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Experimenting with the "Right to Die" in the Laboratory of the States

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> *Today we decide only that one State's practice does not violate the Constitution; the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the "laboratory" of the States, . . . in the first instance.*[1]

I. INTRODUCTION

Justice O'Connor concludes her initial examination of the constitutional parameters of the so-called right to die[2] by invoking the frequently cited metaphor of the "states as laboratories." This metaphor is significant in many respects. It raises an image of a scientific experiment, the result of which is uncertain. The scientific image is all the more poignant in the context of invasive medical technologies that separate life from death. The image of experimentation also signals an openness to various possible answers to an admittedly difficult question. Before casting rules in the comparatively rigid stone of federal constitutional law, the Court encourages states to experiment with different standards and proce-

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[1] Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2859 (1990) (O'Connor, J., concurring).

[2] We are using the phrase "right to die" in its popular sense as describing all cases in which patients, or those acting on their behalf, object to the initiation or continuation of potentially lifesaving medical treatment.

dures.[3] If the day comes when the Court deems it necessary to frame federal constitutional guidelines governing decisions to withdraw or withhold life-sustaining treatment, it may do so against the backdrop of a variety of state experiences.

In this Article, we describe the current status of experimentation with the right to forgo life-sustaining treatment in the laboratory of the states. The laboratory has been quite busy. State courts have decided dozens of cases set in an incredible array of factual contexts and against the backdrop of significantly differing state statutory and constitutional provisions. There is no "typical" case. Patients may range in age from infants[4] to the elderly,[5] or any age in between.[6] Some patients are fully competent when they decide to refuse treatment.[7] Other patients, while once competent, are no longer capable of making treatment decisions.[8] Still other patients never were competent to direct the course of their treatment.[9] Some courts are aided by unequivocal prior expressions of intent by the now-incompetent patient,[10] while others must render judgment with inconclusive evidence of the patient's desires.[11] The

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[3] *Cruzan*, 110 S. Ct. at 2859 (O'Connor, J., concurring) (citing New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting)).

[4] *See, e.g.*, *In re* Barry, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984); *In re* L.H.R., 253 Ga. 439, 321 S.E.2d 716 (1984).

[5] *See, e.g.*, *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987); *In re* Westchester County Medical Center *ex rel.* O'Connor, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 ((1983).

[6] *See, e.g.*, Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841 (1990) (32 years old); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987) (31 years old); *In re* Grant, 109 Wash. 2d 545, 747 P.2d 445 (1987) (22 years old).

[7] *See, e.g.*, Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); State v. McAfee, 259 Ga. 579, 385 S.E.2d 651 (1989); *In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987).

[8] *See, e.g.*, *Cruzan*, 110 S. Ct. at 2841; *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied*, 429 U.S. 922 (1977); Brophy v. New England Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986); *In re* Torres, 357 N.W.2d 332 (Minn. 1984).

[9] *See, e.g.*, *In re* L.H.R., 253 Ga. 439, 321 S.E.2d 716 (1984); *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981); *In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984).

[10] *See, e.g.*, McConnell v. Beverly Enters.-Conn., Inc., 209 Conn. 692, 553 A.2d 596 (1989); *In re* Browning, 568 So. 2d 4 (Fla. 1990); John F. Kennedy Hosp. v. Bludworth, 452 So. 2d 921 (Fla. 1984); *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987).

[11] *See, e.g.*, Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987); *In re* Conroy, 98 N.J.321, 486 A.2d 1209 (1985); *In re* Westchester County Medical Center *ex rel.* O'Connor, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).

prognosis of the patient may vary significantly. In some cases, the proposed treatment can cure the underlying illness or restore the patient to a fully cognitive life.[12] In other cases, the medical intervention can sustain life for a considerable length of time, but not cure the underlying illness.[13] In still other instances, the treatment at issue can only postpone death for a short time.[14] The proposed treatment may involve blood transfusions,[15] nutrition and hydration,[16] respirators,[17] chemotherapy,[18] surgery,[19] kidney dialysis[20] and other procedures.[21] Even the controlling law varies from deci-

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[12] *See, e.g.*, Public Health Trust v. Wons, 541 So. 2d 96 (Fla. 1989); Fosmire v. Nicoleau, 75 N.Y.2d 218, 551 N.E.2d 77, 551 N.Y.S.2d 876 (1990); Department of Public Welfare v. Kallinger, 134 Pa. Cmwlth. 415, 580 A.2d 887 (1990).

[13] *See, e.g.*, Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841 (1990); State v. McAfee, 259 Ga. 579, 385 S.E.2d 651 (1989); *In re* Torres, 357 N.W.2d 332 (Minn. 1984).

[14] *See, e.g.*, Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987); *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

[15] *See, e.g.*, Public Health Trust v. Wons, 541 So. 2d 96 (Fla. 1989); Fosmire v. Nicoleau, 75 N.Y.2d 218, 551 N.E.2d 77, 551 N.Y.S.2d 876, (1990); *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981); *In re* Estate of Dorone, 517 Pa. 3, 534 A.2d 452 (1987).

[16] *See, e.g.*, Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841 (1990); McConnell v. Beverly Enters.-Conn., Inc., 209 Conn. 692, 553 A.2d 596 (1989); *In re* Browning, 568 So. 2d 4 (Fla. 1990); *In re* Estate of Greenspan, 137 Ill. 2d 1, 558 N.E.2d 1194 (1990); *In re* Estate of Longeway, 133 Ill. 2d 33, 549 N.E.2d 292 (1989); *In re* Gardner, 534 A.2d 947 (Me. 1987); Brophy v. New England Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987); *In re* Westchester County Medical Center *ex rel.* O'Connor, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988); *cf.* Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986) (involving 28-year-old woman suffering from severe cerebral palsy who resolved to starve herself and was involuntarily force fed); Department of Public Welfare v. Kallinger, 134 Pa. Cmwlth. 415, 580 A.2d 887 (1990) (involving prisoner who refused to eat or drink);

[17] *See, e.g.*, Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984); John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921 (Fla. 1984); State v. McAfee, 259 Ga. 579, 385 S.E.2d 651 (1989) (ventilator); McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990); *In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied*, 429 U.S. 922 (1977); *In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).

[18] *See, e.g.*, Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977).

[19] *See, e.g.*, Lane v. Candura, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978); *In re* Quackenbush, 156 N.J. Super. 282, 383 A.2d 785 (1978).

[20] *See, e.g.*, *In re* Spring, 380 Mass. 629, 405 N.E.2d 115 (1980).

[21] *See, e.g.*, Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987) (involving placement of "do not resuscitate" (DNR) and "do not hospitalize" (DNH) order on medical chart); *In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984) (involving DNR order and withholding of antibiotics).

sion to decision. Some courts have resolved treatment disputes by turning to principles of federal or state constitutional law or both.[22] Other decisions avoid making any constitutional pronouncements and instead rely on state statutory or common law.[23] A few courts rest their decisions on both constitutional and common law without making any clear differentiation between them.[24]

Despite the variety of factual contexts and sources of controlling law, state court decisions reflect substantial, if not universal, harmony on two basic principles. First, courts acknowledge the basic right of individual patients to control the course of their own treatment.[25] Second, most states allow a surrogate decisionmaker to act on the patient's behalf in certain circumstances when the patient is not capable of dictating her treatment preferences.[26] Yet there remain significant differences regarding the substantive standards for surrogate decisionmaking and the procedures by which right-to-die decisions are made.[27]

The purposes of this Article are twofold. Our first purpose is to reexamine the legal foundations of a patient's right to refuse treatment. The Court's equivocal handling of the federal constitutional issues in *Cruzan v. Director, Missouri Department of Health*[28] invites a closer look at state constitutional, statutory and common law. The source of the underlying right will affect state experimen-

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[22] *See, e.g., In re* Browning, 568 So. 2d 4, 9-12 (Fla. 1990); State v. McAfee, 259 Ga. 579, 385 S.E.2d 651 (1989); *In re* Quinlan, 70 N.J. 10, 38-42, 355 A.2d 647, 662-664, *cert. denied*, 429 U.S. 922 (1977); *In re* Grant, 109 Wash. 2d 545, 552-553, 553 n.1, 747 P.2d 445, 448-449, 449 n.1 (1987).

[23] *See, e.g., In re* Estate of Longeway, 133 Ill. 2d 33, 43, 549 N.E.2d 292, 297 (1989) (right found in both common and statutory law); *In re* Westchester County Medical Center *ex rel.* O'Connor, 72 N.Y.2d 517, 528, 531 N.E.2d 607, 611, 534 N.Y.S.2d 886, 890 (1988) (using well-recognized common-law right to decline life-saving treatment, absent overriding state interest).

[24] *See, e.g.*, Rasmussen v. Fleming, 154 Ariz. 207, 214-216, 741 P.2d 674, 682-83 (1987) (holding right to refuse medical treatment based on federal and state constitutional right of privacy as well as by common-law right to be free from nonconsensual physical invasions); *In re* Farrell, 108 N.J. 335, 348, 529 A.2d 404, 410 (stating that, while right to refuse treatment is "primarily protected by the common law, . . . it is also protected by the federal and state constitutional right of privacy").

[25] *E.g.*, Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2851 (1990); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied*, 429 U.S. 922 (1977).

[26] *See infra* notes 137-39 and accompanying text.

[27] *See infra* notes 155-64, 170-76, 188-218 and accompanying text.

[28] 110 S. Ct. 2841 (1990).

tation with substantive and procedural rules in this area. Our second purpose is to describe the current status of the states' experiments with the right to die. That is, we elaborate in more detail on the state constitutional, statutory and common law governing the decisions to withdraw or withhold life-sustaining treatment. An accurate picture of current law will aid courts and legislatures called upon to formulate rules in the post-*Cruzan* world. Part II of the Article discusses the constitutional and common-law framework of the right to refuse treatment. It illustrates the ambiguity of judicial opinions in defining precisely the source of the underlying right. Part II also points out some of the practical consequences of resting the right to refuse treatment on constitutional or common law. Part III describes the current state of judicial experimentation with the right to die. We highlight the areas of agreement and disagreement among state courts in their efforts to define substantive and procedural guidelines governing right-to-die cases. After analyzing judicial developments, we turn to legislative initiatives. Part IV compares the similarities and differences among state living-will statutes. Part V makes a similar comparison for more recent legislation regarding durable powers of attorney for health care. Part VI concludes with an assessment of how *Cruzan* might affect future judicial and legislative activity.

II. THE UNCERTAIN SOURCE OF THE RIGHT TO DIE

A. The Basic Analytical Building Blocks of Quinlan *and* Saikewicz

The first major case exploring the right of an incompetent individual to refuse life-sustaining treatment was *In re Quinlan*.[29] A tragic combination of drugs and alcohol caused young Karen Quinlan to stop breathing for at least two fifteen-minute periods.[30] The oxygen deprivation during this time produced serious and permanent brain damage. It was the medical consensus that Karen, "in addition to being comatose [was] in a chronic and persistent 'vegetative' state, having no awareness of anything or anyone around

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[29] 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied*, 429 U.S. 922 (1977).

[30] *Id.* at 22-24, 355 A.2d at 653-54. Although the court attributed the exact cause of cessation of breathing to "reasons still unclear," contribution of drugs and alcohol were well known. *See* B. SPRING & E. LARSON, EUTHANASIA 44 (1988).

her and existing at a primitive reflex level."[31] Unable to breathe on her own, Karen was being kept alive by means of a mechanical respirator. Joseph Quinlan, Karen's father, petitioned the court to be appointed Karen's guardian with express authority to order the discontinuance of all extraordinary medical procedures. Mr. Quinlan was convinced that his daughter would not want to be maintained by mechanical means in a vegetative state with no hope for improvement.

The New Jersey Supreme Court granted the petition and in so doing articulated the basic framework for recognizing a constitutional right to refuse treatment. The court reviewed the federal "privacy" cases running from *Griswold v. Connecticut*[32] through *Roe v. Wade*[33] and concluded that they applied to the decision to forgo life-sustaining treatment.[34] As additional authority, the court cited the right of privacy protected by the New Jersey Constitution.[35] The court then turned to the scope of this constitutional right when the patient lies in a persistent vegetative state. The constitutional right of privacy is not surrendered, the court declared, by reason of having become incompetent. "The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment . . . as to whether she would exercise it in these circumstances."[36] The New Jersey opinion thus sets forth two fundamental propositions. First, the right to refuse treatment is grounded in federal and state constitutional law.[37] Second, this right may be exercised by surrogate decisionmakers on behalf of incompetent patients.[38]

The second influential early case was the Massachusetts Supreme Court's decision in *Superintendent of Belchertown State School v. Saikewicz*.[39] This case raised the question of whether a guardian could withhold consent to chemotherapy on behalf of Jo-

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[31] *Quinlan*, 70 N.J. at 26, 355 A.2d at 655.

[32] 381 U.S. 479 (1965).

[33] 410 U.S. 113 (1973).

[34] *Quinlan*, 70 N.J. at 41, 355 A.2d at 664.

[35] N.J. CONST., art. I, par. 1 (1947). This provision does not explicitly protect "privacy," but refers to "unalienable rights," including "liberty." *See infra* note 71 and accompanying text.

[36] *Quinlan*, 70 N.J. at 41, 355 A.2d at 664.

[37] *Id.* at 38-42, 355 A.2d at 662-64.

[38] *Id.* at 53-54, 355 A.2d at 670-71.

[39] 373 Mass. 728, 370 N.E.2d 417 (1977).

seph Saikewicz, a sixty-seven-year-old man suffering from leukemia who had been profoundly mentally retarded since birth. The treatment offered a thirty to forty percent chance of extending Saikewicz's life for a short period of time, but would produce serious adverse side effects that Saikewicz was unable to comprehend. Doctors estimated that Saikewicz would die in "a matter of weeks or, perhaps, several months"[40] if left untreated. The Massachusetts court embraced much of the *Quinlan* opinion's basic analysis. It agreed that a federal constitutional right of privacy protected persons from unwanted state-compelled treatment and that this right could be exercised by a guardian on behalf of an incompetent patient.[41] *Saikewicz* found additional common-law support for recognizing a right to refuse treatment in the torts of battery and informed consent.[42] *Saikewicz*'s major contributions to the early formulation of law in this area were its discussion of countervailing state interests and articulation of a standard of decisionmaking. The court recognized that an individual's privacy interest in refusing treatment must sometimes yield to countervailing state interests. The relevant state interests were: "(1) the preservation of life; (2) the protection of the interests of innocent third parties; (3) the prevention of suicide; and (4) maintaining the ethical integrity of the medical profession."[43]

The court then explained why these interests were not sufficient to override Saikewicz's constitutional right to refuse treatment. The state's interest in preserving life diminishes when, as here, "the issue is not whether but when, for how long, and at what cost to the individual that life may be briefly extended."[44] Thus, as in *Quinlan*,[45] the patient's poor prognosis undermined the assertion

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[40] *Id.* at 733, 370 N.E.2d at 421.

[41] *Id.* at 739-740, 370 N.E.2d at 424.

[42] *Id.*

[43] *Id.* at 741, 370 N.E.2d at 425. These are the four most commonly discussed, but not the only recognized, state interests. Other state interests may play an important role in some cases. *See, e.g.*, Commissioner of Correction v. Myers, 379 Mass. 255, 399 N.E.2d 452 (1979) (finding state interest in maintaining discipline in prisons is sufficient to override inmate's interest in refusing hemodialysis); McKay v. Bergstedt, 801 P.2d 617, 628 (Nev. 1990) (recognizing state interest in encouraging charitable and humane care of inflicted persons).

[44] *Saikewicz*, 373 Mass. at 742, 370 N.E.2d at 426.

[45] "We think that State's interest [in preserving life] weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest." *In re* Quinlan, 70 N.J. 10, 41, 355 A.2d 647, 664 (1976), *cert. denied*, 429 U.S. 922 (1977).

of this state interest. Second, the state's interest in protecting innocent third parties was factually irrelevant because no third persons would be affected by the guardian's decision to forgo chemotherapy. The court further concluded: "Recognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores; such a doctrine does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the State's interest in protecting the same."[46] Interestingly, the Massachusetts court deemed the state's interest in preventing suicide to merit "little if any discussion."[47] Death resulting from refusing medical treatment is not suicide because "(1) in refusing treatment the patient may not have the specific intent to die, and (2) even if he did, to the extent that the cause of death was from natural causes the patient did not set the death producing agent in motion with the intent of causing his own death."[48]

Having concluded that an incompetent patient has a constitutional right to refuse treatment and that the countervailing state interests did not outweigh that right, the court addressed the proper standard for surrogate decisionmaking. The court adopted a standard commonly referred to as "substituted judgment."[49] The goal of substituted judgment is to determine as accurately as possible what the incompetent patient would choose to do if he were able to choose.[50] Thus, the guardian should withhold consent to chemotherapy if the patient would do so were he competent to convey his desires. The application of a substituted judgment anal-

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[46] *Saikewicz*, 373 Mass. at 743-744, 370 N.E.2d at 426-27.

[47] *Id.* at 743 n.11, 370 N.E.2d at 426 n.11. Justice Scalia, on the other hand, devotes a considerable portion of his concurring opinion in *Cruzan* arguing that refusing life-sustaining treatment is tantamount to suicide. Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2860-2862 (Scalia, J., concurring).

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

[49] *Id.* at 751, 370 N.E.2d at 431.

[50] *Id.* at 750-52, 370 N.E.2d at 430-31. There is extensive academic commentary on the propriety and feasibility of basing life-and-death decisions on what a third party believes an incompetent patient would choose. *See* A. MEISEL, THE RIGHT TO DIE (1989); Dresser, *Relitigating Life and Death*, 51 OHIO STATE L.J. 425 (1990); Kamisar, *When is There a Constitutional "Right to Die"? When is There* No *Constitutional Right to Die*, 25 GA. L. REV. 1203 (1991); Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375 (1988); Robertson, Cruzan *and the Constitutional Status of Nontreatment Decisions for Incompetent Patients*, 25 GA. L. REV. 1139 (1991). Our purpose here is to describe—not to endorse or criticize—the substantive standards for proxy decisionmaking reflected in judicial opinions.

ysis to a person like Joseph Saikewicz, who had never been competent, posed some obvious conceptual problems. Substituted judgment involves an assessment of the patient's subjective desire. Saikewicz had never been able to formulate or communicate rationally his personal choice regarding treatment. Nonetheless, the court identified six factors that supported the conclusion that, given his limited mental capacity, Joseph Saikewicz would not consent to chemotherapy were he able to express his views. These factors included: (1) his age; (2) the probable side effects of treatment; (3) the low chance of producing remission; (4) the certainty that treatment would produce immediate suffering; (5) his inability to cooperate with and comprehend the need for the treatment; and (6) "the quality of life possible for him even if the treatment does bring about remission."[51] In light of these considerations, the court upheld the trial judge's approval of the guardian's withholding of consent to chemotherapy.[52]

Together,[53] *Quinlan* and *Saikewicz* lay the basic analytical building blocks for the subsequent doctrinal development of law in this area by state courts: a right to refuse life-sustaining treatment can be found in the common law, the state constitution or in the federal constitutional right of privacy;[54] this right can be asserted by a surrogate decisionmaker when the patient is incompetent;[55] countervailing state interests are severely discounted when the

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[51] *Saikewicz*, 373 Mass. at 753-754, 370 N.E.2d at 432. The factors identified by the court as weighing in favor of administering chemotherapy included: (1) most people elect the treatment; and (2) the chance for a longer life, including the possibility a cure will be discovered during the period of remission. *Id.* at 753, 370 N.E.2d at 431-32.

