

# Cruzan v. Director, Missouri Department of Health: To Die or Not to Die: That is the Question - But Who Decides?

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***Cruzan v. Director, Missouri Department of Health: To Die or Not to Die: That is the Question—But Who Decides?***

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## I. INTRODUCTION

On January 11, 1983, at approximately 12:50 a.m., Nancy Cruzan died.<sup>1</sup> She was "lifeless and not breathing" and had apparently died.<sup>2</sup> At approximately 1:10 a.m. paramedics started cardiopulmonary resuscitation and at 1:11 a.m. they commenced advanced life support procedures, including intubation and intravenous infusions. By 1:13 a.m. Nancy had essentially been brought back to life; she exhibited a faint heartbeat as well as spontaneous breathing.<sup>3</sup>

The trial court judge estimated that Nancy suffered from anoxia, the deprivation of oxygen to the brain, for a period of 12 to 14 minutes.<sup>4</sup> Under ordinary circumstances, the maximum period for the brain to be without oxygen without permanent brain damage resulting is generally thought to be less than six minutes.<sup>5</sup>

Nancy remained in a coma for three weeks and then progressed to an unconscious state, commonly referred to as a persistent vegetative state.<sup>6</sup> A gastrostomy nutrition and hydration tube<sup>7</sup> was implanted in her stomach, but she never improved.<sup>8</sup> In 1988 Nancy's parents requested that her doctors terminate artificial nutrition and hydration, but the hospital refused to do so without a court order. After the Cruzans filed a declaratory judgment action and a hearing was held, the trial court ordered<sup>9</sup> the hospital to carry out the Cruzans' request. The trial court based its decision on the existence of a "fundamental natural right" in the Constitution to "refuse or direct the withholding or withdrawal of artificial death prolonging procedures when the person has no more cognitive brain function . . . and there is no hope of further recovery."<sup>10</sup> The court based the Cruzans' authority to act for Nancy on "[h]er expressed thoughts at age twenty-five in somewhat serious conversation

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1. *Cruzan v. Harmon*, 760 S.W.2d 408, 430 (Mo. 1988) (en banc) (Higgins, J., dissenting). Apparently Nancy's car ran off the road and overturned several times. Nancy was found 35 feet away from her car face down in a ditch.

2. *Id.* at 430.

3. *Id.* at 430-31.

4. *Id.* at 431.

5. *Id.*

6. See *infra* notes 30-38 and accompanying text.

7. See *infra* notes 19-29 and accompanying text.

8. Pursuant to this Supreme Court case, Jasper County Probate Judge Charles Teel ruled, after new evidence was introduced, that there was clear and convincing evidence of Nancy's intent to have life-sustaining treatment withdrawn and that the feeding tube which had kept her alive since 1983 could be disconnected. The ruling was not appealed and Nancy died on Dec. 26, 1990.

9. *Estate of Cruzan*, Estate No. CV384-9P (P. Div. Cir. Ct., Jasper County, Mo., July 27, 1988).

10. *Cruzan v. Harmon*, 760 S.W.2d 408, 434 (Mo. 1988) (en banc) (Higgins, J., dissenting) (quoting the trial court).

with a housemate friend that if sick or injured she would not wish to continue her life unless she could live at least halfway normally."<sup>11</sup>

The state and the guardian *ad litem* (Nancy's court-appointed representative) both appealed.<sup>12</sup> The Supreme Court of Missouri, in a four-three vote<sup>13</sup> reversed. Because Missouri promotes the preservation of life as a strong state interest, the Missouri Supreme Court held that no one is entitled to exercise another's right to refuse medical treatment "in the absence of the formalities required under Missouri's Living Will statutes or the clear and convincing, inherently reliable evidence absent here."<sup>14</sup>

The United States Supreme Court granted the petition for writ of certiorari<sup>15</sup> and affirmed,<sup>16</sup> holding that the Constitution did not forbid Missouri from requiring clear and convincing evidence of Nancy's own desires as to whether life-sustaining treatment should be terminated. Four justices dissented,<sup>17</sup> evidencing the usual divergence of views surrounding an intensely personal subject, such as the right to die.

As the Court itself said in *Cruzan v. Director, Missouri Department of Health*, "in deciding 'a question of such magnitude and importance . . . it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject.'"<sup>18</sup> Therefore, this note will only cover the major developments and implications in the *Cruzan* opinion.

In order to understand the importance and relevance of *Cruzan*, this note begins with a discussion of the effect of medical technological advances and an explanation of the persistent vegetative state. This note

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11. *Id.* at 433.

12. It is interesting to note that Nancy's court-appointed representative, the guardian *ad litem*, found himself "believing that it is in Nancy's 'best interest to have the tube feeding discontinued,' but 'feeling that an appeal should be made because our responsibility to her as attorneys and guardians *ad litem* was to pursue this matter to the highest court in the state in view of the fact that this is a case of first impression in the State of Missouri.'" *Id.* at 410 n.1.

13. One of the judges in the majority was not a member of the court but only sitting temporarily. Judge Welliver in his dissent argued that the case should have been decided by appointed members of the court. "It is deeply regrettable to me that an issue of this magnitude and importance to every citizen of the State is decided by the single vote of any special judge while the sitting members of the regular Court are evenly divided on this issue." *Id.* at 442 (Welliver, J., dissenting).

14. *Id.* at 425.

15. *Cruzan v. Director, Missouri Dept. of Health*, 109 S. Ct. 3240 (1989).

16. *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841 (1990).

17. Chief Justice Rehnquist delivered the opinion of the Court, in which Justices White, O'Connor, Scalia and Kennedy joined. O'Connor and Scalia filed concurring opinions. Justice Stevens filed a dissenting opinion, as did Justice Brennan, in which Justices Marshall and Blackmun joined.

18. *Cruzan*, 110 S. Ct. at 2851 (quoting *Twin City Bank v. Nebeker*, 167 U.S. 196, 202, 17 S. Ct. 766, 769 (1897)).

continues with the Court's recognition of nutrition and hydration as medical treatment. Next, this note will address the Court's consideration of informed consent and the common law right to self-determination and bodily integrity as a basis for the right to refuse life-sustaining treatment. An analysis of the Court's evasiveness on a Constitutional right to privacy in this area, and the Court's approval of Missouri's evidentiary standard will follow. Additionally, this note will review the state interests commonly referred to by the state courts as potentially outweighing a person's right to refuse life-sustaining treatment. This note will then explore, through a survey of state cases, the various tests that courts have adopted in deciding whether a third party has the authority to exercise an incompetent's right to refuse treatment. The note concludes with a brief survey and explanation of the role living wills play in an incompetent's right to refuse medical treatment.

## II. IMPORTANCE AND RELEVANCE OF *CRUZAN*

### A. *Medical Technological Advances—The Ability to Sustain Life—But at What Costs?*

*"No other country goes to nearly such lengths to preserve life. Japanese surgeons perform no organ transplants. In Britain kidney dialysis isn't generally available to anyone over fifty-five. . . ." Because we do not turn away from the greater technology, we face the deeper dilemma.<sup>19</sup>*

The advance of medical technology to a degree where doctors can now keep patients—who otherwise would have died—alive on a variety of machines and medications has led to a proliferation of cases on a patient's right to die.<sup>20</sup> These cases are usually brought by a relative or guardian who recognizes that although the body's biological functions are still operative, there is "no sense of pain or pleasure, fear or joy, love or hate, understanding or appreciation, taste or touch or smell or any other aspect of life's experience, with no realistic possibility of sentient life."<sup>21</sup>

A disturbing effect of technological advances in medicine is their use on patients for whom they were not originally intended.<sup>22</sup> Two

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19. Robertson, Is "Substituted Judgment" a Valid Legal Concept?, 5 Issues in L. & Med. 198 (1989) (quoting Smith, What Do We Owe to the Elderly?, Fortune, Mar. 27, 1989, at 54, 55).

20. *Cruzan*, 110 S. Ct. at 2847.

21. Gray by Gray v. Romeo, 697 F. Supp. 580, 584 (D.R.I. 1988).

22. Rhoden, Litigating Life and Death, 102 Harv. L. Rev. 375, 423 (1988).

examples of this, cardiopulmonary resuscitation (CPR) and artificial nourishment, were used to keep Nancy Cruzan alive. CPR was initially developed to aid healthy persons whose hearts stopped beating after surgery, near drowning, or during other traumatic events—not to “prolong terminally ill patients’ dying processes by reviving them time and time again.”<sup>23</sup> Nancy Cruzan would not have existed for so long in a persistent vegetative state if paramedics, knowing she had suffered anoxia for over ten minutes, had not performed CPR on her and brought her back to life. Additionally, artificial nourishment, or feeding by a nasogastric or gastrostomy tube, originally developed to assist *curable* patients during periods of incapability, is now used to sustain the 5,000 to 10,000 patients in the United States in a persistent vegetative state.<sup>24</sup>

A second consideration in the area of medical breakthroughs is that of the quality of life experienced by the patient in a persistent vegetative state kept alive by machinery. A description of Nancy Cruzan’s medical condition while she was in a persistent vegetative state is illustrative here. Although her respiration and circulation were not artificially maintained, she was “oblivious to her environment except for reflexive responses to sound and perhaps painful stimuli.”<sup>25</sup> The ventricles of her brain were enlarged and filled with cerebrospinal fluid, so that her cerebral cortex had degenerated irreversibly and progressively. She was a quadriplegic, and her four limbs were contracted so severely that her fingernails cut into her wrists. She had no cognitive ability and was basically lacking all consciousness.<sup>26</sup>

Although some may nevertheless view existence in this condition as “life,” most would say it is a life not worth living. In a 1988 American Medical Association poll, eighty percent of those questioned would choose withdrawal of life support systems from hopelessly ill or irreversibly comatose patients if they or their families requested it.<sup>27</sup> In a 1988 poll by the Colorado University Graduate School of Public Affairs, eighty-five percent of those surveyed would not want their own lives maintained by artificial nutrition and hydration should they become permanently unconscious.<sup>28</sup> Justice Handler of the New Jersey Supreme Court summarized his feelings on the subject in *In re Conroy*:

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23. *Id.*

24. Cranford & Smith, *Consciousness: The Most Critical Moral (Constitutional) Standard for Human Personhood*, 13 *Am. J.L. & Med.* 233, 238 (1987).

25. *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2845 n.1 (1990).

26. *Id.* See also, *id.* at 2869 n.10 (1990) (Brennan, J., dissenting).

27. *Id.* at 2869 n.11 (Brennan, J., dissenting) (quoting *New York Times*, June 5, 1988, at 14, col. 4 (citing *American Medical News*, June 3, 1988 at 9, col. 1)).

28. *Cruzan*, 110 S. Ct. at 2869 n.11 (Brennan, J., dissenting) (quoting from the *Coloradoan*, Sept. 29, 1988, at 1).

Eventually, pervasive bodily intrusions, even for the best motives, will arouse feelings akin to humiliation and mortification for the helpless patient. When cherished values of human dignity and personal privacy, which belong to every person living or dying, are sufficiently transgressed by what is being done to the individual, we should be ready to say: enough.<sup>29</sup>

### *B. What is the Persistent Vegetative State?*

Although allowing someone to die by withdrawing life-sustaining medical treatment seems cruel and horrific at first glance, a better understanding of the true nature of the persistent vegetative state may lead the reader to see the deeper motivation for such action. According to Dr. Fred Plum, the creator of the term, a persistent vegetative state is one in which the body's internal functions operate to maintain temperature, heart beat, pulmonary ventilation, digestive activity and conditional reflex activity.<sup>30</sup> There is, however, no "behavioral evidence of either self-awareness or awareness of the surroundings in a learned manner."<sup>31</sup> The persistent vegetative state results from damage to the higher areas of the brain, while the brain stem remains intact. Because the brain stem is not damaged, the patient can breathe on his own and even appears to be awake, but the patient is completely unaware and unconscious. These patients can live for years or even decades with artificial feeding and hydration.<sup>32</sup>

Once society fully grasps the medical reality of a persistently vegetative patient lacking consciousness, personality and even what some consider a soul, certain value judgments are likely to follow. These may include a "weak presumption toward medical treatment and preservation of life, one which is easily overcome by relevant considerations for non-treatment."<sup>33</sup> This value judgment translates into a lower evidentiary requirement for one seeking to remove a loved one from life-sustaining treatment. For example, society initially resisted the notion of brain death as a legal basis for determining the death of a person;<sup>34</sup> however,

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29. *In re Conroy*, 98 N.J. 321, 399, 486 A.2d 1209, 1250 (1985) (Handler, J., concurring in part and dissenting in part).

