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Articles

CONSTITUTIONALIZING THE "RIGHT TO DIE"

THOMAS WM. MAYO*

"Concepts without perceptions are empty; perceptions without concepts are blind."¹

INTRODUCTION

On July 3, 1989, the United States Supreme Court handed down its long-awaited decision on abortion in *Webster v. Reproductive Health Services*.² On the same day, the Court not only accepted three more abortion cases for review in its 1989 Term,³ but also agreed to hear for the first time a case involving the withdrawal of life-sustaining medical treatment: *Cruzan v. Director, Missouri Department of Health*.⁴

The Court's speed in accepting three new abortion cases for its next term was surprising. *Webster* had subjected the Court to a barrage of publicity, demonstrations, and amicus briefs that probably was without equal in the Court's history.⁵ Moreover, the process of

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1. The quotation has been attributed to Immanuel Kant. See A. MACINTYRE, *A SHORT HISTORY OF ETHICS* 191 (1966). Try as I might, I have not found the original source of this quotation, although its sense pervades most of Kant's *Critique of Pure Reason*. See Walsh, *Immanuel Kant*, in 4 *ENCYCLOPEDIA OF PHILOSOPHY* 305 (P. Edwards ed. 1967).

2. 109 S. Ct. 3040 (1989).

3. *Ohio v. Akron Center for Reproductive Health*, 109 S. Ct. 3239 (1989) (probable jurisdiction noted); *Turnock v. Ragsdale*, 109 S. Ct. 3239 (1989) (question of jurisdiction postponed to hearing of case on the merits), *dismissed by consent of parties*, 1989 U.S. LEXIS 5818; *Hodgson v. Minnesota*, 109 S. Ct. 3240 (1989) (certiorari granted).

4. 109 S. Ct. 3240 (1989) (certiorari granted).

5. See Kolbert, *The Webster Amicus Curiae Briefs: Perspectives on the Abortion Controversy and the Role of the Supreme Court*, 15 *AM. J.L. & MED.* 153, 154 nn. 5 & 6 (1989); see also 109 S. Ct. at 3064 (Scalia, J., concurring) (noting the Court's "sovereignty [over abortion law] which . . . quite properly, but to the great damage of the Court, makes it the

decision, if the final opinions are any guide, must have been a bruising one.⁶ Court observers might have been excused their mistaken belief that the Court would wait for at least a year before reopening these fresh wounds.

The decision to accept *Cruzan*, on the other hand, was both more and less of a surprise. It was more surprising because the Court had never before accepted a so-called "right to die"⁷ case,

object of the sort of organized public pressure that political institutions in a democracy ought to receive").

6. The case produced five separate opinions. See *Webster*, 109 S. Ct. at 3046 (Rehnquist, C.J., plurality opinion); *id.* at 3058 (O'Connor, J., concurring); *id.* at 3064 (Scalia, J., concurring); *id.* at 3067 (Blackmun, Brennan & Marshall, JJ., concurring in part and dissenting in part); *id.* at 3079 (Stevens, J., concurring in part and dissenting in part). Chief Justice Rehnquist's opinion for the Court consisted of a statement of facts (Part I) and analysis (Parts II-A through -C). *Id.* at 3047, 3049-54. Part II-D of his opinion and his conclusion (Part III) were joined only by Justices White and Kennedy. *Id.* at 3054-58. The Chief Justice's opinion was joined by three different alignments of the Justices. In addition, the Justices' divisiveness in *Webster* occasionally was matched by the hostile and even scornful tone of their rhetoric. For example, Justice Scalia wrote that part of Justice O'Connor's opinion "cannot be taken seriously," *id.* at 3064, and characterized both the result in *Webster* and another of Justice O'Connor's arguments as "irrational," *id.* at 3066 n.*. Justice Blackmun's opinion evidences a similar exasperation with his colleagues:

Never in my memory has a plurality announced a judgment of this Court that so foments disregard for the law and for our standing decisions. . . . Nor in my memory has a plurality gone about its decision in such a deceptive fashion. . . . I fear for the integrity of, and public esteem for, this Court.

Id. at 3067 (Blackmun, J., concurring in part and dissenting in part).

7. Commentators are fond of putting the words "right to die" in quotation marks, as the title of this article does, as if to preface them with the phrase "the so-called." See, e.g., B. FURROW, S. JOHNSON, T. JOST & R. SCHWARTZ, *HEALTH LAW—CASES, MATERIALS AND PROBLEMS* 835-954 (1987); J. NOWAK, R. ROTUNDA & J. YOUNG, *CONSTITUTIONAL LAW* 764-65 (2d ed. 1983); Fletcher, *The "Right" to Live and the "Right" to Die*, *HUMANIST*, July-Aug. 1974, at 12; Rhoden, *Litigating Life and Death*, 102 *HARV. L. REV.* 375, 375 (1988); Comment, *Suicidal Competence and the Patient's Right to Refuse Lifesaving Treatment*, 75 *CALIF. L. REV.* 707, 719 (1987); Note, *Criminal Liability for Assisting Suicide*, 86 *COLUM. L. REV.* 348, 354 (1986) [hereinafter Note, *Criminal Liability*]; Note, *Appointing an Agent to Make Medical Treatment Choices*, 84 *COLUM. L. REV.* 985, 987 (1984); Verhovek, *'Right to Die' Inquiries Rise After Rulings*, *N.Y. Times*, June 26, 1987, B1, col. 2. Although "right to die" is an instantly evocative phrase, for some of these writers the preferred statement of the issue invokes the right to refuse treatment rather than the right to die. E.g., Annas, *The Insane Root Takes Reason Prisoner*, *HASTINGS CENTER REP.*, Jan.-Feb. 1989, at 29. Is this anything more than a linguistic dodge? After all, when dealing with life-sustaining treatment, a patient's or guardian's refusal to consent to treatment surely will lead to the patient's death; that is the whole point. Why should we not confront this inevitable and sought-after end in our statement and analysis of the issue?

One reason for avoiding the "right to die" formulation of the patient treatment problem is that it merely pits one set of preferences against another: the patient's choice of a hastened death versus the state's traditional role of preserving and protecting life. The claimed right to die unavoidably bumps up against the state's duty to protect and preserve life. It, however, is a conflict that lacks rules and standards for decision. When

despite its opportunities to do so,⁸ and because some respectable doubt existed as to whether the federal constitutional right of privacy recognized in *Griswold v. Connecticut*⁹ and *Roe v. Wade*¹⁰ extended to medical decision-making in such cases.¹¹ Admittedly, the Court's mere acceptance of the case does not constitute a declaration that the federal right of privacy extends to medical decision-

this clash of naked preferences occurs in litigation, there is precious little legal content to guide decision-makers but, rather, a subjective choice by a judge whose own preferences are the likeliest guide to a result.

Moreover, viewing these as "right to refuse treatment" cases brings into view the doctrine, recognized to some extent in all American jurisdictions, of informed consent. The right of a patient not only to be given the relevant information needed to make a choice concerning medical treatment, but also to decide in favor of a given treatment option or against all treatment options, is fundamental to both ethical and legal thinking about the rights of patients. See P. APPELBAUM, C. LIDZ & A. MEISEL, *INFORMED CONSENT: LEGAL THEORY AND CLINICAL PRACTICE* 17-32, 35-129 (1987); R. FADEN & T. BEAUCHAMP, *A HISTORY AND THEORY OF INFORMED CONSENT* 3-22, 60-150 (1986); J. KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 48-84 (1984); 1 PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *MAKING HEALTH CARE DECISIONS: A REPORT ON THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP* 18-31, 41-111 (1982). Thus, the shift from "right to die" to "right to refuse life-sustaining medical treatment" introduces, on the patient's side of the argument, a well-recognized legal right that evokes the patient's actual circumstances, against which the state's powerful and basic, but somewhat abstract, preference for life must be weighed.

8. See, e.g., *In re Quinlan*, 137 N.J. Super. 227, 348 A.2d 801 (Ch. Div. 1975), modified, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922 (1976); *In re Storar*, 106 Misc. 2d 880, 433 N.Y.S.2d 388 (Sup. Ct.), aff'd, 78 A.D.2d 1013, 434 N.Y.S.2d 46 (1980), rev'd sub nom. Soper v. Storar (*In re Storar*), 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981); *In re Eichner*, 102 Misc. 2d 184, 423 N.Y.S.2d 580 (Sup. Ct. 1979), aff'd sub nom. Eichner v. Dillon (*In re Eichner*), 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980), modified sub nom. Soper v. Storar (*In re Storar*), 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981).

9. 381 U.S. 479 (1965).

10. 410 U.S. 113 (1973).

11. For example, in *In re Quinlan*, the New Jersey Supreme Court held that the federal right of privacy developed by the United States Supreme Court "is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances." 70 N.J. at 40, 355 A.2d at 663. In *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985), however, the New Jersey Supreme Court appeared to back away from its earlier holding despite the striking similarities between the patient's situations in *Quinlan* and *Conroy*: "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 348, 486 A.2d at 1223 (emphasis added). Only a handful of decisions (and only one by a federal court) have rested the right of an incompetent patient to refuse medical treatment solely upon the federal constitutional right to privacy. See *Gray v. Romeo*, 697 F. Supp. 580, 585-86 (D.R.I. 1988); *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1347 (Del. 1980); *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So. 2d 921, 924 (Fla. 1984); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 739-40, 370 N.E.2d 417, 424-25 (1977); *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1, 9-10, 426 N.E.2d 809, 814-15 (1980).

making. It does suggest, however, that there are not six justices who firmly believe that there is no such federal right.¹² Moreover, a decision to bring the "right to die" cases within the ambit of federal privacy law could thrust the Court into the role of "super medical practice board" for the nation, a role that some justices have abjured in the Court's abortion cases.¹³ Finally, *Cruzan* involves a patient in a persistent vegetative state (PVS)¹⁴ who is receiving artificial nutrition and hydration¹⁵ and who did not execute an advance directive (such as a living will), arguably the most difficult of the "right to die" cases from both a medical and a legal point of view.¹⁶

Nevertheless, there was a certain predictability about the

12. A third possibility should be mentioned, namely, that at least four justices agreed to accept the case to state definitively that no federal constitutional rights are implicated by the Missouri Supreme Court's decision in *Cruzan*.

13. See *Webster v. Reproductive Health Servs.*, 109 S. Ct. 3040, 3057 (1989) (pluralist opinion) (Rehnquist, C.J., joined by White & Kennedy, JJ.); *Planned Parenthood v. Danforth*, 428 U.S. 52, 99 (1976) (Burger, C.J., White & Rehnquist, JJ., concurring in part and dissenting in part).

14. *Cruzan v. Harmon*, 760 S.W.2d 408, 410, 411 (Mo. 1988) (en banc), cert. granted, 109 S. Ct. 3240 (1989). The term "persistent vegetative state" (PVS) is one that has caused considerable confusion in both the legal and medical communities. See Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, HASTINGS CENTER REP., Feb.-Mar. 1988, at 27; Wolf, *The Persistent Problem of PVS*, HASTINGS CENTER REP., Mar.-Apr. 1988, at 26. Unlike "brain death," which denotes the cessation of all brain activity (in both the cerebral hemispheres and the brain stem), PVS is characterized by a relatively intact brain stem system. Thus, the usual brain stem functions—eye movements, pupillary response to light, spontaneous respiration, and the cough, gag, and swallowing reflexes—are present. In part because the protective reflexes are usually normal, which helps to prevent the frequent respiratory infections experienced by comatose patients, the PVS patient without other terminal illness or injury often can survive for long periods of time. Cranford, *supra*, at 27-28.

15. Because PVS patients may retain their gag, cough, and swallowing reflexes, Cranford, *supra* note 14, at 31, "it is theoretically, and in rare cases practically possible, to feed these patients by hand. . . . However, the overwhelming majority of patients are given fluids and nutrition by nasogastric tubing, gastrostomy, or other medical means." *Id.*

16. Professor Yale Kamisar, in his Philip A. Hart Lecture at Georgetown University Law Center, considered the argument that passive euthanasia as it has come to be practiced in the United States risks moving us toward a greater willingness to accept active euthanasia. Kamisar, who believes the "slippery slope" argument has some validity in this instance, offered three plausible and useful points at which we could have drawn the line and forbidden the practice of passive euthanasia:

We might, for example, have (1) stopped short of discontinuing nourishment and hydration; (2) restricted the so-called right to die to *competent* patients who express a desire to die or to those who executed a living will or its equivalent before becoming incompetent; or (3) limited the right to *dying* patients. We have done none of these things.

Y. Kamisar, *Some Call It "Death With Dignity," Others Call It the "Right to Die." What Is It Really?*, Philip A. Hart Lecture, Georgetown Univ. Law Center 4 (Apr. 14, 1988) (empha-

Court's decision to accept *Cruzan*—at least in hindsight. As with other issues repeatedly presented to the Court for decision, the question of a constitutional right to refuse life-sustaining treatment probably needed to "percolate" for a period of time in the lower courts before the Supreme Court could feel comfortable dealing with it. With nearly fifteen years' worth of cases since the New Jersey courts decided *In re Quinlan*,¹⁷ the Court now may feel that the issue has developed sufficiently for a closer look.¹⁸

sis in original) (copy on file with *Maryland Law Review*). All three of Professor Kamisar's proffered stopping-off points, of course, are critical factors present in the *Cruzan* case.

17. 137 N.J. Super. 227, 348 A.2d 801 (Ch. Div. 1975), *modified*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

18. *See, e.g.*, *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987) (en banc); *Drabick v. Drabick (In re Drabick)*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840, *cert. denied*, 109 S. Ct. 399 (1988); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983); *Dority v. Superior Court*, 145 Cal. App. 3d 273, 193 Cal. Rptr. 288 (1983); *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 482 A.2d 713 (1984); *Severns v. Wilmington Medical Center (In re Severns)*, 425 A.2d 156 (Del. Ch. 1980); *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So. 2d 921 (Fla. 1984); *Wons v. Public Health Trust*, 500 So. 2d 679 (Fla. Dist. Ct. App. 1987), *approved*, 541 So. 2d 96 (Fla. 1989); *Corbett v. D'Alessandro*, 487 So. 2d 368 (Fla. Dist. Ct. App.), *review denied*, 492 So. 2d 1331 (Fla. 1986); *In re Guardianship of Barry*, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984); *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *approved*, 379 So. 2d 359 (Fla. 1980); *In re L.H.R.*, 253 Ga. 439, 321 S.E.2d 716 (1984); *Morgan v. Olds*, 417 N.W.2d 232 (Iowa Ct. App. 1987); *In re P.V.W.*, 424 So. 2d 1015 (La. 1982); *In re Gardner*, 534 A.2d 947 (Me. 1987); *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 497 N.E.2d 626 (1986); *Custody of a Minor*, 385 Mass. 697, 434 N.E.2d 601 (1982); *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Hier*, 18 Mass. App. Ct. 200, 464 N.E.2d 959, *review denied*, 392 Mass. 1102, 465 N.E.2d 261 (1984); *In re Dinnerstein*, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978); *In re Conservatorship of Torres*, 357 N.W.2d 332 (Minn. 1984); *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987); *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987); *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *Quinlan*, 70 N.J. 10, 355 A.2d 647; *In re Requena*, 213 N.J. Super. 475, 517 A.2d 886 (Ch. Div.), *aff'd*, 213 N.J. Super. 443, 517 A.2d 869 (App. Div. 1986); *In re Clark*, 210 N.J. Super. 548, 510 A.2d 136 (Ch. Div. 1986), *aff'd*, 216 N.J. Super. 497, 524 A.2d 448 (App. Div. 1987); *In re Visbeck*, 210 N.J. Super. 527, 510 A.2d 125 (Ch. Div. 1986); *Soper v. Storar (In re Storar)*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981); *In re Beth Israel Medical Center*, 136 Misc. 2d 931, 519 N.Y.S.2d 511 (Sup. Ct. 1987); *Workmen's Circle Home & Infirmary for the Aged v. Fink*, 135 Misc. 2d 270, 514 N.Y.S.2d 893 (Sup. Ct. 1987); *In re O'Brien*, 135 Misc. 2d 1076, 517 N.Y.S.2d 346 (Sup. Ct. 1986); *Delio v. Westchester County Medical Center (In re Delio)*, 134 Misc. 2d 206, 510 N.Y.S.2d 415 (Sup. Ct. 1986), *rev'd*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (1987); *Vogel v. Forman*, 134 Misc. 2d 395, 512 N.Y.S.2d 622 (Sup. Ct. 1986); *Saunders v. State (In re Saunders)*, 129 Misc. 2d 45, 492 N.Y.S.2d 510 (Sup. Ct. 1985); *Crouse Irving Memorial Hosp. v. Pad-dock*, 127 Misc. 2d 101, 485 N.Y.S. 2d 443 (Sup. Ct. 1985); *A. B. v. C.*, 124 Misc. 2d 672, 477 N.Y.S.2d 281 (Sup. Ct. 1984); *In re Lydia E. Hall Hosp. v. Cinque*, 116 Misc. 2d 477, 455 N.Y.S.2d 706 (Sup. Ct. 1982); *In re Milton*, 29 Ohio St. 2d 20, 505 N.E.2d 255, *cert.*

Moreover, *Cruzan* was the first of these cases to come to the Court in which the court of decision had not respected a surrogate decision-maker's request to forego life-sustaining treatment.¹⁹ Earlier cases presented to the Court had found such a right and based their holding on either state law or a combination of state and federal law. Thus, the existence of an independent state ground for these lower court decisions made them unlikely candidates for Supreme Court review.²⁰ The *Cruzan* case, by contrast, presented the federal question in perfect relief. As the following recitation of the facts in *Cruzan* illustrates, however, the Court has accepted a proverbial "hard case" for its first attempt to grapple with the notion of a federal right to die.

Following a car accident, Nancy Beth Cruzan was found by a state highway patrol trooper approximately thirty-five feet from her vehicle.²¹ She was not breathing and had no perceptible pulse.²² Although her heart beat and respiration were revived, she did not regain consciousness.²³ Ms. Cruzan had experienced significant deprivation of oxygen to her brain for a period of twelve to fourteen minutes, resulting in irreversible atrophy of her cerebral hemispheres.²⁴ While she has normal respiratory and circulatory function, she lacks both her voluntary and involuntary swallowing ability, and shows no response to all but the most painful stimuli.²⁵ Although her medical condition probably has shortened her life expectancy somewhat,²⁶ medical testimony to the trial court indicated that she could live in this condition for another thirty years.²⁷

denied, 484 U.S. 820 (1987); *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980); *In re Estate of Dorone*, 349 Pa. Super. 59, 502 A.2d 1271 (1985), *aff'd*, 517 Pa. 3, 534 A.2d 452 (1987); *In re Guardianship of Grant*, 109 Wash. 2d 545, 747 P.2d 445 (1987) (en banc); *In re Guardianship of Ingram*, 102 Wash. 2d 827, 689 P.2d 1363 (1984) (en banc); *In re Guardianship of Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984) (en banc); *Dinino v. State ex rel. Gorton*, 102 Wash. 2d 327, 684 P.2d 1297 (1984) (en banc); *In re Welfare of Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983) (en banc).