[52] *Id.* at 728, 370 N.E.2d at 417.

[53] This is not to say that the two cases adopt identical analytical positions. The most widely noted difference between the two decisions involves the procedure by which decisions to forgo life-sustaining treatment are to be made. *In re* Quinlan, 70 N.J. 10, 55, 355 A.2d 647, 671-72 (1976), envisioned a collective decisionmaking process involving physicians, family members and the hospital "ethics committee." Judicial approval of particular decisions would not be necessary when these parties were in agreement. *Saikewicz*, 373 Mass. at 755-59, 370 N.E.2d at 434-35, on the other hand, reflects the view that judicial guardianship proceedings should be used in most instances. This aspect of the two cases sparked spirited commentary. *See*, Annas, *Reconciling* Quinlan *and* Saikewicz*: Decision Making for the Terminally Ill Incompetent*, 4 AM. J.L. & MED. 367 (1978); Barron, *Medical Paternalism and the Rule of Law: A Reply to Dr. Relman*, 4 AM. J.L. & MED. 337 (1978); Relman, *The* Saikewicz *Decision: A Medical Viewpoint*, 4 AM. J.L. & MED. 233 (1978).

[54] *See infra* notes 58-59, 88-89 and accompanying text.

[55] *See infra* notes 137-39 and accompanying text.

medical diagnosis and prognosis of the patient are poor;[56] and the proper standard for surrogate decisionmaking is "substituted judgment."[57] It is against this backdrop that we now examine in more detail the significance of the source of the right to refuse treatment.

B. *The Role of State Constitutional Law*

While almost every reported decision since *Quinlan* and *Saikewicz* has upheld a patient's right to refuse treatment, there is surprising ambivalence in identifying the precise source of that right. Many decisions follow *Quinlan*'s lead by invoking either a federal or state constitutional right. Several courts base the right to refuse treatment on a federal constitutional right of privacy.[58] State constitutional protections have been relied on as additional authority by several other courts.[59] The Minnesota Supreme Court intimated that patients' have "a constitutional right of privacy" that encompasses a right to refuse treatment without making clear whether this right is grounded in the state or federal constitution.[60]

One striking feature of these decisions is their almost cavalier treatment of the state and federal constitutional issues. *Quinlan* is treated as the definitive analysis of the federal constitutional right of privacy.[61] The deference given to a New Jersey decision on a matter of federal constitutional law may be surprising by itself. It is all the more so when the existence of a federal constitutional

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[56] *See infra* notes 107-08 and accompanying text.

[57] *See infra* notes 140-45 and accompanying text.

[58] *See, e.g., In re* Severns, 425 A.2d 156 (Del. Ch. 1980); Leach v. Akron Gen. Med. Center, 68 Ohio Misc. 1, 426 N.E.2d 809 (Com. Pl. 1980); Gray v. Romeo, 697 F. Supp. 580 (D.R.I. 1988).

[59] *See, e.g.*, Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987); Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921 (Fla. 1984); *In re* L.H.R., 253 Ga. 439, 321 S.E.2d 716 (1984); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).

[60] *In re* Torres, 357 N.W.2d 332, 339 (Minn. 1984).

[61] *See, e.g., Rasmussen*, 154 Ariz. at 215 n.8, 741 P.2d at 682 n.8; McConnell v. Beverly Enters.-Conn., Inc., 209 Conn. 692, 702, 553 A.2d 596, 601; Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 739-740, 370 N.E.2d 417, 424 (1977); *In re Colyer*, 99 Wash. 2d at 119-121, 660 P.2d at 741-742. *But cf.* Cruzan v. Harmon, 760 S.W.2d 408, 418 (Mo. 1988), *aff'd sub nom.* Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841 (1990) ("Based on our analysis of the right to privacy decisions of the Supreme Court, we carry grave doubts as to the applicability of privacy rights to decisions to terminate the provision of food and water to an incompetent patient."

right of privacy is controversial[62] and the United States Supreme Court had never addressed the right to die prior to *Cruzan*.[63] Analytical precision is no greater when state constitutional rights are invoked. Citations to state constitutional provisions appear in many decisions as an afterthought. No consideration is given to whether the state constitutional guarantees provide lesser, greater or identical protections than the federal constitution.[64]

Perhaps the absence of sharp constitutional analysis can be explained by the pre-*Cruzan* consensus in recognizing a right to refuse treatment. The existence of the underlying right has been far less controversial than clarifying its scope. Judicial opinions reflect more care in defining the standards and procedures governing proxy decisionmaking than in identifying the source of the underlying right.

One consequence of *Cruzan* may be to encourage state courts to define more precisely the scope of rights guaranteed by state constitutions. A reexamination of state constitutional law is prompted by *Cruzan*'s halting treatment of the federal constitutional issues. *Cruzan* never embraces *Quinlan*'s analysis of a federal constitutional right of privacy. The majority opinion speaks in terms of a "liberty interest" in refusing treatment. The Court never characterizes this "interest" as "fundamental" and conspicuously avoids

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[62] *See, e.g.*, R. BERGER, GOVERNMENT BY JUDICIARY: THE TRANSFORMATION OF THE FOURTEENTH AMENDMENT 392 (1977); R. BORK, THE TEMPTING OF AMERICA: THE POLITICAL SEDUCTION OF THE LAW 95 (1990); J. ELY, DEMOCRACY AND DISTRUST (1980). For recent commentary critical of casting a right to refuse life-sustaining treatment in terms of a federal constitutional right of privacy see, Mayo, *Constitutionalizing the "Right to Die"*, 49 MD. L. REV. 103 (1990); Note, *The Right to Die: An Exercise of Informed Consent, Not an Extension of the Constitutional Right to Privacy*, 58 U. CINN. L. REV. 1367 (1990).

[63] The Court had previously upheld the power of the state to compel a blood transfusion to save the life of a minor over the religious objections of the child's parents. Jehovah's Witnesses v. King County Hosp., 390 U.S. 598 (1968). It had also granted certiorari to consider whether an involuntarily committed mentally ill patient has a constitutional right to refuse psychotropic drugs, but did not reach the merits of the patient's claim. Mills v. Rogers, 457 U.S. 291 (1982). In Washington v. Harper, 110 S. Ct. 1028 (1990), decided the same term as *Cruzan*, the Court found that prisoners enjoy a "liberty interest" in refusing antipsychotic drugs, but that inmate's rights were not violated by a state policy that was "reasonably related to a legitimate penological interest." 110 S. Ct. at 1037.

[64] *See, e.g.*, Rasmussen v. Fleming, 154 Ariz. 207, 215, 741 P.2d 674, 682 (1987); Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr. 297, 301 (1986); *In re* L.H.R., 253 Ga. 439, 446, 321 S.E.2d 716, 722 (1984); *In re* Quinlan, 70 N.J. 10, 40, 355 A.2d 647, 663 (1976), *cert. denied*, 429 U.S. 922 (1977); *In re* Colyer, 99 Wash. 2d 114, 120, 660 P.2d 738, 742 (1983).

the doctrinal label of "privacy."[65] A "liberty interest" analysis invites a balancing of competing state interests that gives states considerable flexibility in regulating conduct.[66] The majority opinion, moreover, merely "*assume[s]* that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."[67] Furthermore, the Court reserves the issue of whether advanced directives must be enforced as a matter of federal constitutional law.[68] In short, *Cruzan* provides no unequivocal guidelines on the scope of federal constitutional protection of an individual's "interest" in refusing treatment. It merely *holds* that the Constitution permits a state to demand clear and convincing evidence of a patient's intent before authorizing a surrogate to withdraw life-sustaining treatment.

Given the *Cruzan* Court's reluctance to embrace a federal constitutional right of privacy, state courts may turn to other sources of law to resolve right-to-die issues. State constitutions, of course, provide an independent basis for protecting individual rights,[69] including a right to refuse treatment.[70] Some state courts have found a right of privacy in general constitutional provisions protecting "liberty."[71] Several state constitutions contain an express right of

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[65] Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2851 n.7 (1990).

[66] *See, e.g.*, Washington v. Harper, 110 S. Ct. 1028, 1037 (1990); Bowers v. Hardwick, 478 U.S. 186, 194-95 (1986); Zablocki v. Redhail, 434 U.S. 374, 392-93 (1977) (Stewart, J., concurring). *See Constitutional Law Conference*, 59 U.S.L.W. 2272, 2281 (Nov. 6, 1990) (reporting Professor Tribe's comment that footnote 7 of *Cruzan* helps make clear that term "liberty" entails use of rational basis test to justify regulation, while "fundamental rights"—like privacy—can be restricted based on test of compelling necessity).

[67] *Cruzan*, 110 S. Ct. at 2852 (emphasis added).

[68] *Id.* at 2856 n.12.

[69] There is a burgeoning body of commentary on the importance of state constitutional law in protecting individual rights. *See*, Brennan, *The Bill of Rights and the States: The Revival of State Constitutions as Guardians of Individual Rights*, 61 N.Y.U. L. REV. 535 (1986); Brennan, *State Constitutions and the Protection of Individual Rights*, 90 HARV. L. REV. 489 (1977); Linde, *E Pluribus-Constitutional Theory and State Courts*, 18 GA. L. REV. 165 (1984); Linde, *First Things First: Rediscovering the States' Bills of Rights*, 9 U. BALT. L. REV. 379 (1980); Sedler, *The State Constitutions and the Supplemental Protections of Individual Rights*, 16 U. TOL. L. REV. 465 (1985); Wilkes, *The New Federalism in Criminal Procedure: State Court Evasion of the Burger Court*, 62 KY. L.J. 421 (1974).

[70] *See generally* Kempic, *The Right to Refuse Medical Treatment Under the State Constitutions*, 5 COOLEY L. REV. 313 (1988) (examining evolving role of state constitutions as well as significance of relying upon state constitutions in support of right to refuse medical intervention).

[71] *See, e.g.*, State v. McAfee, 259 Ga. 579, 580, 385 S.E.2d 651, 652 (1989) (citing GA. CONST. art. I, § 1, par. 1 (1983), which provides that "[n]o person shall be deprived of life,

privacy.[72] It is entirely plausible that states, especially those with explicit privacy provisions, will afford greater protection to the right to refuse treatment under the state constitution than provided by the federal Constitution as construed in *Cruzan*.[73]

The evolution of Florida law may illustrate the increased importance of state constitutional law in the post-*Cruzan* world. The Florida Supreme Court first embraced a constitutional right to refuse treatment in the 1980 case of *Satz v. Perlmutter*.[74] *Perlmutter* made no reference to the Florida Constitution and instead cited *Quinlan*, *Saikewicz* and other cases invoking a federal constitutional analysis.[75] Following *Perlmutter*, the Florida constitution was amended to incorporate an explicit right of privacy.[76] In 1984 the Florida Supreme Court reaffirmed the constitutional dimension of the right to refuse treatment, but cited only *Perlmutter* and not

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liberty, or property except by due process of law"); *In re* Quinlan, 70 N.J. 10, 40, 355 A.2d 647, 663 (1976) (citing N.J. CONST., art. I, par. 1 (1947), which protects "certain natural and unalienable rights, among which are those of enjoying and defending life and liberty,. . . and of pursuing and obtaining safety and happiness"), *cert. denied*, 429 U.S. 922 (1977). *Cf.* Opinion of the Justices, 123 N.H. 554, 559-60, 465 A.2d 484, 489 (1983) (recognizing "liberty interest" of mentally ill persons to refuse treatment under New Hampshire Constitution); State *ex rel.* Jones v. Gerhardstein, 135 Wis. 2d 161, 400 N.W.2d 1 (Wis. Ct. App. 1986) (recognizing privacy right of mentally ill under WIS. CONST., art. I, § 1 protecting "life, liberty and the pursuit of happiness").

[72] *See, e.g.*, ALASKA CONST. art. I, § 22; ARIZ. CONST. art. II, § 8; CAL. CONST. art. I, § 1; FLA. CONST. art. I, § 23; HAW. CONST. art. I, § 6; ILL. CONST. art. I, §§ 6 & 12; LA. CONST. art. I, § 5; MONT. CONST. art. II, §§ 9 & 10; S.C. CONST. art. I, § 10; WASH. CONST. art. I, § 7. *See also* Cope, *To Be Let Alone: Florida's Proposed Right of Privacy*, 6 FLA. ST. U.L. REV. 671 (1978); Feldman and Abney, *The Double Security of Federalism: Protecting Individual Liberty Under the Arizona Constitution*, 20 ARIZ. ST. L.J. 115, 130-134 (1988); Gerstein, *California's Constitutional Right to Privacy: The Development of the Protection of Private Life*, 9 HASTINGS CONST. L.Q. 385 (1982); Harrington, *Privacy and the Texas Constitution*, 13 VT. L. REV. 155 (1988); Note, *Privacy Rights in State Constitutions: Models for Illinois*, 1989 U. ILL. L. REV. 215.

[73] *Cf.* Winfield v. Division of Pari-Mutuel Wagering, 477 So. 2d 544, 548 (Fla. 1985) ("Since the people of this state exercised their prerogative and enacted an amendment to the Florida Constitution which expressly and succinctly provides for a strong right of privacy not found in the United States Constitution, it can only be concluded that the right is much broader in scope than that of the Federal Constitution."); State v. Kam, 748 P.2d 372, 377 (Haw. 1988) ("As the ultimate judicial tribunal with final, unreviewable authority to interpret and enforce the Hawaii Constitution, we are free to give broader privacy protection than that given by the federal constitution.").

[74] 379 So. 2d 359 (Fla. 1980) (adopting 362 So. 2d 160 (Fla. App. 1978)).

[75] *Id.* at 360.

[76] FLA. CONST., art.I, § 23.

the subsequent constitutional amendment.[77] In 1989 the court revisited the right to refuse treatment and upheld the right of a Jehovah's Witness to refuse a medically needed blood transfusion.[78] The majority again relied primarily on *Perlmutter* for authority. The concurring opinion, however, referred to the constitutional amendment and noted:

> Since *Perlmutter*, the people of this state have chosen to provide more protection for privacy rights in Florida than that provided by the United States Constitution. That alone could justify broadening the scope of that decision.[79]

In *In re Browning*,[80] its first right-to-die decision since *Cruzan*, the Florida Supreme Court relied extensively on the state constitution in reaffirming the "constitutional right to choose or refuse medical treatment."[81] Thus, the state constitution has gradually displaced the federal constitution as the primary source of the underlying right.

C. *Constitutional Rights and Experimentation*

While *Cruzan* might encourage some courts to look more closely at their state constitutions as a source of law, it should also serve as a reminder of the pragmatic consequences of adopting a constitutional framework of analysis. This latter concern has been virtually ignored by courts that have found either a state or federal constitutional right to refuse treatment.[82] Finding a "constitutional" right to refuse treatment increases the degree of protection for that right, but also diminishes flexibility to experiment with different approaches to the problem.

Federal constitutional rights restrict experimentation through the operation of the Supremacy Clause.[83] One function of the Supremacy Clause is to ensure uniform application of constitutional rights. This lesson was most forcefully illustrated in the con-

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[77] John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921, 923-24 (Fla. 1984).
[78] Public Health Trust v. Wons, 541 So. 2d 96 (Fla. 1989).
[79] *Id.* at 102 (Ehrlich, C.J., concurring).
[80] 568 So. 2d 4 (Fla. 1990).
[81] *Id.* at 11.
[82] *See supra* notes 22, 24, 58-60 and accompanying text.
[83] U.S. CONST., art. VI, cl. 2.

text of school desegregation. In *Cooper v. Aaron*,[84] the Court declared that racially segregated schools in Little Rock, Arkansas, were no more constitutionally tolerable than those in Topeka, Kansas. Similarly, there would be less room for diversity in standards and procedures among the states if the right to refuse medical treatment arises from the federal constitution rather than from state constitutional, statutory or common law. If a terminally ill sixty-seven-year-old profoundly retarded man has a federal constitutional right to discontinue cancer treatment in Massachusetts, surely that right would apply to a terminally ill and profoundly retarded fifty-two-year-old resident of New York regardless of what New York State lawmakers might say or do.[85]

Constitutional protections are less susceptible to experimentation in yet another way. An unwise statute or common-law judicial decision can be modified by legislative action.[86] An imprudently recognized federal or state constitutional right can be altered only through the cumbersome process of constitutional amendment or the relatively rare occurrence of judicial reversal.[87] The compara-

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[84] 358 U.S. 1 (1958). The Court stated: "Marbury v. Madison . . . declared the basic principle that the federal judiciary is supreme in the exposition of the law of the Constitution, and that principle has ever since been respected by this Court and the Country as a permanent and indispensable feature of our constitutional system. It follows that the interpretation of the Fourteenth Amendment enunciated by that Court in the *Brown* case is the supreme law of the land." *Id.* at 18.

[85] *Compare* Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) (authorizing cessation of chemotherapy) *with In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 644, 38 N.Y.S.2d 266, (1981) (requiring continuation of blood transfusions to terminally ill cancer patient).

[86] For example, in People v. Eulo, 63 N.Y.2d 341, 472 N.E.2d 286, 482 N.Y.S.2d 436 (1984) the New York Court of Appeals ruled that the right to refuse treatment could not be exercised by a third party when the patient is unable to do so. In *In re* Westchester County Medical Center *ex rel.* O'Connor, 72 N.Y.2d 517, 529 n.2, 531 N.E.2d 607, 612 n.2, 534 N.Y.S.2d 886, 891 n.2 (1988), the court noted that "[t]he status of the law on this point has since been changed to some extent by legislation."

[87] Amending the federal constitution is notoriously difficult. Despite vigorous political activity, efforts to overturn Roe v. Wade, 410 U.S. 113 (1973), through constitutional amendment have failed. *See* Pearson and Kurtz, *The Abortion Controversy: A Study in Law and Politics*, 8 HARV. J.L. PUB. POL'Y 427, 446-453 (1985). State constitutions are more easily amended than their federal counterpart, but even here obstacles are great. Consider the history of the right of privacy under the Alaska Constitution. In 1975 the Alaska Supreme Court ruled that the right of privacy secured by ALASKA CONST art. I, § 22 protected the noncommercial possession of small amounts of marijuana in private homes. Ravin v. State, 537 P.2d 494 (Alaska 1975). The Alaska Constitution cannot be amended by popular initiative. Amendments must be approved by two-thirds of each house of the legislature before being submitted to the voters. ALASKA CONST. art. XIII; State v. Lewis, 559 P.2d 630 (Alaska

tive rigidity of constitutional rules, be they federal or state, are inherently less conducive to experimentation than statutory or common law.

