1989

From Medicalization to Legalization to Politicization: Cruzan, O'Connor and Refusal of Treatment in the 1990s

Sandra H. Johnson
Saint Louis University School of Law

FROM MEDICALIZATION TO LEGALIZATION TO POLITICIZATION: *O'CONNOR, CRUZAN,* AND REFUSAL OF TREATMENT IN THE 1990s*

*by Sandra H. Johnson***

> *As police and stunned hospital officials looked on helplessly, a distraught gunman unplugged the life-support equipment attached to his comatose infant son Wednesday, then cradled the baby until he died . . . . [The father] handed the [child's] lifeless body . . . to a nurse, put down the [loaded] gun, . . . and collapsed into tears . . . .*[1]

The father in this incident was arrested and charged with murder. The hospital, Rush-Presbyterian-St. Luke's in Chicago, claimed that "federal law" required the hospital "to provide life support for the baby or risk prosecution for child neglect."[2] The hospital further claimed that the parents of the child had been advised of the need for them to bring an action in court, which the hospital would not oppose, in order to discontinue the respirator for their child who had been in a coma for eighteen months. Others claimed that the law was not the culprit. Rather, "hospital policy and [poor] communication between health-care workers and grieving parents" caused this tragedy.[3]

Whatever the cause, this incident dramatizes, perhaps somewhat

---

* This article was delivered on March 29, 1989 as a part of a symposium on Law and Medicine in the 1990s at the University of Connecticut School of Law. In July, the United States Supreme Court granted certiorari in *Cruzan v. Harmon.*

** Professor of Law, Associate Professor of Law in Internal Medicine, and Director of the Center for Health Law Studies, St. Louis University School of Law. H.A.B., St. Louis University; J.D., New York University; LL.M., Yale Law School. The author acknowledges the research assistance of Jacqueline Ohlms and the comments of her colleague Professor Thomas Greaney.

1. Blau & Griffin, *Father: Killed Son Because I Love Him*, Chicago Tribune, Apr. 27, 1989, at 1, col. 2.

2. Griffin & Grady, *Hospital in Center of Storm*, Chicago Tribune, Apr. 28, 1989, at 24, col. 2.

3. *Id.* at 1, col. 5.

more starkly than the norm, the high stakes and human drama that continue to accompany end-of-life decisionmaking. Rather than settling into strong and predictable principles of decisionmaking, these decisions still engender disagreement over the appropriate roles of families, doctors, legislatures, and courts. That disagreement surfaced in late 1988, when the highest courts in two states issued decisions that were surprising to many who have followed the development of the law concerning termination/refusal of treatment.[4] In October, the New York Court of Appeals, in *In re Westchester County Medical Center (O'Connor)*,[5] decided that the insertion of a nasogastric tube was legally required for Mary O'Connor. In November, the Supreme Court of Missouri, in *Cruzan v. Harmon*,[6] held that there was no legal basis to support the withdrawal of Nancy Cruzan's gastrostomy.

This article analyzes *O'Connor* and *Cruzan* both for their place in the jurisprudence of medical treatment decisionmaking of the 1980s and for their foreshadowing of conflicts waiting in the 1990s. The first two major sections present arguments that would tend to limit these cases, first, to their respective jurisdictions and, second, to their facts. Yet although the application of *O'Connor* and *Cruzan* can be limited, these decisions represent a significant and growing challenge to the scope of an individual's right to refuse treatment. After examining the potential reach of these cases, the article concludes that it is critical that the patient retain the power to make his or her own health care decisions. The vitality of this self-determination model, not only as a concept or principle, but also as a legally enforceable right, should continue to be the cornerstone of medical treatment decisionmaking policy in the 1990s.

---

4. As one author notes:

> Nostradamus allegedly said, "Prediction is difficult, especially about the future." For a dozen years a steady stream of appellate courts have forcefully affirmed the right of competent individuals to refuse treatment, and the right of incompetent individuals to have their previously expressed treatment directions followed. I would have predicted New York would join in.

Annas, *Precatory Prediction and Mindless Mimicry: The Case of Mary O'Connor*, 18 HASTINGS CENTER REP., Dec. 1988, at 31 [hereinafter Annas, *Precatory Prediction*]; *see also* Annas, *The Insane Root Takes Reason Prisoner*, 19 HASTINGS CENTER REP., Jan./Feb. 1989, at 29 [hereinafter Annas, *The Insane Root*]; *Missouri, New York Rulings Unlikely to Prevail*, 14 CONCERN FOR DYING NEWSLETTER, Winter 1988, at 1.

5. 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988).

6. 760 S.W.2d 408 (Mo. 1988) (en banc), *cert. granted sub nom.* Cruzan v. Missouri Dep't of Health, 109 S. Ct. 3240 (1989).

I. BACKGROUND: *O'Connor* AND *Cruzan*

A. *Mary O'Connor*

When her case was filed, Mary O'Connor was a seventy-seven-year-old widow with two adult daughters.[7] She had suffered a series of strokes beginning in July 1985, which left her severely debilitated.[8] One of her daughters cared for her at home for several years after the strokes but then admitted her to a nursing home in February 1988.[9] In June 1988, she was transferred to Westchester County Medical Center, suffering from sepsis, dehydration, and probably pneumonia.[10] Although she was " 'stuporous [and] virtually not responsive' " when admitted,[11] she showed improvement after being treated at the hospital.[12] Although the extent to which she was aware of, and responsive to, her environment was a matter of dispute,[13] each of the physicians involved

---

7. *In re* Westchester County Medical Center (O'Connor), 72 N.Y.2d 517, 523, 531 N.E.2d 607, 608, 534 N.Y.S.2d 886, 887 (1988).

8. *Id.* at 523, 531 N.E.2d at 608-09, 534 N.Y.S.2d at 887-88.

9. *Id.* at 523, 531 N.E.2d at 609, 534 N.Y.S.2d at 888. The appellate division opinion does not mention the care by the daughter. *In re* Westchester County Medical Center (O'Connor), 139 A.D.2d 344, 532 N.Y.S.2d 133, *rev'd*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988).

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

11. *Id.*

12. *Id.* The majority for the appellate division, in contrast, does not note any improvement in O'Connor's condition within the one to two months between her admission to the hospital (and the initiation of intravenous feeding) and the time of the proceeding. The dissenting opinion of Justice Balletta, however, states that "[t]he record before this court clearly shows that Mary O'Connor's condition improved after entry into the hospital and being given nutrition through an intravenous tube." *O'Connor*, 139 A.D.2d at 353, 532 N.Y.S.2d at 139 (Balletta, J., dissenting). The court of appeals noted that O'Connor "showed marked improvement after receiving fluids, limited nourishment and antibiotics intravenously. *Within a few days* she became alert, able to follow simple commands and respond verbally to simple questions." *O'Connor*, 72 N.Y.2d at 524, 531 N.E.2d at 609, 534 N.Y.S.2d at 888 (emphasis added). Neither Balletta, nor the New York Court of Appeals, made anything of the noted improvement in O'Connor's condition except to emphasize that O'Connor was not comatose, a fact agreed upon by all parties. *See infra* text accompanying note 14.

13. The majority for the court of appeals believed that Mary O'Connor was "able to follow simple commands and respond verbally to simple questions" and was "capable of responding to simple questions or requests sometimes by squeezing the questioner's hand and sometimes verbally." *In re* Westchester County Medical Center (O'Connor), 72 N.Y.2d 517, 525, 531 N.E.2d 607, 609, 534 N.Y.S.2d 886, 888 (1988). The majority for the appellate division found that she responded "only . . . sporadically to some simple questions (although not always appropriately)." *O'Connor*, 139 A.D.2d at 346, 532 N.Y.S.2d at 134. The dissent for the New York Court of Appeals quoted an expert testifying at the hearing: " 'She will phonate, make a sound and sometimes answer yes. She will answer when asked what her name is, she'll say 'Mary' and phonate. That's about it really.' " *O'Connor*, 72 N.Y.2d at 544, 531 N.E.2d at 622, 534 N.Y.S.2d at 901 (Simons, J., dissenting). The dissent went on to say that "[n]either of the doctors could testify

agreed that O'Connor was not unconscious or comatose.[14] They also agreed, however, that brain damage was substantial and irreparable and that she would never regain "significant mental capacity."[15]

When O'Connor developed an inability to swallow, her daughters refused to grant the hospital permission to insert a nasogastric tube for nutrition.[16] The hospital ethics committee found that it would be inappropriate to withhold nutrition in this case, and the hospital sought a court order to allow insertion of the tube.[17]

The daughters claimed that their mother would reject such treatment. They based this claim on statements their mother had consistently made over a period of approximately fifteen years concerning medical treatment.[18] According to her daughters, Mary O'Connor had stated that "she would not want to go on living if she could not 'take care of herself and make her own decisions' " and that she " 'would never want any sort of intervention any sort of life support systems to maintain or prolong her life.' "[19] A former hospital co-worker of O'Connor's testified that O'Connor had stated several times that "it is 'monstrous' to keep someone alive by using 'machinery, things like that' when they are 'not going to get better.' "[20] The daughters argued that these oral statements fairly represented O'Connor's choice because she made them while caring for several family members who were suffering from severe and terminal illnesses and after her own hospitalization following a heart attack.[21] Moreover, these statements were consistent with O'Connor's religious beliefs.[22] Based on this evidence, the trial and intermediate appellate courts each refused to issue an order compelling insertion of the nasogastric tube.[23]

---

with assurance, moreover, that she even understood the questions she 'answered.' " *Id.*

14. *O'Connor*, 72 N.Y.2d at 524-25, 531 N.E.2d at 609-10, 534 N.Y.S.2d at 888-89.

15. *Id.* at 525, 531 N.E.2d at 610, 534 N.Y.S.2d at 889.

16. *Id.* at 524, 531 N.E.2d at 609, 534 N.Y.S.2d at 888.

17. *Id.*

18. *Id.* at 524, 527, 532, 531 N.E.2d at 609, 611, 614, 534 N.Y.S.2d at 888, 890, 893.

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

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

21. *See id.* at 527, 531 N.E.2d at 611, 534 N.Y.S.2d at 890; *In re* Westchester County Medical Center (O'Connor), 139 A.D.2d 344, 348, 532 N.Y.S.2d 133, 135, *rev'd*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988).

22. *See In re* Westchester County Medical Center (O'Connor), 72 N.Y.2d 517, 526, 531 N.E.2d 607, 611, 534 N.Y.S.2d 886, 890 (1988). Mrs. O'Connor was described as a " 'very religious woman' " who " 'felt that nature should take its course.' " *Id.*

23. *Id.* at 527, 531 N.E.2d at 611, 534 N.Y.S.2d at 890. The majority opinion for the appellate division commented that arguments that O'Connor's statements were not sufficiently specific, particularly as to nutrition and hydration, "place[] an unfair burden on those who are not well

The New York Court of Appeals, however, ordered that the nasogastric tube be inserted.[24] While acknowledging the testimony recounting O'Connor's statements about treatment, the court noted that all of the witnesses agreed that O'Connor had never specifically discussed nutrition and hydration.[25] Moreover, when one of the daughters was asked what choice her mother would make if that choice could lead to a painful death, the daughter responded that she did not know.[26] Finding that there was no "clear and convincing" evidence of O'Connor's own choice in this matter, the court ordered that treatment be initiated and continued. The court, however, was divided: four judges signed the majority opinion; one judge concurred in the result, but in a separate opinion severely criticized the requirement of clear and convincing evidence of the patient's choice as the sole basis for treatment decisions for incompetent patients;[27] and two judges dissented.[28]

B. *Nancy Cruzan*

Nancy Cruzan is in her early thirties and has been in a persistent vegetative state for six years. According to the court, she is "oblivious to her environment except for reflexive responses . . . ; [she has] cerebral cortical atrophy [that] is irreversible, permanent, progressive and ongoing; . . . she is a spastic quadriplegic; [and] her four extremities are contracted with irreversible muscular and tendon damage."[29]

Cruzan sustained these injuries in a car accident that caused deprivation of oxygen to her brain for a period of approximately twelve to fourteen minutes before she was resuscitated by paramedics.[30] The gastrostomy was inserted nearly four weeks after the accident when there was still hope of recovery.[31] Now there is no such hope, and Cruzan could survive in her current state for thirty or more years.[32]

---

versed in the area of modern medical technology and, in a broader sense, reflect[] a failure on their proponent's part to appreciate the constant advances that are made in the area of medical technology." *O'Connor*, 139 A.D.2d at 349, 532 N.Y.S.2d at 136.

24. *O'Connor*, 72 N.Y.2d at 534-35, 531 N.E.2d at 616, 534 N.Y.S.2d at 895.

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

26. *Id.*

27. *Id.* at 535-39, 531 N.E.2d at 616-18, 534 N.Y.S.2d at 895-97 (Hancock, J., concurring).

28. *Id.* at 539-52, 531 N.E.2d at 618-27, 534 N.Y.S.2d at 897-906 (Simons, J., dissenting).

29. Cruzan v. Harmon, 760 S.W.2d 408, 411 (Mo. 1988) (en banc), *cert. granted sub nom.* Cruzan v. Missouri Dep't of Health, 109 S. Ct. 3240 (1989).