19. Compare *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (en banc) with cases cited *supra* note 8.

20. See, e.g., *Herb v. Pitcairn*, 324 U.S. 117, 125-28 (1945) (judgments of state courts resting on adequate and independent state grounds will not be reviewed); *Fox Film Corp. v. Miller*, 296 U.S. 207, 210 (1935) (same); *Enterprise Irrigation Dist. v. Farmers' Mut. Canal Co.*, 243 U.S. 157, 164-65 (1917) (same).

21. *Cruzan*, 760 S.W.2d at 410-11.

22. *Id.* at 411.

23. *Id.* at 410-11.

24. *Id.*

25. *Id.*

26. See Cranford, *supra* note 14, at 30-31.

27. *Cruzan*, 760 S.W.2d at 411. Such testimony must be read in light of the substan-

After three weeks in a transient coma,²⁸ Ms. Cruzan recovered somewhat and was able to take food and water orally.²⁹ Thereafter, a gastrostomy tube was inserted through her abdominal wall "to assist her recovery and ease the feeding process."³⁰ She then evolved into a fully developed persistent vegetative state and now gets all of her nutrition and hydration through the gastrostomy tube.³¹

Ms. Cruzan's case became a legal one when her parents, as co-guardians, requested that their daughter's artificial hydration and nutrition be terminated.³² Employees of the Mount Vernon State Hospital, where Ms. Cruzan was being cared for, refused to do so.³³ Her parents then sought, and received, a declaratory judgment that Missouri law could not prevent the removal of her gastrostomy tube without violating her "right to liberty, due process of law and equal protection under the state and federal constitutions."³⁴ The Missouri Supreme Court, sitting en banc, reversed.³⁵

The court held that neither the state nor the federal constitution gave Nancy Beth Cruzan the right to have her gastrostomy tube removed.³⁶ Relying upon Missouri's interest "in the prolongation

tial uncertainty that naturally surrounds such a medical judgment. Nancy Beth Cruzan is young enough that she probably will not be as prone to as many of the "medical complications secondary to prolonged immobility and unresponsiveness" as are elderly PVS patients. See Cranford, *supra* note 14, at 31. On the other hand, her long-term prospects for survival in a persistent vegetative state also depend upon the relative effectiveness of her cough and gag reflexes, as well as the strength of her natural resistance to infection. *Id.* As of March 1988, "[t]he longest reported, well documented, survival (without recovery) was thirty-seven years, 111 days." *Id.*

28. PVS patients who, like Nancy Beth Cruzan, have experienced a significant deprivation of oxygen to the brain for several minutes, are typically in a coma (eyes closed, unconsciousness and impaired or absent involuntary reflexes) before entering a PVS. See Cranford, *supra* note 14, at 28; see also Council on Scientific Affairs & Council on Ethical and Judicial Affairs, *Persistent Vegetative State and the Decision to Withdraw or Withhold Life Support*, 263 J. A.M.A. 426, 427 (1990) [hereinafter *Council Report*].

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

30. *Id.*

31. *Id.*

32. See *id.* at 410.

33. *Id.* As explained by Solicitor General Starr during oral argument before the Supreme Court, Mount Vernon is a rehabilitation facility that is dedicated to the long-term care of patients in chronic conditions and has never before agreed to the removal of nutrition and hydration. See Transcript of Oral Argument at 45-47, *Cruzan v. Director, Missouri Dep't of Health* (U.S. No. 88-1503) (Dec. 6, 1989).

34. *Cruzan*, 760 S.W.2d at 410.

35. *Id.*

36. *Id.* at 417-18. The court's ruling on the Missouri constitution has an elusive, almost surreal quality to it. In the court's view, the issue was whether Nancy Beth Cruzan enjoyed an "unfettered right of privacy under our constitution that would support the right of a person to refuse medical treatment in every circumstance." *Id.* at 417. The court's conclusion, not too surprisingly in light of their unbounded formulation of the

of the life of the individual patient and . . . in the sanctity of life itself,"³⁷ interests that the court deemed unqualified by considerations of the quality of life of a particular patient,³⁸ the court concluded that the state's interests outweighed Nancy Beth Cruzan's interest in refusing treatment.³⁹

Thus, *Cruzan* ultimately turns on a fairly straightforward constitutional issue: Whether the federal constitutional right of privacy extends to decisions, made on behalf of permanently unconscious patients,⁴⁰ to have life-sustaining medical treatment discontinued and, if so, whether a state's interest in the sanctity of life can override the patient's privacy right?⁴¹ This article argues that on doctrinal as well as policy grounds, no such right should be recognized as

question presented, was that she did not. *Id.* at 418. The court's treatment of the federal constitutional issue starts with the same broad question—"If Nancy possesses *such a right*, it must be found to derive from the federal constitutional right to privacy." *Id.* (emphasis added). The court stated that it "carr[ie]d grave doubts as to the applicability of privacy rights to decisions to terminate the provision of food and water to an incompetent patient." *Id.* It went on to conclude—somewhat less broadly, however—that "a decision by Nancy's co-guardians to withdraw food and water *under these circumstances* cannot be sustained." *Id.* (emphasis added).

37. *Id.* at 419.

38. *Id.* at 420; *see also id.* at 422 ("[T]he state's interest is not in quality of life. The state's interest is an unqualified interest in life.").

39. *Id.* at 424. The Missouri Supreme Court never conclusively determined that the federal constitutional right of privacy applied to this situation. Rather, the court in effect concluded that the state's interest in life outweighed whatever federal right Nancy Beth Cruzan might have in having her medical treatment discontinued.

40. Throughout this article, unless the context indicates otherwise, "incompetent patient" refers to patients who have lost consciousness without any reasonable hope of recovery. Different, and in some ways more difficult, issues are raised by the problem of medical decision-making for incompetent patients who are conscious and aware. An example of such a patient is Mary O'Connor in *In re Westchester County Medical Center*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988). It seems remarkable, and somewhat chilling, that neither the New York Court of Appeals nor the press coverage of the case acknowledged that for the first time, the New York Court had implicitly accepted the application of the "substituted judgment" standard to an incompetent patient who was still conscious. *See, e.g., Shipp, Many Courts Have Upheld Right to Die*, N.Y. Times, Oct. 15, 1988, at A36, col. 6; Shipp, *New York's Highest Court Rejects Family's Plea in Right-to-Die Case*, N.Y. Times, Oct. 15, 1988, at A1, col. 1. Despite the ease with which the court appeared to apply to Mary O'Connor legal standards that previously had been applied only to patients who were incompetent and unconscious, the extension of the prior case law to an incompetent, conscious patient seriously challenges the traditional distinction between "killing" and "letting die." It also highlights the "quality of life" determination that is lurking behind most, if not all, decisions to withhold treatment (including nutrition and hydration), even when hospitals, physicians, and courts purport to be following the patient's earlier-expressed wishes.

41. The lower court in *Cruzan* held "that to deny Nancy's co-guardians authority to act under these circumstances would deprive Nancy of equal protection of the law." 760 S.W.2d at 411. The Missouri Supreme Court, with the acquiescence of the parties, viewed "th[e] issue [as] a broad one, invoking . . . the amorphous mass of constitutional

a matter of federal constitutional law. Part I of the article reviews the Supreme Court's privacy decisions, with a special emphasis on the abortion decisions, and concludes that current privacy doctrine does not extend to medical decision-making on behalf of PVS patients. Part II considers whether there are reasons for recognizing a "fundamental right" that is protected by the federal constitution to refuse life-sustaining medical treatment for PVS patients. Part II concludes that, as important as it is to develop a response to the problem of incompetent patients that is ethically, legally, and medically acceptable, strong arguments nonetheless militate against such a move by the Supreme Court and in favor of continued state sovereignty over this issue at this time.

I. THE SUPREME COURT'S PRIVACY CASES

A. *Early Development*

In *Whalen v. Roe*,⁴² Justice Stevens wrote for the Court: "The cases sometimes characterized as protecting 'privacy' have in fact involved at least two different kinds of interests. One is the individual interest in avoiding disclosure of personal matters, and another is *the interest in independence in making certain kinds of important deci-*

rights generally described as the 'right to liberty', the 'right to privacy', equal protection and due process." *Id.* at 412.

For purposes of this article, it is enough to note that, in modern cases, the Supreme Court has regarded the "privacy" right as fundamental to the notion of liberty protected by the due process clause of the fourteenth amendment. See U.S. CONST. amend. XIV, § 1 ("nor shall any State deprive any person of life, liberty, or property, without due process of law"); see also, e.g., *Roe v. Wade*, 410 U.S. 113, 153 (1973) ("This right of privacy [is] founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action."); *id.* at 170 (Stewart, J., concurring) ("Clearly, therefore, the Court today is correct in holding that the right asserted by Jane Roe is embraced within the personal liberty protected by the Due Process Clause of the Fourteenth Amendment."); Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 YALE L.J. 920, 920 (1973) ("The broad outlines of [the Supreme Court's] argument [in *Roe v. Wade*] are not difficult to make out: . . . The right to privacy . . . is protected by the Due Process Clause of the Fourteenth Amendment."). It is of no particular moment whether state action that infringes upon this fundamental right is to be judged under the rubric of "substantive due process" or "equal protection." See, e.g., Schneider, *State Interest Analysis in Fourteenth Amendment "Privacy" Law: An Essay on the Constitutionalization of Social Issues*, 51 LAW & CONTEMP. PROBS. 79, 81 & n.7 (1988); cf. Ely, *supra*, at 928 n.58 ("[The Court's] inability to pigeonhole confidently the right involved [privacy] is not important in and of itself."). The Supreme Court in *Roe* either "borrowed" or "applied" the equal protection clause's heightened judicial scrutiny and required that the state's interference with the privacy right must be justified by reference to a "compelling state interest." See 410 U.S. at 155-56.

42. 429 U.S. 589 (1977).

sions."⁴³ Over the course of more than a dozen privacy decisions, the Supreme Court repeatedly has expressed itself in similar terms that could encompass a patient's right to refuse life-sustaining medical treatment.⁴⁴

The second interest implicated by the right of privacy reflects the Supreme Court's historical willingness to protect the concept of autonomy. In each new privacy case the Court has delineated a little more fully those areas of human conduct in which the Court is willing to make the individual secure from unwarranted intrusion by the state.

This formulation of the privacy issue illuminates the two levels on which a struggle for dominance is played out. The first-order conflict is between the individual who wishes to pursue his or her self-deterministic course, and the state, which—under the expansive rubric of the police power—seeks either to regulate that course of action or to curtail it altogether.⁴⁵ When the claimed right is the

43. *Id.* at 598-600 (emphasis added) (footnotes omitted). The quoted language in the text echoes the Court's words in *Roe*, 410 U.S. at 152 (citations omitted):

The Constitution does not explicitly mention any right of privacy. In a line of decisions, however, . . . the Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution. . . . These decisions make it clear that only personal rights that can be deemed "fundamental" or "implicit in the concept of ordered liberty," are included in this guarantee of personal privacy.

44. *E.g.*, *Webster v. Reproductive Health Servs.*, 109 S. Ct. 3040, 3058 (1989); *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 772 (1986); *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 427 (1983); *Bellotti v. Baird*, 443 U.S. 622, 655 (1979) (Blackmun, J., concurring); *Colautti v. Franklin*, 439 U.S. 379, 386 (1979); *Planned Parenthood v. Danforth*, 428 U.S. 52, 70 n.11 (1976); *Roe*, 410 U.S. at 153 (1973); *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972); *Loving v. Virginia*, 388 U.S. 1, 7 (1967); *Griswold v. Connecticut*, 381 U.S. 479, 484-85 (1965); *Prince v. Massachusetts*, 321 U.S. 158, 166 (1944); *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942); *Pierce v. Society of Sisters*, 268 U.S. 510, 534-35 (1925); *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923); *Allgeyer v. Louisiana*, 165 U.S. 578, 589-90 (1897); *see also, e.g.*, *Doe v. Bolton*, 410 U.S. 179 (implying recognition of a patient's right to refuse treatment).

45. Most courts have, to one degree or another, treated the right to die issue as one involving a balance of individual rights and state interests. In *In re Quinlan*, the New Jersey Supreme Court saw the dispute as one between the patient's right to die, on the one hand, and the state's interest in preserving life and the physician's right to administer medical treatment according to his or her best judgment, on the other. 70 N.J. 10, 40-42, 355 A.2d 647, 663-64, *cert. denied*, 429 U.S. 922 (1976). Later cases adopted this general approach. *See, e.g.*, *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 195, 209 Cal. Rptr. 220, 225 (1986); *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); *In re Jobes*, 108 N.J. 394, 426-27, 529 A.2d 434, 451 (1987); *Estate of Leach v. Shapiro*, 13 Ohio App. 3d 393, 395, 469 N.E.2d 1047, 1051-52 (1984).

The balancing approach received its most influential restatement by the Massachu-

right to refuse medical treatment, the courts in the seventeen states that have considered the question⁴⁶ have been, on the whole, quite yielding. They generally recognize at least a qualified right to refuse life-sustaining medical treatment that may be exercised by competent patients⁴⁷ and by guardians or others on behalf of incompetent patients.⁴⁸ By contrast, *Cruzan* represents one of the few cases in which the state refused to yield to the autonomy claimed on behalf of an incompetent patient.⁴⁹

The second-order conflict is between the states, who would draw the boundaries and define the content of any right to refuse to consent to medical treatment, and the federal government, represented by the Supreme Court, which holds the ultimate trump card of the federal constitution. Thus, one of the questions raised by *Cruzan*, as with all privacy cases, is whether the autonomous right of

sets Supreme Judicial Court in *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977). In that case, the patient was a 67-year-old state institutionalized resident with an I.Q. of 10 suffering from leukemia, for whom the treatment issue involved chemotherapy. *Id.* at 731, 370 N.E.2d at 420. The court identified four countervailing state interests to be weighed against the wishes expressed on behalf of the incompetent patient: the state's "interest in: (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." *Id.* at 741, 370 N.E.2d at 425. These interests have been recited with talismanic regularity in the majority of right to die cases decided since *Saikewicz*.

46. See *supra* note 18.

47. See, e.g., *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr. 297, 300 (1986); *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 195, 209 Cal. Rptr. 220, 225 (1984); *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978), approved, 379 So. 2d 359 (Fla. 1980); *Lane v. Candura*, 6 Mass. App. Ct. 377, 384, 376 N.E.2d 1232, 1236 (1978); *In re Quackenbush*, 156 N.J. Super. 282, 290, 383 A.2d 785, 789 (Prob. Div. 1978); *Erickson v. Dilgard*, 44 Misc. 2d 27, 28, 252 N.Y.S.2d 705, 706 (1962); *In re Yetter*, 62 Pa. D. & C.2d 619, 623 (1973). Professor George Annas' comments reflect the clear trend: "It is almost incredible that anyone could ever think that it was acceptable to force unwanted treatment on a patient. Competent adults may refuse any treatment, including life-saving and life-sustaining treatment, and artificial nutrition and hydration." G. ANNAS, *THE RIGHTS OF PATIENTS* 199-200 (1989) (emphasis in original).

48. E.g., *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 431, 441, 497 N.E.2d 626, 633, 639-40 (1986); *In re Torres*, 357 N.W.2d 332, 341 (Minn. 1984); *In re Eichner*, 52 N.Y.2d 363, 372, 420 N.E.2d 64, 68, 438 N.Y.S.2d 266, 270 (1981) (but only when clear and convincing evidence existed as to the patient's desires regarding the use of such procedures); *In re Colyer*, 99 Wash. 2d 114, 127-28, 660 P.2d 738, 746 (1983).

49. See also, e.g., *Vogel v. Forman*, 134 Misc. 2d 395, 398-99, 512 N.Y.S.2d 622, 624 (Sup. Ct. 1986) (denying the application for authorization to remove a tube supplying nutrition and hydration to stroke victim in vegetative state when the patient is not brain dead or terminally ill); cf. *In re Westchester County Medical Center*, 72 N.Y.2d 517, 534-35, 531 N.E.2d 607, 615-16, 534 N.Y.S.2d 886, 894-95 (1988) (disallowing an incompetent patient's daughters to "substitute judgment" and withhold life support because no one knew what the patient would do if she were competent to make the decision).

self-determination claimed by (or on behalf of) the individual involves an area of activity or a set of relationships that the Supreme Court regards as so important that a state cannot burden that right except to the extent necessary to promote a compelling state interest.⁵⁰

Has the Supreme Court viewed the right of patients to refuse medical treatment as fundamentally important to ingrained notions of individual freedom and autonomy? Although many lower courts have posited a constitutional basis for informed consent, the Court has discussed "informed consent" in fewer than twenty cases. With the exception of the occasional reference to the concept in cases outside the health care setting,⁵¹ the Court has discussed informed consent most extensively in its abortion opinions.⁵²

In the abortion cases, the Court has written at some length about both the doctrine of informed consent and the physician-patient relationship. To understand the Court's position on these two subjects and their relationship to privacy doctrine, some more general observations about the Court's treatment of privacy are required.

The Supreme Court's decision in *Griswold v. Connecticut*⁵³ is the starting point for any discussion of privacy. *Griswold* is the first case in which the Supreme Court recognized the right of privacy, not as a core value protected by a particular provision of the Bill of Rights—such as the first, fourth, and fifth amendments—but as an independent constitutional right.⁵⁴ Although it is not clear whether the right to privacy exists at the confluence of several other rights explicitly mentioned in the Bill of Rights, or is to be found within their penumbra,⁵⁵ the Court concluded in *Griswold* that Connecticut's prohibition against the use of contraceptives impermissibly infringed

50. See *Roe v. Wade*, 410 U.S. 113, 154 (1973); *Boddie v. Connecticut*, 401 U.S. 371, 377 (1971); *Loving v. Virginia*, 388 U.S. 1, 12 (1967).