D. *The Interplay of Constitutional and Common Law*

A number of jurisdictions incorporate a common-law analysis into their right-to-die decisions to supplement constitutional law.[88] Other courts, perhaps anticipating the uncertainty or limitations of a constitutional approach, analyze the right to refuse treatment exclusively in terms of common law.[89] Individual autonomy has long been an important value in the structure of the common law. Almost a century ago, the Supreme Court declared:

> No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.[90]

Respect for personal autonomy in medical decisionmaking is reflected in Judge Cardozo's classic treatment of the tort of battery:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.[91]

1977). The Alaska legislature has steadfastly resisted sustained efforts to recriminalize marijuana possession. Denied satisfaction in the legislature, proponents of recriminalization hope to convince the Alaska Supreme Court to reverse its decision in *Ravin*. In November 1990, the voters approved an initiative reinstituting criminal penalties for possession of marijuana. Both proponents and opponents of the initiative anticipate that its constitutionality will be challenged, providing the Alaska Supreme Court with an opportunity to revisit *Ravin* and the scope of the state's constitutional right of privacy. *See* Berliner, *New Marijuana Battle Certain in Alaska*, UPI wire report (Nov. 8, 1990); Wohlforth, *Off the Pot: Alaska Weeds Out Weed*, 203 THE NEW REPUBLIC (Dec. 3, 1990).

[88] *See, e.g.*, Rasmussen v. Fleming, 154 Ariz. 207, 215-216, 741 P.2d 682-83 (1987); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 738-740, 370 N.E.2d 417, 424 (1977); *In re* Conroy, 98 N.J. 321, 347, 486 A.2d 1209, 1222 (1985).

[89] *See, e.g., In re* Estate of Longeway, 133 Ill. 2d 33, 43, 549 N.E.2d 292, 297 (1989); *In re* Gardner, 534 A.2d 947, 951 (Me. 1987); *In re* Storar, 52 N.Y.2d 363, 378, 420 N.E.2d 64, 70, 438 N.Y.S.2d 266, 273 (1981).

[90] Union Pacific Ry. v. Botsford, 141 U.S. 250, 251 (1891).

[91] Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93

The evolution of the doctrine of informed consent from the tort of battery is yet another example of common law's respect for self-determination in medical care.[92] Thus, common law provides an ample foundation to support a right to refuse treatment.

The interplay of constitutional and common law is illustrated by the case of *McConnell v. Beverly Enterprises-Connecticut, Inc.*[93] Carol McConnell, a fifty-seven-year-old registered nurse, was seriously injured in an automobile accident. She never regained consciousness and was diagnosed as being in an irreversible vegetative state with no prospect of improvement.[94] Her husband and children sought judicial approval to remove a gastrostomy tube that was providing McConnell nutrition and hydration. Prior to her accident, McConnell had clearly expressed her desire not to be maintained by artificial means—including feeding tubes—if she were reduced to a permanently noncognitive condition. The Connecticut Supreme Court acknowledged that "[c]ourt after court" has recognized both a common-law and constitutional right to remove life-support systems, including feeding tubes, from permanently vegetative patients.[95] The state attorney general argued that the Connecticut Removal of Life Support Systems Act[96] precluded the removal of feeding tubes from McConnell. The statute mandates that "beneficial medical treatment and nutrition and hydration must be provided" to nonterminal patients.[97] Even though McConnell apparently could have survived indefinitely with treatment, she was diagnosed as terminal by her treating physician, and the trial court so found.[98] Thus, one potential statutory roadblock to the requested relief was avoided.

The attorney general's second argument focused on the express

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(1914).

[92] Several courts recognize that a right to refuse unwanted medical treatment follows from the tort of informed consent. *See, e.g.*, Rasmussen v. Fleming, 154 Ariz. 207, 216, 741 P.2d 674, 682-83 (1987); *In re Gardner*, 534 A.2d at 951; *In re* Colyer, 99 Wash. 2d 114, 121-122, 660 P.2d 738, 743 (1983). *See generally*, Note, *supra* note 62 (surveying development of right to refuse life-sustaining medical treatment as extension of common-law doctrine of informed consent).

[93] 209 Conn. 692, 553 A.2d 596 (1989).

[94] *Id.* at 696-97, 553 A.2d at 598.

[95] *Id.* at 702, 553 A.2d at 601.

[96] CONN. GEN. STAT. §§ 19a-570 to 19a-575 (Supp. 1990).

[97] *Id.* § 19a-571.

[98] *McConnell*, 209 Conn. at 707, 553 A.2d at 604.

exclusion of nutrition and hydration from the definition of "life support system" whose removal is authorized by the statute.[99] On its face, this portion of the statute could be read to preclude the relief sought by the McConnell family. If her right to refuse treatment stems only from common law, a statutory prohibition of the withdrawal of feeding tubes would presumably prevail. On the other hand, the statute might be unconstitutional if McConnell held a federal or state constitutional right to refuse treatment under these circumstances. The Connecticut Supreme Court sidestepped the constitutional issues by construing the statute in a manner that permitted the family to authorize the withdrawal of the feeding tube. The court distinguished between "nutrition and hydration," on the one hand, and "artificial technology to assist nutrition and hydration," on the other hand.[100] The court concluded that "read in its entirety . . . [the Act] implicitly contemplates the possible removal from a terminally ill patient of artificial technology in the form of a device such as a gastrostomy tube, but it does not, under any circumstances, permit the withholding of normal nutritional aids such as a spoon or a straw."[101]

Only through such a creative reading of the statute was the *McConnell* court able to avoid tackling the constitutional issues lurking in the case. *McConnell* continued the prevailing practice of courts to simply acknowledge that common-law and constitutional interests are involved without any clear distinction between them. Ultimately, however, any statutory restriction on the withholding or withdrawal of treatment will face a constitutional challenge.[102]

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[99] CONN. GEN. STAT. § 19a-571 (Supp. 1990).

[100] *McConnell*, 209 Conn. at 704, 553 A.2d at 602.

[101] *Id.* at 705, 553 A.2d at 603 (footnote omitted).

[102] See Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986), where the New York court found the common-law right to refuse treatment is coextensive with the patient's liberty interest protected by the due process clause of the state constitution. N.Y. CONST. art. I, § 6. *Katz* presented the question of whether an involuntarily committed mental patient could refuse the administration of antipsychotic drugs. Involuntary medication had been initiated pursuant to a state statute. New York courts had previously avoided constitutional pronouncements in cases involving unwanted treatment, relying instead on common-law principles. *E.g. In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981). If the patient held only common-law rights, the statute authorizing treatment presumably would be upheld. By finding the common-law right to be coextensive with state constitutional protections, the court opened the possibility that the forced medication of this patient was illegal despite the apparent statutory authorization. *Cf. In re* Estate of Greenspan, 137 Ill. 2d 1, 558 N.E.2d 1194 (1990) (finding case was not controlled by statu-

At some point, courts will be forced to identify more precisely the source of the underlying right and acknowledge the significant pragmatic consequences that attach thereto.

Courts that favor flexibility and experimentation will tend to rely on the common-law approach. Those that want to more completely insulate the right to refuse treatment from majoritarian encroachment will seek constitutional grounding. As previously noted, the Florida Supreme Court recently signalled that it will rely on state constitutional law to a greater extent than in the past.[103] This will necessarily place more limitations on legislative solutions to right-to-die issues than would a common-law approach. Interestingly, the New Jersey Supreme Court that relied on a constitutional analysis in *Quinlan*, now prefers to base its decisions on common-law principles. In its more recent opinions, the New Jersey court has backed away from a constitutional framework and instead based its rulings on common law and statutes.[104] Perhaps the direction taken by the New Jersey court reflects a basic agreement with Justice O'Connor that resolution of right-to-die issues calls for experimentation[105]—experimentation that is most readily conducted within a common-law and statutory analytical framework. Alternatively, it may simply reflect an appreciation that the federal constitutional basis for this right is growing increasingly uncertain and the New Jersey state constitution lacks a provision expressly protecting privacy.

III. Standards and Procedures for Implementing the Right to Refuse Treatment

Regardless of its source, courts have developed a rich body of case law defining the standards and procedures for implementing the right to refuse life-sustaining treatment. Because these cases

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tory restrictions on withdrawal of food and water contained in state's living-will legislation); *see also*, Okla. Stat. Ann. tit. 63, §§ 3101-3111 (West Supp. 1990) (placing restrictions on withdrawal of nutrition and hydration from incompetent patients).

[103] *In re* Browning, 568 So. 2d 4, 10 (Fla. 1990).

[104] *See, e.g., In re* Conroy, 98 N.J. 321, 348, 486 A.2d 1209, 1223 (1985) ("While this [constitutional] right of privacy might apply in a case such as this, we need not decide that issue since the right to decline medical treatment is, in any event, embraced within the common-law right of self-determination."); *cf. In re* Peter, 108 N.J. 365, 372, 529 A.2d 419, 423 (1987) (referring to patient's "rights to self-determination and privacy" without distinguishing between common law and constitutional law).

[105] *See supra* note 1.

arise in a bewildering variety of factual contexts, it is impossible to capture the "law" in this area in a one or two sentence summary. A number of factors appear to influence the outcomes of particular cases. Among the most significant factors are the clarity of the patient's expression of treatment preference and the medical diagnosis and prognosis. We organize our analysis of these cases by distinguishing among patients on the basis of competency and clarity of their expression of treatment preferences. The first group of cases involves patients who are competent and express their subjective intent when treatment is contemplated. The next group of cases involves patients who are not currently competent to direct their treatment, but who have provided clear evidence of their desires. The third, and most difficult, category of cases involves incompetent patients who did not provide clear directions.

A. The Right To Refuse Treatment and The Currently Competent Patient

1. Competent Patients with Poor Medical Prognoses. Courts have almost always upheld the decision of a currently competent patient to forgo life-sustaining treatment. The critical factors in these cases are the unquestioned clarity of the patient's treatment preferences and their competency[106] to make life-and-death decisions on their own behalf. Most of these cases involve patients whose medical diagnoses and prognoses are poor—either in the sense that continued treatment will not improve the quality of their life or cure the underlying illness or disease. Courts have allowed persons inflicted with amyotrophic lateral sclerosis (Lou

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[106] Selecting a standard for determining "competency" presents a host of complex issues that lie beyond the scope of this article. For a useful introduction to the various legal and medical standards of competency, see T. GRISSO, EVALUATING COMPETENCIES (1986); Roth, Meisel & Lidz, *Tests of Competency to Consent to Treatment*, 134 AM. J. PSYCHIATRY 279 (1977); Note, *Determining Patient Competency In Treatment Refusal Cases*, 24 GA. L. REV. 733 (1990). Courts have sometimes upheld the right of patients to refuse life-sustaining treatment when the choice was unequivocal, but the mental health of the patient was suspect. *E.g.*, Lane v. Candura, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978) (77-year-old woman who was "lucid on some matters and confused on others" was allowed to refuse to submit to amputation of her leg that had become infected with gangrene); *In re* Quackenbush, 156 N.J. Super. 282, 383 A.2d 785 (1978) (elderly patient subject to fluctuations in mental lucidity was deemed competent to refuse operation to amputate gangrenous legs). In each case, the court was satisfied that the patient was capable of appreciating the nature and consequences of the decision to forgo treatment.

Gerhig's Disease) to be disconnected from their respirators even when doing so was certain to bring death.[107] In these cases, continued use of the respirator would only postpone the moment of death as the disease is both progressive and inevitably fatal. The state's interest in preserving the sanctity of life is said to be threatened more "by the failure to allow a competent human being the right of choice" than by allowing a terminal illness to take its unstoppable course.[108] Similarly, the death is not considered suicide as it "merely allows the disease to take its natural course . . . and not the result of a self-inflicted injury."[109]

Other patients have an incurable, but not terminal, condition that makes life difficult to endure. Elizabeth Bouvia suffers from cerebral palsy[110] and Larry McAfee was rendered quadriplegic by a motorcycle accident.[111] Ms. Bouvia can be kept alive in her current condition through feeding tubes. Mr. McAfee cannot breath on his own and requires the use of a respirator. Each felt that their lives were or could become unbearable and successfully obtained a court order authorizing the discontinuance of their respective life support systems upon their request.[112] In each instance, the clarity of the patient's personal choice coupled with the unfavorable medical diagnosis and prognosis trumped any countervailing state interests.[113] The result reached in both cases illustrates that, while courts purport to balance individual and state interests, patient choice is the primary substantive legal standard.

Although the controlling substantive standard in cases like *Bouvia* and *McAfee* is clear, little is said about the process by which the decision is made. Who determines whether the patient is competent? Who conducts the balancing process? Must the parties ask courts to make or review these decisions before life-sustaining

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[107] *See* Satz v. Perlmutter, 379 So. 2d 359 (Fla. 1980); *In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987); *cf.* Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984) (holding that, with incurable tumor on lung, disconnection still allowed).

[108] *In re Farrell*, 108 N.J. at 349, 529 A.2d at 411 (quoting *In re* Conroy, 98 N.J. 321, 350, 486 A.2d 1209, 1224) (1985).

[109] *Id.* at 350, 529 A.2d at 411.

[110] Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986).

[111] State v. McAfee, 259 Ga. 579, 385 S.E.2d 651 (1989).

[112] *Bouvia*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297; *McAfee*, 259 Ga. 579, 385 S.E.2d 651.

[113] The courts in *Bouvia* and *McAfee* relied on similar rationales. At last report, neither patient has yet invoked their judicially recognized right to refuse treatment.

treatment may be withdrawn or withheld from competent patients? Some courts have expressed dismay at the delay and cost associated with such judicial procedures, but offer no specific nonjudicial alternatives.[114] Perhaps courts are less concerned about process in this class of cases because the controlling substantive principle is patient self-determination and the patient is presently able to clearly express her choice. The patient's competency at the very moment the life-and-death decision is made reduces the risk of inaccurately determining her actual treatment preferences.

The recent case of *McKay v. Bergstedt*[115] provides the most comprehensive discussion of the procedural aspects of right-to-die cases involving competent patients. The Nevada Supreme Court distinguished between competent patients with terminal illness and those with nonterminal conditions. The terminal patient[116] may exercise her right to refuse treatment without resort to judicial proceeding if two non-attending physicians attest that (a) the patient is terminal; (b) the condition is irreversible; (c) the patient is mentally competent to understand her medical prognosis; (d) the patient has been informed of treatment alternatives; and (e) the patient appears free from coercion or pressure in making her decision.[117] If the patient is not suffering from a terminal condition (that is, could live six months or more with treatment) the non-attending physicians must additionally inform the patient of "care options available to the patient through governmental, charitable and private sources."[118] The nonterminal patient must secure judicial approval before life-sustaining treatment can be withheld or

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[114] *See, e.g.*, Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); Satz v. Perlmutter, 379 So. 2d 359 (Fla. 1980); State v. McAfee, 259 Ga. 579, 385 S.E.2d 651 (1989); *In re* Farrell, 108 N.J. 335, 357, 529 A.2d 404, 415 (1987).

[115] 801 P.2d 617 (Nev. 1990). Kenneth Bergstedt was a thirty-one-year-old quadriplegic who sought a judicial order permitting the removal of his respirator. Thus, the case is similar to *Bouvia* and *McAfee* in that the patient was competent and suffered from a noncurable, but nonterminal, condition. Mr. Bergstedt's petition was motivated by the pending death of his father and a fear of "being left at the mercy of strangers." *Id.* at 619 n.1. Bergstedt died before the case was decided. The Nevada Supreme Court ultimately upheld Bergstedt's right to refuse treatment.

[116] Terminal condition is defined by the court in terms of a life expectancy of six months or less. *Bergstedt*, 801 P.2d at 630.

[117] *Id.*

[118] *Id.* This additional information is needed to protect what the Nevada court identified as a fifth state interest—encouraging the charitable and humane care of inflicted persons. *Id.* at 628.

withdrawn. Thus, the court "shall determine [whether] the interests of the State outweigh the [nonterminal] patient's rights to refuse or terminate medical treatment."[119]

Whether *Bergstedt*'s elaborate procedural mechanism will be adopted by other states remains to be seen. The requirement of balancing personal against state interests in cases involving nonterminal patients suggests that there might be circumstances where state interests will override the clearly expressed contrary preferences of competent individuals. Perhaps the *Bergstedt* court would give greater weight to the state's interests when the medical prognosis with treatment is favorable, or if interests of third parties were more clearly implicated. The next group of cases presents such a situation.

2. Competent Patients With a Favorable Prognosis: Jehovah's Witnesses and Blood Transfusions. One of the earliest fact patterns in which courts considered the right of a competent adult to refuse treatment involved Jehovah's Witnesses who objected to blood transfusions.[120] In most instances, the patient enjoyed a favorable prognosis if the blood transfusion were given. That is, the treatment would likely save the patient's life and allow a complete recovery from the underlying illness or injury.

Several early decisions authorized blood transfusions over the objections of the competent adult.[121] These decisions were justified in terms of the state's interest in preserving life,[122] preventing the commission of suicide[123] or protecting the interest of minor children.[124] Perhaps the most widely cited expression of this latter in-

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[119] *Id.* at 631.

[120] The objection was first articulated in terms of religious freedom under the first amendment. *E.g., In re* President of Georgetown College, 331 F.2d 1000 (D.C. Cir. 1964). More recent cases raise the additional issue of a general right of privacy. *See, e.g.*, Norwood Hosp. v. Munoz, 564 N.E.2d 1017 (Mass. 1991); *In re* Brown, 478 So. 2d 1033 (Miss. 1985).

[121] We are dealing here only with cases in which the patient is a competent adult. The constitutional authority of the state to compel life-saving blood transfusions for children over the objections of their parents has long been established. Jehovah's Witnesses v. King County Hosp., 390 U.S. 598 (1968); *In re* McCauley, 565 N.E.2d 411 (Mass. 1991).

[122] *See, e.g.*, John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 584, 279 A.2d 670, 674 (1971). *Quinlan* did not overrule *Heston* on this point. The *Quinlan* court explained that the state's interest in preserving life diminished when the prognosis of the patient is poor. 70 N.J. at 41-42, 355 A.2d at 664.

[123] *See, e.g., Georgetown College*, 331 F.2d at 1008-09.