30. *Id.*

31. *Id.*

32. *Id.*

Cruzan's family, consisting of her mother, father, and sister,[33] asked that the state rehabilitation center in which Cruzan resides cease administering nutrition through the gastrostomy. The center, however, refused to terminate treatment without a court order.[34] Ultimately, the trial court issued an order that the center comply with the family's decision.[35]

Like the New York Court of Appeals in *O'Connor*, the Missouri Supreme Court was divided in this case: the majority opinion was signed by four judges, while three others filed dissenting opinions.[36] As in *O'Connor*, the *Cruzan* majority found the evidence of the patient's choice unpersuasive.[37]

In addition, however, the Missouri Supreme Court explicitly rejected both the claim to self-determination (expressed in the doctrine of informed consent) and the claim to a constitutional right to privacy, claims which are commonly viewed as supporting the right to refuse

---

33. The court described the Cruzan family as a "loving family" who had "exhausted any wellspring of hope which might have earlier accompanied their now interminable bedside vigil." *Id.* at 412.

34. *Id.* at 410.

35. Estate of Cruzan, Estate No. CV384-9P (P. Div. Cir. Ct., Jasper County, Mo. July 27, 1988). The trial court's judgment is not reported, but it is reprinted in Judge Higgins's dissent to the majority opinion of the Missouri Supreme Court. Cruzan v. Harmon, 760 S.W.2d 408, 430-41 (Mo. 1988) (en banc) (Higgins, J., dissenting), *cert. granted sub nom.* Cruzan v. Missouri Dep't of Health, 109 S. Ct. 3240 (1989).

36. One of the judges who signed the majority opinion was not a member of the court, but was sitting on the court temporarily. In his dissent, Judge Welliver argued that the magnitude of the public policy at issue mandated a hearing by the full court of regularly appointed members: "It is deeply regrettable to me that an issue of this magnitude and importance to every citizen of the State is decided by the single vote of any special judge while the *sitting* members of the regular Court are evenly divided on this issue." *Cruzan*, 760 S.W.2d at 442 (Welliver, J., dissenting).

37. *Id.* at 424. The trial court had found sufficient evidence of Cruzan's choice prior to becoming incompetent:

> About a year prior to her accident in discussions with her then housemate, friend and co-worder [sic], she expressed the feeling that she would not wish to continue living if she couldn't be at least halfway normal. Her lifestyle and other statements to family and friends suggest that she would not wish to continue her present existence without hope as it is.

Id. at 432. Judge Higgins, in a dissenting opinion, argued that the court should have affirmed the finding of the trial court concerning Cruzan's expressed desires. *Id.* at 436 (Higgins, J., dissenting).

In contrast, Judge Blackmar argued in his dissent:

> I do not place primary emphasis on the patient's expressions, except possibly in the very unusual case, . . . in which the patient expresses a view that all available life supports should be made use of. Those closest to the patient are best positioned to make judgments about the patient's best interest.

Id. at 428 (Blackmar, J., dissenting).

treatment on behalf of incompetent patients. The court rejected informed consent as a basis for the decision to terminate treatment and stated that "it is definitionally impossible for a person to make an informed decision—either to consent or to refuse—under hypothetical circumstances."[38] The court also expressed "grave doubts" that the right of privacy extends to decisions to "terminate the provision of food and water to an incompetent patient."[39] Finally, the court substituted for the self-determination framework a "pro-life" policy requiring treatment, enforceable by the state's courts.[40]

II. LIMITING *O'Connor* AND *Cruzan* TO NEW YORK AND MISSOURI

On one level, these two cases are surprising simply in their result. As the Missouri Supreme Court noted in *Cruzan*, "[n]early unanimously, those courts [considering rejection of medical treatment] have found a way to allow persons wishing to die, or those who seek the death of a ward, to meet the end sought."[41] Unlike the courts in *Cruzan* and *O'Connor*, the vast majority of courts considering discontinuation of treatment have concluded, for various reasons, that termination of treatment was, or would have been,[42] appropriate in the case before them.[43]

On another level, both *O'Connor* and *Cruzan* are provocative in their commentary on the dominant legal framework that has developed for the resolution of disputes concerning rejection of available medical treatments. This model is fairly described as a "self-determination model" and is derived from the common law doctrine of informed consent and the constitutional right to privacy.[44]

---

38. *Id.* at 417.

39. *Id.* at 418. The court also stated that "even if we recognize such a broadly sweeping right of privacy, a decision by Nancy's co-guardians to withdraw food and water under these circumstances cannot be sustained." *Id.*

40. *See infra* notes 57-65 and accompanying text.

41. Cruzan v. Harmon, 760 S.W.2d 408, 413 (Mo. 1988) (en banc), *cert. granted sub nom.* Cruzan v. Missouri Dep't of Health, 109 S. Ct. 3240 (1989). One commentator stated that "Justice Robertson [the author of the majority opinion] acted like someone asked to write the fiftieth chapter of a novel who begins by declaring that the first forty-nine chapters are irrelevant to his endeavor." Annas, *The Insane Root*, *supra* note 4, at 29. Justice Robertson accuses the dissenters of taking a "me too" attitude without analyzing the prior cases. *Cruzan*, 760 S.W.2d at 413 n.5.

42. In several of the cases generally cited as allowing treatment to be withdrawn, the patient had died prior to the court's decision. *See, e.g.*, *In re* Spring, 380 Mass. 629, 405 N.E.2d 115 (1980); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

43. See cases cited by the majority in *Cruzan*, 760 S.W.2d at 412 n.4.

44. *See, e.g.*, Gray v. Romeo, 697 F. Supp. 580, 584-85 (D.R.I. 1988) (holding that the constitutional right to privacy reached refusals of medical treatment); Superintendent of Belchertown

The starting point for such an analysis is the nearly unlimited right of a competent patient to refuse even lifesaving medical treatment.[45] The earliest cases on termination of treatment posited that the right to refuse medical treatment "must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both."[46] This model of granting the right of self-determination to incompetent patients has dominated the legal analysis of decisions involving termination of treatment for incompetent pa-

---

State School v. Saikewicz, 373 Mass. 728, 738-40, 370 N.E.2d 417, 424 (1977) (relying on both the doctrine of informed consent and a constitutional right to privacy); *Conroy*, 98 N.J. at 346-48, 486 A.2d at 1222-23 (relying on the doctrine of informed consent and reserving judgment as to the constitutional right).

45. *See, e.g.*, 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).

The competent adult's right to refuse treatment is limited by four state's interests: protecting innocent third parties, protecting the ethical integrity of the medical profession, preventing suicide, and preserving the sanctity of life. *See* D. MEYERS, MEDICO-LEGAL IMPLICATIONS OF DEATH AND DYING §§ 10:12-:16 (1981 & Supp. 1988). In those cases denying a competent patient a right to refuse a particular treatment—originally in cases involving Jehovah's Witnesses who refused lifesaving blood transfusions—the courts have relied primarily on the interest in protecting innocent third parties, particularly dependent or unborn children. *See, e.g., In re* Application of President & Directors of Georgetown College, 331 F.2d 1000, 1008 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964). The state's interest in protecting the ethical integrity of the medical profession has two aspects: a presumption against forcing a particular physician to participate in actions that he finds unethical and a broader concern for harmony between legal norms and medical ethics in deference to the professionalism of doctors. In *Quinlan*, however, the court found that the decision by Karen Quinlan's physicians (declining to withdraw the respirator) was "consistent with . . . the then existing medical standards and practices." *In re* Quinlan, 70 N.J. 10, 45, 355 A.2d 647, 666, *cert. denied*, 429 U.S. 922 (1976). The court, however, went on to find that "the state of the pertinent medical standards and practices . . . is not such as would justify this Court in deeming itself bound or controlled thereby." *Id.* at 51, 355 A.2d at 669. Later cases have relied heavily on the change in the medical community's standards, which allow for withdrawal of treatment in certain situations. *See, e.g.*, Brophy v. New Eng. Sinai Hosp., 398 Mass. 417, 439-40, 497 N.E.2d 626, 638-39 (1986); *Saikewicz*, 373 Mass. at 744-45, 370 N.E.2d at 426-27; *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738, 743-44 (1983) (en banc). In *Brophy*, the court held that neither the patient's rights nor federal or state law justifies compelling medical professionals to take active measures contrary to their view of their ethical duty toward their patients. 398 Mass. at 441, 497 N.E.2d at 639; *see also Conroy*, 98 N.J. at 351, 486 A.2d at 1224-25; *Colyer*, 99 Wash. 2d at 124, 660 P.2d at 743-44. *But see In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987). In *Jobes*, the New Jersey Supreme Court ordered a facility to comply with the court's order to withdraw treatment because of the extreme difficulty of finding a substitute health care facility. The court held that a transfer of the patient would "essentially frustrate [the patient's] right to self-determination." *Id.* at 425, 529 A.2d at 450. The facility had not indicated its unwillingness to participate in such withdrawals of treatment at the time of the patient's admission. *Id.* The prevention of suicide has been handled definitionally—refusing medical treatment is not suicide. *See, e.g., Brophy*, 398 Mass. at 439, 497 N.E.2d at 638. For a discussion of the interest in preserving life, see *infra* notes 64-65 and accompanying text.

46. *Saikewicz*, 373 Mass. at 745, 370 N.E.2d at 427.

tients.[47] The result of the widespread adoption of this model is that the major, though certainly not sole, focus in litigation has been on the discernment of the patient's putative choice.[48]

Of course, the most difficult, and in many ways the most important, question to be asked from the perspective of the development of the law is whether *O'Connor* and *Cruzan* are aberrations in a well-established framework or whether they reflect a significant and emerging trend. Their proximity in time alone gives the appearance of a significant change in the development of the law.[49] Yet *O'Connor* and *Cruzan* are clearly products of factors unique to New York and Missouri, beyond what some might argue is a matter of political "climate" in these two states.[50]

---

47. *See, e.g.*, Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987); Foody v. Manchester Memorial Hosp., 40 Conn. Supp. 127, 482 A.2d 713 (1984); Corbett v. D'Alessandro, 487 So. 2d 368 (Fla. Dist. Ct. App.), *rev. denied*, 492 So. 2d 1331 (Fla. 1986) (mem.); *In re* Guardianship of Barry, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984); *In re* Gardner, 534 A.2d 947 (Me. 1987); *In re* Guardianship of Grant, 109 Wash. 2d 545, 747 P.2d 445 (1987).

48. *O'Connor* exemplifies this approach. *See also* McConnell v. Beverly Enters.-Conn., 209 Conn. 692, 553 A.2d 596 (1989) (patient was a nurse who was very specific in her statements); *Foody*, 40 Conn. Supp. at 127, 482 A.2d at 713 (allowing information concerning the patient's choice to be gleaned from family relationship); Severns v. Wilmington Medical Center, Inc. (*In re* Severns), 425 A.2d 156 (Del. Ch. 1980); *Gardner*, 534 A.2d at 947; *In re* Spring, 380 Mass. 629, 405 N.E.2d 115 (1980); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); Eichner *ex rel.* Fox v. Dillon, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

49. In October 1988, however, the district court in Gray v. Romeo, 697 F. Supp. 580 (D.R.I. 1988), held that the constitutional right to privacy supported a decision to withdraw a feeding tube from a woman who was in a persistent vegetative state, thereby becoming the first federal court to rely explicitly on a constitutional right to order cessation of a particular medical treatment. *Id.* at 586, 591.

In January 1989, the Supreme Court of Connecticut ordered the removal of a gastrostomy tube for a patient who was in a "terminal coma" and who had expressed clearly and specifically a desire for removal of medically provided nutrition prior to her incompetency. *McConnell*, 209 Conn. at 692, 553 A.2d at 596.

50. For example, New York's struggles with proposed legislation in bioethics are well-known: "Bioethical experts say New York has lagged behind other states in legislating solutions to the quandaries posed by high-tech medicine." Kerr, *Controversy Over Medical Proxies*, Newsday, June 17, 1989, at 10, col. 1 (discussing the controversy over health care proxy bills before the New York State legislature, particularly the "lobbying efforts by the right-to-life lobby, especially on Long Island"). Missouri has gained notice as a state with an influential anti-abortion movement. Supreme Court cases on abortion rights subsequent to Roe v. Wade, 410 U.S. 113 (1973), frequently arose in Missouri. *See, e.g.*, Webster v. Reproductive Health Servs., 109 S. Ct. 3040 (1989) (Missouri statute declaring that human life begins at conception and regulating abortions after the twentieth week of pregnancy held constitutional); Planned Parenthood Ass'n v. Ashcroft, 462 U.S. 476 (1983) (declaring unconstitutional a Missouri statute requiring abortions after 12 weeks of pregnancy to be performed in hospital); Poelker v. Doe, 432 U.S. 519 (1977) (City of Saint Louis policy to refuse publicly financed hospital services for nontherapeutic abortions, while providing services for childbirth, not a violation of equal protection); Singleton v. Wulff, 428 U.S.

