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## The Assault on Privacy in Healthcare Decisionmaking

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# THE ASSAULT ON PRIVACY IN HEALTHCARE DECISIONMAKING

BEN A. RICH\*

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## I. INTRODUCTION

Thousands of times a day, in hospitals and physicians' offices throughout the country, patients or their surrogate decisionmakers decide to accept or refuse suggested diagnostic or therapeutic procedures. Only in a very small number of instances where the patient or his surrogate decides to decline the proposed treatment, does the treating physician or the hospital file a legal action seeking to overturn the decision.

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Judicial opinion's in these cases warrant our close scrutiny because of their far-reaching effect. The fact that these cases are brought by health-care providers and decided by judges in the name of beneficence<sup>1</sup> is no reason to accord them any less attention.<sup>2</sup>

In this article I will argue that the concepts of privacy and autonomy are both literally and constitutionally involved in healthcare decision-making. Their application in that context has been complicated by a number of factors. Privacy, in particular, has longstanding recognition in tort law,<sup>3</sup> as well as in constitutional law, at least with regard to the fourth amendment; however, since the recognition of a separate and distinct right of privacy in *Griswold v. Connecticut*,<sup>4</sup> the concepts of autonomy and privacy have been used interchangeably. I shall illustrate that, at least in the context of treatment refusals, autonomy and privacy in the constitutional sense should be treated separately.

The title of this article is not intended to be polemical, but strongly suggestive of the fact that there has been an assault on privacy in health-care decisionmaking.<sup>5</sup> I intend to show the means necessary to defeat this assault, which exist within the currently accepted principles of contract, procedural and constitutional law. First, I will explore the fundamentally contractual nature of the physician-patient relationship and demonstrate that the legal implications of that relationship have either been dismissed or intentionally disregarded in most, if not all, of the treatment-refusal cases. Second, I will elucidate the four state interests and the questionable procedural posture in which they become decisive factors in the outcome of treatment refusal cases. I will argue that an appropriately rigorous application of the concepts of justiciability and case and controversy, as well as the rules of procedure applicable to determination of the real party in interest, would significantly reduce the number of cases decided by the courts. At the very least, such application would compel the state to ensure the responsibility for asserting its interests as an actual party to such litigation. Thirdly, I will elucidate

1. Beneficence is a bioethical term indicating a focus on whether the giving or withholding of a particular treatment would be in the patient's best interest. It is often utilized in contradistinction to autonomy in situations in which the patient's actual wishes cannot be communicated or otherwise determined. For a thorough analysis and discussion of the principle of beneficence see T. BEAUCHAMP & J. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 194-255(3d ed. 1989).

2. As Justice Brandeis observed: "Experience should teach us to be most on our guard to protect liberty when the Government's purposes are beneficent. . . . [For] [t]he greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding." *Olmstead v. United States*, 277 U.S. 438, 479 (1928) (Brandeis, J., dissenting), *overruled by*, *Berger v. New York*, 388 U.S. 51 (1967).

3. See generally PROSSER & KEETON *ON THE LAW OF TORTS* 849-869 (5th ed. 1984) (on the Right of Privacy).

4. 381 U.S. 479 (1965).

5. Among those commentators whose recent works support the thesis of this article are: Rhoden, *The Judge in the Delivery Room: The Emergence of Court Ordered Caesareans*, 74 CALIF. L. REV. 1951 (1986); Johnson, *From Medicalization to Legalization to Politicization: O'Connor, Cruzan, and the Refusal of Treatment in the 1990's*, 21 CONN. L. REV. 685 (1989); Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375 (1988); and Nelson, Buggy & Weil, *Forced Medical Treatment of Pregnant Women: Compelling Each to Live as Seems Good to the Rest*, 37 HASTINGS L.J. 703 (1986).

and critique the state interests and the questionable manner in which they become decisive factors in the outcome of treatment-refusal cases. Finally, I will make the case for a constitutional right to privacy in healthcare decisionmaking that distinguishes privacy from autonomy. This approach protects those who are temporarily or permanently mentally incapacitated from unwarranted governmental intrusion and preserves the proper role of the family.

As a frame of reference for this analysis, I propose the following hypothetical factual situation: A thirty-eight year old male with a wife not employed outside the home and two minor children presents to his physician with a number of physical complaints that have become increasingly troublesome during the past few months. The physician performs a battery of diagnostic procedures which lead to a conclusive diagnosis of intermediate stage Hodgkins disease.<sup>6</sup> The patient's prognosis is presented to him in the following manner. If he immediately submits to intensive chemotherapy, there is a sixty to seventy percent likelihood of complete remission in nine to twelve months. Without this treatment regimen, there is a ninety percent probability that he will not survive more than eighteen months.

The patient gives full and complete consideration to all of the relevant information provided by his physician, discusses the matter at length with his wife and adult parents who live in the same community, and then advises his physician that he declines to undergo the therapy. The patient submits a letter of resignation to his employer and prepares to devote the remaining months or years of his life to quality time with his family.

Upon receiving this declaration from his patient, and having failed in his repeated efforts to dissuade the patient from a course of inaction, the physician contacts the attorney who provides legal services to his clinic. The physician files an action in a state court of general jurisdiction seeking an order "compelling the patient to submit involuntarily to the chemotherapy deemed necessary by competent medical authority to save his life and prevent the wanton, willful, and malicious abandonment of his dependents."

The distinctions between the hypothetical situation and the factual background of most reported cases are as follows: 1) the patient is not currently hospitalized; 2) the patient's refusal of treatment is unequivocal and not based on any alleged incapacity to understand and appreciate the consequences; and 3) the patient's refusal of treatment is not the product of religious scruples. I will argue, however, that in light of the applicable substantive and procedural principles, none of these distinctions should have a material impact upon the outcome of the legal proceeding.<sup>7</sup>

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6. Hodgkins disease involves malignant tumors of the immune system. For a thorough discussion of the epidemiology, etiology, natural history, clinical manifestations, and treatment, see HARRISON'S PRINCIPLES OF INTERNAL MEDICINE 1555-60 (11th ed. 1987).

7. Another factor which may influence the ultimate disposition of the case is the pa-

## II. THE NATURE OF THE PHYSICIAN-PATIENT RELATIONSHIP

### A. *Implied Contract*

How the physician-patient relationship is characterized varies with the orientation of the person making the characterization. From the standpoint of a legal analysis, there is virtual unanimity of opinion that the essential nature of the relationship is contractual.<sup>8</sup> In the typical physician-patient relationship the contract is established by implication when the patient visits the physician complaining of some ailment and the physician performs an examination usually coupled with other diagnostic procedures in order to determine the cause of the symptoms. At this point the only written evidence of a contractual relationship is a few standard forms which indicate the essential aspects of the patient's medical history and the nature of his insurance coverage. There has probably been no discussion between physician and patient of important matters such as the physician's customary charges, the patient's religious or philosophical views that might impact upon modes of treatment, respective views on informed consent and the nature and extent of the information to be exchanged in the process of medical decisionmaking, or other issues that may have life and death implications for the patient.

The amorphous nature of this unwritten contract is rooted in the historically paternalistic nature of the relationship.<sup>9</sup> In the past, the patient sought out the physician in much the same way as the New Age pilgrim approaches the guru, in a posture of awe, reverence, and submission. The physician unilaterally defined the nature and conditions of the relationship. The role of the patient was limited to answering the physician's questions, strictly adhering to his admonitions, and seeing to it that the charges for his professional services were promptly paid. There is much ongoing debate as to the extent to which society has moved away from this paternalistic model;<sup>10</sup> however, with the exception of a few cases having to do with refusal of treatment by women in the third trimester of pregnancy,<sup>11</sup> the appellate decisions in all jurisdictions uphold the legal right of the competent patient to accept all, some

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tient's gender. A recent article has analyzed "all appellate-level, civil, state 'right-to-die' cases involving incompetent, adult patients" and concluded that gender profoundly affects judicial analysis of right-to-die cases. Miles & August, *Courts, Gender and 'The Right to Die'*, 18 LAW, MEDICINE AND HEALTH CARE 85 (1990).

8. See, e.g., S. FISCINA, *MEDICAL LAW FOR THE ATTENDING PHYSICIAN: A CASE ORIENTED ANALYSIS* 3-8 (1982); A. HOLDER, *MEDICAL MALPRACTICE LAW* 1-7 (2d ed. 1978).

9. Thomasma, *Beyond Medical Paternalism and Patient Autonomy: A Model of Physician Conscience for the Physician-Patient Relationship*, in *BIOETHICS: READINGS AND CASES* 113 (B. Brody & H. Engelhardt 1987).

10. One of the most articulate and persuasive works that addresses this subject is J. KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984). Although the overall topic of this work is the doctrine of informed consent, Professor Katz, a physician, carefully explicates the paternalistic nature of the physician-patient relationship and convincingly establishes it as the basis for the late and grudging acceptance among the medical profession of the "shared decisionmaking" approach to the physician-patient encounter.

11. *Jefferson v. Griffin Spalding County Hosp.*, 247 Ga. 86, 274 S.E.2d 457 (1981); *Raleigh Fitkin-Paul Morgan Mem. Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537, cert. denied, 377 U.S. 985 (1964).

or none of the physician's recommendations unless a countervailing state interest is found to be superseding.<sup>12</sup>

As with most other contractual relationships, that between physician and patient is mutually revocable. The patient can, without question, withdraw from and terminate the relationship at any time with payment for services rendered to date as the only obligation; however, in recognition of the special vulnerability of a patient in need of medical care, the physician's ability unilaterally to terminate the relationship is significantly more circumscribed. If the physician is to avoid being subject to an allegation of patient abandonment, he must give the patient reasonable notice of his withdrawal, assist the patient in securing another physician, and provide essential treatment to the patient for an interim period of reasonable duration.<sup>13</sup>

### B. *Fiduciary Relationship*

The wide disparity of knowledge and experience in medical matters between physician and patient justifies the characterization of the relationship as fiduciary. A recognition of this disparity and an effort to redress the imbalance is found in the evolving doctrine of informed consent.<sup>14</sup> Before a physician can undertake any mode of diagnosis or treatment that involves significant risks, he must first provide the patient with a package of relevant information regarding such things as the nature and purpose of the procedure or treatment, its anticipated risks, benefits, and consequences, the feasible alternative procedures and treatments and their risks, benefits, and consequences, and the consequences to the patient if nothing is done.<sup>15</sup> There have been a significant number of medical malpractice cases in which the major issue was the alleged failure of the physician to provide the patient with the appropriate amount of information so as to render his consent truly "informed."<sup>16</sup> The legal recognition of the applicability of the doctrine of informed consent to the physician-patient relationship suggests that shared decisionmaking should replace paternalistic decisionmaking.<sup>17</sup> The actions of the physician in our hypothetical case, as well as actual

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12. See, e.g., A. MEISEL, *THE RIGHT TO DIE* 45-46 (1989).

13. See S. FISCINA, *supra* note 8, at 19-30 and A. HOLDER, *supra* note 8, at 372-389.

14. There is a wealth of literature on the subject of informed consent. For this reason, I will eschew a detailed discussion and analysis of the doctrine, and refer the reader to the following recent and comprehensive treatments of the subject. F. ROZOVSKY, *CONSENT TO TREATMENT: A PRACTICAL GUIDE* (2d ed. 1990); R. FADEN & T. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* (1986); A. ROSOFF, *INFORMED CONSENT: A GUIDE FOR HEALTH CARE PROVIDERS* (1981).

In addition to reducing the knowledge gap between physician and patient, the doctrine of informed consent (and hence refusal) is a judicial assertion that the principle of patient autonomy, rather than physician paternalism, should govern the relationship.

15. A. ROSOFF, *supra* note 14, at 318.

16. An exhaustive list of the cases would be neither useful nor practical; however, the following cases discuss the major considerations: *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972); *Cobbs v. Grant*, 8 Cal. 3d 229, 104 Cal Rptr. 505, 502 P.2d 1 (1972); *Natanson v. Kline*, 186 Kan. 393, 350 P.2d 1093, reh'g denied, 187 Kan. 186, 354 P.2d 670 (1960).

17. Paul Ramsey, a medical ethicist, argues that the proper characterization of the

cases discussed in section III *infra*, demonstrate the persistent paternalistic perception of the relationship by many physicians.<sup>18</sup>

### C. Confidentiality and Privacy

Another significant feature of the physician-patient relationship is the patient's expectation of confidentiality. The law recognizes and reinforces this expectation in a number of ways. The records which document the patient's care and treatment, whether they are in the custody of the individual physician or a hospital, are deemed confidential. Only with the written consent of the patient may any portion of the records be made available to a third person. Furthermore, in almost every jurisdiction there is a statutory recognition of the physician-patient privilege which provides that the physician may not be required to divulge private and personal information about his patient without that patient's prior consent.<sup>19</sup> There are limited exceptions to the rule, of course, such as when the patient is a party to the litigation and may reasonably be presumed to have put his medical condition or the particulars of the medical care and treatment in issue. Additional exceptions to the general rule of confidentiality are statutory reporting requirements in circumstances such as contagious disease, wounds inflicted by deadly weapons, and child abuse. These latter exceptions are clearly instances in which certain societal interests have been deemed so significant as to override the patient's need for and expectation of privacy.<sup>20</sup>

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physician-patient relationship is that of partnership rather than contract. His reasoning is as follows:

I suggest that men's capacity to become joint adventurers in a common cause makes possible a consent to enter the relation of patient to physician . . . . This means that *partnership* is a better term than *contract* in conceptualizing the relation between patient and physician. . . . The fact that these . . . people are joint adventurers is evident from the fact that consent is a continuing and repeatable requirement. We can legitimately appeal to permissions presumably granted by or implied in the original contact only to the extent that these are not incompatible with the demands of an ongoing partnership sustained by an actual or implied *present* consent and terminable by any present or future dissent from it. For this to be at all a human enterprise—a covenantal relation between the man who performs these procedures and the man who is patient in them—the latter must make a reasonably free and an adequately informed consent. Ideally, he must be constantly engaged in doing so. This is basic to the cooperative enterprise in which he is one partner.

P. RAMSEY, *THE PATIENT AS PERSON* 6 (1970).

18. Although many fine opinions have been written by judges in medical malpractice cases alleging a lack of informed consent, this purported judicial recognition of a person's dominion over his own body shrinks to virtual invisibility in the treatment-refusal cases.

19. The Colorado statute is typical. It provides generally that:

A physician, surgeon, or registered professional nurse duly authorized to practice his profession pursuant to the laws of this state or any other state shall not be examined without the consent of his patient as to any information acquired in attending the patient which was necessary to enable him to prescribe or act for the patient . . . .

COLO. REV. STAT. § 13-90-107(1)(d) (1987). The statute creates certain exceptions, such as when the healthcare provider is sued for malpractice by the patient, or when the provider's clinical services are under review by appropriate administrative agencies charged with insuring professional competence.

20. Perhaps the furthest extension of the duty of a physician to disclose what would otherwise be privileged and confidential aspects of his relationship to a patient is the line

Except for the situations mentioned above, government's role has been to foster and protect the relationship between physician and patient. State licensing requirements protect the public from unskilled or incompetent physicians, and Medicaid, Medicare and medical indigence legislation promotes the formation of the physician-patient relationship by subsidizing the cost of care to disadvantaged groups of citizens. None of this suggests, however, either the right or the responsibility of government or society to dictate the terms of the relationship between the individual patient and his physician.<sup>21</sup>

The fact that today a much larger portion of physician-patient encounters take place in hospitals than ever before does not, as a matter of law, alter the privileged nature of the relationship. In a major medical center the individual practitioner is augmented by a "team" comprised of an attending physician from one or more departments, senior and junior residents, staff nurses, technologists, therapists, and social workers.<sup>22</sup> The inclusion of these additional parties facilitates the relationship between the primary attending physician and the patient. It does not, however, diminish the patient's right to and expectations of privacy, confidentiality and autonomy.<sup>23</sup>

When a physician seeks to override a competent patient's refusal to consent to a recommended treatment, he breaches the privacy and confidentiality of the relationship. Challenging a patient's decision involves filing a petition with the court documenting the patient's medical condition. Unless special procedures are followed, private and personal information about the patient becomes a matter of public record. Beyond the pure legalities of this breach of an implicit element of privacy and confidentiality, the psychological impact upon the interpersonal dynam-

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of cases flowing from *Tarasoff v. Regents of the Univ. of Cal.*, 17 Cal. 3d 425, 131 Cal. Rptr. 14, 551 P.2d 334 (1976), in which an imminent threat of harm to an identifiable individual was communicated to a psychiatrist. The physician, in such a situation, was held to have a duty to warn the person at risk, or appropriate authorities, which took precedence over patient confidentiality.

21. Leon Kass, a physician and bioethicist, emphasizes two important aspects of the physician-patient relationship. First, that it encompasses the "intimate life—world" of the patient which includes the family or household. Second, that the patient admits this professional stranger into his "life—world" in the hope of a cure, and upon the condition "that he keeps private what he sees and hears." L. KASS, *TOWARD A MORE NATURAL SCIENCE: BIOLOGY AND HUMAN AFFAIRS*, 237-38 (1985).

22. See Rich, *Malpractice Issues in the Academic Medical Center*, 13 J.C.U.L. 149, 153-56 (1986).

23. As medical care has become more technologically complex, tort law has attempted to adapt by recognizing the changed circumstances. For example, the "Captain of the Ship" doctrine, which holds that the surgeon in the operating room is ultimately responsible for the acts and omissions of the entire surgical team, including the anesthesiologist, has all but disappeared in recognition of the independent roles and responsibilities of each member of the surgical team. *But see* *Schultz v. Mutch*, 165 Cal. App. 3d 66, 211 Cal. Rptr. 445 (1985). Also, the doctrine of "corporate negligence" was created in recognition of the fact that the modern hospital is not simply a building in which physicians treat their patients. Rather, it is a corporate entity that undertakes separate and independent responsibilities toward patients who are admitted by members of its medical staff. *Johnson v. Misericordia Community Hosp.*, 99 Wis. 2d 708, 301 N.W.2d 156 (1981); *Darling v. Charleston Community Mem. Hosp.*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied*, 383 U.S. 946 (1966).



ics of the relationship is devastating. How can the requisite mutual trust and confidence ever be restored when the physician takes an adversarial posture with regard to his patient?<sup>24</sup>

There is an exquisite irony in such scenarios when one considers the antipathy that physicians have historically demonstrated for lawyers and judges. Physicians have taken the position that the law should stay out of the medical practice, that the physician-patient relationship is an area in which the law is neither competent, sensitive, nor has legitimate authority. Despite such uniformly expressed protestations, over the last three decades a growing number of physicians have invoked the legal process when the intransigence of their own patients differs from the technological imperative of modern medical practice.<sup>25</sup> The Hippocratic admonition: "Above all else do no harm" has been amended to read: "Above all else do something," even if you must breach the confidentiality of the relationship, transform your patient into a legal adversary, and write your prescription in the form of a court order for treatment against the patient's will.