[124] *See, e.g., id.* at 1008; *In re* Winthrop Univ. Hosp., 128 Misc. 2d 804, 490 N.Y.S.2d 996 (Sup. Ct. 1985).

terest appears in *In re President of Georgetown College*[125] when the highly respected jurist Skelly Wright explained:

> The patient, 25 years old, was the mother of a seven-month-old child. The state, as *parens patriae*, will not allow a parent to abandon a child, and so it should not allow this most ultimate of voluntary abandonments. The patient had a responsibility to the community to care for her infant. Thus the people had an interest in preserving the life of this mother.[126]

Other decisions, however, have upheld the right of the adult Jehovah's Witness to refuse a blood transfusion even when death is likely to ensue and the patient has minor children.[127] In *Fosmire v. Nicoleau*,[128] for example, a pregnant adult Jehovah's Witness went into labor prematurely and her child was delivered by a Caesarean section. The mother then began to hemorrhage and her doctors determined that she would die unless she had a blood transfusion. The New York Court of Appeals affirmed the woman's right to refuse the blood transfusion. The court specifically ruled that the common-law right to refuse treatment was not limited to instances in which the patient suffered a terminal or incurable condition.[129] In addition, the court found that the state's interest in protecting minor children did not justify overriding the patient's decision to forgo treatment, at least when there would be one surviving parent capable of caring for the child.[130] A concurring opinion would give

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[125] 331 F.2d 1000 (D.C. Cir. 1964).

[126] *Georgetown College*, 331 F.2d at 1008.

[127] *See In re* Osborne, 294 A.2d 372 (D.C. Ct. App. 1972); Public Health Trust v. Wons, 541 So. 2d 96 (Fla. 1989); Norwood Hosp. v. Munoz, 569 N.E.2d 1017 (Mass. 1991); *cf. In re* Estate of Brooks, 32 Ill. 2d 361, 205 N.E.2d 435 (1965) (upholding right of competent adult to refuse blood transfusion; no minor children involved); Mercy Hosp. v. Jackson, 62 Md. App. 409, 489 A.2d 1130 (1985) (upholding right of pregnant woman to refuse blood transfusion during Caesarean section delivery when refusal posed no risk to child), *vacated as moot*, 306 Md. 556, 510 A.2d 562 (1986); *In re* Brown, 478 So. 2d 1033 (Miss. 1985) (upholding right of adult to refuse blood transfusion in face of state's argument that patient was needed to testify in the prosecution of a serious crime).

[128] 75 N.Y.2d 218, 551 N.E.2d 77, 551 N.Y.S.2d 876 (1990).

[129] *Id.* at 228-30, 551 N.E.2d at 82-83, 551 N.Y.S.2d at 881-82. The implication of this and other Jehovah's Witnesses cases on the general right to refuse treatment is clouded, however, by the additional consideration of religious freedom. *See, e.g., id.* at 234, 551 N.E.2d at 86, 551 N.Y.S.2d at 885 (Simmons, J., concurring).

[130] *Id.* at 230-31, 551 N.E.2d at 83-84, 551 N.Y.S.2d at 882-83. It may be important that the father was available and able to care for the child should the mother die. The court

the state's interests greater weight when the patient's condition is neither terminal nor incurable and the treatment poses few risks and is likely to completely restore the patient's health.[131]

The differences reflected among and within these decisions illustrate the variability of any balancing test. The balance between individual and state interests may be struck differently depending on the prevailing values of the tribunal.[132] To the extent that the right to refuse treatment rests on common law, considerable room remains for experimentation among the states. State constitutional law may place limitations on state legislative initiatives, but still allow for differences among the states. A balance struck as a matter of federal constitutional law imposes even greater limits on legislative or judicial experimentation.[133]

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recognized that some decisions suggest that the state could compel a blood transfusion if the child would otherwise be left parentless. The majority opinion does not express its agreement or disagreement with these decisions. *Id.* at 229, 551 N.E.2d at 82-83, 551 N.Y.S.2d at 881-82.

[131] *Id.* at 232-33, 551 N.E.2d at 84-85, 551 N.Y.S.2d at 884 (Simons, J., concurring). The dissenting justice in a recent Florida Supreme Court opinion similarly criticizes the majority for failing "to recognize the distinction between cases where the prognosis that the patient can be restored to normal life with proper medical procedures is extremely good and cases where the possibility of recovery is slight and the person is diagnosed as terminal." Public Health Trust v. Wons, 541 So. 2d at 104 (Overton, J., dissenting).

[132] Cases involving the forced treatment of prison inmates offer yet another example of how courts reach different conclusions in striking the balance between state and individual interests. Most courts have found that incarceration diminishes the individual's interest in refusing treatment, while at the same time, the need to maintain discipline and control in the prison setting increases the state's interest in compelling treatment. Thus, the balance is most often struck in favor of government-compelled treatment. *E.g.*, Washington v. Harper, 110 S. Ct. 1028, 1039-40 (1990) (upholding forced administration of anti-psychotic drugs); Commissioner of Correction v. Myers, 379 Mass. 255, 265, 399 N.E.2d 452, 458 (1979) (allowing forced hemodialysis); Von Holden v. Chapman, 87 A.D. 2d 66, 69, 450 N.Y.S. 2d 623, 626 (App. Div. 1982) (allowing forced feeding of inmate attempting to starve himself); Department of Pub. Welfare v. Kallinger, 580 A.2d 887, 893 (Pa. Commw. 1990) (permitting involuntary administration of nutrition and hydration to prisoner); West Virginia *ex rel.* White v. Narick, 292 S.E.2d 54, 58 (W. Va. 1982) (upholding forced feeding of inmate on a hunger strike). The Supreme Court of Georgia, on the other hand, affirmed a lower court's determination that the state does not "have the right to feed . . . [an inmate] to prevent his death from starvation if that is his wish." Zant v. Prevatte, 248 Ga. 832, 833, 286 S.E. 2d 715, 716 (1982). *See generally*, Comment, *Forced Feeding of a Prisoner on a Hunger Strike: A Violation of an Inmate's Right of Privacy*, 61 N.C.L. REV. 714 (1983) (concluding that prisoners have constitutional right to be free from force-feeding).

[133] *See supra* notes 83-87 and accompanying text.

B. Formerly Competent Patients With "Clear" Evidence of Treatment Preference

1. Substituted Judgment as the Standard for Decisionmaking. Most right-to-die cases involve patients who once were competent, but are not currently capable of directing their treatment. These persons are the victims of automobile accidents,[134] strokes[135] and other debilitating conditions.[136] As these patients are currently incompetent, treatment decisions must be rendered by a surrogate or proxy. Courts have exhibited a strong preference for naming family members as the appropriate surrogate decisionmaker.[137] Sometimes a close friend may be appointed to be the proxy decisionmaker,[138] or the patient may have previously designated a specific individual to act in that capacity.[139] Regardless of who is named to make decisions on behalf of the now-incompetent patient, courts must determine the appropriate substantive basis for decisionmaking.

In many instances, there is evidence indicating whether these patients would choose to continue receiving treatment if able to express their preference. In such cases, the value of patient self-determination supports the adoption of substituted judgment as the substantive standard for surrogate decisionmaking.[140] However, some courts and commentators have expressed reservations about

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[134] *See, e.g.*, Cruzan v. Harmon, 760 S.W.2d 408, 410-11 (Mo. 1988), *aff'd sub nom.* Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841 (1990).

[135] *See, e.g., In re* Westchester County Medical Center *ex rel.* O'Connor, 72 N.Y.2d 517, 523, 531 N.E.2d 607, 608-09, 534 N.Y.S.2d 886, 887-88 (1988).

[136] *See, e.g.*, Brophy v. New England Sinai Hosp., 398 Mass. 417, 421, 497 N.E.2d 626, 628 (1986) (disabling aneurysm).

[137] "Family members are best qualified to make substituted judgments for incompetent patients not only because of their peculiar grasp of the patient's approach to life, but also because of their special bonds with him or her. Our common human experience informs us that family members are generally most concerned with the welfare of a patient. It is they who provide for the patient's comfort, care, and best interests . . . ." *In re* Jobes, 108 N.J. 394, 416, 529 A.2d 434, 445 (1987). *See also*, John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921, 925-26 (Fla. 1984); *In re* Estate of Longeway, 133 Ill. 2d 33, 50, 549 N.E.2d 292, 300 (1989). *See generally*, Comment, *The Role of the Family in Medical Decisionmaking for Incompetent Adult Patients: A Historical Perspective and Case Analysis*, 48 U. PITT. L. REV. 539 (1987).

[138] *E.g., In re* Storar, 52 N.Y.2d 363, 371-73, 420 N.E.2d 64, 67-68, 438 N.Y.S.2d 266, 269-70 (1981).

[139] *See, e.g., In re* Peter, 108 N.J. 365, 370-71, 529 A.2d 419, 422 (1987); *cf. In re* Browning, 568 So. 2d 4, 13, 15 (Fla. 1990) (noting court's approval of use of powers of attorney).

[140] *See generally*, A. MEISEL, *supra* note 50, §§ 9.10-9.13.

the substituted judgment standard in this context. Professors Robertson and Dresser argue that statements made in the past cannot adequately take into account interests of the speaker that become clear only after she becomes incompetent.[141] Consequently, they conclude, a surrogate's decision based on the patient's past statements of treatment preferences may not adequately protect the patient's current interests. New York courts recognize the "inherent problems" in relying on past statements to determine present intent.[142] The patient may have "since changed his or her mind" or the assumed medical circumstances that prompted the past statements may not "coincide perfectly" with the patient's current conditions.

Notwithstanding these concerns, courts have overwhelmingly embraced substituted judgment as the basis for surrogate decisionmaking. The surrogate decisionmaker is to be guided by the treatment choice the patient would make if competent to do so. When the evidence is "clear" that the patient would refuse life-sustaining treatment, courts have consistently upheld the authority of the surrogate decisonmaker to withhold consent,[143] regardless of whether the patient is deemed "terminal"[144] or of the nature of the

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[141] Dresser and Robertson, *Quality of Life and Non-Treatment Decisions for Incompetent Patients: A Critique of the Orthodox Approach*, 17 LAW, MED. & HEALTH CARE 234, 238-39 (1989); Dresser, *supra* note 50; Robertson, *supra* note 50; *cf. In re* Storar, 52 N.Y.2d 363, 380, 420 N.E.2d 64, 72, 438 N.Y.S.2d 266, 274 (1981) (discussing incompetent patient's right to self-determination).

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

[143] *See, e.g., In re* Browning, 568 So. 2d 4 (Fla. 1990); *In re* Gardner, 534 A.2d 947 (Me. 1987); *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987). The cases in which life-sustaining treatment was continued over the objection of the proxy decisionmaker involved patients whose treatment preferences were not deemed clear. For an example, see *infra* notes 160-63 and accompanying text.

[144] Some judicial opinions are limited by their facts to instances involving "terminal" patients. *See, e.g.*, McConnell v. Beverly Enters.-Conn., Inc., 209 Conn. 692, 553 A.2d 596 (1989); John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921 (Fla. 1984); *In re* Estate of Greenspan, 137 Ill. 2d 1, 558 N.E.2d 1194 (1990). Other opinions authorize surrogate decisionmakers to withhold life-sustaining treatment even when death is not imminent. *E.g., In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987). Some confusion may exist because judicial opinions often do not elaborate on the legal or medical meaning of the word "terminal." A persistent vegetative state apparently is considered a terminal condition by some courts but not by others. *Compare McConnell*, 209 Conn. at 696, 553 A.2d at 598 ("She is in an irreversible persistent vegetative state . . . her condition is terminal . . . .") *with Peter*, 108 N.J. at 371, 529 A.2d at 422 ("Though she is vegetative without any hope of recovery . . . [s]he could survive for many years, possibly decades."). In any event, there are no reported

treatment to be withheld.[145]

2. Procedural Issues. Procedure takes on additional importance in right-to-die cases involving incompetent patients. Any misjudgment about the patient's intent would either be fatal or result in unwanted treatment that might only prolong the dying process. Consequently, it is crucial that the procedures by which one determines an incompetent patient's subjective desire be designed to reduce the risk of error. At the same time, judicial opinions often convey a concern for privacy and efficiency. That is, many opinions express the view that treatment decisions for incompetent patients should ordinarily be made without judicial involvement. The procedural dynamics of right-to-die cases often reflect an effort to accommodate the competing and sometimes inconsistent objectives of reducing error and protecting privacy.

There is widespread support for requiring "clear and convincing evidence" of the incompetent patient's desire to refuse treatment.[146] The Supreme Court in *Cruzan* explained that this heightened level of proof provides appropriate protection against an erroneous decision to terminate life-sustaining treatment.[147] What

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appellate decisions ordering the continuation of treatment when the incompetent patient's previously expressed desire to refuse treatment was deemed "clear." The only instances of compelled treatment involve incompetent patients whose treatment preferences were not known. *E.g.* Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988), *aff'd sub nom.* Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841 (1990); *O'Connor*, 72 N.Y.2d at 517, 531 N.E.2d at 607, 534 N.Y.S.2d at 886. The decisive factor appears to be the clarity of patient's prior expression of treatment preference rather than the characterization of the underlying condition as terminal.

[145] Courts have not distinguished between the withholding of nutrition and hydration and the withholding of other forms of life-sustaining treatment. When satisfied that the patient would not want such treatment initiated or continued, courts have authorized surrogate decisionmakers to withhold consent. *See, e.g.*, *McConnell*, 209 Conn. at 705, 553 A.2d at 603 ("no logical distinction between removal of a respirator and removal of a gastrostomy tube"); *Browning*, 568 So. 2d at 11-12; *In re* Estate of Longeway, 133 Ill. 2d 33, 54-55, 549 N.E.2d 292, 301-02 (1989); *Gardner*, 534 A.2d at 954. Some legislatures, on the other hand, exclude nutrition and hydration from the definition of "life support systems" that may be discontinued under their living-will statutes. *See infra* notes 218 & 254-259 and accompanying text; *see also* OKLA. STAT. ANN. tit. 63, §§ 3102 to 3103 (West Supp. 1991) (placing restrictions on withdrawal of food and water from incompetent patients).

[146] *E.g.*, *McConnell*, 209 Conn. at 708, 553 A.2d at 605; *Browning*, 568 So. 2d at 15; *Longeway*, 133 Ill. 2d at 50-51, 549 N.E.2d at 300; *Gardner*, 534 A.2d at 953; *O'Connor*, 72 N.Y.2d at 529, 531 N.E.2d at 612, 534 N.Y.S.2d at 891.

[147] "We believe that Missouri may permissibly place an increased risk of an erroneous decision on those seeking to terminate an incompetent individual's life-sustaining treatment. An erroneous decision not to terminate results in a maintenance of the status quo

constitutes clear and convincing evidence, however, is somewhat subjective and often controversial.

There are several types of relevant evidence to be considered in assessing a formerly competent patient's subjective desires. Perhaps the most persuasive evidence is written documentation, such as a living will or durable power of attorney for healthcare.[148] Indeed, the Florida Supreme Court has ruled that "a written declaration or designation of proxy, in the absence of any evidence of intent to the contrary, establishes a rebuttable presumption that constitutes clear and convincing evidence of the patient's wishes."[149]

Written documentation of the incompetent patient's intent is rare, however.[150] Most courts are forced, as a practical matter, to consider the oral statements of the patient as evidence of intent.[151] Prior out-of-court statements by the patient may be admissible evidence within the "existing state of mind" exception to the hearsay rule.[152] Intent may also "be deduced from a person's religious beliefs . . . or from the patient's consistent pattern of conduct with respect to prior decisions about his own medical care."[153]

The most critical evidentiary aspect of these cases is not the type of evidence, but rather the weight the evidence ought to be

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. . . . An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction." *Cruzan*, 110 S. Ct. at 2854.

[148] *See, e.g., In re* Conroy, 98 N.J. 321, 361, 486 A.2d 1209, 1229-30 (1985); *see also In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987) (holding agent designated pursuant to durable power of attorney is authorized to order removal of nasogastric feeding tube).

[149] *Browning*, 568 So. 2d at 16.

[150] *See Cruzan*, 110 S. Ct. at 2857 (O'Connor, J., concurring).

[151] *See, e.g.*, McConnell v. Beverly Enters.-Conn., Inc., 209 Conn. 692, 696-97, 553 A.2d 596, 598-99 (1989); *In re* Gardner, 534 A.2d 947, 953 (Me. 1987); *Conroy*, 98 N.J. at 362, 486 A.2d at 1230; *In re* Storar, 52 N.Y.2d 363, 371-72, 379-80, 420 N.E.2d 64, at 67-68, 72, 438 N.Y.S.2d 266, 269-70, 274 (1981).

[152] *Conroy*, 98 N.J. at 361 n.6, 486 A.2d at 1230 n.6; *see also, In re* Torres, 357 N.W.2d 332, 341 (Minn. 1984) (probate judge "should be given wide latitude in admitting testimony [of prior statements of patient] because 'the proceeding is not by its nature an adversarial one.' ") (quoting argument by respondent conservator in favor of lower court's fact-finding process).

[153] *Conroy*, 98 N.J. at 361-62, 486 A.2d at 1230. *But cf. In re* Estate of Dorone, 349 Pa. Super. 59, 73-75, 502 A.2d 1271, 1278-79 (1985). *Dorone* affirmed the decision of lower court to appoint a guardian to authorize administration of blood transfusion to twenty-two-year-old Jehovah's Witness who had signed "medical alert" card stating "I direct that no blood transfusions be administered to me even though others deem such necessary to preserve my life or health." *Id.* at 70, 502 A.2d at 1277.

given. When do past statements constitute "clear" evidence that the now incompetent patient would refuse treatment? The context[154] and specificity of the prior oral statements by the patient may be very important. Statements that are made under reflective conditions are more probative of the patient's intent than those that appear to be offhand remarks.[155] Another important consideration is how closely the assumed conditions in the patient's prior statement approximate her current condition.[156] Some statements are remarkably specific about the circumstances in which the patient would refuse life-sustaining treatment.[157] Other statements by the patient concerning treatment are more generalized.

Some courts are more demanding than others in determining whether general statements reflect an intent to refuse specific treatment. Massachusetts courts may represent the less demanding end of the spectrum. Ten years before suffering a disabling aneurysm, Paul Brophy commented on the Karen Quinlan case and stated: "I don't ever want to be on a life-support system. No way do I want to live like that; that is not living."[158] The court relied on this and other generalized statements in concluding that the now-

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[154] "We conclude that prior statements may be probative in determining the wishes of an incompetent patient, with the age and maturity of the patient, the context of the statements, and the connection of the statements to the debilitating event being factors to be weighed by the guardian." *In re* Colyer, 99 Wash. 2d 114, 131-32, 660 P.2d 738, 748 (1983).

[155] *Compare In re* Storar, 52 N.Y.2d 363, 380, 420 N.E.2d 64, 72, 438 N.Y.S.2d 266 (1981) ("These were obviously solemn pronouncements and not casual remarks made at some social gathering, nor can it be said that he was too young to realize or feel the consequences of his statements.") *with Conroy*, 98 N.J. at 362-63, 486 A.2d at 1230 ("[A]n offhand remark about not wanting to live under certain circumstances made by a person when young and in the peak of health would not in itself constitute clear proof twenty years later that he would want life-sustaining treatment withheld under those circumstances.").

[156] "[I]t is relevant to the fundamental question—the patient's desires—to consider whether the infirmities she was concerned with and the procedures she eschewed are qualitatively different than those now presented." *In re* Westchester County Medical Center *ex rel.* O'Connor, 72 N.Y.2d 517, 533, 531 N.E.2d 607, 614, 534 N.Y.S.2d 886, 893 (1988).