The *O'Connor* case involved application of New York's standard of proof: the requirement that an incompetent patient's previous statements expressing a choice to refuse treatment must be supported by "clear and convincing" evidence if the statements are to be used as a basis for refusing medical treatment. This doctrine was expressed in *Eichner ex rel. Fox v. Dillon*,[51] in which the New York Court of Appeals considered the situation of Brother Fox, a member of the Catholic religious order of the Society of St. Mary, who entered a persistent vegetative state after suffering a cardiac arrest during surgery.[52] The court allowed withdrawal of a respirator based on "compelling" proof that Brother Fox would not want "any of this 'extraordinary business' " and so would want the respirator removed.[53] The *Eichner* court found that Brother Fox had made several serious and reflective statements concerning both the morality of such choices and his own preferences subsequent to the *Quinlan* case.[54] The "clear and convincing" standard is a very exacting requirement.[55] It is fair to say that Mary O'Connor's statements were not unlike those used by other courts to find that an

---

106 (1976) (two physicians challenging the constitutionality of Missouri's exclusion from Medicaid funding of abortions not "medically indicated" held to have standing); Planned Parenthood v. Danforth, 428 U.S. 52 (1976) (declaring unconstitutional a Missouri statute requiring the consent of the parents of minors seeking abortions).

The *Cruzan* majority described the constitutional issues in the case as arising from "the amorphous mass of constitutional rights generally described as the 'right to liberty,' 'the right to privacy,' equal protection and due process." Cruzan v. Harmon, 760 S.W.2d 408, 412 (Mo. 1988) (en banc), *cert. granted sub nom.* Cruzan v. Missouri Dep't of Health, 109 S. Ct. 3240 (1989).

51. 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

In *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), the companion case to *Eichner*, the court of appeals ordered that blood transfusions be continued for a severely retarded adult with terminal bladder cancer despite his mother's decision to reject the transfusions on behalf of her son. The court in *Storar* held that the attempt to determine John Storar's own choice was "unrealistic" and that the case must be decided on the principle that a "parent . . . may not deprive a child of life saving treatment, however well intentioned." *Id.* at 380, 420 N.E.2d at 72-73, 438 N.Y.S.2d at 275.

52. *Eichner*, 52 N.Y.2d at 370-71, 420 N.E.2d at 67, 438 N.Y.S.2d at 273-74.

53. *Id.* at 372, 379, 420 N.E.2d at 68, 72, 438 N.Y.S.2d at 275, 282.

54. *Id.* at 380, 420 N.E.2d at 72, 438 N.Y.S.2d at 283; *see also In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

55. The majority opinion in *Cruzan* indicates that *if* the patient's previously expressed desires were to be followed, the party urging termination of treatment would have to meet the clear and convincing evidence standard. Cruzan v. Harmon, 760 S.W.2d 408, 424-25 (Mo. 1988) (en banc), *cert. granted sub nom.* Cruzan v. Missouri Dep't of Health, 109 S. Ct. 3240 (1989); *see also* Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987) (indicating that in cases in which there is a dispute between the physician and family or among the family members concerning appropriateness of treatment, the clear and convincing standard would be used).

incompetent patient would choose to refuse treatment.[56]

In *Cruzan*, the Missouri Supreme Court relied heavily on that state's "strong predisposition in favor of preserving life" as the basis for its decision requiring continuation of treatment.[57] The court found this "predisposition" in Missouri's abortion statute, which states the " 'intention of the General Assembly of Missouri to grant the right to life to all humans, born and unborn' " and that a fetus is viable " 'when the life of the unborn child may be continued indefinitely outside the womb by natural or *artificial lifesupport systems*.' "[58]

The court cited Missouri's living will statute as evidence that Missouri's "policy strongly favoring life" applied at the end of life as well.[59] The majority acknowledged that the living will statute did not apply to this case because Cruzan had not executed a living will;[60] in fact, the statute had been enacted several years after Cruzan's injury.[61] The court, however, considered the statute as a statement of public policy by the Missouri General Assembly[62] concerning the primacy of the

---

56. Both the trial and intermediate appellate courts found that the evidence of Mary O'Connor's previously stated desires met even New York's clear and convincing standard. *In re* Westchester County Medical Center (O'Connor), 139 A.D.2d 344, 346, 532 N.Y.S.2d 133, 134, *rev'd*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988). In his dissent from the majority opinion for the court of appeals, Judge Simons viewed the application of the clear and convincing standard in *O'Connor* to be a "new requirement." *In re* Westchester County Medical Center (O'Connor), 72 N.Y.2d 517, 539, 531 N.E.2d 607, 619, 534 N.Y.S.2d 886, 899 (1988) (Simons, J., dissenting). George Annas calls the rejection of the evidence in *O'Connor* "astonishing." Annas, *Precatory Prediction*, *supra* note 4, at 31.

57. 760 S.W.2d at 419.

58. *Id.* (citing MO. REV. STAT. §§ 188.010, .015(7) (1986)).

59. *Id.* Missouri's living will statute: 1) defines terminal condition as "an incurable or irreversible condition which . . . is such that death will occur within a short time *regardless of the application of medical procedures*"; 2) excludes "any procedure to provide nutrition or hydration" from procedures that may be refused under the living will; and 3) includes a statement that the statute does not "condone, authorize or approve mercy killing or euthanasia nor permit any affirmative or deliberate act or omission to shorten or end life." MO. REV. STAT. §§ 459.010(3), .010(6), .015.3, .055(5) (1986) (emphasis added), *discussed in Cruzan*, 760 S.W.2d at 420. Judge Welliver in his dissent argued that the "Missouri Living Will Act is a fraud on Missourians who believe we have been given a right to execute a living will, and to die naturally, respectably, and in peace." *Cruzan*, 760 S.W.2d at 442 (Welliver, J., dissenting).

60. Cruzan v. Harmon, 760 S.W.2d 408, 420 (Mo. 1988) (en banc), *cert. granted sub nom.* Cruzan v. Missouri Dep't of Health, 109 S. Ct. 3240 (1989).

61. *Id.*

62. The court compared the Missouri living will statute with the Uniform Rights of the Terminally Ill Act and noted "substantial modifications [in the Missouri Act] which reflect this State's strong interest in life," including the statute's narrow definition of "terminal condition" and its exclusion of nutrition and hydration procedures from coverage under the statute. *Id.* at 419-20.

sanctity of life.[63] This identified "pro-life" policy allowed the court to put special emphasis on the state's interest in preservation of life when it balanced that interest against the patient's right to refuse treatment.[64] Such a policy, as interpreted by the court, distinguishes Missouri from all other states that have upheld the withholding or withdrawal of treatment.[65]

Commentators could easily relegate *O'Connor* and *Cruzan* to the category of strange decisions from strange states. It would be a mistake, however, to attribute *O'Connor* and *Cruzan* entirely to eccentricities of New York or Missouri law and politics and to underestimate the breadth and depth of the controversy underlying these decisions.[66] Within the narrow area of refusal of treatment, these two decisions have occurred coincidentally with increasing criticism of the self-determination model of treatment decisionmaking for incompetent patients[67]

---

63. The court stated that it did not judge "whether the common law right to refuse medical treatment is broader than the Living Will statute." *Id.* at 420.

64. The court refused to "equate the state's interest in the preservation of life with some measure of quality of life" noting that the Missouri "legislature make[s] no such distinction, nor shall we." *Id.* The court further stated that "[t]he state's interest is an unqualified interest in life. In striking the balance between a patient's right to refuse treatment . . . and the state's interest in life, we may not arbitrarily discount either side of the equation to reach a result which we find desirable." *Id.* at 422. Finally, the court held: "Given the fact that Nancy is alive and that the burdens of her treatment are not excessive for her, we do not believe her right to refuse treatment . . . outweighs the immense, clear fact of life in which the state maintains a vital interest." *Id.* at 424.

65. The court commented that:

> In casting the balance between the patient's common law right to refuse treatment/constitutional right to privacy and the state's interest in life, we acknowledge that the great majority of courts allow the termination of life-sustaining treatment. In doing so, these courts invariably find that the patient's right to refuse treatment outweighs the state's interest in preserving life.

Id. at 420. Some cases have interpreted the strength of the state's interest in preservation of life as waning with the imminence of death or the irreversible loss of consciousness. *See, e.g.*, Foody v. Manchester Memorial Hosp., 40 Conn. Supp. 127, 134, 482 A.2d 713, 718 (1984); Brophy v. New Eng. Sinai Hosp., 398 Mass. 417, 433, 497 N.E.2d 626, 635 (1986); *In re* Quinlan, 70 N.J. 10, 41, 355 A.2d 647, 664, *cert. denied*, 429 U.S. 922 (1976). More recently, some courts have described the state's interest in the preservation of life as the preservation of the legal capacity of the individual patient to avoid involuntary treatment. *See, e.g., In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

66. Even the popular television drama *L.A. Law* included a *Cruzan*-type plot in an episode this spring. The court in *L.A. Law* ordered that nutrition treatment for a patient in a persistent vegetative state be continued. *L.A. Law* (NBC television broadcast 1989).

67. *See, e.g.*, Chapman, *Fateful Treatment Choices for Critically Ill Adults, Part I: The Judicial Model*, 37 ARK. L. REV. 908 (1984); Destro, *Quality-of-Life Ethics and Constitutional Jurisprudence: The Demise of Natural Rights and Equal Protection for the Disabled and Incompetent*, 2 J. CONTEMP. HEALTH L. & POL'Y 71 (1986); Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373 (1986);

and with unresolved conflict concerning the morality of withholding medically provided nutrition and hydration from incompetent patients.[68] Highly visible claims of a right to assisted suicide, based on a "right to die" or autonomy, are also emerging.[69] Each of these positions questions the scope of an individual's right to make decisions concerning medical treatment and the appropriate role of society and the legal system in the decisions of patients, their surrogates, and their doctors. The synergy of these claims—that is, that decisions to reject certain available medical treatments on behalf of incompetent patients are immoral and that it is inappropriate for society to prohibit physicians from assisting consenting individuals in suicide—certainly will influence the future of self-determination in refusing medical treatment.[70]

III. LIMITING *O'Connor* AND *Cruzan* TO THEIR FACTS

When assessing the potential impact of *O'Connor* and *Cruzan*, a first course is to limit the applicability of these cases to their facts. This analysis would support a conclusion that much of the structure of the

---

Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375 (1988).

68. *See infra* notes 71-80 and accompanying text.

69. An effort to place a proposed statute allowing assisted suicide on the ballot in California failed for lack of the requisite number of signatures. Americans Against Human Suffering intends to try again in California in 1990 and to make similar efforts in Washington, Oregon, and Florida. Editorial, *Euthanasia*, 319 NEW ENG. J. MED. 1348, 1349 (1988); *see also* Engelhardt & Malloy, *Suicide and Assisting Suicide: A Critique of Legal Sanctions*, 36 SW. L.J. 1003 (1982); O'Brien, *Facilitating Euthanatic, Rational Suicide: Help Me Go Gentle into That Good Night*, 31 ST. LOUIS U.L.J. 655 (1987); Winslade, *Guarding the Exit Door: A Plea for Limited Toleration of Euthanasia*, 25 HOUS. L. REV. 517 (1988). For a variety of viewpoints, see *Mercy, Murder, and Morality: Perspectives on Euthanasia*, 19 HASTINGS CENTER REP., Jan./Feb. 1989, Special Supp. at 4.

70. Many have noted the interrelationship of the claims. "If we as a society are to retain the prohibition against active killing, the admittedly wavering line demarcating permissible 'allowing to die' must exclude death by avoidable starvation." Weisbard & Siegler, *On Killing Patients with Kindness: An Appeal for Caution*, in ETHICAL ISSUES IN MODERN MEDICINE 215, 218 (3d ed. 1989).

The Missouri Supreme Court observed that "[o]nce prognosis becomes irrelevant, and the patient's choice always more important than the state's interest, this standard leads to the judicial approval of suicide." Cruzan v. Harmon, 760 S.W.2d 408, 422 (Mo. 1988) (en banc) (citing L. TRIBE, AMERICAN CONSTITUTIONAL LAW 1367 (2d ed. 1988)), *cert. granted sub nom.* Cruzan v. Missouri Dep't of Health, 109 S. Ct. 3240 (1989).

In contrast, Daniel Callahan attributes the "renewed vitality" of the interest in active euthanasia to the "fear of dying in the company of modern medicine . . . . We will need a dampening of the push for medical progress, a return to older traditions of caring as an alternative to curing, and a willingness to accept decline and death as a part of the human condition (not a notable feature of American medicine)." Callahan, *Can We Return Death to Disease?*, 19 HASTINGS CENTER REP., Jan./Feb. 1989, Special Supp. at 4.

self-determination model of the 1980s remains untouched in these cases. For example, both *O'Connor* and *Cruzan* may be interpreted as being limited to situations involving medically provided nutrition and hydration to incompetent patients who are not "terminally ill" and who have not clearly stated their specific desires prior to incompetency.

A. *Medically Provided Nutrition and Hydration*

The leading public policy organizations, professional medical associations, and the courts have generally adopted the principle that medical provision of nutrition and hydration does not differ analytically from any other medical treatment. The report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, for example, argued that nutrition and hydration should be analyzed on the same basis as any other medical treatment.[71] Several physicians' associations have promulgated policy statements that recommend analyzing the goals of nutrition and hydration in the same way they would analyze the goals of other medical treatments, such as chemotherapy, surgery, or ventilator support.[72] Fi-

---

71. PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 90 (1983) [hereinafter PRESIDENT'S COMM'N]; *see also* HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING 59 (1987); *see infra* text accompanying note 79. Many scholars have argued in favor of similar positions. *See, e.g.*, Landsman, *Terminating Food and Water: Emerging Legal Rules*, in BY NO EXTRAORDINARY MEANS: THE CHOICE TO FOREGO LIFE-SUSTAINING FOOD AND WATER 136 (Lynn ed. 1986); Lynn & Childress, *Must Patients Always Be Given Food and Water?*, 13 HASTINGS CENTER REP., Oct. 1983, at 20; Meyers, *Legal Aspects of Withdrawing Nourishment from an Incurably Ill Patient*, 145 ARCHIVES INTERNAL MED. 125 (1985); Micetich, Steinecker & Thomasma, *Are Intravenous Fluids Morally Required for a Dying Patient?*, 143 ARCHIVES INTERNAL MED. 975 (1983); Steinbrook & Lo, *Artificial Feeding—Solid Ground, Not a Slippery Slope*, 318 NEW ENG. J. MED. 286 (1988).