What motivates the physician who seeks to impose treatment upon a non-consenting patient? Surely, the sociological phenomenon of employing a remedial measure simply because it exists (Technological Imperative) is an insufficient explanation. Modern physicians are more than simply technocrats. The reason most often mentioned by individual physicians and hospital administrators (hospitals are often the petitioners in such proceedings), is the fear of a subsequent malpractice claim by a member of the patient's family.<sup>26</sup> The gravamen of such a

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24. The evils of coercive medical practice, made possible through the agency of the judiciary in treatment refusal cases, are the same as the evils of coercive legislation enacted for the allegedly noble purpose of maintaining the moral fiber of society. Physicians, in practicing their art, are supposed to be guided by compassion for the patient and his condition. Yet, as Michael Perry has observed:

To coerce someone to make a choice she does not want to make is to cause her to suffer. [C]oercing someone to do something she not merely does not want to do, but believes destructive of her well-being to do, even forbidden for her to do . . . causes extreme suffering. And extreme resentment. A moral community that values individual conscientiousness or personal integrity—that believes that ultimately, after careful, informed deliberation, a person should choose on the basis of conscience—will be wary, therefore, about pursuing a legislative strategy of extreme coercion.

M. PERRY, *MORALITY, POLITICS, AND LAW: A BICENTENNIAL ESSAY* 100-01 (1988).

25. Eric Fromm posits two principles of the technological system or "technetronic society," the first of which is the maxim that "something *ought* to be done because it is technically *possible* to do it." Fromm also credits a paper by Hasan Ozbekhan entitled "The Triumph of Technology: 'Can' Implies 'Ought,'" for this lucid observation of the phenomenon: "Thus, feasibility, which is a strategic concept, becomes elevated into a normative concept, with the result that whatever technological reality indicates we *can* do is taken as implying that we *must* do it." E. FROMM, *THE REVOLUTION OF HOPE: TOWARD A HUMANIZED TECHNOLOGY* 33-34 (1968).

For a discussion of the operation of the principle in the medical context, see R. WEIR, *ABATING TREATMENT WITH CRITICALLY ILL PATIENTS* 30-33 (1989).

26. Professor Alexander Capron, in a recent article adapted from a presentation to the National Conference of the State Judiciary on Bioethical Issues, addresses this concern:

Frankly, this fear seems greatly exaggerated. . . . First, if informed decisionmaking has occurred . . . there is little likelihood of a suit being brought and even less of

civil suit would be that the patient was "incapacitated" to such an extent that his refusal of consent was not valid. Thus the failure of the healthcare providers to recognize this situation and obtain judicially-approved, substituted consent resulted in harm to the patient for which they could be held liable in damages.

Undermining this "justification," however is the fact that most of the refusal-of-treatment cases, regardless of whether they involve competent or allegedly incapacitated patients, do not end with a ruling by a trial court judge, even when the healthcare provider brings the action. The losing healthcare provider regularly appeals these cases to the highest court of the jurisdiction.<sup>27</sup> Such prosecutorial zeal can hardly be explained by a fear of malpractice claims, for surely a trial court ruling upholding the patient's refusal of treatment would constitute an adequate defense to any such suit and would be an even more compelling defense to criminal prosecution.<sup>28</sup> Furthermore, concern over future litigation cannot legally or ethically justify seeking to override a competent patient's refusal of consent any more than it would justify "dumping" a patient in dire condition on another hospital.<sup>29</sup>

Another argument physicians assert in justification for taking their patients to court to seek authorization of treatment in the face of an informed refusal is that not to do so would violate the Hippocratic Oath and assist the patient in suicide. The Hippocratic Oath portrays the physician as a benign, authoritarian, paternalistic decisionmaker who takes full responsibility for determining what the patient requires in the way of medical care. It contains no recognition that the patient has any decisionmaking role in determining his medical fate.<sup>30</sup> This anachronistic view of medical decisionmaking has clearly been superseded by the common law of informed consent and therefore cannot reasonably be asserted by physicians as justification for litigating treatment refusals by patients.<sup>31</sup>

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its succeeding. As for the risk of criminal prosecution, physicians are never convicted for carrying out decisions mutually made with qualified surrogates, much less patients. Thus, there should be little cause for judges to intervene simply to dispense advance absolution for health care providers.

Capron, *The Burden of Decision*, 20 HASTINGS CENTER REP. 37 (1990).

27. See, e.g., *Fosmire v. Nicoleau*, 75 N.Y.2d 218, 551 N.E.2d 77, 551 N.Y.S.2d 876 (1990); *In re Westchester County Medical Center*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988).

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

29. "Dumping" is a new term of art in health care delivery referring to the practice of private hospitals which do not want to render necessary treatment to uninsured or underinsured patients inappropriately transferring them to public hospitals in the area. The practice became so widespread that Congress enacted federal anti-dumping legislation as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164-67 (codified at 42 U.S.C. § 1395dd (1986)). For a discussion of the patient-dumping phenomenon and the effects of COBRA, see Enfield & Sklar, *Patient Dumping in the Hospital Emergency Department: Renewed Interest in an Old Problem*, 13 AM. J.L. & MED. 561 (1988).

30. E. PELLEGRINO & D. THOMASMA, FOR THE PATIENT'S GOOD: THE RESTORATION OF BENEFICENCE IN HEALTHCARE 4 (1988).

31. Faden and Beauchamp observe that:

[M]edicine was jolted from an exclusive preoccupation with a beneficence model

As for the notion that accepting the patient's decision would be tantamount to assisting suicide, the American Medical Association and major medical specialty organizations have promulgated ethical rulings and other statements of principle to the effect that the withholding or withdrawal of life-sustaining treatment does not constitute homicide, suicide, or aiding, abetting or assisting suicide, and that rather, the underlying disease process is the ultimate cause of the patient's death.<sup>32</sup> Furthermore, in situations where the attending physician is uncomfortable with following the patient's decision the patient can usually be transferred to a physician who can abide by the patient's wishes.

### III. PROCEDURAL ISSUES IN TREATMENT REFUSAL CASES

Customarily, when an individual or an entity initiates a legal action against another individual or entity, the purpose is to endorse a legal right that the plaintiff has vis-a-vis the defendant. Except for instances in which one party is legally empowered to bring an action on behalf of another, such as a parent on behalf of a child or a guardian on behalf of an incompetent, courts will dismiss a legal action which is not prosecuted by "the real party in interest."<sup>33</sup> The treatment refusal cases, however, constitute a curious exception to this general principle of the law of civil procedure. In most of these cases, the healthcare provider does not assert *per se* a legal right to treat the patient over her objection or a legal duty on the part of the patient to submit to the treatment directives of the healthcare provider. The reason they do not will be discussed later in this section. Rather, the health care provider purports to assert certain interests of the state that may override the common law and constitutional (state & federal) rights of the patient to refuse treatment. Because of the pivotal role these interests play in the judicial analysis and outcome of treatment refusal cases, I will analyze them at some length in the first part of this section. I will then discuss the process by which courts transform treatment refusal cases into actions which balance certain state interests against the patient's privacy and autonomy interests. It is important to remember that such cases typically arise in one of two formats. Either the physician or the healthcare insti-

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to awareness of an autonomy model of responsibility for the patient. Physicians had heretofore considered the physician-patient relationship by beginning from the patient's submission to the physician's professional beneficence. The law enlarged that perspective by viewing the relationship within a wider social framework, emphasizing instead that patients voluntarily initiate the relationship and have the right to define its boundaries to fit their own ends.

R. FADEN & T. BEAUCHAMP, *supra* note 14, at 142-43.

32. See e.g. AMERICAN MEDICAL ASSOCIATION, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS § 2.18 (1986).

33. Fed. R. Civ. P. 17(a) provides in pertinent part that:

Every action shall be prosecuted in the name of the real party in interest. . . . No action shall be dismissed on the ground that it is not prosecuted in the name of the real party in interest until a reasonable time has been allowed after objection for ratification of commencement of the action by, or joinder or substitution of, the real party in interest; and such ratification, joinder, or substitution shall have the same effect as if the action had been commenced in the name of the real party in interest.

tution as plaintiff seeks a court order authorizing treatment over the defendant patient's objection, or the patient as plaintiff seeks a court order requiring the defendant healthcare provider to honor the patient's refusal of treatment. My position is that there are significant procedural infirmities which should preclude the courts from granting the relief sought by the plaintiff in the former situation, and substantive infirmities which should preclude the courts from denying the relief sought in the latter situation.

Courts circumvent these infirmities by balancing the interests of the patient and the state. Since in most cases the courts do so without the state being a party to the litigation, I argue that this approach is contrary to the fundamental procedural law and inures to the detriment of the patient. Throughout the section I also highlight procedural tools available to the patient and her counsel when attempting to slow-down and reverse the juggernaut that treatment refusal cases tend to become.

#### A. *The Four State Interests*

##### 1. Origins of the Interests

The case most often cited for the existence, identity and applicability of overriding state interests is *Superintendent of Belchertown State School v. Saikewicz*;<sup>34</sup> however, as in many other cases that cite it as authority, *Saikewicz* merely names the four interests without giving any historical, philosophical, or legal analysis. It then proceeds to apply them to the facts of the case at bar. Although many commentators have correctly pointed out that in the case of a competent adult these state interests rarely prevail, only one commentator has seriously challenged their actual validity or applicability.<sup>35</sup>

It has also been suggested that *Saikewicz* actually derived the four state interests from the *Georgetown College* case.<sup>36</sup> Certainly Judge Skelly

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34. 373 Mass. 728, 741, 370 N.E.2d 417, 425 (1977). The four state interests are: "(1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) maintaining the ethical integrity of the medical profession." This case involved a profoundly retarded, non-verbal 67 year old man. He suffered these afflictions all of his life. After being diagnosed with leukemia, chemotherapy was recommended by his physician. Although the court acknowledged that the average person would, in all likelihood, consent to the treatment, in Mr. Saikewicz's situation it was held to be inappropriate. Several factors influenced the court's decision: the patient would not understand the nature and purpose of the treatment, and therefore, would probably resist it; the pain, nausea and vomiting it would engender would appear to Mr. Saikewicz as torture; and even with the treatment the prognosis was very poor — only a 30% to 50% chance of a brief remission.

Although this case is heavily relied upon for the application of the four state interests in treatment refusal cases, the reasoning of the court in applying a substituted judgment standard to a patient who has never been competent has generated unprecedented criticism—both in terms of volume and harshness—in the literature. See, e.g., Ramsey, *The Saikewicz Precedent: What's Good for an Incompetent Patient*, 8 Hastings Center Rep., Dec. 1978, at 36, 39.

35. Oberman, *Withdrawal of Life Support: Individual Autonomy Against Alleged State Interests in Preserving Life*, 20 Loy. U. CHI. L.J. 797 (1989).

36. Morgan & Harty-Golder, *Constitutional Development of Judicial Criteria in Right-to-Die Cases: From Brain Dead to Persistent Vegetative State*, 23 WAKE FOREST L. REV. 721, 736 (1988).

Wright, in his opinion supporting the order of the transfusion over the patient's objection, justifies his ruling by the *parens patriae* power of the state. This power protects the lives of children and adults whose capacity to make decisions is impaired. Further, it promotes society's legal and moral sanctions against suicide. Additionally, it facilitates the state's interest in preventing parents from abandoning their minor children.<sup>37</sup>

While the doctrine of physician-patient privilege provided a basis for Judge Wright's decision, the urgent circumstances of the case clearly precluded a careful study of the legitimacy of the state's interests in this situation. It is evident that these circumstances played a role in Judge Wright's decision. In reviewing Judge Wright's decision, Judge Miller of the court of appeals stated:

[Judge Wright was] . . . impelled, I am sure, by humanitarian impulses and doubtless was himself under considerable strain . . . . In the interval of about an hour and twenty minutes between the appearance of the attorneys at his chambers and the signing of the order at the hospital, the judge had no opportunity for research as to the substantive legal problems and procedural questions involved. He should not have been asked to act in these circumstances.<sup>38</sup>

Sadly, many appellate courts have reviewed similar hasty trial court rulings and have not bothered carefully and critically to analyze the dubious origins of these four state interests which remain obstacles to patients who wish to refuse necessary medical treatment.<sup>39</sup>

The moral and political basis of government in the United States is indisputably the promotion of respect for and protection of each citizen's right to life, liberty, and the pursuit of happiness.<sup>40</sup> Cases such as *Jacobson v. Massachusetts*,<sup>41</sup> upholding compulsory vaccination against smallpox, limit a person's right to refuse medical "treatment" on the grounds that the general public safety and welfare would be unreasonably jeopardized.<sup>42</sup> Conversely, there are no public health, safety, or wel-

37. *In re President of Georgetown College*, 331 F.2d 1000, 1007-09 (D.C. Cir.), cert. denied *sub nom.*, *Jones v. President of Georgetown College, Inc.*, 377 U.S. 978 (1964).

38. *Id.* at 1014. In treatment refusal cases there appears to be a judicial imperative to act that parallels the medical one. It seems that judges, like the physicians who petition them, all too readily succumb to the admonition "above all else, do something." *Cf. infra* notes 76 and 77 and accompanying text.

39. This includes the U.S. Supreme Court decision in *Cruzan*, which lists and gives constitutional stature to these interests without critical analysis or discussion. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2843 (1990).

40. Declaration of Independence.

41. 197 U.S. 11 (1905).

42. The possession and enjoyment of all rights are subject to such *reasonable* conditions as may be deemed by the governing authority of the country *essential* to the safety, health, peace, good order, and morals of the community. Even liberty itself, the greatest of all rights, is not unrestricted license to act according to one's own will. It is only freedom from restraint under conditions essential to the *equal enjoyment* of the same right by others.

*Id.* at 26-27 (Emphasis added) (quoting *Crowley v. Christensen*, 137 U.S. 86, 89 (1890)). It is interesting to note, in the context of the discussion of forcing treatment on unwilling patients, that the Supreme Court prioritized liberty, not life, as the greatest of all rights.

fare issues raised when an individual patient declines treatment proffered by a healthcare provider.

## 2. Preserving Life

The first state interest is said to be that of "preserving life" or, using the ecclesiastical phraseology, maintaining the sanctity of life. This interest involves two separate but related concerns. The first is an interest in preserving the life of the particular patient in the case at bar; the second is a more generalized interest in maintaining the sanctity of all life.<sup>43</sup> The implicit assumption justifying this state interest as one which *must* be considered in treatment refusal cases, is that if the state, through its licensed medical practitioners, hospitals and courts, allowed patients to decide to refuse life-sustaining treatment, it would inevitably result in a widespread trend which would ultimately undermine the proposition that life is sacred. Without invading the province of the next section of this article, it is important to note the implications of judicially confronting a patient who has refused a recommended medical therapy after due and informed deliberation with the long term societal implications of this most private and personal decision. By introducing this element into the equation, the courts are asserting that a competent adult may be commandeered into service as living proof of his government's regard for life by being forced to undergo treatment that she has consciously rejected.<sup>44</sup> To do so, even in only one case out of a hundred, is to violate the fundamental Kantian principle that individuals are to be treated as ends and not as means.<sup>45</sup>

Certainly those who question the legitimacy of and beneficent motivation for asserting such a countervailing state interest could take some comfort if the courts were openly to refuse to discuss the state's interest in the sanctity of life on the ground that it did not apply to at least some portion of treatment-refusal cases. There are, however, no reported decisions in which a court has refused to accept jurisdiction on the grounds that a private physician has no legal right to force treatment on a competent patient, or that the state is not a party to the proceeding so as to properly invoke either the *parens patriae* power or the four state interests.

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This view, or course, is consistent with the perceptions of the Founders, most memorably stated by Patrick Henry, that a life lived in the absence of freedom is not preferable to death. Furthermore, the human bondage inflicted by many diseases rivals and often surpasses any other kind known to man.

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

44. As Justice Stevens stated in his dissenting opinion in *Cruzan*: "However commendable may be the State's interest in human life, it cannot pursue that interest by appropriating Nancy Cruzan's life as a symbol for its own purposes." *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2892 (1990) (Stevens, J., dissenting).

45. I. KANT, *GROUNDWORK OF THE METAPHYSIC OF MORALS* 96 (H. Paton trans. 1949). The instances in which this proposition is more frequently violated involve pregnant women. See generally Rhoden, *The Judge in the Delivery Room: The Emergence of Court-Ordered Caesareans*, *supra* note 5.

### 3. Prevention of Suicide

The second state interest is the prevention of suicide. The weight of authority currently supports the proposition that refusing life-saving medical treatment, whether it is the amputation of a gangrenous limb<sup>46</sup> or the use of a mechanical ventilator,<sup>47</sup> does not constitute suicide. The ensuing death is deemed to be the result of the underlying medical condition, not the patient's act of refusing treatment.<sup>48</sup> The moment we attempt to qualify the right to consent or refuse to consent to treatment based upon the purported "wisdom" of the decision or its potentially lethal consequences (when they are wholly or primarily self-regarding), the right disappears in a swarm of qualifications and judgmental characterizations. The right to choose should not be limited by the stipulation that it be a wise choice.<sup>49</sup> It simply must be a choice that does not invade the rights of others. Neither physicians, hospitals, nor even immediate family members have rights that are in any way invaded by a patient's exercise of such a choice. To argue to the contrary, in the case of the members of the immediate family, for example, would be to assert that a spouse or minor child could prevent the other adult parent from engaging in any inherently dangerous activity, such as skydiving, hang-gliding, or mountain-climbing, on the grounds that he or she created an unreasonable risk of death or grave injury that could deprive the family of its "right" to his or her continued existence in the home. We have never, as a society founded upon the principles of liberty and self-determination, embraced such a proposition.<sup>50</sup>

### 4. Protection of Innocent Third Parties

The third state interest is the protection of innocent third parties. In treatment refusal cases, the third party is usually a fetus or minor child of the patient.<sup>51</sup> As discussed in the next section, it is this author's

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46. *Lane v. Candura*, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978); *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (1978); *In re Beth Israel Medical Center*, 136 Misc. 2d 931, 519 N.Y.S.2d 511 (N.Y. Sup. Ct. 1987).

47. *John F. Kennedy Memorial Hosp. v. Blutworth*, 452 So. 2d 921 (Fla. 1984); *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980); *In re Grant*, 109 Wash. 2d 545, 747 P.2d 445 (1987).

48. See generally A. MEISEL, *supra* note 12, at 66-69 (1989).

49. *Bouvia v. Superior Ct.*, 179 Cal. App. 3d 1127, 1145, 225 Cal. Rptr. 297, 306 (Cal. App. Dep't Super. Ct. 1986).

50. J.S. Mill's statement regarding private decisionmaking is even more compelling in the refusal of treatment context:

[W]ith respect to his own feelings and circumstances, the most ordinary man or woman has means of knowledge immeasurably surpassing those that can be possessed by anyone else. The interference of society to overrule his judgment and purposes in what only regards himself, must be grounded on general presumptions; which may be altogether wrong and, even if right, are as likely as not to be misapplied to individual cases, by persons no better acquainted with the circumstances of such cases than those who look at them merely from without.

J. MILL, *ON LIBERTY* 74 (E. Rapaport 1978).

51. The issues raised by the refusals of pregnant women to consent to procedures necessary to save the life of their fetuses are sufficiently complex to be beyond the scope of this article. Therefore, the discussion that follows will be restricted to refusals of treatment by the parents of minor children. For cogent discussion of the issues with regard to fe-

view that there are significant constitutional problems inherent in the contention that being the parent of a minor child, particularly a single or an indigent parent, somehow circumscribes one's right to give or withhold consent to his or her own medical treatment as opposed to that of the minor child.<sup>52</sup> Beyond the constitutional dimension, however, is the fact alluded to above that society does not purport to circumscribe fundamental life choices of adults solely on the grounds that they are parents. Fathers and mothers of minor children can engage in the full range of lawful but nevertheless inherently dangerous activities — they can use tobacco products and consume alcoholic beverages, they can even separate, divorce, and permanently remove themselves from the minor child's life, subject only to state laws governing financial support. Indeed, the state even countenances the ultimate voluntary abandonment, placing the child in an adoptive home. Logically an individual's right to autonomy, privacy and bodily integrity inherent in the informed consent doctrine should hold with the same vigor for parents of minor children as it does for any other competent adult.