30. *Cruzan*, 110 S. Ct. at 2845 n.1 (quoting *In re Jobes*, 108 N.J. 394, 403, 529 A.2d 434, 438 (1987)).

31. *Id.*

32. Damage to the brain stem itself causes a coma, normally requiring that the patients be put on a respirator. Cranford & Smith, *supra* note 24, at 238.

33. Cranford & Smith, *supra* note 24, at 243.

34. Louisiana's definition of death:

A person will be considered dead if in the announced opinion of a physician, duly licensed in the state of Louisiana based on ordinary standards of approved

once the medical profession expressed specific criteria to be met and showed that brain death could be diagnosed with an extremely high degree of certainty, the public more readily accepted it.<sup>35</sup>

Doctors are now able to diagnose the persistent vegetative state with a very high degree of accuracy.<sup>36</sup> The American Academy of Neurology postulates three medical bases for the conclusion that these patients are not able to experience any thoughts or feelings. First, "direct clinical experience" with the patients reveals they have no awareness of pain or suffering. Second, post-mortem examinations of persistently vegetative patients show extreme damage to the cerebral hemispheres to a degree "incompatible with consciousness" while the patients were alive. Third, positron emission tomography indicates the metabolic rate for glucose in the cerebral cortex is reduced in persistent vegetative patients to a degree "incompatible with consciousness."<sup>37</sup>

Medical evidence shows that patients in a persistent vegetative state are permanently unconscious. They do not live; they only exist. As Justice Blackmar of the Missouri Supreme Court aptly described it in his dissent in *Cruzan v. Harmon*, those who believe in preserving this existence "without regard to its quality . . . dwell in ivory towers."<sup>38</sup>

### III. DEVELOPMENTS IN THE SUPREME COURT'S OPINION

#### A. Nutrition and Hydration as Medical Treatment

In *Cruzan*, the Supreme Court implied that the right to refuse medical treatment included the right to refuse life-sustaining nutrition

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medical practice, the person has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person will be considered dead if in the announced opinion of a physician, . . . the person has experienced an irreversible total cessation of brain function. Death will have occurred at the time when the relevant functions ceased. . . .

La. R.S. 9:111 (1991).

35. Cranford & Smith, *supra* note 24, at 236.

36. "Out of the 100,000 patients who, like Nancy, have fallen into persistive vegetative states in the past 20 years due to loss of oxygen to the brain, there have been only three even partial recoveries documented in the medical literature. . . . The longest any person has ever been in a persistent vegetative state and recovered was 22 months." (emphasis added) (Nancy has been in this state for seven years.). *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2868 n.8 (1990) (Brennan, J., dissenting) (referring to Brief for American Medical Association et al. as Amici Curiae, 11-12, and Snyder, Cranford, Rubens, Bundlie, & Rockswold, *Delayed Recovery from Postanoxic Persistent Vegetative State*, 14 *Annals Neurol.* 156 (1983)).

37. Cranford & Smith, *supra* note 24, at 239-40.

38. *Cruzan v. Harmon*, 760 S.W.2d 408, 429 (Mo. 1988) (en banc) (Blackmar, J., dissenting).



and hydration when the Court "assume[d]," "for purposes of this case," "that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."<sup>39</sup> The recognition of nutrition and hydration as medical treatment by the Court does not seem very persuasive at first glance because of the ambivalent language used. The Court, however, could have used the nutrition and hydration issue to avoid deciding at all the real issues—whether there exists a constitutional right to die and whether Missouri could require clear and convincing evidence. That the Court did not take the easier route of focusing on the nutrition/hydration issue to resolve the case reveals that the justices of the majority believe, if not forcefully, that the administration of life-sustaining nutrition and hydration is medical treatment. Additionally, Justice O'Connor, in her concurring opinion, clearly states that proposition: "Artificial feeding cannot readily be distinguished from other forms of medical treatment."<sup>40</sup> Justice Brennan echoes this sentiment in his dissent, in which Justices Marshall and Blackmun joined: "No material distinction can be drawn between the treatment to which Nancy Cruzan continues to be subject—artificial nutrition and hydration—and any other medical treatment."<sup>41</sup>

Although the withholding of food and water evokes a strong emotional response from a society which views the two as the "necessities of life," they do constitute medical treatment when delivered artificially. A gastrostomy tube, as was used to feed and hydrate Nancy Cruzan, is surgically implanted into the stomach through an incision in the abdominal wall.<sup>42</sup> A significant risk of adverse complications exists, just as with any serious medical treatment procedure.<sup>43</sup>

Most leading medical organizations<sup>44</sup> and the lower courts<sup>45</sup> consider artificially provided nutrition and hydration to be medical treatment.

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39. *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2852 (1990).

40. *Id.* at 2857 (O'Connor, J., concurring).

41. *Id.* at 2866 (Brennan, J., dissenting).

42. *Id.* at 2857 (O'Connor, J., concurring), and at 2866 (Brennan, J., dissenting).

43. Possible complications include the tube's obstruction of the intestinal tract, erosion and piercing of the stomach wall, or leakage of the stomach's contents into the abdominal cavity. Additionally, pneumonia may result from seepage of the stomach's contents into the lungs. *Id.* at 2866 (Brennan, J., dissenting).

44. Council on Ethical and Judicial Affairs of the American Medical Association, *Current Opinions* sec. 2.20 (1989) ("[I]t is not unethical to discontinue all means of life-prolonging medical treatment," including nutrition and hydration where patient is in irreversible coma); Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient, 39 *Neurology* 125, 125 (1989) ("The artificial provision of nutrition and hydration is analogous to other forms of life-sustaining treatment, such as the use of the respirator."); President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical,*

However, a vociferous group of dissenters still remains.<sup>46</sup> Additionally, at least twenty-two states specifically *exclude* nutrition and hydration from medical treatment that a patient could refuse in a living will.<sup>47</sup> In its next case on the subject, the Supreme Court should clearly state whether the administration of nutrition and hydration is medical treatment. Based on the fact that four Justices specifically held and five Justices implied that food and water constitute medical treatment, as well as the indication that most, if not all lower courts feel the same, the Court will probably clearly hold that the administration of food and water is medical treatment.

Those who object to the withdrawal of nutrition and hydration from a person in a persistent vegetative state concentrate on the type of death that will occur, for it essentially involves starving a person to death.<sup>48</sup>

and Legal Issues in Treatment Decisions 90 (1983) ("[N]o particular treatments—including such 'ordinary' hospital interventions as parenteral nutrition or hydration," were found to be "obligatory" for a patient to accept.); see also Hastings Center, Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying 59 (1987).

45. See, e.g., *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (Cal. App. 2d Dist. 1986); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1016, 195 Cal. Rptr. 484, 490 (Cal. App. 2d Dist. 1983); *Corbett v. D'Allessandro*, 487 So. 2d 368, 371 (Fla. App. 2d Dist. 1986); *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986); *In re Gardner*, 534 A.2d 947, 954-55 (Me. 1987); *In re Conroy*, 98 N.J. 321, 373, 486 A.2d 1209, 1235-37 (1985); *In re Grant*, 109 Wash. 2d 545, 559-65, 747 P.2d 445, 452-55 (1987).

46. Harris & Bostrom, *Is the Continued Provision of Food and Fluids in Nancy Cruzan's Best Interests?*, 5 Issues in L. & Med. 415 (1990); May, Barry, Griese, Grisez, Johnstone, Marzen, McHugh, Meilaender, Siegler & Smith, *Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons*, 3 Issues in L. & Med. 203 (1987); Office of the Vicar General, Archdiocese of New York, *Principles in Regard to Withholding or Withdrawing Artificially Assisted Nutrition/Hydration*, 6 Issues in L. & Med. 89 (1990).

47. See, e.g., Missouri's living will statute: "Death-prolonging procedure shall not include . . . the performance of any procedure to provide nutrition or hydration;" Mo. Rev. Stat. § 459.010(3) (Supp. 1991).

48. See *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 444 n.2, 497 N.E.2d 626, 641 n.2 (1986) (Lynch, J., dissenting). Justice Lynch observed:

Removal of the G tube would likely create various effects from the lack of hydration and nutrition, leading ultimately to death. Brophy's mouth would dry out and become caked or coated with thick material. His lips would become parched and cracked. His tongue would swell, and might crack. His eyes would recede back into their orbits and his cheeks would become hollow. The lining of his nose might crack and cause his nose to bleed. His skin would hang loose on his body and become dry and scaly. His urine would become highly concentrated, leading to burning of the bladder. The lining of his stomach would dry out and he would experience dry heaves and vomiting. His body temperature would become very high. His brain cells would dry out, causing convulsions. His respiratory tract would dry out, and the thick secretions that would result could plug his lungs and cause death. At some point within five days to three weeks his major organs, including his lungs, heart, and brain, would give out and he would die.

They must remember, however, that persons in this condition, according to medical authority,<sup>49</sup> *feel absolutely nothing*.

*B. Basis for a Right to Refuse Treatment: Informed Consent and a "Liberty Interest"*

In order to find a basis for the right to refuse life-saving medical treatment, the Court looked to three areas: (1) the common law doctrine of informed consent, (2) the federal right to privacy, and (3) a constitutionally protected "liberty interest."

First, the United States Supreme Court in *Cruzan* recognized that the common law doctrine of informed consent forms a basis for the right to refuse life-sustaining medical treatment.<sup>50</sup> The notion of bodily integrity was originally enunciated by the Court in *Union Pacific Railway Co. v. Botsford*:<sup>51</sup> "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."<sup>52</sup>

This idea later developed into the requirement that informed consent must be obtained from a patient before medical treatment could be performed,<sup>53</sup> and the "logical corollary" of this doctrine, as the Court noted in *Cruzan*, is the right to refuse treatment.<sup>54</sup>

In addition to discussing the common law right of informed consent, the Court also considered a federal constitutional right as a basis for the right to refuse life-sustaining medical treatment. The constitutional right in this area commonly referred to by state courts is the right to privacy. Although the United States Constitution does not explicitly enunciate such a right, the Court in *Griswold v. Connecticut*<sup>55</sup> found such a right emanating from "penumbras" in the Bill of Rights that

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49. See *supra* text accompanying notes 30-38.

50. *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2851 (1990) ("[T]he common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment.").

51. 141 U.S. 250, 11 S. Ct. 1000 (1891).

52. *Id.* at 251, 11 S. Ct. at 1001.

53. *Cruzan*, 110 S. Ct. at 2846-47 (referring to *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129-130, 105 N.E. 92, 93 (1914); Justice Cardozo said: "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.").

54. *Cruzan*, 110 S. Ct. at 2847. See also *In re Conroy*, 98 N.J. 321, 347, 486 A.2d 1209, 1222 (1985) ("The patient's ability to control his bodily integrity through informed consent is significant only when one recognizes that this right also encompasses a right to informed refusal.").

55. 381 U.S. 479, 85 S. Ct. 1678 (1965).

create "zones of privacy."<sup>56</sup> The Court has extended this right to privacy to include contraception,<sup>57</sup> marriage,<sup>58</sup> procreation,<sup>59</sup> child rearing,<sup>60</sup> and abortion.<sup>61</sup> The right to privacy is not absolute, however,<sup>62</sup> and only those fundamental rights which are "deeply rooted in this nation's history and tradition,"<sup>63</sup> or "implicit in the concept of ordered liberty"<sup>64</sup> are included.<sup>65</sup>

Although many of the lower courts have based their decisions upholding a right to refuse life-sustaining medical treatment on a federal constitutional right to privacy,<sup>66</sup> the Court in *Cruzan* refused to characterize this constitutional right as one based on privacy and instead labeled it a "liberty interest."<sup>67</sup>

56. *Id.* at 484, 85 S. Ct. at 1681.

