to appreciate the distinctions central to the development of withholding doctrine and to make responsible use of them.

The distinction between active and passive hastening of death is the most tenuous of the distinctions.⁴⁸⁹ The debate over the propriety of permitting active suicide and euthanasia is complex and ongoing. But there is no evidence that its outcome will turn on an erosion of current values caused by past acquiescence in passive withholding. It belittles the arguments in favor of active suicide to suggest

Cutting off food and water from a patient would have met enormous resistance if done in one step. But we did it in two steps." *Id.*

486. *E.g.*, Koop & Grant, *supra* note 430, at 589-91; Kamisar, *supra* note 454, at 1031-34.

487. PRESIDENT'S COMMISSION, *supra* note 4, at 30.

488. *Id.* at 30-31.

489. Many commentators have expressed the fear that objections to active euthanasia will erode. *See, e.g., Right to Die*, *supra* note 453, at 7-8; Koop & Grant, *supra* note 430, at 595 (prohibition would be hypocritical).

that only a degradation of social values could explain any increased toleration of active suicide, assisted suicide, or voluntary euthanasia.

The distinction between voluntary and involuntary withholding is much more important and seems unlikely to suffer from current practice. Respect for patient wishes can be readily distinguished from the withholding of life-saving treatment against a patient's wishes. That distinction between voluntary and involuntary action reflects and reinforces this country's long-standing emphasis on individual freedom. The seeds for legitimization of involuntary withholding of treatment on a broad scale are more likely to be sown by the decisions of government and private insurers to fund some life-saving technologies, such as dialysis, but not others, such as experimental organ transplantation, than by deference to patient refusals.⁴⁹⁰ By comparison, current withholding doctrine constitutes a trivial threat to patient autonomy.

In fact, restrictions on patient autonomy seem more likely to endanger future patients than deference to patient wishes. While respect for autonomy confirms that life belongs to the individual and not to the state, restrictions on patient autonomy, on the other hand, would be precedent for elevating the state's perception of a person's interests over his own. Treatment against a patient's interests would establish precedent for the proposition that the state may harm individuals to support its abstract moral values or to avoid highly speculative future societal risks. The dangers of this precedent are obvious. In the future, similarly tenuous state interests might then be relied upon to justify the *termination* of treatment against a patient's wishes and interests. This danger seems just as serious as that posed by ethically sound extensions of withholding doctrine. Yet, the danger posed by state-mandated treatment against a patient's interests is less tolerable because it is not independently defensible.

The risks of illegitimate extension of withholding doctrine multiply, however, when mercy killing is not firmly founded in patient autonomy. Best interest analysis, substituted judgment, and the blending of the two are materially more problematic because they authorize mercy killing despite doubts about the patient's wishes.⁴⁹¹ The less clear the patient's wishes, the less "voluntary" the death. Death is then premised on the patient's interests, not his wishes.⁴⁹² When patient volition is absent, withholding is nonvoluntary and more closely borders on "involuntary" elimination of the unfit. Critics fear that every act of euthanasia could euphemistically be

490. These allocation decisions may themselves be justifiable. The point is not that they are illegitimate, but that they are more likely to cause rethinking and reshaping of current ideas about the involuntary termination of medical treatment than the case law of withholding.

491. That courts have used terms such as substituted judgment to describe this decisionmaking process, even when the patient has never been competent, thereby clothing existing doctrine in the armor of autonomy, arguably also reduces the danger that society will come to tolerate involuntary euthanasia. But the deception is transparent and may have the undesired effect of diluting the protection provided by the ideal of autonomy by suggesting that one person's views of another person's wishes or interests constitutes a sufficient autonomy. Courts would better serve society by admitting that proxy assessments of patient interests often play a role in medical treatment decisionmaking. So long as they insist that the task be patient-centered, they will reinforce the primacy of patient interests in the best interests assessment.