### 5. Medical Ethics

The last of the four interests, maintaining the ethical integrity of the medical profession, is perhaps the most perplexing of all. Given the contractual nature of the physician-patient relationship,<sup>53</sup> one might reasonably ask how abiding by a competent patient's decision whether or not to consent to a particular procedure could ever compromise the ethics of the physician. Unfortunately, the courts have given credence to the proposition that abiding by patient refusals may compromise the ethics of the profession.<sup>54</sup> Judicial recognition of the merits of such an argument is tantamount to creating a common law right of physicians to

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tuses, see: Nelson, Buggy & Weil, *supra* note 5; Rhoden, *supra* note 5; Note, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 YALE L.J. 599 (1986).

52. See *infra* note 208-210 and accompanying text. The legal basis and ethical propriety of precluding parents from withholding necessary medical treatment from their minor children is well established. See generally Annotation, *Power of Court or Other Public Agency to Order Medical Treatment over Parental Religious Objections for Child Whose Life Is Not Immediately Endangered*, 52 A.L.R.3d 1118 (1973).

53. See *supra* notes 13-17 and accompanying text.

54. The case of *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965), involved far more than a mere allusion to the interest. In what appears to be a shocking instance of judicial duplicity, the federal judge who decided the case went to the bedside of a hospitalized patient who was refusing on religious grounds a transfusion as part of the treatment for a bleeding ulcer. After reassuring the patient that the court had no power to force a transfusion upon him, and that he was free to continue to decline the transfusion, the judge thereupon signed an order allowing the hospital to administer such transfusions as the attending physicians deemed necessary to save the patient's life. In the opinion issued in conjunction with the order, the judge explained his ruling as follows:

In the difficult realm of religious liberty it is often assumed only the religious conscience is imperiled. Here, however, the doctor's conscience and professional oath must be respected. In the present case the patient voluntarily submitted himself to and insisted upon medical care. Simultaneously he sought to dictate to the treating physicians a course of treatment amounting to medical malpractice. To require these doctors to ignore the mandates of their own consciences, even in the name of free religious exercise, cannot be justified under these circum-



practice paternalistic medicine. This so-called state interest gives new meaning to the concept of "therapeutic belligerence."<sup>55</sup>

Lurking beneath this state interest is an attitude that individuals who are not prepared to submit fully to the recommendations of physicians or hospitals should stay away from both. In justifying the hospital's action in bringing the *Georgetown College* case, Judge Wright says: "Mrs. Jones sought medical attention and placed on the hospital the legal responsibility for her proper care. In its dilemma, not of its own making, the hospital sought judicial direction."<sup>56</sup> Judge Wright ignores the fact that part of the hospital's legal responsibility to each patient is to undertake invasive procedures only when the patient has given a valid consent.

In the same vein, a commentator has admonished the independent-minded patients and patients whose religious convictions conflict with some aspects of accepted medical practice requiring them to stay out of hospitals.<sup>57</sup> In one final example, the court in *Long Island Jewish-Hillside Medical Center v. Levitt*,<sup>58</sup> states, "The Court takes note that once Mr. Levitt became a patient at [the hospital], it was the responsibility of the hospital and doctors to treat him" (impliedly even without his consent). Such language transcends even the most rigid views of medical paternalism by suggesting that entering a hospital or initiating a physician-patient relationship is akin to indentured servitude in that the patient is denied any decisionmaking responsibility.<sup>59</sup> Fortunately, we have advanced our thinking somewhat since the above examples. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has promulgated a "Patient's Bill of Rights,"<sup>60</sup> and the major medical

stances. The patient may knowingly decline treatment, but he may not demand mistreatment.

*Id.* at 754. It is hard to imagine a case in which a patient's refusal of medical treatment necessary to save his life would not come within this court's definition of "mistreatment."

55. E. PELLEGRINO & D. THOMASMA, FOR THE PATIENT'S GOOD: THE RESTORATION OF BENEFICENCE IN HEALTH CARE 94 (1988).

56. *In re* President of Georgetown College, 331 F.2d 1000, 1007 (D.C. Cir.), *cert. denied sub nom.*, *Jones v. President of Georgetown College, Inc.*, 377 U.S. 978 (1964).

57. Sharpe & Hargest, *Lifesaving Treatment for Unwilling Patients*, 36 FORDHAM L. REV. 695, 706 (1968). Interestingly, elsewhere in this article the authors acknowledged that the standing of physicians and hospitals in treatment refusal cases, either to assert their own interests or those of the state, is highly questionable in light of the fact that treatment refusals are the exception and citizens do not have a legal responsibility to submit to medical care either to please healthcare providers or to maintain themselves for society's benefit. *Id.* at 698-704.

58. 73 Misc. 395, 396, 342 N.Y.S.2d 356, 358 (Sup. Ct. 1973).

59. At one point the Hippocratic Oath describes the physician-patient relationship as being between one who orders and one who obeys. "Oath of Hippocrates," in HIPPOCRATES, LOEB CLASSICAL LIBRARY 289 (W. Jones trans. 1972).

60. In order to be accredited, hospitals must adopt a statement of patients' rights that provides, in pertinent part:

The patient shall not be subjected to any procedure without his voluntary, competent, and understanding consent or that of his legally authorized representative. . . .

The patient may refuse treatment to the extent permitted by law. When refusal of treatment by the patient or his legally authorized representative prevents the provision of appropriate care in accordance with professional standards, the relationship with the patient may be terminated upon reasonable notice.

organizations have issued statements that it is not a violation of any ethical principles of medicine to withhold or withdraw life-sustaining treatment at the request of the patient or a proper surrogate, or when such treatment cannot reasonably be expected to benefit the patient.<sup>61</sup>

### B. *Justiciability and Standing*

The vast majority of treatment refusal cases are decided by state courts. The immediate and significant distinction between state and federal courts is jurisdiction. Federal courts are characterized as courts of limited jurisdiction. The practical significance of this characterization is that a person seeking to invoke the jurisdiction of a federal court must, as a condition precedent, demonstrate that the case which he is bringing "is within the competence of such a court."<sup>62</sup> This requirement is based upon the presumption that a federal court lacks jurisdiction in a particular case unless the plaintiff or petitioner has demonstrated that jurisdiction over the subject matter of the litigation exists.<sup>63</sup> A finding of subject matter jurisdiction, however, is simply the first step. Questions of justiciability and standing must also be answered in the plaintiff's favor before the court may properly proceed with the case. Furthermore, federal subject-matter jurisdiction extends only to "cases" and "controversies."<sup>64</sup> These terms denote two distinct requirements. The first is that the question at issue in the litigation must be presented in a genuinely adversarial context as well as in a form which has been historically accepted "as capable of resolution through the judicial process."<sup>65</sup> The controversy requirement recognizes the tripartite allocation of power in the federal system, and requires the judiciary to steer clear of areas committed to the legislative and executive branches of the government.<sup>66</sup>

The next hurdle for the would-be federal litigant is the question of standing. One who seeks to invoke federal jurisdiction must demonstrate "personal injury fairly traceable to the defendant's allegedly unlawful conduct likely to be redressed by the requested relief."<sup>67</sup> Although standing is a well established requirement for federal jurisdiction, federal courts sometimes down play its importance. A case in point is *In re President Georgetown College, Inc.*<sup>68</sup> In that case, a teaching hospital sought an order from federal Judge Skelly Wright allowing the treating

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JCAHO, Accreditation Manual XIII (1988).

61. See *infra* note 62.

62. C. WRIGHT, HANDBOOK OF THE LAW OF FEDERAL COURTS 15 (2d ed. 1970).

63. *Id.*

64. U.S. CONST. art. III, § 2.

65. L. TRIBE, AMERICAN CONSTITUTIONAL LAW § 3-7, at 67 (2d ed. 1988).

66. *Id.*

67. *Allen v. Wright*, 468 U.S. 737, 751 (1984). Professor Tribe, referring to the language quoted from this opinion, observes that: "Were the case-or-controversy inquiry focused on the existence of a concrete dispute and vigorous advocacy, a litigant alleging no injury to his own 'interests,' whether statutory or otherwise, might nonetheless have standing." L. TRIBE, *supra* note 65, § 3-15, at 111 n.4 (citation omitted).

68. 331 F.2d 1000 (D.C. Cir.), *cert. denied sub nom.*, 377 U.S. 978 (1964).

physician to administer transfusions to an adult patient over her religiously-based objections. In the course of his discussion of the facts and the applicable legal principles, Judge Wright at no time discussed the issues of standing and justiciability. Instead, he focused on his personal view that the refusal of life-sustaining treatment was tantamount to suicide, and that the patient had a responsibility to the community to care for her infant. Therefore, he concluded, the people had an interest in preserving the patient's life which presumably was a more compelling interest than the patient's interests in autonomy, self-determination, and bodily integrity.<sup>69</sup>

The most significant aspect of this case for purposes of this article is the dissenting opinion written by Justice Burger in the decision by the United States Court of Appeals for the District of Columbia Circuit denying rehearing en banc. Justice Burger asserted that courts "have an obligation to deal with the basic question whether any judicially cognizable issue is presented when a legally competent adult refuses, on grounds of conscience, to consent to a medical treatment essential to preserve life."<sup>70</sup> Since the "touchstone" of justiciability is "injury to a legally protected right," [t]he threshold issue . . . [must be] whether the hospital had a right which it was entitled to require the court to enforce."<sup>71</sup> It was undisputed in this case that both the patient and her husband had offered to provide the hospital with a written release from liability for any adverse consequences that might flow from honoring the patient's refusal to authorize the transfusions. Since apparently the only "injury" the hospital could put forward was a potential lawsuit by some other party claiming to have suffered an economic loss from the death of the patient, Justice Burger found the hospital's assertion of economic damage unsupported.<sup>72</sup>

Justice Burger's discussion of the justiciability issue is instructive for right to refuse treatment cases in state courts as well. Quoting Justice Frankfurter's opinion in *Joint Anti-Fascist Refugee Committee v. McGrath*, Burger asserts:

Limitation on "the judicial power of the United States" is expressed by the requirement that the litigant must have "stand-

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69. *Id.* at 1008. In his opinion Judge Wright also makes reference to the *parens patriae* power of the state. As will be discussed at greater length hereinafter, the judge in this and virtually every other case assumes that the healthcare providers, even when they are private institutions or individuals, can invoke and assert this sovereign power of the state. This is an assumption that is subject to serious question.

70. 331 F.2d at 1015 (Burger, dissenting).

71. *Id.* (quoting *Joint Anti-Fascist Refugee Committee v. McGrath*, 341 U.S. 123 (1950)). A review of the right to refuse treatment cases painfully demonstrates that this question is one which state and federal trial and appellate judges rarely, if ever, bother to ask in such cases.

72. *Id.* at 1015-16. Without any regard to procedural or jurisdictional niceties, the courts in such cases allow the plaintiff healthcare provider, without legitimate portfolio, to don the cloak of the state and assert its supposed interests. In criticizing this phenomenon, I am, of course, excluding those cases which are properly decided in the procedural posture of a guardianship hearing which seeks to demonstrate that the patient, because of decisional incapacity, is an appropriate subject of the state's *parens patriae* power.

ing to sue" or, more comprehensively, that a federal court may entertain a controversy only if it is "justiciable." Both characterizations mean that a court will not decide a question unless the nature of the action challenged, the kind of injury inflicted, and the relationship between the parties are such that judicial determination is consonant with what was, generally speaking, the business of the Colonial courts and the courts of Westminster when the Constitution was framed.<sup>73</sup>

Justice Burger goes on to interpret the above language as addressing more than merely the well-established concept of limited federal jurisdiction as compared with broader state court jurisdiction since the Colonial courts and the Courts of Westminster of the 1780's were courts of general jurisdiction. Frankfurter's point, according to Burger, is that there are matters of "strictly private concern" that do not fit properly within the legitimate authority of any of the three branches of government. Addressing the appropriateness of any federal or state court taking jurisdiction over cases brought by healthcare providers when presumably competent patients refuse life-sustaining procedures, he opines:

[W]e must inquire where an assumption of jurisdiction over such matters could lead us. Physicians, surgeons and hospitals and others as well are often confronted with seemingly irreconcilable demands and conflicting pressures. Philosophers and theologians have pondered these problems and different religious groups have evolved different solutions; the solutions and doctrines of one group are sometimes not acceptable to other groups or sects. . . . May the physician or hospital require the courts to decide? A patient may be in a critical condition requiring, in the minds of experts, certain medical or surgical procedure. If the patient has objections to that treatment . . . are the courts empowered to decide for him?

Some of our greatest jurists have emphasized the need for judicial awareness of the limits on judicial power which is simply an acknowledgement of human fallibility.

. . . .  
[W]e should . . . reconcile ourselves to the idea that there are myriads of problems and troubles which judges are powerless to solve; and this is as it should be. Some matters of essentially private concern and others of enormous public concern, are beyond the reach of judges.<sup>74</sup>

In 1964 Justice Burger was a voice crying in the wilderness. To a disturbingly significant degree, few judges at any level have expressed similar concerns about the encroachment of government and the courts into matters of private decisionmaking.<sup>75</sup> Perhaps, like Judge Skelly

73. 331 F.2d 1000, 1016 (1964) (Burger J., dissenting) (quoting Joint Anti-Fascist Refugee Committee v. McGrath, 341 U.S. 123, 150 (1950)).

74. *In re* President of Georgetown College, 331 F.2d 1000, 1017-18 (D.C. Cir.) (footnote omitted), *cert. denied sub nom.*, *Jones v. President of Georgetown College, Inc.*, 377 U.S. 978 (1964).

75. Treatment refusal cases are replete with judicial references to the "unacceptable"

Wright, they are unable or unwilling to maintain their judicial demeanor and detachment when the healthcare provider's lawyer calls and says: "We need an order for treatment stat!"<sup>76</sup> Judge Markowitz of New York, one of the few state court judges to have demonstrated sensitivity to issues of jurisdiction, standing, and justiciability, nevertheless succumbed to the pressures of a life or death situation in at least one of several such cases that came before him during his years on the bench. His anxiety is evident in the reported opinion:

Never before had my judicial robe weighed so heavily on my shoulders. Years of legal training, experience and responsibility had added a new dimension to my mental processes — I, almost by reflex action, subjected the papers to the test of justiciability, jurisdiction and legality. I read *Application of President and Directors of Georgetown College, Inc.* and was convinced of the proper course from a legal standpoint. Yet, ultimately, my decision to act to save this woman's life was rooted in more fundamental precepts.<sup>77</sup>

Unlike Judge Markowitz, most state court judges do not make a distinction between general and unlimited jurisdiction. If left unchal-

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position in which patients place health care providers when they seek medical assistance but then proceed to pick and choose the types of treatment they accept and those they reject. See *supra* notes 55-59 and accompanying text.

76. Consider, for example, the following case of a 72 year old female who was hospitalized for pneumonia. A week after admission she was found to have gangrene in both legs and was told she would need to undergo bilateral, below-the-knee amputations in order to have more than an estimated 10% chance of survival. The patient refused to consent to the amputations, whereupon a psychiatric consult was immediately sought, requiring the consulting psychiatrist to drive through a snowstorm to the hospital to examine the patient and give an immediate opinion. In all likelihood, the surgeons would have performed the amputations without such a consult and based only on the patient's consent, if the patient had in fact consented. But because she refused her consent, a psychiatric consult was ordered. The psychiatrist concluded, solely on the basis of the patient's refusal of consent despite the bleak prognosis, that her refusal was persuasive evidence of her incapacity to give an informed consent or refusal. The very next day the state department of human services, having been brought into the matter by the hospital, sought custody of the patient and authority to consent to the surgery. The trial court judge, who granted the custody petition which resulted in the patient's legs being amputated, acknowledged later that he had allowed himself to be misled by the way in which the case was presented. He was given the impression that the surgeon was waiting with scalpel in hand by the telephone. The consulting psychiatrist, when subsequently queried, similarly acknowledged that he had not adequately examined the patient when he reached his conclusion, but that was because he was in a time crunch because of the purported life-threatening situation. Abernathy, *Compassion, Control, and Decisions About Competency*, in *BIOETHICS: READINGS AND CASES* 60 (B. Brody & H. Engelhardt 1987).

77. *Powell v. Columbian Presbyterian Medical Center*, 49 Misc. 2d 215, 216, 267 N.Y.S.2d 450, 451 (1965). This case, like *Georgetown College*, involved a Jehovah's Witness patient who would not consent to a transfusion but who did not necessarily regard one administered over her objection as placing her in a religious quandary.

Judge Markowitz also decided a case in which an elderly female patient who clearly was incapacitated refused to consent to an amputation. In denying the guardianship petition, he observed that there was "serious doubt here as to the existence of a truly justiciable legal controversy, despite the claimed vital factor of a human life hanging in the balance." *In re Nemser*, 51 Misc. 2d 616, 621, 273 N.Y.S.2d 624, 628 (1966). He went on to state, in the same vein as Justice Burger in *Georgetown College*: "Confronted by a situation such as this, I am of the opinion that the time has come for courts to inquire where a continued condonation of such action and where a continued assumption of jurisdiction over such matters lead." *Id.* at 623, 273 N.Y.S.2d at 630.

lenged by the defendants in refusal-of-treatment cases, judges operate on the presumption that they have jurisdiction over such controversies.<sup>78</sup> The question remains nevertheless, at least in those cases in which the patient-defendant is represented by competent counsel, why issues of jurisdiction and standing are not raised. Even in cases of bedside hearings by the judge, those issues can and should be raised, thereby preserving them for appeal if the court refuses to consider them at the time. The absence of jurisdictional discussion in the growing body of appellate decisions is perplexing and troubling. Mootness cannot be the answer. Appellate courts often refuse to dismiss the appeal on the grounds of mootness in order to assure that important issues which are likely to recur are ultimately resolved.<sup>79</sup>

### C. *Elements of a Cause of Action*

The case or controversy doctrine is based upon the principle that courts exist (federal and state) for the determination of actual and presently existing controversies, and not, except under special and limited provisions for declaratory judgments, to provide a basis for judicial opinions upon discrete points of law. It is, therefore, axiomatic that unless a claim presented to a court contains all of the requisite elements of a cause of action, it must fail and should be dismissed. An examination of the essential elements of a valid cause of action clearly demonstrates the fatal flaws in most refusal-of-treatment lawsuits.

The first element is the existence of a "primary legal right" with which the law has invested the plaintiff and for which the law provides a remedy against the party infringing that right.<sup>80</sup> Thus, in the case of a competent patient refusing to submit to an invasive procedure by a physician, the law must invest the physician with a legal right to perform the procedure with or without the patient's consent. The law of informed consent provides exactly the opposite. Without valid consent, actual or presumed, the physician has no right to perform such a procedure, and in fact can be held liable to the patient on a theory of battery or medical malpractice.

Since the first element of a cause of action is absent, the physician's petition should be dismissed because it is defective. If the physician has no legal right to treat a patient without his consent, then clearly the second element, violation of a right or duty owed to the plaintiff by the defendant, is absent as well. Patients, once they engage in the contractual physician-patient relationship, have no duty to submit to any treatment recommended by the physician. As set out in the previous section, the relationship must be constantly reaffirmed at every stage, and the patient must be the final arbiter.<sup>81</sup> If the physician considers himself

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78. *C. Wright, supra* note 62.

