

COMMENT

DEFINING THE RIGHT TO DIE

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*Many die too late, and few die too early. The doctrine still sounds strange: "Die at the right time!"*¹

Although Friedrich Nietzsche was not noted for his views on medical ethics, the above quotation captures the essence of James Lindgren's article.² Lindgren posits that the recent *O'Connor*³ and *Cruzan*⁴ decisions signal a shift in the law on the withdrawal or withholding of treatment. He concludes that the requirement set forth in those cases—that an individual must have clearly and convincingly expressed his or her wishes before treatment can be terminated—errs unduly on the side of life. Basing his conclusion primarily on preferences revealed by public opinion polls, he contends that a better rule would be to presume, subject to proof otherwise, that an individual desires death when the individual falls into one or more of fourteen specified categories.⁵

Lindgren's arguments have considerable appeal. As his excellent compilation of polls reveal, a substantial majority of individuals would prefer that life supports be withdrawn in the event of a terminal illness or irreversible coma. Yet, only a tiny minority have executed an advance directive with regard to their future care,⁶ and a majority have not otherwise made their views known.⁷

Lindgren overstates his case, however. His conclusion that *O'Connor* and *Cruzan* represent a change in direction is incorrect. Furthermore, while presumed intent should play a role in the formulation of a rule on the termination of treatment, it should not be made the exclusive test.

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1. Friedrich Nietzsche, *Thus Spoke Zarathustra: First Part*, in THE PORTABLE NIETZSCHE 183 (Walter Kaufmann ed., 1954).

2. James Lindgren, *Death By Default*, 56 LAW & CONTEMP. PROBS. 185 (Summer 1993).

3. *In re Westchester County Medical Center on behalf of O'Connor*, 531 N.E.2d 607 (N.Y. 1988).

4. *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988), *aff'd sub nom* *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261 (1990).

5. For the categories, see Lindgren, *supra* note 2, at 228-29.

6. The results of a recent North Carolina survey are striking. Of 75 nursing home residents interviewed, 65 expressed a desire to have treatment withdrawn under at least some circumstances, but none had executed a living will. Elizabeth R. Gamble, Penelope J. McDonald & Peter R. Lichstein, *Knowledge, Attitudes, and Behavior of Elderly Persons Regarding Living Wills*, 151 ARCHIVES INTERNAL MED. 277 (1991).

7. The results of a recent New York nursing home survey are similarly striking. Of 103 residents interviewed, 62 had not discussed their feelings about future care with anyone. Jiska Cohen-Mansfield et al., *The Decision to Execute a Durable Power of Attorney for Health Care and Preferences Regarding the Utilization of Life-Sustaining Treatments in Nursing Home Residents*, 151 ARCHIVES INTERNAL MED. 289, 291 (1991).

Although Lindgren states that "[t]here are almost as many appellate approaches to withdrawing life-sustaining treatment as there are appellate cases,"⁸ in reality there are only two main approaches. *Cruzan* and *O'Connor* represent the extreme. Other courts have not been so restrictive. Like *Cruzan* and *O'Connor*, they recognize clear and convincing evidence of an individual's prior express wishes as a standard, but, absent such evidence, treatment also may be withheld or withdrawn under either a substituted judgment⁹ or best interests test.¹⁰ Furthermore, since the Supreme Court's decision in *Cruzan*, there is little evidence of a retreat from this more liberal approach. Florida¹¹ and Illinois¹² have reconfirmed their approval of the substituted judgment test, and Indiana has allowed the withdrawal of treatment from an individual who never had the capacity to express her views on the subject.¹³

Despite the liberality of a majority of the courts, one cannot conclude that the results are totally satisfactory. The express wishes standard, as applied, has been too restrictive. Patients who have met this standard have generally made their views known only following the onset of a terminal illness,¹⁴ or under circumstances where their professional training and background added extra credibility to their statements.¹⁵ Statements made without such a clear focus or added authority have generally been held insufficient.¹⁶

8. Lindgren, *supra* note 2, at 188.

9. The substituted judgment test requires that the surrogate decisionmaker attempt to ascertain the decision that the patient would have made had the patient been competent to decide.