492. Because it is premised on those interests, withholding seems mandatory. But if this is the kind of mandatory euthanasia feared by Judge Robertson, his basis for objecting to it is unclear.

considered “voluntary.”⁴⁹³ Once the line between voluntary and involuntary euthanasia is obscured, some commentators claim that the foundation is laid for involuntary euthanasia of the impaired.⁴⁹⁴ The right to die could become the right to kill.⁴⁹⁵

These risks are real, but they can easily be overstated. Without question, this slide away from patient autonomy to third-party assessment of patient interests dictates careful supervision. Great care must be taken to ensure that the decision-makers do not impose unrealistically demanding notions of the minimum tolerable quality of life or make decisions based upon their perceptions of the patient’s social worth. Thus, the principal doctrinal protection against abusive interest assessments is provided by the last of the three “fences”—the distinction between patient-centered best interests analysis and decisionmaking based on social worth.

Lawmakers considering the slippery slope danger must, therefore, evaluate not only the risk that current health care decisionmakers will be unable to withstand illegitimate pressures to ignore patient interests (an error and abuse problem), but also the risk that routine interest assessment will eventually make currently prohibited social worth assessments tolerable (a slippery slope problem). At present, at least, the distinction between a patient’s own interests and the patient’s social worth seems sufficiently clear and consonant with existing social values to serve as a workable “fence.” As it builds upon the ordinary feelings that family and providers have towards patients, it seems unlikely to undergo unwitting erosion. That is not to say that no utility considerations will ever enter this arena. Ultimately, the social resource allocation issues raised by evolving technology will have to be addressed. But current appreciation of the difference between the patient’s own interests and his claim to social resources seems sufficiently strong to resist any pressures to blur or deny the difference. Thus, any effort to raise the allocation issues is likely to receive the serious debate that it deserves. Current doctrine will not impair our ability to undertake this debate.

On the other hand, lawmakers assessing these slippery slope dangers must bear in mind that slippery slopes can facilitate laudable value changes as well as damnable ones. When women were first given the right to vote, some savants no doubt predicted that an irreversible and undesirable slide toward employment, contract, credit, and reproductive rights for women had begun. Even if America at that time abhorred this prospect, it is difficult to conclude in hindsight that the transition was morally unsound. While our consciences will intuitively dictate that we nurture values we currently feel important, we must exercise great caution in assuming the superiority or timelessness of past or current value judgments. It seems reasonable to suggest that the ethically sound development of a withholding doctrine

493. Koop & Grant, *supra* note 430, at 621.

494. *Id.* at 595; see also Citizens for Life Brief, *supra* note 430, at 43–48. Koop and Grant appear to assume that this step would be accompanied by a shift from a patient-centered interest assessment to decisionmaking based wholly or partially upon the burden posed by the patient to society.

495. Koop & Grant, *supra* note 430, at 621. Not only does the discretion inherent in substituted judgment and best interests analysis provide latitude for abuse, but the collective process of exercising that discretion could accommodate a gradual shift in our presumptions about the interests of the seriously disabled.

that is based on respect for human dignity and welfare, like women's suffrage, is as likely to nurture a desirable evolution of social values as to "erode" currently sacrosanct values.

Still, supporters of the *Quinlan* and *Cruzan* balancing tests may feel that these tests provide better fences than the three previously mentioned. To be sure, both tests appear to bar the withholding of medical treatment in cases where a preference for death on the part of the patient or surrogate is most apparent. Arguably, this limitation reduces the likelihood that the right to refuse treatment will be extended to active suicide. As discussed earlier in this Part, however, that possibility does not justify restrictions on otherwise sound withholding doctrine.

In addition, the *Cruzan* test prohibits consideration of a patient's physical condition. Even though it does permit quality of life assessments when the treatment is burdensome, it superficially preserves the ideal that all lives are worth living because it focuses on the burdens of "treatment," rather than the burdens of "life." As a result, some observers believe that this approach decreases the danger that current doctrine will lead eventually to illegitimate killing.⁴⁹⁶ These arguments are plausible, but the speculative benefits of this approach come at great cost to the patients whose actual interests are disregarded by the *Cruzan* test. To the extent that the test seeks to guard against a slide from legitimate patient-centered interest assessment to illegitimate social worth assessments, it does so by denying a sizeable group of patients the treatment decisions that best reflect their own interests. This remedy seems too harsh, the tool too blunt.

