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1999]

THE MYTH OF AUTONOMY AT THE END-OF-LIFE:
QUESTIONING THE PARADIGM OF RIGHTS

SUSAN ADLER CHANNICK*

*"If I am not for me, then who is for me?
If I am just for me, then who am I?
And if not now, then when?"*¹

I. INTRODUCTION: MY FATHER'S STORY

LAWYERS and professors have been thinking about death and dying for a long time. This is not just morbid fascination. Lawyers must counsel clients in estate planning and professors must prepare them to do so, teaching the nuances of the various property, family protection and healthcare decision-making legal doctrines of death planning. People have a difficult time talking about death both in the abstract and particularly as applied to themselves—estate planning is less painful as an exercise in maximizing wealth transfer than as a confrontation with one's own mortality.² Maybe, in that sense, talking about death resembles sex education in school, an exercise in "magical thinking"; if we ignore it, if we pretend it doesn't exist, maybe it really doesn't.³ Of course, even this

* Professor of Law, California Western School of Law. This Article is dedicated to the memory of my parents and to the great dignity with which they accepted their deaths. I would like to thank my research assistant, Janette Reyes-Speer, without whom this Article would not have been possible.

1. Hillel Mishna, *Abot*, in A TREASURY OF JEWISH QUOTATIONS 442 (Joseph L. Baron ed., 1956) (listing Jewish maxims, proverbs and comments concerning one's "self").

2. See John L. Levy, *How to Help Clients Faced with Decisions about Keeping an Estate in the Family*, 15 EST. PLAN. 152, 155 (1988) ("Many people [plan their estates] with a great deal of pain and fear, not only because this forces them to face their own mortality, but also because the decisions they are making have such important and emotion-laden consequences. Clients usually try to . . . hide such 'unworthy' feelings, and many attorneys . . . tend to avoid emotional issues.").

3. See, e.g., JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 151 (1984) (recognizing phenomenon in conduct of physicians who continue to treat patients in hopes of magical cure notwithstanding all contrary scientific and empirical evidence). A search for references to the term "magical thinking" reveals references in the most unlikely contexts. See, e.g., George J. Annas, *Faith (Healing), Hope and Charity at the FDA: The Politics of AIDS Drug Trials*, 34 VILL. L. REV. 771, 771 (1989) (noting that people conceptualize as magical medical technology that which is not understood and that medical professionals are not immune from such "magical thinking"); Martha Grace Duncan, *In Slime and Darkness: The Metaphor of Filth in Criminal Justice*, 68 TUL. L. REV. 725, 755 (1994) (stating that practice of banishing criminals has its roots in superstition and "magical thinking"); Natsu Saito Jenga, *Unconscious: The "Just Say No" Response to Racism*, 81 IOWA L. REV. 1503, 1508 (1996)

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ultimate in self-deception lacks the force to alter the inevitable: eventually we all must confront the death of our loved ones or of ourselves.⁴

In recent decades, the law of death and dying has infused popular culture.⁵ The law's attention to such a difficult sociological phenomenon, which is ordinarily subject to great denial, is due to the confluence of two relevant sociological factors: technological advances in medicine and a surging national population caused by the baby-boomers' advancing ages.⁶ The population of the United States, and the world at large, is aging.⁷ Medical technology has advanced sufficiently to increase significantly life expectancy by keeping alive people who, in the not-so-distant past, would have died from their underlying medical conditions.⁸ Although at first

(describing as "magical thinking" notion that eliminating color-consciousness will in turn eliminate racism).

4. See generally Robert L. Trivers, *Deceit and Self-deception: The Relationship Between Communication and Consciousness*, in *MAN AND BEAST REVISITED* (M.H. Robinson & L. Tiger eds., 1991) (noting evolutionary mandate of human mortality).

5. See *Vacco v. Quill*, 521 U.S. 793, 808 (1997) (holding that New York's prohibition on assisting suicide does not violate Equal Protection Clause of Fourteenth Amendment); *Washington v. Glucksberg*, 521 U.S. 702, 705 (1997) (holding assistance in committing suicide is not fundamental liberty interest protected by Due Process Clause of Fourteenth Amendment); *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 263 (1990) (holding that Missouri's requirement of evidence of incompetent's wishes with regards to removal of life-sustaining treatment must be proven by clear and convincing evidence did not offend Constitution); *Lee v. Oregon*, 107 F.3d 1382, 1386 (9th Cir. 1997) (holding that physicians and caretakers for terminally ill patients lacked standing to assert Oregon's Death with Dignity Act violated equal protection clause, due process clause, Americans with Disabilities Act and Rehabilitation Act, on behalf of their patients), *cert. denied* 118 S. Ct. 328 (1997); *Kevorkian v. Arnett*, 939 F. Supp. 725, 730 (C.D. Cal. 1994) (holding that criminalizing actions of physicians that aid patients in suicide violates due process rights of patients seeking physician assisted suicide); *Quill v. Koppell*, 870 F. Supp. 78, 85 (S.D.N.Y. 1994) (holding that physician assisted suicide by prescription of lethal drug to competent, terminally ill patient seeking to avoid continued suffering does not involve fundamental liberty interest under due process clause); *Hamilton v. Myers*, 943 P.2d 214, 220 (Or. 1997) (holding that attorney general's wording for ballot to repeal Oregon's Death with Dignity Act as appropriate); see also PATRICIA EWING & SUSAN S. SILBEY, *THE COMMON PLACE OF LAW: STORIES FROM EVERYDAY LIFE* 242-44 (1998) (expressing the notion that storytelling is culturally relevant because it represents socially organized phenomena, not individualized experiences); MARY ANN GLENDON, *RIGHTS TALK: THE IMPOVERISHMENT OF POLITICAL DISCOURSE* 45 (1993) (expressing notion of existence of implication when one exercises rights without regard for others).

6. See U.S. CENSUS BUREAU, *POPULATION AND HOUSING CHARACTERISTICS OF BABY BOOMERS 26 TO 44 YEARS OLD* (last modified Feb. 1996) <<http://www.census.gov/population/censusdata/cph-1-160h.txt>> (stating that baby boomers total approximately 76,542,735 people).

7. See U.S. CENSUS BUREAU, *INTERNATIONAL DATA BASE, POPULATION COMPOSITION: THE ELDERLY POPULATION IN LESS DEVELOPED COUNTRIES WILL MORE THAN DOUBLE BY 2020* (last modified 1996) <<http://www.census.gov/ipc/prod/wp96/wp96017.pdf>> (suggesting that populations most elderly will increase by 70% in developed nations by year 2020 but by over 300% in developing countries).

8. See Joseph Nolan, *Healing Medicare and Stabilizing Social Security: Two Defining Economic Issues for the 21st Century*, *Transcript*, 63 VITAL SPEECHES 430, 430 (1997)

blush beneficial, these phenomena have produced tragic stories that have become an integral part of our uniquely late twentieth century culture of death and dying—stories about the ultimate in decision-making.

The first case of death and dying to reach the national consciousness was *In re Quinlan*,⁹ the case of Karen Ann Quinlan, a twenty-one year old who inexplicably suffered interrupted respiration resulting in irreversible brain damage.¹⁰ Although doctors did not consider her brain dead, Karen existed in a “persistent vegetative state” maintained by a ventilator.¹¹ Because Karen’s attending physician refused to disconnect the ventilator, her personal choice of “living” or “dying” was instead cast as a conflict of rights to be played out on the stage of a courtroom.¹² Joseph Quinlan, Karen’s father and legal guardian, acted as her proxy, and the Attorney General of New Jersey represented the state.¹³ While competent,

(“The growing numbers of seniors living longer now consume more than one-third of all health care in the United States, and that proportion continues to climb. Innovative technology has helped push average life expectancy from 70 to 76. Just half as many Americans now die from heart attacks, and one-third as many from strokes.”); see also U.S. CENSUS BUREAU, LONGEVITY AND HEALTH CHARACTERISTICS (last modified 1996) <<http://www.census.gov/prod/1/pop/p23-190.g.pdf>> (stating that average expectation of additional years of life at age 65 increased by 46% between 1900 and 1991—from 11.9 years to 17.4 years). Medical advances caused mortality rates to decline steadily for most of this century, with the most rapid drops between 1936 and 1954 (due mainly to new drugs, such as antibiotics) and between 1968 and 1982 (due to further advances in medical technology). See generally Brad Edmondson, *Trends in How We Die: Changes in Causes of Death*, 1997 CURRENT 26.

9. 348 A.2d 801 (N.J. Super. Ct. Ch. Div. 1975), *modified and remanded*, 355 A.2d 647 (N.J. 1976).

10. See *In re Quinlan*, 355 A.2d 647, 653-54 (noting that Karen’s stay at hospital for 100 degree fever preceded coma).

11. See *In re Quinlan*, 348 A.2d at 810. Certain physicians have opined, “An organ, brain or other, that no longer functions and has no possibility of functioning again is for all purposes dead.” Ad Hoc Committee of Harvard Medical School, *A Definition of Irreversible Coma*, 205 JAMA 337, 337 (1968). Doctors use the following characteristics to determine whether a brain is permanently nonfunctioning: (1) unresponsiveness and unresponsivity, a total unawareness to externally applied stimuli, even the most intensely painful stimuli; (2) lack of motion or breath during a physician-observed period of at least one hour; (3) lack of reflexes, an abolition of central nervous system activity evidenced in part by the absence of elicitable reflexes, such as a fixed and dilated pupil that will not respond to a direct source of bright light; and (4) flat electroencephalogram, which is of great confirmatory value assuming all steps have been properly performed and the instrument is functioning correctly. See *id.* at 337-38. Brain death may be satisfactorily diagnosed by assessing characteristics one, two or three; characteristic four provides confirmatory data only and should be used when available. See *id.* at 337.

12. See *In re Quinlan*, 348 A.2d at 822 (noting when being urged on behalf of child through parent, right of privacy must be fettered when in conflict with doctor’s duty to provide life-giving care).

13. See *id.* at 805. “An incompetent, like a minor child, is a ward of the state, and the state’s *parens patriae* power supports the authority of its courts to allow decisions to be made for an incompetent that serve the incompetent’s best interest, even if the person’s wishes cannot be clearly established.” *In re Matter of Claire C. Conroy*, 486 A.2d 1209, 1231 (N.J. 1985). States may use this power to authorize

Karen had not made legally significant statements regarding her choice in such a situation.¹⁴ The New Jersey Supreme Court, however, seized upon the then recent abortion decision in *Roe v. Wade*¹⁵ and found that Karen had a constitutional privacy right to refuse treatment.¹⁶ Remarkable primarily in hindsight, the New Jersey Supreme Court presciently ruled that Karen's incompetency did not negate her "right" that her parents could exercise on her behalf.¹⁷

Since *In re Quinlan*, death and dying jurisprudence has followed the conflict of rights model, pitting the right of the individual to make medical decisions against the right of the state to protect those citizens unable to protect themselves. This is not surprising, considering the status of

guardians to withhold or withdraw life-sustaining treatment from an incompetent patient "if it is manifest that such action would further the patient's best interests in a narrow sense of the phrase . . ." *Id.*

14. See *In re Quinlan*, 355 A.2d at 653 (noting Karen's wish not to have life prolonged by otherwise futile use of extraordinary measures).

15. 410 U.S. 113 (1973).

16. See *In re Quinlan*, 355 A.2d at 663 (stating that, under certain circumstances, unwritten constitutional right to privacy is broad enough to encompass patient's decision declining medical treatment).

17. See *id.* at 664 (noting that Karen's right of privacy may be asserted on her behalf by her guardian and family under particular circumstances presented); see also *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 280 (1990) (upholding Missouri law allowing surrogate to act for patients in such way to cause death when such action conforms to wishes expressed by patient when competent). The doctrine of substituted judgment ensures that a person will retain his autonomy despite losing his ability to directly exercise that right. See *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 431 (Mass. 1977) (stating guardian ad litem's recommendations and judges' decisions should ascertain incompetents' actual interests and preferences). The *Saikewicz* court held that substituted judgment requires guardians and judges to ascertain the incompetent person's actual interests and preferences. See *id.* (noting decision in similar cases should be those that would have been made by incompetent patient if competent). In short, the resulting decision should be that which the incompetent person would have made if he or she was competent, but also taking into account the present and future incompetency of the individual as one of the factors affecting the decision-making process of the competent person. See *id.*

Cases have used substituted judgment as a way to fulfill the wishes, proven by existing evidence, of an incompetent patient. See, e.g., *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So. 2d 921, 926 (Fla. 1984) (holding right of irreversibly comatose patient to refuse extraordinary measures may be exercised by either close family members or by guardian of patients appointed by court); *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626, 639 (Mass. 1986) (holding that substitute judgment of patient in vegetative state to be disconnected from artificial maintenance of nutrition and hydration must be honored); *In re Torres*, 357 N.W.2d 332, 340 (Minn. 1984) (holding individual's right to refuse medical treatment and to forego life-sustaining treatment also includes right to order disconnection of extraordinary life support systems); *In re Conroy*, 486 A.2d 1209, 1249 (N.J. 1985) (holding substitute decision maker must seek to respect simultaneously patient's right to live and right to die of natural causes without medical intervention in attempting to exercise incompetent patient's right to accept or to refuse medical treatment).

“legal” discourse talk in popular culture.¹⁸ According to one commentator:

for most of our history, political discourse was not so liberally salted with rights talk as it is today, nor was rights discourse so legalistic. The high season of rights came upon the land only rather recently, propelled by, and itself promoting, a gradual evolution in the role of the courts.¹⁹

In death and dying jurisprudence, the centerpiece of rights talk is personal autonomy—the almost unassailable right of an individual to make medical treatment decisions even when such decisions result in the accelerated death of the actor.²⁰ For some time, surrogate decision-makers successfully asserted the “right to die” on behalf of incompetent persons who had not expressed their treatment or non-treatment choices while competent. In other words, in no case had a competent individual actor asserted his or her autonomy prospectively.²¹ Not until the United States Supreme

18. See Lawrence M. Friedman, *Law, Lawyers, and Popular Culture*, 98 YALE L.J. 1579, 1598 (1989) (stating that modern American life has become “a vast, diffuse school of law”).

19. GLENDON, *supra* note 5, at 4 (discussing extent to which legal concepts have permeated popular and political discourse).

20. See Michael R. Flick, *The Due Process of Dying*, 79 CAL. L. REV. 1121, 1129 (1991) (discussing law’s grounding in individuality and autonomy and its vision of right of each person to choose his or her own destiny without interference of others). Of course, no individual right, including the “right” to die, is absolute. See Laurence H. Tribe & Michael C. Dorf, *Levels of Generality in the Definition of Rights*, 57 U. CHI. L. REV. 1057, 1106 (1990) (suggesting that rights are not absolute but rather expand or constrict depending upon generality of their definition).

21. See *generally* *People v. Adams*, 265 Cal. Rptr. 568, 572 (Ct. App. 1990) (noting that adult persons have right, in case of terminal condition, to refuse any medical treatment); *Bartling v. Superior Ct.*, 209 Cal. Rptr. 220, 226 (Ct. App. 1984) (stating that compliance by hospital with request of competent adult patient who had terminal illness that ventilator be disconnected would not have been tantamount to aiding suicide); *McConnell v. Beverly Enterprises-Connecticut*, 553 A.2d 596, 603 (Conn. 1989) (noting that Removal of Life Support Systems Act authorized removal of gastronomic tube from comatose terminally ill patient); *In re Guardianship of Browning*, 568 So. 2d 4 (Fla. 1990) (noting that competency of person’s constitutionally protected right to choose or refuse medical treatment is not lost or diminished by virtue of subsequent physical or mental incapacity); *Kirby v. Spivey*, 307 S.E.2d 538, 540 (Ga. 1983) (holding that lucid adult has right to withhold consent to suggested and recommended medical procedures); *Matter of Westchester County Med. Ctr. on Behalf of O’Connor*, 531 N.E.2d 607, 625 (N.Y. 1988) (noting that “clear and convincing” evidence standard required to terminate artificial life support for incompetent patient based on patient’s previously expressed wishes, while competent, not to be kept alive by artificial means, was not met); *Delio v. Westchester County Med. Ctr.*, 516 N.Y.S.2d 677, 679 (App. Div. 1987) (stating that individual’s right to decline life-sustaining medical treatment must, under certain circumstances, yield to state limitations upon exercise of person’s right to refuse treatment); *Saunders v. State*, 492 N.Y.S.2d 510, 517 (Sup. Ct. 1985) (holding that living will should be given great weight by hospital authorities when making decisions to decline certain medical treatment by artificial means).

Court decision in *Cruzan v. Director, Missouri Department of Health*²² did a story tragically close, both factually and legally, to Karen Quinlan's force a court to question the well-entrenched legal fiction of autonomous decision making by an incompetent actor.²³ Unfortunately, the majority's logical rights analysis left Nancy Cruzan and her family in an inescapable limbo between life and death.²⁴

22. 497 U.S. 261 (1990).

23. *See id.* at 262-64 (holding that U.S. Constitution does not forbid Missouri from requiring evidence of incompetent's wishes as to withdrawal of life sustaining treatment be provided by clear and convincing evidence). The height of absurdity with regard to this legal fiction is Superintendent of Belchertown State School v. Saikewicz. *See* 370 N.E.2d 417, 427 (Mass. 1977) (describing how never-competent patient was said to have exercised right to make medical decision). Nancy's persistent vegetative state was caused by hypoxia following an automobile accident. *See Cruzan*, 497 U.S. at 266 (noting permanent brain damage results after six minutes in anoxic state). Because she was breathing on her own when she was admitted to the hospital, no ventilator was required; instead the hospital staff surgically inserted a feeding tube to assist Nancy with eating and drinking. *See id.* (noting gastrostomy feeding and hydration tube implanted in Cruzan, which eased feeding and further recovery). Otherwise, the two cases were remarkably similar with the biggest distinction being jurisdictional; while Karen's hospitalization took place in New Jersey, a non-vitalist state, Nancy's took place in Missouri, a vitalist state. *See id.* at 270 (noting decision by Supreme Court of New Jersey that held patient's right of privacy to terminate treatment not absolute).

24. *See* Laurie Abraham, *Ethicists Try to Define Status of Vegetative Patients: Dead? Alive? Treatment Plans Hang on Decisions*, AM. MED. NEWS, Feb. 24, 1989, at 3 (quoting Nancy Cruzan's father as saying "It's like having a death in the family, and the state says, 'I'm sorry, but you can't bury that person'"). *Cruzan* was a five-four decision with two very strong dissents by Justices Brennan and Stevens. *See Cruzan*, 497 U.S. at 330-357 (Stevens, J., dissenting) (stating that majority opinion discards evidence of Nancy's intent). Even the unanimity of the majority was diluted somewhat by two concurring opinions by Justices Scalia and O'Connor. Justice Scalia wrote separately to affirm again his belief that certain sociological issues, such as the ability of modern medicine to artificially prolong life, are properly addressed as legislative rather than constitutional issues. *See id.* at 293 (Scalia, J., concurring) (noting that courts have no business in preventing suicides). Justice O'Connor wrote separately in part to clarify her belief that the fundamental right to refuse treatment was probably meaningless without a concomitant right of a surrogate to make such decisions on behalf of an incompetent. *See id.* at 289 (O'Connor, J., concurring) (stating that majority opinion fails to decide whether state must also give effect to decisions of surrogate decision-maker).

The entire court, except perhaps Justice Scalia, reluctantly (in the case of the majority opinion) or emphatically (in the case of the dissents) recognized the existence of a constitutional right to choose to withdraw medical treatment. Of course, under traditional rights analysis, for an incompetent person like Nancy Cruzan, the existence of the right is irrelevant without the ability to exercise it. Justice Brennan correctly argued that very few people know they can prospectively exercise such a fundamental right, much less know how to do so. *See id.* at 323 (Brennan, J., dissenting) (noting too few people exercise living wills to use their existence as evidentiary standard). It appears that Justice Brennan was arguing for a lower evidentiary standard and/or a substituted judgment standard. Although this seems sound, it would be much more comfortable, both analytically and pragmatically, to simply concede that the law's traditional rights analysis does not suit the medical decision-making model.

Recently, I have begun to think about death and dying less as a professor and more as a person connected to the human community in the various ways that we all are: as parent, child, spouse, friend and colleague. Although my latest thoughts have been informed by the Supreme Court's assisted suicide cases and a wealth of extra-legal literature, they have also been undeniably shaped by my own inexorable move toward life's end. They have also been shaped by the role I played in my father's end-of-life decision-making.

When my father was in his eighties and still relatively competent, he lived in a quite expensive proprietary care facility. During an extended visit, a social worker attached to the facility called and asked me, somewhat conspiratorially, to convince my father to execute some form of healthcare directive. The residential facility could then keep this directive on file, presumably for its and my father's protection.

The social worker told me that the facility had held multiple seminars on the importance of executing such documents, and most of the residents had complied by executing a healthcare directive. My father, however, had not attended any of the meetings and had refused to execute the document in question. No amount of peer pressure or reasonable exhortations had persuaded him to the contrary. At this point, I was his only support—my mother had died six years earlier, and I had assumed the primary responsibility for helping my father make long-term decisions. As my father's closest family, I agreed to try to convince him to sign the directive.

Despite my formal training in such matters, shouldering the responsibility of convincing my father to execute the healthcare directive proved difficult. As a practicing attorney who specialized in transactional law, I had drafted my share of estate planning documents. As a professor who had taught courses in estate planning, I knew a great deal about healthcare documents, the art and science of which were, at that time, still in their infancy. My father was a pathologist who had been involved in the practice of medicine until well into his seventies. He was also competent during and had provided support throughout my mother's illness and death from cancer.

My father had, however, suffered several bouts of clinical depression during his adult life. One of the symptoms of his depression was great difficulty in making and actuating decisions. Moreover, he had been raised in Poland until the age of ten. Raised during the pogroms, his youth must have been a true nightmare; he once told me that soon after moving to Vienna, he could not remember one word of Polish.²⁵ Therefore, although my father was no stranger to the "culture of death," his

25. See Howard Markel, *Di Goldmine Medina (The Golden Land): Historical Perspectives of Eugenics and the East European (Ashkenazi) Jewish-American Community, 1880-1925*, 7 HEALTH MATRIX 49, 52 (1990) (noting Czar Alexander III's anti-semitic policy beginning in 1882, which included mass orders of expulsion and violent, life threatening pogroms).

experiences had taught him to treat death as an enemy, never to be embraced.²⁶

For the remainder of my visit, I tried to discuss and to persuade my father of the importance of executing an advance directive. After all of my convincing, he agreed. Although his background as a physician guaranteed his execution of the directive was knowing, it was anything but voluntary. Effectively, I coerced him into signing a document that stated he wanted no life-sustaining or heroic measures such as nutrition and hydration. I am certain now, however, in light of the way he later battled death, that he probably wanted just the opposite.²⁷ Despite his unvocalized desire to the contrary, he caved under the weight of my filial arguments and institutional pressure. The staff placed the advance directive in the official files of the residential care facility. Soon thereafter, my father's advancing age forced the facility to place him on assisted living.

Approximately two years later, I received a telephone call from the residential care facility. A nurse informed me that my father was semi-comatose and that the staff was unsure what to do because his advance directive declined all medical treatment. Unaware that there even was a problem, I told her to get my father to a hospital immediately. After being rehydrated, he eventually regained consciousness. It turned out that a small stroke, which the nursing staff had failed to diagnose, had impeded his ability to swallow and led to his dehydration.

My father lived for another year. Had I not been home when the nurse called, he would have died from a minor stroke—robbing me of another year with him. Because of those events, I have alternately been fascinated and haunted by the part that I played in my father's "exercise of autonomy." They have convinced me that rights talk is an inapt paradigm for death and dying jurisprudence. The paradigm is inapposite both for incompetents and many who would pass muster under *Cruzan*.²⁸

26. See Craig A. Brandt et al., *Model Aid-In-Dying Act*, 75 IOWA L. REV. 125, 126 (1989) (discussing increasing concern on dying has led to advent of hospices, books and courses on dying, reform movements, living wills and durable powers of attorney); Nancy K. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375, 377 (1988) (arguing that legal standards for terminating treatment can only rarely be met); Jed Rubenfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 737 (1989) (discussing notion that privacy doctrine should focus on what law affirmatively brings about instead of what laws prohibit); Elizabeth Shaver, *Do Not Resuscitate: The Failure to Protect the Incompetent Patient's Right of Self Determination*, 75 CORNELL L. REV. 218, 218 (1989) (noting that terminally ill must consider moral, ethical and religious values in addition to medical values).

27. See generally RACHEL NAOMI REMEN, *KITCHEN TABLE WISDOM: STORIES THAT HEAL* 5-14 (1996) (noting strength of humanity's drive to live).

28. See Roger B. Dworkin, *Medical Law and Ethics in the Post-Autonomy Age*, 68 IND. L.J. 727, 731 (1993) (noting that commitment to individual autonomy in right-to-die law is half-hearted in many state statutes); Sandra H. Johnson, *The Changing Nature of the Bioethics Movement*, 53 MD. L. REV. 1051, 1052 (1994) (noting that bioethics is moving towards personal choice and autonomy); Bernice A. Pesco-solido, *Society and the Balance of Professional Dominance and Patient Autonomy in Medical Care*, 69 IND. L.J. 1115, 1119 (1994) (discussing question of whether indi-

Although one cannot shift paradigms without difficulty, particularly a shift away from the hegemony of rights talk, many voices have already begun this task. I would like to add my own voice to the growing chorus of scholars that suggests weakening the stranglehold of autonomy on the jurisprudence and legislation of death and dying.