51. See, e.g., *Burger v. Kemp*, 483 U.S. 776, 797-98 (1987) (Blackmun, J., dissenting) (attorney-client relationship); *Cuyler v. Sullivan*, 446 U.S. 335, 354 (1980) (Marshall, J., dissenting) (same).

52. See, e.g., *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 759 (1986); *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 439 (1983); *Bellotti v. Baird*, 443 U.S. 622, 647, 650 (1979) (plurality opinion); *Colautti v. Franklin*, 439 U.S. 379, 382-85 (1979); *Guste v. Jackson*, 429 U.S. 399, 400 (1977); *Planned Parenthood v. Danforth*, 428 U.S. 52, 65 (1976).

53. 381 U.S. 479 (1965).

54. *Id.* at 485.

55. The rhetorical difficulties that result from the Court's use of metaphors, and especially its reliance on "penumbra," are analyzed in Greely, *A Footnote to "Penumbra" in Griswold v. Connecticut*, 6 CONST. COMMENTARY 251 (1989).

married persons' right of privacy.⁵⁶

The Court invalidated Connecticut's statute because it threatened two values the Court sought to protect: the right not to be unreasonably or unnecessarily required to divulge intimate details about oneself, and the right to engage in the personal, intimate relationship of marriage free of government intrusion through regulation.⁵⁷ If the latter of these interests had been given primacy in the Court's opinion, *Griswold* could be seen as the modern basis for a right to be free from excessive state regulation of a panoply of private, intimate decisions—including medical decisions—since some forms of contraception may involve drugs or devices ordered by a physician. It is difficult to read *Griswold* this broadly, however, given the *Griswold* majority's more serious concern with the pervasive state surveillance and investigation required to enforce Connecticut's statute.⁵⁸

More recent developments have de-emphasized *Griswold's* concern with excessive surveillance and investigation, but make it equally clear that *Griswold* did not establish a broad right of privacy extending to a large class of personal, intimate decisions. For example, in its post-*Griswold* opinions, the Court has been unwilling to check the government's power to investigate with a broad, independent right of privacy. Thus, the Court rejected privacy challenges to governmental investigations in cases involving the government's access to cancelled checks⁵⁹ and individual tax records.⁶⁰

The Court's opinion in *Stanley v. Georgia*⁶¹ appeared to go against this grain. In *Stanley*, the Court held that the state of Georgia could not criminalize the private possession of obscene materials

56. 381 U.S. at 485.

57. *Id.* at 484-85.

58. Writing for the majority, Justice Douglas relied heavily upon the Court's earlier third, fourth, and fifth amendment cases to make the case for a constitutional "right of privacy." See *id.* Douglas' arguments seem to build up to the rhetorical question, "Would we allow the police to search the sacred precincts of marital bedrooms for tell-tale signs of the use of contraceptives?" *Id.* at 485.

59. *United States v. Miller*, 425 U.S. 435, 440 (1976).

60. *Fisher v. United States*, 425 U.S. 391, 399 (1976). In *Zurcher v. Stanford Daily*, 436 U.S. 547 (1978), the Court further demonstrated its intention to limit governmental powers of surveillance and investigation by reference to the fourth and fifth amendments rather than to other possible sources of privacy rights. In *Zurcher*, the Court scarcely mentioned the applicability of the first amendment to a student newspaper's challenge to an *ex parte* search warrant of the paper's offices. *Id.* at 563-66; see also *Branzburg v. Hayes*, 408 U.S. 665, 667 (1972) (compelled grand jury testimony of newsmen held not to violate first amendment).

61. 394 U.S. 557 (1969).

for solely private use, relying on the "right to be free, except in very limited circumstances, from unwanted governmental intrusions into one's privacy."⁶² The significance of this opinion, however, as precedent for an independent privacy-based right to be free from governmental investigations proved to be short-lived. In *Bowers v. Hardwick*,⁶³ the Court abandoned its efforts to limit *Stanley* to its facts⁶⁴ and reinterpreted the case as being "firmly grounded in the First Amendment."⁶⁵

The Court's opinion in *Bowers* illustrates both post-*Griswold* trends: the Court's continued movement away from *Griswold*'s privacy-based concern with governmental surveillance and investigation, as well as its reluctance to read *Griswold*'s protection for private, intimate decisions broadly. In *Bowers*, the Court rejected a privacy challenge to Georgia's sodomy statute and spurned the argument that the Court's privacy cases "stand for the proposition that any kind of private sexual conduct between consenting adults is constitutionally insulated from state proscription."⁶⁶ As it had in *Carey v. Populations Services International*,⁶⁷ the majority characterized the Court's contraception⁶⁸ and abortion⁶⁹ decisions as involving the fourteenth amendment's protection of the "fundamental individual right to decide whether or not to beget or bear a child."⁷⁰ Implicitly, and with hindsight, the dominant theme of *Griswold* has become that Connecticut lacked a sufficient governmental interest to justify its attempt to burden the intimate, personal decision whether to become a parent. This reading is supported by the *Bowers* majority's rejection⁷¹ of the dissent's arguments that Georgia's enforcement of its statute by criminal prosecution impermissibly intruded into a private place (the bedroom of one's own home) that was especially protected by the privacy doctrine.⁷²

In sum, *Griswold*'s apparent holding that the surveillance and

62. *Id.* at 564-65.

63. 478 U.S. 186 (1986).

64. See *United States v. Thirty-Seven Photographs*, 402 U.S. 363, 375-76 (1971); *United States v. Reid*, 402 U.S. 351, 354-56 (1971).

65. 478 U.S. at 195.

66. *Id.* at 191.

67. 431 U.S. 678, 688-89 (1977).

68. *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965).

69. *Roe v. Wade*, 410 U.S. 113 (1973).

70. *Bowers*, 478 U.S. at 190.

71. *Id.* at 196.

72. *Id.* at 199-214 (Blackmun, Brennan, Marshall & Stevens, JJ., dissenting); *id.* at 214-20 (Stevens, Brennan & Marshall, JJ., dissenting).

investigatory powers of the state are subject to limitations that may be inferred from the general right of privacy has extremely limited remaining significance today.⁷³ Moreover, the second privacy theme upon which *Griswold* arguably was based—that individuals enjoy constitutional protection for personal, intimate decisions—must be read narrowly as well. Far from giving broad protection to such decisions, *Griswold* added conception to the short (but growing) list of activities and interests that are protected from unwarranted governmental regulation by the privacy doctrine. The list apparently now includes child rearing and education, family relationships, procreation, marriage, contraception, and abortion.⁷⁴

Missing from this list of privacy-protected activities and interests is medical decision-making in general and, more specifically, the right to consent or refuse to consent to life sustaining medical treatment. In *Mills v. Rogers*,⁷⁵ the Court assumed that the right to refuse medical treatment was a constitutionally protected "liberty" interest, but it did not have to decide that issue, as the parties in *Mills* had agreed that the Constitution protected the right to refuse medical treatment.⁷⁶

Similarly, in *Bowen v. American Hospital Association*,⁷⁷ the Court assumed the existence of "constitutional doctrines on regulation, direct or indirect, of speech in general and of decision-making by health professionals in particular."⁷⁸ *Bowen* involved a challenge to the so-called "Baby Doe" regulations of the Department of Health and Human Services (HHS).⁷⁹ The regulations required, among other things, that state child protective services agencies "prevent instances of unlawful medical neglect of handicapped infants."⁸⁰ The Court held that section 504 of the Rehabilitation Act of 1973⁸¹ did not authorize the rules promulgated by HHS.⁸² The Court made its

73. See, e.g., *Whalen v. Roe*, 429 U.S. 589, 609 (1977) (Stewart, J., concurring) ("Whatever the *ratio decidendi* of *Griswold*, it does not recognize a general interest in freedom from disclosure of private information.").

74. See *Bowers v. Hardwick*, 478 U.S. 186, 190 (1986) (describing the reach of the Court's privacy cases).

75. 457 U.S. 291 (1982).

76. *Id.* at 299. Because an intervening decision of the Massachusetts Supreme Judicial Court strengthened patients' rights under federal and state law, *id.* at 303, the Court remanded the case for reconsideration in light of the change in state law. *Id.* at 306. Consequently, the Court did not decide the case on the merits.

77. 476 U.S. 610 (1986).

78. *Id.* at 636 n.22 (emphasis added).

79. 45 C.F.R. § 84.55 (1985).

80. *Id.*

81. 2 U.S.C. § 794 (1988).

82. *Bowen*, 476 U.S. at 647.

comment about the constitutional doctrines dealing with "decision-making by health professionals" in connection with an argument advanced by Justice White in dissent and, thus, was dicta at best, since the Court's holding was not based on constitutional grounds at all.⁸³

The Court came closer to extending the privacy doctrine to individuals' medical decision-making in *Whalen v. Roe*.⁸⁴ In *Whalen*, the plaintiffs were patients who regularly received prescriptions for drugs classified by a New York statute as "Schedule II" drugs, a class that included opium and opium derivatives, ritalin, percodan, cocaine, methadone, amphetamines, and methaqualone.⁸⁵ Plaintiffs challenged portions of the state's Controlled Substances Act of 1972⁸⁶ that provided for the maintenance of a centralized, computerized file containing the names and addresses of all persons who obtained Schedule II drugs pursuant to a physician's prescription.⁸⁷ The district court held that "the doctor-patient relationship is one of the zones of privacy accorded constitutional protection"⁸⁸ and that the New York statute invaded that zone with "a needlessly broad sweep."⁸⁹ In light of the testimony of patients, the parents of minor patients, and physicians,⁹⁰ the court found that the central-

83. *Id.* at 636 n.22.

84. 429 U.S. 589 (1977).

85. *Id.* at 592-93 & n.8.

86. Act of June 8, 1972, ch. 878, 1972 N.Y. Laws 2608 (codified as amended at N.Y. PUB. HEALTH LAW §§ 3300-3397g (McKinney 1989)).

87. *Whalen*, 429 U.S. at 591.

88. *Roe v. Ingraham*, 403 F. Supp. 931, 936 (S.D.N.Y. 1975), *rev'd*, 429 U.S. 589 (1977). The court "read *Roe v. Wade* as holding implicitly and *Doe v. Bolton* as holding explicitly that the doctor-patient relationship" was so protected. *Id.* (citations omitted).

89. *Id.* at 937.

90. *Id.* at 934-35. The court found compelling testimony concerning the negative impact of the centralized prescription register on the patients' medical decision-making and on the physician-patient relationship. For example, a parent testified that she stopped giving her child ritalin, a Schedule II drug, because she was afraid that the state record would stigmatize her son. *Id.* at 934. The parent testified that although "the child is not doing well without the medication, . . . the alternative . . . is to have him branded for life." *Id.* Another woman testified that "[w]hen she learned that under the new regulation her name was to go on a computer because the amphetamine with which her condition was treated was a Schedule II drug, she believed she would be labeled a drug addict." *Id.* When another woman learned of the law, she stopped taking her medication. Her migraines returned, and she was forced to resume treatment. *Id.* at 934-35. She, however, had no confidence that the information would remain confidential. *Id.*

Several physicians also testified to the law's negative impact. *Id.* at 935. One was concerned with the adverse affect on the patient and another with interference with the physician-patient relationship. *Id.*

All testified that they felt obligated to advise their patients or a responsible member of their family about the state prescription program for Schedule II drugs, and reported a reaction of shock, fear and concern on the part of their

ized registry created a "fear that the adults or children will be stigmatized if their use of the drug becomes known . . . [and] intrudes upon and interferes with the doctor-patient relationship."⁹¹

The Supreme Court reversed,⁹² and not because it necessarily disagreed with the district court's inclusion of medical decision-making and the physician-patient relationship within a zone of constitutionally protected privacy interests. Rather, the Court held that "neither the immediate nor the threatened impact of the [registry scheme] on either the reputation nor the independence of patients for whom Schedule II drugs are medically indicated is sufficient to constitute an invasion of any right or liberty protected by the Fourteenth Amendment."⁹³ Although Justice Brennan would have held that the right of privacy extends to medical decision-making such as was involved in *Whalen*,⁹⁴ that clearly was not the Court's holding. Having concluded that the centralized registry did not have a significant effect on patients or their physicians, the Court did not need to evaluate the state's claim that its interest in such a system was compelling. Indeed, it did not even have to decide that a constitutionally protected privacy interest was implicated by the patients' claims at all. The most that can be said of *Whalen* on this issue is that the question of the constitutional status of the patients' claims was left open.⁹⁵

B. *The Abortion Cases*

The remaining basis for a claim that the Court has extended privacy protection to medical decision-making and the physician-patient relationship is *Roe v. Wade*⁹⁶ and its progeny. The claim, however, does not survive close scrutiny of the Court's abortion decisions.

In *Roe v. Wade*, the Supreme Court recognized a personal right of privacy that is protected by the due process clause and that in-

patients on learning that their names would be sent to Albany and put on a computer.

Id.

91. *Id.* at 937.

92. *Whalen*, 429 U.S. at 603-04.

93. *Id.*

94. *Id.* at 606 (Brennan, J., concurring) ("Broad dissemination by state officials of such information, however, would clearly implicate constitutionally protected privacy rights, and would presumably be justified only by compelling state interests.").

95. *See id.* at 607-09 (Stewart, J., concurring) (refuting the opinion by Justice Brennan because the cases referred to therein do not support a general constitutional right to privacy).

96. 410 U.S. 113 (1973).

cludes a qualified right of "a woman [to decide] whether or not to terminate her pregnancy."⁹⁷ The Court almost simultaneously recited the psychological and physical factors that "the woman and her responsible physician necessarily will consider in consultation,"⁹⁸ but it is clear that the physician-patient relationship derived its constitutional protection in *Roe* because of its integral role in the woman's abortion decision, not the other way around. In other words, the protection extended to the physician-patient relationship and to the woman's right to make a medical decision about her pregnancy was the necessary, secondary consequence of the Court's decision to extend the right of privacy to abortion decisions.⁹⁹

Some confusion on this point is due to Justice Blackmun's summary of the Court's holding in *Roe* in terms that emphasized the role of the physician and the medical nature of the woman's decision.¹⁰⁰ For example, his opinion for the majority states "that, for the period prior to [the end of the first trimester], the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated."¹⁰¹ The Court's discussion of the physician-patient aspect of abortion should not be misconstrued; it does not signal the recognition of a constitutional right to practice medicine,¹⁰² to participate in a physician-patient relationship, or to make personal medical decisions.¹⁰³

This seems true for at least three reasons. First, the criminal statute struck down in *Roe v. Wade* "restrict[ed] legal abortions to those 'procured or attempted by medical advice for the purpose of saving the life of the mother.'"¹⁰⁴ Because the restriction was in reference to the medical judgment and discretion of the physician, it

97. *Id.* at 153.

98. *Id.*

99. *But see Doe v. Bolton*, 410 U.S. 179, 219 (1973) (Douglas, J., concurring) ("the right of privacy has no more conspicuous place than in the physician-patient relationship, unless it be in the priest-penitent relationship").

100. 410 U.S. at 163-64 ("For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.").

101. *Id.* at 163.

102. *See, e.g., Singleton v. Wulff*, 428 U.S. 106, 113 (1976) (plurality opinion) (refusing to decide whether physicians have a constitutionally protected right to practice medicine). *Roe's* companion case, *Doe v. Bolton*, might be read otherwise. *See infra* notes 109-118 and accompanying text.

103. *But see Roe v. Ingraham*, 403 F. Supp. 931, 936 (S.D.N.Y. 1976) ("[W]e read *Roe v. Wade* as holding implicitly . . . that the doctor-patient relationship is one of the zones of privacy accorded constitutional protection."), *rev'd*, 429 U.S. 589 (1977).

104. 410 U.S. at 164 (quoting TEX. PENAL CODE ANN. art. 1196 (1972)).

is natural that the Court's formulations of its holding would be expressed in similar terms.

Second, a woman's right to decide whether to terminate her pregnancy can be infringed either by a restriction that operates directly upon her (such as making a woman who obtains an abortion guilty of a crime or requiring spousal consent) or by one that operates primarily upon something or someone else and has the secondary effect of limiting her access to the abortion she seeks. Examples of the latter type of restriction include licensing requirements for abortion clinics¹⁰⁵ and restrictions upon the scope of medical practice by physicians licensed by the state.¹⁰⁶ A statement of the holding in *Roe v. Wade* in terms of a secondary restriction need not alter the scope or nature of the primary right being given constitutional protection.

Finally, as Professor Tribe has suggested, the Court simply may have believed that its extraordinary decision in *Roe v. Wade* would be more readily accepted if the Court "couched the abortion holding in medical rather than ethical terms."¹⁰⁷ If this speculation is true, the nonsubstantive nature of the Court's language regarding the medical aspects of abortion would be manifest. Even if, as Professor Susan Frelich plausibly has maintained, the Court has persisted in "the view that the doctor's discretion is an intrinsic part of the patient's 'privacy' and something more than an inevitable incident of the medical nature of the abortion procedure,"¹⁰⁸ there is no logical basis for recognizing a privacy-based constitutional protection for the physician-patient relationship of medical decision-making other than in connection with abortion.

Doe v. Bolton,¹⁰⁹ the companion case to *Roe v. Wade*, challenges this reading of *Roe* but does not overcome it. In *Roe*, the only physician-party to the action (Dr. Hallford) was ordered dismissed from the case on *Younger*-abstention grounds.¹¹⁰ Thus, absent from the

105. See *Ragsdale v. Turnock*, 625 F. Supp. 1212 (N.D. Ill. 1985), *aff'd in part and vacated in part*, 841 F.2d 1358 (7th Cir. 1988), *juris. postponed*, 109 S. Ct. 3239, *dismissed by consent of parties*, 1989 U.S. LEXIS 5818.

106. This was the type of restriction involved in *Roe v. Wade* itself.

107. Tribe, *The Supreme Court, 1972 Term, Foreword: Toward a Model of Roles in the Due Process of Life and Law*, 87 HARV. L. REV. 1, 38 n.168 (1973).

108. Frelich, *Doctors, Patients and the Constitution: A Theoretical Analysis of the Physician's Role in 'Private' Reproductive Decisions*, 63 WASH. U.L.Q. 183, 202-03 (1985).

109. 410 U.S. 179 (1973).