79. *See, e.g., Fosmire v. Nicoleau*, 75 N.Y.2d 218, 221 n.1, 551 N.E.2d 77, 78 n.1, 551 N.Y.S.2d 876, 887 n.1 (Ct. App. 1990).

80. *Granahan v. Celanese Corp.*, 3 N.J. 187, 191, 69 A.2d 572, 574 (1949).

81. *See supra* note 17.

ethically compromised by the patient's refusal, his only legitimate recourse is to withdraw from the relationship. By filing an action in pursuit of a court order compelling the patient to submit to the physician's recommended treatment, the physician seeks specific performance of a purported contractual obligation of the patient to accept treatment. No such contractual obligation exists.

Finally, it is a well-established principle that the proper exercise of a legal right cannot constitute a legal wrong for which an action will lie, even if the other party can demonstrate an adverse consequence. Therefore, since the patient has the right to refuse medical treatment, the exercise of that right cannot be actionable on the part of the physician even if he can demonstrate some damage, such as compromising his perception of medical ethics or creating a fear that ultimately the non-treatment may be the subject of a malpractice claim. Such damage is to be considered *damnum absque injuria*. ("Damage without wrong.")<sup>82</sup>

#### D. *Procedural Challenges to Actions Seeking to Force Treatment*

The rules of civil procedure in effect in every jurisdiction, and particularly Federal Rule 12(b), provide a theoretically effective means to challenge efforts to force treatment on unwilling, competent patients.<sup>83</sup> Rule 12(b)(1), for example, authorizes the filing of a motion to dismiss a petition or complaint on the grounds that the court lacks subject matter jurisdiction. Similarly, a motion under Rule 12(b)(6) asserts that the complaint fails to state a claim upon which relief can be granted. Once filed, the court must rule on the motion before proceeding further with the case.<sup>84</sup> In the context of such motions a patient can properly assert that his refusal of treatment does not constitute a civil wrong to the hospital or his treating physician, or a breach of contract. To the contrary, the bringing of such an action is an attempt by the healthcare provider to extend the contractual relationship beyond the limits of mutual consent in violation of the fundamental principles which govern the physi-

82. *Atlantic Coast Line R.R. v. State Highway Comm'n*, 268 N.C. 92, 96, 150 S.E.2d 70, 73 (1966).

83. Similar rules exist in most, if not all, states. FED. R. CIV. P. 12(b) states in pertinent part:

Every defense, in law or fact, to a claim for relief in any pleading, whether a claim, counterclaim, cross-claim, or third-party claim, shall be asserted in the responsive pleading thereto if one is required, except that the following defenses may at the option of the pleader be made by motion: (1) lack of jurisdiction over the subject matter, (2) lack of jurisdiction over the person, (3) improper venue, (4) insufficiency of process, (5) insufficiency of service of process, (6) failure to state a claim upon which relief can be granted, (7) failure to join a party under Rule 19. . . . If, on a motion asserting the defense numbered (6) to dismiss for failure of the pleading to state a claim upon which relief can be granted, matters outside the pleading are presented to and not excluded by the court, the motion shall be treated as one for summary judgment and disposed of as provided in Rule 56, and all parties shall be given reasonable opportunity to present all material made pertinent to such a motion by Rule 56.

84. *See, e.g.*, 4 R. HARDAWAY & S. HYATT, *COLORADO PRACTICE* 108 (2d ed. 1985). Even if the patient does not make a formal motion, the court may *sua sponte* (on its own motion) dismiss the complaint for failure to state a claim.

cian-patient relationship and the doctrine of informed consent.<sup>85</sup>

When the issue is whether the physician has a legitimate cause of action against the patient, a motion for summary judgment is a more expeditious and effective method to achieve the prompt termination of an action that lacks substantive merit. Usually there are no disputed issues of material fact in these cases unless the patient's competence has been called into question. Therefore, the facts alleged in the healthcare provider's petition, as opposed to conclusory allegations that do not necessarily follow from the facts, will be assumed to be true, and the ultimate question of law decided.<sup>86</sup>

In the typical case, the healthcare provider initiating the action does not assert interests of a private or personal nature. Were that the case, it is very difficult to imagine how the petition could survive a Rule 12(b) motion. Rather, the healthcare provider attempts, in most cases successfully, to characterize its role as spokesperson of or surrogate for society and/or the state. No reported cases have been found in which the patient-defendant, or the court on its own motion, has challenged the standing of a healthcare provider to assert the interests of the state in the litigation without any special designation or without the formal intervention of a party for the expressed purpose of representing the state.<sup>87</sup> Since this issue never seems to be raised and discussed in the cases, one can only speculate how this procedural sleight of hand is accomplished. Perhaps the state court judge presumes to "look after" these purported state interests.<sup>88</sup> As a matter of impartiality and judicial ethics, however, one might well ask how the patient is to receive a fair hearing if both the plaintiff healthcare provider and the judge are making certain that the interests of the state are respected. Despite the efforts of healthcare providers and judges to assert the contrary, these are *adversarial* proceedings—one party seeks to compel the other party's submission to an invasive medical procedure with inherent risks. In re-

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85. See *supra* notes 14-18 and accompanying text.

86. FED. R. CIV. PRO. 56(b) provides: "A party against whom a claim, counterclaim, or cross-claim is asserted or a declaratory judgment is sought may, at any time, move with or without supporting affidavits for a summary judgment in the party's favor as to all or any part thereof."

87. Several cases, however, involve the states as a party because the trial court brought the attorney general into the litigation on its own motion. See *infra* note 99.

88. One argument that has not been explicitly put forward but must be considered as to how a court from a procedural standpoint can apply the interests of a non-party (the state) so as to overcome the interests of an actual party (the patient) is that the state interests are in the nature of public policy. Courts routinely invoke such principles in litigation between private parties in ways which affect the outcome of the case at bar without ever making a representative of the public a party to the action. For example, conduct or contracts of an illegal or immoral nature cannot be a proper basis for judicial relief at law or in equity. In response to this rationale for application of the state interests in treatment refusal cases, I would suggest three flaws: first, this justification has never been expressly offered by the courts; second, the "void as against public policy" principle has always been applied as an absolute bar to the action, never as a countervailing consideration; and third, the right to refuse treatment as a general principle has too much support in the case law and the legal and ethical literature to simply be dismissed as against public policy.



gard to these purported state interests, the protection of its citizen's rights to autonomy and bodily integrity is rarely asserted.

If, as a matter of fact and law, it is the state's interests and not those of the healthcare providers that are actually counterpoised to the patient's well-established right to refuse treatment, then the court should not proceed further without the state becoming a party to the suit. Rule 12(b)(7) provides as a basis for a motion to dismiss situations in which a necessary party as defined by Rule 19 has not been joined. For such a motion to be granted, the court must determine that disposition of the action in that party's absence might prejudice the missing party or the parties already before the court. Now that the United States Supreme Court has recognized both the patient's constitutional right to refuse treatment and the state's (not the healthcare provider's) right to assert its countervailing interests,<sup>89</sup> the patient should insist that the state come forward and affirmatively demonstrate in court what its interests are in the matter and why they should prevail. Without the state's participation as an actual party, the patient is prejudiced by the speculative nature in which these state interests are introduced. Although a civil matter, there is a sense in which the patient has the same need to confront his "accuser" (who would override his constitutional and common law right to privacy and bodily integrity) as a defendant in a criminal case.<sup>90</sup>

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89. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2041 (1990). This case is the first so-called "right-to-die" case that the Supreme Court has considered. Briefly, the case involves an adult female patient, Nancy Cruzan, who has been in a chronic vegetative state since an automobile accident in 1983. She receives nutrition and hydration through a gastrostomy tube surgically implanted in her stomach. Based upon her physician's opinion that she will not return to a cognitive, sapient state, and her own statements while competent that she would not want to be maintained in a vegetative condition, her parents requested that the gastrostomy tube be removed. When the nursing home in which she resides refused, the parents initiated legal proceedings. The hearing judge ruled, consistent with the position of the guardian ad litem appointed to represent Nancy Cruzan, that her parents, as co-guardians of her person, were acting in her best interests and consistent with her previously expressed wishes when they requested removal of the gastrostomy tube. Therefore, the respondents were ordered to follow their instructions. On appeal, a divided Missouri Supreme Court reversed, holding that in the absence of clear and convincing evidence that Nancy Cruzan would have refused artificial nutrition and hydration, her parents were without authority to order it.

The Supreme Court, in an opinion written by Chief Justice Rehnquist, held that although competent patients have a constitutional right to refuse medical treatment arising out of the liberty interest protected by the fourteenth amendment, the state may properly assert its countervailing interests and may constitutionally require, in the case of incompetent patients, clear and convincing evidence of the patient's views before allowing a surrogate to order the removal of life-sustaining treatment.

90. The decision in *Cruzan* suggests, in a brief and somewhat cryptic reference, that the "guarantee of accurate factfinding that the adversary process brings with it" is not a requirement imposed by the Constitution upon states in proceedings involving the termination of life-sustaining medical treatment for an incompetent patient. *Cruzan*, 110 S. Ct. at 2853. This view, however, presumes that such proceedings could never result in a legally cognizable injury to the patient, a point which the dissenting justices and many other thoughtful persons would contest. Arguably, an incompetent patient such as Nancy Cruzan, who is maintained on life-support when her conscious and competent choice would have been to the contrary, is seriously injured by governmental action, and hence is entitled not merely to the rigors and formalities of an adversarial proceeding, but also to

In cases where the trial court refuses to consider and rule upon a Rule 12(b) motion, and instead wrongfully assumes jurisdiction ordering treatment over a competent adult's objection, most states provide an avenue for speedy relief directly from the state supreme court *before* the trial court order is carried out. For example, Colorado Rule of Civil Procedure 106(4) provides that in a case in which it is alleged that an inferior state tribunal has exceeded its jurisdiction, and there is no plain, speedy, and adequate remedy at law, the Colorado Supreme Court may direct that tribunal to show cause why it should not be prohibited from proceeding further.<sup>91</sup> The supreme court review is solely to determine whether jurisdiction has been exceeded or abused.<sup>92</sup> The review is by no means a cursory one in which the lower court's exercise of jurisdiction is rubber-stamped or automatically assumed proper. In this regard, the Colorado Supreme Court has stated:

"[n]o question of greater 'public importance' can arise than one in which a court is proceeding without jurisdiction of the person or subject matter." In the interest of justice, we consider it as much our duty, when our superintending control of inferior tribunals is invoked, to keep such tribunals within their jurisdiction, as it is to correct errors of such tribunals exercising proper jurisdiction.<sup>93</sup>

Clearly such a challenge to the exercise of jurisdiction by a trial court in our hypothetical case would be appropriate. There is no allegation that the patient lacks capacity to make an informed decision; therefore, the court cannot base its assumption of jurisdiction upon a guardianship proceeding for an incompetent adult. Neither can the plaintiff physician demonstrate any common law claim, contractual right, or tortious wrong suffered because his recommendations were not followed.<sup>94</sup>

#### E. *Applying the State Interests*

Returning to the hypothetical case, perhaps the only one of the four state interests that cannot be applied is the last, and only because our

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the due process protection of the sixth amendment. *See, e.g.,* *Fitzgerald v. Hampton*, 467 F.2d 755, 763 (D.C. Cir. 1972).

91. This review is discretionary, and one would, of course, need to seek a stay of the trial court's ruling pending any Rule 106 disposition by the supreme court.

92. *Kellner v. District Court*, 127 Colo. 320, 324, 256 P.2d 887, 889 (1953).

93. *Id.* at 324, 256 P.2d at 889 (quoting *Carlson v. District Court*, 116 Colo. 330, 343, 180 P.2d 525, 532 (1947)).

94. Relying for support on language in cases such as *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 197, 209 Cal. Rptr. 220, 226 (1984) and *In re Storar*, 52 N.Y.2d 363, 382, 420 N.E.2d 64, 71, *cert. denied*, 454 U.S. 858 (1981), one article states unequivocally:

[N]o statute, regulation, or judicial decision places an affirmative duty on physicians . . . to seek a court order that would override the wishes of any competent adult patient, including a pregnant woman. . . . There is no reported case imposing civil damages or criminal penalties on any physician for failing to seek judicial review of a competent adult's refusal of treatment. In fact, courts have flatly rejected the notion that a physician could be held civilly or criminally liable for honoring the competent adult's refusal of medical treatment.

Nelson, *Buggy & Weil*, *supra* note 5, at 724-25.

patient is neither hospitalized nor seeking alternative treatment from the physician. The state can claim an interest in his continued life, which is a realistic possibility (beyond 18 months) only if he undergoes chemotherapy. If chemotherapy in his case would be life-saving, then those with Judge Skelly Wright's viewpoint can call his refusal an act of suicide.<sup>95</sup> The most compelling of the three state interests as applied to the situation of our hypothetical patient is that his acceptance of death by cancer can be characterized as a form of abandonment of his economically-dependent wife and minor children, which might ultimately create a financial drain on the state treasury. Proponents of the viability and propriety of these state interests would find in this hypothetical a compelling case for a court order subjecting our patient to treatment against his will.

The aspect of the hypothetical that might cause a court to hesitate, even if presided over by a state interests advocate, is that the patient is not in the hospital or, as yet, in a seriously debilitated condition. Consequently, if the order for treatment were issued but the patient refused to comply with it, there would likely be only two practical alternatives open to the judge, both of them highly repugnant to the citizens of a democratic society. The first alternative would be to hold the patient in contempt of court for failing to submit to treatment. Like journalists who have been ordered but refuse to divulge confidential sources, he would be placed in jail until he purged himself of contempt or obtained his release on bond pending appellate review of the trial court's order.<sup>96</sup> The second option would be for the court, pursuant to the order, to have the patient taken from his home by the police, hospitalized in a locked unit, and perhaps even placed in four-point restraints for purposes of the actual administration of chemotherapy. Such "shock the conscience" behavior by a court of law would reach far beyond what the United States Supreme Court has upheld with regard to forced bodily examination or treatment of criminal suspects,<sup>97</sup> thus most courts would probably be convinced, in light of the logistical difficulties posed by the hypothetical, that the four interests of the individual—in autonomy, self-determination, privacy, and bodily integrity—are more compelling in this case.<sup>98</sup> The point, however, is that continued recognition of these

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95. In his concurring opinion in *Cruzan v. Director, Mo. Dep't of Health*, Justice Scalia joins the decimated ranks of those who still consider the refusal of life-sustaining medical treatment to be suicide. 110 S. Ct. 2041 at 2059-62 (1990) (Scalia, J., concurring).

96. This would hardly fulfill the patient's expressed desires to spend his remaining days in quality time with his family.

97. See, e.g., *Winston v. Lee*, 470 U.S. 753 (1985) (disallowing law enforcement efforts to force surgery on a suspect to remove a bullet); *Rochin v. California*, 342 U.S. 165 (1952) (holding a forcible stomach pump to obtain swallowed narcotics to be unconstitutional).

98. Professor Meisel makes the point that the proclivity of the courts in treatment refusal cases to assert the state interests in an adversarial fashion against the liberty interests of the individual "erroneously" suggests that the state has no concern for the autonomy, self-determination, privacy, and bodily integrity of its citizens. However, he cites only one case in which the state demonstrated any concern for those individual interests. In that case, *Mercy Hosp. v. Jackson*, 62 Md. App. 409, 489 A.2d 1130 (1985), *vacated* 306

state interests in the case of a competent patient, and the willingness of courts to overlook genuine issues of justiciability and proper parties, means that *every* patient is at risk of having his or her refusal to consent to recommended treatment subjected to judicial review. Furthermore, the patient has virtually no recourse against the healthcare provider for this fundamental violation of privacy expectations.<sup>99</sup> The time has come, therefore, as the Supreme Court recognized in *Cruzan*, to acknowledge the constitutional stature of the right to refuse treatment.

#### IV. CONSTITUTIONAL PRIVACY AND THE RIGHT TO REFUSE TREATMENT

The constitutional dimension of the right to refuse treatment was recognized by the New Jersey Supreme Court in *In re Quinlan*.<sup>100</sup> Since then, commentators have noted a trend by state courts away from a constitutional basis for recognizing the right to refuse treatment and toward primary, if not exclusive, reliance upon the common law.<sup>101</sup> In particu-

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Md. 556, 510 A.2d 562 (1986), the state, in an amicus brief, opposed the hospital's effort to override a competent patient's refusal of a potentially life-saving transfusion on the grounds that in such a case fundamental individual liberty overrode the state interest in preserving life. A. MEISEL, *supra* note 12, at 96-97.

In a case decided subsequent to Professor Meisel's book, *Georgia v. McAfee*, 259 Ga. 579, 385 S.E.2d 651 (1989), a similar conclusion was reached. That case involved a motorcycle accident victim whose spinal cord injury rendered him a quadriplegic and incapable of spontaneous respiration. When, after four years of ventilator dependency, he requested that the respirator be turned off, the public hospital and attending physician declined to follow his request. The patient filed an action in the state trial court seeking an order that the respirator be turned off and that he be provided with appropriate medication to alleviate the pain that he would thereafter experience.

The trial judge brought the Georgia Attorney General into the case to represent the interests of the state; however, the Attorney General took the position that although the state did not advocate or approve of the course of action the patient sought to pursue, there was no basis on the facts of the case upon which the state could legitimately intervene and oppose the patient's exercise of his right to refuse treatment. The patient prevailed at the trial court level, as well as in the state supreme court, where an appeal was taken by the Attorney General at the direction of the trial court because the case was one of first impression in Georgia.

99. See Miller, *Right-to-Die Damage Actions: Developments in the Law*, 65 DEN. U.L. REV. 181 (1988) for a review of the dismal prospects for patients in such countersuits. Although far short of a trend, two recent decisions as reported in 18 HEALTH L. DIG. 6 (1990) offer a glimmer of hope that the trend may be reversing. In *Malette v. Shulman* (1990, 72 O.R. (2d) 417; [1990] O.J. No. 450; Doc. No. CA 29/88 (Ont. C.A.), a trial court award of \$20,000 was upheld in favor of a patient in an action in which she alleged that the treating physician disregarded a card stating that she was a Jehovah's Witness and, as a matter of religious belief, rejected blood transfusions under any circumstance. The plaintiff was unconscious at the time the transfusions were administered. In the second case, *Lunsford v. Regents of the Univ. of Cal.*, No. 837936, Cal. Sup. Ct., Co. of San Francisco (April 13, 1990), the parents recovered \$500,000 in a special verdict against the medical center and surgeons for fraud and intentional infliction of emotional distress. Plaintiffs were Jehovah's Witness parents of a child with kidney disease. In authorizing a kidney transplant, they specified that transfusions were not to be used. When that was reported to be unacceptable to the transplant team, the parents made arrangements for transfer of their child to a hospital in Houston where the procedure would be performed without transfusions. Thereupon, the parents were advised that the team in San Francisco would perform the transplant without transfusions when in fact arrangements were being made for court-ordered transfusions.

100. *In re Quinlan*, 70 N.J. 10, 38, 355 A.2d 647, 668, cert. denied, 429 U.S. 922 (1976).

101. See L. TRIBE, *supra* note 65, § 15-11, at 1365.

lar, it is noted that the New Jersey Supreme Court in *In re Conroy*<sup>102</sup> expressly stated that it was relying exclusively on common law principles.<sup>103</sup> Although it may be sound judicial policy, particularly on the part of a state court, to rely on a common law right of citizens in an area in which the United States Supreme Court has not yet spoken, such reliance should not be viewed as a denigration or denial of a constitutional basis for the same right.