Part II of this work examines the history and evolution of the autonomy paradigm and how it has become the centerpiece of medical decision making, particularly at the end-of-life.²⁹ This “truth” is played out not only in end-of-life jurisprudence, but also in the necessarily related area of prospective decision-making.³⁰ Parts III and IV examine the Supreme Court’s most recent look at rights jurisprudence at end-of-life in the context of the two recent assisted suicide cases.³¹ These sections deconstruct the Court’s views of individual rights to make end-of-life decisions and demonstrate the inherent inconsistency of rights-based jurisprudence in the assisted suicide cases.³² Part V cautiously proposes a shift away from autonomy as the inescapable model for end-of-life decision-making, and Part VI examines a possible alternative to the autonomy model.³³

II. THE AUTONOMY PARADIGM

The word “autonomy” comes from the Greek *autos*, meaning self, and *nomos*, meaning rule, governance or law.³⁴ Literally, autonomy means living by a law that one imposes on oneself or, in other words, the right to live one’s own life in one’s own way.³⁵ Perhaps the most important cur-

viduals are, should be or want to be autonomous decision-makers); Carl E. Schneider, *Bioethics With a Human Face*, 69 IND. L.J. 1075, 1079 (1994) (stating that hyper-rationalism, substitution of reason for information and analysis, exacerbates human rationality resulting in understatement of social and cultural factors in patients’ lives); Peter H. Schuck, *Rethinking Informed Consent*, 103 YALE L.J. 899, 924 (1994) (stating that autonomy principle is deeply entrenched in American culture and law); Susan M. Wolf, *Pragmatism in the Face of Death: The Role of Facts in the Assisted Suicide Debate*, 82 MINN. L. REV. 1063, 1070 (1998) (stating that abstract lawyerly conceptions of rights and transactions are inadequate when applied to death and dying). The paradigm is especially inapt for incompetent persons because few Americans execute documents prospectively to plan for this contingency.

29. For a discussion of the autonomy paradigm, see *infra* notes 34-76 and accompanying text.

30. For a discussion of prospective decision-making in death and dying cases, see *infra* notes 49-76 and accompanying text.

31. For a discussion of these recent cases, see *infra* notes 77-161 and accompanying text.

32. For a discussion of the Court’s views and a deconstruction of them, see *infra* notes 162-289 and accompanying text.

33. For a discussion of proposals and alternatives, see *infra* notes 290-354 and accompanying text.

34. See WILLARD GAYLIN & BRUCE JENNINGS, *THE PERVERSION OF AUTONOMY: THE PROPER USES OF COERCION AND CONSTRAINTS IN A LIBERAL SOCIETY* 30 (1996) (discussing definition of autonomy and various applications of term over time).

35. See *id.* (describing most commonly referenced definition of autonomy).

rent conceptualization of autonomy is autonomy as a negative liberty interest establishing a zone of privacy and noninterference around each person.³⁶ The Bill of Rights embodies certain principles that, at their most abstract, command the government to treat its citizens with nothing less than equal respect and concern.³⁷ This “principled” Constitution proscribes the government’s infringing on the most basic freedoms, “those liberties essential . . . to the very idea of ‘ordered liberty.’”³⁸

In its best sense, autonomy changes the power balance of unequal and potentially exploitative relationships by insisting that all parties participate in decision-making.³⁹ By elevating hyper-rational conduct above an unquestioning respect for authority, autonomy encourages subjecting the rules that “need” to be obeyed to a skeptical, judging ego.⁴⁰ But, as noted by two eminent philosophers and bioethicists, while “autonomy of the individual represents Americans’ greatest moral strength, . . . [it also] now, peculiarly, [represents] its most insidious moral danger.”⁴¹ Individual autonomy injures the community by replacing beneficence and trust with a new consumerism that is, at its core, distrustful and adversarial.⁴²

The autonomy paradigm is most evident in the practice of medicine. Paternalism and beneficence, principles that elevated the authority of the physician over the autonomy of the patient, were the hallmarks of the traditional physician-patient relationship.⁴³ Since the early twentieth century’s recognition of a competent individual’s right of self-determination, however, the paradigm of the physician-patient relationship has shifted.⁴⁴ The former paternalistic model, in which the physician commanded and the patient obeyed, has slowly given way to a shared decision-making

36. See *Two Concepts of Liberty* in ISAIAH BERLIN, *FOUR ESSAYS ON LIBERTY* 127 (1969) (describing liberty as “absence of interference”).

37. See GAYLIN & JENNINGS, *supra* note 34, at 45 (discussing rights protecting individuals from state power in Constitution).

38. RONALD DWORKIN, *LIFE’S DOMINION* 128 (1993) (quoting *Palko v. Connecticut*, 302 U.S. 319, 325 (1937) (Cardozo, J.)).

39. See GAYLIN & JENNINGS, *supra* note 34, at 54-55 (describing conscious concern for autonomy in professional relationships leading to better protection against potential exploitation).

40. See *id.* at 42 (describing sense of autonomy experienced when socially detached rational judgment is exercised in every day life).

41. *Id.* at 54 (noting unprecedented freedoms and autonomy granted to individuals as America’s greatest achievement).

42. See *id.* at 54-55 (discussing rise of autonomy and its inherent distrust of authority).

43. See *id.* (noting that emphasis on patient’s rights has supplanted benevolent physician paternalism).

44. See *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.) (“Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent, commits an assault, for which he is liable in damages.”).

model where the ultimate decision lies with the patient.⁴⁵ The now well-entrenched bioethical canon of informed consent, which requires the physician to inform the patient of all information necessary for a knowing decision, is the cornerstone of this shift from paternalism to individual patient autonomy.⁴⁶ The corollary of informed consent is the right to refuse recommended, even lifesaving, medical treatment.⁴⁷ The right of self-determination includes this corollary right.

Because independence and self-reliance are crucial aspects of autonomy, competency is a predicate to the exercise of autonomy.⁴⁸ In the healthcare environment, the loss or lack of competency has tested the outer edges of the autonomy principle. One solution is the creation of procedures by which competent individuals prospectively make healthcare decisions, including end-of-life decisions. Should patients suffer a loss of competency, this prospective exercise of rights preserves the patient's autonomy.

The evolution of instruments of prospective healthcare decision-making is well documented.⁴⁹ Prior to the Missouri Supreme Court decision

45. See GAYLIN & JENNINGS, *supra* note 34, at 54-55 (discussing emphasis on patient's "informed consent").

46. See, e.g., *Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 317 P.2d 170, 181 (Cal. Ct. App. 1957) ("A physician violates his duty to his patient and subjects himself to liability if he withholds any facts which are necessary to form the basis of an intelligent consent by the patient to the proposed treatment."). Ever since *Salgo*, the first judicial decision to use the term "informed consent" to characterize a physician's duty of disclosure to the patient, the doctrine of informed consent has developed in to a fundamental principle of medical jurisprudence. See KATZ, *supra* note 3, at 2-3 (discussing judge-made doctrine of informed consent and its jurisprudential purpose).

47. See *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 270 (1990) ("The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment.").

48. See GAYLIN & JENNINGS, *supra* note 34, at 38 (discussing relation between dependency and autonomy).

49. See 2 ALAN MEISEL, *THE RIGHT TO DIE* § 10.2 (2d ed. 1995) (noting that advance directives, through their many forms, allow competent people to plan for future medical decision-making in case they become incompetent). Beginning with California in 1976, almost all states enacted living will statutes. See *id.* § 11.1. Living wills are written advance directives in which people express what they want to happen to them upon incapacitation. See *id.* § 10.5 (defining "advance directive" and "living will"). The next type of healthcare decision-making instrument created is the powers of attorney, which are also known as proxy directives. See *id.* (describing "health care proxy" or "power of attorney"). Here, a person appoints another to make their healthcare decisions for them in the event of incapacity. See *id.* (noting healthcare proxy or power of attorney methods by which individuals may appoint others to make future healthcare decisions as alternatives to living wills). The last type of healthcare decision-making instrument is the surrogate (family) statutes. See *id.* § 14.1 (discussing fundamental issues in surrogate decision-making statutes). States enacting this legislation designate who has the legal authority to make medical decisions on behalf of incompetent patients who have not already selected another to do so. See *id.* (noting that purpose of surrogate decision-making statutes is to avoid judicial proceedings and reinforce case law

in *Cruzan v. Harmon*,⁵⁰ no appellate court had discussed the efficacy of the instruments used as prospective implements of the common law right of self-determination. Instead, earlier state court decisions that upheld an individual's right to refuse medical treatment had been based either in the common law of self-determination or the individual state constitutional right to privacy.⁵¹ Because Nancy Cruzan had not executed a living will prior to her debilitating accident, the court addressed the issue of living wills only in dicta.⁵² It noted that in Nancy's case, because the scope of the state statute did not extend to these acts, Missouri's living will statute would not have given Nancy the prospective authority to require her physi-

decisions allowing family members to make decisions for patients lacking decision-making capacity).

50. 760 S.W.2d 408 (Mo. 1988) (en banc).

51. See *People v. Adams*, 265 Cal. Rptr. 568, 572 (Ct. App. 1990) (noting right to refuse treatment guaranteed through right of privacy set forth in state constitution); *Bartling v. Superior Ct.*, 163 Cal. App. 3d 186, 195 (Ct. App. 1984) (noting that right of competent adult to refuse medical treatment is constitutionally guaranteed); *McConnell v. Beverly Enterprises-Connecticut*, 553 A.2d 596, 601 (Conn. 1989) (noting right to refuse medical treatment is rooted in fundamental legal tradition of self-determination); *In re Guardianship of Browning*, 568 So. 2d 4, 9 (Fla. 1990) (noting patient's fundamental right to self-determination); *Kirby v. Spivey*, 307 S.E.2d 538, 540 (Ga. 1983) (noting that right of privacy allows patient to refuse medical treatment); *Matter of Westchester County Med. Ctr. on Behalf of O'Connor*, 531 N.E.2d 607, 611 (N.Y. 1988) (noting common law rule in New York that allows persons right to decline medical treatment); *Delio v. Westchester County Med. Ctr.*, 516 N.Y.S.2d 677, 685 (App. Div. 1987) (noting that age or medical condition of person has no effect on right to self-determination).

Decision-making instruments such as living wills, advance directives and healthcare proxies are the means by which competent individuals are authorized to exercise their autonomy in advance of any incapacity. There is abundant literature, however, that demonstrates that even when individuals exercise these instruments, they are ignored by physicians and family of the incapacitated patient. See Linda S. Crawford, *Wrongful Life Cases: Damned If You Do, Damned If You Don't*, 15 No. 5 MED. MALPRACTICE L. & STRATEGY 1, 2 (1998) (noting that doctors often ignore medical directives); Edward J. Larson & Thomas A. Eaton, *The Limits of Advance Directives: A History and Assessment of the Patient Self-Determined Act*, 32 WAKE FOREST L. REV. 249, 278 (1997) (noting that most end-of-life treatment decisions are not determined by advance directive); Adam A. Milani, *Better Off Dead Than Disabled?: Should Courts Recognize a "Wrongful Living" Cause of Action when Doctors Fail to Honor Patients' Advance Directives?*, 54 WASH. & LEE L. REV. 149, 163-64 (1997) (noting that desire of patients to discontinue life-sustaining treatment is often misunderstood or ignored by healthcare providers); Philip G. Peters, *The Illusion of Autonomy at the End of Life: Unconsented Life Support and the Wrongful Life Analogy*, 45 UCLA L. REV. 673, 677 (1998) (discussing results of studies showing that doctors routinely ignore patient preferences); Melvin I. Urofsky, *Leaving the Door Ajar: The Supreme Court and Assisted Suicide*, 32 U. RICH. L. REV. 313, 319 (1998) (discussing physicians' refusal to honor living wills in face of consistent validation of state living will statutes); Tamar Lewin, *Suits Accuse Medical Community of Ignoring Right to Die Orders*, N.Y. TIMES, June 2, 1996, at A1 (describing seizure victim that signed advance directive which hospital later ignored).

52. See *Cruzan*, 760 S.W.2d 408, 419 (Mo. 1988) (describing how legislatures have responded to dilemmas involving medical advances in prolonging life through drafting living will statutes).

cians to discontinue artificial feeding and hydration.⁵³ The court reasoned, moreover, that Nancy's statements of prospective self-determination failed to satisfy Missouri's "clear and convincing evidence" standard for an incompetent's expression of the right of self-determination.⁵⁴

The only question presented for review to the United States Supreme Court was whether Missouri's clear and convincing evidence requirement violated a recognized federal constitutional right.⁵⁵ To answer this question, the Justices assumed the existence of a constitutionally protected "right to die."⁵⁶ Had the Court not assumed such a right existed, the questions of how and by whom the "right" could be exercised would have been irrelevant, making Nancy Cruzan's appeal non-justiciable.⁵⁷ The Court

53. *See id.* at 420 (discussing section of Missouri statute that instructs life-sustaining procedures shall not include medical procedures to provide comfort, nutrition or hydration or alleviate pain). Query whether this exclusion makes the statute unconstitutional, particularly in light of the Court's discussion of the scope of the constitutional liberty interest in bodily integrity. *See Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 278 (1990) (recognizing liberty interest under Due Process Clause).

54. *See Cruzan*, 760 S.W.2d at 424 (noting that Nancy's statements to roommate that she would not want to continue in present state was informal expression and did not constitute clear and convincing evidence of patient's intent). Because Nancy was no longer a minor, Joe and Joyce Cruzan sought and received guardianship of Nancy under Missouri's guardianship statutes. *See id.* at 410. It was as Nancy's legal guardian that her parents finally made the agonizing decision, after almost four years of PVS and a diagnosis that Nancy's state was irreversible, to request that the feeding tube be removed. *See* MARILYN WEBB, *THE GOOD DEATH: THE NEW AMERICAN SEARCH TO RESHAPE THE END OF LIFE* 156 (1997) (noting that Nancy's parents requested that hospital staff withdraw artificial hydration and nutrition from Nancy). On July 27, 1988, Jasper County Probate Judge Charles Teel authorized the removal based on statements allegedly made by Nancy and related by Nancy's family and friends to the court. *See id.* at 157 (noting trial court's decision to honor guardian's request). The guardian ad litem appointed by the court, who had said all along that regardless of the outcome he would appeal the case to the state supreme court to clarify the law, did so. "And on August 3, 1988, the Missouri Attorney General William Webster filed notice that the state would oppose the Cruzans." *Id.* at 158.

55. *See Cruzan*, 497 U.S. at 269 (noting that Court granted certiorari to determine constitutionality of Missouri state court's clear and convincing evidence standard). Prior to the Missouri Supreme Court's decision not to accept Joe Cruzan's request to forego life-sustaining treatment, all state courts presented with a similar question had found an independent state ground for accepting the surrogate's decision. *See id.* at 270-77 (discussing several cases decided by state courts upholding surrogates' decisions).

56. *See id.* at 278 (Rehnquist, C.J.) (presuming that Constitution supports right to die). For a discussion of the methods used to determine whether a particular but unenumerated liberty is a "fundamental right," see generally Laurence H. Tribe & Michael C. Dorf, *Levels of Generality in the Definition of Rights*, 57 U. CHI. L. REV. 1057 (1990).

57. *See Washington v. Glucksberg*, 521 U.S. 702, 709 (1997) (failing to find constitutional "right to assisted suicide"); *see also* *Vacco v. Quill*, 521 U.S. 793, 799 (1997) (holding that interest in assisted suicide was not fundamental right); Robert A. Burt, *Disorder in the Court: Physician-Assisted Suicide and the Constitution*, 82

then turned to the real issue before it: whether such a right extends to an incompetent person and, perhaps more importantly, by whom and how that right can be exercised.⁵⁸ Although the Court found that the right to die could be exercised by a surrogate decision-maker, it did not address the question of how a surrogate should exercise that right.⁵⁹ Despite recognizing an incompetent patient's right to die, however, the Court found that the states, by "simply assert[ing] an unqualified interest in the preservation of life," had a countervailing interest in exercising its duty of *parens patriae* to protect incompetent patients without regard to the "quality" of the patient's life.⁶⁰ Because Nancy's surrogate could not prove her wishes

MINN. L. REV. 965, 965-66 (1998) (suggesting that right to assisted suicide was not ripe for definitive constitutional resolution).

58. See *Cruzan*, 497 U.S. at 279 (stating petitioner's assertion that incompetent person possesses same rights as competent person). Because the right to refuse life-sustaining treatment was not being sought by a competent, rational rights-bearer, the *Cruzan* right or liberty interest only needed to be stipulated to by the Chief Justice. It may very well be that this stipulation was more a political or consensus act than the act of one who believed in a real right to refuse life-sustaining treatment. Justice O'Connor, who provided the fifth vote in *Cruzan*, stated a concurring opinion that she would have granted the right to a competent, rational actor requesting the removal of a feeding tube. See *id.* at 287 (O'Connor, J., concurring) ("I agree that a protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions I write separately to clarify why I believe this to be so."); see also Leon R. Kass, *Is There a Right to Die?*, HASTINGS CENTER REP., Jan.-Feb. 1993, at 34, 41 (discussing Justice O'Connor's concurring opinion). Some suggest that a right, however "constitutionalized," is impotent without a legitimate and practical means to exercise it. See *id.* at 43 (noting that respectability of individual rights is weakened by permitting their weakening with no grounding or basis). I find this to be one of the most serious defects of rights-based analysis in the medical decision-making arena.

59. See, e.g., Carl E. Schneider, *From Consumer Choice to Consumer Welfare*, HASTINGS CENTER REP., Nov.-Dec. 1995, at S25 (suggesting that truly thorny problem with regard to incompetent patients is not who makes decisions but how decisions are to be made). I would take that thesis one step further and argue that this may be the real issue for all patients facing end-of-life decisions, competent or incompetent.

60. *Cruzan*, 497 U.S. at 282. Ronald Dworkin makes the argument that "sanctity of life," as a detached rather than derivative interest, makes most sense as an interest to be protected in cases that involve the edges of life, i.e. birth and death. See DWORKIN, *supra* note 38, at 11-14 (discussing distinction between derivative and detached grounds for protecting human life in context of abortion and euthanasia). By a detached interest, Dworkin means an interest in preserving human life because of its intrinsic value apart from its personal value. See *id.* at 11 (stating that detached interest is innate value). He makes this argument particularly around the abortion cases. See *id.* (noting that detached objection to abortion is wrong because it insults sacredness of human life). If the interests sought to be protected by the state in *Roe v. Wade*, 410 U.S. 113 (1973), were derivative from the fetus, then the *Roe* argument turns on whether a fetus is a person from the moment of conception and the conflict is between the rights of the pregnant woman and the rights of the fetus. See *id.* at 25 (construing central legal and political controversy in *Roe* as what constitutes rights of fetus). There is no question about the answer; the Constitution grants the states the right, indeed the duty, to protect its citizens, particularly those who cannot protect themselves. See *id.* at 108. If, however, the interest is detached, then the crucial question becomes whether a state can impose

to the degree of certainty required by Missouri, the surrogate lacked derivative authority to direct the state to remove her feeding tube.⁶¹

Since the *Cruzan* decision, a flurry of legislative, judicial and empirical activity has attempted to define more clearly the parameters of the right to die.⁶² The States' response to the wisdom of *Cruzan* has been explosive; virtually all of the states presently have some combination of advance directive, healthcare proxy and family surrogacy legislation.⁶³ In addition to state legislation, the *Cruzan* ruling provided the necessary boost to the then-proposed Patient Self-Determination Act⁶⁴ ("PSDA"), which both houses of Congress included in their version of the Omnibus Reconciliation Act of 1990.⁶⁵ One of the PSDA's stated purposes was to encourage compliance with states' advance directive statutes. To that end, the PSDA required that all healthcare facilities receiving federal Medicare or Medicaid funds inform each patient of their right to make decisions concerning their own medical care, including the right to accept or to refuse medical treatment.⁶⁶ Almost eight years after the enactment of the PSDA,

the majority's conception of the sacred on everyone. *See id.* at 107-09 (discussing result of treating state interest as detached).

61. *See Cruzan*, 497 U.S. at 265 (stating that Nancy's wishes could not be proved with required degree of certainty).

62. *See, e.g., In re Martin*, 517 N.W.2d 749, 756 (Mich. Ct. App. 1994) (honoring request of surrogate decision-maker to derivatively exercise constitutionally protected right to die by withdrawal of patient's life-sustaining interventions), *rev'd*, 538 N.W.2d 399 (Mich. 1995). Mrs. Martin, her husband's guardian, presented the court with a plethora of oral testimony regarding her husband's statements about lifesaving procedures. *See id.* at 752-53. The Supreme Court of Michigan, in reversing the decision of the appellate court, cited from the appellant's brief in regard to Mrs. Martin's evidence. *See In re Martin*, 538 N.W.2d at 411. The language cited by the court was the most disturbing from the perspective of the exercise of prospective autonomy:

[T]he remarks . . . were remote in time and place from his present circumstances. At the time the remarks were made, Michael was young and healthy. The remarks were general, vague and casual, because Mr. Martin was not presently experiencing and likely never had experienced the form of "helplessness" he supposedly disliked, and thus, he could not bring to bear his specific views about specific circumstances of which he was intimately knowledgeable. *Not being informed by his actual experience, Michaels purported remarks thus were "no different than those that many of us might make after witnessing an agonizing death of another."*

Id. (emphasis added).

63. *See, e.g., ARIZ. REV. STAT. ANN.* § 36-3261 (West 1997); *DEL. CODE ANN.* tit. 16, § 2501-2509 (1997); *FLA. STAT. ANN.* § 765.112 (West 1997); *HAW. REV. STAT.* § 327D-21 (1997); *IND. CODE ANN.* § 16-36-1-7 (West 1998); *N.C. GEN. STAT.* § 90-323 (1997); *N.J. STAT. ANN.* § 46:2B-8 (West 1997); *WASH. REV. CODE ANN.* (West 1997).

64. Pub. L. No. 101-508, §§ 4206, 4751, 104 Stat. 1388, 1388-115-117, 1388-204-206 (1990).

65. Pub. L. No. 101-508, 104 Stat. 1388; *see Larson & Eaton, supra* note 51, at 255-56 (stating that *Cruzan* decision bolstered efforts to pass PSDA).

66. Patient Self-Determination Act, Pub. L. No. 101-508, § 4751(2)(A)(1).

however, it appears that this legislation has not significantly increased the percentage of the population executing advance directives.⁶⁷

Perhaps the most unexpected and puzzling finding regarding the efficacy of the autonomy paradigm in health decisions has come from the Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment ("SUPPORT"). SUPPORT, the largest piece of contemporary research on the end stage of dying in America, was a \$28 million project funded by the Robert Wood Johnson Foundation and co-directed by Joanne Lynn, M.D., now head of the Center to Improve Care of the Dying, and William A. Knaus, M.D., now chief of the department of health evaluative sciences at the University of Virginia School of Medicine.⁶⁸ The purpose of the study was to discover what happened to patients and their families in the weeks and months following an acute episode that precipitated hospitalization for advanced illnesses.⁶⁹ After observing the patients' treatment and medical decision-making, the study decided that patients received overly aggressive treatment without sufficient discussion beforehand to enable the patient to understand the consequences of such treatment and, presumably, to make informed choices.⁷⁰ To remedy this perceived failure, the study divided the patients into two groups. The first group continued to receive the same treatment while the second group's treatment included interventions by medical staff designed to enable patients to make truly "informed" decisions.⁷¹

Astonishingly, the SUPPORT investigators found that the interventions, although designed to enhance patient autonomy, did not significantly affect patient choices regarding treatment.⁷² Equally surprising was

67. See generally Mary K. Robinson et al., *Effects of the Patient Self-Determination Act of Patient Knowledge and Behavior*, 37 J. FAM. PRAC. 363, 366 (1993) (stating that "the PSDA had no statistically significant effect on whether [hospital patients] had obtained and signed a living will"). But see Ezekiel J. Emanuel et al., *How Well is the Patient Self-Determination Act Working? An Early Assessment*, 95 AM. J. MED. 619, 628 (1993) (providing favorable commentary about the PSDA).

68. For a discussion of SUPPORT, see WEBB, *supra* note 54, at 49 (stating that SUPPORT study followed 9000 patients over five-year period from 1989 to 1994). The patients were in the final stages of one of nine specific illnesses; they were well enough to survive the first 48 hours after hospital admission but sick enough to have only an average of a 50-50 chance of surviving another six months. See *id.*

69. See The Support Principle Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT)*, 274 JAMA 1591, 1591-92 (1995) (explaining objectives and methodology of SUPPORT study); *Correction*, 275 JAMA 1232 (1996) (correcting authorship of article to Writing Group for Support Investigators).

70. See Support Principle Investigators, *supra* note 69, at 1592 (stating that better informing patients of procedures' risks reduces time spent in pain before death).

71. See *id.* at 1592-93 (explaining how study split patients into groups and made interventions to improve end-of-life decision-making process).