10. For a comprehensive discussion of the judicially created standards for the withdrawal or withholding of treatment, see ALAN MEISEL, *THE RIGHT TO DIE* § 9.1-.35 (1989 & 1992 Supp.) There are variations, to be sure. Florida, for example, recognizes substituted judgment, but has rejected a best interests approach. See *In re Browning*, 543 So. 2d 258, 273 (Fla. Dist. Ct. App. 1989), *aff'd*, 568 So. 2d 4 (Fla. 1990). New Jersey has come up with its own formulation for conscious individuals who will die within a year or less. Treatment may be withheld or withdrawn under either a "subjective," "limited-objective," or "objective" test. The subjective test is the same as express wishes, however, and the objective is the same as best interests, at least as applied in some states. Only the limited-objective test stakes out new ground. While substituted judgment is the primary criteria, treatment may only be withheld or withdrawn if the burdens of treatment markedly outweigh the benefits. See *In re Conroy*, 486 A.2d 1209 (N.J. 1985).

11. In *In re Browning*, 568 So. 2d at 17, the court approved the enforcement of a living will. While a living will might be said to be clear and convincing evidence of an individual's express wishes, the court approved the withdrawal of treatment pursuant to a substituted judgment standard.

12. *In re Estate of Greenspan*, 558 N.E.2d 1194 (Ill. 1990). The importance of *Estate of Greenspan*, however, is undercut somewhat by the fact that it was decided only 14 days after the Supreme Court's decision in *Cruzan* and failed to cite the Supreme Court's opinion.

13. *In re Lawrance*, 579 N.E.2d 32 (Ind. 1991). *Lawrance* is especially significant because it is the first Indiana appellate court case to address termination of treatment.

14. See *Couture v. Couture*, 549 N.E.2d 571, 576 (Ohio Ct. App. 1989); *Leach v. Akron General Medical Center*, 426 N.E.2d 809, 815 (Ohio C.P. 1980).

15. See *In re Eichner*, 420 N.E.2d 64 (N.Y. 1981) (member of religious order expressed views on use of respirator following seminar on *Quinlan* and later reiterated views immediately prior to surgery); *McConnell v. Beverly Enterprises-Connecticut, Inc.*, 553 A.2d 596 (Conn. 1989) (head nurse and manager of emergency room repeatedly told family and co-workers that she did not want to be kept alive by artificial means, including by a feeding tube).

16. See *Cruzan*, 760 S.W.2d at 411, 424; *In re Jobes*, 529 A.2d 434, 443 (N.J. 1987); *In re O'Connor*, 531 N.E.2d at 613. Maine is the exception. See *In re Swan*, 569 A.2d 1202 (Me. 1990); *In re Gardner*, 534 A.2d 947 (Me. 1987).

Substituted judgment has not fared much better. It has been inappropriately applied to infants and to never-competent adults,¹⁷ whose personal values are purely speculative. There is no agreement on the relevant factors.¹⁸ Consequently, it provides little guidance on how to infer the patient's choice.¹⁹ Furthermore, the limited number of empirical studies raise questions as to the accuracy of the surrogate decisionmakers' predictions.²⁰

The best interests test has played a clearly subordinate role. No consensus exists as to what is meant by "best interests," but there are some emerging trends. One approach has been to balance the burdens of treatment against its expected benefits, although that has proven unworkable when applied to permanently unconscious patients.²¹ The test has been applied to require that a guardian follow his or her own conception of the ward's best interests, following consideration of all available information, including the ward's prior statements.²² It has been stated that best interests should be based on societal norms,²³ or should reflect the decision of a hypothetical reasonable person.²⁴

Lindgren would reverse the present system. Instead of requiring a showing that treatment should be discontinued under an express wishes, substituted judgment, or best interests theory, he lists fourteen situations where a presumption of nontreatment would apply,²⁵ although, for purposes of the present discussion, they will be reduced to four:

17. See *In re Barry*, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984) (infant); *Custody of a Minor*, 434 N.E.2d 601 (Mass. 1982) (infant); *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977) (never-competent adult).