[157] *See, e.g.*, McConnell v. Beverly Enters.-Conn., Inc., 209 Conn. 692, 696, 553 A.2d at 596, 599 (1989) ("She had, in fact, expressly and repeatedly told her family and her coworkers that, in the event of her permanent total incapacity, she did not want to be kept alive by any artificial means, including life-sustaining feeding tubes."); *In re* Gardner, 534 A.2d at 947, 949 (Me. 1987) ("Prior to the 1985 accident Gardner had declared his 'intent and desire that he not be maintained on the nasogastric tube'; that he would rather die than be maintained in a persistent vegetative state by artificial means.").

[158] Brophy v. New England Sinai Hosp., 398 Mass. 417, 428 n.22, 497 N.E.2d 626, 632 n.22 (1986). *See also In re* Torres, 357 N.W. 2d 332, 340-41 (Minn. 1984) (upholding admission of "speculative" hearsay evidence of the patient's views of life-sustaining treatment).

vegetative Brophy would direct the removal of his feeding tube if he were able to do so, even though the *Quinlan* case did not involve a feeding tube.[159]

A more demanding approach is reflected in the case of *In re Westchester County Medical Center ex rel. O'Connor*.[160] Mary O'Connor was a seventy-seven-year-old widow who had suffered several strokes. Although severely physically and mentally impaired, O'Connor was neither comatose nor vegetative. As her condition deteriorated, O'Connor became unable to feed herself. O'Connor's daughters objected to the hospital's request to insert a nasogastric feeding tube.[161] The daughters believed that their mother would not want to be kept alive in such a manner. O'Connor had expressed her desire to decline lifesaving treatments over a number of years. Yet the New York Court of Appeals found that "[h]er comments—that she would never want to lose her dignity before she passed away, that nature should be permitted to take its course, that it is 'monstrous' to use life-support machinery—are, in fact, no different than those that many of us might make after witnessing an agonizing death."[162] Such statements were not deemed clear and convincing evidence because "Mrs. O'Connor had never discussed providing food or water with medical assistance, nor had she ever said that she would adhere to her view and decline medical treatment 'by artificial means' if that would produce a painful death."[163]

Thus, while courts appear willing to be guided by the clear direction of the now-incompetent patient, they may often disagree concerning whether the direction is clear.[164] The rigor with which

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[159] In addition to Brophy's expressed preferences, the court also considered "his religious convictions and their relation to refusal of treatment . . . the impact on his family . . . the probability of adverse side effects . . . the prognosis, both with and without treatment." *Brophy*, 398 Mass. at 427, 497 N.E.2d at 631.

[160] 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988).

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

[162] *Id.* at 532, 531 N.E.2d at 614, 534 N.Y.S.2d at 893.

[163] *Id.* at 527, 531 N.E.2d at 611, 534 N.Y.S.2d at 890. *See also* Cruzan v. Harmon, 760 S.W.2d 408, 424 (Mo. 1988), *aff'd sub nom.* Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841 (1990); *cf. In re* Jobes, 108 N.J. 394, 412, 529 A.2d 434, 443 (1987) ("All of the statements about life-support that were attributed to Mrs. Jobes were remote, general, spontaneous, and made in casual circumstances.").

[164] The cases reflect substantial disagreement within as well as among courts. The four member majority in *In re Gardner* found that prior to becoming incompetent, the patient had clearly declared his " 'intent and desire that he not be maintained on the nasogastric

courts demand clear and convincing evidence may have a greater effect on the outcome of cases than any other individual factor.

Even if a court or surrogate decisionmaker is satisfied that the incompetent patient would refuse life-sustaining treatment if his condition was "terminal" or otherwise irreversible, the question remains whether this medical pre-condition exists. A second common procedural safeguard is the requirement of an independent confirmation of the patient's medical diagnosis and prognosis. The New Jersey Supreme Court in *Quinlan* suggested that this confirmation might be made by a hospital ethics committee.[165] The Washington Supreme Court called for consultations with a "prognosis board."[166] The most common practice is to require two consulting physicians to concur in the diagnosis and prognosis.[167] Patients residing in nursing homes may be subject to special considerations. Many states have enacted legislation to safeguard against the abuse of the elderly who reside in nursing homes.[168] The New Jersey Office of the Ombudsman, under its statutory authority to investigate suspected "abuse," has been charged by the courts to investigate the withholding or withdrawal of life-sustaining treatment from elderly nursing home patients.[169] These various forms of "second opinions" help guarantee that the surrogate decisionmaker is guided by an accurate assessment of the incompetent patient's medical condition.

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tube.' " 534 A.2d 947, 949 (Me. 1987) (quoting facts found by lower court). The three dissenting justices did not find the patient's declaration to be so clear and argued that the decision to refuse treatment should be at least as informed as the decision to consent to treatment. *Id.* at 956-57 (Clifford, J., dissenting). Similarly, the four member majority of the Missouri Supreme Court found that the evidence of Nancy Cruzan's treatment preference fell below the clear and convincing standard, *Cruzan*, 760 S.W. 2d at 424, while the three dissenting justices would have affirmed the trial court's ruling on that issue. *Id.* at 443-44 (Higgins, J., dissenting).

[165] *In re* Quinlan, 70 N.J. 10, 49-51, 355 A.2d 647, 668-69 (1976). In *In re Jobes*, the court observed that 85% of New Jersey's acute-care hospitals have established prognosis committees. 108 N.J. 394, 421, 529 A.2d 434, 448 (1987).

[166] *In re* Colyer, 99 Wash. 2d 114, 134, 660 P.2d 738, 749 (1983).

[167] *E.g.*, John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921, 926 (Fla. 1984); *In re* Estate of Longeway, 133 Ill. 2d 33, 48, 549 N.E.2d 292, 299 (1989); *In re* Conroy, 98 N.J. 321, 384, 486 A.2d 1209, 1242 (1985).

[168] *See generally* S. JOHNSON, N. TERRY & M. WOLFF, NURSING HOMES AND THE LAW: STATE REGULATION AND PRIVATE LITIGATION (1985).

[169] *Conroy*, 98 N.J. at 383-84, 486 A.2d at 1242; *see also In re* Peter, 108 N.J. 365, 383, 529 A.2d 419, 429 (1987); *cf. Jobes*, 108 N.J. at 422, 529 A.2d at 448 (stating Ombudsman has no jurisdiction over nursing home residents under age of 60).

A third procedural issue concerns the role of the courts. There is little doubt that judicial procedures are cumbersome and expensive; but they might provide important protections against hasty and fatal decisions. Florida,[170] Washington,[171] New York[172] and New Jersey[173] courts have expressed a desire to minimize judicial involvement in the right-to-die process. So long as the patient's family (or other designated proxy), physicians and appropriate outside consultants agree, a decision to withhold or withdraw life-sustaining treatment may be implemented without judicial approval.[174] Of course, courts in these jurisdictions remain open to resolve disputes should there be any disagreement about the patient's intent or medical condition.

Other states appear to favor judicial involvement in most, if not all, cases. The Illinois Supreme Court, for example, recognized that the "slow, deliberate nature of the court system may frustrate the family and loved ones of the patient."[175] Nonetheless, it held that judicial approval of a decision to withdraw artificially administered nutrition and hydration was necessary. The admittedly slow judicial process was needed to (1) protect the state's interest in preserving the sanctity of human life; (2) "guard against the remote, yet real possibility that greed may taint the judgment of the surrogate decisionmaker"; (3) enable the court to protect the estate and person of incompetents; and (4) guarantee procedural due process

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[170] *In re* Browning, 568 So. 2d 4, 15-16 (Fla 1990); *Bludworth*, 452 So. 2d at 926.

[171] *Colyer*, 99 Wash. 2d at 136-37, 660 P.2d at 750-51; *In re* Grant, 109 Wash. 2d 545, 566, 747 P.2d 445, 456 (1987).

[172] *In re* Storar, 52 N.Y.2d 363, 382-83, 420 N.E.2d 64, 74, 438 N.Y.S.2d 266, 276 (1981).

[173] *In re* Jobes, 108 N.J. 394, 423, 529 A.2d 434, 449 (1987).

[174] Note that there are varying degrees of judicial non-involvement within these cases. For example, the *Colyer* court required the judicial appointment of a guardian in all cases. 99 Wash. 2d at 136, 660 P.2d at 750. In *Grant*, the Washington Supreme Court stated that the judicial appointment of a guardian is necessary only when the family's consent to the withdrawal of treatment is not unanimous. 109 Wash. 2d at 566 n.4, 747 P.2d at 456 n.4. Once appointed, the guardian may act without judicial approval of treatment decisions. *Id.* at 566-67, 747 P.2d at 456. Florida does not even require the judicial appointment of the guardian. *Browning*, 568 So. 2d at 17.

[175] *In re* Estate of Longeway, 133 Ill. 2d 33, 52, 549 N.E.2d 292, 301 (1989). *See also* Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 758, 370 N.E.2d 417, 434 (1977) (rejecting *Quinlan*'s use of hospital ethics committee and requiring judicial appointment of guardian); *cf. In re* Torres, 357 N.W.2d 332, 341 n.4 (Minn. 1984) (holding that judicial approval of decision to remove respirator was necessary in the present case, but suggesting that judicial approval is not essential in all cases).

to those whose life may be deprived pursuant to state law.[176]

The majority opinion in *Cruzan* does not indicate whether clear past directives of now-incompetent patients must be obeyed as a matter of federal constitutional law.[177] State courts appear willing to do so. Nonetheless, the cases discussed above reflect substantial differences among and within courts in determining whether a patient's directive is clear. *Cruzan* signals that lower court rulings on this evidentiary point are not likely to be reversed as a matter of federal constitutional law.[178] Thus, factually similar cases may be decided differently in different jurisdictions. The most fertile ground for substantive experimentation lies in cases involving incompetent patients who do not provide clear evidence of their treatment choice. We now turn to those cases.

C. Incompetent Patients With No Clear Evidence of Treatment Preference

Patients who fall into this category cannot now speak for themselves and did not leave clear evidence of their treatment preferences. Some, such as infants and profoundly retarded adults,[179] were never able to articulate their desires. Others had the chance to do so, but simply did not make their preferences known with sufficient clarity.[180] Because of the absence of clear and convincing

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[176] *Longeway*, 133 Ill. 2d at 51-52, 549 N.E.2d at 300-01.

[177] *See* Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2856 n.12 (1990).

[178] *Id.* at 2855 (deferring to Missouri Supreme Court's conclusion that there was no clear and convincing evidence of Nancy Cruzan's wishes).

[179] *See, e.g., In re* Barry, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984) (terminally ill comatose 10-month-old child); *In re* L.H.R., 253 Ga. 439, 321 S.E.2d 716 (1984) (vegetative infant); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) (profoundly retarded terminally ill 67-year-old man); *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981) (profoundly retarded terminally ill 52-year-old man); *In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984) (42-year-old profoundly retarded man).

[180] *E.g, In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); *In re* Westchester County Medical Center *ex rel.* O'Connor, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988); *cf.* Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841 (1990) (affirming Missouri Supreme Court's decision that found Nancy Cruzan's statements did not constitute clear and convincing evidence of her intent to forego life-sustaining treatment). After the Supreme Court rendered its decision in *Cruzan*, the trial court considered "new evidence" of Nancy's intent. The trial court found that the additional testimony constituted clear and convincing evidence of Nancy's desire not to be maintained in a vegetative state by artificially administered feeding. The Missouri Attorney General did not participate in this proceeding, and no appeal was taken. The feeding tube was removed and Nancy died on December 26, 1990. Lewin, *Nancy Cruzan Dies, Outlived by Debate*

evidence of patient preference, a determination of substituted judgment becomes quite problematic, if not fictional.[181] Values other than patient self-determination take on a more influential role in shaping the law. Some decisions reflect the view that the primary concern of the courts should be the protection of incompetent persons.[182] Courts adopting this position tend to avoid any consideration of the patient's quality of life. The more prevailing view, however, incorporates qualitative factors into the analysis.[183]

As a starting point for our discussion, we distinguish between patients on the basis of their consciousness. Some individuals may be severely impaired, but retain a limited capacity to interact with their environment. Patients in a persistent vegetative state, however, no longer retain any cognitive brain function. The former class of patients may feel pain and pleasure in response to external stimulation, while the latter class do not appear to do so.[184] Perhaps it is not surprising that some states will demand greater caution in withholding or withdrawing life-sustaining treatment from patients with diminished consciousness than they require in cases involving vegetative patients. The experiences of New York,[185] New Jersey[186] and Missouri[187] illustrate how states may differ in formulating standards for dealing with requests to withdraw life-sustaining treatment from various types of incompetent patients who did not provide clear evidence of their treatment preferences.

1. Patients With Limited Consciousness.

a. The New York Approach: Protecting the Incompetent Patient's Interest in Sustaining Life

The New York courts highlighted the importance of protecting incompetent persons who leave no clear treatment directives in

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Over the Right to Die, N.Y. Times, Dec. 27, 1990, at A1, col. 1 (late ed.).

[181] *See* Minow, *Beyond State Intervention in the Family: For Baby Jane Doe*, 18 U MICH. J.L. REF. 933, 972-73 (1985) (characterizing substituted judgment as "fraught with guesswork"). For additional references, see *supra* notes 141-42 and accompanying text.

[182] For two New York decisions espousing this view, see *infra* notes 190-97 and accompanying text.

[183] *See infra* notes 198-203 and accompanying text.

[184] *See In re* Peter, 108 N.J. 365, 373-77, 529 A.2d 419, 423-25 (1987).

[185] *See infra* notes 188-97 and accompanying text.

[186] *See infra* notes 198-203, 208-13 and accompanying text.

[187] *See infra* notes 214-18 and accompanying text.

companion cases involving Brother Fox and John Storar.[188] In the first case, the state's high court allowed the guardian to authorize the removal of a respirator from Brother Fox because "the proof was compelling" that he would not want to be maintained in a permanent vegetative state.[189]

The second case involved an adult patient who had been profoundly retarded since birth. He suffered from a cancer that was not being treated and would soon kill him. His life could be prolonged for a few months in a relatively undiminished capacity by transfusions that simply replaced blood being lost through the cancerous lesions.[190] Storar's mother opposed the continuation of the transfusions because of her son's limited life expectancy, his inability to comprehend the nature of or need for the treatment and his occasional physical resistance to the treatment because he found them "disagreeable."[191] The court, concluding that it was impossible to determine whether the patient wanted to continue the treatment, wrote:

> John Storar was never competent at any time in his life. He was always totally incapable of understanding or making a reasoned decision about medical treatment. Thus it is unrealistic to attempt to determine whether he would want to continue potentially life prolonging treatment if he were competent.[192]

Lacking any clear direction from the patient, the court ordered the continuation of blood transfusions over the objections of his mother. The court believed that, given Storar's physical condition, such treatment was in the patient's best interests. In so ruling, the

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[188] *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, (1981) (combination of appeals from *In re* Storar, 78 A.D.2d 1013, 434 N.Y.S.2d 46 (1980) and Eichner v. Dillon, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980)).

[189] *Storar*, 52 N.Y.2d at 379, 420 N.E.2d at 72, 438 N.Y.S.2d at 274. Brother Fox was a member of a religious order which operated a high school. He stated his opposition to being maintained in a vegetative coma by a respirator in formal discussions of the *Quinlan* case conducted as part of the school's mission to teach and promulgate Catholic moral principles. *Id.* at 371-72, 420 N.E.2d at 68, 438 N.Y.S.2d at 270. Since his comments were "solemn pronouncements" that contemplated circumstances "identical" to his own, the court found they satisfied the clear and convincing evidence standard. *Id.* at 380, 420 N.E.2d at 72, 438 N.Y.S.2d at 274.

[190] *Id.* at 373-75, 420 N.E.2d at 69-70, 438 N.Y.S.2d at 271-72.

[191] *Id.* at 375, 420 N.E.2d at 69, 438 N.Y.S.2d at 271.

[192] *Id.* at 380, 420 N.E.2d at 72, 438 N.Y.S.2d at 274-75.

court upheld the role of the state as *parens patriae*, by not "allow[ing] an incompetent patient to bleed to death because someone, even someone as close as a parent or sibling, feels that this is best for one with an incurable disease."[193]

The court's commitment to protecting the life of incompetent persons was reinforced in *In re Westchester County Medical Center ex rel. O'Connor*.[194] Whereas John Storar was incapable of ever forming reasoned judgments about his own treatment, Mary O'Connor had repeatedly stated when competent that she would not want to be kept alive by artificial life support systems. Because her statements were general in nature, the court concluded they did not constitute clear and convincing evidence that she would want to have her feeding tube removed.[195] "Nothing less than unequivocal proof will suffice when the decision to terminate life supports is at issue."[196] The court explicitly refused to "substitute its judgment as to what would be an acceptable quality of life for another."[197]

John Storar was severely mentally impaired, terminally ill, but fully conscious. Mary O'Connor suffered from an incurable but not terminal condition. Although severely mentally impaired, O'Connor retained some limited consciousness. Despite their serious impairments, the New York courts refused to sanction the denial of life-sustaining treatment. Taken together, *Storar* and *O'Connor* reflect the view that quality of life factors should not be considered in determining what is in a patient's interest and whether to continue treatment. In New York, even severely impaired life must be judicially protected unless the individual patient has clearly chosen a contrary course.

b. The New Jersey Approach: Factoring in Quality of Life Considerations

Across the Hudson River from New York, New Jersey courts have plotted a different and more complex set of guidelines that expressly incorporate quality of life considerations. These guide-

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[193] *Id.* at 382, 420 N.E.2d at 73, 438 N.Y.S.2d at 275-76.
[194] 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988).
[195] *Id.* at 533-34, 531 N.E.2d at 615, 534 N.Y.S.2d at 894.
[196] *Id.* at 529, 531 N.E.2d at 612, 534 N.Y.S.2d at 891 (footnote omitted).
[197] *Id.* at 530, 531 N.E.2d at 613, 534 N.Y.S.2d at 892 (citation omitted).

lines, first articulated in *In re Conroy*,[198] make several subtle distinctions. Decisions to withhold life-sustaining treatment from patients of limited consciousness are governed by different standards than those which apply in cases involving vegetative patients. Further distinctions rest on the strength of proof of the patient's intent.