In this section I will first discuss the United States Supreme Court decision in the *Cruzan* case. I will then propose that basing the right to refuse treatment on constitutional privacy grounds provides a more rational and effective means of preserving and protecting the interests of the individual from unwarranted intrusion by the state. I will discuss the sources for such a constitutional right, and, in doing so, I will take issue with recent commentators who argue that constitutional arguments are superfluous in right-to-die cases. Finally, I will distinguish, on constitutional principles, between privacy and autonomy, and suggest that the former, construed in the context of the historic nature of the physician-patient relationship, is a proper basis for a presumed family guardianship that would drastically limit the role of the state in private healthcare decisionmaking.

#### A. *Cruzan v. Director, Missouri Department of Health*

The United States Supreme Court has just handed down its decision in the *Cruzan* case.<sup>104</sup> While it presumes that competent patients have a constitutional right to refuse medical treatment, including nutrition and hydration, based upon the liberty interest of the fourteenth amendment, it holds that Missouri law does not unconstitutionally encumber that right by requiring that the surrogate decisionmaker for an incompetent patient present clear and convincing evidence that the patient would have refused nutrition and hydration under the current circumstances. As noted by Chief Justice Rehnquist in the opinion of the Court, "determining that a person has a 'liberty interest' under the Due Process Clause does not end the inquiry; 'whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests.'"<sup>105</sup> Regrettably, the Court saw no need to analyze these interests, not even the interest relied upon by Missouri in *Cruzan*—preserving life.

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

103. Finally, in *Quinlan*, . . . we indicated that the right of privacy enunciated by the Supreme Court "is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances" even if that decision might lead to the patient's death. While this right of privacy might apply in a case such as this, we need not decide that issue since the right to decline medical treatment is, in any event, embraced within the common-law right to self-determination.

*Id.* at 1223 (quoting *In re Quinlan*, 70 N.J. 10, 40, 355 A.2d 647, 663 (1976)) (citations omitted).

104. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990). See *supra* note 89 for the factual and procedural background of the case.

105. *Id.* at 2851 (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)).

There are several aspects of the *Cruzan* case which are particularly relevant to issues raised in this article. The first is the particular source in the Constitution for a right to refuse medical treatment. Later in this section I will discuss in some detail the importance of recognizing a Constitutional zone of privacy within which medical decisionmaking occurs. It is interesting to note that although the opinion of the Court bases the right to refuse treatment on the liberty interest protected by the Due Process Clause of the fourteenth amendment, discussion of the basis for to such a right for medical decisions is oblique and equivocal at best. The Court's only reference to privacy is the following language in a footnote: "Although many state courts have held that a right to refuse treatment is encompassed by a generalized right of privacy, we have never so held. We believe this issue is *more properly* analyzed in terms of a Fourteenth Amendment liberty interest."<sup>106</sup>

In the same footnote, the Court cites language from *Bowers v. Hardwick*<sup>107</sup> which is critical of creating nontextual constitutional rights. It is clear that the Court is not comfortable in declaring that constitutional privacy does not encompass medical decisionmaking; however, by relying on the liberty interest, which equates with autonomy, the Court runs headlong into the problems posed by the incompetent patient. The Court notes that:

Petitioners go on to assert that an incompetent person should possess the same right in this respect as is possessed by a competent person.

. . . .

The difficulty with petitioners' claim is that in a sense it begs the question: an incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right. Such a "right" must be exercised for her, if at all, by some sort of surrogate.<sup>108</sup>

Later in this section I will argue in favor of a constitutional right to refuse treatment based on privacy as opposed to a right based on liberty or autonomy, which not only avoids the question-begging criticism, but also comports with the historical context of medical decisionmaking as well as the overwhelming consensus of the American people.<sup>109</sup>

Perhaps the most important language in the opinions written by the various justices in the *Cruzan* case is that of Justice O'Connor's concurring opinion in which she discusses the holding of the Court:

[T]he Court does not today decide the issue whether a State must also give effect to the decisions of a surrogate decisionmaker. In my view, such a duty may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment. Few individuals provide explicit oral or written instructions regarding their intent to refuse medical

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106. *Id.* at 2851 n.7 (emphasis added).

107. *Bowers v. Hardwick*, 478 U.S. 186, 194-95 (1986).

108. *Cruzan*, 110 S. Ct. at 2852.

109. *See infra* note 196 and accompanying text.

treatment should they become incompetent. States which decline to consider any evidence other than such instructions may frequently fail to honor a patient's intent.

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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 a future determination that the Constitution requires the States to implement the decisions of a patient's duly appointed surrogate.<sup>110</sup>

Since Justice O'Connor is clearly a swing vote on the issues raised by the *Cruzan* case, states seeking to legislate in the area of treatment refusals by surrogates must carefully consider what would constitute clear and convincing evidence of the patient's intent. This will not be any easy task. Missouri's clear and convincing evidence standard, which O'Connor approves, "decline[s] to consider any evidence other than [explicit oral or written] instructions."<sup>111</sup> Since Justice O'Connor is clearly concerned about the fact that few individuals provide such explicit directives as living wills, or duly appoint surrogates through durable powers of attorney for medical care, it is not readily apparent how she believes states can simultaneously uphold the sanctity of human life regardless of its quality and simultaneously safeguard the liberty interest of the typical incompetent patient who has not left clear and convincing evidence that he would decline life-sustaining treatment in his current compromised condition.

If Nancy Cruzan had left a living will that rejected nutrition and hydration should she be diagnosed as being in a chronic vegetative state, Justice O'Connor's concurrence suggests that she would join the four dissenting justices in holding that Missouri's refusal to give effect to such provisions in its living will statute violates the liberty interests of patients.<sup>112</sup> Whether Chief Justice Rehnquist or Justices White or Kennedy would join in such a decision would depend upon how they balanced the state's interest in preserving the life of a patient in a chronic vegetative state against the patient's right to refuse treatment. One of the key issues left unresolved by the *Cruzan* case is the methodology for balancing the conflicting interests of the patient and the state. In the case of a patient who has left a living will, who has no dependents, whose physicians agree that there is no likelihood of ever returning to a cognitive, sapient state, and whose next of kin strongly urge the withdrawal of nutrition and hydration, it is difficult to imagine what state interests could prevail over the expressed wishes of the patient.<sup>113</sup>

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110. *Cruzan*, 110 S. Ct. at 2057-58 (O'Connor, J., concurring).

111. *Id.*

112. See *infra* note 212 and accompanying text.

113. The Missouri Supreme Court gave a very strong indication as to how it would balance Nancy Cruzan's right to refuse nutrition and hydration against the state's interest in preserving life:

Given the fact that Nancy is alive and that the burdens of her treatment are not excessive for her, we do not believe her right to refuse treatment, whether that

The most disturbing aspect of the *Cruzan* decision is the total disregard of the patient as a person. The Court's ruling in *Cruzan* allows Missouri to totally disregard the best interests of an incompetent patient in situations in which there is an absence of clear and convincing evidence that life-sustaining treatment would have been refused. It is this abject refusal to consider what is in Nancy Cruzan's best interests as a human being that clearly demonstrates what interest Missouri deems paramount. That interest is not the protection of innocent, incompetent patients from abuse or neglect at the hands of ignorant or malevolent surrogates, but rather an abstract, dogmatic, quasi-religious principle of the sanctity of life. The failure of the Missouri appellate courts to address the best interests of Nancy Cruzan with an objective test<sup>114</sup> prompted Justice Stevens to conclude that the heart of Missouri's policy is an effort to define life. He states, in that regard:

Missouri insists, without regard to Nancy Cruzan's own interests, upon equating her life with the biological persistence of her bodily functions.

The State's unflagging determination to perpetuate Nancy Cruzan's physical existence is comprehensible only as an effort to define life's meaning, not as an attempt to preserve its sanctity.

....  
The failure of Missouri's policy to heed the interests of a dying individual with respect to matters so private is ample evidence of the policy's illegitimacy.

Only because Missouri has arrogated to itself the power to define life, and only because the Court permits this usurpation, are Nancy Cruzan's life and liberty put into disquieting conflict. If Nancy Cruzan's life were defined by reference to her own interests, . . . then her constitutionally protected interest in freedom from unwanted treatment would not come into conflict with her constitutionally protected interest in life.<sup>115</sup>

Much more can and certainly will be written about the strengths, weaknesses and implications of the *Cruzan* decision. For purposes of this article, however, the most compelling aspect of that case is that the

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right proceeds from a constitutional right of privacy or a common law right to refuse treatment, outweighs the immense, clear fact of life in which the state maintains a vital interest.

*Cruzan v. Harmon*, 760 S.W.2d 408, 424 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S.Ct. 2841 (1990).

114. *Contra In re Conroy*, 98 N.J. 321, 365-68, 486 A.2d 1209, 1232-33 (1985) (discussing several best-interest tests).

115. *Cruzan*, 110 S. Ct. at 2886-89 (Stevens, J., dissenting). Such a mandate to preserve life even at the expense of the person who must live it is religious in origin and nature. Such was the basis upon which Paul Ramsey, *infra* note 124, argued that the individual person holds his life in trust as a gift from God and therefore may not decline any medical treatment necessary to maintain the gift. Only when this notion is openly acknowledged to be religious, however, can the additional protection of the first amendment be marshaled in support of patients who resist being held hostage to the state's concept of physicians as the acolytes of a supreme being who declines to grant individuals dominion over their own bodies. See also K. Clouser, *Sanctity of Life*, in *MEDICAL ETHICS* 71 (M. Abrams & M. Buchner eds. 1983).



states are free, but at the present time not required, to rely heavily upon the family as surrogate decisionmaker. In this regard the Court stated: "If the State were required by the United States Constitution to repose a right of 'substituted judgment' with anyone, the Cruzans would surely qualify. But we do not think the Due Process Clause requires the State to repose judgment on these matters with anyone but the patient herself."<sup>116</sup>

### B. *Refusal of Treatment Based on a Constitutional Right to Privacy*

As discussed in section III above, once a healthcare provider declines to accept a refusal of treatment decision by a patient or his surrogate, the state government, primarily through the courts, becomes heavily involved in the decisionmaking process. The outcome, even in cases that are virtually indistinguishable on their facts, will vary from court to court and from jurisdiction to jurisdiction.<sup>117</sup> If, as many litigants, judges, legal commentators, and bioethicists have argued, the right to refuse treatment is fundamental, then that right should not vary from jurisdiction to jurisdiction.<sup>118</sup> Let us examine the case for the existence of a fundamental constitutional right to refuse treatment based upon the right to privacy.

Thomas Jefferson observed that "[t]he legitimate powers of government extend to such acts only as are injurious to others."<sup>119</sup> This statement expresses the fundamental libertarian principle extant among the Founders and those whom they represented that governments are instituted among free men for the purpose of securing the rights of the people, not to create such rights or infringe upon them when their exercise is in the form of wholly self-regarding conduct.<sup>120</sup> Behind this principle of democratic government is the basic concept that the individual, not the state, ought to be the supreme judge of his own best interests. This is an essential aspect of self-determination.<sup>121</sup> The "moral fact" that a person belongs to himself and not to the state is undermined by a routine balancing of state interests in an effort to determine whether a patient's refusal of consent to medical treatment should be upheld.<sup>122</sup>

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

117. For example, in many jurisdictions courts have upheld the request of a close family member that life sustaining measures, including respirators and naso-gastric tubes, be withdrawn from patients in an irreversible coma. Nevertheless, in *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990) and *In re Westchester County Medical Center*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1989) such requests were denied by the highest courts of the respective states.

118. *Cf.* L. TRIBE, *supra* note 65, § 15-10, at 1358 (discussing jurisdictional variations in treatment of fundamental rights as concerns abortion).

119. JEFFERSON, NOTES ON THE STATE OF VIRGINIA, quoted in D. RICHARDS, *TOLERATION AND THE CONSTITUTION* 246 (1986).

120. L. LEVY, *ORIGINAL INTENT AND THE FRAMER'S CONSTITUTION* 283 (1988).

121. "Anglo-American law starts with the premise of thorough-going self determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, . . ." *Natanson v. Kline*, 186 Kan. 393, 404, 350 P.2d 1093, 1104 (1960).

122. "[T]he concept of privacy embodies the *moral fact* that a person belongs to himself

These purported state interests, particularly that of maintaining the sanctity of life, strongly suggest the notion that the state is asserting a proprietary interest in the lives and bodies of its citizens. Such a notion is repugnant to the language of the Declaration of Independence that "all men are endowed by their creator with certain inalienable rights [and] among these are life, liberty and the pursuit of happiness." Governments exist for the purpose of securing these pre-existing rights.<sup>123</sup>

An interesting argument has been proffered, primarily from a religious perspective, that the use of the word "inalienable" in referring to the right to life indicates that one may not refuse life-saving medical procedures, for to do so would be to attempt to alienate that which is inalienable. Although purportedly speaking from an ethical rather than a theological perspective, Paul Ramsey ultimately acknowledges the religious underpinnings of his conviction that a patient cannot morally refuse treatment that will be likely to extend the patient's life.<sup>124</sup> Fundamental rights have never been conceived in such a one-dimensional sense.

The contrary argument, which is not only more consistent with a secular-pluralist society, but also more consistent with the concept of individual rights in Western societies in the last half of the twentieth century, is that the right to die (which in the context of this article means foregoing treatment intended to sustain life) is the other side of the right to life. One cannot have, in any truly meaningful sense, a right to life unless one is able to elect not to go on living.<sup>125</sup>

Too much has been made, however, of the so-called "right to die." Particularly in the context of a discussion of fundamental but unenumerated constitutional rights, one can be impaled upon such a semantic

and not to others nor to society as a whole." *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 776 n.5 (1986) (Stevens, J., concurring) (emphasis added).

123. L. LEVY, *supra* note 120, at 349. Professor Levy, in arguing for the existence of unenumerated yet fundamental rights, takes issue with the views of those such as John Ely in *DEMOCRACY AND DISTRUST* (1980) that the natural rights principles expressed in the Declaration of Independence had, for all intents and purposes, disappeared by the time of the Constitutional Convention.

124. Ramsey characterizes life as a gift from God, a perception based upon the Judeo-Christian heritage that has influenced medicine toward a pro-life stance. Choosing any course of action or inaction that results in death would be to throw the gift of life back in the face of the giver. Similarly, Ramsey believes that religious faith affirms that life is a trust; consequently we are only stewards and not owners of our lives. P. RAMSEY, *ETHICS AT THE EDGES OF LIFE* 146-47 (1978).

125. Joel Feinberg makes this very point in his essay, *The Concept of an Inalienable Right: The right to die is simply the other side of the coin of the right to live. . . . Just as my right to live imposes a duty on others not to kill me, so my right to die, which it entails, imposes a duty on others not to prevent me from implementing my choice of death, except for the purpose of determining whether that choice is genuinely voluntary, hence truly mine. . . . In exercising my own choice in these matters, I am not renouncing, abjuring, forswearing, resigning, or relinquishing my right to life; quite the contrary, I am acting on that right by exercising it one way or the other. . . . To alienate the right would be to abandon my discretion; to waive the right is to exercise that discretion. The right itself, as opposed to that to which I have the right, is inalienable.*

J. FEINBERG, *RIGHTS, JUSTICE, AND THE BOUNDS OF LIBERTY* 249 (1980).

sword. To argue for a constitutional "right to die" is to invite the conservative members of the Supreme Court to reply that there is no textual support for the proposition that one may commit suicide and enlist others to assist him,<sup>126</sup> just as they recently stated that there is no fundamental right of homosexuals to engage in sodomy.<sup>127</sup> As stated earlier, I am not necessarily breaking any new constitutional ground in arguing for a right to refuse medical intervention.<sup>128</sup> Justice Douglas, in a concurring opinion in *Doe v. Bolton*,<sup>129</sup> enumerates a few of the "Blessings of Liberty" as that term is used in the preamble to the Constitution. The first is the autonomous control over the development and expression of one's intellect, tastes, and personality. The second is the freedom of choice in the basic decisions of life such as marriage, divorce, procreation, contraception, and the education of one's children. The third is the freedom from bodily restraint or compulsion and to care for one's health and person.<sup>130</sup> Decisions about whether to undergo major medical procedures, whether or not they are deemed life-saving, involve all three of these liberties. They are an expression of one's individuality, they are among the more important and basic decisions in one's life, and most importantly, they are an exercise of autonomy.

In an effort to shift the focus from a narrow right to die to a broader right to accept or refuse recommended treatment, which has a long and distinguished history in our common law, I am compelled to address a contention by the authors of a recent article to the effect that courts are mistaken when they analyze right to die cases according to the same criteria as right to refuse treatment cases.<sup>131</sup> Morgan and Harty-Golder, in discussing the balancing of the four state interests against the patient's rights of autonomy, privacy and bodily integrity, suggest that it is much more likely that the state interests will prevail in treatment refusal cases. The authors characterize treatment refusals as those cases in which medical treatment for curable conditions is rejected. Right-to-die cases, on the other hand, they argue, are those in which life sustaining therapy for an incurable condition is rejected.<sup>132</sup> Different treatment by the courts is warranted because the right to die, they contend, is a natural right, superior even to fundamental constitutional rights, and therefore not subject to balancing against state interests.<sup>133</sup> Why the right to auton-

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126. See, e.g., *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2856 (1990) (Scalia, J., concurring).

127. *Bowers v. Hardwick*, 478 U.S. 186, 190 (1986). This is not to suggest, of course, that Professor Tribe, who argued the case for Michael Hardwick, made any such simplistic contentions. As another commentator has observed, by stating the issue in this fashion, it is clear that the Court's conclusion preceded its analysis. Rubinfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 747 (1989).

128. See *supra* notes 100 and 101 and accompanying text.

129. 410 U.S. 179, 209 (Douglas, J., concurring), *reh'g denied*, 410 U.S. 959 (1973).

130. *Id.* at 211-14.

131. Morgan & Harty-Golder, *Constitutional Development of Judicial Criteria in Right-To-Die Cases: From Brain Dead To Persistent Vegetative State*, 23 WAKE FOREST L. REV. 721 (1988).

132. *Id.* at 724.

133. The courts in right-to-die cases have consistently maintained that the right to refuse life-sustaining treatment must be balanced against the countervailing state interests

omy, privacy and bodily integrity are not natural rights, but the right-to-die is, the authors do not explain. The inference is that the outcome is determinative of the right. In other words, since by their definition treatment refusal cases always involve a rejection of a presumed successful medical intervention, while right to die cases involve refusals of futile medical interventions, then the latter constitute the exercise of a natural right while the former do not. Yet, as a matter of sound jurisprudential and philosophical analysis, rights, particularly natural rights that transcend the constitutions of men, ought to be outcome-independent. This is particularly true if we assume, for the sake of a parallel discussion, that the conduct of the patient in both situations is completely self-regarding.

Although Morgan and Harty-Golder use the term "emergencies" to describe many of what they characterize as treatment refusal cases, they do not appear to be referring to the presumed consent that is appropriate when the patient is brought to the hospital *in extremis*, as a result of which consent is presumed because the patient is unable to give it and a surrogate is not immediately available.<sup>134</sup> As an example, they use the *Georgetown College*<sup>135</sup> case, which involved an adult female Jehovah's Witness patient who, consistent with her religious beliefs, refused to consent to a blood transfusion. Such cases do not qualify for the presumption of consent in a medical emergency because the patient has already refused to consent. During the time in which a genuine emergency procedure would be performed, the physicians wait while their attorneys attempt to persuade a judge to override the patient's wishes.