110. 410 U.S. 113, 126-27 (1973). The Court ruled that the lower court should not have granted declaratory relief to Dr. Hallford, who was a defendant in a pending criminal prosecution for violating Texas' abortion statute. *Id.* (relying on *Younger v. Harris*, 401 U.S. 37, 43-54 (1971) (disallowing a federal court authority to grant declaratory

case was the one party in a position to argue that the physician-patient relationship enjoys constitutional protection because of a privacy right unrelated to the woman's personal right to choose an abortion. In *Doe*, on the other hand, nine physicians licensed in Georgia joined a Georgia woman's challenge to the state's criminal abortion statute.¹¹¹ The Court held justiciable¹¹² their claims that the Georgia law " 'chilled and deterred' them from practicing their . . . profession[] and deprived them of rights guaranteed by the First, Fourth, and Fourteenth Amendments."¹¹³ The Court went on to address numerous challenges to the Georgia statute, which required it to consider (among other things)¹¹⁴ the factors that a physician must be allowed to consider in deciding whether an abortion is "necessary,"¹¹⁵ as well as the Georgia statute's requirement that such determinations be confirmed by the independent examinations of the patient by two other licensed physicians.¹¹⁶

Because of the Georgia statute's terms and the nature of the claims raised against it, the Court's opinion in *Doe v. Bolton* contains numerous references to professional, medical judgment.¹¹⁷ In this case, however, medical judgment never quite receives independent constitutional protection apart from the pregnancy- and abortion-related rights of the physician's patient. As the Court states in a particularly telling passage:

relief as to state statute when prosecution under such statute is pending in the state court at time federal suit is initiated)).

111. 410 U.S. at 184-85.

112. *Id.* at 188.

113. *Id.* at 186. The Court declined to reverse the lower court's ruling that other plaintiffs—seven nurses, five clergy, two social workers, and two non-profit corporations—did not present justiciable claims. *Id.* at 189. The Court's ruling with respect to the non-physicians was not based on any skepticism toward their claims, but rather on the prudential ground that "the issues are sufficiently and adequately presented by *Doe* and the physician-appellants, and nothing is gained or lost by the[ir] presence or absence." *Id.*

114. In addition to the issues discussed in the text, the Court also ruled that Georgia's residence requirement violated the privileges and immunities clause, U.S. CONST. art. IV, § 2, because it infringes upon the rights of patients "who enter Georgia seeking the medical services that are available there." *Doe*, 410 U.S. at 200.

The Court also addressed two procedural requirements imposed upon abortion by the Georgia statute in addition to the procedural requirement mentioned in the text: "(1) that the abortion be performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals: (2) that the [abortion] be approved by the hospital staff abortion committee . . ." *Id.* at 192-98 (footnote omitted). The Court struck down both requirements on the ground that they unduly restricted the pregnant woman's rights earlier recognized in *Roe*. *Id.* at 194, 198.

115. *Id.* at 191-92.

116. *Id.* at 198-200.

117. *See id.* at 191, 192, 196-97, 199-200.

We agree . . . that the medical judgment may be exercised in light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment. *And it is room that operates for the benefit, not the disadvantage, of the pregnant woman.*¹¹⁸

The constitutional right vindicated in *Doe*, therefore, is the right to choose an abortion on the basis of medical advice that is not unduly fettered by unnecessary (and thus unjustified) state restrictions; it is not a more general right to give or be given medical advice, or to direct one's own medical care.

After *Roe* and *Doe*, as most Americans who have lived through the last seventeen years know all too well, the Court has considered a number of state restrictions upon abortion. Many of these cases dealt with informed consent and reviewed laws requiring informed consent,¹¹⁹ specifying the information required to be given to the patient by the physician before an abortion could be performed,¹²⁰ imposing a waiting period after a woman's informed consent,¹²¹ and allowing parents or spouses to veto a woman's decision to have an abortion.¹²² Other cases dealt with the clinical, medical details of abortion practice. These cases reviewed laws requiring hospital-

118. *Id.* at 192 (emphasis added). *Roe* and *Doe* undoubtedly paint a somewhat warped picture of the physician-patient relationship and the process of medical decision-making. As Professor Susan Frelich has pointed out, these cases and a number of the abortion decisions that followed them evidence a "preoccupation with deference to doctors and the standards of their practice" that flows from *Roe v. Wade's* tendency to "cast[] the doctor as the decisionmaker with a status equal to or greater than the individual most intimately involved." Frelich, *supra* note 108, at 226, 235 (citing *Simopoulos v. Virginia*, 462 U.S. 506, 519 (1983)); *Planned Parenthood v. Ashcroft*, 462 U.S. 476, 481-83 (1983); *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 427 (1983). This is undoubtedly true, and for the reasons stated in Professor Frelich's perceptive article. This is yet another reason why the cases should be read as "abortion cases" and not "informed consent" or "medical decision-making cases."

119. *See, e.g., Akron Center for Reproductive Health*, 462 U.S. at 439-42 (holding unconstitutional blanket requirements for parental consent for abortions on minors under age 15); *Planned Parenthood v. Danforth*, 428 U.S. 52, 65-75 (1976) (holding unconstitutional spousal and parental consent requirements for abortions for minors, but upholding requirement that a woman give informed consent).

120. *See, e.g., Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 764-65 (1986) (holding unconstitutional requirements for informed consent that woman be informed by physician of detrimental physical and psychological effects, and medical risks); *Akron Center for Reproductive Health*, 462 U.S. at 448-49 (holding unreasonable the state's insistence that only a physician provide the information and counseling relevant to informed consent).

121. *See Akron Center for Reproductive Health*, 462 U.S. at 450-51.

122. *See Danforth*, 428 U.S. at 67-75.

only abortions,¹²³ the licensing of abortion clinics,¹²⁴ pathology reports,¹²⁵ the presence of a second physician during the abortion,¹²⁶ detailed reporting and record-keeping by the physician,¹²⁷ and restrictions on the choice of abortion technique.¹²⁸

Broadly speaking, these cases concerned medical decision-making and medical practice. All recognized that constitutional protections can extend to medical decision-making and medical practice (although some of the state restrictions were upheld as reasonable regulations that further a sufficiently compelling state interest). But, and this is the significance of these cases, all trace the constitutional protections to a woman's fundamental constitutional right to decide to have an abortion without undue interference by the state.

There is no inconsistency, or even irony, between the Court's extension of constitutional protections to a patient's choice of medical treatment to end the biological existence of a fetus, on the one hand, and the conclusion that the same privacy right does not extend necessarily to the decision to terminate an incompetent patient's life-sustaining medical treatment. The Court in *Roe* declined

123. See, e.g., *Simopoulos v. Virginia*, 462 U.S. 506, 510-19 (1983) (upholding hospitalization requirement by construing it broadly to include licensed outpatient clinic); *Planned Parenthood v. Ashcroft*, 462 U.S. 476, 481-82 (1983) (hospitalization requirement invalid); *Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 431-39 (1983) (same); see also *Doe v. Bolton*, 410 U.S. 179, 193-95 (1973) (same).

124. See, e.g., *Simopoulos*, 462 U.S. at 510-17 (requirement that second-trimester abortions be performed in hospital valid as applied to licensed outpatient clinic that meets reasonable regulations designed to protect the health of the pregnant woman); *Ashcroft*, 462 U.S. at 489-90 (certain regulations of even first-trimester abortions that "have no significant impact on the woman's exercise of her right [to decide to have an abortion] may be permissible where justified by important state health objectives" (alterations by the Court) (quoting *Akron Center for Reproductive Health*, 462 U.S. at 430)); *Ragsdale v. Turnock*, 841 F.2d 1358 (7th Cir. 1988), *juris. postponed*, 109 S. Ct. 3239 (agreeing to review Illinois' comprehensive scheme for regulating abortion clinics), *dismissed by consent of parties*, 1989 U.S. LEXIS 5818.

125. See, e.g., *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 765-68 (1986) (holding unconstitutional requirement that the physician report complications of the procedure, information about the patient, and the circumstances under which the abortion was performed); *Planned Parenthood v. Danforth*, 428 U.S. 52, 79-81 (1978) (requirement that health care facilities and physicians keep records and reports on abortions for seven years).

126. See, e.g., *Ashcroft*, 462 U.S. at 482-86, 505 (upholding second-physician requirement for second-trimester abortions).

127. See, e.g., *Thornburgh*, 476 U.S. at 765-66.

128. See *Colautti v. Franklin*, 439 U.S. 379, 397-401 (1979) (holding statute requiring abortion technique that provides for the greatest chance of fetus being born alive to be unconstitutionally vague); *Danforth*, 428 U.S. at 75-79 (holding legislative proscription of saline method to be unreasonable regulation).

to hold that a fetus is a "person,"¹²⁹ and it consistently has adhered to that position through its abortion decision last term in *Webster*.¹³⁰ The only relevant person in the Court's abortion analysis is the pregnant woman, whose life and health, not death, the Court has sought to protect by keeping the process of choice as private as possible.

In sum, none of the Supreme Court's privacy decisions has established the right at issue in *Cruzan*. Concededly, the Court has been quite solicitous of the rights of a pregnant woman to make the abortion decision for herself, with the assistance of medical professionals, and to obtain an abortion without undue restrictions. It would strain the Court's language and logic, however, to divorce the element of abortion from these cases and find a generalized right to make significant medical decisions. Moreover, the carefully wrought compromise that has produced majority decisions in these cases, evident in the increasingly narrow distinctions and the ever more slender majorities, should not be separated from the dominant concern of *Roe* and its progeny: abortion.

None of this is to say that the Court could not conclude that the right to decline life-sustaining medical treatment is a "fundamental" right that enjoys qualified protection under the fourteenth amendment, only that it has not. Whether it should so conclude depends upon the many policy issues considered in the next part of this article.

II. FUNDAMENTAL RIGHTS

Judicial self-restraint will not, I suggest, be brought about in the 'due process' area by the historically unfounded incorporation formula It will be achieved in this area, as in other constitutional areas, only by continual insistence upon respect for the teachings of history, solid recognition of the basic values that underlie our society, and wise appreciation of the great roles that the doctrines of federalism and separation of powers have played in establishing and preserving American freedoms.¹³¹

129. 410 U.S. 113, 156-59 (1973).

130. 109 S. Ct. 3040 (1989) (plurality opinion). The *Webster* majority reaffirmed the conceptual framework of *Roe* (fundamental right/trimester-based sliding scale of interests), including the proposition that a fetus is not a person. *See id.* at 3049-54. It did so despite the skepticism of a plurality of the Court, *see id.* at 3056-58, and the urging of Justice Scalia. *See id.* at 3064-67 (Scalia, J., concurring in part and concurring in the judgment).

131. *Griswold v. Connecticut*, 381 U.S. 479, 501 (1965) (Harlan, J., concurring).

A. Overview

Is the right of a PVS patient to refuse life-sustaining treatment a fundamental right that should enjoy the protection of the fourteenth amendment? This simple question simply begets more questions. How can we tell if the fourteenth amendment recognizes such a fundamental right? To what kinds of sources will we look to find an answer? How are institutional and political concerns to be balanced against individual ones?

This part of the article proposes an answer to these questions. In brief, my answer is this:

1. By most traditional measures—reason, tradition, natural law, consensus—the right of an incompetent patient to refuse life-sustaining treatment does not enjoy enough support to be accurately labeled a “fundamental” right, at least not when the patient is, like Nancy Beth Cruzan, in a persistent vegetative state and has not executed an advance directive. More significantly, even if broad agreement could be found for the general proposition that under some circumstances incompetent patients should be able to refuse life-sustaining treatment, there is not widespread agreement as to many of the important procedural and substantive issues implicit in that statement.

2. The Court should not extend federal constitutional protection to the right, because constitutionalization will cause more damage to evolving standards of medical practice and consensus-building on this important subject than it cures.

B. The “Rights” Stuff

The Supreme Court’s forays into fundamental-rights analysis fall roughly into two groups. First are those cases involving democratic rights of political participation—having to do, for example, with voter qualifications,¹³² the weighing of votes,¹³³ apportionment and districting,¹³⁴ and access to the ballot.¹³⁵ These decisions fall

132. See, e.g., *Dunn v. Blumstein*, 405 U.S. 330, 333 (1972) (durational residency requirement as a qualification to vote held unconstitutional); *Evans v. Cornman*, 398 U.S. 419, 426 (1970) (state cannot treat persons on federal enclaves as residents for criminal, taxing, and other purposes but as nonresidents for purposes of voting); *Harper v. Virginia Bd. of Elections*, 383 U.S. 663, 666 (1966) (holding state’s poll tax requirement unconstitutional).

133. See, e.g., *Gordon v. Lance*, 403 U.S. 1, 8 (1971) (upholding supermajority requirement in bond referendum); *Gray v. Sanders*, 372 U.S. 368, 381 (1963) (Georgia’s county unit system held unconstitutional).

134. See, e.g., *Davis v. Bandemer*, 478 U.S. 109, 143 (1986) (holding charge of partisan gerrymandering in state legislative redistricting justiciable under fourteenth amend-

into that category of cases, in Professor Ely's words, "fueled . . . by a desire to ensure that the political process . . . was open to those of all viewpoints on something approaching an equal basis."¹³⁶

The second grouping of cases involves all other rights, not limited to rights of democratic participation, that the Court has identified as so important that state restrictions on them shall be given "heightened judicial scrutiny." These rights include the right to travel,¹³⁷ the right to marry,¹³⁸ and the broadly defined right of privacy.¹³⁹ The Court also has held that some rights properly are not included on this list of fundamental rights, including the right to receive welfare;¹⁴⁰ the right to basic levels of education,¹⁴¹ health

ment); *Karcher v. Daggett*, 462 U.S. 725, 744 (1983) (allowance for margin of error in census figures does not justify departure from population equity in redistricting); *Rogers v. Lodge*, 458 U.S. 613, 627 (1982) (multimember electoral system maintained for racially discriminatory purpose held unconstitutional).

135. See, e.g., *Bullock v. Carter*, 405 U.S. 134, 149 (1972) (state may not condition indigent candidate's access to ballot upon filing fees he cannot pay); *Williams v. Rhodes*, 393 U.S. 23 (1968) (complicated statute that kept independent and third-party candidates off the ballot held unconstitutional).

136. J. ELY, *DEMOCRACY AND DISTRUST* 74 (1980). Some of these decisions also might fit within Professor Ely's second, related category of fundamental rights cases sounding democratic, participational themes: "[T]he Court's message here was that insofar as political officials had chosen to provide or protect X for some people (generally people like themselves), they had better make sure that everyone was being similarly accommodated or be prepared to explain pretty convincingly why not." *Id.*

137. See, e.g., *Sosna v. Iowa*, 419 U.S. 393, 410 (1975) (upholding one year durational residency requirement for commencing divorce proceedings); *Shapiro v. Thompson*, 394 U.S. 618, 642 (1969) (state's durational residency requirement as a condition of welfare held unconstitutional); cf. *Attorney Gen. v. Soto-Lopez*, 476 U.S. 898, 911 (1986) (plurality opinion) (regarding statute restricting veterans preference for state employment to veterans who were state residents when they entered service an invalid infringement of right to travel); *id.* at 912, 916 (Burger, C.J. & White, J., concurring) (regarding statute as simply irrational).

138. See, e.g., *Zablocki v. Redhail*, 434 U.S. 374, 383 (1978) (statute prohibiting a non-custodial parent under a support order from marrying without court approval unnecessarily infringes on the fundamental right to marry); *Loving v. Virginia*, 388 U.S. 1, 7-12 (1967) (right to marry is a fundamental freedom that cannot be restricted by racial classifications); *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1941) (state sterilization sanction infringed on the fundamental rights of marriage and procreation); cf. *Lehr v. Robertson*, 463 U.S. 248, 250 (1983) (a putative father has no absolute right to notice before his child is adopted); *Quilloin v. Walcott*, 434 U.S. 246, 256 (1978) (a state may give an unwed father less adoption veto power than it gives a married father).

139. See *supra* notes 53-74 and accompanying text.

140. See, e.g., *Jefferson v. Hackney*, 406 U.S. 535, 549 (1972) (differential effect of various welfare programs subject to judicial review for mere rationality); *Dandridge v. Williams*, 397 U.S. 471, 485-87 (1970) (federal Aid to Families with Dependent Children program deals with economics and social welfare and, absent invidious discrimination, is subject to minimal scrutiny by reviewing court).

141. See, e.g., *San Antonio Indep. School Dist. v. Rodriguez*, 411 U.S. 1, 55 (1973)

care,¹⁴² or housing;¹⁴³ and the right to government employment.¹⁴⁴ Most, if not all, of these exclusions from the list of fundamental rights are explained, at least in part, by the Court's continued refusal to regard governmental classifications based upon wealth as "suspect" classifications that can be justified only by reference to a suitably "compelling" state interest.¹⁴⁵

How does the Court decide, with respect to this second group of cases, which rights are "fundamental" in some important enough way to warrant heightened judicial protection under the fourteenth amendment? Members of the Court can seldom agree among themselves as to the precise source of these rights or the justification for regarding them as "fundamental." The absence from the text of the Constitution of any mention of these rights makes the job of justify-

(state's use of local property taxes to finance public education upheld under standard of mere rationality).

142. In a series of abortion-funding cases, the Supreme Court held that neither the federal government nor the states were required to pay for abortions. *Harris v. McRae*, 448 U.S. 297, 324-26 (1980); *Maher v. Roe*, 432 U.S. 464, 478-80 (1977); *Beal v. Doe*, 432 U.S. 438, 445-46 (1977). Thus, even though abortion is a fundamental right (as is the right to bear a child to birth), the government's refusal to fund abortions could be justified as "rationally related" to the government's preference for childbirth over abortion. If abortion does not implicate a right to a minimal level of governmental assistance, then neither does health care generally. See generally Bovbjerg & Kopit, *Coverage and Care for the Medically Indigent: Public and Private Options*, 19 IND. L. REV. 857, 872-74 (1986).

143. See, e.g., *Arlington Heights v. Metropolitan Hous. Dev. Corp.*, 429 U.S. 252, 265 (1977) (exclusion of multifamily housing from village, absent proof of race-based animus, not subject to strict scrutiny); *Village of Belle Terre v. Boraas*, 416 U.S. 1, 7-8 (1974) (village's zoning ordinance may provide only for housing that serves "traditional" families without infringing upon any fundamental interest); *James v. Valtierra*, 402 U.S. 137, 143 (1971) (state constitutional provision calling for referendum and majority support among residents before low-income housing could be built; reviewed and upheld under mere rationality standard of judicial review).