For nursing home patients with some consciousness and limited life expectancy[199] who have not left clear evidence of their treatment preferences, the New Jersey Supreme Court adopted two types of "best interests" tests. A "limited-objective" test is appropriate when there is some "trustworthy"—but not "clear and convincing"—evidence that the patient would have refused treatment. Under this test, discontinuing treatment is appropriate if the decisionmaker is satisfied that the "burdens of the patient's continued life with the treatment outweigh the benefits of that life for him."[200] The burdens of continued life include the degree of pain and suffering. The benefits of continued life include physical pleasure, emotional enjoyment, and intellectual satisfaction.[201]

The second measure of "best interests" is labeled by the *Conroy* court as a "pure-objective" test, which is applied when there is less than "trustworthy" evidence that the patient would refuse treatment.[202] Under this test, life-sustaining treatment may be withdrawn when "the net burdens of the patient's life with the treatment . . . clearly and markedly outweigh the benefits that the patient derives from life . . . [and] the effect of administering life-sustaining treatment would be inhumane" because of "unavoidable and severe pain."[203] While both of these best-interests tests require a balancing of the burdens and benefits of continued life, the pure-objective test is met only if the pain resulting from prolonged life would be considered inhumane. Under either the limited or pure-objective tests, the decisionmaker invariably must attempt to assess the quality of the patient's life.

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[198] 98 N.J. 321, 486 A.2d 1209 (1985).

[199] The *Conroy* court limited its opinion to "elderly, incompetent nursing-home resident[s] with severe and permanent mental and physical impairments and a life expectancy of approximately one year or less." *Id.* at 363, 486 A.2d at 1231.

[200] *Id.* at 365, 486 A.2d at 1232.

[201] *Id.*

[202] *Id.* at 366, 486 A.2d at 1232.

[203] *Id.*

The New York decisions leave little room for consideration of the quality of the patient's life. They focus on the clarity and competence of the patient's expression of treatment preference.[204] The New Jersey decisions distinguish between "clear and convincing evidence" and "trustworthy evidence" of patient intent, and demand an assessment of the quality of the patient's life whenever the patient's directives are not clear.[205] The difference between the New York and New Jersey approaches could alter the outcome of particular cases. Mary O'Connor's statements did not satisfy New York's demand for clear and convincing evidence of the patient's treatment choice, but they may well have constituted "trustworthy" enough evidence to satisfy New Jersey's limited-objective test. It is at least debatable whether the burdens of O'Connor's continued existence outweighed the benefits.[206] O'Connor's daughters may have been allowed to withhold consent to the insertion of a feeding tube if she had resided in New Jersey instead of New York.[207]

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[204] *See supra* notes 188-97 and accompanying text.

[205] *See supra* notes 198-203 and accompanying text.

[206] Mary O'Connor had suffered several disabling strokes which rendered her unable to care for herself. She "could not walk, eat, dress or care for her bodily needs without assistance from others." *In re* Westchester County Medical Center *ex rel.* O'Connor, 72 N.Y.2d 517, 523, 531 N.E.2d 607, 609, 534 N.Y.S.2d 886, 888 (1988). After a second major stroke, Mrs. O'Connor became so disabled that her daughters could no longer care for her at home. Mrs. O'Connor was then transferred to a long-term geriatric care facility. Her condition continued to deteriorate. Mrs. O'Connor "lost her gag reflex, making it impossible for her to swallow food or liquids without medical assistance." *Id.* at 524, 531 N.E.2d at 609, 534 N.Y.S.2d at 888. At the time her daughters refused to consent to the insertion of a nasogastric tube, Mrs. O'Connor was able to respond to simple commands. *Id.*

[207] John Storar's case would be analyzed under the pure-objective test of *Conroy*, see *infra* notes 202-03 and accompanying text, as he never was competent to provide trustworthy evidence of his intent. Even though the pure-objective test would require a balancing of benefits and burdens, it is unlikely that such a calculus would alter the ultimate outcome of the case. While the blood transfusions may have been "disagreeable," see *supra* note 191 and accompanying text, it is most doubtful that they produced sufficient pain to be considered "inhumane." *See supra* note 203 and accompanying text. The Massachussetts court employed a substituted judgment analysis in *Saikewicz*, however, to justify the cessation of treatment under facts similar to those presented in *Storar*. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 759, 370 N.E.2d 417, 435 (1977) (severely mentally retarded 67-year-old male with acute leukemia).

2. Patients in a Persistent Vegetative State.

a. The New Jersey Approach: The Best Judgment of the Surrogate Decisionmaker

Patients in a persistent vegetative state are viewed by the New Jersey courts as presenting a "special situation."[208] As these patients experience neither pain nor pleasure in response to external stimulation, the various balancing tests of *Conroy* are deemed inappropriate. Rather, such cases are governed by the general principles first articulated in *Quinlan*.[209] Treatment may be withdrawn from the persistently vegetative patient when the family or guardian concludes that

> the patient would not want to be sustained by life-supporting treatment, and the attending physician agrees that the life-support apparatus should be discontinued, and both the attending physician and hospital prognosis committee verify the patient's medical condition. . . . The . . . [surrogate decisionmaker] need not have clear and convincing evidence of the patient's intentions; they need only "render their best judgment" as to what medical decision the patient would want them to make.[210]

This standard retains some faithfulness to the ideal of patient self-determination. On its face, the family or guardian is directed to follow the patient's desires. The court candidly recognizes, however, that evidence of patient choice may be weak.[211] The critical factor here is not the evidence of patient choice, but the quality of her life. The New Jersey courts, and those of most other states that have addressed the issue,[212] do not deem it essential that the

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[208] *In re* Peter, 108 N.J. 365, 375, 529 A.2d 419, 424 (1987).

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

[210] *Peter*, 108 N.J. at 377, 529 A.2d at 425 (quoting *In re* Quinlan, 70 N.J. 10, 41, 355 A.2d 647, 664 (1976)). *Accord In re* Jobes, 108 N.J. 394, 417-20, 529 A.2d 434, 446-47 (1987).

[211] *See Jobes*, 108 N.J. at 412-13, 529 A.2d at 443.

[212] With the exception of the Missouri court's decision in *Cruzan*, state courts overwhelmingly approve of the withdrawal or withholding of life-sustaining treatment of vegetative patients. *See* Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987); McConnell v. Beverly Enters.-Conn., Inc., 209 Conn. 692, 553 A.2d 596 (1989); John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921 (Fla. 1984); *In re* L.H.R., 253 Ga. 439, 321 S.E.2d 716 (1984); *In re* Estate of Greenspan, 137 Ill. 2d 1, 558 N.E.2d 1194 (1990); *In re* Estate of Longeway, 133 Ill. 2d 33, 549 N.E.2d 292 (1989); *In re* Gardner, 534 A.2d 947 (Me. 1987);

state prolong hopelessly vegetative life. The collective decisionmaking process involving family, attending physician and prognosis committee is directed more at ensuring an accurate assessment of the patient's medical condition than with determining her subjective desires. Once the medical diagnosis and prognosis are clear,[213] the surrogate decisionmaker may authorize the withdrawal of life-sustaining treatment, including nutrition and hydration, with minimal judicial oversight.

b. The Missouri Approach: An Unqualified State Interest in Preserving Life

Nancy Cruzan was severely injured in an automobile accident in 1983 and lapsed into a persistent vegetative state. Her parents sought judicial approval to terminate artificial hydration and nutrition. Prior to the accident, she had expressed in "somewhat serious conversation" that she would not want to continue her life unless she could live "halfway normally."[214] The trial court found that this and other similar statements provided sufficiently clear guidance that she would not want to be maintained in a vegetative condition.[215] The Missouri Supreme Court reversed, concluding that the testimony did not amount to clear and convincing evidence that Nancy Cruzan would want to have the feeding tube removed.[216] In the absence of clear and convincing evidence of Nancy's treatment preferences, the state's interest in preserving life would prevail.

Cruzan's parents argued that the state's interest in preserving life is related to the quality of that life. Because their daughter was vegetative with no hope for improvement, the state's interests

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Brophy v. New England Sinai Hosp., 398 Mass. 417, 497 N.E.2d 626 (1986); *In re* Torres, 357 N.W.2d 332 (Minn. 1984); *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976); *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981); *In re* Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).

[213] This is not to suggest that the medical questions are always clear. The diagnosis of persistent vegetative state may be controversial. *See, e.g., Jobes*, 108 N.J. at 408, 529 A.2d at 441 (finding evidence that patient was in persistent vegetative state to be clear and convincing even though two physicians disagreed with diagnosis).

[214] Cruzan v. Harmon, 760 S.W.2d 408, 411 (Mo. 1988), *aff'd. sub nom.* Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841 (1990) (quoting trial court findings).

[215] *Id.* at 411.

[216] *Id.* at 424.

should be significantly discounted.[217] The Missouri Supreme Court expressly refused to do so, commenting:

> It is tempting to equate the state's interest in the preservation of life with some measure of quality of life. . . . [S]ome courts find quality of life a convenient focus when justifying the termination of treatment. But the state's interest is not in quality of life. The broad policy statements of the legislature make no such distinction; nor shall we. Were quality of life at issue, persons with all manner of handicaps might find the state seeking to terminate their lives. Instead, the state's interest is in life; that interest is unqualified.[218]

Thus, Missouri has clearly rejected a quality-of-life analysis.

The New York, New Jersey and Missouri cases reflect a range of views on how to handle right-to-die cases when incompetent patients do not leave clear evidence of their desires. New Jersey courts take quality of life factors into account whether the patient is cognitive or vegetative.[219] Cases such as *Conroy* clearly contemplate that under certain circumstances, life-sustaining treatment may be withheld even from patients with some degree of consciousness.[220] In *O'Connor*, the New York Court of Appeals refused to factor in quality of life considerations when the patient retained some ability to respond and interact.[221] The Missouri Supreme Court in *Cruzan* goes the furthest in rejecting quality of life considerations. Even vegetative life will be preserved in Missouri, at least in the absence of a clear directive to the contrary by the

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[217] *Id.* at 420.

[218] *Id. See also id.* at 422 ("As we previously stated, however, the state's interest is not in quality of life. The state's interest is an unqualified interest in life."). The legislative policy statements referred to in the passage quoted in the text refer to the state's abortion and living-will statutes. The abortion statute protects the unborn child "when the life . . . may be continued indefinitely outside the womb by natural or artificial life-supportive systems." MO. REV. STAT. § 188.015(7) (1986). The Missouri living-will legislation excludes nutrition and hydration from the statutory definition of "death-prolonging procedure" which may be legally withheld under the Act. *Id.* § 459.010(3).

[219] *See supra* notes 198-203, 208-13 and accompanying text.

[220] *See In re* Conroy, 98 N.J. 321, 359, 486 A.2d 1209, 1228-29 (1985) (patient able to make facial expressions and to move head and arms).

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

patient.[222]

D. Summarizing Judicial Developments

This part of the Article has described judicial activity in the laboratory of the states. There is widespread consensus on certain issues: patient self-determination is the ideal standard for making treatment decisions;[223] surrogate decisionmakers may act on behalf of a patient who becomes incompetent;[224] and judicially mandated "second opinions" help ensure that the surrogate bases life and death decisions on accurate medical information.[225] On other issues, the laboratory has produced a diverse array of potential solutions. Courts disagree as to what constitutes clear evidence of the patient's choice. More importantly, judicial opinions announce a range of options when the patient's choice is not clear. Some states, such as New Jersey, are willing to take the patient's quality of life into account in making treatment decisions,[226] while New York[227] and Missouri[228] are not. Procedural guidelines and the degree of judicial oversight of treatment decisions vary considerably among the states.

In short, the judicial laboratory is functioning in much the manner as the metaphor would suggest. Courts are reaching consensus on some issues and devising divergent approaches to others. So long as the federal constitutional dimensions of right-to-die cases remain only vaguely defined, the laboratory is likely to continue operating in this fashion.

IV. Living Wills

The judiciary is not the only branch of state government experimenting with regard to the right to die. Perhaps because of the widespread public support for personal control over terminal healthcare decisions, state legislatures have become quite active in crafting statutes providing and protecting the right to refuse life-

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[222] Cruzan v. Harmon, 760 S.W.2d 408, 420 (Mo. 1988), *aff'd sub nom.* Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841 (1990).

[223] *See supra* notes 143-45 and accompanying text.

[224] *See supra* notes 137-39 and accompanying text.

[225] *See supra* notes 165-69 and accompanying text.

[226] *See supra* notes 198-203, 208-13 and accompanying text.

[227] *See supra* notes 188-97 and accompanying text.

[228] *See supra* notes 214-18 and accompanying text.

sustaining procedures.[229] Courts invited this development. In *Quinlan*, the first modern right-to-die decision, the New Jersey Supreme Court stressed the need for lawmaking in this area.[230] Even though the New Jersey legislature did not respond, other legislatures took up the challenge. Within weeks after *Quinlan*, California enacted the first living-will statute.[231] Most states followed suit over the next decade, each of them experimenting with its own particular variation on a common theme. Many of these enactments were prodded by further judicial calls for legislative action, especially in states where the legislature appeared reluctant to act. For example, the Florida Supreme Court wrote in a 1980 decision authorizing the termination of treatment:

> Because the issue with all its ramifications is fraught with complexity and encompasses the interests of the law, both civil and criminal, medical ethics and social morality, it is not one which is well-suited for resolution in an adversary judicial proceeding. It is the type issue which is more suitably addressed in the legislative forum, where fact finding can be less confined and the viewpoints of all interested institutions and disciplines can be presented and synthesized. In this manner only can the subject be dealt with comprehensively and the interests of all institutions and individuals be properly accommodated.[232]

The Florida legislature voted to authorize living wills three years later.[233]

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[229] This widespread, popular support is reviewed in Emanuel, Stoeckle, Ettelson & Emanuel, *Advance Directives for Medical Care—A Case for Greater Use*, 324 NEW ENG. J. MED. 889-91 (1991) [hereinafter *Advance Directives*].

[230] *In re* Quinlan, 70 N.J. 10, 32-33, 355 A.2d 647, 659-60 (1976).

[231] Natural Death Act, CAL. HEALTH & SAFETY CODE §§ 7185-7195 (1976).

[232] Satz v. Perlmutter, 379 So. 2d 359, 360 (Fla. 1980). *See also, e.g.*, Barber v. Superior Court, 147 Cal. App. 3d 1006, 1014, 195 Cal. Rptr. 484, 488 (1983) ("[T]he only long-term solution to this problem is necessarily legislative in nature."); *In re* Storar, 52 N.Y.2d 363, 383, 420 N.E.2d 64, 74, 438 N.Y.S.2d 266, 276 (1981) (concluding that legislation alone should enlarge the role of courts in cases dealing with discontinuance of life-sustaining treatment for incompetents); *In re* Hamlin, 102 Wash. 2d 810, 821-22, 689 P.2d 1372, 1379 (1984) ("The Legislature is the better forum in which to fashion the necessary procedures to safeguard the rights and liabilities of the many persons and institutions involved in this complex area.").

[233] Life-Prolonging Procedure Act of Florida, FLA. STAT. ANN. §§ 765.01-765.15 (1984).

The New Jersey Supreme Court has continued to press for legislative action. In a 1987 right-to-die case it commented, "We recognize, as we did in *Conroy*, and as have numerous other courts, that given the fundamental societal questions that must be resolved, the Legislature is the proper branch of government to set guidelines in this area."[234] By that time, as the court noted, thirty-eight state legislatures had adopted living-will statutes.[235] Some legislatures were beginning to experiment with other types of right-to-die legislation as well, most notably durable powers of attorney (DPA) for making healthcare decisions and statutes designating surrogate decisionmakers (usually the next-of-kin) to act where there is no court-appointed guardian or named agent.[236] Last year, Justice O'Connor recognized and encouraged this trend in her *Cruzan* opinion. "Delegating the authority to make medical decisions to a family member or friend is becoming a common method of planning for the future," she wrote.[237] "Several States have recognized the practical wisdom of such a procedure by enacting durable power of attorney statutes that specifically authorize an individual to appoint a surrogate to make medical treatment decisions."[238] She described such procedures for surrogate decisionmaking as "a valuable additional safeguard of the patient's interest in directing his medical care."[239] The next two parts of this Article will survey this legislative experimentation, focusing on the range of statutory alternatives. Throughout, we rely heavily on the language of the statutes because there have been few cases construing them. True to their invitation for legislative action, courts have rarely intervened in the operation of living wills and DPAs for healthcare.

A. *The Basics of a Living Will*

A living will involves a simple concept. It is a document in which

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[234] *In re* Farrell, 108 N.J. 335, 341-42, 529 A.2d 404, 417 (1987). *Accord In re* Jobes, 108 N.J. 394, 428, 529 A.2d 434, 452 (1987); *In re* Peter, 108 N.J. 365, 385, 529 A.2d 419, 429 (1987); *In re* Conroy, 98 N.J. 321, 344-45, 486 A.2d 1209, 1220-21 (1985).

[235] *Farrell*, 108 N.J. at 342 n.2, 529 A.2d at 407 n.2.

[236] *See* Francis, *The Evanescence of Living Wills*, 14 J. CONTEMP. L. 27, 45 (1988); *Move Toward Proxies Gains Momentum*, SOC'Y RIGHT TO DIE NEWSL., Fall 1987, at 1.

[237] Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2857 (1990) (O'Connor, J., concurring).

[238] *Id.* (footnote omitted).

[239] *Id.* at 2858.

a person expresses her desire to forgo life-sustaining treatment during the final stages of a terminal illness. It is intended to provide clear direction at a time when the patient is no longer mentally competent or physically able to communicate with her doctor. The living will offers a vehicle for effectuating patient self-determination—the ideal standard for decisionmaking that animates many of the judicial opinions discussed in the previous part. Legislation authorizing living wills encourages their acceptance by removing doubts about their legality, protecting physicians and other health-care providers from liability for implementing the directive and guaranteeing that the patient's death will not constitute suicide for insurance and other purposes.[240]

State legislatures have been enacting and refining living-will laws for fifteen years. California adopted the nation's first such statute in 1976, shortly after *Quinlan*.[241] Most states rapidly followed suit.[242] Forty-one states and the District of Columbia currently have such statutes, with many of these laws having been periodically revised.[243]

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[240] *See, e.g.*, ME. REV. STAT. ANN. tit. 18A, §§ 5-709 to 5-711 (Supp. 1990).

[241] *See supra* note 231 and accompanying text.

[242] SOCIETY FOR THE RIGHT TO DIE, THE PHYSICIAN AND THE HOPELESSLY ILL PATIENT 81-82 (1985) (listing statutes).