57. *Eisenstadt v. Baird*, 405 U.S. 438, 92 S. Ct. 1029 (1972).

58. *Zablocki v. Redhail*, 434 U.S. 374, 98 S. Ct. 673 (1978); *Loving v. Virginia*, 388 U.S. 1, 87 S. Ct. 1817 (1967).

59. *Skinner v. Oklahoma ex rel Williamson*, 316 U.S. 535, 62 S. Ct. 1110 (1942).

60. *Meyer v. Nebraska*, 262 U.S. 390, 43 S. Ct. 625 (1923).

61. *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 705 (1973).

62. *Id.* at 154, 93 S. Ct. at 727.

63. *Bowers v. Hardwick*, 487 U.S. 186, 192, 106 S. Ct. 2841, 2844 (1986) (quoting *Moore v. East Cleveland*, 431 U.S. 494, 503, 97 S. Ct. 1932, 1938 (1977)).

64. *Palko v. Connecticut*, 302 U.S. 319, 325, 58 S. Ct. 149, 152 (1937).

65. Justice Scalia in his concurrence in *Cruzan* felt the right to refuse life-sustaining medical treatment was not one that was "fundamental" because it amounted to suicide, and that the Court should not involve itself in this field.

I would have preferred that we announce, clearly and promptly, that the federal courts have no business in this field; that American law has always accorded the State the power to prevent, by force if necessary, suicide—including suicide by refusing to take appropriate measures necessary to preserve one's life; that the point at which life becomes "worthless," and the point at which the means necessary to preserve it become "extraordinary" or "inappropriate," are neither set forth in the Constitution nor known to the nine Justices of this Court any better than they are known to nine people picked at random from the Kansas City telephone directory; and hence, that even when it is demonstrated by clear and convincing evidence that a patient no longer wishes certain measures to be taken to preserve her life, it is up to the citizens of Missouri to decide, through their elected representatives, whether that wish will be honored.

*Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2859 (1990) (Scalia, J., concurring).

66. See, e.g., *Rasmussen by Mitchell v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (Cal. App. 2d Dist. 1986); *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 482 A.2d 713 (1984); *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986); *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976).

67. The Court stated: "Although many state courts have held that a right to refuse treatment is encompassed by a generalized constitutional right of privacy, we have never so held. We believe this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest." *Cruzan*, 110 S. Ct. at 2851 n.7.

Why did the Supreme Court completely fail to consider a right to privacy in this area? One possible reason is that the rights traditionally protected by the right to privacy are "family-oriented," and the Court did not want to extend the right of privacy beyond that realm. This argument fails, however, under even the lightest of scrutiny for if the right to choose whether to bring a child into this world is included in the right to privacy, a fortiori so should be the right to refuse life-sustaining treatment for yourself. A second explanation may be that the Court felt uncomfortable in giving the right to die the substantive protection of the right to privacy because the exercise of this right leads to death, whereas the typical exercise of the right to privacy does not have such extreme consequences. The final and most probable possibility is that the conservative Court wanted to tighten the reins on the growing right to privacy. As Ross Nankivell noted in *This Far and No Further*, before the Court handed down its decision:

[I]n recent years the Court's conservative majority has shown a growing restiveness with the expansive privacy rulings of the Warren and Burger years, and it may be that *Cruzan* offers a chance to trim the privacy right without having to use abortion—always a volatile issue—to do so.<sup>68</sup>

### 1. Liberty Interest

In *Cruzan*, the Court avoided the right to privacy and instead labeled the right to refuse life-sustaining treatment as a liberty interest. Although the liberty interest and the right to privacy are both rooted in the due process clauses of the fifth and fourteenth amendments, each is the result of a different interpretation of the clauses as explained by the Supreme Court in *Bowers v. Hardwick*.<sup>69</sup> A literal reading of the clauses focuses on "the processes by which life, liberty, or property is taken"<sup>70</sup>—commonly known as procedural due process. Thus, any right classified as a liberty interest can be infringed upon by the state or federal governments if certain processes or preconditions are met.<sup>71</sup> Of course,

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68. Nankivell, *This Far and No Further: Is There a Constitutional Right to Die?*, A.B.A. J., April 1990, at 67.

69. 478 U.S. 186, 106 S. Ct. 2841 (1986).

70. *Id.* at 191, 106 S. Ct. at 2844.

71. For examples of cases involving liberty interests, see, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11, 25 S. Ct. 358 (1905); *Breithaupt v. Abram*, 352 U.S. 432, 77 S. Ct. 408 (1957); *Bowers*, 478 U.S. 186, 106 S. Ct. 2841; *Washington v. Harper*, 110 S. Ct. 1028 (1990).

relevant state interests will determine the amount or type of process required for a liberty interest to be infringed.<sup>72</sup>

The right to privacy, on the other hand, has developed from a line of cases<sup>73</sup> which interpreted the due process clauses to have substantive content, creating "rights that to a great extent are immune from federal or state regulation or proscription." The privacy rights as the *Bowers* Court explained, thus "have little or no textual support in the constitutional language" yet receive "heightened judicial protection."<sup>74</sup> In *Bowers*, the Court explained its reasons for scrutinizing the rights which are proposed as falling under the right to privacy.

Striving to assure itself and the public that announcing rights not readily identifiable in the Constitution's text involves much more than the imposition of the Justices' own choice of values on the States and the Federal Government, the Court has sought to identify the nature of the rights qualifying for heightened judicial protection.<sup>75</sup>

The Court's classification of the right to refuse life-sustaining medical treatment as a liberty interest is certainly reasonable considering the magnitude of what is at stake—life itself. The state can infringe on the "right-to-die," as a liberty interest, as long as the individual is guaranteed certain processes. The extent of state infringement will depend on a balancing test between the relevant state interests and the right to refuse life-sustaining medical treatment.<sup>76</sup> Problems with such a classification will arise, however, where the process guaranteed the individual is an

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72. *Breithaupt*, 352 U.S. at 439, 77 U.S. at 412. The *Breithaupt* Court stated: "As against the right of an individual that his person be held inviolable, . . . must be set the interests of society. . . ." The Court balanced society's interest in determining intoxication to help prevent drunk driving accidents against *Breithaupt's* right of bodily integrity to be free from an unwanted blood test.

73. See *supra* text accompanying notes 55-65.

74. *Bowers*, 478 U.S. at 191, 106 S. Ct. at 2844.

75. *Id.*, 106 S. Ct. at 2844. The Court also stated in *Bowers*: "The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution." *Id.* at 194, 106 S. Ct. at 2846.

76. One possible hypothetical based on the Court's classification of the right to refuse life-sustaining medical treatment as a liberty interest subject only to procedural and not substantive protection would involve the case of a super-intelligent rocket scientist who is the "brain" behind the United States defense program. If he had a terminal disease and wanted to die, but was able to be kept alive and productive through a series of painful medical treatments, could the United States do so merely by conducting a hearing and showing that the national interests in security outweigh his liberty interest in refusing medical treatment? If the right to die is only a procedurally protected liberty interest which can be infringed on if certain "processes" are met, one would think this could occur.

unfair one. An example of this may be Missouri's requirement that a surrogate meet an extremely strict burden of proof before he can exercise an incompetent's right to refuse treatment.

*C. Right to Die for Incompetent Patients—Court Approves a State-Imposed Evidentiary Requirement*

After finding that a person has a constitutionally protected liberty interest in refusing life-sustaining medical treatment, the Court then considered the constitutionality of the "test" Missouri applies when a surrogate is seeking to exercise an incompetent's right to die. The Supreme Court held that Missouri's requirement of clear and convincing evidence of the incompetent's wishes as to the withdrawal of life-saving treatment did not violate an incompetent's constitutional rights.<sup>77</sup>

After "assuming," "for purposes of this case,"<sup>78</sup> that the United States Constitution would grant a *competent* person a constitutionally protected right in refusing life-sustaining nutrition and hydration, the *Cruzan* Court noted that an *incompetent* person could not exercise this right himself because such a person, "is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment. . . ."<sup>79</sup> Therefore, a surrogate must exercise the right for the incompetent patient.

Under an essentially procedural due process analysis, the Court balanced Missouri's requirement of clear and convincing evidence of the incompetent's wishes along with various state interests against the right of an incompetent patient to have a surrogate exercise his "right to die." Based on Missouri's interest in the protection and preservation of human life, the Court held: first, that Missouri could safeguard the "deeply personal decision"<sup>80</sup> of refusing life-saving treatment through a heightened evidentiary standard; second, that Missouri was entitled to guard against potential abuse in situations where family members may not be acting in the best interest of the patient; third, that Missouri could require a heavier evidentiary standard where it considered a judicial proceeding not to be a truly adversarial one; and fourth, that Missouri could decline to consider the "quality" of life which the incompetent person enjoys and instead "assert an unqualified interest in the preservation of human life."<sup>81</sup>

Because a standard of proof serves to "instruct the factfinder concerning the degree of confidence our society thinks he should have in

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77. *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2852-54 (1990).

78. *Id.* at 2852.

79. *Id.*

80. *Id.*

81. *Id.* at 2853.

the correctness of factual conclusions for a particular type of adjudication”<sup>82</sup> and also acts as “a societal judgment about how the risk of error should be distributed between the litigants,”<sup>83</sup> the Court held Missouri could require clear and convincing evidence<sup>84</sup> in a “right to die” situation involving an incompetent.

### 1. *The Evidentiary Standard Applied to Nancy Cruzan*

*When a person tells family or close friends that she does not want her life sustained artificially, she is “express[ing] her wishes in the only terms familiar to her, and . . . as clearly as a lay person should be asked to express them. To require more is unrealistic, and for all practical purposes, it precludes the rights of patients to forego life-sustaining treatment.”*<sup>85</sup>

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82. *Id.* (quoting *Addington v. Texas*, 441 U.S. 418, 423, 99 S. Ct. 1804, 1808 (1979) (quoting *In re Winship*, 397 U.S. 358, 370, 90 S. Ct. 1068, 1076 (1970) (Harlan, J., concurring))).

83. *Id.* at 2854 (quoting *Santosky v. Kramer*, 455 U.S. 745, 755, 102 S. Ct. 1388, 1395 (1982)). The Court in *Cruzan* found that Missouri could place the risk of an erroneous decision on the surrogate seeking to terminate an incompetent’s life-sustaining treatment.

We believe that Missouri may permissibly place an increased risk of an erroneous decision on those seeking to terminate an incompetent individual’s life-sustaining treatment. An erroneous decision not to terminate results in a maintenance of the status quo; the possibility of subsequent developments such as advancements in medical science, the discovery of new evidence regarding the patient’s intent, changes in the law, or simply the unexpected death of the patient despite the administration of life-sustaining treatment, at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction.

*Id.* at 2854.

84. The Supreme Court has required clear and convincing evidence in deportation proceedings, *Woodby v. Immigration & Naturalization Serv.*, 385 U.S. 276, 87 S. Ct. 483 (1966), in denaturalization cases, *Schneiderman v. United States*, 320 U.S. 118, 63 S. Ct. 1333 (1943), in civil commitment proceedings, *Addington v. Texas*, 441 U.S. 418, 99 S. Ct. 1804 (1979), and in proceedings for the termination of parental rights, *Santosky v. Kramer*, 455 U.S. 745, 102 S. Ct. 1388 (1982). Although the requirement of clear and convincing evidence in these cases and in *Cruzan* operates to recognize the seriousness of the individual interests at stake, it is used in the above cases as a *defense to protect* an individual right, i.e., the government must produce clear and convincing evidence to deport, denaturalize, commit and to terminate parental rights. In *Cruzan*, Missouri’s evidentiary requirement acts as a *bar* in preventing the assertion of Nancy’s rights. The Supreme Court notes that in *Cruzan* it is seeking to protect the interests of an individual rather than to take action against a person, but says this is “of no moment.” *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2853-54 n.10 (1990).