72. See *id.* at 1594-96 (explaining that interventions did not affect patients' choices). Although unanticipated, this result does not seem so astonishing in retrospect. See RACHEL REMEN, *KITCHEN TABLE WISDOM* xxvii-xxxii (1996) (opining

the level of satisfaction with medical treatment expressed by the two groups; the group without autonomy interventions was just as satisfied with its medical treatment as the group that had received interventions.⁷³ This clearly was not the result that the researchers had expected.⁷⁴ The study had presupposed that interventions, designed to enhance the quality of patient participation in the dying process, would increase patient satisfaction with his or her care.⁷⁵

The SUPPORT outcome casts even greater doubt on the viability of prospective autonomy. Competent patients are, potentially, full partners in the decisional relationship; physicians and family may at least try to ascertain their choices, made within the context of present circumstances. But for the incompetent patient, the decisional relationship lacks an active partner whose possible, although unlikely, exercise of her prospective autonomy lacks the richness of context. So what does this say about constitutionalizing the right to die? Do all fundamental rights have an intrinsic value that renders any pragmatic or empirical inquiry irrelevant and indeed dangerous, or does naked recognition of a right without more blind us to more apt constructs?⁷⁶ A deconstruction of the assisted suicide cases, the Supreme Court's most recent incursion into death and dying jurisprudence should frame the discussion.

III. THE ASSISTED SUICIDE CASES

In addition to legislative and empirical activity post-*Cruzan*, the preponderance of end-of-life jurisprudence has focused on the issue of assisted suicide.⁷⁷ With the exception of Oregon, the States' attempts to legislate "death with dignity" have failed.⁷⁸ Given that the Supreme Court

that time and skill required to elicit patients' feelings and treatment choices may not be able to be replicated in hospital setting). If this is true, then perhaps the hospital environment precludes meaningful treatment choices.

73. See Support Principle Investigators, *supra* note 69, at 1596 (stating that families were satisfied regardless of outcome).

74. See *id.* (expressing doubt that improvement in healthcare will occur through better informing patients).

75. See *id.* at 1591 (stating study's objective was to improve end-of-life decision making through better communication with patients).

76. See Susan M. Wolf, *Pragmatism in the Face of Death: The Role of Facts in the Assisted Suicide Debate*, 82 MINN. L. REV. 1063, 1073-76 (1998) (stating that there are many pressures and coercions that come into play in patient's end-of-life decision-making process).

77. See, e.g., DEREK HUMPHREY, FINAL EXIT: THE PRACTICALITIES OF SELF-DELIVERANCE AND ASSISTED SUICIDE FOR THE DYING 106-08 (1991) (discussing Death with Dignity Act); Timothy Quill, *Death and Dignity - A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691, 693 (1991) (recounting episode of assisted suicide); Lisa Belkin, *Doctor Tells of First Death Using His Suicide Device*, N.Y. TIMES, June 6, 1990, at A1 (discussing genesis of Jack Kevorkian's campaign of assisted suicide in 1990).

78. See Ezekiel J. Emanuel, *The Future of Euthanasia and Physician-Assisted Suicide: Beyond Rights Talk to Informed Public Policy*, 82 MINN. L. REV. 983, 1001 (1998) (discussing defeat of Washington and California referendum on physician assisted

has placed its constitutional imprimatur on competent patients' right to die, it is hardly surprising that proponents of assisted suicide saw the judiciary as their most sympathetic partner.⁷⁹ Although previous legislative initiatives to remove states' bans on assisting suicide had failed, Oregon voters, in 1994, passed an initiative making it legal to assist a suicide in Oregon.⁸⁰ It was in this relatively positive legislative and judicial climate that two groups of physicians and terminally-ill patients decided to test the judicial waters of assisted suicide.

*Compassion in Dying v. Washington*⁸¹ and *Vacco v. Quill*⁸² were filed in federal district courts to challenge the constitutionality of their respective states' bans on assisting suicide.⁸³ The plaintiffs in both cases were a coalition of terminally ill patients and their physicians, who alleged that their states' criminal statutes violated their Fourteenth Amendment guarantees of liberty and equal protection.⁸⁴ While the United States District Court for the Southern District of New York dismissed the *Quill* equal protection challenge on a summary judgment motion, the United States District

suicide); Yale Kamisar, *On the Meaning and Impact of the Physician-Assisted Suicide Cases*, 82 MINN. L. REV. 895, 896-97 (1998) (noting that none of more than twenty states to attempt to pass legislation to legalize physician assisted suicide has succeeded); Urofsky, *supra* note 51, at 332 (noting that forty-four states prohibit or condemn assisted suicide); Susan M. Wolf, *Physician Assisted Suicide: Facing Death after Glucksberg and Quill*, 82 MINN. L. REV. 885, 887-88 (1998) (noting that state courts have struck down state bans on assisted suicide); Patrick M. Curran, Jr., Note, *Regulating Death: Oregon's Death with Dignity Act and The Legalization of Physician-Assisted Suicide*, 86 GEO. L.J. 725, 727 (1998) (noting defeat of Washington and California referendum on physician assisted suicide); *see also* Linda C. Fentiman, *Law & Ethics at the End of Life: High Court Speaks. Where Do We Stand After Decisions on Physician-Assisted Suicide?*, 218 N.Y.L.J. 5, 8 (1997) (noting defeat of New York's legislation to prohibit physician assisted suicide).

79. *See Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 278 (placing Court's constitutional imprimatur on "right to die" for competent persons); 1 ALAN MEISEL, *THE RIGHT TO DIE* 454-55 (2d ed. 1995) (discussing court's appointment of guardian ad litem). *But see* *Death With Dignity Act*, OR. REV. STAT. § 127.870 (Supp. II 1998) (exemplifying successful attempt to implement "death with dignity"). Although most states have long since decriminalized suicide, assisting a suicide remains a crime.

80. *See* OR. REV. STATE. §§ 127.810-897 (1997). Other states' attempts to regulate physician assisted suicide prior to that time were unsuccessful. *See* Yale Kamisar, *Devil in the Detail, Not Money, Defeated Assisted Suicide Plan*, DETROIT NEWS, Nov. 5, 1998, at A12 (discussing Michigan, Washington and California voters' rejection of such initiatives in early 1990s).

81. 850 F. Supp. 1454 (W.D. Wash. 1994), *rev'd*, 49 F.3d 586 (9th Cir. 1995), *rev'd en banc*, 79 F.3d 790 (9th Cir. 1996), *rev'd sub nom.* *Washington v. Glucksberg*, 521 U.S. 702 (1997).

82. 870 F. Supp. 78 (S.D.N.Y. 1994), *rev'd sub nom.* *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *rev'd*, 521 U.S. 793 (1997).

83. *See Compassion in Dying*, 850 F. Supp. at 1455-56 (challenging constitutionality of Washington's ban on assisted suicide); *see also Quill*, 870 F. Supp. at 79 (challenging constitutionality of New York's ban on assisted suicide.)

84. *See Compassion in Dying*, 850 F. Supp. at 1456-59 (describing plaintiffs and their claims); *see also Quill*, 870 F. Supp. at 79-80 (discussing composition of plaintiffs and their allegations).

Court for the Western District of Washington ruled in favor of the *Compassion in Dying* plaintiffs on their due process challenge.⁸⁵ On appeal, both the United States Courts of Appeals for the Ninth and Second Circuits held the respective state statutes unconstitutional.⁸⁶

The United States Supreme Court granted certiorari in its 1996 term, however, and reversed both rulings.⁸⁷ Although the Court's opinions

85. See *Quill*, 870 F. Supp. at 79 (dismissing equal protection challenge on summary judgement motion); *Compassion in Dying*, 850 F. Supp. at 1467 (ruling for plaintiffs on their due process challenge).

86. See *Compassion in Dying v. Washington*, 79 F.3d 790, 793-94 (9th Cir. 1996) (holding that statute violates Due Process Clause of Fourteenth Amendment), *rev'g en banc* 49 F.3d 586 (9th Cir. 1995), *rev'd sub nom.* *Washington v. Glucksberg*, 521 U.S. 702 (1997); see also *Quill v. Vacco*, 80 F.3d 716, 731 (2d Cir. 1996) (holding that state statute violates Equal Protection Clause of Fourteenth Amendment), *rev'd*, 521 U.S. 793 (1997).

87. See *Washington v. Glucksberg*, 521 U.S. 702, 705-06 (1997) (reversing earlier ruling); *Quill v. Vacco*, 521 U.S. 793, 7997 (1997) (reversing earlier ruling). An array of literature dissects and critiques the circuit courts' rulings. See, e.g., Emanuel, *supra* note 78, at 983 (suggesting that Supreme Court decisions will shift debate from courts to legislatures); Kamisar, *supra* note 78, at 895-901 (discussing how physician-assisted suicide cases hindered cause); Patricia A. King & Leslie E. Wolf, *Empowering and Protecting Patients: Lessons for Physician-Assisted Suicide from the African-American Experience*, 82 MINN. L. REV. 1015, 1016-17 (1998) (arguing that terminal patients should also be protected from prejudice, stereotyping and "social indifference"); Kathryn L. Tucker, *The Death with Dignity Movement: Protecting Rights and Expanding Options After Glucksberg and Quill*, 82 MINN. L. REV. 923, 923-24 (1998) (showing that despite poll results indicating that most physicians would like patients to have option of lethal dose to end suffering, most states have statutes outlawing assisted suicide); Urofsky, *supra* note 51, at 313 (stating that although Supreme Court ruled on Federal law, states had wide latitude to create legislation); Wolf, *supra* note 76, at 888-90 (discussing debate spawned by *Glucksberg* and *Quill* rulings). Howard Brody, a physician, ethicist, professor and director of the Center for Ethics & Humanities in the Life Sciences, Michigan State University, presents one of the more provocative and unique comments. See Howard Brody, *Physician-Assisted Suicide in the Courts: Moral Equivalence, Double Effect, and Clinical Practice*, 82 MINN. L. REV. 939, 939 (1998) (arguing that circuit court opinions turn two well-entrenched ethical concepts, moral equivalence principle and principle of double effect, on their heads). He suggests that "[t]he moral equivalence [principle] holds that if allowing a patient to die by forgoing life-sustaining [measures] is moral (or immoral), then physician-assisted suicide . . . must be moral (or immoral) to the same degree." *Id.* at 939. He continues, stating that "[t]he principle of double effect holds that it is moral to administer high-dose narcotics to dying patients, even though there may be some risk of hastening death, whereas it is not moral to administer an overdose of such drugs deliberately to cause death." *Id.* The practice of medicine operates on the belief that the principle of double effect is true while the moral equivalence principle is false. See *id.* at 939. By bootstrapping the right to assistance in suicide on the already recognized constitutional right to refuse lifesaving treatment, the courts embraced the moral equivalence doctrine while dismissing the principle of double effect as essentially devoid of value. See *id.* at 952-58. Brody argues that such a position not only collides with accepted medical practice but also gives short shrift to the real issues of assisted suicide that need to be confronted before such a practice becomes part of accepted end-of-life medical practice. See *id.* at 958-62 (arguing that both sides of debate should try to effectuate wishes of terminal patients and their end-of-life decisions).

were unanimous, they were also diverse.⁸⁸ As a matter of rights analysis, the Court held that the right to assistance in suicide was not fundamental either as an enumerated right or one “deeply rooted in this Nation’s history and tradition.”⁸⁹ As Professor Robert Burt has noted, the “two opinions adopt the narrow, unambitious approach to constitutional adjudication that has been the particular hallmark of Rehnquist’s jurisprudence.”⁹⁰ The *Glucksberg* and *Quill* opinions are, accordingly, more interesting for their subtext than for their text. Both sides of the assisted suicide debate have an abiding interest in untangling the legal and ethical questions of end-of-life decision-making, as well as, an interest in the more practical question of whether the Court might, or should, revisit the issue.⁹¹

To examine the aptness of the autonomy model in death and dying jurisprudence, one must deconstruct the rights analysis of the Court in the assisted suicide cases. To that end, this work compares the cases of the patients in *Glucksberg*, *Quill* and *Cruzan*, and applies analogical reasoning to determine: (1) why the Court distinguished between the rights asserted in each case and (2) found a right to hasten death in the *Cruzan*, but not in *Glucksberg* or *Quill*.⁹²

First, the status of those asserting a constitutional right differed in the three cases.⁹³ In *Cruzan*, the petitioner was Joe Cruzan, legal guardian for his daughter Nancy Cruzan.⁹⁴ In *Glucksberg* and *Quill*, the respondents

88. See generally *Quill*, 521 U.S. 793 (reversing earlier ruling); *Glucksberg*, 521 U.S. 702 (including majority opinion by Chief Justice Rehnquist, joined by Justices O’Connor, Scalia, Kennedy and Thomas, concurring opinion by Justice O’Connor concurred in part by Justices Breyer and Ginsberg, and separate concurring opinions by Justices Souter, Breyer, Ginsberg and Stevens). Plurality decisions suggest that the case presents a problem that requires further study. Rather than papering over disagreement with a weak and inconclusive, but apparent, majority, it is probably preferable for the Court to admit some doubt, and thereby extend its consideration of the issues in question. See Robert C. Power, *Affirmative Action and Judicial Incoherence*, 55 OHIO ST. L.J. 79, 159 (1994) (citing Linda Novak, Note, *The Precedential Value of Supreme Court Plurality Decisions*, 80 COLUM. L. REV. 756, 781 (1980) (arguing that plurality opinions state uncertainty and seek additional argument)).

89. *Glucksberg*, 521 U.S. at 703 (citing *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977)).

90. Burt, *supra* note 57, at 966.

91. See M. Cathleen Kaveny, *Assisted Suicide, the Supreme Court, and the Constitutive Function of the Law*, HASTINGS CTR. REP., Sept.-Oct. 1997, at 29 (discussing possibility of Supreme Court’s revisiting issue of physician-assisted suicide).

92. See generally Cass Sunstein, *On Analogical Reasoning*, 106 HARV. L. REV. 741 (1993) (describing analogical reasoning framework).

93. Compare *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261, 268-69 (1990) (noting that party asserting right appealed to Supreme Court from Missouri Supreme Court), with *Glucksberg*, 521 U.S. at 707 (noting that party asserting right was respondent having prevailed on issue in circuit court), and *Quill*, 521 U.S. at 797 (same).

94. See *Cruzan*, 497 U.S. at 266 (describing Nancy Cruzan’s condition since her accident).

were the physicians of terminally ill but competent patients who had died before their cases came before the Supreme Court,⁹⁵ and in *Glucksberg*, *Compassion in Dying*, a nonprofit organization that counsels people considering physician-assisted suicide.⁹⁶ Second, the petitioners asserted different rights. In *Cruzan*, the constitutional right asserted by Joe Cruzan was the right, derived from his incompetent daughter, to refuse life-sustaining nutrition and hydration.⁹⁷ In *Glucksberg* and *Quill*, the right asserted was to physician assistance in hastening death for competent, terminally-ill rights-bearers.⁹⁸ In *Cruzan*, the Court unanimously recognized as fundamental the right of a competent individual to refuse lifesaving treatment, but refused, in a divided opinion, to overrule Missouri's evidentiary bar to exercising that right.⁹⁹ In *Glucksberg* and *Quill*, the Court unanimously refused to recognize as fundamental the right to assistance in suicide either as a matter of substantive due process or equal protection, without regard to the patients' competency.¹⁰⁰

It is easy enough to say, as a matter of traditional rights jurisprudence, that the right to refuse unwanted treatment alleged in *Cruzan* is fundamental because it is deeply rooted in American history and tradition.¹⁰¹ The Chief Justice carefully articulated that the predicate to expanding due process beyond a constitutionally enumerated right was whether such a right could be found "by examining our Nation's history, legal traditions, and practices."¹⁰² The respondents in *Glucksberg* and *Quill* were challenging a statute criminalizing assisting suicide, the state of the law in almost every jurisdiction. As a matter of proper constitutional methodology, the Court was required to "carefully describe" the liberty interest asserted by the respondents.¹⁰³ The Court did so by narrowly construing the "right"

95. See *Glucksberg*, 521 U.S. at 707 (identifying respondents); *Quill*, 521 U.S. at 797 (same).

96. See *Cruzan*, 497 U.S. at 261 (describing parties to case).

97. See *id.* at 268-69 (describing rights asserted).

98. See *Glucksberg*, 521 U.S. at 708 (describing rights asserted); *Quill*, 521 U.S. at 797 (same).

99. See *Cruzan*, 497 U.S. at 279 (Rehnquist, C.J.) ("[W]e think the logic of [precedent] would embrace . . . a liberty interest [to refuse treatment]. . . . [W]e assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.").

100. See *Glucksberg*, 521 U.S. at 719-35 (explaining why physician-assisted suicide is not liberty interest protected by due process); *Quill*, 521 U.S. at 799-809 (explaining why prohibition against physician-assisted suicide does not violate Equal Protection Clause of Fourteenth Amendment).

101. See *Cruzan*, 497 U.S. at 269-79 (tracing history and tradition beginning with common law torts of battery and informed consent, and self-determination jurisprudence of *Quinlan* and its progeny); *Glucksberg*, 521 U.S. at 710-19 (tracing constitutional history of liberty interest in controlling one's death).

102. *Glucksberg*, 521 U.S. at 710.

103. See *id.* at 720-21 (noting that constitutional methodology involves two-pronged test when determining whether to extend constitutional protection to asserted liberty interest). As stated in *Glucksberg*:

asserted.¹⁰⁴ As in *Cruzan*, where the Court assumed that the Constitution grants competent persons a narrow right to refuse lifesaving hydration and nutrition, Justice Rehnquist described the right asserted by the respondents in *Glucksberg* and *Quill* as “a right to commit suicide which itself includes a right to assistance in doing so.”¹⁰⁵ In contrast to the historical and traditional analysis of *Cruzan*, however, the *Glucksberg* and *Quill* decisions found that the states’ bans on assisting suicide are, rather than innovations, “long-standing expressions of the States’ commitment to the protection and preservation of all human life.”¹⁰⁶ The outcome is clear

Our established method of substantive-due-process analysis has two primary features: First, we have regularly observed that the Due Process Clause specially protects those fundamental rights and liberties which are, objectively, “deeply rooted in this Nation’s history and tradition” and “implicit in the concept of ordered liberty” such that “neither liberty nor justice would exist if they were sacrificed.” Second, we have required in substantive-due-process cases a “careful description” of the asserted fundamental liberty interest.

Id. (citations omitted). “Carefully describing” in constitutional law-speak means narrowly, rather than broadly, describing the right. See Tribe & Dorf, *supra* note 20, at 1058 (“The more abstractly one states the already-protected right, the more likely it becomes that the claimed right will fall within its protection.”). In the health decision cases such as *Cruzan* and *Glucksberg*, if the right is described as one of personal autonomy in cases of bodily integrity, then both the right to refuse treatment and the right to assistance in suicide can easily be incorporated into a right to decide on the timing of one’s death. See Martha Minow, *Which Question? Which Lie? Reflections on the Physician-Assisted Suicide Cases*, 1997 SUP. CT. REV. 1, 4 (1997) (“When identifying and assessing the competing interest of liberty and authority, for example, the breadth of expression that a litigant or a judge selects in stating the competing principles will have much to do with the outcome and may be dispositive.”).

104. See *Glucksberg*, 521 U.S. at 720 (Rehnquist, C.J.). According to Chief Justice Rehnquist:

By extending constitutional protection to an asserted right or liberty interest, we . . . place the matter outside the arena of public debate and legislative action. We must therefore “exercise the utmost care whenever we are asked to break new ground in the field,” lest the liberty protected by the Due Process Clause be subtly transformed into the policy preferences of the members of this Court.

Id.

105. *Glucksberg*, 521 U.S. at 723; see also *Cruzan*, 497 U.S. at 279 (“[W]e assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.”).

106. *Glucksberg*, 521 U.S. at 710. In comparison, Justice Calabresi’s concurring opinion traces the history of criminalizing suicide, attempted suicide and assisting a suicide. See *Quill v. Vacco*, 80 F.3d 716, 732-35 (2d Cir. 1996) (tracing history of liberties that enjoy protection of Due Process and Equal Protection Clauses of Fourteenth Amendment), *rev’d*, 521 U.S. 793 (1997). Although statutes criminalizing a suicide or attempted suicide were deleted from the criminal codes, statutes criminalizing assisting a suicide were left in place. See *id.* Justice Calabresi notes that it is not until recently that the law was called upon to make choices for human beings in the twilight of life and death. See *id.* at 732. Although doctors did not advertise their role in hastening death in appropriate circumstances, historically patients in long-term relationships with physicians knew that their physicians could be depended on for assistance when the time came. See *id.* Therefore, Justice

from the very first paragraph of constitutional analysis: the umbrella of protection created by a history of recognizing a right of self-determination with regard to bodily integrity will not be broad enough to protect even a voluntary, knowing right to seek the assistance of a physician in hastening death.¹⁰⁷

Why does the Court refuse the right to a dignified death to such a worthy group of patients when it could have held the statute unconstitutional as applied to the terminally ill, competent, well-counseled patients of *Glucksberg* and *Quill*?¹⁰⁸ A great deal of speculation surrounds the Court's decision.¹⁰⁹ One cogent argument focuses on the judicial preemption of political discourse and debate, positing that where the judiciary interrupts the political process it also short-circuits the majoritarian process.¹¹⁰ Chief Justice Rehnquist concludes the opinion of the Court by stating that, "[t]hroughout the Nation, Americans are engaged in an earnest and profound debate about the morality, legality and practicality of physician-assisted suicide. Our holding permits this debate to continue, as it should in a democratic society."¹¹¹ Justice Souter's concurring opinion states that individual rights analysis does not justify judicial intervention "merely to identify a reasonable resolution of contending values that differs from the terms of the legislation under review."¹¹² A clash between the right of a State to exercise its power legitimately to protect its citizens and a claimed individual right can be resolved only through ascertaining the necessary facts. The question before the court is whether the facts are

Calabresi speculates that laws prohibiting assisting a suicide may never have been intended to apply to physicians; in any case, whether they were meant to apply is unclear. *See id.* Perhaps more importantly, Justice Calabresi argues that although statutes forbidding assisting a suicide are still nominally on the books, the original reason for the statutes is long since gone and the enforcement of the laws themselves has fallen into virtual desuetude. *See id.* at 735.

107. *See Glucksberg*, 521 U.S. at 710-11 (discussing endurance of laws that impose criminal penalties for assisting suicide).

108. *See Kaveny*, *supra* note 91, at 30 (opining that after *Glucksberg*, the community should focus on protecting its most vulnerable members); Sylvia A. Law, *Physician-Assisted Death: An Essay on Constitutional Rights and Remedies*, 55 Md. L. Rev. 292, 334 (1996) (stating that courts upheld law that denied constitutionally protected liberties to parties to litigation). *But see Glucksberg*, 521 U.S. at 787 (Souter, J., concurring) (stating that although grant of absolute right to assistance in suicide may be apt for *Glucksberg* rights-bearers, it has grave possibility of threatening safety and lives of those less competent, informed, powerful or proactive by compromising States' ability to protect them). It is difficult to imagine a worthier group of patients: terminally ill, in physical and emotional pain, mentally competent and with apparently full understanding of the consequences of their request, with physicians willing to assist them in hastening their deaths.

109. *See Burt*, *supra* note 57, at 972-73 (suggesting that judicial preemption of political discourse upsets the majoritarian process).

110. *See id.* (discussing how Court's decisions cut off political discourse, thus interrupting majoritarian process). This is surely a reference to cases like *Brown v. Bd. of Educ.*, 347 U.S. 483 (1954) and *Roe v. Wade*, 410 U.S. 113 (1973).

111. *Glucksberg*, 521 U.S. at 735.

112. *Id.* at 768.

more readily discernible through the judicial process or through legislative fact-finding and experimentation.¹¹³ Much remains unknown about the possible dislocative effects of decriminalizing assisting suicide.¹¹⁴ Therefore, the rights analysis, in this sense, is not ripe for judicial determination.¹¹⁵

The opinions of Justices Rehnquist, O'Connor and Breyer make the ripeness argument in another way, describing it as an issue of the character of the respondents' statutory challenge.¹¹⁶ The Chief Justice introduces this argument at the very end of the opinion of the Court, in footnote twenty-four of the *Glucksberg* opinion.¹¹⁷ In that note, Justice Rehnquist clarifies that the Court rejects not only the respondents' facial

113. See *id.* at 786-87 (stating that necessary facts cannot be divorced through judicial process, but rather by legislative experimentation and discovery).

114. See, e.g., Belkin, *supra* note 77, at A1 (discussing crusade of doctor Jack Kevorkian); Jim Irwin, *Kevorkian Aids 33rd Suicide, Takes Body to Hospital*, NEWS & OBSERVER, July 11, 1996, at A7 (discussing Kevorkian's crusade to bring debate into political mainstream). Kevorkian has become a hero because he promises control over a never-ending vision of death. See *Conference Transcript Socially-Assisted Dying: Media, Money & Meaning*, 7 CORNELL J.L. & PUB. POL'Y 267, 327-29 (1997) (discussing Kevorkian's popularity). Curiously, a large percentage of Michigan voters support Kevorkian. See *Michigan Poll Backs Kevorkian*, NEWS & OBSERVER (Raleigh, N.C.), June 30, 1996, at A9 (stating that 73% of Michigan voters think that prosecutors should quit taking Kevorkian to trial).