[243] *See* ALA. CODE §§ 22-8A-1 to 22-8A-10 (1990); ALASKA STAT. §§ 18.12.010-18.12.100 (1986); ARIZ. REV. STAT. ANN. §§ 36-3201 to 36-3210 (1986); ARK. STAT. ANN. §§ 20-17-201 to 20-12-218 (Supp. 1989); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1991); COLO. REV. STAT. §§ 15-18-101 to 15-18-113 (1987 & Supp. 1990); CONN. GEN. STAT. §§ 19a-570 to 19a-575 (1989); DEL. CODE ANN. tit. 16, §§ 2501-2508 (1983); D.C. CODE ANN. §§ 6-2421 to 6-2430 (1989); FLA. STAT. ANN. §§ 765.01-765.15 (West Supp. 1989); GA. CODE ANN. §§ 31-32-1 to 31-32-12 (1985 & Supp. 1990)); HAW. REV. STAT. §§ 327 D-1 to 327 D-27 (Supp. 1989); IDAHO CODE §§ 39-4501 to 39-4509 (1985 & Supp. 1990); ILL. ANN. STAT. ch. 110 ½, paras. 701-710 (Smith-Hurd Supp. 1990); IND. CODE ANN. §§ 16-8-11-1 to 16-8-11-22 (Burns 1990); IOWA CODE §§ 144A.1-144A.11 (Supp. 1989); KAN. STAT. ANN. §§ 65-28,101 to 65-28,120 (1985); KY. REV. STAT. ANN. §§ 311.622-311.644 (Baldwin 1990); LA. REV. STAT. ANN. §§ 40:1299.58.1-40:1299.58.10 (West Supp. 1990); ME. REV. STAT. ANN. tit. 18-A, §§ 5-701 to 5-714 (Supp. 1990); MD. HEALTH-GEN. CODE ANN. §§ 5-601 to 5-614 (1990); MINN. STAT. §§ 145B.01-145B.17 (1990); MISS. CODE ANN. §§ 41-41-101 to 41-41-121 (Supp. 1990); MO. REV. STAT. §§ 459.010-459.055 (1986); MONT. CODE ANN. §§ 50-9-101 to 50-9-206 (1989); NEV. REV. STAT. §§ 449.540-449.690 (1989); N.H. REV. STAT. ANN. §§ 137-H:1 to 137-H:16 (1990); N.M. STAT. ANN. §§ 24-7-1 to 24-7-11 (1986); N.C. GEN. STAT. §§ 90-320 to 90-323 (1990); N.D. CENT. CODE §§ 23-06.4-01 to 23-06.4-14 (Supp. 1989); OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West Supp. 1991); OR. REV. STAT. §§ 127.605-127.650 (1989); S.C. CODE ANN. §§ 44-77-10 to 44-77-160 (Law. Co-op. Supp. 1990); TENN. CODE ANN. §§ 32-11-101 to 32-11-110 (Supp. 1990); TEX. HEALTH & SAFETY CODE ANN. §§ 672.001-672.021 (Vernon 1991); UTAH CODE ANN. §§ 75-2-1101 to 75-2-1118 (Supp. 1990); VT. STAT. ANN. tit. 18, §§ 5251-5262 (1987); VA. CODE ANN. §§ 54.1-2981 to 54.1-2992; WASH. REV. CODE ANN. §§ 70.122.010-70.122.905 (Supp.

The simple concept of a living will becomes somewhat complicated at the point of putting it into practice, however, because the forty-two enabling acts differ from one another. Many of these differences are superficial. Even superficial differences can have significant consequences, however, because most living-will statutes include sample forms and specify implementation procedures that must be substantially followed. No two of these forms and procedures are identical. Both the substantive and procedural aspects of living-will statutes can be reviewed by examining Maine's new act[244] and comparing it to other statutes. Maine offers a particularly useful starting point because it was the first state to have enacted a law based on the 1989 version of the Uniform Rights for the Terminally Ill Act, which is likely to influence future legislation in this area.[245]

1. Forms and Declarations. The heart of any living will consists of a declaration stating that life-sustaining procedures should be withheld or withdrawn if the declarant lapses into a terminal condition and is then unable to participate in treatment decisions. This portion of a living will can be quite brief, such as the following one-sentence "Declaration" suggested in Maine's law:

> If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make or communicate decisions regarding my medical treatment, I direct my attending physician, pursuant to the Uniform Rights of the Terminally Ill Act of this State, to withhold or withdraw such treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.[246]

1991); W. VA. CODE §§ 16-30-1 to 16-30-10 (1991); WIS. STAT. ANN. §§ 154.01-154.15 (West 1989); WYO. STAT. §§ 35-22-101 to 35-22-109 (1988). The nine states without living-will statutes are Massachusetts, Michigan, Nebraska, New Jersey, New York, Ohio, Pennsylvania, Rhode Island and South Dakota. *Significant Gains in Legislation Mark Year at Midpoint*, CONCERN FOR DYING/SOC'Y RIGHT TO DIE NEWSL., Summer 1990, at 2 [hereinafter *Significant Gains*].

[244] ME. REV. STAT. ANN. tit. 18-A, §§ 5-701 to 5-714 (Supp. 1990).

[245] *See Significant Gains*, *supra* note 243, at 2.

[246] ME. REV. STAT. ANN. tit. 18-A, § 5-702(b) (Supp. 1990).

At the other extreme, the Georgia statute mandates the use of a declaration that substantially follows a prescribed six-paragraph form, which includes definitions of key terms and conditions of the law.[247]

Aside from the fact that many states require that their particular form be substantially followed, the language of the document makes little difference.[248] Unless personal modifications are made in the state-supplied form, the underlying enabling act will control how and when the document applies. A more detailed form simply carries more of the definitions and terms from the act into the document itself; it does not change them.[249] Although more detailed forms *may* communicate more information to declarants, and thereby alert them to the document's potential consequences, the Uniform Law Commissioners concluded that their simplified language (adopted in the Maine law) provides clear "notice of exactly what is to be effectuated through these documents," and suggested that "more detailed declarations" might increase confusion and decrease flexibility.[250] Both arguments have force; detail can either confuse or enlighten. It can also intimidate people from using the form altogether, which is perhaps the major argument in favor of simplicity.[251]

a. Life-Sustaining Procedures

One provision in the Maine law illustrates how the enabling act controls the meaning of terms used in the form document. Maine's statutory "Declaration" directs the termination of "life-sustaining procedures" but does not expressly define that term. The statute,

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[247] GA. CODE ANN. § 31-32-3(b) (Supp. 1990). The Texas form is as long as the Georgia form but its use is only recommended, not mandated. TEX. HEALTH & SAFETY CODE ANN. § 672-004 (Vernon 1991).

[248] Requiring that a particular form be precisely or substantially followed limits the use of a living will in other states. Maine's uniform act avoids this limitation by recognizing the validity of foreign living wills. ME. REV. STAT. ANN. tit. 18-A, § 5-713 (Supp. 1990).

[249] For example, Georgia's form states that the declarant is "of sound mind," is "at least 18 years of age," may "revoke this living will at any time," and other such affirmations that are also required by Maine's law but are not included in Maine's form document. *Compare* GA. CODE ANN. § 31-32-3(b) (Supp. 1990) *with* ME. REV. STAT. ANN. tit. 18-A, § 5-702 (b) (Supp. 1990).

[250] UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 2, Comment, 9B U.L.A. 67, 71 (Supp. 1989).

[251] *See id.* at 67-68 (prefatory note).

however, states that it "means any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying."[252] By contrast, Arkansas' prescribed forms also use the term "life-sustaining procedures" without defining it, but the underlying statutory definition includes procedures "to maintain the patient in a condition of permanent unconsciousness."[253] Even though this addition addresses the sensitive issue of terminating treatment for vegetative patients and might lead to radically different treatment consequences than those under a Maine living will, the forms seen and signed by patients in the two states could be identical.

Perhaps the most controversial issue surrounding the definition of "life-sustaining procedures" is whether or not the term includes artificially administered nutrition and hydration. Approximately half of the statutes expressly exempt such treatments from the definition of "life-sustaining procedures," with many of them *not* noting this exemption in the prescribed form.[254] Most other statutes (and their prescribed forms) are silent on the issue, suggesting that prevailing medical opinion, which views tube-feeding as simply another type of terminable treatment, should control.[255] As a result, for example, signers of standard living wills in North Carolina authorize the termination of tube feeding in certain situations but those in neighboring Georgia do not—all without anything about the issue appearing in the documents themselves.[256] To avoid any ambiguity, Maine adds an optional provision to its form Declaration stating, "I direct my attending physician to withhold or withdraw artificially administered nutrition and hydration which only prolongs the process of dying."[257] This provision must be signed separately to be effective, thereby forcing declarants to

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[252] ME. REV. STAT. ANN. tit. 18-A, § 5-701(4) (Supp. 1990).

[253] ARK. STAT. ANN. § 20-17-201(4) (Supp. 1989).

[254] Francis, *supra* note 236, at 33-34.

[255] *See* AMA COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, WITHHOLDING AND WITHDRAWING LIFE PROLONGING MEDICAL TREATMENT (Mar. 15, 1986). Of course, except in the few states that require using a precise form, declarants may specify their intentions on this issue in an amendment to their living wills.

[256] *Compare* N.C. GEN. STAT. § 90-321(a)(2) (1990) *with* GA. CODE ANN. § 31-32-2(5)(A) (1985). Both forms are silent on this issue. *Compare* N.C. GEN. STAT. § 90-321(d) *with* GA. CODE ANN. § 31-32-3(b) (Supp. 1990).

[257] ME. REV. STAT. ANN. tit. 18-A, § 5-702(b) (Supp. 1990).

choose.[258]

The variety of legislative approaches to nutrition and hydration raises additional substantive issues. Does an express exclusion of artificial nutrition and hydration from the definition of "life-sustaining treatment" in a state's living-will law *prohibit* the removal or withholding of such treatment in all circumstances?[259] The answer to this question may depend on whether the living will statute supplements or supplants existing common law. To the extent a statutory exclusion is construed to prohibit the removal of feeding tubes from vegetative patients, it would conflict with prevailing medical practices and case law. Such a potential conflict underscores the importance of clearly identifying the source of the right to refuse treatment. If such a right arises solely from common law, the legislature may enact restrictive limitations on the withholding of nutrition and hydration. The constitutionality of legislative restrictions is called into question, however, if the right to refuse treatment is grounded in federal or state constitutional law.

b. Terminal Condition

Legislative experimentation has also generated differing definitions for "terminal condition," the status that typically triggers the end of life-sustaining procedures under most living wills. The objective here is to pinpoint the circumstances when life-sustaining treatment should be withheld or withdrawn. Capturing the com-

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[258] *Id.* Alaska's form living will forces this choice even more clearly and directly by including the following: "I [ ] do [ ] do not desire that nutrition and hydration (food and water) be provided by gastric tube or intravenously if necessary." ALASKA STAT. § 18.12.010(c) (1986).

[259] This question splintered the Washington Supreme Court in *In re* Grant, 109 Wash. 2d 545, 747 P.2d 445 (1988). Originally the five-member majority of that nine-justice court ruled that tube-feeding could be discontinued for a patient, even though the state's living-will statute was silent on the issue. *Id.* at 553-63, 747 P.2d at 449-54. Four dissenting justices said that silence precluded discontinuing tube-feeding because the legislature had repeatedly rejected amendments to include artificial nutrition and hydration within the statutory definition of life-sustaining treatment. *Id.* at 570, 747 P.2d at 458 (Anderson, J., dissenting); *Grant*, 109 Wash. 2d at 578-79, 747 P.2d at 462-63 (Dore, J., dissenting). This apparent resolution of the issue later became confused when one of the justices in the majority switched her vote without further explanation. *Grant*, 109 Wash. 2d at 545, 757 P.2d at 534 (revising listing of concurring justices). One justice of the Washington Supreme Court interprets the final ruling in *Grant* as prohibiting the withdrawal of nutrition and hydration in all cases. *See*, Farnam v. CRISTA Ministries, 116 Wash. 2d 659, 683-88, 807 P.2d 830 (1991) (Dore, J., concurring). For further developments in Washington, see *infra* notes 400-02 and accompanying text.

plexity of this value-laden term within a statutory definition has proven difficult. One common source of difficulty stems from incorporating some nearness-of-death time reference into the definition. The difficulty is compounded by the question of whether this time limit would be met only if treatment is discontinued. This difficulty is not simply an academic issue, but has important practical implications for when and to whom the termination of treatment applies. The result can lead to living-will statutes that are either underinclusive or overinclusive.

For example, consider the Maryland statute, which defines terminal condition as "an incurable condition of a patient caused by injury, disease, or illness which, to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life-sustaining procedures, there can be no recovery."[260] Under this definition, persistently vegetative patients such as Nancy Cruzan and Karen Quinlan would not be considered "terminal" because their death was not "imminent" if life-sustaining procedures were continued. Consequently, a validly executed Maryland living will would not have authorized the removal of the respirator or feeding tube in either case even though these are precisely the cases that define the right-to-die issue for most people. Surely, a statute that does not reach them is underinclusive.

One way to include persons like Cruzan and Quinlan is to extend the time limit for the proximity of death. For example, Colorado's living-will law broadly declares: " 'Terminal condition' means an incurable or irreversible condition for which the administration of life-sustaining procedures will serve only to postpone the moment of death."[261] This definition presumably includes patients in an irreversible coma or persistent vegetative state.[262] Yet, ambiguities remain. When does treatment "serve only to postpone the moment of death"? Some diabetics suffer from an "irreversible condition" that for which only the administration of life-sustaining insulin serves "to postpone the moment of death." Any living-will statute that treats diabetes as a "terminal condition," and which directs the discontinuation of treatment, is patently overinclusive.

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[260] MD. HEALTH-GEN. CODE ANN. § 5-601(g) (1990).

[261] COLO. REV. STAT. § 15-18-103(10) (1987).

[262] New Mexico resolved any remaining ambiguity on this point by expressly extending its living wills to include the irreversibly comatose. N.M. STAT. ANN. § 24-7-3.A (1986).

Maine's act attempts to chart a middle course on the issue of the nearness of death by providing: " 'Terminal condition' means an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time."[263] This definition could still cover irreversibly comatose patients because death must only be near *without* treatment, and that terminable treatment may (at the option of the declarant) include tube feeding.[264] Tennessee also uses the "within a short period of time" approach to the nearness of death, but reaches a different result for the comatose by requiring that such time period be met "regardless of the use or discontinuance of medical treatment."[265]

While some states include their definition of "terminal condition" in the language of their prescribed living-will form, and thereby present this information to declarants, many do not.[266] Knowing this definition is of limited practical value when signing a living will, however, because there is not much that the declarant can do to change it.[267] While declarants typically may personalize their living wills regarding the types of life-sustaining treatment to be terminated, the statute's definition of "terminal condition" generally controls when the declaration takes effect.[268] These various statutory definitions of the core concept of terminal condition may reflect *bona fide* policy differences among the states in establishing when life-sustaining treatment may be withheld. It may also illustrate the difficulty of reducing complex ideas to simple definitions. In any event, the living wills nurtured in the laboratory of the states have produced considerable variety on this point.

2. Procedural Variations. State experimentation has not been limited to the language of form documents and the definitions of key terms, but reaches to the most mundane procedures for executing or revoking living wills and provisions for implementing

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[263] ME. REV. STAT. ANN. tit. 18-A, § 5-701(9) (Supp. 1990).

[264] *Id.* at § 5-701(4) & (9). For commentary on this section, see UNIF. RIGHTS OF THE TERMINALLY ILL ACT § 1, Comment, 9B U.L.A. 67, 69-70 (Supp. 1989).

[265] TENN. CODE ANN. § 32-11-103(9) (Supp. 1990).

[266] *E.g., compare* ME. REV. STAT. ANN. tit. 18-A, § 5-702(b) (Supp. 1990), *with* COLO. REV. STAT. § 15-18-104(3) (1987 & Supp. 1990).

[267] Of course, a declarant can use this information in deciding whether to execute a living will.

[268] *See, e.g.*, ME. REV. STAT. ANN. tit. 18-A, § 5-703 (Supp. 1990) (statutory definition of terminal condition controls when declaration becomes operative).

them. A sample of these procedures and provisions fills out the picture of how living wills operate and underscores the practical significance of state differences.

Rules governing the creation of living wills tend to be similar, but not identical. For example, most statutes authorize any competent adult to make a living will, but four states extend this authority to minors.[269] Every statute permits written living wills, but four also permit oral declarations.[270] Most statutes require that the declarant sign the living will, but several authorize someone else to sign on the declarant's behalf and at her direction if she is unable to do so.[271] The signing usually must be witnessed by two competent adults, with a few states adding that it must also be notarized.[272] South Carolina requires two witnesses and a notary or other officer authorized to administer oaths.[273] Various statutory restrictions are imposed on who is permitted to serve as a witness, including the exclusion in some states of relatives, heirs, attending physicians or persons "financially responsible for the declarant's medical care."[274] Some statutes require specific witnesses, such as the patient ombudsman for nursing home residents.[275] Thus, all living-will statutes require considerable formality in executing the document. No court has imposed such formality on the common-law or constitutional right to refuse treatment.

There is little state variation on procedures for revoking living wills. Maine's act is typical:

> A declarant may revoke a declaration at any time and in any manner, without regard to the declarant's mental or physical condition. A revocation is effective upon its communication to the attending physician or other health-care provider by the declarant or a witness to the revocation.[276]

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[269] *E.g.*, TEX. HEALTH & SAFETY CODE ANN. § 672.006 (Vernon 1991).

[270] *See, e.g.*, FLA. STAT. § 765.04(1) (1989).

[271] *See, e.g.*, ALASKA STAT. § 18.12.010 (1986).

[272] *See* B. MISHKIN, A MATTER OF CHOICE 21 (1986).

[273] S.C. CODE ANN. § 44-77-40(2) (Supp. 1990).

[274] *See, e.g.*, GA. CODE ANN. § 31-32-3(a) (Supp. 1990). *See generally*, Comment, *Comparison of the Living Will Statutes of the Fifty States*, 14 J. CONTEMP. L. 113-14 (1988) (authored by Christopher J. Condie).

[275] *See, e.g.*, DEL. CODE ANN. tit. 16, § 2506(c) (1983).

[276] ME. REV. STAT. ANN. tit. 18-A, § 5-704(a) (Supp. 1990). Only Connecticut's statute

Some statutes supplement such a provision by giving examples of how a declarant may revoke a living will, including by oral or written statements or by defacing or destroying the document.[277] The California statute provides that living wills are valid only for five years,[278] but others provide that declarations are valid until they are revoked.[279] Some legal scholars criticize giving incompetent patients the power to revoke their living wills, arguing that they may not then know what they are doing,[280] but this uniform provision avoids the risk of requiring the withdrawal of life-sustaining treatment from dying patients who claim to want it.

Statutory provisions for implementing living wills vary widely beyond a few core guarantees. Every statute protects physicians from liability for complying in good faith with a living will and provides that neither making nor implementing a living will affects the declarant's life insurance.[281] The current Uniform Act[282] and a few newer statutes[283] require only that the attending physician determine that the patient is in a terminal condition before implementing a living will. The original Uniform Act and most existing statutes, in contrast, require that this determination be made (and sometimes "certified") by two physicians.[284] No statute forces a physician to implement a living will, but most require noncomplying physicians to transfer the patient to someone who is willing to implement it, and some impose penalties for failing to do so.[285] Over half of the statutes prohibit the implementation of a living will while a patient is pregnant,[286] but Maine's act omits such a restriction.

3. Effect in Other States. The single most serious possible conse-

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omits any provision for revoking living wills. *See* CONN. GEN. STAT. §§ 19a-570 to 19a-575 (1989).

[277] *See, e.g.*, GA. CODE ANN. § 31-32-5 (Supp. 1990).

[278] CAL. HEALTH & SAFETY CODE § 7189.5 (West Supp. 1991).