144. See *Vance v. Bradley*, 440 U.S. 93, 96-97 (1979) (mandatory retirement age for federal employee does not infringe fundamental right); *Massachusetts Bd. of Retirement v. Murgia*, 427 U.S. 307, 313 (1976) (mandatory retirement age for state employees does not infringe fundamental right).

145. A classic exchange of articles debated the Supreme Court's unwillingness to find a constitutional right to a subsistence level of governmental support for those necessities that enable a citizen to participate in the life of the society and to exercise other fundamental rights. See Michelman, *Foreword: On Protecting the Poor Through the Fourteenth Amendment*, 83 HARV. L. REV. 7 (1969); Winter, *Poverty, Economic Equality and the Equal Protection Clause*, 1972 SUP. CT. REV. 41. A similarly spirited exchange considered the question of a fundamental right to a certain level of health care. See Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 TEX. L. REV. 1345 (1981); Rosenblatt, *Rationing "Normal" Health Care: The Hidden Legal Issues*, 59 TEX. L. REV. 1401 (1981); Blumstein, *Distinguishing Government's Responsibility in Rationing Public and Private Medical Resources*, 60 TEX. L. REV. 899 (1982); Rosenblatt, *Rationing "Normal" Health Care Through Market Mechanisms: A Response to Professor Blumstein*, 60 TEX. L. REV. 919 (1982).

ing these decisions doctrinally difficult. The Court's tendency to identify these rights and then, as in the case of privacy, to expand on them, has thrown constitutional scholars into one of the most divisive and enduring battles of the past thirty years.¹⁴⁶

Professor Ely has surveyed the various rationales put forward to explain and to justify the occasions when the Court has settled upon one right or another as "fundamental."¹⁴⁷ Ely is a skeptic,¹⁴⁸ but his guide is useful. Concluding that all of these external sources of value are wanting in one way or another, Ely discusses the personal values of the deciding judge,¹⁴⁹ natural law,¹⁵⁰ neutral principles,¹⁵¹ reason,¹⁵² tradition,¹⁵³ consensus,¹⁵⁴ and the judge's "best estimate of what tomorrow's observers would be prepared to credit as progress."¹⁵⁵ In the course of his survey of constitutional law scholarship on the subject of "fundamental rights," Dean Choper produced a similar list of approaches.¹⁵⁶

Considered together, these sources might be expressed by Dean Choper's necessarily loose phrase, "some evolving societal consensus."¹⁵⁷ Indeed, of all of the approaches on Ely's list, the Supreme Court has appeared, especially in its recent cases, to rely most explicitly upon consensus—focusing especially upon ostensibly objective indicia of society's "widely shared values," of conventional morality—which Ely says "turns out to be at the core of most 'fundamental values' positions."¹⁵⁸ This article will apply this sense

146. One of the more recent and more public manifestations of this debate took the form of hearings on the nomination of Judge Robert Bork to the Supreme Court. See Chemerinsky, *The Constitution is Not "Hard Law": The Bork Rejection and the Future of Constitutional Jurisprudence*, 6 CONST. COMMENTARY 29, 29 (1989).

147. See J. ELY, *supra* note 136, at 43-72.

148. See, e.g., *id.* at 73 ("When we search for an external source of values with which to fill in the Constitution's open texture, however—one that will not simply end up constituting the Court a council of legislative revision—we search in vain.")

149. *Id.* at 44-48.

150. *Id.* at 48-54.

151. *Id.* at 54-55.

152. *Id.* at 56-60.

153. *Id.* at 60-63.

154. *Id.* at 63-69.

155. *Id.* at 69.

156. See J. CHOPER, *JUDICIAL REVIEW AND THE NATIONAL POLITICAL PROCESS* 73-75 (1980). The approaches include the development of "impersonal and durable principles;" resort to "our natural law inheritance," "natural rights," "conventional morality," "political morality," or "basic human values." *Id.* at 74.

157. *Id.* at 75. Dean Choper uses the term to describe the arguments of constitutional law scholars in favor of the Justices' "defin[ition of] contemporary fundamental norms that are manifested by some evolving societal consensus." *Id.*

158. J. ELY, *supra* note 136, at 63.

of "consensus"—broad, inclusionary, historical, and progressive—to the constitutional issue raised by *Cruzan*.

First, however, some words of caution are in order. In Ely's view, the use of consensus as a guide to discovering fundamental values has three major flaws. The first is the assumption that consensus may exist at all, when in fact the United States may have devolved into a system of special interest domination through temporary coalitions and legislative logrolling.¹⁵⁹ Developments in public choice theory tend to support this conclusion.¹⁶⁰

The second and more serious flaw focuses on our inability to define the content and scope of a consensus, even if we assume the possibility that a consensus may exist.¹⁶¹ As Ely puts it, "when one gets down to cases, one finds much the same mix we found when the reference was to 'natural law'—a mix of the uselessly general and the controversially specific."¹⁶²

The most serious flaw of all for Ely is the illogic of appealing to majoritarian consensus on questions of fundamental rights.¹⁶³ One reason for the appeal to fundamental rights might be to assure that the majority's interest in a fundamental right is protected adequately, a job the legislature clearly is better suited to perform. On the other hand, if the reason for appealing to fundamental rights is to protect the rights of an individual or minority from the tyranny of the majority, it seems somewhat self-defeating to appeal to the sense of the majority to determine whether such fundamental individual or minority rights exist.¹⁶⁴

Most of Ely's objections are illustrated by a recent privacy case in which the Supreme Court justified its limitation upon the funda-

159. *See id.* at 63-64; *see also id.* at 64 (quoting Levinson, *The Specious Morality of the Law*, HARPER'S, May 1977, at 35, 40) (emphasis added):

Latter-day disputes concerning the legitimate role of race in governmental decision-making, whether for purposes of segregation or affirmative action, or the legitimacy of the state's allowing the cessation of the possibility of life, by abortion or euthanasia, also present differences of the greatest magnitude regarding conceptions of justice.

160. For a clear and concise review of the public choice literature (and an excellent bibliography), see Tollison, *Public Choice and Legislation*, 74 VA. L. REV. 339 (1988). *See also* J. BUCHANAN & G. TULLOCK, *THE CALCULUS OF CONSENT: LOGICAL FOUNDATIONS OF CONSTITUTIONAL DEMOCRACY* 265-306 (1965); D. MUELLER, *PUBLIC CHOICE* 263-70 (1979); M. OLSON, *THE LOGIC OF COLLECTIVE ACTION: PUBLIC GOODS AND THE THEORY OF GROUPS* 111-67 (2d printing 1971).

161. *See* J. ELY, *supra* note 136, at 64-69.

162. *Id.* at 64.

163. *Id.* at 68-69.

164. *Id.* at 69.

mental right to privacy by noting the absence of consensus.¹⁶⁵ In

165. Another example of the Court's recurring appeal to statutory consensus to give meaning to an open-textured constitutional provision—and of the conceptual difficulties such an appeal raises—is the Court's decision this past term in *Stanford v. Kentucky*, 109 S. Ct. 2969 (1989). This case did not involve a "fundamental rights" issue under the fourteenth amendment, but rather the meaning of the eighth amendment's prohibition against "cruel and unusual punishments." U.S. CONST. amend. VIII. The specific issue raised by *Stanford* was whether the execution of a prisoner convicted of a crime he committed when he was still a minor constitutes "cruel and unusual punishment." 109 S. Ct. at 2974. For an answer to this question, Justice Scalia, writing for a five-Justice majority, looked to the criminal laws of the states, which the Court regards as "'[f]irst' among the "'objective indicia that reflect the public attitude toward a given sanction.'" *Id.* at 2975 (quoting *McCleskey v. Kemp*, 481 U.S. 279, 300 (1987) (quoting *Gregg v. Georgia*, 428 U.S. 153, 173 (1976))). Justice Scalia's review revealed that more than half of the states that allow capital punishment allow its imposition upon 16- and 17-year-olds. *Id.* at 2975. Because the burden was on the defendant to establish a national consensus against the penalty, *id.* at 2977, the Court upheld Kentucky's death penalty as applied to him. *Id.* at 2980.

The Court's approach in such cases ignores the possibility that "cruel and unusual punishment" may not be synonymous with the majority's will. If fundamental values have an historical dimension, for example, or could be based upon more transcendent values (*e.g.*, natural law principles), a present-day national majority is at best a very imperfect guide to decision. The Court, however, has answered this objection with a tautology: "cruel and unusual" means what a majority of the states today says it means. *Id.* at 2974-75.

The case reveals some of the further difficulties inherent in the Court's consensus-seeking methodology. The Court's conclusion that a majority of states do not prohibit the execution of felons who were minors at the time they committed their offense rests upon a shaky foundation. In fact, by the Court's own count, 25 states decline to impose the death penalty upon 17-year-old offenders and 28 decline to impose it upon 16-year-old offenders. *Id.* at 2975. The ratio of states that permit executions of minor offenders to those that do not produces a "majority of states" that permit the execution of juvenile offenders only if the states that do not permit capital punishment at all are excluded from the denominator. This difference between the majority and the four dissenting Justices, *see id.* at 2982-83 (Brennan, Marshall, Blackmun & Stevens, JJ., dissenting), illustrates Ely's point that defining precisely the propositions for which there is a consensus may be a hopeless undertaking.

Furthermore, the majority opinion falls into an egregious logical trap when it refuses to count states that prohibit all capital punishment in assessing the consensus position on the execution of minor offenders. *See id.* at 2975 n.2. Justice Scalia writes that counting the prohibition states in the denominator "is rather like discerning a national consensus that wagering on cockfights is inhumane by counting within that consensus those States that bar all wagering." *Id.* at 2975 n.2. In Justice Scalia's example, states that bar all wagering arguably should not be counted, because their motivation in adopting such a prohibition undoubtedly includes economic, social, and moral concerns about gambling in general that tell us nothing about their attitudes toward the different issue of cruelty to animals. By contrast, can it plausibly be maintained that states that have banned capital punishment for all offenders also do not believe that capital punishment is at least equally inappropriate for minor offenders and for adult offenders? The majority requires that these states somehow single out minor offenders for special protection—an impossibility for states that have banned capital punishment for all offenders—

Bowers v. Hardwick,¹⁶⁶ the Court concluded that prior cases “would [not] extend a fundamental right to homosexuals to engage in acts of consensual sodomy.”¹⁶⁷ The Court reached this conclusion by noting that “[s]odomy was a criminal offense at common law and was forbidden by the laws of the original 13 States when they ratified the Bill of Rights”¹⁶⁸ and “[i]n 1868, when the Fourteenth Amendment was ratified, all but 5 of the 37 states in the Union had criminal sodomy laws.”¹⁶⁹ The Court’s reliance upon historical consensus presumably is justified by one of the Court’s alternative definitions of “fundamental rights”: “those liberties that are ‘deeply rooted in this Nation’s history and tradition.’ ”¹⁷⁰

Yet, the *Bowers* Court could not conclude with any real justification that consensual sodomy—along with other decisions that profoundly touch individual notions of sexuality and identity such as contraception and abortion—is not included within our core understanding of “privacy rights.” The Court’s notion of consensus on this subject lacks credibility when twenty-four states and the District of Columbia have criminalized sodomy but twenty-six states have not.¹⁷¹ Whatever the level of consensus in the past, the Justices’ figures illustrate a clear historical shift away from criminalizing sodomy. Yet that trend was not factored into the majority’s discussion of consensus. For that matter, it is difficult to say how a historical shift in attitudes should be factored into the Court’s analysis.

Finally, “consensus” requires an issue, a proposition, that a majority can agree on, and that issue or proposition should be relevant to the case at hand. Imagine that a representative sampling of citizens or legislators was asked, “Should the constitution protect con-

and concludes from the failure of those states to do so that they must not believe that capital punishment for minor offenders is “cruel and unusual” punishment.

Moreover, as the dissent points out, *id.* at 2983 (Brennan, Marshall, Blackmun & Stevens, JJ., dissenting), 18 of the states in which minor offenders can be executed have not reached that position by explicitly considering the issue. Execution of minor offenders is a possibility in those states, not because any statute provides for such executions in so many words, and not necessarily because the majority of citizens or their elected representatives consciously reached a consensus on the subject, but because juvenile offenders can be transferred from juvenile court to be tried as adults and their capital punishment statutes do not distinguish between adult and minor offenders. *See id.* The question whether these states should count toward a consensus is not answered easily.

166. 478 U.S. 186 (1986).

167. *Id.* at 192.

168. *Id.*

169. *Id.* at 192-93.

170. *Id.* at 192 (quoting *Moore v. East Cleveland*, 431 U.S. 494, 503 (1977)).

171. *See id.* at 198 n.1 (Powell, J., concurring).

sensual homosexual sodomy?"¹⁷² and another sampling was asked, "Should the constitution protect the right to be left alone¹⁷³ or the right to conduct intimate relationships in the intimacy of your own home?"¹⁷⁴ How would the answers to either set of questions provide an answer to whether the fundamental right to privacy permitted Georgia's punishment of Michael Hardwick?

The foregoing discussion illustrates how tenuous—as a matter of logic, history, and constitutional doctrine—the Court's reliance upon consensus can be as a guide to identifying and defining fundamental rights. Having charted a course in this area that relies upon consensus, however, the Court appears unwilling or unable to turn back, and it could not do so without undoing settled law. For example, *Roe v. Wade* and its progeny depend upon a non-statutory consensus for their conclusion that the constitution protects a woman's right to choose to have an abortion.¹⁷⁵ With all of these difficulties in mind, we turn next to the question whether any such consensus exists on the question of an incompetent patient's right to refuse life-sustaining treatment.

C. Terminating Treatment

"No answer is what the wrong question begets"¹⁷⁶

172. This is the majority's version of the relevant privacy issue. *See id.* at 192.

173. *See id.* at 199 (Blackmun, Brennan, Marshall & Stevens, JJ., dissenting).

174. *See id.* at 208.

175. *See Roe v. Wade*, 410 U.S. 113, 129-48 (1973). In addition to surveying ancient attitudes, the Hippocratic Oath, common law, and English statutory law, the majority considered both historical and present-day American law and the positions of the American Medical, American Public Health, and American Bar Associations on the issue. *Id.* Although a substantial minority of the Justices appear to be ready to overrule *Roe*, a majority of Justices is unwilling to do so. *Compare Webster v. Reproductive Health Servs.*, 109 S. Ct. 3040, 3056-57 (1989) (Rehnquist, C.J., White & Kennedy, JJ., plurality opinion) and *id.* at 3064-67 (Scalia, J., concurring in part and concurring in the judgment) with *id.* at 3058, 3061 (O'Connor, J., concurring in part and concurring in the judgment), *id.* at 3067-79 (Blackmun, Brennan & Marshall, JJ., concurring in part and dissenting in part) and *id.* at 3079, 3079-80 (Stevens, J., concurring in part and dissenting in part).

176. A. BICKEL, *THE LEAST DANGEROUS BRANCH, THE SUPREME COURT AT THE BAR OF POLITICS* 103 (1962). The utility of this quotation was first suggested by reading John Hart Ely's chapter on "Discovering Fundamental Values" in J. ELY, *supra* note 136, at 43. For Professor Bickel, "to seek in historical materials relevant to the framing of the Constitution, or in the language of the Constitution itself, specific answers to specific present problems is to ask the wrong question. With adequate scholarship, the answer that must emerge in the vast majority of cases is no answer." A. BICKEL, *supra*, at 102. For Professor Ely, to look outside the Constitution, its structure, and its functions in an attempt to identify fundamental values by consulting the value system represented by the judge, natural law, neutral principles, tradition, and popular consensus, is also to ask the wrong

The question of the legal status of an incompetent patient's right to refuse life-sustaining medical treatment produces different answers depending upon how the question is framed. Consider, for example, the states' "living will" legislation. As of 1988, thirty-eight states and the District of Columbia had enacted some type of statute that empowered a competent patient to execute an advance medical directive that would allow life-sustaining treatment to be withheld or withdrawn in the event the patient becomes incompetent and is terminally ill.¹⁷⁷ At one level of generality, these thirty-nine statutes reflect a national consensus (based upon the agreement of nearly eighty percent of the states) that life-sustaining treatment can be withheld or withdrawn from incompetent patients, at least under some limited circumstances, when the patient has executed an advance written directive.

Only two of these state statutes, however—Arkansas¹⁷⁸ and, very recently, Texas¹⁷⁹—would appear to permit patients who are

question. J. ELY, *supra* note 136, at 43-72. As the discussion that follows should illustrate, the question posed in the text is the wrong question for other reasons as well.

177. See A. MEISEL, *THE RIGHT TO DIE* 359 (1989) (table). The statutes include: ALA. CODE §§ 22-8A-1 to 22-8A-10 (1984); ALASKA STAT. §§ 18.12.010 to 18.12.100 (1986); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1986); ARK. CODE ANN. §§ 27-17-101 to 27-17-203 (1987); CAL. HEALTH & SAFETY CODE §§ 7185 to 7195 (West Supp. 1989); COLO. REV. STAT. §§ 15-18-101 to 15-18-113 (1987); CONN. GEN. STAT. ANN. §§ 19a-570 to 19a-575 (West Supp. 1989); DEL. CODE ANN. tit. 16, §§ 2501 to 2508 (1983); D.C. CODE ANN. §§ 6-2401 to 2430 (1989); FLA. STAT. ANN. §§ 765.01 to 765.15 (West 1986); GA. CODE ANN. §§ 31-32-1 to 31-32-12 (1985 & Supp. 1989); HAW. REV. STAT. §§ 327D-1 to 327D-27 (1988); IDAHO CODE §§ 39-4501 to 39-4508 (1985 & Supp. 1989); ILL. ANN. STAT. ch. 110 1/2, paras. 701-710 (Smith-Hurd Supp. 1989); IND. CODE ANN. §§ 16-8-11-1 to 16-8-11-22 (Burns Supp. 1989); IOWA CODE ANN. §§ 144A.1 to 144A.11 (West 1989); KAN. STAT. ANN. §§ 65-28,101 to 65-28,109 (1985); LA. REV. STAT. ANN. §§ 40:1299.58.1 to 40:1299.58.10 (West 1989); ME. REV. STAT. ANN. tit. 22, §§ 2921 to 2931 (Supp. 1989); MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (Supp. 1989); MISS. CODE ANN. §§ 41-41-101 to 41-41-121 (Supp. 1989); MO. ANN. STAT. §§ 459.010 to 459.055 (Vernon Supp. 1989); MONT. CODE ANN. §§ 50-9-101 to 50-9-206 (1988); NEV. REV. STAT. ANN. §§ 449.540 to 449.690 (Michie 1986 & Supp. 1989); N.H. REV. STAT. ANN. §§ 137-H:1 to 137-H:16 (Supp. 1988); N.M. STAT. ANN. §§ 24-7-1 to 24-7-10 (1986); N.C. GEN. STAT. §§ 90-320 to -323 (1985); OKLA. STAT. ANN. tit. 63, §§ 3101 to 3011 (West Supp. 1989); OR. REV. STAT. §§ 97.050 to 97.090 (1983 & Supp. 1988); S.C. CODE ANN. §§ 44-77-10 to 44-77-160 (Law. Co-op. Supp. 1988); TENN. CODE ANN. §§ 32-11-101 to 32-11-110 (Supp. 1989); TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon Supp. 1989); UTAH CODE ANN. §§ 75-2-1101 to 75-2-1118 (Supp. 1989); VT. STAT. ANN. tit. 18, §§ 5251 to 5262 (1987); VA. CODE ANN. §§ 54.1-2981 to 54.1-2992 (1988 & Supp. 1989); WASH. REV. CODE ANN. §§ 70.122.010 to 70.122.905 (Supp. 1989); W. VA. CODE §§ 16-30-1 to 16-30-10 (1985); WIS. STAT. ANN. §§ 154.01 to 154.15 (West 1989); WYO. STAT. §§ 35-22-101 to 35-22-109 (1988).