115. See CHARLES ALAN WRIGHT, FEDERAL COURTS 60-67 (5th ed. 1994) (defining constitutional ripeness as doctrine that delimits authority of courts to questions presented in adversary context and forecloses judicial incursions into areas committed to other branches of government). Although lack of ripeness did not deprive the Court of the authority to hear the case, perhaps the reluctance of the Court to deal more squarely with the rights issue arose from a collective belief that to do so would be to intrude on the purview of the legislature. Justice Souter does not foreclose the possibility of judicial determination at some later date. See *Glucksberg*, 521 U.S. at 788 (Souter, J., concurring) ("Sometimes a court may be bound to act regardless of the institutional preferability of the political branches as forums for addressing constitutional claims."). As an example of judicial intervention, Justice Souter cites to *Bolling v. Sharpe*, 347 U.S. 497 (1954), the companion case to *Brown v. Bd. of Educ.*, 347 U.S. 483 (1954). See *id.* (citing segregation cases). Justice Souter's reference to *Bolling* refers to the Southern states' failure to eradicate school segregation not only before they were constitutionally required to by *Brown* and *Bolling*, but also to their resistance thereafter. See Burt, *supra* note 57, at 973-74 (praising Court's recognition that legislature was better suited to engage in fact finding before judicial determination).

116. See *Glucksberg*, 521 U.S. at 735 n.24 (discussing, implicitly, difference between facial and applied constitutional statutory challenges). A "facial" challenge to a statute is a generalized challenge as to its unconstitutionality. The Court will find the statute unconstitutional only if there are no or almost no cases in which its application will be constitutional. See Law, *supra* note 108, at 324-42 (discussing judicial remedies that violate constitutional rights of some of those to whom statutes apply); see also Michael C. Dorf, *Facial Challenges to State and Federal Statutes*, 46 STAN. L. REV. 235, 237 (1994) (analyzing Court's facial challenge doctrine). An "as applied" challenge is one that challenges the constitutionality of a statute as applied to the particular plaintiff bringing the challenge. See *id.*

117. See *Glucksberg*, 521 U.S. at 735 n.24 (rejecting statute "as applied" as well as facially).

challenge of the statute but also the court of appeals' specific holding that the Washington statute is unconstitutional "as applied."¹¹⁸ At the end of the note, he alludes to the possibility that the Court will revisit the matter, but gives no hint as to how the facts or the constitutional challenges must change in order to support such a future claim successfully.¹¹⁹ Justices O'Connor and Breyer make this argument more clearly.¹²⁰ As a matter of facial constitutional challenge, the statute survives.¹²¹ As Professor Sylvia Law notes, this statute should survive a facial challenge because a ban on assisted suicide protects people in various situations, such as not terminally ill patients or those who seek death because of situational acute depression.¹²²

The Court chose not to reach the narrower question of whether the statute survives as applied to a class of terminally ill but competent patients because, according to Justice O'Connor, the respondents failed to allege any legal barriers "to obtaining medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death."¹²³ Justice Breyer states a future petitioner's claim even more clearly. He suggests that a successful constitutional claim would have to include the avoidance of severe physical pain inflicted as a result of the arbitrary imposition of a state's law "prohibit[ing] doctors from providing patients with drugs sufficient to control pain despite the risk that

118. See *Compassion in Dying v. Washington*, 79 F.3d 790, 797 (9th Cir. 1996) (making it clear that challenge to Washington's assisted suicide statute is both facial and "as applied to terminally ill, mentally competent adults who wish to hasten their own deaths with the help of medication prescribed by their doctors"). The holding of the court of appeals is that the Washington statute violates the Due Process Clause of the Fourteenth Amendment as applied to terminally ill, competent adults who wish to hasten their own deaths. See *id.* at 793-94.

119. See *Glucksberg*, 521 U.S. at 735 n.24 (emphasizing that future plaintiff with more particularized challenge may prevail over assisted suicide statute); Burt, *supra* note 57, at 967-68 (explaining that footnote was included as matter of judicial politics).

120. See *Glucksberg*, 521 U.S. at 736 (O'Connor, J., concurring) (discussing possibility that facial challenge by plaintiff could succeed if plaintiff could show that state policy toward palliative care disrupts plaintiff's right to die without suffering).

121. See *id.* at 738 (Stevens, J., concurring) (explaining that Court took this challenge to be general rather than applied because no patient or doctor stood as patient before Court, therefore the Court's "analysis and eventual holding that the statute was unconstitutional was not limited to a particular set of plaintiffs before it"); see also *id.* at 736 (O'Connor, J., concurring) (justifying state's ban on assisting suicide because "the State's interests in protecting those who are not truly competent or facing imminent death, or those whose decisions to hasten death would not truly be voluntary, are sufficiently weighty").

122. See Law, *supra* note 108, at 334 (agreeing that state has sufficient interest in protecting those who are not truly competent or whose decisions to end life are not voluntary).

123. *Glucksberg*, 521 U.S. at 736 (O'Connor, J., concurring); see also Brody, *supra* note 87, at 939 (discussing principle of double effects).

those drugs themselves will kill.”¹²⁴ In this rather surprising analytical twist, Justices O’Connor and Breyer reformulate a right not alleged by the respondents: the right of patients at the end-of-life to obtain relief from suffering.¹²⁵ Dr. Ezekiel Emanuel calls this right to be free from suffering “the sadistic state” exception to the general prohibition against assisted suicide.¹²⁶ Because Justices O’Connor and Breyer seem to believe that terminal patients face no legal obstacle to receiving palliative care in New York and Washington, both felt that the *Glucksberg* and *Quill* respondents failed to make out a successful claim for challenging the statute as applied to them, terminally ill but competent patients seeking a dignified death.¹²⁷

Justice Stevens, although acknowledging that the state statutes withstand a facial constitutional challenge, stands alone because he does not “foreclose the possibility that an individual patient seeking to hasten her death . . . could prevail in a more particularized challenge.”¹²⁸ Although he does not specify what a terminally ill, competent person would need to assert in order to challenge successfully the state law “as applied,” Justice Stevens disagrees with Justices O’Connor and Breyer that a successful plaintiff would have to show that the state’s policy toward palliative care abridges that plaintiff’s right to an end-of-life free from suffering.¹²⁹ Justice Stevens instead contemplates that a terminally ill but competent and

124. *Glucksberg*, 521 U.S. at 789-90 (Breyer, J., concurring); see also *id.* at 752 (Souter, J., concurring) (arguing for application of Harlan substantive due process analysis from *Planned Parenthood v. Casey*, 505 U.S. 833 (1992)). Justice Breyer seems to agree with Justice Souter’s form of due process analysis. See *id.* at 789-90 (Breyer, J., concurring).

125. See *id.* at 791 (Breyer, J., concurring) (demonstrating that Justice Breyer would also reformulate Court’s right to assistance in suicide into “a right to die with dignity” that includes personal control over manner of death, professional medical assistance and avoidance of unnecessary and severe physical suffering).

126. Emanuel, *supra* note 78, at 986-87 (examining Justice O’Connor’s implied notion that Court would consider right to assisted suicide only if patients were not receiving adequate care).

127. But see *Glucksberg*, 521 U.S. at 792 (Breyer, J., concurring) (hedging above mentioned contentions by stating that situations occur where patients do not receive certain end-of-life care, not because of “a prohibitive set of laws” but rather because of “institutional reasons” or physician’s inhibitions); see also Burt, *supra* note 57, at 969-71 (suggesting that if statute prohibited palliative care, physical suffering would be at issue). Justices O’Connor and Breyer both seem to believe that there is no legal obstacle to terminal patients’ receiving palliative care in New York or Washington. See *Glucksberg*, 521 U.S. at 736 (O’Connor, J., concurring) (illustrating Justice O’Connor’s contention that individuals dying in New York and Washington could receive medical treatment even if it could cause their death); *id.* at 791 (Breyer, J., concurring) (demonstrating Justice Breyer’s belief that Washington and New York laws do not preclude physicians from administering drugs that may lead to patient’s death).

128. *Id.* at 750 (suggesting that although these statutes are facially constitutional, they could be vulnerable to future particularized challenge).

129. See Wolf, *supra* note 76, at 1095 (contending that individual’s challenge may succeed if case was unusual).

non-depressed plaintiff who makes a rational choice to forego palliative treatment in favor of assisted suicide might indeed successfully challenge a state statute "as applied."¹³⁰ "For such an individual," he writes, "the State's interest in preventing potential abuse and mistake is only minimally implicated."¹³¹

Consequently, Justice Stevens' concurrence is almost a dissent. Although he agrees that the history and traditions of the United States do not support an open-ended constitutional right to assistance in suicide, he contemplates the possibility of a plaintiff whose particular facts are similar enough to Nancy Cruzan's to entitle the plaintiff to a specific interest in assisted suicide.¹³² To make this argument, Justice Stevens describes the right recognized by *Cruzan* not as a general liberty interest in refusing life-saving treatment, but rather as an interest by persons who no longer have the option of deciding whether to live or to die because they are already on the threshold of death.¹³³ Just as *Cruzan* was not the normal case of an individual choosing to forego life-sustaining treatment, neither is the case of a voluntary and informed choice to forego palliative care made by a non-depressed, terminally-ill, competent person.¹³⁴ For such a person, a

130. *See id.* (contending that particularized facts persuade Justice Stevens in death and dying cases).

131. *Glucksberg*, 521 U.S. at 748.

132. *See id.* at 750 (suggesting more particularized challenge by patient seeking assistance from doctor or seeking help to hasten death might prevail in court). I gather that Justice Stevens' point is that an individual right is not absolute, not only because it must be properly weighed against the State's interest but also because the existence of certain constitutional liberties is factually dependent. *See id.* at 751; *see also* *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 332, 345 (1990) (suggesting individual right must be tempered by state interest in preserving life). In *Cruzan*, the fact that Nancy existed in an irreversible coma, from which she had no chance of recovery, should have persuaded the Court. Life was not a choice for her; her only choice was how she would exit from life. Additionally, there was very little room for error, mistake or abuse. Her permanent condition combined with her parents' loving and unstinting campaign to withdraw the life-sustaining treatment made the possibility of error or abuse negligible. *See id.* at 354-55.

133. *See* Tribe & Dorf, *supra* note 20, at 1058 (explaining that more abstractly already-existing right is described, more likely it is that claimed right will be protected as well). One of the basic differences between Justice Stevens opinion and the opinion of the Court is that he would formulate the constitutional right of *Cruzan* in a broader framework. *See Glucksberg*, 521 U.S. at 743 (Stevens, J., concurring) (noting that right to refuse treatment is broader and more basic than *Cruzan's* common law analysis indicates).

134. *See Glucksberg*, 521 U.S. at 742 (Stevens, J., concurring) (discussing dominance of state interest over individual interest). For example, Justice Stevens states that, "In most cases, the individual's constitutionally protected interest in his or her own physical autonomy, including the right to refuse unwanted medical treatment, will give way to the State's interest in preserving human life." *Id.* Justice Stevens means that in Nancy Cruzan's case, there was no chance that she would regain consciousness and have a meaningful life; her condition was irreversible. In such cases, the State's interest in preserving life is relatively meaningless and the individual's interest in refusing life-sustaining treatment is coextensive with controlling the manner and time of her death. Does this mean that an individual's

statute criminalizing assisting suicide could be unconstitutional as an arbitrary infringement of her right to make decisions on how to confront imminent death.

Perhaps the moral value most persuasive to all the Justices is the protection of life, as evidenced by an almost universal legislative framework in which the states have created an absolute rule against assisted suicide.¹³⁵ As the Chief Justice states, "the State has an interest in protecting vulnerable groups . . . from abuse, neglect and mistakes The State's interest here goes beyond protecting the vulnerable from coercion; it extends to protecting disabled and terminally ill people from prejudice, negative and inaccurate stereotypes, and 'societal indifference.'"¹³⁶ Justice Souter shares this view. He disposes of the rights argument because the State's interests, particularly the interest in protecting patients from mistakenly and involuntarily ending their lives, defeat the respondents' claim that the states' assisted suicide bans are unreasonable intrusions.¹³⁷ Even Justice Stevens' concurrence acknowledges the State's legitimate interest in preserving life in order to foster the community of ideas, affection and memories.¹³⁸ He writes, "The value to others of a person's life is far too precious to allow the individual to claim a constitutional entitlement to complete autonomy in making a decision to end that life."¹³⁹

Paradoxically, *Glucksberg* and *Quill* are constitutional rights cases that fail to squarely address the protection of patient choice.¹⁴⁰ The two opinions are a primer on how the Rehnquist Court identifies an individual, fundamental right deserving of constitutional protection.¹⁴¹ The Court

exercise of prospective autonomy in an advance directive is always subject to an examination of the interest of the State in preserving life? It is important to note that the case of a terminally-ill, competent person who is not depressed and makes an informed, voluntary decision to forego available palliative care is also unusual. See NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, *DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT* 120 (1994) (theorizing situation where ideal case would satisfy all safeguards to eliminate risk of physician assisted suicide, such as screening for depression, administering medications and family support).

135. See Kaveny, *supra* note 91, at 31 (asserting that all states except Oregon maintain absolute ban on assisted suicide).

136. *Glucksberg*, 521 U.S. at 731.

137. See *id.* at 782 (expressing belief that state's interest in protecting individuals from involuntary or mistaken suicide is sufficient to justify Washington law).

138. See *id.* at 741 (noting that when state like Washington utilizes death penalty it acknowledges that human life does not always require preservation and therefore must accept that other legitimate reasons could exist for hastening death).

139. *Id.*

140. See Sylvia A. Law, *Birth and Death: Doctor Control vs. Patient Choice*, 82 MINN. L. REV. 1045, 1058 (1998) (concluding that court failed to address issue of patients' choice).

141. See Law, *supra* note 108, at 297-98 (describing Court's changing fundamental rights analysis). The Court traditionally has identified the right as fundamental or one that can be defined as an opportunity for social or economic advantage. See *id.* at 297 (discussing dichotomy between fundamental individual

focuses on the history and legal tradition of suicide, constitutional analysis of fundamental rights, facial versus as applied constitutional challenges and a preemption of the legislative majoritarian process.¹⁴² In addition, several of the concurring opinions address the possibility of judicially revisiting the debate.¹⁴³ The Court talks little, however, about autonomy.¹⁴⁴ The opinion pays scant attention to the fact that the patients, all competent and aware, thoughtfully deliberated their decisions to hasten their deaths.¹⁴⁵ That the non-profit organization, Compassion in Dying, provided patients with complex counseling to ensure authentic, informed and voluntary patient choice was surely of no moment.¹⁴⁶ This paradox is extraordinarily perplexing, considering that the patients in *Glucksberg* and *Quill* perfectly represent the abstract model for thoughtful, uncoerced decision-making that rarely occurs clinically.¹⁴⁷

rights and state autonomy). If the individual liberty is "fundamental," the state must demonstrate strong and precise, or "compelling" justification for restricting it. Recently this traditional approach has given way to the Court's approach in *Planned Parenthood v. Casey*, where state restrictions are permitted in the absence of a compelling state interest, so long as no undue burden is imposed on the exercise of the liberty. See *id.* at 297-98 (emphasizing importance of state's upholding fundamental individual liberties).

142. See Kaveny, *supra* note 91, at 32-33 (analyzing sources Court uses to bolster its rationale); see also *Glucksberg*, 521 U.S. at 727 (noting that United States law has historically rejected attempts to permit assisted suicide and that Court follows "historical continuity" rather than "theoretical consistency" in deciding that due process affords no protection to assisted suicide).

143. See Wolf, *supra* note 76, at 889 (suggesting that Court may have to further review debate over euthanasia).

144. *But see* Burt, *supra* note 57, at 968-69 (noting fallacy of the Justices' beliefs that there is no bar to receiving pain medication including sedation to narcotic coma).

145. See *Glucksberg*, 521 U.S. at 724 (noting respondents theory that "liberty jurisprudence" frees end-of-life decisions from government interference, but framing question as whether due process clause protects physicians' actions in assisting suicide); *id.* at 726-27 (stating that although due process protects many rights and liberties with regards to autonomy, not every personal decision is afforded automatic protection).

146. See Law, *supra* note 108, at 337 (arguing that one possible remedy of Court facing issue of unconstitutional law is to declare law unconstitutional as applied to some but not as to all and attempt to explain what is and what is not unconstitutional). In *Glucksberg*, for example, the Court could have chosen to find the statute unconstitutional as applied to physicians assisting patients under the guidelines of *Compassion in Dying*. The claims involved in *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc), were not before the court of appeals and therefore not before the Supreme Court, "The district court suggested that it would reach those additional claims at a later stage in the proceedings if Compassion In Dying so desired." *Id.* at 797.

147. See Joanne Lynn, *Unexpected Returns: Insights from SUPPORT in TO IMPROVE HEALTH AND HEALTH CARE 1997*, at 178-80 (Stephen L. Isaacs & James R. Knickman eds., 1997) (describing end-of-life decision-making, which generally reflects patterned behavior instead of patients' wishes); see also George J. Annas, *How We Lie, Dying Well in the Hospital: Lessons from SUPPORT*, HASTINGS CTR. REP., Nov.-Dec. 1995, at S12 (criticizing hospital culture for valuing teaching and research over patients' rights); Rosemarie B. Hakim et al., *Factors Associated with Do-Not-Resus-*

To the extent that the Court recognizes any right at all, it recognizes patients' rights to be free from pain through access to physician supervised palliative care.¹⁴⁸ Indeed, a patient who can demonstrate failure to obtain such relief can challenge the constitutionality of state statutes prohibiting assisting suicide.¹⁴⁹ Because Justice O'Connor provided the fifth and deciding vote in *Glucksberg* and *Quill*, the cases recognize a right that the parties themselves did not propose: a constitutional right to adequate pain medication at the end-of-life.¹⁵⁰ It is interesting to speculate about the value of this right for three reasons. First, the fact that the parties themselves did not request this right militates against its importance. Second, the principle of "double effect," an already existing normative clinical practice, demonstrates that physicians have long found it "moral to administer high-dose narcotics to dying patients, even though there may be some risk of hastening death."¹⁵¹ Third, the sympathetic picture of a patient writhing in pain and pleading with her physician for assistance in ending her life, invoked by the Supreme Court Justices in *Glucksberg* and *Quill*, is largely a myth.¹⁵²

This is not to say that palliative care is an unimportant or unworthy issue.¹⁵³ One of the more dismaying findings of SUPPORT was that fully one-half of the study's patients spent most of their time at the end-of-life

citate Orders: Patients' Preferences, Prognoses, and Physicians' Judgments, 125 ANNALS INTERNAL MED. 284, 292 (1996) (suggesting end-of-life decisions are influenced by institutional characteristics rather than patient choices).

148. See Brody, *supra* note 87, at 958 (suggesting that *Glucksberg* and *Quill* reestablish clinical equilibrium that existed in medical community prior to Ninth and Second Circuit decisions).

149. See Burt, *supra* note 57, at 968 (noting Court's uncertainty about what constitutional argument or facts plaintiff must present to gain relief); Law, *supra* note 140, at 1056 (suggesting patient could challenge state's triplicate form requirement because it discourages doctors from prescribing medicine that patients have right to receive).

150. See Tucker, *supra* note 87, at 928-29 (observing that Court inadvertently answered question not posed to it, thus accidentally recognizing right to adequate pain relief through medication); see also Robert A. Burt, *The Supreme Court Speaks: Not Assisted Suicide But a Constitutional Right to Palliative Care*, 337 NEW ENG. J. MED. 1234, 1236 (1997) (suggesting that Court unexpectedly requires state law not to interfere with patients' rights to receive adequate pain relief).

151. Brody, *supra* note 87, at 939 (noting it is already moral to administer drugs to dying patient, although it may hasten death, but immoral if intent is to cause death).

152. See Emanuel, *supra* note 78, at 997 ("All the available evidence indicates that there is virtually no causal connection between pain and interest in PAS [physician-assisted suicide] or euthanasia. Using intolerable pain as the framework in which to think about PAS or euthanasia, distorts the assessment of their benefits and harms.").

153. See Arthur Kleinman, *Intimations of Solidarity? The Popular Culture Responds to Assisted Suicide*, HASTINGS CTR. REP., Sept.-Oct. 1997, at 34 (hypothesizing that Court's rationale is "bizarre" because, considering that millions lack health insurance or access to healthcare and economic factors dominate quality of care decisions, little if any data is available to determine "what constitutes an adequate end of life experience").

in moderate to severe pain.¹⁵⁴ One of the deficiencies of the current healthcare climate, noted by the Institute of Medicine, is a failure of palliative care.¹⁵⁵ The study asserts that legal, institutional and economic obstacles such as flawed prescription laws and their interpretations by state medical boards often conspire to frustrate consistently excellent healthcare.¹⁵⁶ The study calls for changes in the regulations that impede effective use of medications to relieve pain and suffering.¹⁵⁷

The Court's decisions in this area have value. One value of *Glucksberg* and *Quill* is the Court's placing its imprimatur on an already robust movement toward improving patient care at the end-of-life. To the extent that the Court's opinions have changed the focus of the discussion from rights talk to informing public policy, the otherwise disappointing decisions have merit because they provide guidance for terminally-ill patients on a legal quest for a dignified death.¹⁵⁸ A second value of the Court's refusal to recognize a right to assistance in suicide is that it rejects the moral equivalence principle—the principle that the morality of allowing a patient to die by foregoing life-sustaining treatment dictates the morality of physician-assisted suicide.¹⁵⁹ *Glucksberg* and *Quill* force assisted suicide's proponents to make the case for assisted suicide as a moral and desirable social practice rather than one bootstrapped on the *Cruzan* right to refuse life-saving treatment.¹⁶⁰ The effect of the Court's ruling is intentionally indirect because it is policy based rather than rights based, putting the issue of assisted suicide squarely in the public forum. The amount of time the Justices will allow the States to debate the issue may to some extent, be dictated by the school desegregation structural injunction cases brought

154. See Support Principle Investigators, *supra* note 69, at 1668 (noting that one-half of conscious patients experienced moderate to severe pain).

155. See INSTITUTE OF MEDICINE, *APPROACHING DEATH: IMPROVING CARE AT THE END OF LIFE*, Summ. 5 (Marilyn J. Field & Christine K. Cassel eds., 1997).

156. See *id.* at Summ. 3-4 (expressing belief that although science and medicine will improve opportunities for end-of-life care, other obstacles will prevent its complete utilization).

157. See *id.* at Summ. 6 (noting underuse of opioids, despite their low addictive rates).

158. See Emanuel, *supra* note 78, at 983-84 (suggesting that debate is better suited to public fora). Emanuel writes:

[T]he majority holdings permanently shifted the forum, the arguments, the perspective, and the justifications The forum is no longer the courts, but the legislatures and public squares. The arguments are no longer about constitutional rights, but ethics and prudent policies. The perspective is no longer first person, but third person. And the justifications no longer appeal to individual autonomy and beneficence, but to probably social goods and harms. This is as it should be in a democracy.

Id.

159. See Susan M. Wolf, *Holding the Line on Euthanasia*, 19 HASTINGS CTR. REP., Jan.-Feb. 1989, at S13 (warning that adopting moral equivalence hypothesis puts right to refuse unwanted treatment at risk).

160. See Brody, *supra* note 87, at 958 (concluding that defending physician-assisted suicide should be done straightforwardly, rather than "on the cheap" by relying on similar medical practices that courts tolerate).

in the lower courts that sought to carry out judicially what the Supreme Court had dictated as a legislative mandate.¹⁶¹

IV. THE AUTONOMY PARADIGM AND THE ASSISTED SUICIDE CASES

Aside from placing the Court's imprimatur on the patient care movement and rejecting the moral equivalency principle, the Court's assisted suicide cases have a third, more hidden, value: they demonstrate that rights jurisprudence is generally an inappropriate construct for end-of-life decision-making. As a general rule, in conflicts raised by states' regulation of individual action, respect for the "moral autonomy and human dignity" of the individual should justify a presumption in favor of an individual's decision.¹⁶² The standard for substantive due process review articulated by Justice Harlan in his dissent in *Poe v. Ullman*,¹⁶³ adopted by the Court in *Griswold v. Connecticut*¹⁶⁴ and approved in *Planned Parenthood v. Casey*,¹⁶⁵ supports finding a constitutional right in favor of the individual as against state's legislation "when the legislation's justifying principle, critically valued, is so far from being commensurate with the individual interest as to be arbitrarily or pointlessly applied. . . ."¹⁶⁶ The constitutional rights analysis does not demand reexamining; rather, the appropriateness of such analysis to situations where individuals either have not, cannot or do not wish to exercise their rights under any theory that requires further scrutiny.

As a matter of public policy, the primary significance of the Supreme Court's decisions is two-fold: first, they refocus public debate and attention on improving end-of-life care, and second, they evaluate the assisted suicide question independently of its undeniable constitutional parallels to the issue of refusing life-sustaining treatment. As a matter of social policy, however, the most interesting part of the opinion's subtext is how little the principle of autonomy really influenced the Court's decisions. If au-

161. See generally *Missouri v. Jenkins*, 515 U.S. 70 (1995) (holding that state can still challenge district court's desegregation remedy); *Millikin v. Bradley*, 433 U.S. 267 (1977) (challenging de jure segregation in Detroit); *Swann v. Charlotte-Mecklenburg Bd. of Educ.*, nos. 3:97-CV-482-P, 3:65-CV-1974-P, 1999 WL 285718 (W.D.N.C. Feb 22, 1999) (arguing school system achieved unitary status as required by 1971 desegregation order). These cases seek, judicially, to do what *Brown v. Board of Educ.*, 347 U.S. 483 (1954) and *Brown v. Board of Educ.*, 349 U.S. 294 (1955) dictated as a legislative mandate.