72. In 1986, for example, the Judicial Council of the American Medical Association decided unanimously that it is not unethical for doctors to withhold "all means of life prolonging medical treatment," including "artificially or technologically supplied . . . nutrition or hydration," from patients in irreversible comas. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS OF THE AMERICAN MEDICAL ASSOCIATION, CURRENT OPINIONS OF THE JUDICIAL COUNCIL OF THE AMERICAN MEDICAL ASSOCIATION § 2.20 (1989) [hereinafter CURRENT OPINIONS].

The Executive Board of the American Academy of Neurology issued a position statement regarding the care of a patient in a persistent vegetative state. This position statement directly addresses the use of medical procedures to provide nutrition:

> [T]he decision to discontinue this type of treatment should be made in the same manner as other medical decisions, ie, based on a careful evaluation of the patient's diagnosis and prognosis, the prospective benefits and burdens of the treatment, and the stated preferences of the patient and family . . . . The artificial provision of nutrition and hydration

nally, prior to *Cruzan* and *O'Connor*, courts had consistently adopted this analysis in resolving cases that involved decisions to forego medically provided nutrition and hydration.[73]

Concurrent with these statements, and contrary to the apparently emerging consensus, however, a vocal, and perhaps widespread, dissent remained. Many argued that nutrition and hydration were significantly different from other medical treatments.[74] There is, for example, a repeated concern that the withdrawal of nutrition results in "death by starvation" and that this death is drawn-out and very painful[75] despite assurances that individuals in persistent vegetative states do not have

---

is analogous to other forms of life-sustaining treatment, such as the use of the respirator. *Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient*, 39 NEUROLOGY 125, 125 (1989) [hereinafter *Position of the American Academy of Neurology*].

73. *See, e.g.*, Barber v. Superior Court, 147 Cal. App. 3d 1006, 1016, 195 Cal. Rptr. 484, 490 (1983) ("[W]e view the use of an intravenous administration of nourishment and fluid, under the circumstances, as being the same as the use of the respirator . . . ."); Corbett v. D'Alessandro, 487 So. 2d 368, 371 (Fla. Dist. Ct. App. 1986) ("[W]e see no reason to differentiate between the multitude of artificial devices that may be available to prolong the moment of death."); *In re* Hier, 392 Mass. App. Ct. 200, 207, 464 N.E.2d 959, 964 (1984) (rejecting guardian ad litem's argument that nutrition should be distinguished from treatment with the right of choice confined to the latter); *In re* Conroy, 98 N.J. 321, 373, 486 A.2d 1209, 1236 (1985) ("Analytically, artificial feeding by means of a nasogastric tube . . . can be seen as equivalent to artificial breathing by means of a respirator."); *see also* Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); Brophy v. New Eng. Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986); *cf.* Severns v. Wilmington Medical Center, 421 A.2d 1334 (Del. 1980).

74. *See, e.g.*, Callahan, *On Feeding the Dying*, 13 HASTINGS CENTER REP., Oct. 1983, at 22; Horan & Grant, *The Legal Aspects of Withdrawing Nourishment*, 5 J. LEGAL MED. 595 (1984); May, Barry, Griese, Grisez, Johnstone, Marzen, McHuch, Meilaender, Siegler & Smith, *Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons*, 3 ISSUES L. & MED. 203 (1987); McCormick, *Caring or Starving? The Case of Claire Conroy*, AMERICA, Apr. 6, 1983, at 272; Siegler & Weisbard, *Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued?*, 145 ARCHIVES INTERNAL MED. 129 (1985); *see also Brophy*, 398 Mass. at 442, 497 N.E.2d at 640 (Nolan, J., dissenting); *id.* at 443, 497 N.E.2d at 641 (Lynch, J., dissenting); *cf. ARC Resolution on Cessation of Nutrition and/or Hydration (1986)*, in *Verbatim*, 3 ISSUES L. & MED. 313 (1987); *TASH Resolution on Nutrition and Hydration*, in *Verbatim*, 3 ISSUES L. & MED. 315 (1987).

75. Justice Nolan, in his dissenting opinion in *Brophy*, provided a particularly gruesome portrayal of death subsequent to the withdrawal of medically provided nutrition. 398 Mass. at 444 n.2, 497 N.E.2d at 641 n.2 (Nolan, J., dissenting). Brophy's attending physician reported that Brophy's death was an "amazing peaceful, quiet time." Steinbrook & Lo, *supra* note 71, at 287. Neither Justice Nolan in his dissent, nor the courts in *O'Connor* and *Cruzan*, examined the nature of the alternative for Brophy, O'Connor, or Cruzan. For a patient in a persistent vegetative state who is maintained by medically provided nutrition, death may occur as a result of pneumonia, infection, gangrene due to decubitus ulcers, and other such causes, as well as from a cardiac arrest. It has been suggested that patients are not aware of the nature or implications of "natural death." Battin, *The Least Worse Death*, 13 HASTINGS CENTER REP., Apr. 1983, at 14.

the capacity to sense pain.[76]

The uneasiness concerning medical procedures providing nutrition is reflected in some legislation regarding medically provided nutrition and hydration. At least nineteen state legislatures have isolated nutrition and hydration for special treatment, enacting living will statutes that exclude nutrition and hydration from medical treatments that may be refused through a living will.[77] At least one state prohibits the termination of nutrition or hydration under certain circumstances, aside from the operation of a living will.[78]

The Hastings Center *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* recommends:

> [I]t is wisest and most plausible to understand [medical procedures to provide nutrition and hydration] as medical interventions that may be forgone in some cases. Therefore, the standards to be used for decisions concerning termination of these procedures are essentially those that apply for the termination of other forms of medical treatment.[79]

Recognizing the lack of a strong consensus on the subject, however, the guidelines note that the issue of nutrition and hydration "provokes strong feelings, and for some a sense of moral offense. There is also concern about potential abuse. Thus, caution is necessary."[80]

It may be fair, then, to interpret *O'Connor* and *Cruzan* as limited to artificial nutrition and hydration because of the intense disagreement

---

76. The American Academy of Neurology has stated that patients who are in a persistent vegetative state ("PVS") "do not have the capacity to experience pain or suffering. Pain and suffering are attributes of consciousness requiring cerebral cortical functioning . . . ." *Position of the American Academy of Neurology*, *supra* note 72, at 125. The inability of PVS patients to feel pain has also been used as a basis for *continuing* nutrition and hydration because, balancing the benefits and burdens of treatment, the fact that the patient was insensate eliminated any physical burden of the treatment. *See, e.g.*, Cruzan v. Harmon, 769 S.W.2d 408, 424 (Mo. 1988) (en banc), *cert. granted sub nom.* Cruzan v. Missouri Dep't of Health, 109 S. Ct. 3240 (1989) ("[T]he care provided did not cause Nancy pain. Nor is that care particularly burdensome for her, given that she does not respond to it."). Similarly, in weighing the benefits and burdens of continued treatment in *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985), the New Jersey Supreme Court paid close attention to whether the patient would experience pain as a result of continued or discontinued nutrition. *Id.* at 386, 486 A.2d at 1243.

77. Gregory Gelfand cites 19 living will statutes that exclude medically provided nutrition and hydration from medical procedures that may be refused under a living will. Gelfand, *Living Will Statutes: The First Decade*, 1987 WIS. L. REV. 737, 750.

78. ILL. ANN. STAT. ch. 110 ½ ¶ 702(d) (Smith-Hurd 1978 & Supp. 1989), *discussed in* Gelfand, *supra* note 77, at 750 n.49.

79. HASTINGS CENTER, *supra* note 71, at 59.

80. *Id.*

concerning the appropriateness of discontinuing medically provided nutrition and hydration. In short, these simply may be cautious decisions.

O'Connor, in effect, sets up special "rules of evidence" for the termination of nutrition and hydration even though it disclaims an intent to do so.[81] The New York courts had not previously required clear and convincing evidence of the patient's refusal of the precise treatment under consideration.[82] In its statement of facts, however, the *O'Connor* majority recounts that "Mrs. O'Connor had never discussed providing food or water with medical assistance."[83] In addressing what Mrs. O'Connor *had* discussed, the court states that "the only question is whether she intended by those statements to choose death by starvation and thirst in her present circumstances."[84] Thus, the requirement in *O'Connor* that there be clear and convincing evidence that the patient would refuse a particular medical treatment does distinguish that case.[85] Because this heightened requirement was imposed in a case involving medically provided nutrition, and because the majority opinion describes the result of treatment withdrawal as "death by starvation

---

81. In this regard, the court offered the caveat: "We do not mean to suggest that, to be effective, a patient's expressed desire to decline treatment must specify a precise condition and a particular treatment." *In re* Westchester County Medical Center (O'Connor), 72 N.Y.2d 517, 532, 531 N.E.2d 607, 614, 534 N.Y.S.2d 886, 893 (1988).

82. In his dissenting opinion, Judge Simons argues that the majority rejected Mary O'Connor's statements solely because they were not "sufficiently specific" as to treatment. *Id.* at 552, 531 N.E.2d at 624, 534 N.Y.S.2d at 903 (Simons, J., dissenting). He states further that the majority "narrowly circumscribes our rule to a degree that makes it all but useless." *Id.* at 552, 531 N.E.2d at 626, 534 N.Y.S.2d at 905.

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

84. *Id.* at 534 n.5, 531 N.E.2d at 615 n.5, 534 N.Y.S.2d at 894 n.5.

85. The majority in *O'Connor* cites Delio v. Westchester County Medical Center, 129 A.D.2d 1, 516 N.Y.S.2d 677 (1987), as an illustration of the application of the clear and convincing evidence test. *O'Connor*, 72 N.Y.2d at 529, 531 N.E.2d at 612, 534 N.Y.S.2d at 891. In *Delio*, a New York intermediate appellate court ordered the Medical Center to discontinue nutrition by way of gastrostomy to a patient in a persistent vegetative state. The court based its order on the fact that the patient, prior to incompetency, had clearly expressed his wishes to "die with dignity." *Delio*, 129 A.D.2d at 3, 516 N.Y.S.2d at 679. The appellate court found that the patient had "repeatedly" expressed his opposition to "maintaining an incompetent neocortically dead person on life-sustaining mechanisms." *Id.* at 6, 516 N.Y.S.2d at 681. The patient's wife testified that the patient had "felt it was 'horrible' and 'appalling' to keep a person alive in a vegetative state by artificial infusions of medication and nutrition." *Id.* at 7, 516 N.Y.S.2d at 682. These expressions were strengthened by the fact that the patient had a Ph.D. in exercise physiology, had "intensive scientific training and [was] therefore able to discuss in scientific detail [his] views on 'right to die' issues." *Id.* at 6, 516 N.Y.S.2d at 681. The *Delio* court explicitly stated that the self-determination model adopted by the New York courts applied equally to nutrition and hydration and to other forms of medical treatment. *Id.* at 19, 516 N.Y.S.2d at 689.

and thirst,"[86] *O'Connor* may fairly be limited in terms of its scope to cases involving nutrition and hydration.

There is reason to conclude, however, that the issue of nutrition and hydration does not alone explain the result in *O'Connor*. In *In re Storar*, Judge Wachtler—the author of the majority opinion in *O'Connor*—wrote the majority opinion ordering continued blood transfusions to a profoundly retarded man with terminal bladder cancer, despite his mother's decision to the contrary.[87] Finding that John Storar was, and always had been, incapable of expressing his desires or making a judgment, Judge Wachtler decided the case as one involving a parental medical treatment decision concerning a child: "[T]he courts may not permit a parent to deny a child all treatment for a condition which threatens his life."[88]

In examining the nature of the blood transfusions and concluding that their termination would be inappropriate, Judge Wachtler noted that the cancer was incurable and fatal and that the blood transfusions avoided an earlier death. He explained: "[A]s one of the experts noted, the transfusions were analogous to food—they would not cure the cancer, but they could eliminate the risk of death from another treatable cause."[89] Thus, if the decision in *O'Connor* is based on the nature of the treatment at issue, despite the court's disclaimer, it may actually apply to a broader range of conditions and treatments that prolong life, regardless of their impact on the patient's underlying disease.

In contrast to *O'Connor*, the Missouri Supreme Court in *Cruzan* did frame the issue specifically as one involving the discontinuation of "all nutrition and hydration" to the patient.[90] In addition, the court relied on the exclusion of nutrition and hydration from "death prolong-

---

86. *In re* Westchester County Medical Center (O'Connor), 72 N.Y.2d 517, 529 n.5, 531 N.E.2d 607, 615 n.5, 534 N.Y.S.2d 886, 891 n.5 (1988). The same judge, writing the opinion in *Eichner*, did not refer to Brother Fox's death upon removal from the respirator as "death by suffocation." Eichner *ex rel.* Fox v. Dillon, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

87. 52 N.Y.2d 363, 369, 420 N.E.2d 64, 66, 438 N.Y.S.2d 266, 268, *cert. denied*, 454 U.S. 858 (1988).