178. ARK. CODE ANN. § 20-17-202 (1987); see Comment, *Comparison of the Living Will Statutes of the Fifty States*, 14 J. CONTEMP. L. 105, 111 n.43, 123 (1988).

179. TEX. REV. CIV. STAT. ANN. art. 4590h, § 3(a) (Vernon Supp. 1989). Texas' Natural Death Act defines a "qualified patient" as one who has been "diagnosed . . . to be

not in a terminal condition to execute advance written directives. Thus, with respect to PVS patients with no other illness or injury

afflicted with a terminal condition. . . ." *id.* § 2(6). A "qualified patient," unlike any other competent adult patient, can give an unwritten directive to withhold or withdraw life-sustaining treatment. *Id.* § 3(b). The Natural Death Act, however, was amended in June 1989 by S.B. No. 1785. See 1989 Tex. Sess. Law Serv. 674 (Vernon) (effective Sept. 1, 1989). S.B. No. 1785 amended, among other things, the statutory definition of "terminal condition," and thus amended indirectly the definition of "qualified patient." "Terminal condition" is now defined to be "an incurable or irreversible condition caused by injury, disease, or illness, which, *without* [regardless of] the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serves only to postpone the moment of death of the patient." TEX. REV. CIV. STAT. ANN. art. 4590h, § 1 (Vernon Supp. 1989) (added language in italics; deleted language in brackets). While the former version of this definition literally limited the class of "qualified patients" to those as to whom life-sustaining treatment would have been futile, the new version should cover a PVS patient, like Nancy Beth Cruzan, who—with life-sustaining treatment—may live another 30 years.

This conclusion is bolstered by the changes S.B. No. 1785 made to the statutory definition of "life-sustaining procedure":

a medical procedure or intervention which utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function, which, when applied to a qualified patient, would serve only to artificially prolong the moment of death and where, in the judgment of the attending physician, noted in the qualified patient's medical records, death is imminent whether or not such procedures are utilized or will result within a relatively short time without application of such procedures. . . .

Id. § 1(4) (added language in italics).

If withheld, artificial ventilation, for example, or artificial nutrition and hydration arguably qualifies as a procedure without which death "will result within a relatively short time." The imprecision inherent in this standard leaves some room for doubt, however, whether a death that can be expected a few days to a week or more after the removal of a feeding tube would occur "within a relatively short time."

Some further doubt also exists as to whether the artificial nutrition and hydration that keep Nancy Beth Cruzan alive are "life-sustaining procedures" at all under the Texas Natural Death Act. The statutory definition ends with this sentence: "'Life-sustaining procedure' shall not include the administration of medication or the performance of any medical procedure deemed necessary to provide comfort or care or alleviate pain." *Id.* § 2(4). Food and water often are regarded as fundamental aspects of comfort and care, laden with important communal and social symbolism, that puts them in a seemingly unique class of medical treatment. This makes food and water different in important ways from a ventilator or the techniques of cardiopulmonary resuscitation. See, e.g., Callahan, *On Feeding the Dying*, HASTINGS CENTER REP., Oct. 1983, at 22; see also, e.g., Meilaender, *On Removing Food and Water: Against the Stream*, HASTINGS CENTER REP., Dec. 1984, at 11, 13 (feeding is "ordinary human care [that] is not given as treatment for any life-threatening disease"); Steinbrook & Lo, *Artificial Feeding—Solid Ground, Not a Slippery Slope*, 318 NEW ENG. J. MED. 286, 286 (1988) ("Many physicians consider that basic, humane care requires that patients always be given food and water, because they represent love and concern for the helpless."). But see, e.g., Cassell, *Life as a Work of Art*, HASTINGS CENTER REP., Oct. 1984, at 35, 35 ("there is no theoretical difference between the refusal to eat and the refusal of any other treatment") (emphasis omitted); Lynn & Childress, *Must Patients Always Be Given Food and Water?*, HASTINGS CENTER REP., Oct. 1983, at 17, 21 ("medical nutrition and hydration do not appear to be distinguishable in any

(and whose life expectancy may be measured in years or decades), the vast majority of these statutes do not confer a right to have life-sustaining treatment withdrawn on the basis of a living will.

"Terminal condition" is, of course, a nontechnical term that is capable of being infused with different meanings. For example, it does not specify a period of time within which death is expected to occur.¹⁸⁰ Even if this limitation can be finessed by physicians acting within their reasonable clinical, professional judgment, however, it is difficult to find in these statutes a national consensus in support of the termination of life-sustaining treatment for patients, like Nancy Beth Cruzan, in a persistent vegetative state. This is because the medical needs of such patients, absent infections and the like, are limited to nutrition and hydration (as well as basic nursing care), and nineteen of these thirty-nine statutes do not permit nourishment to be withheld pursuant to a living will.¹⁸¹ Commentators are dramatically and heatedly in disagreement over the issue, as well.¹⁸²

The search for a national consensus on the treatment issues for PVS patients, however, need not be limited to the legislative enactments of the various states. There are at least two reasons why this should be so. First, most patients, like Nancy Beth Cruzan, do not execute living wills before they become incompetent to make their own medical care decisions.¹⁸³ Thus, "living will" legislation is only an indirect source of guidance in cases similar to hers. Second, the Natural Death Acts and "living will" statutes generally are regarded

morally relevant way from other life-sustaining medical treatments that may on occasion be withheld or withdrawn").

When asked, however, whether artificial nutrition is a "life-sustaining procedure" under the Texas Natural Death Act, the state's attorney general stated that it may be, but that the question of "whether it will serve to artificially prolong the moment of death is a question which depends upon the expertise of the medical profession for its resolution in each individual case." Tex. Op. Att'y Gen. No. JM-837 (Dec. 28, 1987).

180. Natural Death Acts and other "living will" statutes usually refer to death occurring "imminently" or within a relatively short period of time. See A. MEISEL, *supra* note 177, at 366-67 & n.50.

181. See Comment, *supra* note 178, at 123-29 (table); see also A. MEISEL, *supra* note 177, at 369-70; Transcript of Oral Argument at 47, *Cruzan v. Director, Missouri Dep't of Health* (U.S. No. 88-1503) (Dec. 6, 1989) (Sol. Gen. Starr). Thirty-three state statutes do not permit comfort or care to be withheld pursuant to a living will. See Comment, *supra* note 178, at 123-29 (table). In an authoritative study of living will legislation, Leslie Pickering Francis found that the trend in recent years has been to exclude nutrition and hydration from the scope of treatment that may be refused. See Francis, *The Evanescence of Living Wills*, 14 J. CONTEMP. L. 27, 33-35 (1988).

182. See, e.g., the disparity among commentators discussed *supra* note 179 regarding whether nutrition and hydration should ever be withheld.

183. See *Cruzan v. Harmon*, 760 S.W.2d 408, 420 (Mo. 1988) (en banc), cert. granted, 109 S. Ct. 3240 (1989).

as having added rights to those that existed at common law, not as being in derogation of those pre-existing rights.¹⁸⁴ Consequently, a complete picture of the national consensus, if any, on this issue must look to other statutes, the case law, and the commentary that has come out of this area. Although there is no logical reason why the Supreme Court could not look to state and lower federal court decisions to determine whether there exists a common-law right to have life-sustaining treatment withdrawn or withheld, it would not be helpful in this case.

The doctrine of informed consent to medical treatment, for example, does not help in the search for a consensus concerning medical decision-making for incompetent patients such as Nancy Beth Cruzan. There undoubtedly is widespread support in the courts¹⁸⁵ for the doctrine, with its twin duties to inform and to obtain consent and its correlative right to refuse consent.¹⁸⁶ Its acceptance within the medical profession, however, has been somewhat grudging, and fidelity to the dictates of informed consent in the clinical setting remains a matter not wholly free from doubt.¹⁸⁷ Finally, there is a lack of realism in looking to informed consent, which posits the right of competent patients to make their own medical treatment decisions, as a basis for finding consensus concerning the rights of incompetent patients to choose a certain course of medical treatment.¹⁸⁸

The "right to die" cases are also an unsatisfactory source of consensus.¹⁸⁹ Professor Alan Meisel's recent summary of these cases deserves to be quoted in full:

184. See A. MEISEL, *supra* note 177, at 358, 360 ("All courts that have considered the issue have held that natural death acts are not intended to preempt common-law rights to make advance directives").

185. Although roughly half of the states now have informed consent statutes, see C. HAVIGHURST, *HEALTH CARE POLICY AND LAW* 852-53 (1988), the doctrine has common-law origins. See *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914) (Cardozo, J.).

186. See P. APPELBAUM, C. LIDZ & A. MEISEL, *supra* note 7, at 190.

187. "In medical practice, the right to refuse treatment often is ignored because it is inconsistent with the history and ethos of the medical profession," *id.*; "If the courts have been caught between the values of autonomy and health, it should come as no surprise that the medical profession has been even more torn by the dilemma of patient refusal." *Id.* at 194; see also J. KATZ, *supra* note 7, at 85 (physicians are resistant to informed consent doctrine).

188. This idea is developed more fully later in this article. See *infra* notes 230-236 and accompanying text.

189. *But see* *Keiner v. Community Convalescent Center (In re Longeway)*, 1989 Ill. LEXIS 152, *4 (noting strong support in the case law for the withdrawal of life-sustaining medical procedures, including nutrition and hydration). The *Longeway* court apparently was referring to an emerging consistency of result, not rationale.

Although the case law since *Quinlan* has added some clarity, it has also added a great deal of confusion to the issue of the right to die. A large majority of jurisdictions still have no case law on the issue. Looking to the law of other jurisdictions is complicated by the fact that it may be unsettled, incomplete, or conflicting. Furthermore, judicial decisions frequently raise more questions than they answer. The New Jersey courts, for example, despite repeated attempts to put the matter to rest with far-reaching if not seemingly definitive opinions, have appeared to be seriously frustrated in their efforts. Indeed, the experience in those jurisdictions (California, Florida, Massachusetts, New Jersey, and New York) that have experienced relatively frequent litigation over these matters has been that litigation raises more questions and breeds more litigation rather than definitive resolution.¹⁹⁰

Professor George Annas, who has been a rather consistent defender of the right to refuse life-sustaining treatment,¹⁹¹ would agree. He describes the decision as to “[w]ho has the right to refuse lifesaving treatment for an incompetent patient as one of the most controversial areas of medical jurisprudence.”¹⁹² As anyone who has attempted to wade through the opinions knows, this is a field in which distinctions and contradictions abound.

Nor, for that matter, has the medical profession itself developed a consensus as to the proper method of dealing with PVS patients. As the Supreme Judicial Court of Massachusetts noted in *Brophy v. New England Mount Sinai Hospital, Inc.*,¹⁹³ “There is substantial disagreement in the medical community over the appropriate medical action.”¹⁹⁴ The steady stream of books and articles about the “right

190. A. MEISEL, *supra* note 177, at 12-13. In a recent “Council Report,” two councils of the American Medical Association attempted to distill those basic propositions on which most courts seem to agree, but the councils noted “the different legal rulings in various states” and concluded that “the law in this area turns very heavily on court cases and legislation in the various states.” *Council Report*, *supra* note 28, at 428, 429.

191. See G. ANNAS, *JUDGING MEDICINE* 259-322 (1988) (a collection of his well-known essays, mostly from *The Hastings Center Report*).

192. G. ANNAS, *supra* note 47, at 204-05; see also Otten, *In Latest Cases, Consensus Fades on Right to Die*, *Wall St. J.*, Nov. 18, 1988, at B1, col. 6 (courts and legislatures split as to whether designated surrogate can make decision to refuse lifesaving treatment for incompetent patient).

193. 398 Mass. 417, 497 N.E.2d 626 (1986).

194. *Id.* at 441, 497 N.E.2d at 639. But see AMERICAN MEDICAL ASSOCIATION, *AMA SURVEYS OF PHYSICIAN AND PUBLIC OPINION ON HEALTH CARE ISSUES: 1988*, at 23-25 (indicating that three-fourths of the physicians surveyed favored the withdrawal of life support systems, including nutrition and hydration, from the hopelessly ill or irreversibly comatose patients if they or their families request it).

to die" is a further illustration of the lack of general agreement on even first principles, let alone the details of the implementation of such principles.

As evidence of the deep, fundamental disagreements that so mark this area, consider the status of the debate over active and passive euthanasia. If there is a dominant position with respect to these terms, it is that passive euthanasia may be ethically and legally permissible under certain circumstances, while active euthanasia is not ethically permissible¹⁹⁵ and constitutes homicide, at least under some circumstances.¹⁹⁶ The distinction between active and passive euthanasia typically is seen as a difficult one to defend logically¹⁹⁷ but important to retain for legal and policy reasons.¹⁹⁸ As the con-

195. See, e.g., PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 60-82, 63 (1983) ("society ought [not] to condone the deliberate use of poisons or similar lethal agents"); HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING 6 (1987) [hereinafter HASTINGS CENTER GUIDELINES] ("[o]ur society forbids assisting suicide or active euthanasia"); Dr. Nancy E. Dickey, 256 J. A.M.A. 471 (letter to the editor stating the opinion of American Medical Association Council on Ethical and Judicial Affairs that discontinuation of life-sustaining medical treatment in case of patients whose "coma is beyond doubt irreversible" and patients who are terminally ill whose death is imminent is ethical; however, physician "should not intentionally cause death").

196. See generally Note, *Criminal Liability*, *supra* note 7 (note surveying criminal liability for suicide assistance and suggesting statutory response).

197. See, e.g., H. KUHSE, THE SANCTITY-OF-LIFE DOCTRINE IN MEDICINE 31-81, 123-46 (1987); J. THOMSON, RIGHTS, RESTITUTION, AND RISK 78-116 (1986).

198. See, e.g., HASTINGS CENTER GUIDELINES, *supra* note 195, at 6 (the prohibition of active euthanasia "serves to sustain the societal value of respect for life and to provide some safeguards against abuse of the authority to take actions that shorten life"); N.Y. STATE TASK FORCE ON LIFE AND THE LAW, LIFE-SUSTAINING TREATMENT: MAKING DECISIONS & APPOINTING A HEALTH CARE AGENT 41 (1987) [hereinafter N.Y. TASK FORCE] ("While the moral distinction between assisting to die and withdrawing treatment is hard to discern in certain cases, . . . [a]ll the Task Force members believe that as a matter of public policy the taking of human life must not be granted legal sanction.").

In addition, most state natural death acts and living will statutes retain the distinction in their recognition of a patient's right to avoid "death prolonging" or "death delaying" treatment. See, e.g., CAL. HEALTH & SAFETY CODE § 7187(c) (West Supp. 1989); COLO. REV. STAT. § 15-18-103 (7) (1987); FLA. STAT. ANN. § 765.03(3) (West 1986); ILL. ANN. STAT. ch. 110 1/2, § 702(d), (g) (Smith-Hurd Supp. 1989); IOWA CODE ANN. § 144A.2(5)(b) (West 1989); WASH. REV. CODE ANN. § 70.122.020(4) (Supp. 1989). Implicit in these provisions is the conclusion that, when life-sustaining procedures are withheld or withdrawn under the circumstances described in the statutes, the cause of death is the patient's underlying condition, not the non-treatment.

Arguably, the distinction between passive and active euthanasia already has become dangerously blurred, if not altogether obliterated, by court decisions that permit the removal of feeding tubes from incompetent patients. This belief is presumably one of the reasons why approximately half of the states' Natural Death Acts and living will statutes prohibit the removal of food and water from qualified patients. See *supra* note 181 and accompanying text; see also A. MEISEL, *supra* note 177, at 129 & n.91 (citing cases); Y.

trovery over the following article in the *Journal of the American Medical Association (JAMA)* illustrates, however, a strong rip tide of dissent runs just below the seemingly placid surface of this general agreement.

In 1988, *JAMA* published *It's Over, Debbie*,¹⁹⁹ an anonymous account of a gynecology resident's decision to inject a young cancer patient with a lethal dose of morphine. The circumstances surrounding the resident's decision to administer the lethal injection were so unusual,²⁰⁰ some readers were tempted to conclude that the story was apocryphal.²⁰¹ In a subsequent editorial defending *JAMA's* decision to print the article, the journal's editor, Dr. George Lundberg, stated that there are "at least six identifiable major types of euthanasia,"²⁰² beginning with "passive," ending with "active," and with at least four presumably intermediate types in between.²⁰³

Kamisar, *supra* note 16, at 10 ("the 'feeding tube' cases have seriously undermined whatever distinction once existed between 'killing' and 'letting die'").

199. 259 J. A.M.A. 272 (1988) (anonymous).

200. Apart from the decision to perform active euthanasia, some of the details of the story were too strange to be believed easily. The physician involved made the decision in the middle of the night, while still drowsy from sleep, about a patient not his own, and without consulting the patient's attending physician. The article suggested that the patient was in unrelenting pain that could not be managed with a nonlethal dose of painkiller, suggesting an almost shocking level of unfamiliarity with basic principles of pain control. The patient's only words were, "Let's get this over with," an ambiguous statement at best that the resident interpreted to mean "Please end my life." *Id.*

201. See, e.g., Gaylin, Kass, Pellegrino & Siegler, *Doctors Must Not Kill*, 259 J. A.M.A. 2139 (1988) [hereinafter Gaylin]; Dr. Verne M. Marshall, 260 J. A.M.A. 787 (1988) (letter to the editor). Another correspondent suggested that the story's reference to an alcohol drip for sedation might place the date of the events some 25 years ago, a time "without all the knowledge that we now have about pain control . . . [and] public scrutiny was not as intense as it is now . . ." Dr. Sheldon T. Berkowitz, 260 J. A.M.A. 788 (1988) (letter to the editor).