162. See Carl E. Schneider, *Right Discourse and Neonatal Euthanasia*, 76 CAL. L. REV. 151, 157 (1988) (discussing deference given to one's choice of actions over state regulation as matter of respect to human dignity and morality).

163. 367 U.S. 497 (1961) Justice Harlan articulated a standard for substantive due process review. See *id.* at 522-55 (supporting injunction against state anti-birth control laws making use of contraceptives criminal act).

164. 381 U.S. 479 (1965) (holding that Connecticut law prohibiting use of contraceptives unconstitutional intrusion on right of marital privacy).

165. 505 U.S. 833 (1992) (prohibiting states from enacting laws that place undue burden on Fourteenth Amendment right to abortion).

166. *Washington v. Glucksberg*, 521 U.S. 702, 768 (1997).

tonomy in the healthcare context means informed participatory decision-making by competent, rational actors, the patient petitioners in *Glucksberg* and *Quill* were paradigmatic. The Court spends little time, however, acknowledging this fact.¹⁶⁷ If autonomy is not really the guiding principle in rights analysis, perhaps we should not delude ourselves by believing that it is. Such a faulty belief system misleads worthy plaintiffs and misinforms legislative and clinical efforts to enhance end-of-life decision-making.¹⁶⁸

A careful examination of the assisted suicide cases should prompt us to question the efficacy and even the security of the autonomy paradigm that the Court approved in *Cruzan*.¹⁶⁹ The *Glucksberg* decision's empirical objections to finding a right for competent, terminally-ill, uncoerced patients to hasten their deaths were grounded in the reasonable fear that an unrestricted right to assistance in suicide could threaten more vulnerable populations.¹⁷⁰ If a blanket right to assistance in suicide became a normative end-of-life option, certain patients might make this choice from a sense of moral obligation to their families.¹⁷¹

If this concern is reasonable in light of available empirical evidence, why should fears of coercion and mistake among vulnerable populations

167. *But see* Brief for Ronald Dworkin et al. as Amici Curiae at 21, *Washington v. Glucksberg*, 521 U.S. 702 (1997), available in 1996 WL 708956 (arguing that states must allow dying patients requesting physician assisted suicide to demonstrate rationality and voluntariness of decision before state denies request).

168. For a discussion of the dangers of this belief system, see *infra* notes 245-271 and accompanying text.

169. *See Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 287 n.12 (1990) (stating that instant case did not present question of "whether a State might be required to defer to the decision of a surrogate if competent and probative evidence established that the patient herself had expressed a desire that the decision to terminate life-sustaining treatment be made for her by that individual").

170. *See* Tribe & Dorf, *supra* note 56, at 1093 (suggesting that opinion's consistent references to history of suicide and assisted suicide arise because opinion focuses on abstraction specifically defining fundamental right as very specific: right to commit suicide that includes right to assistance in committing suicide). A right's definition as fundamental, which makes it deserving of the strictest scrutiny, is a problem that has plagued the Court in substantive due process cases. Justice Harlan suggests one approach to the issue of competing state interests. *See* *Poe v. Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting) (suggesting that liberty protected by Due Process Clause of Fourteenth Amendment "is not a series of isolated points pricked out in terms of the taking of property" but rather is "a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints . . . and which also recognizes . . . that certain interests require particularly careful scrutiny of the state needs asserted to justify their abridgment").

171. *See* NEW YORK STATE TASK FORCE, *supra* note 134, at 120 (suggesting that legalizing assisted suicide and euthanasia "would pose profound risks to many individuals who are ill and vulnerable"). The Task Force also noted that "[t]he risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group." *Id.*

be any less compelling in cases of refusal of life-sustaining treatment?¹⁷² That issue is addressed in *Cruzan*, however, only with respect to an incompetent patient whose end-of-life choices are incomplete or nonexistent.¹⁷³ As the Second Circuit observed in *Quill*, the risks of mistake for patients who request assistance in hastening their deaths are real, but just as real for patients who ask that their life-sustaining treatment be withdrawn.¹⁷⁴ In either case, the difficult issue is not identifying the right, but ensuring the means by which it is exercised. A truly voluntary and informed choice to hasten an already inevitable death greatly reduces the risk of mistake or abuse that concerns the Court.

According to Professor Ronald Dworkin, the possibility of mistake is particularly trenchant in cases where the now incompetent person has left instructions regarding life-sustaining treatment in an advance directive.¹⁷⁵ In cases of prospective autonomy, the potential for mistake or abuse is compounded by the possibility that the advance directive no longer represents the patient's wishes or may be overridden by the instructions of a proxy decision-maker.¹⁷⁶ Interestingly, it is with this issue of proxy decision-making that Justice O'Connor distinguishes herself from the plurality in *Cruzan*.¹⁷⁷ Although she joins the plurality, Justice O'Connor makes it

172. See *Washington v. Glucksberg*, 521 U.S. 702, 732-33 (1997) (using empirical evidence of practice of euthanasia in Netherlands). In the opinion of the Court, the Chief Justice reported that in 1990 in the Netherlands there were 2300 reported cases of voluntary euthanasia, 400 cases of assisted suicide and more than 1000 cases of euthanasia without an explicit request. See *id.* (citing PHYSICIAN-ASSISTED SUICIDE AND EUTHANASIA IN THE NETHERLANDS: A REPORT OF CHAIRMAN CHARLES T. CANADY, at 12-13 (suggesting that euthanasia in Netherlands had not been limited to competent, terminally ill adults and such regulation of practice that has been instituted may not have prevented abuses in cases involving vulnerable populations)). The Court felt that incompetent terminally ill patients must rely on physician or surrogate to make informed consent, which may prove dangerous. See *Glucksberg*, 521 U.S. at 732-33 (citing Netherlands study).

173. See *Cruzan*, 497 U.S. at 287 (noting that some patients will not have family members to make end-of-life decisions on their behalf and in some situations, family members will not act in best interest of patients).

174. See *Quill v. Vacco*, 80 F.3d 716, 730 (2d Cir. 1996) (noting risks in cessation of heroic treatment are same for requesting assistance for hastening death).

175. See Dworkin et al., *supra* note 167, at 14 (discussing danger of advanced directives when individual changed his mind but did not change directive before becoming incompetent).

176. For a further discussion of prospective autonomy, see *supra* notes 44-48 and accompanying text and *infra* notes 265-74 and accompanying text.

177. See *Cruzan*, 497 U.S. at 287 (O'Connor, J., concurring) (writing separately on why protected liberty interest to refuse unwanted medical treatment can be inferred from prior decisions). In so writing, Justice O'Connor exhibits the same ambivalence about the result in *Cruzan* as she does in *Glucksberg*. In both cases, Justice O'Connor provided the crucial fifth vote, but she clearly does so with confusion. See *id.* at 292 (O'Connor, J., concurring) (stating that patients have constitutional right to refuse medical treatment, that intent must be proven by clear and convincing evidence, but surrogates may make decision to refuse treatment as patient's proxy); see also *Glucksberg*, 521 U.S. at 736-38 (O'Connor, J., concurring) (refusing to decide whether competent person has right to physician-

clear that she believes a State may be constitutionally required to give effect to the decisions of a surrogate decision-maker in order to protect an incompetent patient's liberty interest in refusing medical treatment.¹⁷⁸ But if Professor Dworkin is correct, this is the precise scenario that raises the specter of mistake that the *Glucksberg* decision sought to prevent.

In *Cruzan*, the articulated problem for the Court is that Nancy was incompetent and failed to either leave explicit treatment instructions—either oral or written—or appoint a surrogate decision-maker.¹⁷⁹ If Nancy's right to have her futile treatment terminated is grounded in her autonomy, then it is tragically logical that no one but Nancy can exercise that right.¹⁸⁰ Indeed, the very risk that Nancy's guardian might be mistaken about her desired treatment provides the Court with the justification it needs to uphold Missouri's limited restriction of the articulated liberty interest.¹⁸¹ This justification, however, is far from clear. Although the Court upholds a vitalist state regulation limiting a cognizable liberty interest, the Court does not suggest that a state may attempt to avoid such risks entirely by prohibitive legislation—the effect of which would be to negate the liberty interest altogether.¹⁸²

Relying on precedent, Professor Dworkin argues that the patient petitioners in *Glucksberg* had a constitutional liberty interest in hastening their deaths, which flows from individuals' recognized right to make decisions about matters “involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy.”¹⁸³ As a matter of precedent as well as general moral principle, it is difficult to argue with this position. Why then does the Court almost completely ignore this striking and well-publicized document, whose principle author is a respected and prodigious commentator on autonomy as a philosophical construct of legal rights?¹⁸⁴

assisted suicide). To some extent, Justice O'Connor's ambivalence mirrors the general confusion and ambiguity surrounding the whole issue of constitutionalizing the “right to die.”

178. See *Cruzan*, 497 U.S. at 289-90 (suggesting that states may have to defer to surrogate's decision to protect patient's liberty).

179. See *id.* at 286 (stating that due process clause does not require states to follow surrogate's decision without evidence of patient's intent).

180. For a further discussion of Nancy Cruzan, see *supra* notes 14 & 17 and accompanying text.

181. See *Cruzan*, 497 U.S. at 286 (holding surrogate's decision may differ from patient's).

182. See Dworkin et al., *supra* note 167, at 14 (stating that Court never suggested or held that blanket prohibition on assisted suicide is necessary).

183. *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992); see RONALD DWORIN, *A MATTER OF PRINCIPLE* 146-66 (1985) (analogizing process of using precedent to composition of books written by many authors); Tribe & Dorf, *supra* note 56, at 1072 (entitling section of their work on levels of generality in definition of rights, “*How Law is Like Literature*,” after essay of same name by Professor Dworkin).

184. See RONALD DWORIN, *LIFE'S DOMINION* 190-92 (1993) (describing autonomy as philosophical construct where society respects decisions persons make for themselves, even if imprudent, because each person generally knows what is in

Prior to the Court's assisted suicide decisions, Professor Cass Sunstein suggested that any methodology that defines constitutional rights as moral principles is incomplete if it fails to ask what effects such a law will engender.¹⁸⁵ As a basis for assessing what law should be, conceptual analysis about what makes something "law" is necessary but not sufficient. Such an assessment also requires "a set of predictions, largely factual in character, about the consequences of alternative interpretive approaches"¹⁸⁶

This view of constitutional law assessment accords with a growing movement that recognizes the importance of clinical truths in formulating laws that deal with healthcare conflicts.¹⁸⁷ Some have suggested the new paradigm of bioethics may be empiricism—a paradigm based on facts.¹⁸⁸ As Justice Souter notes in *Glucksberg*, the facts "necessary to resolve the [assisted suicide] controversy are not readily ascertainable through the judicial process."¹⁸⁹ Although the rights analysis divorced from factual context is incomplete, it is unclear whether empiricism alone can account for the analogical paradox raised by interposing *Cruzan* and *Glucksberg*. Did the Court really have more dispositive facts before it regarding the effects of a legal rule that would allow patients to choose to terminate life-sus-

their best interest). Dworkin also suggests that we can even respect an unconscious person's autonomy by determining what they would have chosen for themselves by basing that determination on what would be most consistent with the unconscious person's personality as a whole. *See id.* at 223-24.

185. *See* Cass Sunstein, *From Theory To Practice*, 29 ARIZ. ST. L.J. 389, 401-02 (1997) (stating that judges should be cautious about accepting abstract arguments where predicting real-world consequences is difficult); *see also* Washington v. Glucksberg, 521 U.S. 702, 787 (1997) (Souter, J., dissenting) (noting difficulties in predicting effects of assisted suicide and euthanasia based on empirical evidence of foreign country's experience).

186. Sunstein, *supra* note 185, at 398-99 (asserting that critical question is whether right to assisted suicide actually reduces autonomy by fostering environment for doctors to bring about involuntary or non-voluntary suicide). Moreover, this right may decrease the autonomy of individuals, such as the poor or uneducated, who are susceptible to coercion by physicians, or by discouraging all parties involved to confront the inevitability of death. *See id.* at 402-03. Although these questions contain important philosophical dimensions, they are unavoidably empirical; they are not questions philosophers alone can answer. *See id.*

187. *See, e.g., Dying Well in the Hospital: The Lessons of SUPPORT*, 25 HASTINGS CTR. REP. 51, Nov.-Dec. 1995 (Special Supp.) (recognizing that without data that evaluate efficacy of law as applied, analysis of law is incomplete and even unhelpful). This is a growing movement among lawyers and legal academicians, particularly those who deal with legal issues that intersect with other disciplines. *See id.* at 52 (discussing need for interdisciplinary examination of problems associated with dying).

188. *See* Susan M. Wolf, *Shifting Paradigms in Bioethics and Health Law: The Rise of a New Pragmatism*, 20 AM. J.L. & MED. 395, 414 (1994) (arguing that trend towards scrutinizing problems in light of real world has begun to usurp principle or rule driven approaches); *see also* Schneider, *supra* note 28, at 1103 (finding that society must refine current approach to bioethics to take into account competing claims and interests present among individuals).

189. *Glucksberg*, 521 U.S. at 787 (Souter, J., dissenting) (holding that legislature is best equipped to ascertain facts regarding assisted suicide controversy).

taining treatment, or was the determinant more likely the Court's fundamental rights analysis that in *Cruzan* relied almost entirely on a history and tradition of state law recognizing a terminally ill patient's right to refuse life-sustaining treatment?¹⁹⁰

In *Cruzan*, the Supreme Court recognized, or at least assumed, that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.¹⁹¹ The Court, in *Cruzan*, relied on the states' jurisprudence to find a history and tradition of self-determination. Ironically, these state cases involved either an incompetent or never-competent person because the issue of a competent person's right to refuse treatment had yet to be litigated.¹⁹² Without exception, all of the state courts that had been considered the existence of a right to refuse life-sustaining treatment recognized such a liberty interest based either on the common law right to informed consent or, alternatively, a state constitutional privacy right.¹⁹³ Moreover, with the exception of Missouri and New York, all of the states created some legal fiction that made the right exercisable by or for the benefit of the incompetent or never-competent person.¹⁹⁴

190. See *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 270-78 (1990) (citing numerous cases in which courts have gleaned various legal rules to resolve specific assisted suicide controversies); see also *Glucksberg*, 521 U.S. at 730 (holding that right assumed in *Cruzan* was not mere deduction from abstract concepts of personal autonomy, but was instead based on common law rule that forced medication constituted battery, was consistent with nation's history of protecting individuals' decisions to refuse unwanted medical treatment and did not extend legal protection to assisted suicide).

191. See *Cruzan*, 497 U.S. at 292 (demonstrating that, because Nancy Cruzan was incompetent and not likely to ever regain consciousness, issue of competent person's right to refuse treatment did not reach court).

192. See *Conservatorship of Drabick*, 245 Cal. Rptr. 840, 854-55 (Ct. App. 1988) (incompetent); *In re Estate of Longeway*, 549 N.E.2d 292, 299 (Ill. 1989) (incompetent); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 434 (Mass. 1977) (never competent); *In re Conroy*, 486 A.2d 1209, 1217 (N.J. 1985) (incompetent); *In re Quinlan*, 355 A.2d 647, 664 (N.J. 1976) (incompetent); *In re Westchester County Med. Ctr. on behalf of O'Connor*, 531 N.E.2d 607, 608 (N.Y. 1988) (incompetent); *In re Eichner*, 420 N.E.2d 64, 66-68 (N.Y. 1981) (incompetent); *In re Storar*, 420 N.E.2d 64, 455-56 (N.Y. 1981) (never competent). Since its decision in *Cruzan*, the Supreme Court has not revisited the issue of a liberty interest in a competent person to refuse treatment as superseding the right of the State to refuse to comply with that decision. Certain state courts, however, have visited this issue. See, e.g., *Thor v. Superior Ct.*, 855 P.2d 375, 399 (Cal. 1993) (upholding right of quadriplegic then residing in state prison medical facility to refuse unwanted medical procedures for nutrition and medication).

193. See *Cruzan*, 497 U.S. at 270-78 (acknowledging unfettered right to refuse treatment as recognized by states that have been presented with question).

194. See *Cruzan v. Harmon*, 760 S.W.2d 408, 426 (Mo. 1988) (en banc) (holding that incompetent patient's guardians did not have authority to order withdrawal of hydration and nutrition, reasoning that right to refuse medical treatment and right to privacy are not absolute and must be weighed against state's interest in preserving life); *In re Westchester County Med. Ctr.*, 531 N.E.2d at 625 (refusing to accept anything less than clear expression of incompetent's wishes before allowing incompetent to exercise right to refuse treatment through surro-

The Court has yet to consider a case involving either a competent patient's seeking to exercise the right to refuse treatment or a once-competent patient who prospectively exercised the right to terminate treatment. Prior to *Glucksberg*, the *Cruzan* decision might have made one confident that the Court would uphold such a right.¹⁹⁵ In the wake of the assisted suicide cases' focus on the dangers of mistake and abuse of vulnerable populations, the rights outcome for a questionably competent person who has left vague prospective treatment instructions is no longer certain.¹⁹⁶ This argument assumes that autonomy and fundamental rights are at the core of the Supreme Court's analyses in end-of-life cases.¹⁹⁷ As one scholar has eloquently stated, "The current prohibitions against assisted suicide and euthanasia sacrifice the autonomy and dignity of some citizens for the safety and support of others. Its elimination would reverse the terms of the sacrifice but would not avert the tragic choice."¹⁹⁸

The Supreme Court's affirmation of the prohibition of assisted suicide, cast as a case about rights and autonomy, demonstrates a necessary

gate decision-maker). For example, to preserve Karen's privacy right, the *Quinlan* court allowed Karen's guardian and family to decide whether Karen would have exercised her right in her present circumstances. See *In re Quinlan*, 355 A.2d at 664. In *Saikewicz*, 370 N.E.2d at 430-31, the Supreme Judicial Court of Massachusetts, reasoning that an incompetent person retains the same rights as a competent individual because the value of human dignity extends to both, the court adopted a substituted judgment standard where courts were to determine what an incompetent, in this case profoundly developmentally disabled, individual's decision would have been under the circumstances. See *id.*

195. See David Orentlicher, *The Legalization of Physician Assisted Suicide: A Very Modest Revolution*, 38 B.C. L. REV. 443, 454-55 (1997) (noting that cases involving competent person's request to remove life-sustaining treatment have resulted in recognition of such right regardless of whether reason for requests was rejection of burdensomeness of medical treatment or rejection of burdensomeness of patient's life); see also *Thor*, 855 P.2d at 380-83 (finding that under existing state law, competent informed adult has fundamental right to refuse or demand withdrawal of medical treatment); *State of Georgia v. McAfee*, 385 S.E.2d 651, 651-52 (Ga. 1989) (holding that competent patient with terminal illness has right to refuse medical treatment); *McKay v. Bergstedt*, 801 P.2d 617, 624 (Nev. 1990) (acknowledging common law right to refuse medical treatment or discontinue life support so long as individual is competent).

196. See *Cruzan*, 497 U.S. at 284 (finding that parents lacked authority to end life-sustaining treatment without "clear and convincing" evidence of patient's wishes).

197. See Orentlicher, *supra* note 195, at 462-66 (positing that by permitting treatment withdrawal but not permitting assisted suicide, physicians have been allowed to use bright line rule to help in distinguishing morally valid and morally invalid requests for help in end-of-life decision-making). But see Minow, *supra* note 103, at 20 (discussing one of lies countenanced by Court in assisted suicide cases: "that physicians do not already, and regularly, participate in assisting dying patients to end their lives").

198. Seth Kreimer, *Does Pro-Choice Mean Pro-Kevoorkian? An Essay on Roe, Casey, and the Right to Die*, 44 AM. U. L. REV. 803, 807 (1995).

lack of judicial candor.¹⁹⁹ According to one commentator, “The prohibition of assisted suicide is not a direct reallocation of rights from one citizen to another; it is a tragic sacrifice of the suffering of one for the aggregate good of the whole.”²⁰⁰ Although the Court overtly exalts the protectionist value of its assisted suicide decisions, its treatment of the patients’ rights seems deliberately oblique. The Court’s failure to address directly the individual rights issue in its opinions is not a lie in that it is not made with the intent to mislead.²⁰¹ Indeed, the various concurring opinions as well as footnote twenty-four of the *Glucksberg* opinion, leave open the possibility of a successful future rights claim.²⁰² So why does the Court engage in this subterfuge?

More than a decade ago, Professor David Shapiro explored the phenomenon of judicial candor—the obligation of judges to discuss issues openly and truthfully.²⁰³ His article cited an earlier work by Guido Calabresi and Philip Bobbitt, which suggested that dishonesty may actually be desirable where the choice involves a clash of basic values.²⁰⁴ Calabresi and Bobbitt suggested that, in the archetypal case of euthanasia, most people’s general commitment to the sanctity of life would lead them to abhor any set of rules governing the permissible circumstances for euthanasia; however, even those generally committed to life sympathize with the desire not to prolong the suffering of those at the end-of-life.²⁰⁵ Calabresi and Bobbitt suggested that the “aresponsible” jury—the jury that often

199. See David L. Shapiro, *In Defense of Judicial Candor*, 100 HARV. L. REV. 731, 747-48 (1987) (advocating abandonment of judicial subterfuge in favor of judicial candor in cases of conflict between legal and moral rights).

200. Kreimer, *supra* note 198, at 848.

201. See SISSELA BOK, LYING: MORAL CHOICE IN PUBLIC AND PRIVATE LIFE 6-16 (1978) (distinguishing between intent to lie and mistaken truthful intentions).

202. See *Washington v. Glucksberg*, 521 U.S. 702, 789 (1997) (Souter, J., concurring) (stating that recognition of right is matter to be decided by legislature); *id.* at 737 (O’Connor, Breyer and Ginsberg, J., concurring) (requiring that unavailability of pain alleviation be part of showing of worthy plaintiff); *id.* at 752 (Stevens, J., concurring) (noting that future claims will be decided on case by case basis, leaving room for vigorous debate).

203. See Shapiro, *supra* note 199, at 731-32 (discussing phenomenon of judicial candor in context of difference between scholarship and adjudication). Professor Shapiro credits Calabresi for the idea that judges may reject the notion of candor because of the fundamental difference between the role of the scholar and the role of adjudicator. See *id.* at 731. The role of the scholar is to think openly and lucidly about issues while a judge must act in a manner sensitive to certain realities, political and others, and may therefore choose something different from the scholar. See GUIDO CALABRESI, A COMMON LAW FOR THE AGE OF STATUTES 180-81 (1982).

204. See GUIDO CALABRESI & PHILIP BOBBITT, TRAGIC CHOICES 78-79 (1978) (viewing subterfuges as preferable to clear choice of one value over another in absence of clear societal consensus).

205. See Shapiro, *supra* note 199, at 747 (discussing internal value conflicts associated with euthanasia).

inexplicably acquits defendants accused of euthanasia—may offer a “solution” to a dilemma that judges are not prepared to address directly.²⁰⁶

Despite recognizing the role that subterfuge often plays in resolving values conflicts, the moral preference favors candor where possible. Stated another way, “an intense search for accommodation must be made before the field is yielded to dissembling.”²⁰⁷ One such accommodation occurs when guidelines effectively narrow the range of cases in which the conflict of values is sharply felt.²⁰⁸ In the case of euthanasia, Professor Shapiro approvingly cites legislation that recognizes the legitimacy of instruments of prospective decision-making that enhance individual self-governance.²⁰⁹

The question of judicial candor, in the context of the Court’s assisted suicide cases, is also raised somewhat more explicitly by Professor Martha Minow.²¹⁰ She believes that “the most honest statement of the issues presented in the physician-assisted suicide cases is [that] the Court faced a choice of two lies to countenance.”²¹¹ The first lie, alluded to only by Justice Stevens, is that physicians do not already assist their patients in hastening their deaths.²¹² Official prohibition of an existent practice means

206. See CALABRESI & BOBBITT, *supra* note 204, at 57-64 (introducing that our commitment to value of life reconciles itself with mercy killing by allowing juries to acquit individual accused of euthanasia); Kenneth R. Thomas, *Confronting End-of-Life Decisions: Should We Expand the Right to Die?*, 44 FED. LAW. 30, 34 (May 1997) (calling Dr. Jack Kevorkian perfect example of jury nullification because jury failed to convict despite prosecutions satisfying all elements of crime). As Professor Shapiro points out, criminal juries have long had, and still have, a power of nullification: a power to bring in a verdict of acquittal even though they are convinced that application of the law as explained by the judge requires a finding of guilt. See Shapiro, *supra* note 199, at 745 (noting that jurors who have power of nullification will abuse it as long as it does not conflict with oath); see also *id.* at 749 (explaining that judges must lie to avoid immoral judgments).

207. Shapiro, *supra* note 199, at 748. Professor Shapiro refers to other writings of Justice Calabresi where his preference for candor is clear. For example, Calabresi criticizes Justice Powell for choosing the “uncandid way” and argues that a more candid accommodation of competing interests was available. See Guido Calabresi, *Bakke as Pseudo-Tragedy*, 28 CATH. U. L. REV. 427, 432-33 (1997) (noting unavailability of “honest” solution).