85. *Cruzan*, 110 S. Ct. at 2875 (Brennan, J., dissenting) (quoting *In re O’Connor*, 72 N.Y.2d 517, 551, 531 N.E.2d 607, 626, 534 N.Y.S.2d 886, 905 (1988) (Simons, J., dissenting)).



Once the Court approved of Missouri's requirement of clear and convincing evidence, it then considered whether the Missouri Supreme Court had correctly assessed the insufficiency of the evidence. The Court defined the standard of clear and convincing evidence in the area of an incompetent's "right to die" as "proof sufficient to persuade the trier of fact that the patient held a firm and settled commitment to the termination of life supports under the circumstances like those presented,"<sup>86</sup> and as evidence which "produces in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, evidence so clear, direct and weighty and convincing as to enable [the factfinder] to come to a clear conviction, without hesitancy, of the truth of the precise facts in issue."<sup>87</sup>

The United States Supreme Court in *Cruzan* held that the Supreme Court of Missouri did not commit constitutional error when it reversed the lower court's ruling and found insufficient evidence of Nancy's intent.<sup>88</sup> Both the Missouri and United States Supreme Courts, however, failed to properly consider all of the evidence. In finding that clear and convincing evidence was lacking, the Missouri Supreme Court referred only to a conversation between Nancy and her roommate, "best summarized in the testimony of Nancy's roommate that she 'would not want to continue her present existence without hope as it is.'"<sup>89</sup> Justice Brennan in his dissent described the totality of the evidence which the trial court considered but the two Supreme Courts ignored.<sup>90</sup> This included not only Nancy's conversation with her roommate, but also two conversations with her sister, testimony by Nancy's mother and sister, based on past conversations, that they were certain Nancy would want to discontinue the treatment, and the recommendations of the guardian *ad litem*—appointed by the trial court to protect Nancy's interests—that there was clear and convincing evidence that Nancy would want to discontinue the nutrition and hydration.<sup>91</sup>

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86. *Id.* at 2855 n.11 (quoting *In re O'Connor*, 72 N.Y.2d 517, 531, 531 N.E.2d 607, 613, 534 N.Y.S.2d 886, 892 (1988)).

87. *Id.* at 2855 n.11 (quoting *In re Jobes*, 108 N.J. 394, 407-08, 529 A.2d 434, 441 (1987)).

88. The testimony adduced at trial consisted primarily of Nancy Cruzan's statements made to a housemate about a year before her accident that she would not want to live should she face life as a "vegetable," and other observations to the same effect. The observations did not deal in terms of withdrawal of medical treatment or of hydration and nutrition. *Id.* at 2855.

89. *Cruzan v. Harmon*, 760 S.W.2d 408, 424 (Mo. 1988) (en banc).

90. *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2874 nn.19-20 (1990) (Brennan, J., dissenting).

91. *Id.* Brennan looked to the trial record to find other evidence. Nancy's roommate, Athena Comer, described a half-hour conversation which took place approximately one year before Nancy's accident as "very serious." Athena testified that: "Nancy said she

Missouri's interpretation of the standard of clear and convincing evidence seems to require if not a living will,<sup>92</sup> then at the very least, specific statements repeatedly made by the incompetent patient prior to incompetency concerning particular types of treatment. This requirement seems too demanding for a person who is not familiar with the various life-sustaining treatments available. More importantly, people generally are hesitant to discuss death and rarely anticipate an accident or medical condition leading to a persistent vegetative state. A standard requiring detailed conversations about death and references to certain life-sustaining treatments from people who hope to live long, full lives and who do not anticipate becoming permanently unconscious deprives those incompetent people of their right to refuse life-sustaining treatment.<sup>93</sup> As Justice Stevens described it in his dissent: "Because Nancy Beth Cruzan did not have the foresight to preserve her constitutional right in a living will, or some comparable 'clear and convincing' alternative, her right is gone forever. . . ."<sup>94</sup>

As the Court itself noted, Missouri's requirement of clear and convincing evidence of an incompetent's wishes "may have frustrated the

would never want to live [as a vegetative state] because if she couldn't be normal or even, you know, like halfway, and do things for yourself, because Nancy always did, that she didn't want to live . . . and we talked about it a lot.' Tr. 388-389." "[S]he said that she hoped that [all the] people in her family knew that she wouldn't want to live [as a vegetable] because she knew it was usually up to the family whether you lived that way or not.' Id. at 399." Nancy's sister Christy also testified that she and Nancy had had two very serious discussions about a year and a half before the accident. Christy testified that Nancy had said, in response to the news of a stillborn niece, that "maybe it was part of a 'greater plan' that the baby had been stillborn and did not have to face 'the possible life of mere existence.' Tr. 537." After her grandmother had died, Nancy told Christy that "'it was better for my grandmother not to be kind of brought back and forth [by] medical [treatment], brought back from a critical near point of death. . . .' Id., at 541."

Brennan pointed out other evidence the courts failed to consider including testimony by Christy and Nancy's mother that Nancy would want to discontinue the treatment. Christy said "'Nancy would be horrified at the state she is in.' Id., at 535." She would also "'want to take that burden away from [her family].' Id., at 544." Christy added: "'Based on 'a lifetime of experience [I know Nancy's wishes] are to discontinue the hydration and the nutrition.' Id., at 542." Nancy's mother testified: "'Nancy would not want to be like she is now. [I]f it were me up there or Christy or any of us, she would be doing for us what we are trying to do for her. I know she would, . . . as her mother.' Id., at 526."

92. See text accompanying *infra* notes 160-77 on living wills.

93. Gorby, *Admissibility and Weighing Evidence of Intent in Right to Die Cases*, 6 *Issues in L. & Med.* 33, 33-34 (1990). Gorby also notes that right to die cases should be resolved "according to applicable constitutional and legal values of society and not according to peripheral or collateral matters such as rules of evidence. . . ." Using rules of evidence to decide such cases "may even give courts a reprieve, of sorts, on dealing with great substantive legal issues. . . ." Id. at 34 n.3.

94. *Cruzan*, 110 S. Ct. at 2883 (Stevens, J., dissenting).

effectuation of the not-fully-expressed desires of Nancy Cruzan.”<sup>95</sup> However, the Court went on, “the Constitution does not require general rules to work faultlessly; no general rule can.”<sup>96</sup>

The problem may lie with a state's adoption of, as the Court put it, a “general rule.” Instead of choosing one rigid policy which applies in all situations, a state should have different approaches for the various types of right to die cases which may arise. For example, where clear and convincing evidence does exist, this should certainly be sufficient for a surrogate to be able to exercise an incompetent's right to refuse treatment. Where such evidence is lacking, the right, however, should not be foreclosed. An alternative procedure to be discussed later would involve allowing the family to make its best judgment as to what the patient would have chosen. With regard to this alternative procedure, the court would inquire as to whether the family truly has the patient in mind, rather than some possible monetary benefit to be gained by the patient's death.

#### IV. BALANCE OF STATE INTERESTS

*We think that the State's interest . . . weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims.*<sup>97</sup>

In *Cruzan*, the Supreme Court found that a state could infringe upon an individual's liberty interest to refuse lifesaving medical treatment as long as certain procedural due process requirements were met. The extent of the procedure required is determined by a balancing test between state interests in the matter and the applicable liberty interest sought to be infringed. The Court found Missouri's strong interest in the preservation of life, without reference to its quality, justified a clear and convincing evidentiary standard that may impinge on an incompetent person's right to refuse life-sustaining treatment. The lower courts have generally referred to the following four summarized state interests which are balanced against the right to die: preservation of life, prevention of suicide, prevention of harm to third parties, and preservation of the ethical integrity of the medical profession.<sup>98</sup>

##### A. *Preservation of Life*

The state interest in the preservation of life is commonly considered the most important of the four state interests. In fact, the Missouri

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95. *Id.* at 2854.

96. *Id.*

97. *In re Quinlan*, 70 N.J. 10, 41, 355 A.2d 647, 664 (1976).

98. See, e.g., *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980); *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 741, 370 N.E.2d 417, 425 (1977); *In re Conroy*, 98 N.J. 321, 348-49, 486 A.2d 1209, 1223 (1985).

Supreme Court concluded, after identifying the remaining three state interests that, "In this case, only the state's interest in the preservation of life is implicated."<sup>99</sup>

Supporters of this state interest explain that it embraces not only a concern in preserving the life of the particular patient, but also an interest in preserving the sanctity of all life.<sup>100</sup> Although the preservation of life in all instances seems a noble, worthy notion, it disregards the *quality* of life sought to be preserved, for patients in a persistent vegetative state do not live in the true sense of the word. They are not conscious, they do not think, and they do not feel. They merely exist. Thus, one could argue that the "sanctity of life" is more offended *not* where there is a decision to terminate life-sustaining treatment but instead where there is a failure to respect the "individual free choice and self determination"<sup>101</sup> of a patient like Nancy Cruzan who, according to the Missouri Supreme Court, failed to express her wishes with particularity. Additionally, it is easy to distinguish between a state's interest in a patient's life where his affliction is curable as opposed to a state interest in the life of an incurable patient "where, as here, the issue is not whether but when, for how long, and at what cost to the individual that life may be briefly extended."<sup>102</sup>

### B. *Prevention of Suicide*

A state also has an interest in preventing suicide. An interest in the prevention of "irrational self-destruction,"<sup>103</sup> however, does not necessarily apply in this area where a surrogate is exercising a permanently unconscious patient's right to refuse medical treatment. Courts have consistently held that refusing life-sustaining medical treatment does not constitute suicide.<sup>104</sup> "Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury."<sup>105</sup> Moreover, a specific intent to die is

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99. *Cruzan v. Harmon*, 760 S.W.2d 408, 419 (Mo. 1988) (en banc).

100. *Conroy*, 98 N.J. at 349, 486 A.2d at 1223.

101. *Saikewicz*, 373 Mass. at 742, 370 N.E.2d at 426.

102. *Id.* at 742, 370 N.E.2d at 425-26. See also Cranford & Smith, *supra* note 24, at 243. "The state's interest in preserving life is less compelling when a patient retains only the vegetative functions of basic biologic existence and is irreversibly incapable of experiencing anything."

103. *Saikewicz*, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11.

104. See, e.g., *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 137, 482 A.2d 713, 720 (1984); *Saikewicz*, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11; *In re Conroy*, 98 N.J. 321, 350, 486 A.2d 1209, 1224 (1985); *In re Colyer*, 99 Wash. 2d. 114, 123, 660 P.2d 738, 743 (1983).

105. *In re Conroy*, 98 N.J. at 351, 486 A.2d at 1224.

lacking not only because an irreversibly unconscious patient would undoubtedly want to live if he could be restored to his previous condition but also because a persistently vegetative patient is incapable of thought.<sup>106</sup>

The contents of various state living will statutes provide more support for the idea that withholding medical treatment is not suicide. The majority of living will statutes declare that the withholding or withdrawal of life-sustaining treatment pursuant to the requirements of the statute does *not* constitute suicide.<sup>107</sup> It would thus be fallacious to reason that a state has an interest in preventing suicide only where a patient has failed to complete "certain paperwork"<sup>108</sup> pursuant to a living will statute.

### C. *Prevention of Harm to Third Parties*

A third interest that a state may assert is in assuring that a patient's or surrogate's decision to forego medical treatment will not adversely affect third parties, usually children. Thus, courts have: recognized the enforceability of a compulsory smallpox vaccination law,<sup>109</sup> ordered a mother of a seven-month-old infant to submit to blood transfusions over her religious objections because of her responsibility to care for her child,<sup>110</sup> and compelled a young unmarried pregnant woman to submit to blood transfusions that would save her life.<sup>111</sup>

When applied to a situation involving a persistent vegetative patient and removal of life-sustaining treatment,<sup>112</sup> it is immediately apparent

106. *Id.*, 486 A.2d at 1224.