88. *Id.* at 381, 420 N.E.2d at 73, 438 N.Y.S.2d at 275.

89. *Id.*

90. Cruzan v. Harmon, 760 S.W.2d 408, 410 (Mo. 1988) (en banc), *cert. granted sub nom.* Cruzan v. Missouri Dep't of Health, 109 S. Ct. 3240 (1989). Judge Blackmar in his dissent argues that the majority opinion is limited to "continued utilization of a feeding tube which is already in place" and lists as "distinguishable cases" those involving "mechanical respirators, radical surgery, blood transfusions, dialysis, chemotherapy, treatment of infection, or . . . surgical implantation of feeding tubes after all hope of amelioration has vanished." *Id.* at 427 (Blackmar, J., dissenting).

ing treatments," as defined in the state's living will statute,[91] as evidence of the Missouri General Assembly's explicit pro-life policy.[92]

Cruzan was the first appellate case in the state of Missouri that reviewed termination of treatment. Thus, there is no clear contrast available between the manner in which the Missouri Supreme Court handled this case involving nutrition and hydration and how it would handle cases involving other medical treatments. As discussed previously, however, the court's argument in support of the *Cruzan* decision has quite a broad sweep and questions both the common law and the constitutional bases of judicial decisions allowing the termination of treatment to incompetent patients.[93]

The discontinuation of medically provided nutrition, an issue in both *O'Connor* and *Cruzan*, is not necessarily associated, in terms of image, with the battle against the "tyranny of technology"[94] that carried the day in the cases "against" ventilators. *O'Connor* and *Cruzan* could be illustrative of Daniel Callahan's admonition regarding the significance of "feeding the dying" as compared to other medical treatments:

> I see no social disaster in the offing if there remains a deep-seated revulsion at the stopping of feeding even under legitimate circumstances. No doubt some people will live on in ways beneficial neither to them nor to others. No doubt a good bit of money will be wasted indulging rationally hard-to-defend anti-starvation policies. That strikes me as a tolerable price to pay to preserve—with ample margin to spare—one of the few moral emotions that could just as easily be called a necessary social instinct.[95]

It may be that Callahan's view has taken hold in *O'Connor* and *Cruzan* and that a line has been drawn between nutrition and hydration and other medical treatments. There is certainly an argument for reading *O'Connor* and *Cruzan* as limited to cases of medically provided

---

91. *See supra* note 59 and accompanying text.

92. *Cruzan*, 760 S.W.2d at 419-20.

93. Judge Blackmar's dissent remarks that the majority opinion uses "expansive language," which may cause it to be read inappropriately, beyond the "very special facts" of the case. *Id.* at 427 (Blackmar, J., dissenting).

94. Veatch, *Autonomy's Temporary Triumph*, 14 HASTINGS CENTER REP., Oct. 1984, at 38; *see also* Johnson, *Sequential Domination, Autonomy and Living Wills*, 9 W. NEW ENG. L. REV. 113, 118 (1987).

95. Callahan, *supra* note 74, at 22.

nutrition. These opinions are not so narrowly drafted themselves, however. Both *Cruzan* and *O'Connor* reach more broadly, at least by implication.

B. *Terminal Illness*

A second factor that may explain or limit the results in *O'Connor* and *Cruzan* is the medical condition of the individuals involved. Both cases involved patients who were not "terminally ill," if "imminent death" is required in a common definition of that term. The court believed that providing O'Connor nutrition through a nasogastric tube could extend her life for "several months, perhaps several years."[96] Nancy Cruzan was in a persistent vegetative state and, with continued nutrition, could live for another thirty years.[97]

The relevance and utility of the status of "terminal illness" in resolving the appropriateness of honoring demands to terminate particular treatments has been severely criticized.[98] A recent report on life-sustaining procedures argued against the use of criteria such as terminal illness: "The use of medical criteria in protocols for decisions about life-sustaining treatments is controversial, in part because of conceptual difficulties. 'Terminal illness' is not clearly distinguished from chronic, progressive disease . . . . Moreover, reliable clinical measures of these concepts are not available."[99]

---

96. *In re* Westchester County Medical Center (O'Connor), 72 N.Y.2d 517, 525, 531 N.E.2d 607, 610, 534 N.Y.S.2d 886, 889 (1988).

97. Cruzan v. Harmon, 760 S.W.2d 408, 411 (Mo. 1988) (en banc), *cert. granted sub nom.* Cruzan v. Missouri Dep't of Health, 109 S. Ct. 3240 (1989). The Missouri Supreme Court determined that Nancy Cruzan was not terminally ill, but later in the opinion stated that the *Quinlan* case "dealt with a terminally-ill person, . . . in language sufficiently broad that courts cite it for much different purposes." *Id.* at 421. Karen Ann Quinlan, like Nancy Cruzan, was in a persistent vegetative state. *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 424 U.S. 922 (1976).

98. *See, e.g.*, PRESIDENT'S COMM'N, *supra* note 71, at 25-26; Capron, *Borrowed Lessons: The Role of Ethical Distinctions in Framing Law on Self-Sustaining Treatment*, 1984 ARIZ. ST. L.J. 647, 657-58; Johnson, *The Death-Prolonging Procedures Act and Refusal of Treatment in Missouri*, 30 ST. LOUIS U.L.J. 805, 809-14 (1986).

99. OFFICE OF TECHNOLOGY ASSESSMENT, INSTITUTIONAL PROTOCOLS FOR DECISIONS ABOUT LIFE-SUSTAINING TREATMENTS 41 (1988); *see also* Johnson, *supra* note 94, at 126.

> [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. If the patient has a particular cancer that responds to chemotherapy fifty percent of the time, should the patient be considered terminally ill . . . ? If the treatment is successful twenty-five percent of the time? Less than ten percent? These questions cannot be answered by medical expertise alone. [Reliance on terminal illness as a boundary] often inappropriately defer[s] to professional judgment mixed questions of expertise and personal values.

Id.

The projected imminence or distance of the event of death, however, has played a continuing role in the development of case law and statutes on refusals of treatment. While most recent decisions have not required a determination that the patient is terminally ill to justify termination of treatment,[100] as recently as 1985, the New Jersey Supreme Court instituted procedures for treatment refusals that included a substantive requirement that death was expected to occur within one year.[101] Moreover, most living will statutes limit their applicability to patients who are terminally ill, within varying definitions of terminal illness.[102]

Apart from this very limited reliance on the presence of terminal illness, the legal framework developed for treatment decisionmaking has otherwise resisted decisions based on categorizing persons by disease. In part, this position may be a negative reaction to the stereotypical "doctor [who] often perceives the problem as a particular defective organ or disease," rather than as the treatment of a whole person.[103] Yet there is also a more general opposition to a formulaic approach to decisionmaking: "Situations in which these questions arise cannot be jammed into convenient pigeonholes."[104] The self-determination approach certainly has at its core the premise that the weighing of the benefits and burdens of treatment is a process that is more likely than not to be unique to each individual's values and life experiences and is not captured simply by references to the presence of a particular disease. Adopting a self-determination model that rejects generic or "objective" treatment decisions also serves to diminish the apparent need

---

100. *See, e.g.*, Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); Brophy v. New Eng. Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987).

101. *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985). The New Jersey Supreme Court held that the patient must have a life expectancy of "approximately one year or less" for the subjective test to apply. *Id.* at 363, 486 A.2d at 1231. In the first case considered by the Ombudsman according to the procedure established by the court, the Ombudsman concluded that "medical experts find it impossible to state with authority that [the patient] will die within a year." *Ombudsman Bars Food-Tube Removal*, N.Y. Times, Mar. 7, 1986, at B2, col. 1. In 1987, the New Jersey Supreme Court held that the one year life expectancy requirement did not apply to patients who were in a persistent vegetative state. *In re* Peter, 108 N.J. 365, 367, 529 A.2d 419, 424 (1987).

102. Gelfand, *supra* note 77, at 740-44. Gelfand states that "[e]very existing living will act requires that the patient's physical condition or prognosis be 'terminal' or sufficiently poor in order to bring the provisions of the living will into effect." *Id.* at 740.

103. Rhoden, *supra* note 67, at 421.

104. Loewy, *Sounding Board: Treatment Decisions in the Mentally Impaired*, 317 NEW ENG. J. MED. 1465, 1468 (1987).

for a public consensus on the rightness and wrongness of particular decisions.

Despite the many cases and commentaries to the contrary, *O'Connor* and *Cruzan* may confirm that some concept of terminal illness remains a significant de facto boundary on surrogate decisionmaking for incompetent persons, breachable only under very limited circumstances.[105] Although "terminal illness" may not be an analytically strong concept upon which to distinguish among patients, cases and statutes using the concept may reflect a public consensus that is absent with regard to other conditions.[106]

---

105. Of course, Nancy Cruzan and Mary O'Connor suffered from quite different medical conditions. Nancy Cruzan was completely unconscious and in a persistent vegetative state. Mary O'Connor was not unconscious; she was, instead, severely physically and mentally impaired. Although her physical condition was terribly compromised in terms of locomotion, speech, and ability to interact, her condition, other than her inability to swallow, was not *immediately* life-threatening. According to the New York Court of Appeals, Mary O'Connor was much like so many of the very elderly: "simply an elderly person who as a result of several strokes suffers certain disabilities." *In re* Westchester County Medical Center (O'Connor), 72 N.Y.2d 517, 533, 531 N.E.2d 607, 615, 534 N.Y.S.2d 886, 894 (1988). The New York Court of Appeals is not the only court to identify a serious concern for the perceived vulnerability of patients living in nursing homes. The New Jersey Supreme Court in *Conroy* established a special procedure to protect nursing home residents in treatment decisionmaking. *Conroy*, 98 N.J. at 374-80, 486 A.2d at 1237-40. It is difficult, in cases like *O'Connor*, to separate the influences of medical condition and institutionalization in a nursing home. Does the termination of nutrition to even the seriously debilitated elderly create too much of an instrumentalist image? Is there an underlying discomfort that treatment is denied because "physically marginal" people *should* die, for reasons unrelated to their own well-being? Daniel Callahan has commented that

> denial of nutrition may in the long run become the only effective way to make certain that a large number of biologically tenacious patients actually die. Given the increasingly large pool of superannuated, chronically ill, physically marginal elderly, it could well become the nontreatment of choice.

Callahan, *supra* note 74, at 22.

On the other hand, if the concern is related to institutionalization, rather than medical condition, the fear of bad decisions may be attributed to the generally poor public image of nursing homes and the very real differences in the patient-family-physician dynamic. Any special vulnerability presented by the fact of institutionalization should be specifically addressed.

106. Some sense has developed that the persistent vegetative state does play a useful role in distinguishing among patients in regard to the appropriateness of discontinuing medical treatment. Both the American Medical Association and the American Academy of Neurology have promulgated positions that use the persistent vegetative state as a category for which the withdrawal of nutrition and hydration is appropriate. *See supra* note 72. Several cases have described PVS as a medical condition that justifies, or allows for, discontinuation of medical treatment. *See, e.g.*, Foody v. Manchester Memorial Hosp., 40 Conn. Supp. 127, 482 A.2d 713 (1984) (indicating that family members may act as surrogates for persons with a permanent and irreversible loss of the cognitive state); *In re* L.H.R., 253 Ga. 439, 321 S.E.2d 716 (1984) (concluding that the parents of a terminally ill infant who has no reasonable possibility of attaining cognitive function have the right to refuse or discontinue medical treatment for that infant); *In re* Peter, 108 N.J. 365, 381, 529 A.2d 419, 427 (1987) ("[It is] difficult to conceive of a case in which the state could have an

C. *Evidence of Choice*

A final factor in distinguishing *Cruzan* and *O'Connor* from the mainstream of cases is the absence of persuasive evidence, in the view of the two courts of final review, of what Mary O'Connor's and Nancy Cruzan's own treatment decisions would be. There was little evidence of Cruzan's previously stated desires. The trial court in *Cruzan* described the evidence as follows:

> Her expressed thoughts at age twenty-five in somewhat serious conversation with a housemate friend that if sick or injured she would not wish to continue her life unless she could live at least halfway normally suggests that given her present condition she would not wish to continue on with her nutrition or hydration.[107]

The majority characterized these statements as "woefully inadequate, . . . remote, general, spontaneous . . . [and] unreliable for the purpose of determining her intent."[108]

---

interest strong enough to subordinate a patient's right to choose not to be artificially sustained in a persistent vegetative state."). This conclusion might be derived from a judgment that, inter alia, medical treatment for someone who is in a persistent vegetative state is futile, although calling a medical treatment that merely prolongs life "futile" would be a departure from the ordinary sense of the word. "Medical treatment, including the medical provision of artificial nutrition and hydration, provides no benefit to patients in a persistent vegetative state, once the diagnosis has been established to a high degree of medical certainty." *Position of the American Academy of Neurology*, *supra* note 72, at 126.