The burden of proof ought to reside with those who would mandate treatment harmful to today's patients to substantiate their pessimistic view of human nature and the judicial system. They should bear the burden of demonstrating an intolerable risk to future patients. The burden should be placed here because of the concrete and certain costs that a restrictive withholding doctrine will have on current patients. Not only will overly restrictive doctrine impose harmful or futile treatments on many patients, but it may lead other patients and their families to decline potentially useful hospitalizations out of fear that the treatment will be unsuccessful and the patient will become a prisoner of medical technology like Nancy Cruzan.

Furthermore, lawmakers ought not accept the pessimistic view of human society inherent in the slippery slope arguments without first dedicating their energies to identifying the ethically appropriate limits of withholding doctrine and building clear and defensible fences at these borders. The better that these fences are built, the more likely that they will nurture, rather than erode, future societal norms. In this way, lawmakers can better serve the state's interest in preserving social norms without sacrificing the interests of current patients.

496. P. RAMSEY, *supra* note 331, at 171-88; see T. BEAUCHAMP & J. CHILDRESS, *supra* note 151, at 134; Koop & Grant, *supra* note 430, at 606, 614.

VI. CONCLUSION

Because the state's interest in the preservation of life has many facets, no single legal formula can measure all of them. The *Quinlan* balancing test, for example, serves some state purposes reasonably well, but not others. The *Cruzan* test is even less useful, at least if courts and legislatures share this author's distaste for the distinction between the burdens of treatment and the burdens of disease. Moreover, neither test, by its own terms, can differentiate between the circumstances in which its use is apropos and those in which it is not. The *Quinlan* test, for example, makes no distinction between patients whose wishes are known and those whose wishes are not; or between patients whose decisions to refuse treatment are caused by emotional distress or inaccurate information and those who are making a competent and informed refusal of treatment.

By and large, the courts have recognized the weaknesses in these formulae. With the notable exception of Missouri, even the courts which endorse them have refused to enforce them against patient interests. Some courts have even rejected the waxing and waning tests altogether. But by doing so, the courts have exposed themselves to the criticism that they have devalued the state's interest in the preservation and the sanctity of life. In truth, most courts have done nothing of the sort. Instead, they have devoted their attention to formulating procedural and substantive safeguards to guard against the most serious threat to patients' lives—the danger of error or abuse. Indeed, some have been overzealous in this regard. But their failure to associate explicitly these measures with the state's interest in the preservation of life may have created the mistaken impression that they have forsaken this state interest altogether.

Each jurisdiction must strike its own balance between protection and freedom, between overtreatment and premature death. The appropriate balance will vary with factors such as the competency of the patient, the condition of the incompetent patient, the setting in which treatment is rendered, and the potential for adverse impact on future societal norms. The task of melding these factors into an appropriate set of legal rules is too complex and subtle for any single formula. Rather than continue the futile search for that formula, lawmakers should instead articulate more precisely the specific components of the state's interest in the preservation of life which they seek to advance, identify the kinds of regulations that will advance those specific policies, and estimate the impact that those regulations will have on patient interests.

This explicit disentangling of the state's underlying interests will probably be controversial, particularly if many courts acknowledge their skepticism about the state's independent interest in the intrinsic value of life. Thus, the states will probably differ in their selections of state policies to advance or, at least, in the weight to which they assign them.

But the current disagreement between liberal and conservative jurists over the weight to be given to the state's interest has already overemphasized those differences while regrettably overshadowing their shared concerns. Their disagreements over issues such as the burden of proof for informed refusal, the necessity for restrictions

on best interest analysis, and the danger of slippery slopes often have less to do with differences over goals than with disagreements over factual issues, such as the probability of abuse, or over suitable means to achieve their common goals. Jurists should look past the labels that polarize and emphasize their differences, like "sanctity of life" and "quality of life," and recognize their shared dedication to the protection of patient wishes, patient welfare, and societal respect for life. If they did so, the current debate over the weight to be given to the state's interest in the preservation of life and over the terms of the formula which best expresses it could give way to a more focused, more creative, and more productive discussion of specific ways to obtain the facts needed to identify and assess the likely threats to these shared objectives and of ways to protect the interests of patients and the state in appropriate medical decisions.