107. See, e.g., Louisiana's living will statute:

B. (1) The withholding or withdrawal of life-sustaining procedures from a qualified patient in accordance with the provisions of this Part shall not, for any purpose, constitute a suicide.

La. R.S. 40:1299.58.10 B. (1) (Supp. 1991).

108. *Rasmussen by Mitchell v. Fleming*, 154 Ariz. 207, 218, 741 P.2d 674, 685 (Ariz. 1987) (en banc).

109. *Jacobson v. Massachusetts*, 197 U.S. 11, 25 S. Ct. 358 (1905).

110. *Application of President & Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978, 84 S. Ct. 1883 (1964).

111. *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971).

112. Justice Brennan argued against an interest in the protection of third parties because it could be taken too far.

If Missouri were correct that its interests outweigh Nancy's interest in avoiding medical procedures as long as she is free of pain and physical discomfort . . . it is not apparent why a State could not choose to remove one of her kidneys without consent on the ground that society would be better off if the recipient of that kidney were saved from renal poisoning. . . . Patches of her skin could also be removed to provide grafts for burn victims, and scrapings of bone marrow to provide grafts for someone with leukemia. . . . Indeed, why could the State not perform medical experiments on her body, experiments that might

that this state interest is minimal at best. A parent who is unable to comfort, support, protect, or even love the child provides no benefit to the child.

*D. Preservation of the Ethical Integrity of the Medical Profession*

A fourth state interest frequently asserted as a limitation on a patient's right to refuse life-saving medical treatment is preserving the integrity of the medical profession. However, under prevailing medical ethical standards, doctors generally do not advocate prolonging life at all costs. Instead, they recognize that "the dying are more often in need of comfort than treatment."<sup>113</sup> The American Medical Association in 1986 said:

Even if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life prolonging medical treatment.<sup>114</sup>

V. OPTIONS AVAILABLE TO THE STATES

*Today's decision, holding only that the Constitution permits a State to require clear and convincing evidence of Nancy Cruzan's desire to have artificial hydration and nutrition withdrawn, does not preclude . . . States from developing other approaches for protecting an incompetent individual's liberty interest in refusing medical treatment. . . . [T]he more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the "laboratory" of the States . . . in the first instance.*<sup>115</sup>

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save countless lives, and would cause her no greater burden than she already bears by being fed through the gastrostomy tube? This would be too brave a new world for me and, I submit, for our Constitution.

Cruzan v. Director, Missouri Dept. of Health, 110 S. Ct. 2841, 2869, n.13 (1990) (Brennan, J., dissenting). In fact, in *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. 1969), the Kentucky Court of Appeals held that parents of an "incompetent," retarded 27-year-old with a speech defect could exercise substituted judgment on his behalf and order removal of one of his kidneys for transplant in his older brother.

113. *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 743, 370 N.E.2d 417, 426 (1977).

114. *Rasmussen by Mitchell v. Fleming*, 154 Ariz. 207, 217, 741 P.2d 674, 684 (Ariz. 1987) (quoting American Medical Association, Council on Ethical and Judicial Affairs, statement, March 15, 1986).

115. *Cruzan*, 110 S. Ct. at 2858-59 (O'Connor, J., concurring).

In *Cruzan*, the Court did *not* hold that the requirement of clear and convincing evidence was the only *appropriate* burden a state should impose on a surrogate seeking to remove a loved one from life-sustaining nutrition and hydration, but rather that a state *could* constitutionally require it. This leaves open to the "laboratory of the states," as Justice O'Connor said in her concurrence, the job of formulating appropriate procedures for the removal of life-sustaining nutrition and hydration from persons in a persistent vegetative state.

Ever since *In re Quinlan*,<sup>116</sup> the seminal case in the right-to-die arena, various state courts have wrestled with the issue, and five "tests" or "procedures" have emerged: (A1) substituted judgment based on clear and convincing evidence—the type required by Missouri in *Cruzan*, (A2) substituted judgment where the family's best judgment as to the desires of the patient is respected, (A3) a combination of the two, (B) a best interests/pure objective standard, and (C) a limited objective standard.

#### A. Substituted Judgment

First recognized in *In re Quinlan*,<sup>117</sup> substituted judgment in the right-to-die arena is a subjective mechanism by which the court or surrogate makes a decision whether to exercise an incompetent's right to refuse life-sustaining medical treatment. The decision is based on what the *patient himself*, if he were competent, would want when faced with deciding whether to continue treatment.<sup>118</sup> Courts which employ the substituted judgment approach have generally chosen one of three paths in seeking to predict what the incompetent patient's wishes would be. Some courts, like the Missouri Supreme Court in *Cruzan*, require clear and convincing evidence of what the patient would want. Other courts merely allow the family to make its "best judgment" as to what the patient would choose to do, if competent. One line of cases combines both.

##### 1. Substituted Judgment/Clear and Convincing Evidence

One of the strictest applications of a substituted judgment test requiring clear and convincing evidence of the patient's intent is *In re*

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116. 70 N.J. 10, 355 A.2d 647 (1976).

117. *Id.*

118. Liacos, Is "Substituted Judgment" a Valid Legal Concept?, 5 *Issues in L. & Med.* 215, 218 (1989) ("Under the doctrine of substituted judgment, a fact finder makes a determination of what an incompetent person subjectively would want when faced with the decision whether to undergo or terminate invasive medical treatment."). See also *In re Guardianship of Ingram*, 102 Wash. 2d 827, 839, 689 P.2d 1363, 1369 (1984) ("The goal is not to do what most people would do, or what the court believes is the wise thing to do, but rather what this particular individual would do if she were competent and understood all the circumstances.").

*Westchester County Medical Center on Behalf of Mary O'Connor*.<sup>119</sup> Mary O'Connor was an elderly woman who had suffered a number of strokes and was physically incapacitated and mentally incompetent, although not in a persistent vegetative state. Her children did not want the hospital to artificially feed her with a nasogastric tube based on their opinion that their mother, if she were competent, would choose to withhold the life-sustaining treatment.<sup>120</sup> The evidence included: 1. statements of a co-worker that O'Connor had said "I would never want to be a burden on anyone and I would never want to lose my dignity before I passed away," and that it was "monstrous" to keep people who are "suffering very badly" alive on machinery, and 2. testimony of O'Connor's daughters that O'Connor had frequently said, in response to her caring for other sick people, that if she became ill and was unable to care for herself, she would not want her life to be sustained artificially.<sup>121</sup> However, none of the witnesses could say that O'Connor had ever specifically referred to the withholding of nutrition or hydration.<sup>122</sup>

The Court of Appeals of New York, requiring clear and convincing evidence that a patient intended to decline treatment under "particular circumstances"<sup>123</sup> and looking only at a patient's "expressed intent,"<sup>124</sup> held that the evidence was not clear and convincing that O'Connor would want nutrition and hydration withheld.<sup>125</sup>

The Court of Appeals of New York did find clear and convincing evidence in *In re Eichner*.<sup>126</sup> In that case, Brother Fox, a patient in a persistent vegetative state, had stated his views on this "extraordinary business" in discussions at the religious school where he worked. The religious factor apparently held great importance for the court, which

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119. 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988). For other cases requiring clear and convincing evidence, see *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981), cert. denied, 454 U.S. 858, 102 S. Ct. 309 (1981); *In re Gardner*, 534 A.2d 947 (Me. 1987); *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809 (Ohio Ct. of Common Pleas 1980); *In re Guardianship of Browning*, 568 So. 2d 4 (Fla. 1990).

120. *O'Connor*, 72 N.Y.2d at 524, 531 N.E.2d at 609, 534 N.Y.S.2d at 888.

121. *Id.* at 526-27, 531 N.E.2d at 611, 534 N.Y.S.2d at 890.

122. *Id.* at 527, 531 N.E.2d at 611, 534 N.Y.S.2d at 890.

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

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

125. *Id.* at 532, 531 N.E.2d at 614, 534 N.Y.S.2d at 893. The court held that O'Connor's statements were only: 1. "immediate reactions to the unsettling experience of seeing or hearing of another's unnecessarily prolonged death," 2. "no different than those that many of us might make after witnessing an agonizing death," and 3. the "type of statements that older people frequently, almost invariably make." *Id.*

126. 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981), cert. denied, 454 U.S. 858, 102 S. Ct. 309 (1981).



held that the medical treatment, a respirator, could be withdrawn.<sup>127</sup>

The evidence in the *O'Connor* and *Eichner* cases is very similar; however, because of Brother Fox's "unselfish religious devotion," the court gave greater weight to his statements. Although the New York Court of Appeals may have found it relevant that O'Connor, unlike Brother Fox, was not in a persistent vegetative state, the exercise of one's right to refuse medical treatment even by a surrogate should not be subjected to different tests depending on the medical condition of the patient. Additionally, it is unjust and improper for a court to consider a housewife's expressions of intent in a manner typical for a woman who has spent her life caring for other sick people, ("I don't want to be a burden"-type statements) to be insufficient to meet a clear and convincing standard, while at the same time holding that the statements by a member of a religious order must necessarily have been the result of more profound thought and consideration and therefore meet the evidentiary requirement.

Other states have also required clear and convincing evidence of the patient's intent. In *McConnell v. Beverly Enterprises-Connecticut*,<sup>128</sup> the Connecticut Supreme Court found clear and convincing evidence of a comatose woman's desire not to be kept alive through life-sustaining nutrition and hydration. Mrs. McConnell was a registered nurse who was very familiar with the various life-support equipment. She had told a co-worker that if she were ever placed on life-support he should stop it, and she told another co-worker that she "never wanted to be a vegetable or a burden on her family."<sup>129</sup> Additionally, Mrs. McConnell had not wanted her own mother placed on life-support, and all family members testified that Mrs. McConnell did not believe in the use of life-support equipment. This test for clear and convincing evidence seems broader than that in *O'Connor*, where the court's consideration was limited to only the "expressed intent" of O'Connor because in *McConnell*, the court also considered McConnell's act of not placing her mother on life-support as well as her family's *opinion* as to what she would have wanted.

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127. *Eichner*, 52 N.Y.2d at 379-80, 420 N.E.2d at 72, 438 N.Y.S.2d at 274. The court said:

The finding that he carefully reflected on the subject, expressed his views and concluded not to have his life prolonged by medical means if there were no hope of recovery is supported by his religious beliefs and is not inconsistent with his life of unselfish religious devotion. These were obviously solemn pronouncements and not casual remarks made at some social gathering, nor can it be said that he was too young to realize or feel the consequences of his statements.

128. 209 Conn. 692, 553 A.2d 596 (1989).

129. *Id.* at 709, 553 A.2d at 605.

The Missouri Supreme Court's requirement of clear and convincing evidence in *Cruzan* is very similar to *O'Connor* and *Eichner* for in *Cruzan* the Missouri Supreme Court only considered Nancy's statements to her roommate and disregarded the opinions of her sister and mother as to what Nancy would want, based on their familiarity with Nancy in a family relationship.<sup>130</sup> If Missouri had instead considered alternative types of evidence as did the *McConnell* court in reaching the clear and convincing standard, such a test would not have been objectionable. However, where a court limits itself to specific, express statements of the patient as to particular treatments the patient would like withheld, the clear and convincing standard becomes too rigorous a test to meet, and the constitutional right to refuse medical treatment is frequently foreclosed.

It is not the clear and convincing standard of proof that is itself inappropriate. In fact, considering the seriousness of the subject matter sought to be proven, such a standard would seem to be the proper one. However, as illustrated by the above cases, it is a standard which is frequently misapplied and subject to inconsistency. In the case of Brother Fox, the court was swayed by his religious occupation. In *O'Connor*, the New York Court of Appeals limited its perusal of evidence to O'Connor's verbally expressed intent; but, in *McConnell*, the Connecticut Supreme Court considered not only McConnell's statements but also her actions. Clearly, a right that the United States Supreme Court has held to be constitutionally protected should not be subjected to a test which is applied so incongruously.