It may be that an instinctive, even if not empirically supported, understanding of the "general intent" of most patients under those circumstances supports a starting place of discontinuation of treatment, rather than continuation of treatment, allowing those advocating discontinuation in a particular case a presumptive advantage. A recent study of the preferences of patients and their families concerning a willingness to "undergo intensive care" found that "[o]nly when there is no hope for recovery, a vegetative state, or other severe neurologic impairment are a number of patients unwilling to undergo intensive care." Danis, Patrick, Southerland & Green, *Patients' and Families' Preferences for Medical Intensive Care*, 260 J. A.M.A. 797, 802 (1988) [hereinafter Danis]; *see also* Editorial, *Measuring Quality of Life near the End of Life*, 260 J. A.M.A. 839 (1988) (commenting on the study by Danis et al.).

Finally, the irreversible absence of consciousness in the persistent vegetative state has robbed these patients of what some view as a most basic characteristic of personhood. Rhoden, *supra* note 67, at 400. Both *Cruzan*, specifically, and *O'Connor*, by reasonable implication, however, reject the discontinuation of treatment when based solely or primarily on the fact that the person is in a persistent vegetative state. Judge Hancock, in his concurring opinion in *O'Connor*, states that "even where the incompetent patient is completely and irreversibly comatose and vegetative . . . life-sustaining procedures must, apparently, be undertaken and continued." *O'Connor*, 72 N.Y.2d at 537, 531 N.E.2d at 617, 534 N.Y.S.2d at 894 (Hancock, J., concurring) (citations omitted).

107. Cruzan v. Harmon, 760 S.W.2d 408, 433 (Mo. 1988) (en banc), *cert. granted sub nom.* Cruzan v. Missouri Dep't of Health, 109 S. Ct. 3240 (1989).

108. *Id.* at 424.

Mary O'Connor's previous statements were more substantial. Among the frequent statements made by O'Connor, while caring for terminally ill relatives, were statements that she believed that it was " 'monstrous' to keep someone alive by using 'machinery, things like that' when they are 'not going to get better'; that she would never want to be in the same position as her husband . . . and that people who are 'suffering very badly' should be allowed to die."[109] When asked if they could attest to their mother's choice if foregoing medical treatment would "produce a painful death," however, O'Connor's daughters said that they could not.[110] Contrary to the two lower courts, the New York Court of Appeals held that these statements did not constitute clear and convincing evidence of O'Connor's desire while she was competent.[111]

Thus, *Cruzan* and *O'Connor* could leave untouched situations in which the patient's own choice is clear, whether because the patient is competent when the treatment decision must be made, or because the patient had clearly indicated his desire prior to incompetency.[112] *Cruzan* and *O'Connor* are not necessarily in conflict with an evidentiary approach to self-determination; that is, honoring the patient's choice is a primary value and is most of all a question of whether there is sufficient evidence of what the patient's expressed choice was prior to incompetency. As with the other distinguishing factors of these two cases, however, characterizing *Cruzan* and *O'Connor* as cases in which there was simply inadequate evidence of the patient's previously expressed wishes is unsatisfying. There is more at work here.

IV. LIMITING SELF-DETERMINATION

O'Connor and *Cruzan* certainly can be read either as unique to New York and Missouri or as decisions easily confined to their facts—facts that would place them among the more difficult cases in termination of treatment. Each reviewed the appropriateness of termination of medically provided nutrition and hydration for a person who was not terminally ill *and* for whom there existed less than persuasive

109. *O'Connor*, 72 N.Y.2d at 526-27, 531 N.E.2d at 611, 534 N.Y.S.2d at 887.

110. *Id.*

111. *Id.* at 522, 531 N.E.2d at 609, 534 N.Y.S.2d at 887.

112. This is especially true of *O'Connor* in light of the majority's reliance on Delio v. Westchester County Medical Center, 129 A.D.2d 1, 516 N.Y.S.2d 677 (1987), as illustrating the application of the clear and convincing evidentiary standard. *See supra* note 85 and accompanying text.

evidence, at least in the view of the majority opinions, of the patient's own individual choice under the circumstances. These cases are noteworthy, however, not only because they depart from established analysis, but because they dramatically illustrate the inherent limitations of self-determination as a model for medical treatment decisionmaking for incompetent patients. These decisions come at a time when the concept of autonomy, especially as expressed in the constitutional right to privacy, is under aggressive attack.

The *O'Connor* and *Cruzan* decisions cannot be faulted for pulling aside the veil of patient autonomy and revealing that the reliance on patient choice in some cases is merely a sham used either to shield the decisionmaker from moral responsibility or to allow the courts to avoid the discomfort of making decisions based on the goals and limitations of medical treatment and the quality of life.[113] But the principle of patient autonomy—or privacy or self-determination—as a basis for removing legal impediments to decisions to end treatment has a positive aspect as well. Under the rubric of autonomy, the legal system can accommodate the ethical systems and religious beliefs of a heterogeneous people. While one now-incompetent individual may have firmly believed and practiced a faith that holds a vision of an everlasting life after death, another may have equally firmly and devotedly believed that the breath of life on earth is the ultimate value of human life. The value of autonomy as a legal norm is that it can honor both views. Much is lost if that is destroyed, whether in the name of the state's interests in protecting incompetent patients and society in general from certain medical treatment decisions, or under the argument that the choice of an incompetent individual can never be known.

---

113. For a discussion concerning the likelihood of self-deception in legal decisionmaking, see Burt, *Autonomy's Protection and Pretense in Law and Medicine*, in ETHICAL ISSUES IN MODERN MEDICINE, *supra* note 70, at 176. The author asserts that

> [t]his choiceless self-conception is a normatively prized role depiction in the legal system . . . . [B]oth judge and lawyer could invoke professional norms that would commit them to this self-conception. The lawyer could see himself as "simply an advocate" for his client's wishes. The judge could see himself through a more complex, professional role norm but with the same ultimate goal—that he was obligated to set aside his "personal" views of what [the patient] should do and instead to apply standards drawn from "impersonal" legislative and judicial enactments.

Id. at 183.

A. *The Direct Challenge*

The Missouri Supreme Court explicitly states in *Cruzan* that "it is *definitionally* impossible for a person to make an informed decision—either to consent or to refuse—under hypothetical circumstances."[114] Thus, self-determination, as expressed in the common law doctrine of informed consent, is eliminated as a basis for health care decisionmaking on behalf of incompetent patients.[115] The New York Court of Appeals in *O'Connor* asserts that "there always exists the possibility that, despite his or her clear expression in the past, the patient has since changed his or her mind."[116] These two courts are not alone in concluding that the choice a now-incompetent patient would make can *never* be known.[117]

Criticism of individual autonomy as a guiding principle for decisionmaking on behalf of incompetent patients is bolstered by cases in which self-determination is an empty concept at best. Among those cases is *Superintendent of Belchertown State School v. Saikewicz*.[118] Joseph Saikewicz was a mentally retarded sixty-seven-year-old adult with the mental capacity of a two-year-old child.[119] Saikewicz had never exercised independent judgment; thus, what he would have cho-

---

114. Cruzan v. Harmon, 760 S.W.2d 408, 417 (Mo. 1988) (en banc) (emphasis added), *cert. granted sub nom.* Cruzan v. Missouri Dep't of Health, 109 S. Ct. 3240 (1989). The court outlined three prerequisites for informed consent:

> [T]he patient must have the capacity to reason and make judgments, the decision must be made voluntarily and without coercion, and the patient must have a clear understanding of the risks and benefits of the proposed treatment alternatives or nontreatment, along with a full understanding of the nature of the disease and the prognosis.

Id. (quoting Wanzer, Adelstein, Cranford, Federman, Hook, Moertel, Safar, Stone, Taussig & Van Eys, *The Physician's Responsibility Toward Hopelessly Ill Patients*, 310 NEW ENG. J. MED. 955, 957 (1984)). The Missouri Supreme Court's quotation of that article is ironic because the article argues that the discontinuation of medically provided nutrition and hydration to individuals in Cruzan's situation is morally justifiable and that the patient's previously expressed desires are important to that decision. In addition, one of the coauthors of the article, Dr. Ronald Cranford, was an expert on behalf of the Cruzan family.

115. Missouri's living will statute recognizes that "[e]ach person has the primary right to request or refuse medical treatment," making no distinction between competent and incompetent patients. MO. REV. STAT. § 459.055(1) (1985). But it further provides that the statute is not to be interpreted "to increase or decrease the right of a patient to make decisions regarding use of medical procedures so long as the patient is able to do so." *Id.* § 459.055(2).

116. *In re* Westchester County Medical Center (O'Connor), 72 N.Y.2d 517, 530, 531 N.E.2d 607, 613, 534 N.Y.S.2d 886, 892 (1988).

117. *See, e.g.*, Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373, 379-82 (1986).

118. 373 Mass. 728, 370 N.E.2d 417 (1977).

119. *Id.* at 730, 370 N.E.2d at 417.

sen when confronted with a decision to accept or reject chemotherapy is truly unknowable.[120] The Massachusetts Supreme Judicial Court relied on a theory of substituted judgment to justify its decision that chemotherapy would be inappropriate for Saikewicz.[121]

If substituted judgment is understood as exercising on behalf of the incompetent patient the very decision that the patient himself or herself would make, then the criticism of substituted judgment as a sham in a case like *Saikewicz* is accurate.[122] As an exercise of personal choice, *Saikewicz* makes no sense. Once it is accepted that a treatment decision actually exists, however, the case does make sense as illustrating an attempt to decide on behalf of an incompetent patient, using all of the known characteristics of the patient.[123]

---

120. *See also In re* Hier, 18 Mass. App. Ct. 200, 464 N.E.2d 959 (1984). In *Hier*, the court construed the actions of an incompetent patient in forcibly removing the gastrostomy herself as evidence of the burden that she felt and as support for the court's decision to allow the gastrostomy to be removed. The *Hier* decision was criticized both in terms of legal analysis and fact. *See* Annas, *The Case of Mary Hier: When Substituted Judgment Becomes Sleight of Hand*, 14 HASTINGS CENTER REP., Aug. 1984, at 23.

121. *Saikewicz*, 373 Mass. at 751-53, 370 N.E.2d at 431.

122. The use of substituted judgment in *Saikewicz* has received criticism from all viewpoints. For example, both Rebecca Dresser and Nancy Rhoden criticize *Saikewicz*, although they differ significantly in their recommendations for resolution of the issue. Dresser, *supra* note 117, at 376-78; Rhoden, *supra* note 67, at 385-88.

123. A primary weakness of *Saikewicz* is its overbroad complete rejection of "quality of life" as a relevant factor in medical treatment decisionmaking. "To the extent that [the trial judge's] formulation equates the value of life with any measure of the quality of life, we firmly reject it." *Saikewicz*, 373 Mass. at 754, 370 N.E.2d at 432. This rejection appears disingenuous in light of the court's reliance on factors that are easily categorized as "quality of life," for example, Saikewicz's mental retardation. The court, however, did not use this factor to conclude that Saikewicz was less worthy of treatment or that remission of his leukemia would be less valuable to him than to an individual of average intelligence.

The fact that a determinative characteristic in *Saikewicz* was the patient's mental retardation—and that all of the incompetent patients in these cases suffer from disability due to physical or mental incapacity—clearly supports claims that the decision not to treat discriminates against Saikewicz and persons in similar situations. These claims of illegal discrimination, in cases of withholding treatment, have been brought under § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1982 & Supp. V 1987). *See* Bowen v. American Hosp. Ass'n, 476 U.S. 610 (1986) (plurality opinion); *see also* Note, Johnson v. Sullivan, 4 ISSUES L. & MED. 123 (1988). For a discussion of the constitutional issues as well, see Bopp, *Nutrition and Hydration for Patients: The Constitutional Aspect*, 4 ISSUES L. & MED. 3 (1988); Rhoden & Arras, *Withholding Treatment from Baby Doe: From Discrimination to Child Abuse*, 63 MILBANK MEMORIAL FUND Q. 18 (1985).

But the decision not to use a particular treatment is not the only possible discriminatory act: treatment may itself be discriminatory. Discussion of discrimination in individual medical treatment decisions inevitably brings into question the usefulness of the concept of discrimination as a tool of analysis for this purpose. For example, in *Bowen*, the plurality opinion highlighted the problems of applying § 504 in a situation in which parental consent was required for treatment.

The primary goal of the substituted judgment standard for medical treatment decisionmaking on behalf of incompetent patients is to replicate, as much as possible, the decisionmaking that would occur if the patient were competent.[124] Medical treatment decisions by competent patients who actively participate in decisionmaking involve an analysis of the benefits and the burdens or risks of the treatment. Different persons may weigh particular benefits or burdens differently. For example, one individual may have a high tolerance for pain, while another may find the prospect unacceptable. One individual may be willing to undergo a risky procedure for the chance of increased mobility, while another would not. If, as the self-determination model implies, the goal of decisionmaking on behalf of an incompetent patient is to make the same decision as that person would make for himself, the question becomes how to replicate this personal decisionmaking process.

To say that the Massachusetts Supreme Judicial Court in *Saikewicz* attempted to achieve a good end is not to say that it hit the mark. The *Saikewicz* court stated that competent and incompetent patients were alike in their right to refuse medical treatment.[125] Unfortunately, simply saying this does not make it so. The principle of treating like cases alike requires that like cases be alike in all relevant aspects. The patient's competency is particularly relevant if the identified goal is to do as the patient desires. The incompetent patient not only cannot communicate his desires, but in most cases lacks any present judgment on which to base a choice. Incompetent and competent patients, therefore, are not equal to the task of making these decisions. Similarly, persons who were once competent are quite distinguishable from persons who were never competent.