Finally, the authors assert that "[t]he refusal of life-prolonging procedures does not have the adverse impact on society or government that is often involved in the compelled treatment situation."<sup>136</sup> Since no explanation for this remarkable statement is provided, the reader is left to speculate what may have been intended. One might reasonably infer that the authors contend that the state does indeed have a proprietary interest in its citizens, but that the justification for asserting that interest in the former situation is negligible because of the terminal condition of such patients.

Another commentator, Professor Ellman, has suggested, in reference to the *Cruzan* case, that attempting to make constitutional the right to refuse treatment is misguided and superfluous.<sup>137</sup> Ellman's contention is that the balancing of the individual's interests and the state's interests will take place in any event; however, he does concede that if the right to refuse treatment has constitutional dimensions, then every state

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regardless of their theoretical basis. See, e.g., *In re Estate of Longeway*, 133 Ill. 2d 33, 45, 549 N.E.2d 292, 297 (1989); *In re Conroy*, 98 N.J. 321, 348-9, 486 A.2d 1209, 1223 (1985).

134. R. FADEN & T. BEAUCHAMP, *supra* note 14, at 36.

135. *In re President of Georgetown College*, 331 F.2d 1000 (D.C. Cir.), cert. denied *sub nom.* Jones v. President of Georgetown College, Inc., 377 U.S. 978 (1964).

136. Morgan & Harty-Golder, *supra* note 131, at 764.

137. Ellman, *Cruzan v. Harmon and the Dangerous Claim That Others Can Exercise an Incapacitated Patient's Right to Die*, 29 JURIMETRICS J. 389, 393-4 (1989).

must weigh these interests in the same fashion under Supreme Court scrutiny.<sup>138</sup> If the right to refuse treatment is a fundamental right, there would seem to be much more significance to this point than Ellman acknowledges.<sup>139</sup> Thereafter, he throws down the gauntlet with regard to any purported constitutional right of surrogates to refuse life sustaining treatment for incompetents, contending that it would require an entirely different rationale than the patient's right to autonomy and "no such rationale has been offered."<sup>140</sup> Later in this section I will discuss such a rationale.

The ultimate significance of a constitutional right to refuse treatment is potentially reduced when one considers the state action requirement. This is because the constitutional guarantees of individual rights were established to protect citizens from infringement by the government—state or federal.<sup>141</sup> Thus it would appear that a judicially recognized constitutional right to refuse treatment would not protect a patient from forced treatment by private physicians or hospitals; however, consideration of the basis of treatment refusal case decisions clearly demonstrates the error of such an assertion. Federal and state courts invoke the four state interests in all treatment refusal cases<sup>142</sup> regardless of whether the parties to the litigation are private or public. Therefore, so long as state interests are balanced by the court against a patient's right to refuse treatment, state action is present and the federal constitutional right to refuse treatment is applicable.<sup>143</sup>

### C. Sources of the Constitutional Right to Privacy

Before undertaking a discussion and analysis of the proposition that the constitutional right to privacy encompasses the right to refuse treatment by both competent and incompetent adults, it is appropriate to explore the purported constitutional sources of the general principle of privacy. The 1965 Supreme Court decision in *Griswold v. Connecticut*<sup>144</sup> is widely regarded as the first in which the Court struck down a state statute on constitutional privacy grounds that were based on a provision other than the fourth amendment.<sup>145</sup> The foreshadowing of the recog-

138. *Id.* at 394.

139. In *West Virginia Board of Education v. Barnette*, 319 U.S. 624, 638 (1943), the Court stated: "The very purpose of the Bill of Rights was to withdraw certain subjects from the vicissitudes of political controversy . . . Fundamental rights may not be submitted to vote; they depend on the outcome of no elections."

140. Ellman, *supra* note 137, at 395.

141. See generally, L. TRIBE, *supra* note 65, § 18-1, at 1688-91.

142. See *supra* notes 34-52 and 86-94 and accompanying text.

143. *New York Times v. Sullivan*, 376 U.S. 254 (1964) and *Shelley v. Kramer*, 334 U.S. 1 (1948), stand for the proposition that state court application of common law tort and contract principles in an unconstitutional fashion will also serve as the basis for a finding of state action even though the actual parties to the litigation are private.

144. 381 U.S. 479 (1965).

145. Connecticut's law made it a criminal offense for married persons to use contraceptives, or for physicians to aid or abet the offense by providing couples with contraceptives or information regarding their use. Such a regulation, it was held, invaded the zone of privacy created by several fundamental constitutional guarantees (penumbras and emanations from the first, third, fourth, fifth, and ninth amendments).

dition of a constitutional right to privacy dates back to the language of Justice Brandeis in his dissenting opinion in *Olmstead v. United States*.<sup>146</sup> One of the major problems with the constitutional right to privacy as conceived by Justice Brandeis, established by *Griswold*, and subsequently applied in cases such as *Roe v. Wade*,<sup>147</sup> is that its breadth and depth are unknown. Whether it reaches far enough to preclude a particular invasive act of government will not be known unless the Supreme Court agrees to rule on a case presenting the issue. Until *Cruzan*, lower courts and litigants could only speculate upon a constitutional right to refuse treatment.

Many commentators of the privacy cases and the constitutional principles upon which they are or arguably should be based, look primarily to two provisions—the ninth amendment and the privileges and immunities clause of the fourteenth amendment. I shall consider them in that order.

There is little written about the ninth amendment,<sup>148</sup> and so little reliance upon it in constitutional jurisprudence, that when it is referred to at all it is almost always as the “forgotten ninth amendment.” Indeed, the only extensive scholarly treatment of the amendment bears that very title.<sup>149</sup> It begins with an important observation: “There is no clause in the Constitution except the ninth amendment which makes a declaration of the sovereignty and dignity of the individual.”<sup>150</sup> Much of the text consists of an argument for the proposition that the ninth

146. 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting), *overruled*, *Berger v. New York*, 388 U.S. 41 (1967). Justice Burger, in his dissent in the *Georgetown College* case, found the language compelling in its relevance to cases involving the refusal of medical treatment and efforts by physicians and judges to overrule it:

The makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness. They recognized the significance of man's spiritual nature, of his feelings and of his intellect. They knew that only a part of the pain, pleasure, and satisfaction of life can be found in material things. They sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, *as against the government, the right to be let alone* — the most comprehensive of rights and the right most valued by civilized men.

*In re* President of Georgetown College, 331 F.2d 1000, 1016 (1964) (Burger, J., dissenting) (emphasis added) (quoting *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting)).

Justice Burger then went on to elaborate on the above language and bring it to bear directly on the facts of the case before him:

Nothing in this utterance suggests that Justice Brandeis thought an individual possessed these rights only as to *sensible* beliefs, *valid* thoughts, *reasonable* emotions, or *well-founded* sensations. I suggest that he intended to include a great many foolish, unreasonable, and even absurd ideas which do not conform, such as refusing medical treatment even at great risk.

*Id.* at 1017 (emphasis in original).

147. 410 U.S. 113, *reh'g denied*, 410 U.S. 959 (1973).

148. U.S. CONST. amend. IX: “The enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people.”

149. B. PATTERSON, *THE FORGOTTEN NINTH AMENDMENT* (1955). Even the book itself seems to have been largely ignored or forgotten, for more recent commentators have little, if anything, to say about it. I will take issue with this neglect, for there is much in the work which has relevance and significance to a purported constitutional right to refuse treatment that would prevent state courts and legislatures from usurping a patient's right to privacy, autonomy, and bodily integrity in healthcare decisionmaking.

150. *Id.* at 1.

amendment is the elucidation of the Founders' solemn belief that individuals possess natural rights that are antecedent and superior to any specifically referenced in the Bill of Rights, and as such can not be revoked or materially circumscribed by either federal or state governments.<sup>151</sup> Patterson might well have been referring to the cases in which state courts have forced treatment upon competent and unconsenting adults when he observed:

We shudder to think what might have been the result if our human liberties had been left to find determination by the courts of [the] states. The undisputed truth is that in practically all important instances where human rights have been denied, it has been at the hands of the government of a state or its inferior subdivisions.<sup>152</sup>

Patterson's basic thesis is that the Founders placed the ninth amendment in the Bill of Rights in a prescient recognition that man as a social animal is evolving and advancing. Not only was it impossible to enumerate all of the rights that an individual possessed as against others or government, but it was even more difficult to anticipate the ways in which those rights would need to be articulated three hundred years later. The ninth amendment should be the principle vehicle for that process.<sup>153</sup> In concluding words that bear great significance to the proclivity of courts, as the previous section has demonstrated, to persistently balance the countervailing interests of the state against the right of the individual to make his own private medical treatment decisions, he observes:

Whenever we lose the distinction between individual liberty and the necessities of the general welfare, the virtue of our form of government is lost, and we have nothing but the worst form of tyranny, which is a despotism imposed by the force of and under the name of the people themselves. We will have, then, nothing that is preferable to any other form of tyranny or despotism elsewhere.<sup>154</sup>

Another constitutional scholar, Leonard Levy, believes that *Griswold* marks the inception of ninth amendment jurisprudence.<sup>155</sup> Like Patterson, Levy vigorously argues that the ninth amendment is compelling evidence of the Framers' distrust of all government, not just the federal one. James Madison, in response to the contention that a Bill of Rights was unnecessary because the states constitutionally protected freedom,

151. *See id.* at 7-20.

152. *Id.* at 42.

153. With his own piece of prescience, Patterson suggests that:

The right of privacy may be such a right [now making an appearance]. . . . While the courts seem to feel that it should exist, there is a great timidity and lack of forthrightness in the protection of this right, because its existence is not to be found in the written and enumerated law.

*Id.* at 55.

154. *Id.* at 61.

155. L. LEVY, *supra* note 120, at 267-68 (1988). Levy notes that prior to 1965 the ninth amendment was the subject of only incidental references by the Court, whereas in the fifteen years afterward it was invoked in over 1200 state and federal cases.

asserted first that a number of the states had no, or at least a very defective, Bill of Rights, and second that the states constituted a greater danger to individual liberty than the national government.<sup>156</sup> It is from this historical perspective that one must argue for the proposition that the rights "retained by the people" according to the ninth amendment cannot reasonably be interpreted as "retained by the state governments."<sup>157</sup> These unenumerated rights are of individuals as against society or any level of government. As expressed by the late Judge Craven of the Fourth Circuit Court of Appeals, the principles embodied in the Declaration of Independence, the Preamble to the Constitution and the ninth amendment provide that the rights of persons in the United States are not confined to those specifically enumerated.<sup>158</sup>

Clearly, the ninth amendment has no substantive content whatsoever. One commentator has described it as "a license to constitutional decisionmakers to look beyond the substantive commands of the Constitutional text to protect fundamental rights not expressed therein."<sup>159</sup> The more conservative members of the United States Supreme Court are decidedly uncomfortable with this "license" to the extent they even acknowledge its existence. There is also apparent acceptance by the same segment of the Court of the proposition that overturning state legislation that does not clearly contravene an enumerated right constitutes "the mere imposition of the Justices' own values upon the States."<sup>160</sup> I shall address this contention further as I attempt to give credence to a constitutional right to privacy in fundamental healthcare decisions.<sup>161</sup>

The fourteenth amendment,<sup>162</sup> as a source for an unenumerated constitutional right, suffers from much the same "weakness" as the ninth amendment in that the substantive content of phrases such as

156. *Id.* at 272-73.

157. Justice Scalia's arguments in *Cruzan* to the contrary notwithstanding.

158. Craven, *Personhood: The Right To Be Let Alone*, 1976 DUKE L. J. 699, 705.

159. Grey, *Do We Have An Unwritten Constitution?*, 27 STAN. L. REV. 703, 709 (1975). Professor Grey goes on to point out that if the disciples of the "pure interpretive model" such as the late Justice Black, Chief Justice Rehnquist, Judge Bork, and John Ely prevailed, a radical purge of established constitutional doctrine would be necessary, including fundamental procedural fairness in civil and criminal proceedings, prohibitions on racial discrimination by the federal government, the application of the Bill of Rights to the states, and the requirement of strict scrutiny when fundamental interests are affected. *Id.* at 713.

160. *Bowers v. Hardwick*, 478 U.S. 186, 191 (1986). Two concerns relating to the present discussion arise from this proposition. First, the sense that Justice White and his colleagues on the majority in *Bowers* equate "the States" with "the people" of the ninth amendment. Constitutional history, of which Professor Levy contends most Supreme Court justices have been abysmally ignorant (L. LEVY, *supra* note 120, at 300), is to the contrary. Second, one must ask how the ninth amendment can ever be utilized to protect individual rights against state infringement, lacking as it does any substantive content, without that use being subject to Justice White's "imposition of values" charge.

161. See *infra* notes 162-180 and accompanying text.

162. U.S. CONST. amend. XIV provides:

All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.



“privileges or immunities of citizens of the United States” and “life, liberty, or property” must be provided by the Court, and to do so requires that the justices confront the current meaning of these phrases. The Founders could not have anticipated that one of the perils faced by individuals in this era would be the onslaught of the technological imperative of modern medicine, and that the physician-patient relationship might be transformed, through the imposition of court-ordered treatment, to a prison house in which manacles and chains are replaced by tubes and wires. Does that mean that we, as a civilized society under the rule of law of the greatest charter of freedom ever drafted, must look away from this assault or pretend that it does not exist because the Founders neglected to anticipate this scenario and enumerate a constitutional right to be free from unwanted medical treatment?<sup>163</sup> Professor Black, commenting on *Griswold*, observed that:

If our constitutional law could permit such a thing to happen, then we might almost as well not have any law of constitutional limitations, partly because the thing is so outrageous in itself, and partly because a constitutional law inadequate to deal with such an outrage would be too feeble, in method and doctrine, to deal with a great amount of equally outrageous material. Virtually all the intimacies, privacies and autonomies of life would be regulable by the legislature . . . .<sup>164</sup>

Such an autonomy and privacy is the right to refuse medical treatment, which the state seeks to regulate by means of the imposition of its interests through the judiciary, and through legislation such as that in Missouri discussed in the *Cruzan* case.<sup>165</sup> Given the sentiments expressed by the majority in the *Bowers* decision, it will be a daunting task to persuade the Court in future cases that *legitimate* constitutional interpretation justifies the conclusion that the right to a wholly or predominately self-regarding determination to refuse medical treatment rests among the privileges and immunities of citizens of the United States. Yet, are we not embarking upon the ultimate totalitarian nightmare when we suggest that the constitutional right of privacy does not reach far enough to protect the individual from forced medical treatment which serves the interests of the state?<sup>166</sup>

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163. There is an ironic parallel between, on the one hand, the originalist view that if the Founders did not elucidate a right to refuse treatment it is therefore not of constitutional dimensions, and the Missouri Supreme Court's view that if a patient, while competent, did not specifically and solemnly reject the treatment now being administered to him, then his surrogate cannot lawfully refuse it on his behalf.

164. Black, *The Unfinished Business of the Warren Court*, 46 WASH. L. REV. 3, 32 (1970).

165. MO. REV. STAT. § 459.010 (1986).

166. In arguing thus, one admittedly is moving beyond a narrow and rigid concept of what it means to be a citizen of a nation toward the concept of what it means to be a human being, a person in the fullest sense of the word that transcends its historic constitutional dimension. I do so, however, in good company. First, Professor Tribe, addressing the constitutional dimension of personhood, states:

The Constitution . . . contains no discussion of the right to be a *human* being; no definition of a person; and, indeed, no express provisions guaranteeing to persons the right to carry on their lives protected from the 'vicissitudes of the political process' by a zone of privacy or a right of personhood. . . . But the Constitution's is not a totalitarian design, depending for its success upon the ho-

D. *Autonomy v. Privacy*

The constitutional right to privacy suffers from many congenital infirmities, not the least of which is the long period of time which passed in the history of our constitutional jurisprudence before it was discovered and applied. This late arrival of the principle suggests to some that it is probably illegitimate, something created out of the skillful liberal positioning of smoke and mirrors, rather than properly derived from solid and long-standing principles of constitutional interpretation.<sup>167</sup> Another infirmity, and one more critical to the right to refuse treatment, is the interchangeable use by courts and commentators of the terms "privacy" and "autonomy."<sup>168</sup> Professor Henkin correctly observes:

That the Court cites search and seizure cases as precedent for its new zone of autonomy suggests that it does not distinguish between privacy and autonomy and may be treating them both as aspects of "the right to be let alone." But they are, I think, different notions conceptually, with different philosophical, political, social (and, one might have thought legal) assumptions and consequences; they may look different also if viewed as aspects of the confrontation of private right with public good.<sup>169</sup>

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mogenization or depersonalization of humanity. The judiciary has thus reached into the Constitution's spirit and structure, and has elaborated from the spare text an idea of the 'human' and a conception of 'being' not merely contemplated but required.

L. TRIBE, *supra* note 65, § 15-3, at 1308 (footnote omitted). Second, anticipating only slightly the totalitarian nature of the imposition of the demands of the technological imperative upon unwilling patients by courts which worship at the altar of the interests of the state, Professor Kurland observes:

[W]e have arrived at the stage of technological development that Orwell so graphically described in his, to me, still shocking novel, *1984*. The problem of freedom is essentially the problem of avoiding the consequences of that technology so that Orwell's vision might, despite our technological achievements, be frustrated. With government in control of so many essentials of our life, where in the Constitution can we turn for haven against the impositions of *1984*? Until now, we have looked to the Bill of Rights, substantive due process, and substantive equal protection. But nowhere in these provisions is there a basis for claims to the privileges and immunities that will become more and more necessary. . . . [M]ost of all, I should hope to find among the privileges and immunities of citizenship, that most fundamental of rights, still without a base in the Constitution, the right that Mr. Justice Brandeis called 'the right to be let alone.'

Kurland, *The Privileges and Immunities Clause: Its Hour Come Round at Last?*, 1972 WASH. U.L.Q. 405, 419 (footnotes omitted).

167. John Ely, for example, in his critique of the extension of the right to privacy to a woman's decision whether or not to maintain her pregnancy, laments: "What is frightening about *Roe* is that this super-protected right is not inferable from the language of the Constitution, the framers' thinking respecting the specific problem in issue, any general value derivable from the provisions they included, or the nation's governmental structure." Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 YALE L.J. 920, 935-36 (1973).

168. Consider, for example, the following: "Privacy will be defined here as an autonomy of control over the intimacies of personal identity. Autonomy, identity, and intimacy are all necessary (and normally sufficient) for the proper invocation of the concept of privacy." Gerety, *Redefining Privacy*, 12 HARV. C.R.C.L. L. REV. 233, 236 (1977). As we know from the decision in *Bowers v. Hardwick*, a current majority of the Court does not agree, at least when the issue is framed as "the fundamental right [of] homosexuals to engage in sodomy." 478 U.S. 186, 190 (1986).