208. See Shapiro, *supra* note 199, at 748 (discussing solutions to problem of value conflicts in euthanasia cases).

209. See *id.* at 748-49 & n.82 (suggesting that purpose behind legislation was to reduce trenchant problem of end-of-life decision-making for incompetent patients, thereby narrowing range of cases in which conflict of values between commitment to life and deep sympathy for and recognition of rights of terminally suffering patients would arise). As this Article will demonstrate, however, such instruments have far from solved this problem.

210. See Minow, *supra* note 103, at 19-30 (commenting that Court faced choice of two lies to countenance: either approval or toleration of assisted suicide).

211. *Id.* at 19-20.

212. See *Washington v. Glucksberg*, 521 U.S. 702, 749 n.12 (1997) (Stevens, J., concurring) (noting “evidence that a significant number of physicians support the practice of hastening death in particular situations”); Timothy E. Quill, *Risk Taking by Physicians in Legally Gray Areas*, 57 ALB. L. REV. 693, 699 (1994) (acknowledging

countenancing a lie that could potentially drive that practice underground, beyond the regulation of the states, as occurred in the days before *Roe v. Wade*.²¹³ But this unacknowledged choice by the Court is preferable to approving a practice that threatens to put all dying patients at risk of choosing to hasten their deaths because of filial and institutional external pressure or their internal senses of guilt or burden.²¹⁴

If the Court believes that approving the practice of assistance in suicide creates an environment where the potential for abuse makes uncoerced, voluntary choice impossible, framing the issue as one of rights is irrelevant. Although courts typically spend little time discussing the “how” of rights jurisprudence, rights talk has value only if the right can be meaningfully exercised.²¹⁵ As a matter of individual rights, it is unimportant whether the Court chose to disapprove physician-assisted suicide because of its belief that autonomous choice is impossible where assisted suicide is legal, or whether the Court had to make a tragic choice to sacrifice the autonomy of the “unusual” in favor of the safety of the “usual.”²¹⁶ Under either decision-making model, protectionism trumps autonomy and the

secret practice of physician-assisted suicide exists whereby approximately “three to thirty-seven percent of clinicians have actively assisted at least one patient to die”). Amicus briefs have made this contention many times. See Brief for Respondents at 38-42, *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), *rev'd*, 521 U.S. 793 (1997) (No. 95-1858) (noting that patients that wish to be assisted in life ending measures already have means by which to accomplish this end); Brief Amicus Curiae of the American Medical Student Association and a Coalition of Distinguished Medical Professionals in Support of Respondents at 18-19, *Quill*, 80 F.3d 716, (citing statistical evidence that proves physician assisted suicide, although illegal, is prevalent throughout the country); Brief of Amicus Curiae of the Coalition of Hospice Professionals at 16-17, *Quill*, 80 F.3d 716 (claiming that empirical evidence demonstrates that practice of physician assisted suicide already exists in fact); Brief of Amicus Curiae of State Legislation in Support of Respondents at 3-4, *Quill*, 80 F.3d 716 (citing recent poll whereby 20% of doctors surveyed admitted to having helped patient to die).

213. See *Roe v. Wade*, 410 U.S. 113, 139 (1973) (discussing criminality of all abortions except those to save life of mother).

214. See Minow, *supra* note 103, at 219, 221-23 (“A right to the aid of a doctor in ending your life means that dying patients will be invited to think about its exercise, family members will consider it, hospitals and nursing homes will institutionalize it, popular culture will elaborate it, and young, vibrant people will contemplate it.”).

215. See Sharyn A. Lenhart, Letter to the Editor, *All Doctors Should be Trained in Abortion*, CHICAGO SUN-TIMES, May 14, 1998, at 32 (emphasizing need for medical students to be trained in abortion procedure to curb decline in providers). This suggests that abortion rights jurisprudence is meaningful only if women choosing to terminate their pregnancies have access to physicians who are willing and able to assist them. According to Lenhart, “as of 1992, 84 percent of U.S. counties had no abortion provider, and the number of counties with a provider declined by 31 percent between 1978 and 1992.” *Id.* Women can not exercise their constitutional right to an abortion if there are not enough skilled physicians willing to perform such procedures.

216. See Law, *supra* note 108, at 305-06 (discussing how courts frame refusing treatment as passive and assisted suicide as active to make distinction between resisting intrusion and asserting autonomy).

only difference is one of degree. Because the law engages in binary rather than continuum analysis, the degree to which one right trumps another becomes important only when predicting the outcome of a future revisiting of the issue.²¹⁷

At least some of the discomfort expressed by five of the Justices can be attributed to their difficulty in distinguishing between a constitutional right to hasten death by refusing life-sustaining treatment and a constitutional right to hasten death by physician assistance.²¹⁸ Both the Second and Ninth Circuits found no meaningful difference.²¹⁹ Even Justice Scalia, the only member of the *Cruzan* Court to find that no liberty interest was implicated in cases of unwanted medical treatment, made it clear that he could find no sensible difference between assisted suicide and assisted removal of life support.²²⁰ Nonetheless, the Court insists on discussing the issues in rights talk and distinguishing the two rights by narrowly describing them.²²¹ As a matter of constitutional analysis, this methodol-

217. *But see id.* at 334-41 (proposing alternative remedial solutions in situations where statute is facially constitutional but may be unconstitutional to certain classes of plaintiffs).

218. *See Orentlicher, supra* note 195, at 445 (describing distinction between assisted suicide and life-sustaining treatment withdrawal in maintaining moral justification). I have often found it puzzling that, as a matter of law, remedies are very rarely structured so that both parties share liability. For example, when two parties have entered into what turns out to be a losing contract for one of the parties and the non-losing party breaches, the losing party is able to recover in restitution and the contract price is not the ceiling for the breaching party's liability. *See, e.g., United States v. Algernon Blair, Inc.*, 479 F.2d 638, 640-41 (4th Cir. 1973) (holding that non-breaching party to losing contract may recover in quantum meruit value of labor and equipment already furnished). End-of-life jurisprudence is another perfect example. If the issue is refusing treatment, the outcome is almost always that it is permitted; if the issue is assisted suicide, the outcome is always that it is not permitted. *See Orentlicher, supra* note 195, at 445 ("[P]hysician assisted suicide has been prohibited . . . because the distinction between suicide assistance and treatment withdrawal has served as a useful proxy for distinguishing between morally acceptable and morally unacceptable decisions by patients to end their lives."). *But see Brody, supra* note 87, at 960 (discussing need to focus on current moral issues); Wolf, *supra* note 159, at S13 (making argument that moral equivalence potentially undermines patients' right to refuse treatment because of some physicians' beliefs in moral equivalency of refusing life-sustaining treatment and assistance in suicide).

219. *See Quill v. Vacco*, 80 F.3d 716, 729-31 (2d Cir. 1996), *rev'd*, 521 U.S. 793 (1997) (noting that right to refuse life sustaining treatment and right to physician-assisted suicide lack rational difference and treating them as such violates equal protection); *Compassion in Dying v. State of Washington*, 79 F.3d 790, 816 (9th Cir. 1994) ("*Cruzan*, by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, necessarily recognizes a liberty interest in hastening one's own death.").

220. *See Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 296-97 (Scalia, J., concurring) ("[T]he cause of death in both cases is the suicide's conscious decision to 'pu[t] an end to his own existence.'" (quoting 4 W. BLACKSTONE, COMMENTARIES ON THE LAWS OF ENGLAND 189)).

221. *See Washington v. Glucksberg*, 521 U.S. 702, 725 (1997) (differentiating right to refuse treatment from purported right to aid another person in attempting suicide).

ogy is familiar. But as a matter of facilitating public policy in this arena, it obfuscates rather than illuminates.²²²

Assuming the above to be true, the treatment withdrawal cases and the assisted suicide cases are more meaningfully distinguishable not in the definition of the right, but rather in the integrity of the exercise of the right.²²³ I suspect that the five concurring Justices believed that the right to physician assistance in death was cognizable under *Cruzan* and *Casey* for these respondents, but foundered on the issue of remedy.²²⁴ The five ultimately agreed to find no right and, concomitantly, no remedy.²²⁵ It has already been noted that the final footnote in both of the opinions, which indirectly acknowledges the possibility that the Court will revisit this issue, was probably motivated by politics of consensus.²²⁶ In other words, the Chief Justice likely made this concession to form a plurality, ensuring that his opinions became the opinions of the Court.²²⁷

222. See David Orentlicher, *The Supreme Court and Physician-Assisted Suicide: Rejecting Assisted Suicide but Embracing Euthanasia*, 337 NEW ENG. J. MED. 1236, 1236 (1997) (arguing that terminal sedation, although part of traditional and accepted medical care, is a form of euthanasia). There is much speculation that although the Court did not find a right to assisted suicide, it did acknowledge that a right to be free from pain at end-of-life, including terminal sedation, does exist. Dr. Orentlicher suggests that if guidelines exist for terminal sedation, the same guidelines are equally applicable to physician-assisted suicide. See generally *id.*

223. But see Helene Brodowski & Marybeth Malloy, *Suffering Against Their Will: The Terminally Ill and Physician Assisted Suicide-A Constitutional Analysis*, 12 ST. JOHN'S J. LEGAL COMMENT. 171, 172-73 (1996) (stating how removal of life support allows one to die but assisted suicide involves killing); Norman L. Cantor, *Two Opinions in Search of a Justice: The Constitution and Physician-Assisted Suicide*, 28 RUTGERS L.J. 435, 445-48 (1997) (defining rejection of medical intervention as allowing natural dying process to run its course while suicide involves actively seeking artificial means to accelerate death); Jody B. Gabel, *Release from Terminal Suffering? The Impact of Aids on Medically Assisted Suicide Legislation*, 22 FLA. ST. U. L. REV. 369, 387-403 (1994) (explaining how courts have historically found right to remove unwanted medical treatment as aspect of right to privacy while assisted suicide remains illegal).

224. See Shapiro, *supra* note 199, at 743 (suggesting that multiple opinions may be better alternative to dissembling); see also RICHARD A. EPSTEIN, MORTAL PERIL: OUR INALIENABLE RIGHT TO HEALTH CARE 283-98 (1997) (suggesting that right to dignified death with physician assistance was cognizable). According to Professor Law, when the law violates the constitutional rights of the parties in front of it, there are three legitimate remedial choices: it may hold the statute unconstitutional on its face, it may issue an order protecting only the named parties from the application of the statute, or, finally, it may describe what is and what is not constitutionally permissible. See Law, *supra* note 108, at 341 (discussing options in challenging constitutionality of law). For example, in *Glucksberg*, the Court could have described the statute as inapplicable to physicians who assist a suicide in compliance with the strict guidelines of the assisted suicide support organization, Compassion in Dying. See *id.* at 337.

225. See *Washington v Glucksberg*, 521 U.S. 702, 735 (1997) (holding that Washington's assisted-suicide ban does not violate Constitution).

226. See *id.* at 735 n.24 (noting Justice Steven's concurring opinion indicating possibility of future successful claims).

227. See Burt, *supra* note 57, at 968 (arguing that first footnote in *Glucksberg* was likely necessary for Chief Justice Rehnquist to command majority coalition in

What plaintiffs must prove to succeed in a subsequent challenge has already been the subject of much speculation by many physicians, ethicists and constitutional scholars.²²⁸ Perhaps the issue truly is one of ripeness, in that assisted suicide will not be ready for constitutional determination until more and better public debate occurs in the “laboratory of the States.”²²⁹ With that precaution I agree. This is one of the few areas where the treatment refusal and assisted suicide cases are consistent. The real question is the focus and the direction that the debates will now take.

Eight years have passed since Justice O’Connor challenged the states to craft appropriate procedures to safeguard incompetents’ liberty interests.²³⁰ Responding directly to this call, the States have intensified the search for vehicles to ensure prospectively the integrity of individual autonomy. Indeed, the inordinate amount of thought and effort has produced better advance directives and healthcare proxies.²³¹ All of this effort presupposes, however, that autonomy is the correct model for healthcare decision-making, particularly prospective decision-making. As well-intentioned as this effort has been, it has failed to solve the problems of end-of-life decision-making. The real tragedy is that the law seems to operate with blinders on; the model for decision-making in healthcare has swung so completely toward autonomy that we cannot see any alternative. We are so certain this is the right approach that we build bigger and better mousetraps that we rarely look to see if we are catching any mice.

V. AUTONOMY AND THE “RIGHT” TO REFUSE TREATMENT

I have been suggesting that traditional notions of autonomy and rights talk are an inapt paradigm for end-of-life decision-making. The preceding sections have demonstrated, by critically assessing both the Court’s express and implied analysis in the assisted suicide cases, that “constitutionalizing” the right to die makes the Court uneasy.²³² Some of that dis-

support for his opinion); Shapiro, *supra* note 199, at 742-43 (explaining that judicial candor is often sacrificed in favor of collegiality and majority building).

228. See, e.g., NORMAN L. CANTOR, *ADVANCE DIRECTIVES AND THEIR PURSUIT OF DEATH WITH DIGNITY* 34-41 (1993) (discussing increase in creation of living wills and increase in legislation, thus making advance directives inconsistent and confusing for patients, families and doctors).

229. See *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261, 292 (1990) (O’Connor, J., concurring) (finding that national consensus regarding assisted suicide has yet to emerge).

230. See *id.* (declaring that “challenging task of crafting appropriate procedures for safe-guarding incompetents’ liberty interests [are] entrusted to the . . . States”).

231. See, e.g., STAFF DRAFT RECOMMENDATION RELATING TO HEALTH CARE DECISIONS FOR ADULTS WITHOUT DECISION-MAKING CAPACITY, CALIF. L. REVISION. COMM’N (Sept. 17, 1998) (demonstrating years of dedicated effort by California Law Revision Commission in drafting Health Decisions Act that will incorporate healthcare proxy and advance directive).

232. See *Cruzan*, 497 U.S. at 277-80 (discussing problem with making refusal of medical treatment constitutional right); see also *Washington v. Glucksberg*, 521

comfort no doubt reflects society's general discomfort with death, particularly death that is intentionally caused. Some of the discomfort, however, may be attributable to the Court's recognition that this issue is more appropriately cast as an issue of public and medical policy, outside the province of the law. What seems patently clear is that each case of end-of-life decision-making is highly idiosyncratic, a scenario with which a binary, rule-oriented, positivist legal system is ill-equipped to deal.²³³

Although this Article suggest that individual rights and autonomy are inappropriate guiding principles for end-of-life decision-making, individual choice is by no means an unimportant component in the decision-making calculus. The end-of-life context, however, does not fit the traditional autonomy paradigm.²³⁴ That so many factors converge at end-of-life renders the binary model of rights both inapt and unworkable. One of the values of the assisted suicide cases was their illumination of this very issue.²³⁵ The assisted suicide decisions do not undermine the liberty interest recognized in *Cruzan*.²³⁶ They do, however, impliedly focus on the very problems inherent in all end-of-life decisions: regulation and contain-

U.S. 702, 720-21 (1997) (noting importance and caution in expanding constitutional due process claims).

233. See Orentlicher, *supra* note 195, at 462-67 (suggesting that very nature of assisted suicide demonstrates shortcomings of current legal system); see also Flick, *supra* note 20, at 1132 (discussing dynamic process between paternalism and autonomy, physician and patient). According to Dr. Flick:

Medical self-determination requires that power be finally allocated. By denying that both patient and doctor are at once powerful and powerless in their relationship, this static and final assignment ignores power's inevitable uncertainty and reciprocity. Autonomy cannot simply be assumed to be more fitting to the patient than physician dominance When one must prevail, the other must necessarily be subjugated, or even obliterated.

Id. at 1131-32.

234. See Sandra H. Johnson, *End-of-Life Decision Making: What We Don't Know, We Make Up; What We Do Know, We Ignore*, 31 IND. L. REV. 13, 37 (1998) (noting that many assisted suicide opponents argue that such practice undermines patient choice and will place certain groups at risk); Jay Katz, *Informed Consent—Must It Remain A Fairy Tale?*, 10 J. CONTEMP. HEALTH L. & POL'Y 69, 83-87 (1993) (noting that formidable problems exist in informed consent arena and must be addressed before it can truly safeguard patient autonomy and self-determination); David Orentlicher, *The Illusion of Patient Choice in End-of-Life Decisions*, 267 JAMA 2101, 2104 (1992) (positing that patient decisions are often superceded by interjection of physician's values regarding end-of-life decisions); Schuck, *supra* note 28, at 924-25 (stating that individuals faced with serious medical decisions have already surrendered part of autonomy); Wolf, *supra* note 28, at 1074-75 (noting that patients who contemplate suicide are not making decisions in uncoerced environment as is often believed); see also Support Principal Investigators, *supra* note 69, at 1595-96 (introducing results of intensive study regarding decision-making processes of terminally ill patients).

235. See Orentlicher, *supra* note 195, at 462-67 (explaining values attached to distinction between assisted suicide and withdrawal of life-sustaining treatment).

236. See *Washington v. Glucksberg*, 521 U.S. 702, 724-25 (1997) ("The decision to commit suicide with the assistance of another may be just as personal and profound as the decision to refuse unwanted medical treatment, but it has never

ment of the practice of hastening death; elimination of risk to vulnerable populations; assurance of informed, uncoerced choice; and the establishment of procedures that permit the meaningful prospective exercise of incompetent patients' rights.²³⁷

Other less apparent factors may also profoundly affect patients' ability to make informed, uncoerced treatment choices. First, empirical evidence regarding patient choice at the end-of-life suggests that individuals who are ill and weak may not want to make their own treatment decisions.²³⁸ Indeed, they may be indifferent to interventions designed to encourage patient participation in their own medical decision-making.²³⁹ Second, given the uncertainty of treatment outcomes, patients may legitimately lack the knowledge and skill to make treatment choices.²⁴⁰ The lack of meaningful guidelines for terminating life-sustaining treatment makes this decision intellectually and emotionally traumatic for patients, families and physicians.²⁴¹ Indeed, physicians admit that they often do not inform patients of treatment choices but only of the risks and benefits of the treatment choice that the physician has already determined to be the

enjoyed similar legal protection. Indeed, the two acts are widely and reasonably regarded as quite distinct.") (citations omitted).

237. See *id.* at 728-30 (noting that states have vested interest in preservation of life).

238. See, e.g., Julie S. Abramson, *Participation of Elderly Patients in Discharge Planning: Is Self-Determination a Reality?*, 33 SOC. WORK 443, 447 (1988) (finding that high percentage of ill patients had no control in discharge decisions despite physical and mental capacity to do so); Hakim et al., *supra* note 147, at 291 (finding that lack of communication between families, patients and physicians contributed to misinterpretation of patients' wishes at later stages of illness); Jan C. Hoffman et al., *Patient Preferences for Communication with Physicians About End-of-Life Decisions*, 127 ANNALS INTERNAL MED. 1, 48 (1997) (discussing results showing patients do not want to engage in end-of-life discussions); Joanne Lynn, *Unexpected Returns: Insights from SUPPORT*, in TO IMPROVE HEALTH AND HEALTH CARE 1997: THE ROBERT WOOD JOHNSON FOUNDATION ANTHOLOGY 167, 180 (Stephen L. Isaacs & James R. Knickman eds., 1997) (noting that intervention into decision-making process had not improved any problems that study was intended to correct); Lawrence J. Schneiderman et al., *Do Physicians' Own Preferences for Life-Sustaining Treatment Influence Their Perceptions of Patients' Preferences? A Second Look*, 6 CAMBRIDGE Q. HEALTHCARE ETHICS 131, 133-36 (1997) (discussing results of physicians' interpretations of preferences of patients).

239. See Johnson, *supra* note 234, at 41-47 (discussing SUPPORT findings regarding lack of communication of patient preferences, even after interventions geared towards encouraging decisions); Bernard Lo, *End-of-Life Care after Termination of SUPPORT*, 25 HASTINGS CTR. REP. S6 (Nov.-Dec. 1995) (explaining that SUPPORT study of interventions left quality of terminal care virtually unchanged); see also Support Principal Investigators, *supra* note 69, at 1595-97 (determining that no change in patient decision-making occurred after intervention to discourage such decisions).

240. See Katz, *supra* note 234, at 81-82 (discussing that lack of medical certainty constitutes formidable barrier to patient's decision-making capabilities).

241. See Thomas A. Raffin, *Withdrawing Life Support: How is the Decision Made?*, 273 JAMA 738, 738-39 (1995) (explaining that lack of comprehensive study into decision-making process to withdraw life support aids in failure to formulate meaningful guidelines).

appropriate one.²⁴² Third, a growing body of literature refutes the legitimacy of the autonomy model for certain intimate decisions that touch the lives of patients' families and friends.²⁴³ The extraordinary dependence of terminal patients on their care-givers to assist in the previously mundane activities of daily living suggests that the notion of autonomous decision-making at the end-of-life may be illusory.²⁴⁴

Why, then, do we zealously guard and perpetuate autonomy as the model for end-of-life decision-making?²⁴⁵ The doctrine of informed consent, with autonomy at its heart, is such a well-entrenched principle of bioethics that shifting away from or abandoning the principle, even in the light of data to the contrary, is extraordinarily antithetical.²⁴⁶ The doctrine of informed consent arises from the fiduciary relationship of patient and physician and has two essential parts: the physician's disclosure to the patient of all information material to the patient's interests and the patient's consent to treatment by the physician.²⁴⁷ In fact, the fiduciary relationship creates a duty in physicians to place their patient's interests above their own.²⁴⁸ The normative argument favoring informed consent is the principle of autonomy—the notion that individuals not only have the right but also prefer making their own treatment choices.²⁴⁹ It also presupposes that, in a clinical setting, the law on the books, which recognizes a patient's right to self-determination, translates well into the law in prac-

242. See Katz, *supra* note 234, at 84-85 (finding that doctors place emphasis solely on risk disclosures rather than on alternatives, thereby eliminating any meaningful alternatives for patients).

243. See Flick, *supra* note 20, at 1155 ("Rights, with their requirement that people be separate and competing individuals, are not a proper framework for resolving the conflicting responsibilities of people connected in the activity of care."). Cf. CAROL GILLIGAN, IN A DIFFERENT VOICE: PSYCHOLOGICAL THEORY AND WOMEN'S DEVELOPMENT 19 (1982) (discussing women's conception of mortality and rights as centered around caring).

244. See Wolf, *supra* note 28, at 1076-77 (stating that increase in pain and dependence on other strips away from patient's ability to make decisions autonomously).

245. See Rebecca Dresser, *Missing Persons: Legal Perceptions of Incompetent Patients*, 46 RUTGERS L. REV. 609, 617 (1994) (arguing for "reshaping the law according to a revised best-interest principle that both protects patients' experiential welfare and permits surrogate decision-makers to choose from an array of reasonable treatment options . . .").

246. See *id.* at 615-16 (indicating that principle of autonomy is main criteria used in treatment discussions for incompetent patients even though its shortcomings have been well documented).

247. See Schuck, *supra* note 28, at 921 (comparing obligations that doctrine of informed consent imposes on healthcare providers as opposed to product sellers and other risk creators).

248. See *id.* (indicating that physicians must always proceed with patient's best interest in mind, and this duty emphasizes purpose of doctrine of informed consent).

249. See KATZ, *supra* note 3, at 60-65 (providing enlightening discourse on origins of informed consent doctrine).

tice—joint decision-making by physician and patient.²⁵⁰ According to one physician and ethicist, until the social policy of self-determination is translated into accepted and practiced medical policy, “informed consent will remain a charade and joint decision-making will elude us.”²⁵¹

Although the doctrine of informed consent is not unique to the healthcare setting, informed consent in this arena is anomalous.²⁵² First, “the value of autonomy . . . is a function of the range of choice realistically available to the individual.”²⁵³ In the healthcare setting, the fact that patients have few practical treatment choices limits the opportunities for meaningful autonomy through the exercise of idiosyncratic choice.²⁵⁴ Second, the uncertainty of medical diagnosis, treatment and prognosis presents a formidable obstacle to joint decision-making because physicians fear that acknowledgment of their uncertainty will undermine their authority and prestige.²⁵⁵ Third, physicians, even well-meaning physicians, often fail to respect the autonomy of their competent patients.²⁵⁶ For example, many physicians only discuss the risks and benefits of treatment after making unilateral treatment decisions for their patients.²⁵⁷ Moreover, physicians routinely ignore patients’ advance directives—the only possible exercise of autonomous choice available to incompetent patients.²⁵⁸ The movement toward managed care as the new model for

250. *But see* Orentlicher, *supra* note 222, at 2101 (concluding from empirical studies that “patient preferences were respected as long as the physicians thought that the patients’ choices resulted in the best decisions”).

251. Katz, *supra* note 234, at 81; *see* Jay Katz, *Informed Consent—A Fairy Tale? Law’s Vision*, 39 U. PITT. L. REV. 137, 171-72 (1977) (suggesting that translating concept of joint decision-making between doctor and patient into practice is not easily accomplished); *see also* KATZ, *supra* note 3, at 60-65 (describing principle of autonomy in healthcare).

252. *See* Schuck, *supra* note 28, at 909-16 (describing how doctrine of informed consent in healthcare setting deviated from same doctrine with regards to tort law and products liability law).

253. *Id.* at 925.