Employing an evidentiary approach to the question of the previously-competent patient's choice is "the best we can do" if patient au-

---

476 U.S. at 646.

124. Substituted judgment was intended to stand in contrast to the best interest standard in which the judgment of the court, as to what is best for a particular individual, replaces what that individual may have chosen as his own best interest. *See generally* D. MEYERS, *supra* note 45, at §§ 11:6-:10.

125. The court recognized a general right in all persons to refuse medical treatment in appropriate circumstances. "The recognition of that right must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both." *Saikewicz*, 373 Mass. at 745, 370 N.E.2d at 427. The court further stated that "[t]o protect the incompetent person within its power, the State must recognize the dignity and worth of such a person and afford to that person the same panoply of rights and choices it recognizes in competent persons." *Id.* at 746, 370 N.E.2d at 428.

tonomy, and the value it holds for accommodation of diverse beliefs, is to survive incompetency. The personal values and religious beliefs often essential to highly consequential decisions strongly support adherence to the self-determination model for the formerly competent patient. The individuality implicit in the self-determination model is highly preferable to the imposition of uniformity implicit in the "state's interests" model.[126]

B. *The Indirect Challenge*

It should be clear from *O'Connor* that the requirement of clear and convincing evidence of previously expressed desires can be used effectively to divest the vast majority of individuals of the power to exert some control over the course of their medical treatment should they become incompetent. In *Eichner ex rel. Fox v. Dillon*,[127] Judge Wachtler presented a strong case for a high standard of proof for such an important decision: "[T]his standard serves to 'impress the factfinder with the importance of the decision' and it 'forbids relief whenever the evidence is loose, equivocal or contradictory.' "[128] The logic is almost inescapable. This is so important a decision—a matter of life and death—how could it be decided on less?[129]

---

126. The majority opinion in *Cruzan* exemplifies what may be called a state's interests model because of the court's elevation of the state's interest in preserving life over the choice of the now-incompetent patient and her family. In *Cruzan*, the state's interest in preserving physical existence vetoed a decision that was: (1) exercised by a family untainted by any motives of financial gain or by dysfunctional behavior; (2) well within the realm of ethically acceptable medical practice as identified by the American Medical Association, *see supra* note 106, among others; and (3) uniformly identified by courts considering like circumstances as within the common law doctrines. Of course, the court in *Cruzan* relied extensively on public policy statements of the Missouri General Assembly to identify a state's interest unique to Missouri. Cruzan v. Harmon, 760 S.W.2d 408, 420 (Mo. 1988) (en banc), *cert. granted sub nom.* Cruzan v. Missouri Dep't of Health, 109 S. Ct. 3240 (1989); *see supra* note 62. It should be noted, however, that the General Assembly had not passed legislation governing the case before the court.

127. 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

128. *Id.* at 379, 420 N.E.2d at 72, 438 N.Y.S.2d at 274. Judge Wachtler rejected the requirement that the party urging termination of a particular treatment be required to prove the patient's prior decision "beyond a reasonable doubt" as recommended by the district attorney in the case. *Id.*

129. By statute, however, New York has sanctioned decisionmaking based on a lesser standard. On a demonstration basis in two geographic areas of the state, New York State has established two committees to make medical treatment decisions for incompetent patients of state psychiatric hospitals for whom no other surrogate is available. The operation of one of these committees is described in Sundram, *Informed Consent for Major Medical Treatment of Mentally Disabled People*, 318 NEW ENG. J. MED. 1368 (1988). The committee is provided as an alternative to the judicial process and is able to provide authoritative decisions concerning treatment. The standard for the decision is whether the treatment is in the best interests of the patient,

The clear and convincing standard at least pays lip service to the self-determination model in medical treatment decisions for once-competent persons. But if only priests[130] and scientists[131] can satisfy this standard, is the requirement of clear and convincing evidence a good-faith effort to achieve the individuality in medical decisionmaking and the prospective control that has been at the heart of the self-determination model? If particular treatments and medical conditions must be specified, the clear and convincing standard is hardly accessible to the ordinary person.[132] This exclusionary standard makes sense *only* if courts adopt a presumption that all, or at least certain, available medical treatments *must* be used as a matter of law, if not as a matter of ethical compulsion. The patient and his surrogate must then overcome that strong presumption.[133] The New York Court of Appeals offers no

---

defined as

> promoting personal well-being by the assessment of the risks, benefits and alternatives to the patient of a proposed major medical treatment, taking into account factors including the relief of suffering, the preservation or restoration of functioning, improvement in the quality of the patient's life with and without the proposed major medical treatment and consistency with the personal beliefs and values known to be held by the patient.

Id. at 1370. The committee is to arrive at its decision on the basis of a fair preponderance of the evidence. *Id.* The committee's jurisdiction does not include life-sustaining treatments. *Id.* at 1369. One of the cases resolved by the committee, however, involved a 74-year-old mentally retarded resident of a center for the developmentally disabled who was semicomatose and "believed to be suffering from terminal cancer of the brain." *Id.* at 1372. The committee refused consent to several proposed procedures, including the insertion of a gastrostomy tube on the basis that "panel members thought the proposed treatment was medically futile." *Id.*

130. *Eichner* involved a Brother of a Catholic religious order. 52 N.Y.2d at 370, 420 N.E.2d at 67, 438 N.Y.S.2d at 269.

131. *Delio v. Westchester County Medical Center*, in which the court ordered the cessation of treatment, involved a person who had a Ph.D. in exercise physiology. 129 A.D.2d 1, 5, 516 N.Y.S.2d 677, 681 (1987).

132. In *O'Connor*, Judge Simons states in his dissent:

> Even if a patient possessed the remarkable foresight to anticipate some future illness or condition, however, it is unrealistic to expect or require a lay person to be familiar with the support systems available for treatment to say nothing of requiring a determination of which is preferable or the consequences that may result from using or foregoing them.

In re Westchester County Medical Center (O'Connor), 72 N.Y.2d 517, 551, 531 N.E.2d 607, 626, 534 N.Y.S.2d 886, 905 (1988) (Simons, J., dissenting).

133. The problems with this approach have been well-stated. Nancy Rhoden argues that the courts have adopted the medical presumption of continued treatment in the case of incompetents:

> Although it may seem like folly to question the near-sacrosanct medical and legal injunction to "err on the side of life," . . . the medical presumption for treatment incorporates not only the overt and noble commitment to saving life, but also covert and highly questionable psychological, technological, and professional drives.

Rhoden, *supra* note 67, at 420. Rhoden describes the professional self-concept of physicians: "Persons intensively socialized to be decisive, action-oriented healers may find it extraordinarily difficult to refrain from taking action." *Id.* at 421. Further, with the increased availability of technol-

other alternative: "[T]he inquiry must always be narrowed to the patient's expressed intent, with every effort made to minimize the opportunity for error . . . . [I]f an error occurs it should be made on the side of life."[134]

One's view of the appropriateness of the clear and convincing standard, as opposed to a more inclusive and easily satisfied standard, certainly reflects one's judgment of the values and risks at stake. One cannot help but see in *O'Connor* a subscript in which the majority relies on the clear and convincing evidence standard to support a conclusion that the request of the daughters to withhold treatment in that case was unreasonable. This is evidenced in the court's characterizations of Mary O'Connor as "simply an elderly person who as a result of several strokes suffers certain disabilities,"[135] and of her prospective death from withholding of nutrition and hydration as "death by starvation."[136] This same court had previously held that denial of medical treatment that would prolong life, but not alter the course of a terminal illness, was of itself inappropriate and that a decision to withhold such treatment was forbidden by law to a parent on behalf of her child.[137] As much as the veil of autonomy needed lifting in the name of honesty, these underlying presumptions as to the rightness and wrongness of treatment in a particular situation require examination and argument. The court's unstated judgment in *O'Connor* could be accepted as proper, but an evidentiary standard should not be used as a subterfuge for such a conclusion.

V. ISSUES FOR THE 1990s

In re Westchester County Medical Center (O'Connor) and *Cruzan v. Harmon* are troubling cases. They are lightning rods that galvanize positions on both sides of the ethical, legal, and political issues involved in the refusal, withdrawal, and withholding of medical treatment. These cases reveal that the apparent strong consensus of the 1980s, both with regard to the legal framework for resolving such cases and

---

ogy that can have some effect, the medical ethic more than ever includes an attitude that "it is always better to over-diagnose and over-treat than to fail to intervene." *Id.* This sentiment, in turn, is supported by faith in medical power and fear of litigation. *Id.* at 422-23. Therefore, the impact of technology itself on the practice of medicine breeds a "technological imperative." *Id.* at 423-27.

134. *O'Connor*, 72 N.Y.2d at 530-31, 531 N.E.2d at 613, 534 N.Y.S.2d at 892.

135. *Id.* at 533, 531 N.E.2d at 615, 534 N.Y.S.2d at 894.

136. *Id.* at 534 n.5, 531 N.E.2d at 615 n.5, 534 N.Y.S.2d at 894 n.5.

137. *See supra* note 51.

with regard to the legitimacy of nontreatment, is illusory or at least disintegrating.

The 1980s saw a move from the "medicalization" to the "legalization" of medical treatment decisions, from control by physicians to control by the law through patient's rights.[138] Now *O'Connor* and *Cruzan*, together with related developments on the eve of the 1990s, portend an era of politicization of medical treatment in which control over individual treatment decisions shifts again—this time from patients and medical/legal professionals to the political processes of state legislatures or administrative agencies.[139] Whether the self-determination model of the 1980s can endure this further shift is an open question. Certainly, the attacks on a concept of autonomy that transcend a patient's competency are growing. Further, the "state's interests," as balanced against, rather than on the side of, refusal of treatment, are emerging as a potential force in the limitation of medical treatment decisions.

This article has argued in favor of retaining the self-determination model for medical treatment decisionmaking for incompetent patients,

---

138. The allocation of authority of medical treatment decisionmaking to the patient appeared to be complete in the doctrine of informed consent. An American Medical Association opinion on life-prolonging treatments states that where the performance of a physician's duty to sustain life conflicts with his duty to relieve suffering, "the preferences of the patient should prevail." CURRENT OPINIONS, *supra* note 72, at 13. The opinion, however, goes on to state that "[i]f the patient is incompetent to act in his own behalf and did not previously indicate his preferences, the family or other surrogate decisionmaker, . . . in concert with the physician, must act in the best interest of the patient." *Id.* Jay Katz's analysis of the degree of acceptance of that doctrine by both the medical and legal systems, however, indicates that the transformation to patient-controlled decisionmaking is not nearly an accomplished fact. *See generally* J. KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984). The continuing power of the medical profession to make medical treatment decisions is evident in end-of-life decisions as well. *See, e.g.*, Johnson, *supra* note 94, at 126. At least one case explicitly giving the family or other surrogate authority to decide on behalf of the patient has limited that authority to situations in which the doctors agree with the proposed treatment choice. *See, e.g.*, Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987).

139. The role of the New Jersey Ombudsman illustrates an administrative approach to controlling medical treatment decisionmaking. In a letter dated August 30, 1988, the Ombudsman announced that his office must review every case in which potentially life-sustaining medical treatment is withheld, whether the proposal to forego treatment "comes from . . . the patient" himself and whether "the patient has a 'Living Will' or other written or oral instructions." Letter from Hector M. Rodriguez, Acting Ombudsman (Aug. 30, 1988) (discussing the Mandatory Reporting of Adult Abuse Law, N.J. STAT. ANN. § 52:27G-07.1 (West 1986)). The letter recommends in-service training on compliance with this directive to avoid "possible fines, professional censure and other serious penalties." In a December report to the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care, the Ombudsman reports a case intake of 144 cases between January 1 and August 31, 1988.

The Ombudsman states that "[o]nly those who want the further needless deterioration and death of our frail, vulnerable elderly would oppose such effective and limited case involvement as the Ombudsman provides."

at least insofar as formerly competent patients are concerned. The distinction drawn between never-competent and formerly competent patients implies that the capacity of the formerly competent patient to make life choices, develop religious beliefs, and assert preferences concerning medical treatment is relevant to the exercise of autonomy on his behalf. The evidentiary standard used for proof of these choices must strike a balance between protecting the patient from nontreatment, as well as from continued medical intervention. Evidentiary standards certainly should not be so restrictive as to prohibit effectively the vast majority of persons from exercising control over their treatment decisions. Calls that the substituted judgment model be honest in identifying cases in which there is no reliable evidence of choice should apply equally to evidentiary standards that disguise decisions resulting from courts' opposition to nontreatment in general.

The self-determination model of medical treatment decisionmaking will never solve all treatment decisions if viewed simply as an evidentiary process in which the task is to discover what the particular patient would want, even if the burden of proof threshold is quite low. An unresolved question within the self-determination model, then, is what to do when there is *no* reliable proof of the individual's choice. How should these patients be treated? *Cruzan* and *O'Connor* each answered this question by concluding that, even if there is some evidence of this particular patient's choice, treatment must be provided.