169. Henkin, *Privacy and Autonomy*, 34 COLUM. L. REV. 1410, 1425 (1974). See also Allen,

The compelling significance of this lost distinction shall become readily apparent as I discuss the right to refuse treatment in the case of an incompetent as opposed to a competent patient.<sup>170</sup> Before doing so, however, let us complete the review of privacy's infirmities. There is, of course, the fact that it is among the unenumerated rights, one which had to be discovered lurking amidst the penumbras and emanations of the first, third, fourth, fifth, and ninth amendments.<sup>171</sup> The pall of illegitimacy that such rights have about them in the eyes of some members of the Court is probably best expressed by Justice White in this language from the opinion of the Court 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 . . . . There should be, therefore, great resistance to expand the substantive reach of [the Due Process] Clauses, particularly if it requires redefining the category of rights deemed to be fundamental. Otherwise, the Judiciary necessarily takes to itself further authority to govern the country without express constitutional authority.<sup>172</sup>

Proponents of a constitutional right to refuse treatment argue that it should be beyond dispute that the right to accept or decline invasive medical procedures cannot reasonably be regarded as a "redefinition" of rights that are fundamental. It is, rather, a recognition of the fact that control over one's body in such a way as to preclude being made the slave of medical technology is absolutely and indisputably inherent in the concept of ordered liberty.<sup>173</sup>

The final infirmity of the right of privacy is that it has been said to apply only to those "matters . . . fundamentally affecting a person."<sup>174</sup> Demonstrating that one's identity as a person is unconstitutionally compromised by some state action spawns an analysis that is tortuous and ambiguous at best, and always easy prey to the disciples of Justice Black. In a recent article, a commentator has suggested an analytical methodology that avoids legal forays into the existential thicket of personhood.<sup>175</sup> Rather than focusing upon what the state is trying to forbid and asking whether there is a fundamental constitutional right to do so, Rubenfeld suggests that the focus be upon what is being produced by the state's action or prohibition, "the real effects that conformity with the law pro-

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*Taking Liberties: Privacy, Private Choice, and Social Contract Theory*, 56 U. CIN. L. REV. 461, 467 (1987), wherein she argues that the Supreme Court's right-to-privacy jurisprudence is flawed by the confusion of liberty with privacy. While she argues that abortion rights present issues of autonomy, not privacy, my contention is that refusal of treatment cases squarely present both aspects of the concept of constitutional privacy.

170. See *infra* notes 191-199 and accompanying text.

171. *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965).

172. *Bowers v. Hardwick*, 478 U.S. 186, 194-5 (1986).

173. See *Palko v. Connecticut*, 302 U.S. 319, 325 (1937), *overruled by* *Duncan v. Louisiana*, 391 U.S. 145 (1968).

174. *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).

175. Rubenfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 783 (1989).

duces at the level of everyday lives and social practices."<sup>176</sup> Applying his analytical method to persons seeking to be disengaged from life-support systems, Rubenfeld observes:

For right-to-die patients, being forced to live is in fact to be forced into a particular, all-consuming, totally dependent, and indeed rigidly standardized life: the life of one confined to a hospital bed, attached to medical machinery, and tended to by medical professionals. It is a life almost totally occupied. The person's body is, moreover, so far expropriated from his own will, supposing that he seeks to die, that the most elemental acts of existence—such as breathing, digesting, and circulating blood—are forced upon him by an external agency.<sup>177</sup>

It is the totalitarian nature of such state action, he argues, such as requiring that a woman bear an unwanted child or that homosexuals disavow or completely sublimate their sexual preferences, that should be a sufficient basis for invocation of the right to privacy. One might ask, however, in refusal of treatment cases, where the analogy is more that of a strategic incursion rather than a total occupation by the medical professionals, whether this type of analysis would still result in an invocation of the right to privacy to protect the patient from court-ordered treatment.

Let us turn, now, to the way in which the distinctions between autonomy and privacy, competence and incompetence, are interwoven. The Supreme Court privacy decisions establish certain zones of privacy in which the state may not dictate how an individual thinks, feels or acts except where a compelling public interest can be shown and no less burdensome means are available to protect that public interest. The right of privacy in the broad constitutional sense has also been characterized as "the right to make choices and decisions."<sup>178</sup> Thus privacy takes on a figure/ground kind of quality, with the background being zones of presumed state noninterference and the figure being the exercise of personal autonomy within these zones. Much of the discussion of privacy in healthcare decisionmaking, at least as a purported constitutional right, has concentrated on the incompetent or questionably competent patient. Focusing on the figure of autonomous decisionmaking and action rather than the background of a zone of privacy, some commentators argue that it belies truth and logic to discuss a constitutional right to refuse treatment that survives incompetence.<sup>179</sup> Earlier in this article I

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176. *Id.*

177. *Id.* at 795.

178. Feinberg, *Autonomy, Sovereignty, and Privacy: Moral Ideas in the Constitution*, 58 NOTRE DAME L. REV. 445, 454 (1983).

179. Ellman *supra*, note 137, at 394. Professor Ellman, discussing the *Cruzan* case and others involving permanently unconscious patients, contends that, "[a] constitutional right to decide one's own treatment for oneself can thus have no application to her case." He is particularly critical of *Gray v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988), the most recent case to permit the withdrawal of life-sustaining treatment on the basis of a patient's constitutional right to decide her own treatment. The fatal flaw in this reasoning, it is argued, is

mentioned the gauntlet thrown down by Professor Ellman.<sup>180</sup> To be precise, his contention is stated as follows:

Since the autonomy principle is foundational to any constitutional claim that individuals may decide for themselves whether to accept or refuse life-sustaining treatment, the constitutional claim fails in this [the *Cruzan*] case. The family's claim to decide cannot be piggybacked on Nancy's autonomy. Their claim requires an entirely different rationale. Rather surprisingly, since many have made the claim before the Cruzans, no such rationale has been offered.<sup>181</sup>

My position is that privacy in a broad constitutional sense, derived from cases before and after *Griswold*, provides ample precedent for what I shall hereinafter describe as a presumed guardianship of the family intended to protect incompetent patients, such as Nancy Cruzan, from unwarranted state intervention in their private medical affairs.

An important aspect of the physician-patient relationship is the psycho-social quality deriving from its origins, particularly as described by Leon Kass.<sup>182</sup> Dr. Kass correctly observed that in undertaking a therapeutic relationship with a patient, the physician unavoidably enters the intimate life-world of the patient, which he indicates is the family. It is an incontrovertible fact that in the great majority of cases, the patient has close family involved with him in the process of contending with a major illness. It has become the custom and practice of physicians over centuries to work with the patient and his nuclear, and often even extended family, to help return the patient to health. It is, therefore, both distressing and anomalous to find courts treating family involvement in decisions declining treatment as inherently suspicious.<sup>183</sup> Professor

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that the patient never expressed a view on this subject while competent, so the actual decision to discontinue treatment is being made by the patient's family.

The New Jersey Supreme Court, first in *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), and more recently in *In re Conroy*, 98 N.J. 321, 359-60, 486 A.2d 1209, 1229 (1985), established what has become the majority view that the right of an adult who was once competent to determine the course of her medical treatment remains intact even when she is no longer able to assert that right.

180. See *supra* note 137 and accompanying text.

181. Ellman, *supra* note 137, at 395 (footnote omitted). Ellman does not say whether he agrees with the position of the Missouri Supreme Court that a guardian's power to exercise third party choice arises from the state's *parens patriae* power rather than the constitutional rights of the patient when competent. In so holding, the Missouri Supreme Court concludes that the other courts which permitted surrogates to order the withdrawal of life-support from incompetents mistakenly assumed that the surrogate's authority to do so was derivative of the incompetent's right to decide, if competent. *Cruzan v. Harmon*, 760 S.W.2d 408, 424-25 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1190). In the discussion that follows I will contend that on this point, as with so many others throughout the majority opinion in *Cruzan*, the Missouri Supreme Court demonstrates its view that people exist to serve the interests of the state, rather than the state existing to protect the rights of its citizens.

182. See *supra* note 21 and accompanying text.

183. In New Jersey, for example, the legislature created the Office of the Ombudsman for the Institutionalized Elderly (the "Granny Doe" squad) and charged it with the responsibility to guard against "abuse" of such patients. No life-supporting therapy may be withheld or withdrawn from institutionalized patients on the basis of a decision by a surrogate decisionmaker unless the patient has been adjudicated incompetent and a court-appointed guardianship created. Thereafter, the request by the guardian to withhold or withdraw

Meisel, in his recent work, *The Right to Die*, discusses the crucial role of the family in treatment decisions for incompetent patients:

The importance of the role of the family and the doctor is highlighted by the self-evident fact that the vast majority of treatment decisions relative to persons who are incompetent by reason of senility or retardation are made for them, by their family and the doctor, without court proceedings. This practice is sanctioned not merely by tradition but by the institutional limitations in the ability of courts to make day-to-day treatment decisions, even if restricted to treatments of a potentially life-saving or life-prolonging nature.<sup>184</sup>

A similar disrespect for the traditional role of the family in making healthcare decisions on behalf of minors is evidenced by the entire Baby Doe scenario.<sup>185</sup> In both instances, efforts on the part of state legislatures or federal regulators to cause any refusal of consent to automatically trigger governmental inquiry or a finding of neglect renders surrogate decisionmaking authority meaningless. This also reflects the profoundly paternalistic and pessimistic notion that political functionaries should be presumed better able to make private healthcare decisions than the family.<sup>186</sup>

The lineage of the family as the pre-eminent social unit, at least as a general proposition, is long and distinguished. Consider, for example, the observation that "the family unit does not simply co-exist with our constitutional system but is an integral part of it, for our political system is superimposed on and presupposes a social system of family units, not just of isolated individuals. No assumption more deeply underlies our

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life-support, even with the concurrence of the treating physician, must be reported to the Ombudsman and treated by him as a case of potential abuse. In all such cases of potential abuse, the Ombudsman must investigate and make a report to the Commissioner of Human Services within twenty-four hours. The New Jersey Supreme Court in *In re Conroy* 98 N.J. 321, 486 A.2d 1209 (1985) approved of this entire process, which makes no effort to distinguish between patients who have close family and patients who do not. *Id.* at 341-43, 486 A.2d at 1239-42. What makes the ruling still more inexplicable is the language from the same court in two cases decided only two years later. See *infra* note 190.

184. A. MEISEL, *supra* note 12, at 152 n.17.

185. For a concise review of the Baby Doe litigation and regulatory history, see FURROW, JOHNSON, JOST & SCHWARTZ, *HEALTH LAW, CASES, MATERIALS, AND PROBLEMS*, 939-48 (West 1987).

186. Goldstein, *Medical Care for the Child at Risk: On State Supervention of Parental Autonomy*, 86 YALE L.J. 645, 651 (1977).

James J. Kilpatrick, a noted journalist and political commentator of conservative persuasion, offered this opinion of the federal government's role in cases such as Baby Doe: It simply is no business of the federal government . . . to intrude upon the informed and reasonable decisions of a family in such intimate matters as this one. The federal rules say that surgery cannot be denied "when such denial is based on anticipated mental impairment, paralysis or incontinence of such child rather than on reasonable medical judgments that treatment would be futile or unlikely of success."

In the name of the Constitution of the United States, how did we get into such Orwellian nonsense? The surgeon general at the moment is a nice fellow by the name of C. Everett Koop. He too must have the very best of intentions. But did he run for God in some August primary? Did he get elected? What are his credentials—or what are a judge's credentials—for saying to the anguished parents, "Thou shalt operate!"?

Raleigh News and Observer, Nov. 17, 1983, at A5.

society . . . ."<sup>187</sup> It follows from this assumption that the privacy doctrine protects family relationships as much as, if not more than, individual autonomy. Indeed, it is through the proper nurturing role of the family that individuals develop into mature adults with the sense of identity and unique personhood of which autonomous acts are the ultimate definitional expression. As an institution that predates the state and hence and has a *raison d'être* separate and apart from it, the family cannot be as easily dislodged as the primary decisionmaker for its own as the Missouri Supreme Court suggests.<sup>188</sup> The significance of the family as a social phenomenon is not simply its role in the rearing of children. Nevertheless, in cases like *Cruzan* and *O'Connor*, the courts seem to be saying that once a person reaches majority and the existential realm of individual autonomy, he is immediately and irrevocably jettisoned from the protective and nurturing sphere of the family. Thereafter, if he should ever again be legally incapacitated, as during his minority, then his family, immediate, nuclear or extended, shall be without legal or moral authority to act on his behalf except with the prior adjudication and approval of the state.<sup>189</sup> Such a principle is at odds with the history of western civilization and the predisposition of a majority of the citizens of the United States.<sup>190</sup>

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187. L. TRIBE, *supra* note 65, § 15-20, at 1414 (quoting Heymann & Barzelay, *The Forest and the Trees: Roe v. Wade and its Critics*, 53 B.U.L. Rev. 765, 772-73 (1973)).

188. The *parens patriae* power of the state to protect the interests of minors and incompetent adults was intended to protect those who, by virtue of unfortunate circumstances, had no family that could or would look after them. It is a distortion of this original concept, at the very least, to suggest that when loving family members of formerly competent adults are present and seeking to act in the best interests of their loved one who happens to be a patient in an institution, the state can contravene their principled actions to further interests of its own. In this regard, the authors of a recent article argue:

Instead of permitting families to make a decision to terminate treatment in circumstances where such termination is considered good medical practice under standards promulgated by the A.M.A., among others, the Missouri court ruled that Cruzan must continue to be treated *for the sake of the state*, in upholding its "unlimited" interest in human life.

Annas, Glantz & Mariner, *The Right of Privacy Protects the Doctor-Patient Relationship*, 263 J. A.M.A. 858, 861 (1990) (emphasis added).

189. Professor Tribe refers to this phenomenon as "the recurring puzzle of liberal individualism: once the state, whether acting through its courts or otherwise, has 'liberated' the child—and the adult—from the shackles of such intermediate groups as the family, what is to defend the individual against the combined tyranny of the state and her own alienation?" L. TRIBE, *supra* note 65, § 15-20, at 1418 (footnote omitted).

190. In this regard, consider the following language from recent New Jersey Supreme Court decisions:

"The law has traditionally respected the private realm of family life which the state cannot enter . . . . We believe that this tradition of respect for and confidence in the family should ground our approach to the treatment of the sick." *In re Farrell*, 108 N.J. 335, 355-356, 529 A.2d 404, 414 (1987).

"The decisions of patients' families should determine what sort of medical care permanently unconscious patients [who have not left clear directives] receive." *In re Jobs*, 108 N.J. 394, 417, 529 A.2d 434, 446 (1987).

"Public opinion . . . support[s] th[is] approach to surrogate decisionmaking. Public opinion is relevant in the withdrawal-of-treatment cases that we decide today because they present society with moral, social, technological, and philosophical problems that transcend legal issues . . . . Every recent survey that we have found indicates that society believes that a patient's family members should function as his or her surrogate decisionmakers."

A long line of United States Supreme Court decisions stand for the proposition that there exists a "private realm of family life which the state cannot enter," at least not without a compelling reason.<sup>191</sup> These cases relate to the education of children,<sup>192</sup> decisions regarding procreation,<sup>193</sup> and marriage and divorce.<sup>194</sup> In most instances they strike down legislative efforts to regulate critical life choices such as whom one will marry, if and when one will become a parent, and how one will raise, care for, and educate one's children. So long as no demonstrably serious harm will be done to the social order by such private decisions, and so long as no abuse or neglect is inflicted on children, such determinations are to be made, in our constitutional scheme, by the affected individuals and not by the government. There is a recognition by the Court, gleaned from the language in these opinions, of the vital role that privacy and intimacy play in the dynamics of the family not unlike the role that Kass gives privacy in the dynamics of the physician-patient relationship.<sup>195</sup> The following is an apt description of the phenomenon:

The family project of childrearing requires intimacy, a blurring of the boundaries of individual identity. Intimacy in turn requires privacy and autonomy from state intervention. To preserve the necessary intimacy, and the privacy it requires, . . . rights language [should be] reserve[d] for the interaction of the family members with the outside world. But for interfamilial matters, . . . [p]arents can be seen as representing the interest of the family as an integrated whole in addition to representing their own particular interests . . . even when what is at issue is a conflict in interest between the parent as individual and the child as individual.<sup>196</sup>

The role of the family in surrogate decisionmaking is a logical extension of its nurturing role in the rearing of children. Schoeman posits several beneficial effects from the proposition that families are entitled to a presumption of privacy and autonomy within the realm of their private decision making:

1. An intimate sphere is safeguarded from intrusions by third parties;
2. An intimate group is able to foster meaningful autonomy for its members;

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*Id.* at n.11. To put these fine sentiments in perspective, however, we must recall that this same court mandates the involvement of the "Granny Doe" squads in every case of withdrawal of life support from the institutionalized elderly, even where close family members are present. See *supra* note 188.

191. *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944).

192. *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923).

193. *Cleveland Bd. of Educ. v. LaFleur*, 414 U.S. 632 (1974); *Roe v. Wade*, 410 U.S. 113 (1973); *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Skinner v. Oklahoma*, 316 U.S. 535 (1942).

194. *Turner v. Safley*, 482 U.S. 78, (1987); *Zablocki v. Redhail*, 434 U.S. 374 (1978); *Boddie v. Connecticut*, 401 U.S. 371 (1971); *Loving v. Virginia*, 388 U.S. 1 (1967).

195. L. KASS, *supra* note 21.

196. R. GOLDSTEIN, *MOTHER-LOVE AND ABORTION* 35-36 (1988) (quoting Schoeman, *Rights of Children, Rights of Parents, and the Moral Basis of the Family*, 91 *ETHICS* 6, 9 (1980)).



3. In the case of vulnerable and compromised persons, it secures protection from decisions by third parties such as courts, which are inclined to discount the patient's lived world and defer to objective standards.<sup>197</sup>

Schoeman and others<sup>198</sup> who argue for privacy and autonomy in personal and family decisionmaking are often criticized for promoting an arbitrary and subjective decisionmaking process that is devoid of objective standards such as those that would purportedly be applied by courts, ombudspersons, welfare agencies, and other arms of government. Our ultimate goal in surrogate decisionmaking should not be the "right" result, for there is no such thing; nor a perfectly objective result, for competent adults making such critical decisions for themselves are never perfectly objective; but rather, the result that most closely approximates the one the patient would have reached if competent at the critical moment of decision. There can be no one better situated to reach that result than the patient's loved ones.<sup>199</sup>

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197. Jecker, *The Role of Intimate Others in Medical Decision Making*, 30 *THE GERONTOLOGIST* 65, 68 (1990). Number three, of course, reflects the fate of Mary O'Connor and Nancy Cruzan, victims of the rigid application of the clear and convincing evidence standard. In this seminal article on intimate personal relationships, of which the family is the pre-eminent example, Schoeman clearly regards freedom from outside intrusion—by third parties or the state as an entity—as a condition absolutely essential to its existence. In this regard he states:

Privacy and autonomy provide the moral space within which concrete personal relationships can be formed independently of general social concerns. To give the state authority to regulate such relationships would inevitably result in a redirection or 'socialization' of the relationships. We see evidence of this shift in the doctor-patient relationship, wherein doctors are seen increasingly to have direct responsibilities for the health of the population and not for the comfort of specific patients. . . . it should be recognized and made part of our reckoning that systems of meaning can be uprooted in the process of realigning commitments.

Schoeman, *Rights of Children, Rights of Parents and the Moral Basis of the Family*, 91 *ETHICS* 6, 15 (1980). Schoeman admonishes society against utilizing the instrumentality of the state to invade and thereby disrupt institutions such as the family and other committed relationships built upon love and trust, except upon a showing of some clear-and-present danger, for the very reason that such intervention drastically and perhaps irrevocably alters them by violating their privacy and integrity. In Schoeman's own words, "[W]hile the state is quite limited in its ability to promote relationships, it can do much to destroy them." *Id.* at 16.

198. See Fuller, *Human Interaction and the Law*, 14 *AM. J. JURIS.* 1 (1969). Buchanan and Brock also argue against a narrow and rigid definition of family: "For purposes of surrogate decisionmaking, the family is whomever the individual is most closely associated with. This point is especially important at a time when alternatives to marriage and the nuclear family are becoming more common." A. BUCHANAN & D. BROCK, *DECIDING FOR OTHERS* 136 (1989).