254. *See id.* (observing that patient’s level of autonomy is direct function of range and possibilities of choice of treatment available).

255. *See* Katz, *supra* note 234, at 81-82 (observing difficulty most doctors have in communicating to patients uncertainties about proper treatment, thus making doctor-patient decision-making more difficult); *see also* SHERWIN NULAND, *HOW WE DIE* 247-48 (1994) (theorizing that it is often individuals who need to feel superior and in control who are drawn to practice of medicine).

256. *See* Katz, *supra* note 234, at 86 (observing that principle of autonomy requires physician to recognize competent patient as autonomous individual with choice-making capabilities).

257. *See id.* (“I must first make the judgment which treatment alternative is best for patients, and only after I have exercised that professional judgment, will I discuss the risks and benefits of the recommended treatment.”); *see also* Jay Katz, *Reflections on Informed Consent: 40 Years After Its Birth*, J. AM. C. SURGEONS, Apr. 1998, at 466 (explaining how, historically, physicians made unilateral decisions for their patients).

258. *See* Support Principal Investigators, *supra* note 69, at 1593-94 (indicating that even when gravely ill or dying patients have executed advance directives, physicians often disregard them).

healthcare has arguably made the traditional long-term continuing physician-patient relationship an anachronism.²⁵⁹ If the new physician-patient relationship is discrete and episodic, then an analogy to relationships of trust and mutual dependency is inapposite because "informed consent cannot credibly function as the dialogic expression of a relationship that no longer exists."²⁶⁰

Even before SUPPORT demonstrated competent patients' apparent indifference to interventions designed to encourage their participation in end-of-life decision-making, there had already developed a body of literature debating the efficacy of instruments of prospective decision-making.²⁶¹ The paradigm of prospective decision-making documents such as living wills, advance directives and durable powers of attorney is, of course, individual autonomy.²⁶² The initial impetus for the first of such instruments was the plight of Karen Quinlan, who lacked the capacity to refuse life-sustaining treatment.²⁶³ Although the New Jersey Supreme Court recognized the existence of common law and constitutional rights of self-determination in making treatment choices, those rights reflect the choice of the patient most accurately when exercised by the patient.²⁶⁴ To the ex-

259. See Schuck, *supra* note 28, at 926 (positing that concept of informed consent cannot adequately function as physician-patient interaction becomes singular transaction under managed care model of healthcare).

260. *Id.*

261. See DWORKIN, *supra* note 38, at 195 (noting secular and religions notion that human life is sacred and has intrinsic indicating value); Annas, *supra* note 147, at S12-13 (indicating that intervention in form of living wills and healthcare proxies fail to facilitate further communication between doctor and patient, and thus are ineffective decision-making instruments); Daniel Callahan, *Terminating Life-Sustaining Treatment of the Demented*, HASTINGS CTR. REP., Nov.-Dec. 1995, at 25-26 (discussing whether demented patient's previous advance directive should be followed by physician in preference of present desires); Rebecca Dresser, *Dworkin on Dementia: Elegant Theory, Questionable Policy*, HASTINGS CTR. REP. Nov.-Dec. 1995, at 32 (arguing that advance directives of incompetent but conscious individuals should not always be followed if individuals are able to enjoy and participate in lives); Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CAL. L. REV. 857, 871-78 (1992) (indicating that advance directive made by competent patient should not be followed because precedent autonomy is not as compelling as present autonomy and that precedent autonomy is morally overridden by human compassion); see also NULAND, *supra* note 255, at 250-53 (recalling experience with patient where patient's advance directives were ignored in favor of doctor's conceptions of what was best). See generally Arthur L. Caplan, *Can Autonomy Be Saved?*, in IF I WERE A RICH MAN, COULD I BUY A PANCREAS? 256-81 (1992) (discussing inadequacy of advance directives such as living wills and how to improve instruments to protect autonomy for impaired patients).

262. See Kadish, *supra* note 261, at 870 (discussing concept of autonomy in relation to development of living wills and durable powers of attorney).

263. See Dresser, *supra* note 245, at 618-19 (discussing how *Quinlan* brought questions about end-of-life decision-making to forefront of American popular discourse).

264. See Kadish, *supra* note 261, at 862 (noting that New Jersey Supreme Court has found constitutional right to decline medical treatment in some circumstances). The New Jersey Supreme Court recognized the existence of both a common law and constitutional right of self-determination in making treatment

tent that the cornerstone of autonomy is personal choice, this cannot be debated. Therefore, instruments that create opportunities for the prospective exercise of autonomy seem to be the exact right model.

At first blush, it is understandable to consider advance directives and healthcare proxies the proper model for end-of-life decision-making. I remember following the case of Nancy Cruzan from her parents' initial petition in 1988, to Nancy's death in 1990, and finally her father's tragic suicide in 1996.²⁶⁵ I knew then, without equivocation, that if I were in a persistent vegetative state with an infinitesimal chance of regaining a quality life, I would want all life-support terminated. I know the same today. But beyond those facts, equivocation is both natural and unavoidable. How can one choose today the appropriate treatment for some unknown condition one will face in the near or distant future?²⁶⁶ What one identifies as a quality life today is subject to change as one ages and becomes less able to perform at today's capacity.²⁶⁷

choices. See Dresser, *supra* note 245, at 619. The court in *Quinlan* did not rely only on a substituted judgment standard (what Karen would have decided had she been competent); the court also relied on a best interests standard (a standard that demonstrated the court's concern for Karen's present welfare) and a reasonableness standard (that the choice of withdrawing Karen's life-sustaining treatment is a choice that a reasonable person would have made under the circumstances). See Dresser, *supra* note 245, at 619-20 (finding that, although she was unable to make decisions, her choice derived from multiple decisions someone in her position would have made).

The right reflects the choice of the patient most accurately when exercised by her. Indeed, as we now know from *Cruzan*, a state may constitutionally refuse to recognize the right when it is sought to be exercised by someone other than the rights-bearer.

265. See *National Briefs*, THE CHARLESTON GAZETTE, Aug. 20, 1996, at 2A (indicating that Nancy's father, who had fought for so many years to have Nancy's life-sustaining treatment terminated, committed suicide).

266. See CANTOR, *supra* note 228, at 23-24 (noting advance directives' limited ability to deal with unforeseen problems). The linguistic and medical vagueness of the instruments compounds this uncertainty. Not only is it difficult to anticipate the various medical situations where I might want treatment withheld, it is almost impossible to describe these situations in the language of the instrument. See Sana Loue, *Living Wills, Durable Powers of Attorney for Health Care, and HIV Infection*, 16 J. LEGAL MED. 461, 468 (1994) (questioning assumption, which is inherent in concept of living will, that competent patient can adequately determine preferences for treatment if patient's competency diminishes in future); Joanne Lynn, *Why I Don't Have a Living Will*, 19 LAW MED. & HEALTH CARE 101, 102 (1991) (suggesting that asking individual in advance whether individual would want particular end-of-life treatment plan is incomprehensible).

267. See Rebecca Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373, 379 (1986) (explaining that individual's notion of quality of life can be modified as individual experiences various life events, but incompetent individuals cannot revise definition of personal well-being); Kadish, *supra* note 261, at 873-74 (arguing that future medical discoveries and treatments might alter patients' views and attitudes toward treatment plans). See generally CANTOR, *supra* note 228 (suggesting that although practical difficulties do exist with respect to advance directives, physicians must respect principle of self-autonomy because society holds principle of self-determination in high regards); Norman L. Cantor, *Prospective Autonomy: On the Limits of Shaping*

I am uncertain whether, in the future, I would want to or be able to make treatment decisions for myself even if I remained competent. I would certainly want more from my physicians than mere information, treatment choices and respect for my autonomy. I would want their advice, yet would retain a veto power. Anything less would feel like abandonment.²⁶⁸ My model of decision-making, the model that comforts me, is a product of my conscious knowledge and unconscious development as an insider to the medical community.²⁶⁹ Although I share most consumers' jaundiced skepticism of twentieth century healthcare, I have also experienced, first-hand, the caring ethic of most physicians. Most importantly for me, my knowledge and trust are not merely abstract; they are empirical and reciprocal. I trust my physicians' ability and morality, but I also trust myself.

Cruzan, *Glucksberg* and *Quill* demonstrate the half-heartedness of the Court's commitment to the principle of autonomy in end-of-life jurisprudence.²⁷⁰ Although the *Cruzan* Court upheld the right of a vitalist state to require clear and convincing evidence of an incompetent person's treatment choice, presumably the Court itself would not have required such evidence.²⁷¹ Nancy Cruzan's execution of a living will that chose discon-

One's Post Competence Medical Fate, 8 J. CONTEMP. HEALTH L. & POL'Y 13, 34-48 (1992) (stating that knowing advance directive should be followed in order to preserve patient's autonomy). *But see* DWORKIN, *supra* note 38, at 222-29 (suggesting that individual's autonomy is violated if advance directive is ignored). One of the more poignant aspects of my mother's year of dying was her steadfast willingness to accept a "quality life" less and less as her life closed down around her. Although I have no evidence of whether this phenomenon is idiosyncratic or ubiquitous, it is clear that our biological instinct to survive is at work here. *See* Denise A. Dickerson, *A Doctor's Duty to Disclose Life Expectancy Information to Terminally Ill Patients*, 43 CLEV. ST. L. REV. 319, 321 (1995) (explaining that "for most dying persons, hope centers around the quality of remaining life and a general assessment of life's values").

268. *See* Flick, *supra* note 20, at 1131 (discussing dichotomy between patient's need for autonomy and doctor's desire to provide advice and treatment to patient).

269. *See* M. Gregg Bloche, *Beyond Autonomy: Coercion and Morality in Clinical Relationships*, 6 HEALTH MATRIX 229, 229 (1996) (providing discussion of autonomy-preserving and autonomy negating influences in clinical relationships). In this interesting article, Professor Bloche discusses the limitations of both conscious and unconscious coercion on the autonomy model in a clinical setting. *See id.* at 271-83. Although conscious coercion is easier to identify as autonomy-negating, "unconsciously mediated external influences [have] not generally [been] viewed by bioethicists . . . as potentially incompatible with autonomous choice," *i.e.*, as autonomy-negating. *Id.* at 277. This should be contrasted with unconscious internal influence classified under the rubric of psychological incapacity that has always been recognized by the law as autonomy-negating. *See id.*

270. *See* Dworkin, *supra* note 28, at 730-31 (arguing that even in abortion cases, Supreme Court's commitment to autonomy is more rhetorical than real).

271. *See* *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 280 (1990) (indicating that because "[a]n incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment," such right must be exercised for patient by surrogate, and safeguards have been

tinuance of treatment in the event of a persistent vegetative state would only demonstrate compliance with a formality. Indeed, studies indicate that relatively few younger people complete advance treatment directives.²⁷² Although some argue that executing an advance directive should raise a presumption that the person executing the instrument has made a thoughtful, conscious and voluntary choice, little if any empirical evidence supports this assertion.²⁷³ Moreover, there is evidence to suggest that some patients execute advance directives only as general guidelines, not intending that they be followed without some discretion on the part of their physicians.²⁷⁴

In *Cruzan*, Justice O'Connor wrote separately to clarify that the Court's ruling did not foreclose future consideration of the validity of a duly appointed surrogate.²⁷⁵ In fact, Justice O'Connor stated that "such a duty may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment."²⁷⁶ Her separate opinion has engendered a proliferation of proxy decision-making statutes in the states.²⁷⁷ It is difficult to comprehend, except as a matter of form, how the appointment of a surrogate decision-maker is substantively a more compelling exercise of the autonomy of an incapacitated individual than Joe Cruzan's indomitable belief that Nancy would not have chosen to be maintained in a persistent vegetative state.²⁷⁸ It seems that Justice O'Connor would not

established to assure surrogate's decision conforms with prior wishes of now-incompetent patient).

272. See Ben A. Rich, *Advance Directives: The Next Generation*, 19 J. LEGAL MED. 63, 63 (1998) (observing that studies have shown that relatively few Americans participate in end-of-life planning by implementing advance directives).

273. Compare Lynn, *supra* note 147, at 173-74, with CHRISTOPHER B. MUELLER & LAIRD C. KIRKPATRICK, EVIDENCE 134 (1995) ("In effect, presumptions have at least the effect of shifting the burden of production to the party who would be disadvantaged by a finding of the presumed fact.").

274. See Ashwini Sehgal et al., *How Strictly Do Dialysis Patients Want Their Advance Directives Followed?*, 267 JAMA 59, 61-62 (1992) (indicating that strictly following patients' advance directives may not properly reflect patients' actual preferences).

275. See *Cruzan*, 497 U.S. at 289 (O'Connor, J., concurring) (explaining that Court did not decide "the issue whether a state must also give effect to the decision of a surrogate decision-maker").

276. *Id.*

277. See STAFF DRAFT RECOMMENDATION RELATING TO HEALTH CARE DECISIONS FOR ADULTS WITHOUT DECISION-MAKING CAPACITY, *supra* note 231, §§ 4710-4726 (authorizing designated surrogate, statutory surrogate from list of family members and friends to be selected by incompetent patient's physician, or in absence of any designated or statutory surrogate, by surrogate committee comprised of patient's primary physician, his or her nurse and other staff of healthcare institution). Under the proposed California statute, a designated surrogate may be replaced by a statutory surrogate of higher statutory priority by petition to the primary physician, and the patient's primary care physician has extensive authority in designating the proxy. See generally *id.*

278. See Wolf, *supra* note 188, at 410 ("The bottom line is not pretty documents or elegant opinions, but what happens to the patient in the bed.").

have voted with the plurality had Nancy Cruzan, in some cognizable form, designated her father as her proxy decision-maker. To the extent that a healthcare decision will be made on behalf of an incompetent who lacks a proxy decision-maker, state statutes with default proxy designations answer the question of who has the authority to make an end-of-life decision for now incompetent patients.

How one should make the treatment or non-treatment decision remains unanswered. Some have suggested that “[s]urrogate decision-making is premised on the belief that surrogates will make medical decisions that reflect patients’ preferences.”²⁷⁹ By demonstrating that surrogates poorly effectuate their principals’ wishes, however, empirical evidence threatens the popular autonomy paradigm.²⁸⁰ One physician speculates that the reasons for the dissonance between the treatment choices of patients and their surrogates are threefold: a lack of communication between patient and proxy, an undervaluing of the quality of life of elderly and ill patients by the proxy, and often, an understandable reluctance on the part of the proxy to discontinue treatment, which would inevitably lead to death.²⁸¹

It should not be surprising that surrogates have difficulty predicting what competent patients would have decided and making decisions themselves on behalf of their principals.²⁸² All of the problems attendant to decision-making by competent patients exist for surrogates making decisions for their principals. Surrogates’ lack of knowledge of their principals’ preferences further exacerbates these problems.²⁸³ In light of persistent demonstrations of the failings of informed consent in the

279. David Orentlicher, *The Limitations of Legislation*, 53 MD. L. REV. 1255, 1278 (1994).

280. See generally Ezekiel J. Emanuel & Linda L. Emanuel, *Proxy Decision Making for Incompetent Patients: An Ethical and Empirical Analysis*, 267 JAMA 2067, 2069 (1992) (explaining that empirical data demonstrates serious flaws in proxy decision-making); Jan Hare et al., *Agreement Between Patients and Their Self-Selected Surrogates on Difficult Medical Decisions*, 152 ARCHIVES INTERNAL MED. 1049, 1052 (1992); Allison B. Seckler et al., *Substituted Judgment: How Accurate Are Proxy Predictions?*, 115 ANNALS INTERNAL MED. 92 (1991); Jeremiah Suhl et al., *Myth of Substituted Judgment: Surrogate Decision Making Regarding Life Support is Unreliable*, 154 ARCHIVES INTERNAL MED. 90 (1994); Tom Tomlinson et al., *An Empirical Study of Proxy Consent for Elderly Persons*, 30 GERONTOLOGIST 54, 59 (1990) (indicating that elderly patient’s appointing of individual with durable power of attorney does not increase likelihood that power-holder would make decisions preferred by patient); Nancy R. Zweibel, *Treatment Choices at the End of Life: A Comparison of Decisions by Older Patients and Their Physician-Selected Proxies*, 29 GERONTOLOGIST 615, 620 (1989) (indicating that physician-appointed proxies for elderly patients would select treatment for patients that patients would not choose for themselves).

281. See Orentlicher, *supra* note 279, at 1278-79 (explaining that despite benefits of surrogate decision-making, serious limitations affect proper decision-making between individuals and their surrogates).

282. See *id.* at 1278 (discussing empirical data that demonstrate how poorly surrogates carry out patients’ preferences).

283. See *id.*

healthcare context, Professor Carl Schneider has proposed a paradigm shift that would focus on substance rather than procedure.²⁸⁴ He suggests that, until now, the informed consent doctrine has focused on the procedure of patient choice, effectively presuming that if physicians provided their patients with all information about treatment options, patients would choose the option most valuable to them.²⁸⁵ But the lessons of the last two decades have made it clear that, for a myriad of reasons, patients do not make that choice, either prospectively or at the bedside.²⁸⁶ A paradigm shift from a “consumer choice” model to a “consumer welfare” model, a model that elevates substance over procedure may therefore be appropriate.²⁸⁷ Under this model, physicians would present patients with well-thought-out answers to standard kinds of bioethical problems, answers that reflect a social consensus.²⁸⁸ Patient would be free to reject the suggested solution in favor of an idiosyncratic answer better tailored to their individual needs, but for those patients who do not or cannot choose, the answers might act as the default option.²⁸⁹ This model values both the principle of patient autonomy and the empiricism of clinical experience.

VI. CONCLUSION: IF NOT AUTONOMY, THEN WHAT?

The threshold to solving a problem is recognizing and accepting that the problem exists. Having done so, the next step is to formulate a solution in the abstract. It is at this conceptual level of problem solving that principles and theory should be most evident. In bioethics, where the problem is how to ensure patient visibility and empowerment in the patient-physician dyad, self-determination through the exercise of the patient's autonomy has been the overarching principle.²⁹⁰ This principled approach to medical decision-making has led down the legal road of formalism, requiring informed consent for those with the capacity to deter-

284. See Schneider, *supra* note 59, at S25-27.

285. See *id.* at S25-26.

286. See Rich, *supra* note 272, at 63 (estimating that approximately less than 10% of individuals have prospectively executed any kind of healthcare proxy in spite of proliferation of such documents).

287. See Schneider, *supra* note 59, at S27 (supporting concept that time has come for bioethical community to shift focus away from patient choice to improving medical care system generally).

288. See *id.* (“Through processes like the social discussion of cases from *Quinlan* and *Cruzan* we seem to be moving toward a cultural consensus that patients in persistent vegetative states should not be kept alive when hope is gone.”).

289. See *id.* (promoting shift from consumer choice model to consumer welfare model).

290. See generally PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT (Comm. Print 1983) (providing beginnings of bioethics jurisprudence regarding life-sustaining treatment); see also Johnson, *supra* note 234, at 18 (discussing basic principles of bioethics as developed by SUPPORT and President's Commission for study of ethical problems in medicine and biomedical and behavioral research).

mine their own treatment choices and preserving informed consent through mechanisms of prospective autonomy.

Merely formulating a theory, however, does not solve the problem. An equally vital aspect of problem solving is the theory's application to the problem. To that end, physicians, ethicists, attorneys, legislators and scholars have, for the past two decades, accumulated empirical data regarding applied informed consent.²⁹¹ A failure of applied theory is a failure only if one does not learn from one's mistakes, if one does not adjust the theory to accommodate empirical data. Otherwise, a failure of applied theory is due simply to an imperfect model, imperfect for lack of data. As many commentators have previously noted, the "consumer choice" model, however imperfect, was probably necessary to force changes in physician attitudes and conduct that the public found unacceptable.²⁹² We stand at another critical crossroads, reexamining autonomy and informed consent as the linchpins of medical decision-making and trying to perfect the model in light of evidence that was unavailable twenty-five years ago.²⁹³

The rights-based end-of-life experiments of the last two decades suggests a number of conclusions. First, end-of-life decision-making may not be suited to the binary, bright-line approach that the law tends to take.²⁹⁴ The inherent complexity and uncertainty of medical treatment makes it difficult for physicians to present patients with treatment choices. Consequently, even fully competent patients find it difficult to make voluntary, uncoerced and knowledgeable treatment choices. The standard choice of most advance directives—whether to prolong one's life—is simply too

291. See Johnson, *supra* note 234, at 13-17 (discussing various empirical studies undertaken to examine "bioethics at the bedside").

292. See Schneider, *supra* note 59, at S25-28 (discussing fundamental principles of consumer choice model).

293. See Schneider, *supra* note 28, at 1103 (arguing that empirical evidence should be used to introduce complexities of world into concepts of informed consent and autonomy in end-of-life decision-making).

294. See Orentlicher, *supra* note 195, at 462-69 (discussing legal and ethical distinctions between physician assisted suicide and withdrawal of life-sustaining treatment). Dr. Orentlicher makes the argument that, given the unfeasibility of case-by-case judgments in treatment withdrawal and assisted suicide cases with regard to the moral validity of accelerating death, a legal bright line permitting treatment withdrawal but not permitting assisted suicide has given physicians a useful proxy to identify morally valid and morally invalid patient requests. See *id.* at 462-67. Certainly, some treatment withdrawal cases are morally invalid while some assisted suicide requests, like those represented by *Glucksberg* and *Quill* might be identified as morally valid. Professor David Rothman argues this point persuasively when describing his observations about medical practice. See DAVID J. ROTHMAN, STRANGERS AT THE BEDSIDE 7 (1991) ("Perhaps the most remarkable feature of clinical decision making is the extraordinary reliance on a case-by-case approach. No two patients, after all are exactly alike Thus, medicine is as much art as science, and the clinical anecdote becomes highly relevant to treatment decisions."). Professor Rothman goes on to note that clinicians often use this case-by-case approach to solve social and ethical problems as well as clinical ones. See *id.* This approach differs greatly from the more rule-oriented principle-based approach that characterizes other disciplines, notably law. See *id.* at 7-9.

general to be meaningful. Death, as Justice O'Connor acknowledges, is an intensely personal experience that "will be different for all of us."²⁹⁵ To legally recognize a consent form simply because it has been obtained, without regard for its intensely personal content or context, elevates form over substance and makes a hash of autonomy.²⁹⁶

If medical decision-making at the end-of-life is ill-suited to a binary model, other factors, apparent only from empirical data from the past few decades, further stresses the paradigm's failure.²⁹⁷ First, patients with critical illnesses generally do not participate in arms-length transactions with their physicians.²⁹⁸ Patients who make treatment decisions concerning critical or terminal illnesses are generally ill, weak and vulnerable—the window of opportunity for meaningful planning has closed.²⁹⁹ Once the patient has been hospitalized, the culture and ingrained patterns of institutional care manifest without much opportunity for patients to shape what happens to them.³⁰⁰ To truly involve patients in the planning process, physicians must dedicate time and effort to the advance care process prior to hospitalization.³⁰¹

Second, the risk that physician values outweigh patient values in end-of-life decisions further distorts the inequality of bargaining power in the physician-patient relationship.³⁰² Patients so depend on their physician's evaluation of their diagnosis, prognosis and treatment options that physicians can manipulate their patients' decisions.³⁰³ "As any clinician knows,

295. *Washington v. Glucksberg*, 521 U.S. 702, 736 (1997) (O'Connor, J., concurring); see Marshall B. Kapp, *Treating Medical Charts Near the End of Life: How Legal Anxieties Inhibit Good Patient Deaths*, 28 U. TOLEDO L. REV. 521, 523 (1997) (citing Professor George Annas on American view of dying in current healthcare system).

296. See Lynn, *supra* note 147, at 173-74 (highlighting importance of distinguishing form over function in questions of autonomy).

297. See Wolf, *supra* note 28, at 1074 (suggesting that end-of-life issues, which have engendered more data than any other issue in bioethics or health law, have "taught us that an abstract . . . model of patients' rights and autonomy does not bear much resemblance to clinical reality").

298. See *id.* at 1076-77 (recognizing data that correlates pain and depression with significant distress, thus affecting patient decision-making).

299. See Lynn, *supra* note 147, at 174 (reporting that most effective time to do advance care planning where patient is truly participatory is at or just before time of admission to hospital).

300. See *id.* at 172 (discussing study of five hospitals' patterns of sending patients home to die and concluding that suggested bed supply and hospice funding, not demographic of physiologic patterns, were primary determining factors).

301. See *id.* at 174 (stating that SUPPORT's belief that progressive and pervasive advance care planning, or other forms of advance directives not tightly linked to legal forms, should be incorporated into medical practice).

302. See Orentlicher, *supra* note 234, at 2101-02 (summarizing three studies that suggest physician values and medical opinions may override advance directives, do-not-resuscitate orders and family and patient requests).

303. See Edmund D. Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, 10 J. CONTEMP. HEALTH L. & POL'Y 47, 54 (1994) ("[N]o matter what degree of autonomy a patient may want . . . the patient is vulnerable to deception in the information he receives.").

she can get almost any decision she wants from most patients.”³⁰⁴ According to another physician, informed consent will only safeguard patient autonomy and self-determination if the doctrine responds to the theory of the law and, more importantly, the realities of medical practice.³⁰⁵ Attitudes of both patients and physicians, however, which establish the construct and parameters of their relationship, are difficult, perhaps impossible, to change.³⁰⁶ Thus, the doctrines of autonomy and informed consent in healthcare appear incompatible with a culture that continues to value the physician’s superior knowledge and the patient’s deference to it.³⁰⁷

Third, empirical evidence of the preeminence of physician values in the physician-patient dyad are symptomatic of an entire system that needs to undergo a radical change in order for patients and physicians to alter what each expects the system will provide.³⁰⁸ One of the co-directors of SUPPORT has noted that decision-making at the end-of-life, particularly decisions made in an institutionalized environment, resemble habit more

304. *Id.* at 55.