The most commonly expressed alternative to honoring previously expressed choices is for someone to decide what is "best."[140] If this decision is made by "society," whether expressed in legislation, agency action, or as a state's interest in a judicial balancing analysis, the decision is more likely to focus on what is best for *all* patients with similar *physical* conditions. Surely the courts can attempt to make an individualized decision, as did the court in *Saikewicz*.[141] Unfortunately, the position of a court, and even more so, a legislature, is such that its decisions, unlike those of individuals, are seen to carry a power of legitimization. This power raises the stakes. In addition, the public rightfully expects consistency from the courts and from other public decisionmakers. Variations based on intuition or intimacy are not only impossible, they are unacceptable. Like many of the courts deciding

140. The *Conroy* decision, for example, advocates a two-level best interests analysis, called "limited-objective" and "pure-objective" tests, whenever the patient has not clearly expressed a choice prior to incompetency. *In re* Conroy, 98 N.J. 321, 365-66, 486 A.2d 1209, 1232 (1985).

141. *See supra* notes 121-22 and accompanying text.

treatment cases before them,[142] the members of the *Cruzan* majority saw themselves as deciding on behalf of *all* the "Nancy Cruzans."[143] Yet there is another alternative that must be considered, even though rejected by both *O'Connor* and *Cruzan.*

The *O'Connor* and *Cruzan* decisions should be soundly criticized for eliminating completely the role of the family in speaking for, and protecting, its members.[144] It is obvious that many families do not meet the ideal of a loving, benign community acting as one. But in these two cases, as acknowledged by the courts, the O'Connor and Cruzan families were devoted and acting in the sincere belief that stopping medical treatment was best for their loved ones and would have been the course chosen by them.[145]

The medical profession has a long tradition of involving the family in medical decisionmaking on behalf of an incompetent patient.[146] This tradition respects the family as the group most aware of the values of the patient.[147] It also most closely recreates the process of informed

---

142. Several courts have decided medical treatment cases long after the patient had died. *See supra* note 42. Other courts espouse the view that their decisions go far beyond the individual before them. *See, e.g., Conroy*, 98 N.J. at 321, 486 A.2d at 1209 (establishing procedures and substantive guidelines for all persons residing in nursing homes).

143. The court stated that "we must remember that we decide this case not only for Nancy, but for many, many others who may not be surrounded by the loving family with which she is blessed." Cruzan v. Harmon, 760 S.W.2d 408, 412 (Mo. 1988) (en banc), *cert. granted sub nom.* Cruzan v. Missouri Dep't of Health, 109 S. Ct. 3240 (1989).

144. There are many eloquent arguments in favor of recognizing the family as an appropriate decisionmaker on behalf of their spouses, sons, daughters, and parents who have become incompetent. *See, e.g., In re* Farrell, 108 N.J. 335, 355, 529 A.2d 404, 414 (1987) ("Our common human experience teaches us that family members and close friends care most and best for a patient . . . . The importance of the family in medical treatment decisions is axiomatic."); PRESIDENT'S COMM'N, *supra* note 71, at 128 ("The family is generally most concerned about the good of the patient . . . [and] will also usually be the most knowledgeable about the patient's goals, preferences, and values."); Rhoden, *supra* note 67, at 437-45 ("Longstanding knowledge, love, and intimacy make family members the best candidates for implementing the patient's probable wishes and upholding her values.").

145. Mary O'Connor's daughters had cared for her throughout her illnesses and for quite some time in the home of one of the daughters. *In re* Westchester County Medical Center (O'Connor), 72 N.Y.2d 517, 523, 531 N.E.2d 607, 609, 534 N.Y.S.2d 886, 888 (1988). The Cruzan family had maintained an "interminable bedside vigil" at Nancy's side for six years despite the fact that any personal interaction was impossible. *Cruzan*, 760 S.W.2d at 412. The Cruzans were not paying for Nancy's extremely expensive care. *Id.* at 411 n.2.

146. For a discussion of the acceptance of family decisionmaking by medical professionals and the legal system, see Areen, *The Legal Status of Consent Obtained from Families of Adult Patients to Withhold or Withdraw Treatment*, 258 J. A.M.A. 229 (1987).

147. A recent study of attitudes toward medical intensive care found that the preferences expressed by the patients themselves and those expressed by the patient's family for the care of the patient were very similar. Danis, *supra* note 106, at 799.

consent by providing the patient with an individual who can converse with physicians and understand the current diagnosis and prognosis of the patient and the benefits and burdens of medical treatment.[148] In cases in which there is no evidence that the family is malevolent or incapable of making such a decision, the legal system ought to accommodate the family's participation through mechanisms, such as durable powers of attorney, surrogate health care decisionmaking acts, and legal presumptions of deference to the decisions of the family.[149]

The role and authority of family and patient-designated proxies should be considered as arising directly from the rights of the incompetent patient. Surely, the patient-designated surrogate is exercising legal rights on behalf of the incompetent patient; that is the intended purpose of the surrogate.[150] The family's exercise of the patient's right to privacy, absent such delegation, may be based on constitutional protection of "liberty interests" accorded the family[151] or on an implied

---

148. Johnson, *supra* note 94, at 133.

149. For a discussion of the prevalence and scope of such efforts, see Areen, *supra* note 146, at 230.

150. Even the *Cruzan* court may recognize the delegation of such a right:

> It is logically inconsistent to claim that rights which are found lurking in the shadow of the Bill of Rights and which spring from concerns for personal autonomy can be exercised by another *absent the most rigid of formalities* . . . . Just as the State may not delegate to any person the right to veto another's right to privacy choices, no person can assume that choice for an incompetent *in the absence of the formalities required under Missouri's Living Will statutes* or the clear and convincing, inherently reliable evidence absent here.
>
> Nor do we believe that the common law right to refuse treatment—founded in personal autonomy—is exercisable by a third party *absent formalities.*

Cruzan v. Harmon, 760 S.W.2d 408, 425 (Mo. 1988) (en banc) (emphasis added), *cert. granted sub nom.* Cruzan v. Missouri Dep't of Health, 109 S. Ct. 3240 (1989). It rejects the argument that Cruzan's parents, as her legal guardians, exercise Cruzan's individual rights, holding that Nancy Cruzan's parents, as her legal guardians, act under the "state's authority" and are "the delegatee[s] of the state's *parens patriae* power." *Id.*

151. The United States Supreme Court has recognized that parents have primary authority in decisionmaking for children legally incapable of making decisions for themselves and that parental authority has a constitutional status. *See, e.g.*, Wisconsin v. Yoder, 406 U.S. 205 (1972) (recognizing parents' constitutional right to direct their children's religious training); Pierce v. Society of Sisters, 268 U.S. 510 (1925) (recognizing parents' constitutional right to direct their children's education).

Such parental rights have been recognized in contexts relevant to medical treatment decisionmaking. In Bowen v. American Hospital Ass'n, 476 U.S. 610 (1986) (plurality opinion), the Supreme Court addressed the validity of federal regulations concerning medical treatment of newborns. These so-called "Baby Doe" regulations were promulgated under § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (1982 & Supp. V 1987), on the theory that infants denied treatment were illegally discriminated against based on a handicap—their infancy. *See id.* at 619 n.7. The Court, however, overturned these regulations because, in the plurality's view, there was

delegation, in the absence of evidence to the contrary, by the patient in light of the well-established custom in the ordinary patient-physician relationships[152] and the expectations of the public.[153]

Critics of self-determination as a model of medical decisionmaking on behalf of incompetent patients should not be too quick to abandon this model. An important element of the analysis established in the 1980s is the premise that refusal of medical treatment is a legal right that can be exercised on the incompetent person's behalf. There are, of

---

no evidence that there was any hospital rule or state policy denying such infants access to medical services. *Id.* at 624-25.

Both the plurality and dissent in *Bowen* agreed that parental consent was required before an infant could be considered "otherwise qualified," using the terms of the Act, to receive health care. *Id.* at 630, 653 n.7. Because the Court reviewed only the validity of the regulations under the statute, however, *id.* at 647, it did not hold that the parents had a constitutional right to make medical decisions on behalf of their children. Yet this decision indicates that the analysis of legal issues in medical treatment decisionmaking begins with a presumption in favor of parental consent. (In a statement particularly relevant to this issue, the plurality in *Bowen* observed that, in promulgating these regulations, the Department of Health and Human Services held the "*untenable view* that 'the basic provision of nourishment, fluids, and routine nursing care' was 'not an option for medical judgment.' ") *Id.* at 646 (emphasis added).

The source of such parental rights was discussed in Michael H. v. Gerald D., 109 S. Ct. 2333 (plurality opinion), *reh'g denied*, 110 S. Ct. 22 (1989) (mem.). In that case, the putative father of a child filed a filiation action to establish his paternity and right to visitation. *Id.* at 2337. The child was born to the mother while the mother was living with her current husband. *Id.* at 2336. Therefore, under California law the child was presumed to be a child of the marriage. *Id.*

In attempting to establish his paternity, the plaintiff predicated one of his arguments on the assertion that he had a constitutionally protected liberty interest in his relationship with his daughter. *Id.* at 2341. Writing for a plurality, Justice Scalia rejected this claim, commenting that the Court has "insisted not merely that the [constitutional] interest denominated as a 'liberty' be 'fundamental' . . . but also that it be an interest traditionally protected by our society." *Id.* He added that past cases protecting certain family relationships rested upon "the historic respect—indeed, sanctity would not be too strong a term—traditionally accorded to relationships that develop within the unitary family." *Id.* at 2342. Justice Scalia looked for a tradition of protection of such an interest in the "most specific level at which a relevant tradition protecting, or denying protection to, the asserted right can be identified." *Id.* at 2344 n.6.

In cases involving medical treatment decisionmaking, therefore, Scalia's approach might be read to require that there exist a tradition of protecting the right of parents, spouse, or other family members to make medical treatment decisions for incompetent adults.

Justice Scalia's opinion in *Michael H.* was joined by Justices Rehnquist, O'Connor, and Kennedy. Justices O'Connor and Kennedy wrote a joint concurring opinion, however, to make clear that, in their view, the Supreme Court has, in the past, found more general traditions to achieve the status of constitutional rights. *Id.* at 2346-47. In a separate concurring opinion, Justice Stevens indicated that his definition of family relationships would be broader than that adopted by Scalia. *Id.* at 2347.

152. *See generally* Areen, *supra* note 146.

153. One court notes that "[e]very recent survey that we have found indicates that society believes that a patient's family members should function as his or her surrogate decision makers." *In re* Jobes, 108 N.J. 394, 418 n.11, 529 A.2d 434, 446 n.11 (1987).

course, strong analytical arguments against such rights in cases where the right claimed is one of choice, while the one claiming the right can no longer choose. But there is more to "rights talk" than logic. Legal rights fundamentally represent the allocation of power among individuals and between individuals and the state. The right to refuse treatment claimed in these cases relates both to the power of the patient as compared to the doctor and to the power of the individual as compared to the state. It is critical that the patient retain the power to make his or her own health care decisions.

In the absence of expressed decisions, there is no longer, if there ever was, a compelling argument in favor of giving doctors, as opposed to family members or designated surrogates, the power to control medical treatment. Likewise, the only argument in favor of giving the courts or the legislature the power to make individual treatment decisions is that such decisions are required in order to protect the individual or other interests from harm.

Of course, the essential and unresolved disagreement inherent in this issue is the nature and measure of harm. The answer to the question of what *ought* to be done presents itself indirectly, but forcefully, in the standard of proof, the types of procedures established for resolution of particular treatment decisions, and the identification of the appropriate decisionmaker. The answer also presents itself directly in questions concerning the best interests of the patient and the reasonableness of surrogate decisions. There is certainly no consensus on whether medical treatments providing nutrition are beneficial or harmful per se. If the incompetent patient himself, or through his designated representative, has a right to refuse medical treatment, however, the burden is on the state to prove the need to limit that right. Absent the starting point of rights, that burden disappears, and legislatures have the power to mandate what they believe is the best medical treatment for all.[154] State legislatures have proven themselves willing to limit the rights of individuals to refuse unwanted medical treatment. As controversies concerning refusals of treatment continue to arise, legislatures are likely to continue to act. Undoubtedly, statutory restrictions on

154. This is especially intrusive when the patient is represented by family members or a designated surrogate against whom there is no evidence of unreasonableness, malice, or bad faith. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research noted that "[s]ince a protected sphere of privacy and autonomy is required for the flourishing of this interpersonal union [of the family], institutions and the state should be reluctant to intrude, particularly regarding matters that are personal and on which there is a wide range of opinion in society." PRESIDENT'S COMM'N, *supra* note 71, at 128.

medical treatment decisionmaking by patients and their families will be tested. Perhaps the most important battles in the 1990s will take place in the state capitals, and the task of the courts will soon include a closer analysis of the constitutional basis of refusing medical interventions.[155]

This is not a costless decision for the patients involved. Only by abstracting Nancy Cruzan and Mary O'Connor as either ciphers that have no consciousness and, therefore, cannot suffer, or symbols of the sanctity of life that exist to meet the needs of society, is there great comfort in maintaining them indefinitely in their current state. Courts have often referred to their own discomfort in allowing nontreatment; there should be discomfort as well in using the power of the state to compel medical intervention.

155. *See, e.g.*, Gray v. Romeo, 697 F. Supp. 580 (D.R.I. 1988).