18. *Saikewicz*, 370 N.E.2d at 432, which first adopted the test in a termination of treatment context, listed five factors. Alan Meisel, from his review of the case law, has uncovered 16 more. MEISEL, *supra* note 10, § 9.13. Judge Hancock of the New York Court of Appeals has opined that "no exhaustive list can be set forth." *O'Connor*, 531 N.E.2d at 617 (Hancock, J., concurring).

19. This argument has been most forcefully made in Rebecca S. Dresser & John A. Robertson, *Quality of Life and Non-Treatment Decisions for Incompetent Patients: A Critique of the Orthodox Approach*, 17 LAW, MED. & HEALTH CARE 234 (1989).

20. See Richard F. Uhlmann et al., *Physicians' and Spouses' Predictions of Elderly Patients' Resuscitation Preferences*, 43 J. GERONTOLOGY M115 (1988) (spouses significantly overestimated patients' preferences in three of six illness scenarios); Nancy R. Zweibel & Christine K. Cassel, *Treatment Choices at the End of Life: A Comparison of Decisions By Older Patients and their Physician-Selected Proxies*, 29 GERONTOLOGIST 615, 618 table 2 (1989) (proportion of instances where patient wanted the opposite of what their proxies predicted ranged from 24% for tube feeding to 50% for chemotherapy). But see Marion Danis et al., *Patients' and Families' Preferences for Medical Intensive Care*, 260 JAMA 797, 799 (1988) ("[f]amilies' preferences were similar to those of surviving patients").

21. The benefits versus burdens approach was first applied in *Barber v. Superior Court*, 195 Cal. Rptr. 484 (Ct. App. 1983). The principal burdens considered by the courts include pain and indignity. The principal benefit is continued quality of life. See MEISEL, *supra* note 10, §§ 9.27-32. Quality of life, however, was rejected as a factor in the leading benefits versus burdens case. *In re Conroy*, 486 A.2d 1209 (1985). The sole burden that the court was willing to consider was "recurring, unavoidable and severe pain," *id.* at 1232. The court later found it impossible to apply this standard when it was presented with two cases involving patients in persistent vegetative states. See *In re Jobes*, 529 A.2d 434 (N.J. 1987); *In re Peter*, 529 A.2d 419 (N.J. 1987).

22. *In re Drabick*, 245 Cal. Rptr. 840 (Ct. App. 1988).

23. *Foody v. Manchester Memorial Hosp.*, 482 A.2d 713, 720-21 (Conn. 1984).

24. HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING 28-29 (1987).

25. Lindgren, *supra* note 2, at 228-29.

- (1) permanently unconscious patients;
- (2) terminally ill but conscious patients;
- (3) patients suffering a great deal of physical pain; and
- (4) patients with an illness that makes them totally dependent on a family member or other person for their care.

Lindgren recognizes that polls have their limitations, and nowhere are those limitations more obvious than with respect to category (4). Several million individuals would currently appear to fit within that category. It might include a sizeable portion of individuals with development disabilities, a substantial minority, if not a majority of the elderly nursing home population, and a significant number of the elderly who are cared for at home.²⁶

Lindgren stands on far more solid ground when it comes to category (1). In fact, if *O'Connor* and *Cruzan* are regarded as aberrations, Lindgren may have already won the war. Although the theories by which they reach their result may vary, the courts have not been hesitant to authorize withdrawal of treatment from permanently unconscious patients.²⁷ A growing body of commentary argues for the very presumption that Lindgren seeks.²⁸ Nontreatment appears to be becoming the norm.