## 2. *Substituted Judgment/Family's Best Judgment*

A second type of substituted judgment is where the courts do not require clear, express, specific statements by the patient but instead look to other types of evidence and to the family's best judgment as to what the patient, if competent, would choose to do.

The first case<sup>131</sup> to use this approach was *Quinlan*, where the New Jersey Supreme Court was unable to discover from evidence and testimony what Karen Quinlan's choice would be regarding life-sustaining treatment. To preserve her right to privacy, however, her family could decide for her based on what they thought Karen would have chosen.

If a putative decision by Karen to permit this non-cognitive, vegetative existence to terminate by natural forces is regarded

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130. See *supra* text accompanying notes 85-96.

131. See also *In re L.H.R.*, 253 Ga. 439, 321 S.E.2d 716 (1984), and *Gray by Gray v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988) where the court gave great weight to the "depth, quality, and reasoning of the family's prediction of Marcia Gray's intent." *Id.* at 588.

as a valuable incident of her right of privacy, as we believe it to be, then it should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice. The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render *their best judgment*, . . . as to whether she would exercise it in these circumstances.<sup>132</sup>

The Supreme Court of Illinois also adopted this type of standard in *In re Estate of Longeway*.<sup>133</sup> Specifically rejecting *O'Connor's* requirement of "actual, specific express intent,"<sup>134</sup> the court instead held a guardian could substitute her judgment for Longeway based upon "other" evidence of Longeway's intent. The court articulated guidelines for this "other" evidence based on the "patient's personal value system."<sup>135</sup>

[E]ven if no prior specific statements were made, in the context of the individual's entire prior mental life, including his or her philosophical, religious and moral views, life goals, values about the purpose of life and the way it should be lived, and attitudes toward sickness, medical procedures, suffering and death, that individual's likely treatment/nontreatment preferences can be discovered. Family members are most familiar with this entire life context. . . . [T]he family's knowledge exists nevertheless, intuitively felt by them and available as an important decision-making tool.<sup>136</sup>

Figuring most prominently under this standard is the recognition of the family as being in the best position to know what the patient would choose if he were competent to do so. Commentators,<sup>137</sup> medical au-

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132. *In re Quinlan*, 70 N.J. 10, 41, 355 A.2d 647, 664 (1976) (emphasis added).

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

134. *Id.* at 50, 549 N.E.2d at 300.

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

136. *Id.* at 49-50, 549 N.E.2d at 299-300 (quoting Newman, Treatment Refusals for the Critically Ill: Proposed Rules for the Family, the Physician and the State, 3 N.Y.L. Sch. Hum. Rts. Ann. 45-46 (1985), as quoted in *In re Jobes*, 108 N.J. 394, 415, 529 A.2d 434, 445 (1987)).

137. See, e.g., Rhoden, *supra* note 22, at 437-38 ("I submit that the family is indeed the best decisionmaker, and that a preference for family choice can be gleaned from history, from society's respect for the family, and from the fact that family decisionmaking best embodies patient preferences. . . . Not only are family members most likely to be privy to any relevant statements that patients have made on the topics of treatment or its termination, but they also have longstanding knowledge of the patient's character traits. . . . Longstanding knowledge, love, and intimacy make family members the best candidates for implementing the patient's probable wishes and upholding her values. Family members also care most. . . .") and Newman, Treatment Refusals for the Critically Ill: Proposed Rules for the Family, the Physician and the State, 3 N.Y.L. Sch. Hum. Rts. Ann. 35, 45-46 (1985), as quoted in *Jobes*, 108 N.J. at 415-16, 529 A.2d at 445.

thorities,<sup>138</sup> and the public<sup>139</sup> support the *family* as decision-maker when a person is unable to exercise his right to refuse life-sustaining medical treatment.<sup>140</sup>

Family members are best qualified to make substituted judgments for incompetent patients not only because of their peculiar grasp of the patient's approach to life, but also because of their special bonds with him or her. Our common human experience informs us that family members are generally most concerned with the welfare of the patient. It is they who provide for the patient's comfort, care, and best interests, . . . and they who treat the patient as a person, rather than a symbol of a cause.<sup>141</sup>

Of course, the main objection to such a standard is that such a test lends itself to easy manipulation by families with less than noble interests in the life or death of a relative. However, with the assistance of doctors and nurses involved in the case who have observed family interaction with the patient, and with the guidance of an appointed guardian *ad*

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138. *Jobes*, 108 N.J. at 417, 529 A.2d at 446 (quoting President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical and Legal Issues in Treatment Decisions* 4-5 (1983) ("The decisions of patients' families should determine what sort of medical care permanently unconscious patients [who have not left clear directives] receive.")) (quoting New Jersey Chapter of the American College of Physicians Executive Council Policy Statement on Care of Irreversibly Ill Patients (Oct. 1986) ("Family members are presumed to be the appropriate surrogate decisionmakers for patients diagnosed as being incapable of giving informed consent.")) (quoting Statement of the Council on Ethical and Judicial Affairs of the American Medical Association on Withholding or Withdrawing Life Prolonging Medical Treatment (Mar. 15, 1986) ("[T]he choice of the patient, or his family or legal representative if the patient is incompetent to act on his own behalf, should prevail.")).

139. *Jobes*, 108 N.J. at 418-19 n.11, 529 A.2d at 446 n.11. See Newark Star Ledger, Aug. 10, 1986, at 18, col. 4, (84% of 800 persons polled felt a family member should be allowed to discontinue treatment for a comatose relative if the patient had said he or she did not want to be kept alive by life-sustaining treatment. Sixty-four percent said the family should be allowed to discontinue treatment even when the patient had said nothing, but the family believed he or she would not want to be sustained in this condition.) and N.Y. Times, Dec. 2, 1986, at C10, col. 2-6 (70% of the 2000 people questioned "strongly agreed" that family members should decide whether to use life-sustaining medical treatment for one incapable of deciding) as quoted in *Jobes*, 108 N.J. at 418-19 n.11, 529 A.2d at 446 n.11.

140. But see Massachusetts' line of cases starting with *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977) where the substituted judgment is exercised by the court and not the family ("In short, the decision in cases such as this should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person."). *Id.* at 752-53, 370 N.E.2d at 431.

141. *In re Jobes*, 108 N.J. 394, 416, 529 A.2d 434, 445 (1987).

*litem*, the court, should be able to discern whether the family truly has an interest in the patient's well-being.

### 3. *Substituted Judgment/Combination of the Above*

The New Jersey Supreme Court in *In re Peter by Johanning*<sup>142</sup> and *In re Jobes*<sup>143</sup> fashioned a test which combines the above two variations of the substituted judgment test—clear and convincing evidence and family's best judgment.

The New Jersey Supreme Court held that where clear and convincing evidence is present of what the patient, if competent, would choose, a subjective test is applied,<sup>144</sup> but where clear and convincing proof is absent, the patient's right to refuse treatment through a surrogate is not foreclosed. If clear and convincing evidence is absent, the principles of *Quinlan*<sup>145</sup> are applied.<sup>146</sup> Under *Quinlan*, the life-sustaining treatment may be terminated if the guardian or family of the patient in a persistent vegetative state concludes that the patient would not want to be sustained on life-support, if attending physicians conclude there is no reasonable possibility of the patient ever emerging from the persistent vegetative state and that the life-support should be terminated, and if the hospital "Ethics Committee" agrees.<sup>147</sup>

The *Peter/Jobes* approach is clearly one of the better tests that state courts may apply. This approach preserves the aspect of self-determination, one of the bases for a right to refuse life-sustaining medical treatment, by *first* looking to see if there is clear and convincing evidence of an incompetent's wishes. If this evidence is lacking, the court does *not* "punish" a person in a persistent vegetative state for failing to have made statements or expressions about his desires regarding the withholding of life-sustaining treatment. Instead, the court then defers to the family's substituted judgment, based on knowledge gained about the patient in the family relationship, to decide for itself what the patient would have chosen, and if the attending physician and hospital "Ethics Committee" agree that the patient has no chance of ever recovering to a cognitive state, the treatment can be suspended.

The *Peter/Jobes* approach combines the best aspects of the clear and convincing evidence requirement and the family's best judgment

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142. 108 N.J. 365, 529 A.2d 419 (1987).

143. 108 N.J. 394, 529 A.2d 434 (1987).

144. *Peter*, 108 N.J. at 377-78, 529 A.2d at 425; *Jobes*, 108 N.J. at 411-13, 529 A.2d at 443. See *supra* text accompanying notes 119-130 regarding the clear and convincing standard.

145. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976).

146. *Peter*, 108 N.J. at 377, 529 A.2d at 425; *Jobes*, 108 N.J. at 420, 529 A.2d at 447.

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

standard. As such, the courts which adopt this standard preserve the patient's right of self-determination and at the same time recognize the family as occupying a unique role in deciding what the patient would have wanted.

### *B. Best Interests/Pure Objective*

A second test courts use to implement an incompetent patient's right to refuse life-sustaining medical treatment involves an objective assessment of what treatment would be in the patient's best interests. This test is different from a substituted judgment type test because rather than trying to decide what medical decision the patient would have made, the surrogate attempts to make a decision that will be in the "best interests" of the patient. Considerations include a patient's relief from suffering, his prognosis and possibility of recovery, and the quality and extent of his life on the life-sustaining treatment.<sup>148</sup> "An accurate assessment will encompass consideration of the satisfaction of present desires, the opportunities for future satisfactions, and the possibility of developing or regaining the capacity for self-determination."<sup>149</sup>

Under this test, no evidence of the patient's wishes prior to incompetency is required, but such evidence, if it exists would be probative on deciding what action would be in the patient's best interests.<sup>150</sup>

The best interests test has been criticized because it involves a determination by a third person as to the quality of life that a persistent vegetative patient may experience, "thereby undermining the foundation of self-determination and inviolability of the person upon which the

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148. *Rasmussen by Mitchell v. Fleming*, 154 Ariz. 207, 222, 741 P.2d 674, 689 (Ariz. 1987). See also, *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985) where in absence of any evidence at all, life-sustaining treatment may still be withheld if the "net burdens of the patient's life with the treatment should clearly and markedly outweigh the benefits that the patient derives from life." *Id.* at 366, 486 A.2d at 1232. The major factor in the *Conroy* "pure objective" test is the presence of severe pain such that the administration of life-sustaining treatment would be inhumane. Because persistent vegetative patients do not experience any pain, the New Jersey Supreme Court, in *In re Peter by Johanning*, 108 N.J. 365, 529 A.2d 419 (1987) clarified *Conroy* as applying only to marginally cognitive, elderly patients, and instead applied a substituted judgment test where no express evidence of the patient's intent was necessary.

149. *Rasmussen*, 154 Ariz. at 222, 741 P.2d at 689, quoting President's Commission for the Study of Ethical Problems in Medicine & Biomedical & Behavioral Research, *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical and Medical and Legal Issues in Treatment Decisions 1*, 135 (1983).

150. See, *Conservatorship of Drabick*, 200 Cal. App. 3d 185, 210-11, 245 Cal. Rptr. 840, 856 (1988), cert denied, 488 U.S. 958, 109 S. Ct. 399 (1988), reh'g denied, 488 U.S. 1024, 109 S. Ct. 828 (1989); *In re Conservatorship of Torres*, 357 N.W.2d 332, 339 (Minn. 1984) ("At a minimum, any determination of a conservatee's 'best interests' must involve some consideration of the conservatee's wishes.").

right to refuse medical treatment stands."<sup>151</sup> However, a logical extension of this criticism would lead to the conclusion that *no* incompetent person would ever be able to exercise his right to refuse medical treatment through a surrogate, because the incompetent person in such a situation is not making a decision based on self-determination. Courts, regardless of the test they impose, have never so held, and although the reasoning that a patient's right to refuse medical treatment survives incompetence "is a legal fiction at best,"<sup>152</sup> state courts and now the United States Supreme Court in *Cruzan* recognize a right to refuse medical treatment even after incompetency.