202. Lundberg, *'It's Over, Debbie' and the Euthanasia Debate*, 259 J. A.M.A. 2142, 2143 (1988).

203. Lundberg's categories are:

1. *Passive*. A physician may choose not to treat acute bronchopneumonia or sepsis in a person with Alzheimer's disease or may not resuscitate a patient with carcinomatosis who has experienced cardiac arrest.

2. *Semipassive*. A physician may withhold medical treatment, such as nutrition or fluids, from a person in coma from postnecrotic cirrhosis and hepatoma with cerebral metastases.

3. *Semiactive*. A physician may disconnect a ventilator from a patient who is in a stable, vegetative state from massive cerebral infarction and has no hope of regaining consciousness.

4. *Accidental ("Double-effect")*. A physician may administer a narcotic to relieve bone pain in a patient with terminal metastatic breast cancer and the narcotic may incidentally depress respiration sufficiently to cause death directly or to facilitate the development of fatal bronchopneumonia.

5. *Suicidal*. A person with metastatic lung cancer may intentionally over-

Lundberg regarded only "active euthanasia," such as that performed by the resident in *It's Over, Debbie*, to be both illegal and "outside the bounds of thousands of years of medical tradition."²⁰⁴ William Gaylin and three other well-known medical ethicists agreed, condemning the resident for committing premeditated murder and "behav[ing] altogether in a scandalously unprofessional and unethical manner."²⁰⁵ Kenneth Vaux, however, chose to recharacterize the resident's act as "morally acceptable double-effect euthanasia."²⁰⁶ This disagreement might be written off merely as evidence of the difficult moral distinction between passive euthanasia (and its moral equivalents) and active euthanasia, since Vaux avoided the label of "active euthanasia" in his analysis of the resident's conduct. But Vaux's disagreement with the other writers is more fundamental. He stated: "[W]hile positive euthanasia must be proscribed in principle, in exceptional cases it may be abided in deed."²⁰⁷

Other authors, perhaps less cagey than Vaux, have supported the proposition that active euthanasia should not even be proscribed in principle. Thus, in a famous essay, James Rachels wrote: "[T]here is really no moral difference between the two, considered in themselves (there may be important moral differences in some cases in their *consequences*, but, as I pointed out, these differences may make active euthanasia, and not passive euthanasia, the morally preferable option)."²⁰⁸ For its time, Rachels' argument was a notably minority position. Four years later, Joseph Fletcher argued forcefully in favor of "active or direct euthanasia, which helps the patient to die, not merely the passive or indirect form of euthanasia which 'lets the patient go' by simply withholding life-preserving

dose on alcohol and barbiturates, causing his or her own death; the drugs may have been provided by a physician.

6. *Active*. A physician may administer a large, surely fatal overdose of morphine or potassium in a patient with the acquired immunodeficiency syndrome who has widespread Kaposi's sarcoma, *Pneumocystis carinii* pneumonia, and the dementia of cerebral toxoplasmosis.

Id.; cf. J. FLETCHER, HUMANHOOD: ESSAYS IN BIOMEDICAL ETHICS 153-54 (1979) (identifying five categories of "elective death").

204. See Lundberg, *supra* note 202, at 2143.

205. Gaylin, *supra* note 201, at 2139.

206. Vaux, *Debbie's Dying: Mercy Killing and the Good Death*, 259 J. A.M.A. 2140, 2140 (1988). For a brief description of "double-effect" euthanasia, see *supra* note 203.

207. Vaux, *supra* note 206, at 2141.

208. Rachels, *Active and Passive Euthanasia*, 292 NEW ENG. J. MED. 78, 80 (1975) (emphasis in original). Active euthanasia would be preferable, in Rachels' view, when it would eliminate prolonged pain and suffering that would be suffered by a patient as the result of some form of passive euthanasia. *Id.* at 78.

treatments.”²⁰⁹ His argument ended with the prediction, not quite fully realized in 1990, that “other forms [of euthanasia than indirect and involuntary euthanasia] will one day be socially accepted and enacted into law.”²¹⁰ Others have since embraced the Rachels-Fletcher position that no principled basis exists between active and passive euthanasia and that active euthanasia is, therefore, morally defensible.²¹¹

After the infamous “Debbie” piece appeared, physicians and laypeople wrote to *JAMA* and expressed opinions that cover the entire spectrum from Gaylin to Rachels.²¹² As the Vaux article intimates,²¹³ it may well be that there exists a significant chasm between medical ethical theory and medical practice in fact.²¹⁴ The differences of opinion in this area have led to recent scholarly efforts to redefine the terms of the debate in an attempt to clarify the moral terms over which there is so much disagreement.²¹⁵ In the spring of 1989, an influential group of physicians added their voices to the debate by concluding that physician-assisted suicide is not unethical.²¹⁶ Stopping short of a similar endorsement of active euthanasia, the group wrote that physicians “should not feel morally coerced to participate in [euthanasia] . . . [T]he medical profession and the public will continue to debate the role that euthanasia may

209. J. FLETCHER, *supra* note 203, at 149.

210. *Id.* at 158.

211. *See, e.g.*, Kuhse, *The Case for Active Voluntary Euthanasia*, 14 *LAW, MED. & HEALTH CARE* 145, 145 (1986) (patients should sometimes be allowed to die).

212. *See Letters: It's Almost Over—More Letters on Debbie*, 260 *J. A.M.A.* 787, 787-89 (1988); *Letters: It's Over, Debbie*, 259 *J. A.M.A.* 2094, 2094-98 (1988).

213. *See Vaux, supra* note 206, at 2141.

214. Although a 1988 California initiative to legalize euthanasia failed to obtain enough signatures to get onto the California ballot, it may have “failed because of organizational problems, not voter sentiment. Public opinion polls have shown fairly consistently that about three fifths of the American public favor legalizing euthanasia under certain conditions” Angell, *Euthanasia*, 319 *NEW ENG. J. MED.* 1348, 1349 (1988). The California initiative would have limited euthanasia to those who are “terminally ill, with a life expectancy of less than six months with or without medical treatment.” *Id.* The initiative also would have permitted a competent patient to authorize euthanasia by durable power of attorney if the qualifying conditions for euthanasia occurred within seven years. *Id.*

215. *See, e.g.*, Devettere, *Reconceptualizing the Euthanasia Debate*, 17 *LAW, MED. & HEALTH CARE* 145, 148-51 (1989) (classifying all decisions concerning life-sustaining treatment within a “simple descriptive schema” consisting of four categories: performing or not performing actions thought to prevent death and performing or not performing actions thought to cause death).

216. Wanzer, Federman, Adelstein, Cassel, Cassem, Cranford, Hook, Lo, Moertel, Safar, Stone & van Eys, *The Physician's Responsibility Toward Hopelessly Ill Patients*, 320 *NEW ENG. J. MED.* 844, 848 (1989).

have in the treatment of the terminally or hopelessly ill patient."²¹⁷ Answers may not be obvious, but the lack of consensus is.

The shifting attitudes toward passive and active euthanasia should be of great concern to the Court as it considers whether and to what extent it should approve the withholding or withdrawal of nutrition and hydration from Nancy Beth Cruzan. We in the United States already have seen a quite dramatic change in attitudes toward nutrition and hydration, from 1976, when Karen Ann Quinlan's father (who already had petitioned to have his daughter's respirator turned off) reacted with horror at the suggestion to remove her nasogastric tube ("Oh no, that is her nourishment")²¹⁸ to the present, when "courts . . . typically do not give th[e] fact [that nutrition and hydration are being removed] particular note."²¹⁹ How long will it take for our acceptance of passive euthanasia to lead to a grudging and limited acceptance of active euthanasia, followed by a greater willingness to tolerate active euthanasia?

Although it is fashionable in some circles to sneer at slippery slope arguments such as this, one should not do so unthinkingly in this area. Those who support passive euthanasia but oppose active euthanasia, for example, believe the two forms of euthanasia to be different and that the differences are morally significant. But, as Professor Frederick Schauer has pointed out, most slippery slope arguments are based upon the potentially valid assumption of the inability of future decision-makers to understand or defend distinctions we deem important today.²²⁰ The ability or willingness of future decision-makers to maintain the active-passive distinction still thought by most observers to be significant depends upon at least two factors: the logical strength of the distinction and the effect that experience has upon our willingness to maintain the distinction. As to the former, one only need read some of the arguments currently being put forth by proponents of the active-passive distinction to wonder how long the arguments will satisfy the proponents themselves, let alone those who follow some years later.²²¹

217. *Id.* at 849.

218. See Ramsey, *Prolonging Dying: Not Medically Indicated*, HASTINGS CENTER REP., Feb. 1976, at 14, 16.

219. M. HALL & I. ELLMAN, HEALTH CARE LAW AND ETHICS IN A NUTSHELL 331 (1990).

220. See Schauer, *Slippery Slopes*, 99 HARV. L. REV. 361, 381-83 (1985); see also *infra* note 251.

221. The editorialists for *The New Republic*, for example, recently defended the utility of the active-passive distinction by reference to "the fact that active euthanasia, unlike passive euthanasia, brings with it many dicey procedural questions and, ultimately, a slippery slope." *Feeling No Pain*, THE NEW REPUBLIC, Nov. 27, 1989, at 9, 10. The proce-

As for the effect that our experience with legalized passive euthanasia might have on our ability to maintain moral distinctions we currently believe are significant, a few comments may be made. First, the history of our activities and beliefs concerning the ethics of death and dying is a history of lost distinctions of former significance.²²² Slippery slopes simply may go with this psychological and emotional territory. Moreover, the courts (and the Supreme Court in particular) cannot be unmindful of their influence not only as definers of conventional morality but as shapers of it as well. The role of Dutch courts in moving the Netherlands toward legalized active euthanasia provides an example.²²³ As Professor Tribe recently has noted, the courts and the legal system affect reality by changing the conditions of our relations with one another and the state,²²⁴ yet the courts (or at least the Supreme Court) repeatedly fail to take this into account when they address subsequent legal issues without recognizing the extent to which their own past decisions fundamentally altered the experiences, expectations, and conduct of the parties.

Again, the Netherlands may provide an example. One of the essential preconditions for the use of active euthanasia by a Dutch physician is that the patient *freely* request the termination of his or her life,²²⁵ a precondition that proponents of active euthanasia in the United States probably would accept. The notion of free choice, however, becomes troubling as soon as the euthanasia option becomes legalized. As Professor Yale Kamisar noted thirty years ago:

dural issues included how to tell when death is imminent and how to gauge "the sincerity [and] the durability of the patient's expressed willingness to die." *Id.* The "slippery slope question [is:] Once we sanction euthanasia, what is to stop it from entering the domain of cold cost-benefit calculations?" *Id.* Both the procedural issues and the slippery slope question, however, apply with equal force to active *and* passive euthanasia, both of which hasten death (that is the point of euthanasia) and differ only in their means of doing so. If those issues are insufficient to warn us of the use of passive euthanasia, how long will they be effective as bulwarks against active euthanasia? In his critique of rights-based arguments in the debate over neonatal euthanasia, Professor Carl Schneider suggests that the rights discourse is unavoidably complicated by "genuine, numerous, and steep . . . slippery slopes." Schneider, *Rights Discourse and Neonatal Euthanasia*, 76 CALIF. L. REV. 151, 166-73 (1988).

222. See M. HALL & I. ELLMAN, *supra* note 219, at 241-51, 252-55, 330-37 (discussions of the vanishing legal or moral significance of such distinctions as withholding versus withdrawing treatment, ordinary versus extraordinary treatment, and nutrition/hydration versus other types of treatment, as well as the unstable distinction as a matter of logic and pragmatism between active and passive euthanasia).

223. See de Wachter, *Active Euthanasia in the Netherlands*, 262 J. A.M.A. 3316, 3317-18 (1989).

224. See generally Tribe, *The Curvature of Constitutional Space: What Lawyers Can Learn From Modern Physics*, 103 HARV. L. REV. 1 (1989).

225. See de Wachter, *supra* note 223, at 3317.

Even if the patient's choice could be said to be "clear and incontrovertible," do not other difficulties remain? Is this the kind of choice, assuming that it can be made in a fixed and rational manner, that we want to offer a gravely ill person? Will we not sweep up, in the process, some who are not really tired of life, but think others are tired of them; some who do not really want to die, but who feel they should not live on, because to do so when there looms the legal alternative of euthanasia is to do a selfish or cowardly act? Will not some feel an obligation to have themselves "eliminated" in order that funds allocated for their terminal care might be better used by their families or, financial worries aside, in order to relieve their families of the emotional strain involved?²²⁶

In short, just as technology often has seemed to have its own moral imperative ("If it is available, it should be used"), options given the blessings of the law may well become not only thinkable but presumptively so. For the reasons explained in the remainder of this article, the Supreme Court should let these issues continue to develop at the grassroots, with the vigorous debate and the cross-fertilization from one state to another that can happen best, if at all, with the least control from the Court. This seems so at least until the dynamic and fluid "consensus" on these issues coalesces around both conclusions and rationales acceptable to at least the proponents of passive or active euthanasia themselves. Two recent commentaries on the *Cruzan* case by authors who criticize²²⁷ and approve²²⁸ the Missouri Supreme Court's decision support this cautious approach. Both suggest that recognizing a constitutional right to die in a case such as *Cruzan* will seriously threaten the rights of incapacitated patients.²²⁹ One or the other of these positions is likely to be correct, and the resolution of this most difficult of

226. Kamisar, *Some Non-Religious Views Against Proposed "Mercy Killing" Legislation*, 42 MINN. L. REV. 969, 990 (1958).

227. See Ellman, *Cruzan v. Harmon and the Dangerous Claim that Others Can Exercise an Incapacitated Patient's Right to Die*, 29 JURIMETRICS J. 389 (1989).

228. See Meilaender, *The Cruzan Decision: A Moral Commentary*, MIDWEST MED. ETHICS, Winter-Spring 1989, at 6.

229. Professor Ellman, who believes that the withdrawal of nutrition and hydration is sometimes appropriate, argues that the claim of a personal right of autonomy on behalf of incapacitated patients such as Nancy Beth Cruzan rests on a legal fiction that may lead to the wrong result in cases in which the withdrawal of life-sustaining treatment is not in the best interests of the patient. See Ellman, *supra* note 227, at 394-99. Professor Meilaender, on the other hand, opposes all withdrawals of nutrition and hydration from incompetent patients and applauds the Missouri Supreme Court's refusal to recognize a right to die in *Cruzan*. See Meilaender, *supra* note 228, at 7-9.

problems will not be furthered by Supreme Court activism in this case.

Perhaps it has been difficult thus far to discern a consensus in support of the notion that the right of privacy protects an incompetent patient's autonomy because, once a patient is incompetent (at least once irreversibly so), his or her status is incompatible with notions of autonomy and personal decision-making. Certainly when there is no living will or other advance directive (which is most of the time), it should be clear that it is not the patient but someone else—a guardian, perhaps, or attorney-in-fact—who is making his or her medical decisions. The surrogate decision-maker may look for evidence of what the patient would have wanted her treatment to be, or—more perilously—for evidence of what the patient would want now if only she could regain consciousness for a moment.²³⁰ It is at least curious that the claim of a privacy right is made for this treatment decision, which is made for the patient by another, even though the opportunity for consultation with the patient is only symbolically present and the patient's control over the decision is possible only because of the acquiescence of others.²³¹

Even when the incompetent patient has left an advance directive (whether written, in the case of a living will, or oral), or recently has made reasonably concrete and explicit statements about treatment preferences should he or she become incompetent, it is not, strictly speaking, the PVS patient who chooses to terminate treatment. Someone else makes that non-treatment decision for him or her. More specifically, it is someone other than the patient who decides that the living will, oral directive, or clear statement should be given effect.

For example, suppose someone executed a living will three years before an accident left her in a persistent vegetative state. The

230. Of course, this would require the surrogate to assess the patient's earlier statements and actions to determine what she would have said *then* about her supposed wishes *now*. This, in turn, assumes that patients are capable of imagining when they are competent what their wishes for treatment would be after they became incompetent. Professor Rebecca Dresser has argued forcefully against this assumption. Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373, 379-81 (1986).

This "substituted judgment" standard has been criticized by some, see E. PELLEGRINO & D. THOMASMA, *FOR THE PATIENT'S GOOD: THE RESTORATION OF BENEFICENCE IN HEALTH CARE* (1988); Dresser, *supra*, at 374-82, and some courts have discarded it, at least when evidence concerning the wishes of the patient is lacking, in favor of an explicit best-interests-of-the-patient analysis. See, e.g., *In re Conroy*, 98 N.J. 321, 360, 486 A.2d 1209, 1229 (1985).

231. See M. HALL & I. ELLMAN, *supra* note 219, at 282-83.

document she executed states clearly that the patient wishes to refuse all "artificial means of treatment" in the event she has "an extreme physical or mental disability from which there is no reasonable expectation of recovery." Her spouse and adult children, however, strenuously object to terminating artificial feeding. Most physicians faced with this situation simply would not honor the terms of the living will.²³² Moreover, physicians are not likely to honor a living will unless they agree with it²³³ or unless the patient reaffirmed the living will during her hospitalization.²³⁴

The relevancy of these factors to treating physicians underscores the point that non-treatment decisions for incompetent patients are made *by* others *for* the patient. This is not to say that the rhetoric of autonomy and self-determination, as well as the repeated references in the cases to the patient's prior directives or statements

232. Based upon interviews with 57 physicians in California and Vermont in 1985, Joel Zinberg concluded "that physicians will not terminate care if there is persistent family disagreement, even if the physicians are persuaded that continued treatment accurately represents [the] patient's wishes." Zinberg, *Decisions for the Dying: An Empirical Study of Physicians' Responses to Advance Directives*, 13 VT. L. REV. 445, 479 (1989). Apparently physicians in California (where noncompliance may subject a physician to professional discipline if the physician fails to take steps to transfer the patient to another physician, see CAL. HEALTH & SAFETY CODE § 7191(b) (West Supp. 1989)), and Vermont (which requires physicians to comply with the directive or transfer the patient to a physician who will, see VT. STAT. ANN. tit. 18, § 5256 (1987), but does not provide for penalties against a noncomplying physician, see Zinberg, *supra*, at 463) are at least as likely to ignore a living will when family members want treatment to continue as are their counterparts in New York, which has no living will statute at all. See N.Y. TASK FORCE, *supra* note 198, at 76, 176 (table F-1) (reporting results of survey of New York hospitals; 57% would not honor a living will without family members' acquiescence in non-treatment). Over time, the living will in this situation may prove influential in producing a family consensus in favor of termination, see Zinberg, *supra*, at 479, although the consensus may result equally from the mere passage of time and the opportunity for family members to adjust to the situation of their loved one.