The more difficult questions are encountered when it comes to categories (2) and (3). Poll data may suggest that terminally ill but conscious patients would want treatment terminated, but the reliability of those polls as a predictor for public policy is open to question. There is no agreement on what is meant by a "terminal illness."²⁹ Furthermore, the average time between the onset of a final illness and death is twenty-nine months.³⁰ Is Lindgren suggesting that all treatment be stopped upon the first diagnosis? Perhaps what he intends is that treatment should be terminated if the patient has a "terminal illness" as defined in most living will statutes, which require either that death be "imminent,"³¹ or

26. Approximately 1.5 million elderly Americans reside in nursing homes. More than 70% of them are unable to perform three or more activities deemed essential for daily living, and a substantial majority have one or more major psychiatric disorders. In 1985, over 60% of elderly with three or more functional impairments did not reside in nursing homes. See David M. English, *The Rights of Nursing Home Patients*, TR. & EST., July 1991, at 28.

27. Alan Meisel has catalogued 33 cases in which the courts have described the patient as being in either a coma or persistent vegetative state. MEISEL, *supra* note 10, § 5.20. In only two of those decisions was there a final denial by the court of a request to terminate treatment.

28. See, e.g., Charles H. Baron, *Why Withdrawal of Life-Support for PVS Patients Is Not a Family Decision*, 19 LAW, MED. & HEALTH CARE 73 (1991); Norman Cantor, *The Permanently Unconscious Patient, Non-Feeding and Euthanasia*, 15 AM. J. LAW & MED. 381 (1989); Dresser & Robertson, *supra* note 19.

29. The uncertainty is due in part to the fact that "the determination of the presence of terminal illness is itself a question that involves an assessment of risk and a balancing of the benefits and burdens of treatment that might reduce that risk." Sandra H. Johnson, *Sequential Domination, Autonomy and Living Wills*, 9 W. NEW ENG. L. REV. 113, 126 (1987).

30. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *DECIDING TO FORGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS* 18 (1983) [hereinafter PRESIDENT'S COMMISSION].

31. See Gregory Gelfand, *Living Will Statutes: The First Decade*, 1987 WIS. L. REV. 737, 741 n.9 & 744 n.17 (citing 16 living will statutes with "imminent death" requirement).

that death will occur within a "relatively short time."³² Both definitions raise interpretive questions, however, and would not provide the certainty that Lindgren seeks.³³

An all-or-nothing rule for patients in extreme pain should also be rejected. Pain can usually be controlled through medications. Even without medications, the alleviation of pain is a concern in only a minority of cases.³⁴ It would seem inappropriate to mandate termination of treatment for a symptom that may be associated with inadequate care.³⁵

The cases on termination of treatment are often ambiguous, conflicting, and each new opinion typically raises more questions than it answers. Although the cases are subject to criticism, slotting patients into arbitrary categories and then presuming that they would want treatment withheld or withdrawn is an approach fraught with peril. Lindgren's proposal is attractive because it gives the appearance of being a simple solution. But in this area of the law, there can be no simple solutions.

32. See, e.g., UNIFORM RIGHTS OF THE TERMINALLY ILL ACT § 1(9) (1989), 9B U.L.A. 98 (1992 Supp.).

33. "This [relatively short time] definition gives to the physician authority to answer a question that is not entirely a matter of professional judgment. An individual's evaluation of a period of time as 'short' depends on the goals and values of that individual." Johnson, *supra* note 29, at 125-26. See also Joanne Lynn, *Why I Don't Have a Living Will*, 19 LAW, MED. & HEALTH CARE 101 (1991).

34. See generally PRESIDENT'S COMMISSION, *supra* note 30, at 278-86.

35. For example, in one recent study, all of the patients with bed or pressure sores were found to be severely malnourished. Gayle D. Pinchcofsky-Devin & Mitchell V. Kaminski, Jr., *Correlation of Pressure Sores and Nutritional Status*, 34 J. AM. GERIATRICS SOC'Y 435 (1986).