On the other hand, the best interests test is not one of the better tests when compared to the combined *Peter/Jobes* approach, the family's best judgment standard, or even the clear and convincing evidence requirement, all of which strive to achieve what the patient would have wanted, either through express evidence or evidence implied in the family relationship. By failing to truly consider the patient's desires, the best interests test is an anomaly, for the essence of a surrogate's exercise of an incompetent's right to refuse life-sustaining medical treatment lies in achieving what the patient would have chosen if competent. The surrogate is merely exercising the right for the patient because of his incompetency. Additionally, the test involves an assessment by a third person of the benefits and burdens of an incompetent's life, an idea that may put society on the edge of a slippery slope into legalized euthanasia. Taken to the extreme, the best interests test could be applied to the handicapped, the brain damaged, the elderly, or any other group of persons whose lives do not appear to meet the benefits/burdens analysis.

For the above reasons, the best interests standard is not one which should be applied in the right to die arena.

### C. Limited Objective

In addition to the three variations of the substituted judgment test and the best interests test, a third standard is available to the states—which could be called the "limited objective test." In *In re Conroy*,<sup>153</sup> the Supreme Court of New Jersey adopted three tests which apply when

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151. *In re Estate of Longeway*, 133 Ill. 2d 33, 49, 549 N.E.2d 292, 299 (1989). See also, *In re Moe*, 385 Mass. 555, 432 N.E.2d 712 (1982).

To speak solely in terms of the "best interests" of the ward, or of the State's interest, is to obscure the fundamental issue: Is the State to impose a solution on an incompetent based on external criteria, or is it to seek to protect and implement the individual's personal rights and integrity? We reject the former possibility.

*Id.* at 566, 432 N.E.2d at 720.

152. *Drabick*, 200 Cal. App. 3d at 208, 245 Cal. Rptr. at 854.

153. 98 N.J. 321, 486 A.2d 1209 (1985).

a surrogate is seeking to exercise an incompetent's right to refuse treatment. In addition to a substituted judgment standard that required clear and convincing evidence of the patient's desires and a pure objective/best interests test,<sup>154</sup> the court also enunciated a limited objective test. Where the evidence is too "vague, casual, or remote"<sup>155</sup> to constitute clear and convincing evidence but is nevertheless "trustworthy,"<sup>156</sup> and where it is clear that the burdens of life continued by treatment outweigh the benefits of life, life-sustaining treatment could be withdrawn.

The Supreme Court of Washington adopted a very similar type of test in *In re Guardianship of Grant*.<sup>157</sup> The court held that a surrogate could exercise substituted judgment for an incompetent patient if he met one of two prongs. If the surrogate determines that the patient, if competent, would choose to refuse life-sustaining treatment,<sup>158</sup> the treatment could be terminated. An evidentiary standard was not given here. If such a determination could not be made, the surrogate would then look to the best interests of the patient.<sup>159</sup>

Like the *Peter/Jobes* standard, the limited objective test first looks to see if there is clear and convincing evidence, or at least "trustworthy" evidence, of the patient's desires. However, the second prong is not the "family's best judgment" standard but instead a best interests analysis which, as explained previously, is one which least effectuates the policies behind allowing a surrogate to exercise a patient's right to die.

## VI. THE ROLE OF LIVING WILLS

*The day will come when people will be able to carry a card, notarized and legally executed, which explains that they do not*

154. See supra text accompanying notes 148-152.

155. 98 N.J. at 366, 486 A.2d at 1232.

156. *Id.*, 486 A.2d at 1232.

157. 109 Wash. 2d 545, 747 P.2d 445 (1987).

158. *Id.* at 566, 747 P.2d at 456. In determining whether the patient would choose to terminate life-sustaining treatment, factors include, the "patient's character and personality, general attitude towards medical treatment, and prior statements." *Id.* at 567, 747 P.2d at 457.

159. *Id.* at 567, 747 P.2d at 456. In determining what would be in the best interest of the patient, factors are:

[E]vidence about the patient's present level of physical, sensory, emotional, and cognitive functioning; the degree of physical pain resulting from the medical condition, treatment, and termination of treatment, respectively; the degree of humiliation, dependence, and loss of dignity probably resulting from the condition and treatment; the life expectancy and prognosis for recovery with and without treatment; the various treatment options; and the risks, side effects, and benefits of each of those options.

*Id.* at 568, 747 P.2d at 457, quoting *Conroy*, 98 N.J. at 397, 486 A.2d at 1231 (Handler, J., concurring in part and dissenting in part).



*want to be kept alive beyond the humanum point, and authorizing the ending of their biological processes by any of the methods of euthanasia which seems appropriate.*<sup>160</sup>

A living will is a written directive through which a person can provide in advance for the withdrawal of life-sustaining procedures, should they ever become necessary. It is *not* a *prerequisite* for an incompetent patient to be able to exercise through a surrogate his right to the withdrawal of life-sustaining medical procedures—for, as seen in earlier discussion, states have formulated various tests to be applied in situations where there is no living will. However, the presence of a living will which meets all of the statutory requirements will generally preclude any discussion of the patient's best interests or intent, and thus its instructions will be respected.

At least forty-two states<sup>161</sup> have enacted living will legislation. Although each state statute is different, common provisions include sections on: legislative findings,<sup>162</sup> definitions,<sup>163</sup> the form of declaration,<sup>164</sup> pro-

160. Koop, *Decisions at the End of Life*, 5 *Issues in L. & Med.* 225 (1989) (quoting Joseph Fletcher, a prominent Episcopalian theologian who favors active euthanasia).

161. Ala. Code §§ 22-8A-1 to -10 (1990); Alaska Stat. §§ 18.12.010-.100 (1986); Ariz. Rev. Stat. Ann. §§ 36-3201 to -3210 (1986); Ark. Stat. Ann. §§ 20-17-201 to -218 (Supp. 1989); Cal. Health & Safety Code §§ 7185-7195 (West Supp. 1991); Colo. Rev. Stat. §§ 15-18-101 to 113 (1989 & Supp. 1990); Conn. Gen. Stat. Ann. §§ 19a-570 to -575 (West Supp. 1991); Del. Code Ann. tit. 16, §§ 2501-2509 (1983); D.C. Code Ann. §§ 6-2421 to -2430 (1989); Fla. Stat. §§ 765.01-.15 (1986); Ga. Code Ann. §§ 31-32-1 to -12 (1985 & Supp. 1990); Haw. Rev. Stat. §§ 327D-1 to -27 (Supp. 1990); Idaho Code §§ 39-4501 to -4509 (1985 & Supp. 1990); Living Will Act, Ill. Ann. Stat. ch. 110 1/2, para. 701-710 (Smith-Hurd Supp. 1991); Ind. Code Ann. §§ 16-8-11-1 to -22 (West Supp. 1990); Iowa Code Ann. §§ 144A.1 - .11 (West 1989); Kan. Stat. Ann. §§ 65-28,101 to -28,109 (1985); La. R.S. 40:1299.58.1 - .10 (Supp. 1991); Me. Rev. Stat. Ann. tit. 22, §§ 2921-2931 (West Supp. 1990); Md. Health-Gen. Code Ann. §§ 5-601 to -614 (1990); Minn. Stat. Ann. §§ 145B.01-.17 (West Supp. 1991); Miss. Code Ann. §§ 41-41-101 to -121 (Supp. 1990); Mo. Rev. Stat. §§ 459.010-.055 (Supp. 1991); Mont. Code Ann. §§ 50-9-101 to -104, -110 to -111, -201 to -206 (1989); Nev. Rev. Stat. §§ 449.540-690 (1989); N.H. Rev. Stat. Ann. §§ 137-H:1 to -H:16 (Supp. 1989); N.M. Stat. Ann. §§ 24-7-1 to -11 (1986); N.Y. Pub. Health Law §§ 2960-2978 (McKinney Supp. 1991); N.C. Gen. Stat. §§ 90-320 to -323 (1990); N.D. Cent. Code §§ 23-06.4-01 to -14 (Supp. 1989); Okla. Stat. tit. 63, §§ 3101-3111 (Supp. 1991); Or. Rev. Stat. §§ 127.605 to .650 (1990); S.C. Code Ann. §§ 44-77-10 to -160 (Law. Co-op Supp. 1990); Tenn. Code Ann. §§ 32-11-101 to -110 (Supp. 1990); Tex. Health and Safety Code §§ 672.001-.021 (Vernon 1991); Utah Code Ann. §§ 75-2-1101 to -1118 (Supp. 1991); Vt. Stat. Ann. tit. 18, §§ 5251-5262 (1987); Va. Code Ann. §§ 54.1-2981 to -2992 (1991); Wash. Rev. Code Ann. §§ 70.122.010-.905 (Supp. 1991); W. Va. Code §§ 16-30-1 to -13 (1991 & Supp. 1991); Wis. Stat. §§ 154.01-.15 (1989); Wyo. Stat. §§ 35-22-101 to -109 (1988 & Supp. 1991).

162. California's legislative findings and declaration:

The Legislature finds that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care, including the decision to have life-sustaining procedures withheld or withdrawn in instances

cedures for revocation,<sup>165</sup> procedures for doctor non-compliance, state-

of a terminal condition.

The Legislature further finds that modern medical technology has made possible the artificial prolongation of human life beyond natural limits.

The Legislature further finds that, in the interest of protecting individual autonomy, such prolongation of life for persons with a terminal condition may cause loss of patient dignity and unnecessary pain and suffering, while providing nothing medically necessary or beneficial to the patient.

The Legislature further finds that there exists considerable uncertainty in the medical and legal professions as to the legality of terminating the use or application of life-sustaining procedures where the patient has voluntarily and in sound mind evidenced a desire that such procedures be withheld or withdrawn.

In recognition of the dignity and privacy which patients have a right to expect, the Legislature hereby declares that the laws of the State of California shall recognize the right of an adult person to make a written directive instructing his physician to withhold or withdraw life-sustaining procedures in the event of a terminal condition.

Cal. Health & Safety Code § 7186 (West Supp. 1991).

163. California's section on definitions:

(a) "Attending physician" means the physician selected by, or assigned to, the patient who has primary responsibility for the treatment and care of the patient.

(b) "Directive" means a written document voluntarily executed by the declarant in accordance with the requirements of Section 7188. The directive, or a copy of the directive, shall be made part of the patient's medical records.

(c) "Life-sustaining procedure" means any medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, death is imminent whether or not such procedures are utilized. "Life-sustaining procedure" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.

(d) "Physician" means a physician and surgeon licensed by the Medical Board of California or the Board of Osteopathic Examiners.

(e) "Qualified patient" means a patient diagnosed and certified in writing to be afflicted with a terminal condition by two physicians, one of whom shall be the attending physician, who have personally examined the patient.

(f) "Terminal condition" means an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve only to postpone the moment of death of the patient.

Cal. Health & Safety Code § 7187 (West Supp. 1991).

164. Missouri's Declaration:

#### DECLARATION

I have the primary right to make my own decisions concerning treatment that might unduly prolong the dying process. By this declaration I express to my physician, family and friends my intent. If I should have a terminal condition it is my desire that my dying not be prolonged by administration of death-

ments that a living will does not affect insurance, and statements that the state does not approve of euthanasia.<sup>166</sup>

The major problem with the living will is that although millions of people have already executed one,<sup>167</sup> this represents only a small fraction of the population, and even then, there is no guarantee that the patients who fall into a persistent vegetative state will be those who executed living wills.<sup>168</sup> The small number of living wills executed may be due to

prolonging procedures. If my condition is terminal and I am unable to participate in decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw medical procedures that merely prolong the dying process and are not necessary to my comfort or to alleviate pain. It is not my intent to authorize affirmative or deliberate acts or omissions to shorten my life rather only to permit the natural process of dying.

Signed this \_\_\_\_ day of \_\_\_\_

Signature \_\_\_\_\_

City, County and State of residence \_\_\_\_\_

The declarant is known to me, is eighteen years of age or older, of sound mind and voluntarily signed this document in my presence.