305. *See generally* KATZ, *supra* note 3, at 83 (postulating that in order for doctrine of informed consent to reconcile with reality, judges “must acquire . . . a more profound understanding and appreciation of medicine’s vision of patients and professional practice, of the capacities of physicians and patients for autonomous choice, and of the limits of professional knowledge”); Katz, *supra* note 234, at 69, 77-91 (examining theories and methods behind traditional medical care-taking, arguing that pragmatic informed consent doctrine must adopt practice of joint decision-making between physician and patient to preserve patient autonomy); Katz, *supra* note 251, at 164-74 (criticizing ineffectiveness of informed consent doctrine to affect change in patient-physician discourse); Schuck, *supra* note 28, at 959 (suggesting that present effectiveness of informed consent doctrine in achieving goal of patient autonomy is limited and doctrine must be systematically analyzed to meet realities of healthcare). *But see* ROTHMAN, *supra* note 294, at 101-26 (recounting physician-patient relationship before World War II). Professor Rothman criticizes Professor Katz’s vision of the doctor-patient relationship as too narrow. *See id.* at 109-10. He theorizes that the medical community has been so slow to change clinical behaviors in response to the legal redefinition of the patient-physician dyad because physicians would characterize their relationship with their patients as one of mutual trust rather than paternalistic. *See id.* at 110-11 (commenting on necessity of trust to maintain physician client base). According to Professor Rothman, “The element of trust was strong enough to legitimate medical paternalism.” *Id.* at 110.

306. *See* Katz, *supra* note 234, at 90 (noting that physicians and patients have been socialized to assume that patients should be passive and ignorant and that patients are best served by following “doctors’ orders”); *see also* Lynn, *supra* note 147, at 173 (“[I]t is extremely difficult to change widespread and well-integrated practices—hardly a new lesson.”).

307. *Cf.* Joel F. Handler, *Community Care for the Frail Elderly: A Theory of Empowerment*, 50 OHIO ST. L.J. 541, 542-44 (1989) (discussing failure of legal rights regime for nursing home residents in environment where residents are effectively powerless against institutional power regime).

308. *See* Katz, *supra* note 234, at 71 (“[T]he idea that patients have rights to autonomy and self-determination has been an alien one throughout the history of medical practice.”); Orentlicher, *supra* note 234, at 2101-02 (summarizing studies that suggest physician values may override patient preferences).

than choice.³⁰⁹ In response to data from SUPPORT that demonstrate patients' indifference to efforts to improve patient input into decision-making, she postulates that patients' and physicians' responses to end-of-life treatment may "merely reflect patterned behavior more often than they reflect what the patient and family want."³¹⁰ If that is true, the solution requires creating incentives to change the universal patterns rather than changing the idiosyncratic behavior of patients and physicians.³¹¹

This perception comports with the long-time beliefs of Dr. Jay Katz, who has repeatedly stated that, in principle, informed consent is not "a *medical* blueprint for interactions between physicians and patients."³¹² As he presciently noted some fifteen years ago, translating the informed consent model into "useful legal and medical prescriptions that respect patients' wishes to maintain and surrender autonomy, as well as physicians' unending struggles with omnipotence and impotence in the light of medical uncertainty, is a difficult task and has not been pursued in any depth."³¹³ As long as this disconnect persists, there is little hope for meaningfully substantive change. Integration of principle and reality is always most difficult at the intersection of disciplines whose values differ.³¹⁴ Success in medical care has always been cure; death is failure. Our instinctual urge to survive perpetuates this paradigm.³¹⁵ But the natural progress toward death is both inexorable and inevitable. Despite efforts to improve instruments of prospective decision-making, the process of terminal illness is not likely to change perceptibly until the healthcare community values a good death as much as it values a cure.³¹⁶

309. See Lynn, *supra* note 147, at 172.

310. *Id.* at 180.

311. See *id.* ("[R]eform could start with a reduction in the number of hospital beds and an increase in home care, or valuing physicians' skills in pain control or communication rather than in adjusting cardiac output."). Dr. Lynn notes in another part of the same article that advance directives, as now employed, are not a considerable part of the solution, notwithstanding a very expensive effort to improve the documents and promote their use. See *id.* at 173-74. She speculates that the reason for the ineffectiveness of the documents is that they do not create a strong incentive to change existing habits and usual practices. See *id.* at 174. Unfortunately, patients who execute such documents are lulled into thinking they have done everything possible to ensure self-determination, while the healthcare system continues business as usual. See *id.*

312. Katz, *supra* note 234, at 79 (emphasis in original).

313. KATZ, *supra* note 3, at 84.

314. See LOUISE HARMON, FRAGMENTS ON THE DEATHWATCH 147-48 (1998) (pointing out that cross-disciplinary discourse is rare). Doctors talk to doctors and lawyers to lawyers; more cynically, we teach new doctors and new lawyers a vocabulary that can be understood only by other members of the guild. See *id.* at 148. According to Harmon, "We learn a way of looking at the world that makes it difficult to see things through any other prism." *Id.*

315. See Rhoden, *supra* note 26, at 420 ("Self-preservation is the first law of human nature. Humans will fight to live on.").

316. See Lynn, *supra* note 147, at 176-77 (stating that, except for hospice experiences demonstrating meaningfulness of dying process to patient and patient's family, which are not generally part of cultural understanding, what constitutes "a

Our culture's relationship with death has become increasingly uneasy.³¹⁷ As we age as a nation, the dislocations caused by the population's moving closer to death, and our cultural denial of it, are becoming more apparent.³¹⁸ Now is the time for death and dying jurisprudence to come out of the darkness and into the daylight.

Perhaps the only way to change the patterns of treating the dying is to tell the stories of death. Current popular literature that tells stories of sickness and death are, paradoxically, both symptoms of this cultural problem and an important part of the solution.³¹⁹ As Dr. Joanne Lynn has observed, "We are a nation that desperately needs stories—perhaps even myths—about dying to provide some guides to appropriate roles and worthy behavior."³²⁰

A still more pessimistic view of informed consent suggests that the doctrine, although honored in the breach, may be impossible to enforce as a practical matter.³²¹ Professor Peter Schuck lists three empirical explanations as to why the doctrine fails in practice: (1) physician-patient conversations tend to be perfunctory, reinforcing physician control; (2) the treatment context itself discourages patients from exploiting the information they are able to obtain; and (3) the tort system makes it difficult for

good death" is subject to different and varied interpretations). Professor Lynn writes, "Instead, dying is just awful. Dying better is perceived to be merely less awful." *Id.* at 177. Similarly, Dr. Sherwin Nuland says, "The greatest dignity to be found in death is the dignity of the life that preceded it." NULAND, *supra* note 255, at 242. Louise Harmon argues that the good death is one where the dying patient is surrounded by those who care and love her, the "deathwatch." *See* HARMON, *supra* note 314, at 7-16. Once the process of dying moved from the home to the hospital, where access to the dying patient was difficult, the deathwatch all but disappeared. *See id.* at 16-26 ("[A hospital] is not a good place for prayer or resolution, or even idle chatter. It is not a good place at all.").

A physician's training and experience reinforces cure as the ideal goal, sometimes without regard to the patient's wishes. Sherwin Nuland very gracefully describes his changed attitudes towards cure-no-matter-what in describing a 92-year-old woman; though she had expressed her preference for no surgery, Dr. Nuland convinced her otherwise. *See* NULAND, *supra* note 255, at 252-53 ("For Miss Welch, the effort was not justified, no matter what success might have resulted. . . . Had I the chance . . . I would listen more to the patient and ask her less to listen to me.").

317. *See generally* HARMON, *supra* note 314, at 97 (discussing general culture shift away from death as acceptable to death as taboo).

318. *See id.* at 129 (recognizing our culture's obsession with beating death and consequent pressure placed on medical miracles).

319. *See id.* at 107 (noting that talk about death in abstract is non-threatening, while talk about real death, or our own death, is different matter); *see also generally* NULAND, *supra* note 255 (discussing how death is distinctive and comes in multitude of ways); REMEN, *supra* note 27 (containing collection of true short stories that address spiritual issues of suffering, love, faith and miracles).

320. Joanne Lynn, *Introduction*, MARILYN WEBB, *THE GOOD DEATH: THE NEW AMERICAN SEARCH TO RESHAPE THE END OF LIFE* xvii (1997).

321. *See* Schuck, *supra* note 28, at 902-03 ("Everyone, it seems, favors the principle of informed consent; it is 'only' the specific details and applications of the doctrine that arouse serious debate.").

patients to establish a legal claim against their physicians.³²² These impediments to the success of informed consent in action are structural and highly intractable because they reflect “constraints imposed by human psychology, the physician-patient relationship, the tort law system, and an increasingly cost-conscious healthcare delivery system.”³²³

Because of the disconnect between the abstract and the applied, informed consent has not translated well from principle to practice. Professor Schuck calls this distortion the “informed consent gap.”³²⁴ Theorists continue to insist on informed consent as the normative value in treatment decisions, while clinicians point to empirical data suggesting that informed consent is neither desired by patients nor an efficient use of physician time or healthcare resources.³²⁵ This debate, however, seems unproductive. Both sides argue past each other, resorting to the exclusive language and understanding of the problem unique to its own profession.³²⁶ Furthermore, improving the procedures of informed consent will likely fail to achieve either a consensus or solution.³²⁷ Instead, placing the focus on context might prove more productive by restructuring the systems that currently impede quality decision-making. Emphasis may be placed on encouraging patient-physician dialogue and providing patients and their families with well-thought-out and acceptable medical decision models.³²⁸

Finally, autonomy is an imperfect model if it values atomism over interdependence.³²⁹ Humans are relational creatures who generally prefer

322. *See id.* at 932-33 (outlining three impediments to informed consent as revealed by empirical studies).

323. *Id.* at 905.

324. *Id.* at 903.

325. *See id.* at 903-04 (discussing differences between idealist and realist perspectives).

326. *See id.* at 904 (“In a real sense . . . informed consent idealists and realists argue past one another, producing debate that is oblique and inconclusive rather than pointed and fruitful.”).

327. *See Lynn, supra* note 147, at 179-80 (suggesting that obstacles to real decision-making lie not in improving information or enabling better decisions, but in altering patterns of behavior); Schuck, *supra* note 28, at 905 (concluding that problem of informed consent gap is structural and therefore incapable of transforming into informed consent’s idealistic model); *see also KATZ, supra* note 3, at 83-84 (recognizing that current informed consent doctrine clashes with ingrained physician and patient attitudes towards medical decision-making).

328. *See Lynn, supra* note 147, at 180 (reshaping incentives that create entrenched patterns may lead to better reform in medical decision-making); Schuck, *supra* note 28, at 906 (contextualizing informed consent to meet demands of different setting where “risks arise and are discussed, assessed, and acted upon,” will lead to more sensitive, workable doctrine).

329. *See Schneider, supra* note 162, at 157-58 (1988) (proposing that our predisposition in favor of personal autonomy over state regulation does not translate to situations that involve multiple, perhaps conflicting, personalities). Professor Schneider argues that the Mill autonomy paradigm breaks down in family law because often the conflict is not between the person and the state but rather between the person and another person. *See id.* I would argue that the same applies to end-

membership in organizations that encourage sharing rights and responsibilities.³³⁰ The grease that makes relationships run smoothly is trust: trust in others' knowledge, expertise, judgment, affection and love.³³¹ With intimate and difficult decisions such as medical treatment decisions at the end-of-life, trust in family members, close friends, physicians and nurses means that patients can share the responsibility of difficult decision-making with others.³³² This also means that family members are most often in the best position to know, to the extent it is possible to know, what decisions their loved ones would have preferred. This is not necessarily because of their official designation as proxy decision-makers, but more simply because of their relationship to the patient.³³³ But despite the rela-

of-life decision-making where the conflict most often occurs at the bedside between the patient, the patient's physicians and family. See, e.g., Rhoden, *supra* note 26, at 429 (noting that right-to-die cases typically arise when doctors keep patients on life support despite family protest).

330. See generally DANIEL CALLAHAN, *THE TROUBLED DREAM OF LIFE: IN SEARCH OF A PEACEFUL DEATH* (1993) (discussing desire to tame death, and how tyranny of autonomy often frustrates goal of peaceful death). We are social beings, says Callahan, and "[t]he provision of healthcare is increasingly a communal task. We are medically and economically interdependent. We need, therefore, a picture of the self that is compatible with that mutual dependence." *Id.* at 122-23. These organizations advance the norm of sharing both rights and responsibilities. See, e.g., MARTHA MINOW, *MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION AND AMERICAN LAW* 227-66 (1990) (describing urge toward social consensus that marked American Reformists).

331. See generally ROTHMAN, *supra* note 294 (theorizing that erosion of trust of physicians by patients has been significant contributor to ascendancy of rights as preeminent physician-patient paradigm).

332. See generally KATZ, *supra* note 3 (stating that modern medical decision-making must become joint-decision-making between physician and patient). Cf. HILDE LINDEMANN NELSON & JAMES LINDEMANN NELSON, *THE PATIENT IN THE FAMILY: AN ETHICS OF MEDICINE AND FAMILY*, 83-117, 204-11 (1998) (discussing interplay between physicians, patient and family in medical decision-making). There is good reason, however, to be skeptical of the trust relationship between physician and patient in the new world of managed care. If one of the goals of a culture of dying well is trust between patient and physician, then the system must incentivize this norm. See generally KATZ, *supra* note 3, at 95-103 (submitting that traditional model of patient-physician trust based on parent-child interaction must be transformed into model that relies on open communication and understanding between patients and physicians, recognizing willingness to share burden of medical decision-making); NULAND, *supra* note 255, at 260-61, 265-67 (expressing distrust in ability of specialists to make crucial end-of-life decisions for patients and arguing that reorganization of healthcare system must embrace understanding relationship between family doctor and patient).

333. See Martha L. Minow, *The Role of Families in Medical Decisions*, 1991 UTAH L. REV. 1, 21 (1991) ("[D]eference to the family would be better than deference to the state in questions of medical treatment."); Rhoden, *supra* note 26, at 403-10, 429-37 (arguing that legal doctrines employed by courts to replicate patients' end-of-life treatment choices are fictions because patient has made no actual choice); see also *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 325 (1990) (Brennan, J., dissenting) ("The testimony of close friends and family members, on the other hand, may often be the best evidence available of what the patient's choice would be. It is they with whom the patient most likely will have discussed such questions and they who know the patient best."). Because the patient has made no

tionship of patients with their families, the culture of death and dying has conspired to exclude the family from one of life's most intimate moments.³³⁴

Relationships consist not only of rights, but also of responsibilities. Our relationships with those in our social constellations constrain our right to make autonomous choices that restrict interference by a State, which must impose normative conduct on its citizens in order to maintain the social contract.³³⁵ Each decision we make will necessarily affect the nature and quality of the lives of those with whom we are interdependent. We cannot ignore these derivative consequences. Indeed, as recently as the assisted suicide cases, the Supreme Court explicitly enumerated the interdependency of elderly, ill and other vulnerable populations and their families as a reason for denying a "right" to assistance in dying.³³⁶

choice, Professor Rhoden argued for a presumption in favor of family choice constrained by the right of the patients' physician to challenge the choice as unreasonable. See Rhoden, *supra* note 26, at 437-45 (suggesting that failure of judicial subjective and objective medical decision-making standards support contention that family is decision-maker best equipped to effectuate patient preferences). But see Rebecca Dresser, *Relitigating Life and Death*, 51 OHIO ST. L.J. 425, 435 (1990) (challenging Professor Rhoden's proposal because assigning protective role to physicians puts undue burden on them to litigate choice of family).

The irony of the state substituting itself for the family—making decisions for incapacitated persons who cannot make decisions on their own behalf—has not been lost on those who have been confronted with such a horrific situation. See Pete Busalacchi, *How Can They?*, HASTINGS CTR. REP. Sept.-Oct. 1990, at 6 (recounting comments about *Cruzan* made by father of minor in persistent vegetative state: "I made many a decision to guide her into adulthood, and now, when she's incapable of deciding for herself, the state wants to take the place of her father").

334. See HARMON, *supra* note 314, at 19 (lamenting disappearance of death-waive as locus of dying moved from hospital to home); NELSON & NELSON, *supra* note 332, at 46-53 (describing hospitals' alienating effects on patients' families); Kathleen M. Boozang, *An Intimate Passing: Restoring the Role of Family and Religion in Dying*, 58 U. PITT. L. REV. 549, 568 (1997) (commenting on informed consent doctrine's ignorance of family in medical decision-making); Mark G. Kuczewski, *Reconceiving the Family: The Process of Consent in Medical Decision-making*, HASTINGS CTR. REP. Mar.-Apr. 1996, at 30 (examining need to legally accommodate mentally capable older persons who work with families toward shared healthcare decision-making).

335. Cf. *Palko v. Connecticut*, 302 U.S. 319, 325 (1937) (Cardozo, J.) (labeling American democratic regime as experiment in "ordered liberty"). If most Americans agree with this observation, at least in principle, why does "public rhetoric so regularly gloss over the essential interplay between rights and responsibilities, independence and self-discipline, freedom and order?" GLENDON, *supra* note 5, at 10 (observing American phenomenon of talking "rights" while expecting responsibility). Our social constellations particularly include families broadly defined to include "people clustered into configurations that have at least some of a rather wide array of characteristics, no one of which is definitive, but most of which will be present to one degree or another." NELSON & NELSON, *supra* note 332, at 35 (defining characteristics common to most families: emotional, economic and sexual intimacy, fidelity and commitment).

336. See *Washington v. Glucksberg*, 521 U.S. 702, 731-32 (1997) (fearing that right to assisted suicide might encourage groups vulnerable to coercion and undue influence opportunity to spare families financial burden through end-of-life

Although recognizing interdependence as an integral part of the matrix of healthcare decision-making, the Court in *Glucksberg*, *Quill* and *Cruzan* paints families with a suspicious palette—a potentially malevolent force from which the state must protect the vulnerable patient.³³⁷

A robust body of literature, both empirical and popular, portrays a different, more positive, role of the family.³³⁸ This so-called “communitarian” movement conceives of the family as the loving and centering system that comforts and re-orientes its members who, through the illness process, have become increasingly estranged and alienated from their usual, healthy selves.³³⁹ To the extent that family members consider the impact of their healthcare decisions on the other members of their family, the ethics of autonomy are inapposite at worst and incomplete at best.³⁴⁰ Because the autonomy paradigm does not suit the resolution of the “rivalry of care” created when one family member’s healthcare decision restricts the other family members from acting, the construct is an inapt paradigm for end-of-life decision-making.³⁴¹

Historically, autonomy or individual liberty has been most appropriate to protect the individual against the authority of the State.³⁴² As the law continues to expand its jurisdiction into intra-family matters, matters historically considered extra-legal, the need for new guidelines and standards to resolve these intra-family conflicts grows.³⁴³ Otherwise, the hallmark of such legal decisions will be inconsistency, reflecting our

decisions); Minow, *supra* note 103, at 21 (forecasting that right to assisted suicide would give rise to routine pressure from family, physicians, managed care providers or one’s own guilt to end one’s life).

337. See *Cruzan*, 497 U.S. at 279-82 (acknowledging states’ interests in guarding against family members who exploit position as surrogate decision-maker); see also *Gluckberg*, 521 U.S. at 731-32 (inferring that dying patients in vulnerable groups may be unduly influenced by family members’ needs in end-of-life decision-making).

338. See generally NELSON & NELSON, *supra* note 332, at 31-53 (examining family institution in birth, life and illness); WEBB, *supra* note 54, at 193-217 (discussing family’s all-encompassing involvement with terminal patient); Minow, *supra* note 103, at 21-22 (calling for deference to families of incompetent patient to become medical norm).

339. See NELSON & NELSON, *supra* note 332, at 45-49 (identifying families’ ability to combat alienation of ill patients by maintaining ordinariness).

340. See Dallas M. High, *A New Myth About Families of Older People?*, 31 THE GERONTOLOGIST 611, 613-14 (1991) (highlighting two studies on effectiveness of family as surrogate decision-makers that reveal conflicting results).

341. See NELSON & NELSON, *supra* note 332, at 1-29 (pointing to ordinary joint-decision-making habits of families, which is absent in patient-physician dyad).

342. See Schneider, *supra* note 162, at 157 (describing our predisposition to favor individual autonomy over state regulation).

343. See Minow, *supra* note 103, at 11-16 (tracing progression of law of inter-family conflicts from virtual nonexistence to modern recognition and calling for legal guidelines to meet emergence of family conflicts in court). For example, until very recently, the law refused to enforce contracts between family members on the fictionalized theory that family members were effectively incapable of creating legally enforceable relationships. See generally *id.*

ambivalence about the role and the trustworthiness of families to make decisions that affect other family members.³⁴⁴

A fairly recent decision by the Court of Appeals of New York, *Grace Plaza of Great Neck, Inc. v. Elbaum*,³⁴⁵ demonstrates the absurd consequences that result from this ambivalence toward the families' abilities to make medical decisions.³⁴⁶ The patient, Mrs. Elbaum, had been admitted to a nursing home in a persistent vegetative state and her husband agreed contractually to pay for her care.³⁴⁷ Before falling into her vegetative state, Mrs. Elbaum expressed to her family a desire that the hospital remove her feeding tube. When the nursing home refused to follow Mr. Elbaum's instructions, however, Mr. Elbaum refused to pay for further treatment.³⁴⁸ The New York Court of Appeals, upon a finding that the evidence of Mrs. Elbaum's desire to remove the feeding tube satisfied New York's clear and convincing evidence requirement, granted Mr. Elbaum an injunction directing the nursing home to assist in the removal of the feeding tube.³⁴⁹

After Mrs. Elbaum's death, the nursing home brought a subsequent action against Mr. Elbaum for payment of services rendered for his wife's care during the time between Mr. Elbaum's request that the hospital remove the tube and the hospital's court ordered compliance with that request.³⁵⁰ In response, the same New York Court of Appeals found the nursing home's demand for payment proper, reasoning that a provider's uncertainty about an incompetent patient's choice to have life-sustaining treatment withdrawn "does not breach a contract of care nor impair its right to be paid for services rendered" by refusing to discontinue treatment until the issue of choice is legally determined.³⁵¹ The court also recognized that the family is in the best position to know of the patient's wishes, but it refused to shift the burden of proof to the institution "simply because a family member has requested termination of life support."³⁵²

344. See generally *id.* (failing to debate explicitly whether emerging family conflicts will lead to inconsistent individual legal decisions); see also *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997) (demonstrating Court's view of family as trustworthy decision-makers on behalf of incompetent, elderly and other vulnerable family members); *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 319 (1990) (same).

345. 623 N.E.2d 513 (N.Y. 1993).

346. See *id.* at 516 (holding that nursing home was entitled to payment for services rendered to maintain patient's life despite clear and convincing evidence that patient did not want life-sustaining treatment).

347. See *id.* at 514.

348. See *id.*

349. See *Elbaum v. Grace Plaza of Great Neck*, 544 N.Y.S.2d 840, 844-45 (N.Y. App. Div. 1989) (evinced that wife repeatedly extracted promises from family members, under normal emotional circumstances, that family would not allow patient to live in persistent vegetative state).

350. See *Elbaum*, 623 N.Y.S.2d at 515.

351. *Id.* at 516.

352. *Id.* at 389.

Stories like the Elbaum's, the Cruzan's and my own, reflect not only the discontinuity of the law of end-of-life decision-making, but also its tragedy. That Nancy Cruzan's family should have been forced to endure eight years of exquisite torture, caught between wanting to release their daughter from her own private hell and publicly championing her death, is both unconscionable and unimaginable. On the day he buried his daughter, Joe Cruzan said, "I would prefer to have my daughter back and let someone else be this trailblazer."³⁵³ The ordeal must have taken a horrible toll on Joe Cruzan: three years after Nancy's death, Joe Cruzan hanged himself.³⁵⁴

The tragedy of my own father's story is part hyper-rationalism and part hubris. At the time of my father's illness, I elevated the process of prospective autonomy at the expense of any real expression of autonomous choice. At the time of my father's death, I was forced to make his medical decisions without knowing what he really would have wanted. I substituted my judgment for his, both ideally and as a matter of reality. Although I sincerely hope that the choices I made were intelligent and loving, they most assuredly were not an exercise of my father's autonomy. A difficult problem, such as the dismantling of well-entrenched systems, deserves thoughtful and creative solutions. I hope that my story, more than merely adding another voice to the growing dialogue on end-of-life jurisprudence, has helped expose the myth of autonomy at the end-of-life.

353. Scott Canon, *Father's Empathy Recalled Joe Cruzan, Who Fought for Daughter's Right to Die, Committed Suicide*, THE KANSAS CITY STAR, Aug. 19, 1996, at A1.

354. *See id.* (describing unfortunate fate of Joe Cruzan).

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