199. In their recent work devoted entirely to the ethics of surrogate decisionmaking, Buchanan and Brock cogently reinforce the primacy of the family's role in medical decisionmaking for minors and the adult incapacitated over that of the medical profession or the state. In particular, they emphasize the need to protect the family's zone of privacy:

The reasons for allowing this latitude in the family's [surrogate decisionmaking for incapacitated adults] . . . are the fact that the family is generally more knowledgeable about the patient's preferences and values, and more interested in his or her good, and the need to protect the family from unnecessary intrusions. . . . [S]uitable *intervention* principles will allow parents considerable leeway . . . in order to protect the family from intrusions that would violate the privacy which it requires if it is to thrive as an intimate union whose value to those who participate in it depends in great part upon its intimacy.

A. BUCHANAN & D. BROCK, *supra* note 198, at 147, 237. For articulation of the viewpoint

The commingling of autonomy in decisionmaking and privacy from outside interference is essential to the foundation for a presumed guardianship of the family in healthcare decisionmaking. Some semblance of autonomy survives incompetence to the extent that treatment decisions are made by family who know the patient intimately and seek to decide as he would have decided based on their personal knowledge of his goals, beliefs and preferences. But more importantly, the coequal privacy aspect of the constitutional principle—freedom from interference in one's private affairs by strangers in general, and the government in particular — will be fully preserved.<sup>200</sup> Although not actually using the term "presumed guardianship of the family," the President's Commission report on healthcare decisionmaking strongly affirms the primary role of the family in surrogate decisionmaking for many of the reasons already discussed.<sup>201</sup>

Every public opinion poll taken in the last ten years indicates that a clear majority of Americans believe that a patient's family members should make medical decisions on the patient's behalf when he or she is unable to do so. This appears to constitute the kind of evolving societal consensus upon which the Supreme Court has historically based a determination that an unenumerated right is fundamental in a constitutional

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that the family should not only be the surrogate decisionmaker, but should base such decisions on consideration of the family's needs and interests as well as the patient's, see Hardwig, *What About the Family?*, 20 HASTINGS CENTER REP. 5 (1990). Starting from the premise that the lives of patients and those who are close to them cannot be detached for purposes of making treatment decisions, Hardwig argues:

Instead of starting with our usual assumption that physicians are to serve the interests of the patient, we must build our theories on a very different assumption: The medical and nonmedical interests of both the patient and other members of the patient's family are to be considered. . . . I would argue that we must build our theory of medical ethics on the presumption of equality: the interests of patients and family members are morally to be weighed equally; medical and nonmedical interests of the same magnitude deserve equal consideration in making treatment decisions.

*Id.* at 7.

200. In the case of incompetent adults for whom treatment decisions are made by family surrogates, and minor children for whom decisions are made by parents, the decision can be said to be that of the surrogate or the child in the sense that it most closely approximates his interests and hence should be free from state interference. For further elaboration of this viewpoint see Garvey, *Freedom of Choice in Constitutional Decisionmaking*, 94 HARV. L. REV. 1756, 1782-84 (1981).

Other commentators have also alluded to a constitutional dimension to the role of the family as surrogate decisionmaker for incompetent patients. See, e.g., Areen, *The Legal Status of Consent Obtained from Families of Adult Patients to Withhold or Withdraw Treatment*, 258 J. A.M.A. 229, 234 (1987); Comment, *Judicial Postponement of Death Recognition: The Tragic Case of Mary O'Connor*, 15 AM. J. L. & MED. 301, 327-28 (1989); Note, *Privacy, Family and Medical Decisionmaking for Persistent Vegetative Patients*, 11 CARDOZO L. REV. 713, 732-33 (1990).

201. The Commission report urges utilization of close family as surrogates, rather than judges, guardians having no direct familiarity with the patient, or welfare agencies, because the family is most concerned and knowledgeable about the patient's goals, preferences and values, the family is entitled to recognition as an important social unit that should be considered the responsible decisionmaker in matters intimately affecting its members and the family is an institution that requires a protected sphere of privacy and autonomy in order to flourish. For those reasons, the state should not intrude, except for compelling reasons, in highly personal matters about which opinions in society range widely. PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE & BIOMEDICAL & BEHAVIORAL RESEARCH, *MAKING HEALTH CARE DECISIONS* 127-32 (1982).

sense.<sup>202</sup> Given the weight of legal and ethical authority behind the surrogate decisionmaking role of the family, and its support among the population generally, a plausible basis exists for finding a constitutional dimension to a presumed guardianship of the family.

As other commentators who have argued for a presumption of family decisionmaking for incapacitated adult patients have acknowledged, such a presumption must be rebuttable in order to prevent the rare instances of abuse.<sup>203</sup> The important procedural difference under a constitutionally-based presumed guardianship of the family, at least where the family is in agreement on the nontreatment decision, or there is a hierarchy established and the highest-ranking person disagrees with the physician's recommendation of continued treatment, is that the physician or institution must either accept the surrogate's decision or carry the burden to challenge it in court. Liability would attach if neither were done. The most significant difference from the practice currently followed in the majority of such actions is that in any litigation to challenge the surrogate's decision, the physician or institution should have the burden of proving, arguably by clear and convincing evidence, that the surrogate's choice was unreasonable or not in the best interests of the patient.<sup>204</sup> As Justice Brennan points out in *Cruzan*, if there is a fundamental constitutional right to refuse medical treatment that survives incapacity, then Missouri's clear and convincing evidence standard is not the least restrictive means for the state properly to protect patients from abuse by uncaring or ignorant surrogates and unethical physicians.<sup>205</sup> To adequately protect the privacy of the patient, the state should have the burden of proving by clear and convincing evidence that the decision of the surrogate is not what the now incompetent patient would have chosen for herself or is not in her best interest if there is no evidence of what she would have decided. Furthermore, if the countervailing state interests are properly made an issue in the case, then the proponent would have the burden of establishing a compelling reason why they should prevail over the patient's constitutional right to privacy.<sup>206</sup> As noted earlier, the most tragic and demoralizing aspect of the *Cruzan* decision is that the process that was upheld completely fails to consider the patient's interests.

#### E. *Consequences of a Constitutional Right to Refuse Treatment*

Commentators such as Ellman predict dire consequences if such a right, exercisable by surrogates on behalf of incompetent patients, were

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202. See J. CHOPER, *JUDICIAL REVIEW AND THE NATIONAL POLITICAL PROCESS* 73-75 (1980).

203. Rhoden, *Litigating Life and Death*, *supra* note 5, at 440.

204. *Id.* at 441.

205. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2872 (1990) (Brennan, J., dissenting).

206. For a detailed argument in favor of the proposition that there should be a rebuttable presumption that all citizens have a right to conduct their lives free of governmental regulation, at least as to self-regarding conduct, see Craven, *supra* note 158, at 706.

to be elucidated by the Supreme Court.<sup>207</sup> Such "predictions," however, are based upon patently erroneous assumptions such as that of the family being made "the unreviewable arbiter" of treatment decisions, something which no one has advocated in any of the major right to refuse treatment cases.<sup>208</sup> Ellman and others also argue that the Court should abstain from finding a constitutional right in this area in order to leave the state legislatures free to weigh competing considerations.<sup>209</sup> The arguments to the contrary are much more compelling in light of events in the last decade. The New Jersey Supreme Court has decided more significant "right to die" cases than any other court because the New Jersey legislature has failed to produce any relevant legislation during the more than ten years between *Quinlan* and *Jobes*.<sup>210</sup> Furthermore, phrases such as "right to life" and "right to die" are testimony to the politicization of these issues to an extent which virtually insures that the legislative outcome will not be the product of a trenchant, enlightened and interdisciplinary interchange, but rather the strident clash of single-issue politics.<sup>211</sup>

Recognition of a constitutional right to refuse treatment and a presumed guardianship of the family as described above would almost certainly reduce the volume of litigation. First, it would give comfort to responsible healthcare providers that they would not be held civilly or criminally liable for respecting the constitutional rights of patients and their families. Second, from the standpoint of benefits conferred against burdens imposed, the choice between abiding by the decision of the patient or his family and seeking to override it in the face of a presumption of validity would naturally limit the legal challenges to those appropriate cases in which the patient is demonstrably incompetent and the family unreasonably withholds consent to treatment that is clearly in the patient's best interest.

Another major impact of the recognition of such a constitutional right may be the invalidation of a number of state living will statutes. Most such statutes limit their applicability to patients who are terminally ill. In addition to the problem that there is no medical consensus as to when or if a particular condition may be considered terminal, there is

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207. Ellman, *supra* note 137, at 400. See also Mayo, *Constitutionalizing the Right to Die*, 49 MD. L. REV. 103 (1990).

208. Ellman, *supra* note 137, at 400; Mayo, *supra* note 207, at 103.

209. Ellman *supra* note 137 at 401; Mayo, *supra* note 207, at 145.

210. Except, of course, for creation of the "Granny Doe" squads. See, e.g., McIntyre, *The Conroy Decision: A Not-So-Good Death*, in BY NO EXTRAORDINARY MEANS 260 (Lynn ed. 1986).

211. In discussing abortion legislation, Tribe argues that "the customary assumption that legislation reflects a balanced weighing of permissible objectives and is thus entitled to judicial deference is brought to the breaking point when the challenged legislation has been shaped in the cauldron of heated religious controversy." Tribe, *Forward: Toward a Model of Roles in the Due Process of Life and Law*, 87 HARV. L. REV. 1, 31 (1973). The latest and most grotesque example is the abortion bill which was passed by both houses of the Louisiana legislature. Intended to be the vehicle by which *Roe v. Wade*, 410 U.S. 113 (1973) is overturned, it provided no exceptions for cases of rape or incest. The same protagonists in the abortion debates are present and accounted for whenever legislatures debate bills that would empower individuals with regard to decisions affecting control of their bodies.

the more compelling fact that there are no such restrictions on a competent patient's right to refuse treatment. Since the intent of the person who executes a living will is to exercise his legal right to accept or decline certain procedures while competent, in anticipation of a time when he might not be competent, the state may not limit that exercise without a compelling reason. It is difficult to justify a statute that would force incompetent patients to endure invasive procedures that are against the wishes they expressed while competent when the same could not be forced upon patients who never lose competence.

Similarly, a number of living will statutes exclude nutrition and hydration from the medical treatments that may be refused by this form of advance directive. With the recognition of a constitutional right to refuse treatment, such a distinction between the rights of competent and incompetent patients should be highly suspect. It is difficult to discern why, as a matter of sound public policy, a competent patient should be able to prevent the insertion of a nasogastric tube, but should be unable to effectuate the same refusal by written directive in the event of future incompetency.<sup>212</sup>

The last significant change that would be likely to flow from the constitutional stature of the right to refuse treatment is the manner in which the courts have applied the third state interest, the protection of innocent third parties. Thus far, a determinative factor as to whether this state interest will overcome the autonomy of the patient depends on whether the patient is the parent of any minor children who, without her, might become wards of the state. If the patient has no children, then of course the interest is held not to apply. If the patient has minor children, but also has the other parent in the home to care for them, or has at least provided for them financially in the event of her death, there is a basis for the court to find that the state interest has been met or is not sufficiently compelling to override the patient's interest in autonomy.<sup>213</sup> On the other hand, if the patient is a single parent with no means to provide financially for her minor children upon her death, then a court might be inclined to rule that this state interest is sufficiently compelling to justify overriding the patient's refusal of treatment.<sup>214</sup> Such an analysis, and the distinctions that it makes based upon

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212. The ruling of the Court in *Cruzan* gives no clear indication of the situations in which a state's generalized interest in maintaining the sanctity of human life may constitutionally override a competent patient's refusal of treatment or the dictates of an incompetent patient's living will. Under Missouri's living will statute, even if Nancy Cruzan had properly executed a living will clearly declining tube feeding under such circumstances, it would not have been enforced by the Missouri Supreme Court; however, it would appear that at least five U.S. Supreme Court Justices (the dissenters plus Justice O'Connor) would hold that to be a violation of Nancy's liberty interests under the Fourteenth Amendment. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990).

213. See, e.g., *In re Osborne*, 294 A.2d 372 (D.C. 1972) (court refused to order transfusion of a 34-year-old man with two children who had a wife who supported his refusal and who had materially provided for his two minor children).

214. See, e.g., *Hamilton v. McAuliffe*, 277 Md. 336, 353 A.2d 634 (1976) (trial court order for a blood transfusion over the competent patient's objection upheld because he was the sole support of a two-year-old child).

gender, marital status, and financial position, would be very unlikely to withstand fourteenth amendment equal protection scrutiny.<sup>215</sup>

It has been suggested that the issue of refusing medical treatment has been evolving over the last two decades from medicalization in the seventies to legalization in the eighties to politicization in the nineties.<sup>216</sup> The *Cruzan* ruling vindicates Johnson's prediction that the coming decade will shift the focus of treatment refusal to the state legislatures, which, upon the invitation of Justice O'Connor, will serve as the "laboratories" wherein procedures for safeguarding the liberty interests of incompetent patients will be tested.<sup>217</sup>

Now that the Supreme Court has recognized that the four state interests can constitutionally be balanced against a patient's fourteenth amendment liberty interest in determining what medical treatment he will undergo, a puzzling question persists. If what is really at stake in treatment refusal cases is one or more legitimate interests of the state which, in at least some instances may be deemed sufficiently compelling so as to overcome a citizen's fundamental constitutional right, why have the states, even the most zealous among them, Missouri, tolerated such a haphazard mode of assertion? I began this article with the acknowledgement that treatment refusal lawsuits represent a distinct minority of the universe of instances in which patients or their surrogates decline medical treatment necessary to prevent morbidity or mortality. Assuming, *arguendo*, that the state has one or more interests in overriding treatment refusals in all such cases, then in most of them the state's interests will never be asserted or considered. It seems paradoxical at the very least that the states, in view of this obvious and distressing fact, would not at some point during the last decade have created a mechanism for insuring that these interests are always factored into the equation.

For example, rather than relying upon the serendipitous manner in which some physicians challenge some treatment refusals by some patients, legislation might be enacted (such as created the "Granny Doe" squads in New Jersey) that establishes an affirmative obligation on the part of all licensed physicians to immediately report any treatment refusal by a patient or surrogate that poses a likelihood of morbidity or mortality. Once reported by the physician to the designated state authority, the Attorney General could then be charged with filing an action in the proper court so that the state's interests could be balanced against the right of the patient to refuse treatment.

The fact that no such proposal has been implemented, or even proposed to the best of my knowledge, may indicate several things. First, such a mechanism would be extremely cumbersome and costly. Second, it would provoke the wrath of organized medicine and civil liberties in-

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215. For a discussion of the level of scrutiny required when state classifications burden a fundamental constitutional right, see L. TRIBE *supra* note 65, § 16-7, at 1454.

216. Johnson, *From Medicalization to Legalization to Politicization: O'Connor, Cruzan, and Refusal of Treatment in the 1990's*, 21 CONN. L. REV. 685 (1989).

217. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2859 (1990) (O'Connor, J., concurring).

terest groups. But third, and I suggest most importantly from the perspective of this article, the state as the embodiment of the collective political will of its citizens has no real or legitimate interest in such Orwellian medical practice. Although it may be difficult to motivate citizens to rise up in righteous indignation when an isolated patient randomly finds his treatment decision challenged in court by his physician, it would be quite another matter to attempt to systematically subject all patient refusals with serious consequences to bureaucratic scrutiny and legal action. Such a proposal would be political martyrdom for the elected officials who had the temerity to suggest it.

Hopefully, the faith that Justice O'Connor has reposed in the state legislatures will prove to be well-founded, and instead of the totalitarian scenario described above, other states will follow the lead of those that have already recognized the role of the family as surrogate decisionmakers for incompetent patients.<sup>218</sup> Such statutes can be drafted so that individual and family privacy in healthcare decisions is preserved and protected without unduly compromising the legitimate role and responsibility of the state as *parens patriae* when actual cases of abuse or neglect of an incapacitated person are presented.

## V. CONCLUSION

Ivan Illich attacks the phenomenon of iatrogenic disease or illness that results from medical interventions.<sup>219</sup> Since virtually all medical procedures carry risks of adverse consequences, all medications have one or more negative side-effects, and hospitalization presents the possibility of nosocomial infections, medication errors, and other untoward patient incidents, they must be factored into any objective analysis of the impact of medical interventions. Such outcomes are the antithesis of the Hippocratic admonition that before all else the physician should do no harm. Illich's contention is that the increasing medicalization of society has the potential for causing more harm than benefit. Regardless of the extent to which one accepts this proposition, it can also be said that there has occurred a parallel and simultaneous process—the legalization of medical practice. It is quite common for hospitals, once they reach a certain critical mass, to establish in-house legal staffs. Also, as physicians increasingly practice in group settings, in the form of large clinics, HMO's, or as actual employees of hospitals, their interactions with attorneys and reliance, if not dependence, upon legal advice in rendering patient care has significantly increased. One area in which the advice and counsel of attorneys has been increasingly sought and followed is that of treatment refusals by patients or their families.

Just as physicians have a role as "gatekeeper" in modern healthcare

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218. For examples of progressive legislation intended to cover situations such as that in the *Cruzan* case, see N.C. GEN. STAT. § 90-322 (1985); UTAH CODE ANN. § 75-2-1107.

219. I. ILLICH, *MEDICAL NEMESIS* (1975). "Iatrogenic" is derived from the Greek roots "iatros", meaning "doctor" and "genic" meaning "arising from". Iatrogenic illness means one caused by a physician.

delivery, counsel to hospitals and physicians are, in a very real sense, the gatekeepers with regard to the legal system in general and the courts in particular. This role has come under increasing scrutiny and criticism of late.<sup>220</sup> The practice of defensive health law has often translated into the seeking of judicial involvement whenever there is a conflict between the physician's recommendation and the patient's decision. Virtually all of the cases discussed in this article, including *Cruzan*, were precipitated by the refusal of healthcare providers—physicians, hospitals, or nursing homes—to accept the informed refusal of treatment by competent patients or the guardians or close family members of incompetent patients. Few, if any, of these cases posed any actual and material threat of liability to those healthcare providers that legally or ethically justified litigating the refusal of treatment.

Nevertheless, represented by counsel, private medical treatment decisions became public legal controversies, in some instances with numerous amicus briefs filed on both sides of the issue. Since few, if any, courts have ever refused to hear and rule upon these cases, it is not surprising that they proliferate. Unless the more egregious cases are dismissed with a finding that the providers were engaging in groundless and frivolous litigation, no attorney for a health care provider will be able to conscientiously advocate not resolving such disputes through the courts.

The practice of defensive clinical and legal medicine, born of the generally litigious nature of modern American society, in fact produces yet more litigation of the type addressed in this article—iatrogenic litigation. The courts, facing overcrowded dockets and being generally ill-equipped to make the kinds of decisions foisted upon them by hospitals and physicians, can stem this tide of cases through prompt and judicious application of existing contractual, procedural, and constitutional principles. Furthermore, they have the ethical responsibility to do so. Only then will the physician-patient relationship have any reasonable chance of being returned to the realm of the private and personal encounter that is based on confidentiality and mutual trust and respect.

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220. See Nelson & Cranford, *Legal Advice, Moral Paralysis, and the Death of Samuel Linares*, 17 *LAW, MEDICINE, AND HEALTH CARE* 316 (1989).