Witness \_\_\_\_\_

Address \_\_\_\_\_

Witness \_\_\_\_\_

Address \_\_\_\_\_

#### REVOCATION PROVISION

I hereby revoke the above declaration,

Signed \_\_\_\_\_

(signature of declarant)

Date \_\_\_\_\_

Mo. Rev. Stat. § 459.015 (Supp. 1991).

165. Missouri's procedures for revocation:

1. A declaration may be revoked at any time and in any manner by which the declarant is able to communicate his intent to revoke, without regard to mental or physical condition.
2. The attending physician or health care provider shall make the revocation a part of the declarant's medical record.
3. There shall be no criminal or civil liability on the part of any person for failure to act upon a revocation made pursuant to this section unless the revocation is in the patient's medical record or unless that person has actual knowledge of the revocation.

Mo. Rev. Stat. § 459.020 (Supp. 1991).

166. (5) Sections 459.010 to 459.055 do not condone, authorize or approve mercy killing or euthanasia nor permit any affirmative or deliberate act or omission to shorten or end life.

Mo. Rev. Stat. § 459.055(5) (Supp. 1991).

167. Blodgett, *New "Living Wills,"* 72 A.B.A. J. 24 (Sept. 1, 1986) (quoting George Annas, of the Boston University School of Medicine).

168. Brennan wrote in his dissent:

Surveys show that the overwhelming majority of Americans have not executed such written instructions. See Emmanuel & Emmanuel, *The Medical Directive: A New Comprehensive Advance Care Document*, 261 JAMA 3288

a lack of awareness of the statutes, procrastination,<sup>169</sup> a lack of a feeling of "urgency," or even the refusal to dwell on one's own mortality.<sup>170</sup>

Another problem with living wills which may limit their application even where one has been executed is in meeting the statutory requirements. For example, at least twenty-one states specifically *exclude* nutrition and hydration from the types of medical treatment which can be withdrawn pursuant to a directive.<sup>171</sup> Thus, even where a living will has been executed in those states, nutrition and hydration cannot be withdrawn unless the patient meets the so-called "test" the state has adopted to be applied in the absence of a living will.<sup>172</sup> Additionally, of the forty-two states which have living will legislation, thirty-eight specifically require that the patient be in a "terminal condition."<sup>173</sup>

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(1989) (only 9% of Americans execute advance directives about how they would wish treatment decisions to be handled if they became incompetent); American Medical Association Surveys of Physician and Public Opinion on Health Care Issues 29-30 (1988) (only 15% of those surveyed had executed living wills); 2 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions 241-242 (1982) (23% of those surveyed said that they had put treatment instructions in writing).

Cruzan v. Director, Missouri Dept. of Health, 110 S. Ct. 2841, 2875 n.21 (1990) (Brennan, J., dissenting.).

169. *Id.* at 2875 (Brennan, J., dissenting) (quoting Barber v. Superior Court, 147 Cal. App. 3d 1006, 1015, 195 Cal. Rptr. 484, 489 (Cal. App. 2d Dist. 1983)).

The lack of generalized public awareness of the statutory scheme and the typically human characteristics of procrastination and reluctance to contemplate the need for such arrangements however makes this a tool which will all too often go unused by those who might desire it.

170. *Id.* (Brennan, J., dissenting):

The probability of becoming irreversibly vegetative is so low that many people may not feel an urgency to marshal formal evidence of their preferences. Some may not wish to dwell on their own physical deterioration and mortality.

171. Alabama, Arizona, Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Maine, Missouri, Montana, New Hampshire, North Dakota, Oklahoma, Oregon, South Carolina, Tennessee, Utah, Wisconsin, and Wyoming specifically exclude nutrition and hydration from life support able to be withdrawn under a living will. Colorado, Maryland, and Minnesota have rules such that unless it is specifically included in the living will, nutrition and hydration are unable to be withdrawn under a general living will referring only to life-sustaining treatment.

172. See *supra* note 161 for statutory references.

173. Statutes vary in their definition of "terminal." For instance, California defines a terminal condition as: "an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve only to postpone the moment of death of the patient." Cal. Health & Safety Code § 7187(f) (West Supp. 1991). Nancy Cruzan would not have been terminal under this definition where, interpreting "regardless" to mean "with or without," *with* the treatment Nancy could live 30 years. See *supra* note 32 and supporting text. Missouri, Nancy's

Because patients in a persistent vegetative state can live in that condition for the length of a normal life-span,<sup>174</sup> arguably they are not "terminal" and any living will executed would be inapplicable.<sup>175</sup>

At least twelve states,<sup>176</sup> including Louisiana, provide for decision-making procedures in the absence of a living will, such that certain enumerated persons can make the declaration for the incompetent patient.<sup>177</sup> However, the majority of those twelve states still preclude nutrition and hydration from being withheld in the declaration and also require the patient to be in a terminal condition. Thus, even if Missouri had such a provision, Nancy Cruzan's parents would have been prohibited from exercising a declaration for her.

Louisiana's living will statute, Louisiana Revised Statutes 40:1299.58.1-.10, does not explicitly preclude nutrition and hydration from being withheld pursuant to a living will; however, it does state that any treatment which is "necessary to provide comfort care" cannot be

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home state, defines a terminal condition as: "an incurable or irreversible condition which, in the opinion of the attending physician, is such that death will occur within a short time regardless of the application of medical procedures." Mo. Rev. Stat. § 459.010(6) (Supp. 1991). For the same reasons as stated above, if Nancy had had a living will, it would have been inapplicable because she would not have met the definition of terminal.

174. *Cruzan v. Harmon*, 760 S.W.2d 408, 411 (Mo. 1988). Doctors predicted Nancy could have lived another 30 years with the aid of life-sustaining treatment.

175. At this writing, four states require less than a terminal condition. Arkansas requires that a patient be at least "permanently unconscious," Ark. Stat. Ann. § 20-17-201(7) (Supp. 1989); Idaho requires at least a "persistent vegetative state," Idaho Code § 39-4503(3) (1985 & Supp. 1990); New Mexico allows "irreversible coma" although it is defined much like a persistent vegetative state, N.M. Stat. Ann. § 24-7-2-B (1986); and Louisiana defines a qualified patient as one having a terminal and irreversible condition or one in a "continual profound comatose state," La. R.S. 40:1299.58.2(7) (Supp. 1991).

176. Arkansas, Connecticut, Florida, Iowa, Louisiana, New Mexico, New York (although it is limited to a "do not resuscitate order"), North Carolina, Oregon, Texas, Utah, and Virginia all provide for this authority. See *supra* note 161 for statutory references.

177. See, e.g., Louisiana's provision:

(2) When a comatose or incompetent person or a person who is physically or mentally incapable of communication has been certified as a qualified patient and has not previously made a declaration, any of the following individuals in the following order of priority, if there is no individual in a prior class who is reasonably available, willing, and competent to act, may make a declaration on the qualified patient's behalf:

- (a) The judicially appointed tutor or curator of the patient if one has been appointed. . . .
- (b) The patient's spouse not judicially separated.
- (c) An adult child of the patient.
- (d) The parents of the patient.
- (e) The patient's sibling.
- (f) The patient's other ascendants or descendants.

La. R.S. 40:1299.58.5(2) (Supp. 1991).

withheld. Because it is arguable that "comfort care" may be interpreted by a court to include the administration of food and water, a Louisiana citizen may find his right to refuse life-sustaining medical treatment foreclosed even though he signed a living will. Based on the *Cruzan* Court's and numerous lower courts' recognition of nutrition and hydration as medical treatment which a person has the right to refuse, the Louisiana Legislature should clear up the ambiguity in this statute. A possible solution would be the creation of a presumption that a living will's declaration includes the withholding of nutrition and hydration unless otherwise specified.

#### VII. SUMMARY

Medicine has advanced to such a degree that it "has effectively created a twilight zone of suspended animation where death commences while life, in some form, continues."<sup>178</sup> Patients in a persistent vegetative state exist in this twilight zone, irreversibly unaware and unconscious, and robbed of all dignity. As a result, most states have fashioned tests or mechanisms by which a surrogate can exercise such a patient's right to refuse lifesaving medical treatment.

In its first ever right-to-die case, one involving a persistently vegetative patient, the United States Supreme Court recognized a common law right and a federal constitutional right to refuse life-sustaining medical treatment, including nutrition and hydration. Instead of extending the right of privacy to this area, the Court classified the constitutional right as a liberty interest. Thus, the right does not benefit from the heightened judicial protection given privacy rights and instead can be infringed on by states subject to procedural due process requirements, the extent of which is decided by the relevant state interests. Additionally, the Court held that where a patient was incompetent, a state could require clear and convincing evidence in the form of specific, express statements before a surrogate could exercise the patient's right to refuse treatment.

Because the Court did *not* say that the clear and convincing evidentiary requirement was the appropriate one but merely one that could constitutionally be applied, states are free to apply other tests until they are deemed unconstitutional by the Supreme Court. In addition to the substituted judgment test requiring clear and convincing evidence, states may also apply a substituted judgment test which defers to the best judgment of the family as to what the patient would have wanted or a substituted judgment standard combining both the clear and convincing

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178. *Cruzan v. Director, Missouri Dept. of Health*, 110 S. Ct. 2841, 2863 (1990) (Brennan, J., dissenting, quoting *Rasmussen v. Fleming*, 154 Ariz. 207, 211, 741 P.2d 674, 678 (1987)).

and best judgment aspects. Two other tests available include a best interests pure objective approach which balances the benefits and burdens of a patient's life and a limited objective approach which first looks to some "trustworthy" evidence of the patient's intent and then balances the benefits and burdens of continued life.

A living will is a statutory mechanism that is available in many states; however, its use is not yet widespread, and a living will may not always meet the statutory requirements.

#### VIII. CONCLUSION

*I suspect hundreds of thousands of people can rest free, knowing that when death beckons they can meet it face to face with dignity, free from the fear of unwanted and useless medical treatment.*<sup>179</sup>

The last seven years of Nancy's life were not in vain. Although she was not aware of the legal storm swirling around her, many others were, and as a result, families have started to discuss, with particularity, their desires on the withholding or withdrawal of life-sustaining treatment. Additionally, the demand for living wills has grown.<sup>180</sup>

Certainly, these family discussions will make it easier for a surrogate to meet a clear and convincing evidentiary standard imposed by a state; however, our concern should not lie with the families who can meet the burden of proof but with those who cannot. In formulating policies and requirements for a surrogate to exercise an incompetent patient's right to refuse life-sustaining medical treatment, the judiciary and the state legislatures would be wise to remember that many people, because of their youth or perhaps their fear, simply do not foresee an illness or injury that will leave them in a persistent vegetative state. These are the people who do not leave clear and convincing evidence of their wishes; however, this should not doom them to a death "without dignity."

If such a case reaches the Louisiana judicial system, the courts would do well to adopt the well-reasoned approach utilized in *In re Peter* and *In re Jobes*.<sup>181</sup> By first looking to see if there is clear and convincing evidence of the patient's intent and only afterwards to the family's best judgment as to what an incompetent would have chosen if competent, this approach respects the self-determination aspect of such a decision and yet does not foreclose the right to die with dignity if

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179. Written statement by Nancy's father after her death, as quoted in Smolowe, *Bringing an End to Limbo*, *Time Mag.*, p. 64, vol. 136, no. 27, Dec. 24, 1990.

180. Smolowe, *Bringing an End to Limbo*, *Time Mag.*, p. 64, vol. 136, no. 27, Dec. 24, 1990.

181. See *supra* text accompanying notes 142-147 on the *Peter/Jobes* standard.

such evidence is lacking. Instead, the New Jersey Supreme Court then looks to the family's best judgment as to what the patient would have wanted based on unique knowledge gleaned from their relationship with the patient in a family setting.

Once society understands that patients in a persistent vegetative state or an irreversible coma are *permanently* unconscious and essentially "dead," society will realize the horror of keeping these patients alive for years on machinery.

*Anne Marie Gaudin\**

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\* Recipient of the 1990-91 Vinson and Elkins "Best Casenote or Comment" Award.