233. See N.Y. TASK FORCE, *supra* note 198, at 176 (table F-1) (64% of hospitals surveyed required the agreement of the attending physician before they would enforce a living will). As stated *supra* note 232, New York does not have a living will statute. Although that fact would suggest that living wills simply have not gained the same level of acceptance in New York as elsewhere, a comparison between New York, on the one hand, and California and Vermont, on the other, suggests that there is no major difference in professional attitudes in states with living will legislation and states without. See *supra* note 232. These results contrast curiously with those of a recent survey of Arkansas physicians in which almost 80% of the physicians said they viewed advance directives favorably. See Davidson, Hackler, Caradine & McCord, *Physicians' Attitudes on Advance Directives*, 262 J. A.M.A. 2415, 2415 (1989).

234. N.Y. TASK FORCE, *supra* note 198, at 176 (table F-1) (69% of hospitals surveyed stated they would not honor a living will under these circumstances). The developing tort of wrongful refusal to terminate life-sustaining treatment, see *Estate of Leach v. Shapiro*, 13 Ohio App. 3d 393, 395-98, 469 N.E.2d 1047, 1051-55 (1984), may influence a change in physicians' attitudes.

of preference, may not serve a valuable function.²³⁵ The knowledge that non-treatment is what the patient would have wanted undoubtedly helps family members and other loved ones through the difficult experience of prolonged illness or disability with no hope of recovery. The sense that directives and other statements made before entering the hospital will control or influence decision-makers if the patient should become permanently incompetent certainly enhances the sense of autonomy the rest of us enjoy as competent persons. That sense may make it easier for many patients to enter a hospital and undergo risky procedures, at least to the extent they feel assured that their lives will not be maintained artificially after all hope of a meaningful life has vanished. In addition, in our search for a useful guide to medical decision-making for incompetent patients, the "substituted judgment" standard may seem more comforting and less threatening than the "best-interests-of-the-patient" standard, which invites us to make a quality-of-life determination about the patient's condition and which easily could evolve into a more ominous best-interests-of-society standard.

None of these advantages contradicts the fact that we—the surrogate decision-maker and, in turn, the physician, the hospital, the judge, and society—are the ones who choose to let a particular PVS patient die when we direct that nutrition and hydration be terminated. Non-treatment is not a decision that the incompetent patient presently chooses,²³⁶ nor does she experience any sense of diminished self-determination if her advance directives or preferences are not followed. In short, her autonomy interests are not necessarily implicated in the decision whether to terminate life-sustaining treatment and, without an interest in autonomy, her right to privacy

235. Professor Rebecca Dresser has argued in a forceful essay that the supposed advantages of the theory of autonomy and the "substituted judgment" and "reasonable patient" standards are illusory at best and, at worst, may lead to inappropriate treatment decisions. See Dresser, *supra* note 230, at 404-05. Even if one disagrees with Professor Dresser's conclusions, however, her premises seem solid: We have chosen to adopt the prevailing standards for medical decision-making on behalf of incompetent patients. Despite the references those standards make to the patient's own treatment preferences (real or supposed), the surrogate decision-maker in fact decides, even to the point of deciding to be bound by those prior statements. See also Rhoden, *supra* note 7, at 445-46 (disagreeing with Dresser's conclusions, but noting: "It is all-too-tempting to obscure with euphemisms the fact that doctors, families, and courts are letting patients die").

236. The key word here is "presently." While it makes common sense to say a PVS patient who has executed a living will has chosen a course of non-treatment, see, e.g., Rhoden, *supra* note 7, at 382, the patient obviously is not making the choice today. The only decisions being made "today" are those made by proxy decision-makers who choose to give effect to the advance directive.

would seem to be equally irrelevant.²³⁷

Even if the Supreme Court conceptualizes the issue of medical decision-making for PVS patients in the currently prevailing terms of privacy and autonomy, however, a number of concerns counsel against extending the protection of the federal constitution that far. If the Court concludes that the constitution recognizes an interest in refusing life-sustaining medical care, it must then determine the substantive and procedural implications of that constitutional right. For example, in 1982 the Court in *Mills v. Rogers*,²³⁸ agreed to decide whether an involuntarily committed mental patient has a constitutional right to refuse treatment with antipsychotic drugs.²³⁹ Because both parties agreed that the constitution recognizes such a liberty interest,²⁴⁰ the Court was not required to decide the issue. The Court went on:

This question has both substantive and procedural aspects. . . . Assuming [the parties] are correct . . . , the substantive issue involves a definition of that protected constitutional interest, as well as identification of the conditions under which competing state interests might outweigh it. The procedural issue concerns the minimum procedures required by the Constitution for determining that the individual's liberty interest actually is outweighed in a particular instance.²⁴¹

The range of issues that will be presented to the Court is impressively (or depressingly) long and includes:

(1) Is the appropriate standard for decision-making on behalf of an incompetent patient "substituted judgment," "patient's best interests," some combination of the two, or something else?²⁴²

(2) Are nutrition and hydration different enough from other forms of medical treatment to permit many states to continue to prohibit their termination (and would the presence or absence of a living will in the case produce a different result)? In addition to the

237. This seems to be the crux of Professor Tribe's argument that "attributing 'rights' to . . . patients [who are irreversibly comatose or in a chronic vegetative state] at all is somewhat problematic." L. TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 15-11, at 1368 n.25 (2d ed. 1988).

238. 457 U.S. 291 (1982).

239. *Id.* at 294.

240. *See id.* at 299.

241. *Id.* at 299 (citations omitted).

242. The Court conceivably could finesse this issue by holding that none of the standards currently used by state courts impermissibly burdens the privacy rights of incompetent patients.

debate over active and passive euthanasia,²⁴³ this issue implicates the constitutionality of at least nineteen state living will statutes and natural death acts.²⁴⁴

(3) Must a hospital whose policies forbid the termination of life-sustaining treatment acquiesce if the patient's representative requests termination?

(4) May the state balance against the patient's right such factors as the patient's age and marital status and the presence of minor children (and when, if ever, will those factors outweigh the interests of the patient in terminating treatment)?

(5) Does a state's requirement that the incompetent patient's preference for non-treatment be established by clear and convincing evidence, or that the right to refuse treatment cannot be exercised by a third party absent a formally executed living will, impermissibly burden the patient's privacy right?

(6) Will a public hospital that wrongfully refuses to terminate life-sustaining treatment be liable for damages under Title 42, section 1983 of the United States Code, for a constitutional tort, or under some other theory of liability?

(7) May states create presumptions in favor (or against) the continuation of certain forms of treatment if various circumstances exist? Would an irrebuttable presumption against discontinuation of, for example, artificial nutrition and hydration, be constitutional?

(8) What level of proof constitutionally could be required to rebut a presumption concerning medical care? Is the "clear and convincing" standard invoked by New York and Missouri too high as a matter of law? Is it too high as applied by the Missouri Supreme Court in *Cruzan*?

(9) In the case of incompetent patients, may a state constitutionally limit the right to terminate medical care to patients who are terminally ill, or must states extend the right to patients who are in an irreversible condition as well?

(10) May the state apply different rules to conscious incompetent patients than to incompetent patients who are unconscious? One might well ask whether the Supreme Court is institutionally competent to deal effectively with issues that touch, directly or indirectly, on such difficult and sensitive subjects as patient care and standards of medical practice and medical ethics.

Apart from the Court's ability to make discerning judgments

243. See *supra* notes 195-217 and accompanying text.

244. See *supra* note 181 and accompanying text.

about such interdependent, correlative matters on a case-by-case basis, these issues illustrate the significant challenge to federalism presented by cases such as *Cruzan* and those that will follow if the Court holds that they implicated the federal right of privacy. Regulation of medical practice generally is left to the states. State regulation, in turn, has been heavily influenced (and augmented) by accreditation and credentialing entities, medical societies, medical schools, and the like, as well as the influence of tort law and the presence of first-party malpractice insurers and third-party health-care payors. My fear is that the Court cannot involve the federal judiciary in all of these issues without short-circuiting the existing mechanism that is our best bet for developing a workable professional and social consensus for dealing with incompetent patients.

Admittedly, the same argument might be made about abortion—that is, the Court should have let the political, professional, and social processes develop a broad, workable consensus on the subject, rather than impose a rule by judicial fiat. The result of the Court's decisions, it could be argued, has been to extend and intensify the divisive debate over abortion. Even if the debate would have been as long and as hot if the Court had never decided *Roe v. Wade*, the political process, the argument goes, is the more traditional and legitimate vehicle for harmonizing the conflicting demands of the partisans.²⁴⁵

Perhaps ironically, however, my suggestion that the Court not federalize the "right to die" actually is consistent with the Court's interventionism on the abortion front. In its abortion cases, the Court has attempted to eliminate efforts by the states—efforts both crude (criminalization) and subtle (regulation)—to override evolving standards of medical practice and medical ethics with respect to abortion. The Court has done this by, among other things, protecting independent, professional judgment from excessive interference by the states.²⁴⁶ In this regard, the Court can be seen as protecting the primary right to choose an abortion by freeing the sphere of medical judgment and medical practice from unduly restrictive governmental interference.

245. One does not have to agree with this line of argument to recognize that four Justices currently believe something very much like it. The opinions in *Webster* by Chief Justice Rehnquist (for himself and Justices White and Kennedy), *Webster v. Reproductive Health Servs.*, 109 S. Ct. 3040, 3056-57, 3058 (1989), and Justice Scalia, *id.* at 3064-67, emphasize the advantages they see in committing the politically divisive issue of abortion largely, and perhaps entirely, to the political process.

246. See *supra* notes 109-128 and accompanying text.

With respect to an incompetent patient, however, the sphere of medical judgment and medical practice is primary. Recognition of a woman's right to choose an abortion does not give rise to an obligation on the part of any physician to perform it. On the other hand, judicial recognition of a patient's right to choose to have a feeding tube removed or a ventilator turned off does give rise to a physician's or hospital's obligation to comply.

If terminating treatment offends the ethical standards of the hospital or the responsible physician, two options are available. First, a court can order them to terminate treatment, effectively allowing the patient's right not to be treated to override their objections.²⁴⁷ Or, to ameliorate this conflict of values, a court can permit the institution to transfer the patient (in George Annas' telling phrase, "the ethical hot potato")²⁴⁸ to a facility that is willing to terminate the life-sustaining procedures.²⁴⁹ In either event, however, a medical treatment decision will have been made and imposed by order of a court. This is a level of interference with the medical profession that the Court has worked hard in its abortion cases to prevent the states from imposing. It would be ironic if the Court fell into the same role by recognizing an incompetent patient's federal constitutional right to have life-sustaining treatment withheld or withdrawn.

In response, it might be argued that the Missouri court in

247. See, e.g., *Gray v. Romeo*, 697 F. Supp. 580, 591 (D.R.I. 1988); *In re Jobes*, 108 N.J. 394, 424-26, 529 A.2d 434, 450 (1987); *In re Requena*, 213 N.J. Super. 475, 517 A.2d 886, 890 (Ch. Div.), *aff'd*, 213 N.J. Super. 443, 517 A.2d 869 (App. Div. 1986). See generally Miles, Singer & Siegler, *Conflicts Between Patients' Wishes to Forego Treatment and the Policies of Health Care Facilities*, 321 NEW ENG. J. MED. 48 (1989) (review of cases addressing institutions' right to refuse to cooperate with patients who want to refuse further treatment).

248. See Annas, *Transferring the Ethical Hot Potato*, HASTINGS CENTER REP., Feb. 1987, at 20.

249. See, e.g., *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986). The case involved a firefighter in a persistent vegetative state who was receiving his nutrition through a gastrostomy tube. The Massachusetts Supreme Judicial Court ruled that the patient had a right under the common law and the state constitution to have treatment terminated. *Id.* at 430, 497 N.E.2d at 633. The court, however, agreed with the hospital's position that "[n]either . . . the Massachusetts patients' rights statute, the doctrine of informed consent, nor any other provision of law requires the hospital to cease hydration and nutrition upon request of the guardian." *Id.* at 440-41, 497 N.E.2d at 639. The court ruled that Massachusetts law did not "justify compelling medical professionals, in a case such as this, to take measures which are contrary to their view of their ethical duty toward their patients." *Id.* at 441, 497 N.E.2d at 639. Thus, the court directed that "[a] new judgment is to be entered ordering the hospital to assist the guardian in transferring the ward to a suitable facility, or to his home, where his wishes may be effectuated . . ." *Id.*, 497 N.E.2d at 639-40.

Cruzan has overridden the judgment and practice of the physicians and the hospitals in its state, and that the Supreme Court's response should be to recognize the incompetent patient's right and free medical professionals and institutions from the dictates of the Missouri Supreme Court. The argument, though, overlooks the fact that the only way the Supreme Court can eliminate the Missouri-court-as-medical-board is to interpose itself-as-medical-board.

If a supreme court is going to be actively involved in the regulation of medical practice in Missouri, my preference is for that court to be a state court, not federal. The reason is the essentially pragmatic one discussed earlier: the states are the social laboratories in which sometimes disparate answers to these kinds of problems can be developed and compared to the answers produced in other states. The evolution of living will statutes in thirty-eight states, all different and many of them changing over time, is an illustration of the responsiveness of the social and political processes to changing professional norms and personal preferences.²⁵⁰ People—patients, physicians, hospital administrators, legislators—have the motive and the means to change the rules they do not like. In the meantime, caution rather than haste, particularly as we traverse the frontiers of bioethics, and a spirit that seeks to do the greatest good by doing the least harm, should guide the Court.²⁵¹

CONCLUSION

The Supreme Court is confronted with two questions in *Cruzan*. The ultimate question is whether the Missouri Supreme Court correctly determined the rights of Nancy Beth Cruzan, a young woman

250. See *supra* notes 177-181 and accompanying text.

251. In an apparent shift in perspective from the first volume of his treatise to the second, Professor Tribe recently has come out on the side of caution. Compare L. TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 15-11, at 937 (1st ed. 1978) (noting that New Jersey Supreme Court's "premature if reasonably thoughtful constitutionalization of a difficult and still fluid area . . . may have needlessly foreclosed more intelligent legislative solutions in that state") with L. TRIBE, *supra* note 237, § 15-11, at 1370-71:

[T]he judiciary's silence regarding such constitutional principles probably reflects a concern that, once recognized, rights to die might be uncontainable and might prove susceptible to grave abuse, more than it suggests that courts cannot be persuaded that self-determination and personhood may include a right to dictate the circumstances under which life is to be ended. In any event, whatever the reason for the absence in the courts of expansive notions about self-determination, the resulting deference to legislatures may prove wise in light of the complex character of the rights at stake and the significant potential that, without careful statutory guidelines and gradually evolved procedural controls, legalizing euthanasia, rather than respecting people, may endanger personhood.

in a persistent vegetative state, and her parent-guardians. There is no doubt the court has left the parents in agony. There also is little doubt that some state courts would have reached a different result on this ultimate question,²⁵² while other courts likely would have ruled the same way.²⁵³ Moreover, medical ethicists, legal scholars, physicians, and the lay public disagree over the correct way to deal with patients in Nancy Beth Cruzan's condition.

The penultimate question before the Supreme Court, though, is whether the state courts should remain free to disagree, or whether the Supreme Court should begin to mark certain positions out-of-bounds under the fourteenth amendment. This article has attempted to demonstrate that it is not yet time for the Court to fix the terms of the debate over non-treatment decisions for PVS patients.

In his remarkable little book, *Western Attitudes Toward Death: From the Middle Ages to the Present*,²⁵⁴ published a year before Karen Ann Quinlan entered the hospital, Phillipe Ariès described death in the modern hospital:

Death in the hospital is no longer the occasion of a ritual ceremony, over which the dying person presides amidst his assembled relatives and friends. Death is a technical phenomenon obtained by a cessation of care, a cessation determined in a more or less avowed way by a decision of the doctor and the hospital team. Indeed, in the majority of cases the dying person has already lost consciousness. Death has been dissected, cut to bits by a series of little steps, which finally makes it impossible to know which step was the real death, the one in which consciousness was lost, or the one in which breathing stopped. All these little silent deaths have replaced and erased the great dramatic act of death, and no one any longer has the strength or patience to wait over a period of weeks for a moment which has lost a part of its meaning.²⁵⁵

Technology has changed not only the individual experience of death, but its social meaning as well. We continue to struggle with that new meaning, looking for new ways to deal with our new ways of dying, ways that we can live with.

252. See *In re Conroy*, 98 N.J. 321, 381-88, 486 A.2d 1209, 1240-44 (1985).

253. See *In re Westchester County Medical Center*, 72 N.Y.2d 517, 534, 531 N.E.2d 607, 615-16, 534 N.Y.S.2d 886, 894-95 (1988).

254. P. ARIÈS, *WESTERN ATTITUDES TOWARD DEATH: FROM THE MIDDLE AGES TO THE PRESENT* (1974).

255. *Id.* at 88-89.

My criticism of a new "right to die" is neither the usual "charge[] from the right that 'new rights' lack objective foundations [nor] the charge[] from the left that rights are indeterminate" ²⁵⁶ Rather, it is that "rights" language misrepresents and distorts this new experience of dying. We do not solve the problem of PVS patients, or even move closer to a solution of that problem, by "empowering" them or by recognizing their right of autonomy. Recognizing a federal right of privacy in this context moves along the debates over euthanasia and the standards for decision-making for PVS patients only by judicial fiat, rather than by discovering the bases for a shared response. ²⁵⁷

256. Minow, *Interpreting Rights: An Essay for Robert Cover*, 96 YALE L.J. 1860, 1862 (1987).

257. Cf. Schneider, *supra* note 221, at 174-76 (rights language impedes resolution of moral disagreements by making more difficult the accommodation of interests and workable compromise).