[279] *See, e.g.*, MINN. STAT. § 145B.04 (1990). The sample Health Care Declaration form provided in the statute warns the declarant that it "will remain valid and in effect until and unless you amend or revoke it." *Id.*

[280] *See, e.g.*, Francis, *supra* note 243, at 38-41.

[281] *See, e.g.*, ME. REV. STAT. ANN. tit. 18-A, §§ 5-709, 5-711 (Supp. 1990).

[282] UNIF. DURABLE POWER OF ATTORNEY ACT (1990).

[283] *See, e.g.*, ME. REV. STAT. ANN. tit. 18-A, § 5-703 (Supp. 1990).

[284] *E.g., compare id.* (modelled on current Uniform Act) *with* ARK. STAT. ANN. § 20-17-203 (Supp. 1989) (modelled on original Uniform Act).

[285] *See, e.g.*, ME. REV. STAT. ANN. tit. 18-A, § 5-710(a) (Supp. 1990).

[286] *See, e.g.*, TEX. HEALTH & SAFETY CODE ANN. § 672.019 (Vernon 1991).

quence of entrusting this area of law to the laboratory of the states involves the validity of out-of-state living wills. This issue arises whenever an incompetent, terminally ill patient with a living will from one state is institutionalized in another state, which might commonly occur following a travel injury or due to being transferred to an out-of-state hospital. Maine's act resolves this issue by providing, "[a] declaration executed in another state in compliance with the law of that state or of this State is valid."[287] Only a handful of other statutes have such a provision, however.[288] Case law has not yet established if out-of-state living wills generally are valid.

The uncertain validity of foreign living wills is particularly problematic because most statutes prescribed forms that must be substantially followed.[289] Wide differences between these forms raise the distinct possibility that a foreign living will would not satisfy this requirement. As a result, an out-of-state living will might not be enforceable on its face. Nonetheless, it could serve as simply a particularly clear statement of the declarant's wishes. This could then guide a court or surrogate decision regarding terminal healthcare decisions made pursuant to constitutional or common-law rights.[290] Of course, there is a risk in allowing healthcare providers in one state to base decisions on a foreign living will, especially where the two states prescribe substantially different forms. The two statutes may have significantly different substantive provisions, such as regarding the termination of tube-feeding. Unless the statutes for the state where the patient is institutionalized decrees which state's law governs, healthcare providers would not

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[287] ME. REV. STAT. ANN. tit. 18-A, § 5-713 (Supp. 1990).

[288] *See, e.g.*, ARK. STAT. ANN. § 20-17-212 (Supp. 1989). *See generally* Comment, *supra* note 274, at 114 (indicating that Alaska, Hawaii and Maryland recognize declarations executed in another state).

[289] For example, Montana recognizes living wills executed in other states, but *only* if they are "executed in a manner substantially similar to [Montana law] *and* in compliance with the law of that [other] state." MONT. CODE ANN. § 50-9-111 (1989) (emphasis added). The difficulty is magnified further in those states where the prescribed form *must* be precisely followed. *See, e.g.*, OR. REV. STAT. § 127.610 (1990).

[290] Zodin v. Manor Healthcare Corp., No. 9010821007, at 2 (Ga. Sup. Ct., Cobb County, Nov. 21, 1990) (using Texas living will "as evidence" of patient's wishes to obtain an order directing a Georgia nursing home not to reinsert a feeding tube). An analogous situation arose in *In re* Browning, 568 So. 2d 4, 9 (Fla. 1990), in which the Florida Supreme Court used a declaration that did not comply with Florida's living-will statute as a guide in exercising an incompetent patient's constitutional right to terminate treatment.

know which law to follow; complying with local law might not carry out the declarant's intent while following the foreign law might exceed their authority. In either event, entrusting the right to die to the laboratory of the states has exacted a price.

V. DPAs AND STATUTORY SURROGATES

The most recent legislative initiatives in the right-to-die area involve durable powers of attorney (DPA) for healthcare and statutory surrogates. Both DPAs for healthcare and living wills enable people to plan ahead for times when they may no longer be able to direct the course of their own treatment. While DPAs and living wills address the same problem, they do so in a significantly different manner. The living will is a direct communication between the patient and the physician that specifies in some detail, either directly in the document or indirectly through the terms of a living-will statute, the conditions in which the patient does not want continued treatment. Thus, the living will directs a particular treatment decision. DPAs, on the other hand, designate the person who may render treatment decisions on behalf of the now incompetent patient. Although DPAs may provide guidance regarding the patient's treatment preferences, they are directed more at naming a decisionmaker than at specifying any particular decision.[291]

Both living wills and DPA's represent efforts to approximate the ideal of patient self-determination under conditions where the patient cannot speak for herself. In this respect, both the living will and DPA are "next best" solutions. Each approach has its advantages and limitations. The living will approximates the ideal of patient self-determination by enabling the patient to communicate directly with the healthcare provider. The most significant limitation of the living will is that it requires people to make general decisions about life-sustaining treatment before they can know the precise circumstances in which the directive might be invoked. A person executing a living will in 1991 cannot know what the state of medical technology or their personal situation will be in the future. Also, people's minds can change. What may seem to be an intolerably diminished physical condition to a healthy, active person today may seem much better than death to a seriously im-

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[291] *See generally* Francis, *supra* note 236, at 45-46 (discussing possibility of conflict when individual enacts both living will and DPA).

paired accident or stroke victim tomorrow. The inherent uncertainty of future conditions explains why living-will legislation often contains restrictive substantive provisions. As discussed in the preceding part, these restrictions complicate the implementation of living wills, especially those made in other states.

DPAs for healthcare are documents in which a patient empowers a particular individual to make treatment decisions on the patient's behalf.[292] Typically, these documents become effective when the patient becomes mentally or physically unable to direct her own treatment. The DPA is consistent with the ideal of patient self-determination because the patient selects and guides the surrogate decisionmaker. DPAs avoid one problem of the living will in that the surrogate decisionmaker can take current circumstances into account in making treatment decisions. For this reason, statutes authorizing DPAs for healthcare tend to contain fewer substantive limitations than living-will laws. DPA statutes encourage the patient to express her treatment preferences in a general way and require the agent to follow them.[293] At least where the patient has chosen the surrogate, the agent should, and perhaps must, be trusted with the same decisionmaking authority as the patient.[294]

A. The Basics of a DPA for Healthcare

Thirty states have enacted statutes specifically authorizing DPAs to make healthcare decisions, with most of these laws first appearing in the past two years.[295] These statutes offer a range of alternative approaches from simply conferring healthcare decisionmaking power on a traditional DPA agent[296] to creating wholly new forms of agency. Yet *all* the existing alternatives, reflecting the col-

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[292] *See id.* at 45.

[293] *See, e.g.*, GA. CODE ANN. § 31-36-10 (Supp. 1990) (incorporating in statutory DPA form section for the individual to specifically limit powers granted DPA).

[294] The majority in *Cruzan* did not rule on whether advanced directives must be implemented as a matter of federal constitutional law. Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2856 n.12 (1990). Justice O'Connor indicated that the state "may well be constitutionally required" to give effect to the decisions of designated proxies. *Id.* at 2857 (O'Connor, J., concurring).

[295] Rosenthal, *Filling the Gap Where a Living Will Won't Do*, N.Y. Times, Jan. 17, 1991, at B9, col. 1 (listing enacting states).

[296] *See, e.g.*, COLO. REV. STAT. § 15-14-501 (1987) (expressly grants healthcare decisionmaking power under general DPA without requiring any statement to that effect in DPA document).

lective creativity of the laboratory of the states, are essentially similar in that they create special springing durable powers of attorney. These essential similarities can best be appreciated by comparing two of the more exotic healthcare DPA statutes, those of Minnesota[297] and Kentucky,[298] with two of the more traditional, those of Georgia[299] and Washington State.[300] These four statutes, when viewed as a range of alternatives, reflect current legal trends in that they were all enacted during the past two years.

These four statutes represent embellishments on the traditional legal means for a competent adult to authorize another person to act on her behalf—a power of attorney. Traditional powers of attorney automatically terminated when the principal became incompetent, on the theory that the principal could not then act for herself, so no one else could act for her.[301] Over the past quarter century, every state has enacted statutes authorizing written, springing durable powers of attorney that can survive, or become effective upon, the disability of a principal and remain effective as long as the incapacity continues.[302] Powers of attorney were traditionally used to enable relatives and business companions to carry on property or other financial transactions for the principal.[303] It was gradually realized, however, that DPAs also could be used to make healthcare decisions for incapacitated principals, including decisions to end life-sustaining treatment. Some legal authority suggests that a general DPA empowers the agent to make healthcare decisions even if such authority is not expressed in the document.[304] Further, some states have recently amended their DPA statutes to authorize general agents to make healthcare decisions without any alteration in the form document.[305] The more common

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[297] MINN. STAT. §§ 1458.01-1458.17 (1990).

[298] KY. REV. STAT. ANN. §§ 311.970-311.986 (Baldwin Supp. 1990).

[299] GA. CODE ANN. §§ 31-36-1 to 31-36-13 (Supp. 1990).

[300] WASH. REV. CODE ANN. §§ 11.94.010-11.94.046 (Supp. 1991).

[301] W. SEAVEY, HANDBOOK OF THE LAW OF AGENCY 90-91 (1964).

[302] These statutes are listed in Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2858 n.3 (1990) (O'Connor, J., concurring).

[303] F. COLLIN, J. LOMBARD, A. MOSES & H. SPITLER, DRAFTING THE DURABLE POWER OF ATTORNEY 7-8 (1989).

[304] *See, e.g.*, *In re* Peter, 108 N.J. 365, 378-79, 529 A.2d 419, 426 (1987); 73 Op. Md. Att'y Gen. No. 88-046, at 23-24 (1988).

[305] *See, e.g.*, COLO. REV. STAT. § 15-14-501(1) (1987). Of course, principals can always limit the powers of their agents in DPA document.

approach, reflected in all four statutes discussed in this part, is for states to enact enabling legislation authorizing special DPAs expressly for healthcare decisions and to preclude agents without such express power from making these decisions.[306] The rationale for this restriction was noted in the Georgia Durable Power of Attorney for Health Care Act, which states that "the General Assembly recognizes that powers concerning health care decisions are more sensitive than property matters and that particular rules and forms are necessary for health care agencies to ensure their validity and efficacy and to protect health care providers."[307] Thus, the Georgia legislature reasoned, powers to make healthcare decisions should be expressly stated to protect the principal, agent and healthcare provider.[308]

1. Washington State. The Washington State DPA for healthcare represents the simplest possible evolutionary development from a basic DPA without merely granting healthcare decisionmaking power to a general agent. The Washington legislature simply added two amendments to the preexisting DPA statute. The first amendment specifies, "[a] principal *may* authorize his or her attorney-in-fact to provide informed consent for healthcare decisions on the principal's behalf," and then precludes granting that power to the principal's healthcare provider unless the provider is a close relative.[309] The second amendment states that any prior DPA "that specifically authorizes an attorney-in-fact to make decisions relating to the health care of the principal shall be deemed valid."[310] The combined effect of these amendments is to allow the granting of a DPA for healthcare in the same manner as any other DPA except that the document must specify the power to make "healthcare decisions" and that the powers cannot be granted to certain healthcare providers.[311] These minimal protections are included in

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[306] Indeed, most such legislation precludes agents acting under general DPAs executed prior to the statute's enactment from making healthcare decisions unless the earlier DPA specifically granted such power. *E.g.*, WASH. REV. CODE ANN. § 11.94.046 (Supp. 1991).

[307] GA. CODE ANN. § 31-36-2(b) (Supp. 1990).

[308] *See id.* § 31-36-2(c) (indicating that Act "[sets] forth general principles governing health care agencies, as well as a statutory short form durable power of attorney for health care").

[309] WASH. REV. CODE ANN. § 11.94.010(3) (Supp. 1991) (emphasis added).

[310] *Id.* § 11.94.046(1).

[311] Alaska law offers the novel variation of including a list of standard powers, including "health care services," on the form document with the direction that the principal should

nearly all DPA for healthcare statutes.[312] Many, however, add the precaution that a DPA for healthcare must be in a separate document.[313] This, however, complicates the DPA process by requiring two documents when the principal wants to name one agent to exercise both financial and healthcare decisionmaking powers. Certainly separate documents are appropriate where the principal wants to grant these powers to different agents. Separate documentation could be achieved in Washington State by omitting healthcare from the general DPA document and writing a special DPA for healthcare. However, two documents would be necessary in Washington State *only* where two different agents are wanted.

The Washington act has been criticized because, in its simplicity, it does not specify that agents may refuse treatment.[314] Many other simple DPA for healthcare statutes share this defect.[315] Although the more complex enactments, including the three other acts discussed in this part, do specify the power to refuse treatment, they typically do so in the context of describing (rather than expanding) the agent's power.[316] Absent a ruling to the contrary, it should be presumed that the power to provide informed consent for healthcare decisions includes the power to just say no. Indeed, such a construction of the agent's statutory power is consistent with cases that base the right to refuse treatment on the common-law doctrine of informed consent.[317]

2. Georgia. The Georgia statute represents a further stage of development from the basic DPA form, but retains a strong family resemblance to the original type. A Georgia DPA for healthcare is similar to the general DPA for that state in that it confers certain statutorily prescribed powers on an agent.[318] These powers can become effective upon the principal's disability and last for as long as

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"draw a line through" anyone that should not apply. ALASKA STAT. § 13.26.332 (Supp. 1990).

[312] They are also included in two of the other three statutes discussed in this part. *See* GA. CODE ANN. § 31-36-5(b) (Supp. 1990); KY. REV. STAT. ANN. § 311.972(3) (Baldwin Supp. 1990).

[313] *See, e.g.*, OR. REV. STAT. § 127.530 (1990).

[314] *See, e.g.*, SOCIETY RIGHT TO DIE NEWSL., Spring 1990, at 2.

[315] *See, e.g.*, COLO. REV. STAT. § 15-14-501, (1987); 20 PA. CONS. STAT. § 5602(a)(9) (1982); *see also*, Rosenthal, *supra* note 300 (listing states with defective specifications).

[316] *See, e.g.*, GA. CODE ANN. § 31-36-4 (Supp. 1990); KY. REV. STAT. ANN. § 311.970(6) (Baldwin Supp. 1990); MINN. STAT. §§ 145B.03(1), 145B.06(2) (1990).

[317] *See In re* Torres, 357 N.W.2d 332, 337 (Minn. 1984).

[318] *Compare* GA. CODE ANN. § 10-6-5 (1989) *with* GA. CODE ANN. § 31-36-4 (Supp. 1990).

the principal is disabled.[319] A form document that must be substantially followed is prescribed by statute.[320] Specific procedures for creating or revoking the document are set forth in the law, including the requirement that the principal's attending physician witness the signing if the principal is hospitalized at the time.[321] Like Georgia's general DPA statute, agents and others acting in good faith and with due care are protected against liability, with the healthcare DPA act expressly extending such protection to healthcare providers and stating that a principal's death from withholding or withdrawing life-sustaining treatment in accordance with the DPA is not homicide or suicide.[322]

It is from this point that Georgia's DPA for healthcare begins to deviate significantly from its general DPA. The central difference relates to the agent's powers. Of course, those powers relate to healthcare decisions—including the making of anatomical gifts—rather than financial decisions. But while a general DPA typically gives the same powers over financial decisions as held by the principal, the powers for surrogate healthcare decisionmaking are restricted in special ways intended to assure that the principal's wishes are carried out. For example, the prescribed statutory form begins with a long, boldface notice warning potential signers that the document gives "BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU, INCLUDING POWER TO . . . WITHDRAW ANY TYPE OF PERSONAL CARE OR MEDICAL TREATMENT," and advising signers that they may limit these powers.[323] After the prescribed paragraph creating the agency, the form inserts a second boldface notice reemphasizing that the document grants the power "TO OBTAIN OR TERMINATE ANY TYPE OF HEALTH CARE, INCLUDING WITHDRAWAL OF NOURISHMENT AND FLUIDS AND OTHER LIFE-SUSTAINING OR DEATH-DELAYING MEASURES."[324] The form then provides space for the principal to limit these powers, including by adding "a direction to continue nourishment and

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[319] *See* GA. CODE ANN. §§ 31-36-2(a) & (b) to 31-36-10(a) ¶ 3-4 (Supp. 1990).
[320] *Id.* § 31-36-10(a).
[321] *Id.* § 31-36-5(a).
[322] *Id.* § 31-36-8.
[323] *Id.* § 31-36-10(a).
[324] *Id.* § 31-36-10(a)(1).

fluids or other life-sustaining or death-delaying treatment."[325] The document then inserts a third boldface notice warning "THE SUBJECT OF LIFE-SUSTAINING OR DEATH-DELAYING TREATMENT IS OF PARTICULAR IMPORTANCE,"[326] and provides three optional statements expressing preferences regarding such treatment. Those options include not wanting the treatment if "the burdens of the treatment outweigh the expected benefits"; wanting the treatment unless "I am in a coma, including a persistent vegetative state"; or wanting "my life to be prolonged to the greatest extent possible without regard to my condition."[327] The principal is permitted to initial any *one* of these statements, and the agent is directed to make decisions in accordance with the initialled statement.[328] As a final precaution to assure that the principal's intent guides the agent's hand, the statute adds the following:

> An agent under a health care agency shall *not* have the authority to make a particular health care decision different from or contrary to the patient's decision, if any, if the patient is able to understand the general nature of the health care procedure being consented to or refused, as determined by the patient's attending physician based on such physician's good faith judgment.[329]

This restriction applies even if the principal is legally incompetent. No general DPA statute contains such a restriction, nor do any go to such lengths to warn the principal of what the agent may do or to encourage the principal to guide the agent's decisionmaking.[330] These developments reflect special legislative sensitivity to issues of terminal healthcare, especially relating to the termination of nutrition and hydration.[331]

3. Kentucky. The 1990 Health Care Surrogate Act of Kentucky represents a further development from the basic DPA type, so much so that the name for the decisionmaker is changed from the

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[325] *Id.* § 31-36-10(a)(2).
[326] *Id.*
[327] *Id.*
[328] *Id.*
[329] *Id.* § 31-36-5(c) (emphasis added).
[330] *See, e.g.*, UNIF. DURABLE POWER OF ATTORNEY ACT § 1 (1990).
[331] *See, e.g.*, GA. CODE ANN. § 31-36-2(b) (Supp. 1990).

traditional terms of "agent" or "attorney-in-fact," as in the Washington State or Georgia laws, to "surrogate."[332] But like the proverbial renamed rose, this new "surrogate" smells suspiciously similar to a conventional DPA agent. Like typical DPA-for-healthcare statutes, the "grantor" empowers her surrogate "to make any health care decisions for me when I no longer have decisional capacity."[333] This language, on its face, encourages placing less restrictions on the decisonmaking power of a Kentucky healthcare surrogate than the cautionary language of the Georgia Act. In this respect the Kentucky law is more akin to a general DPA statute than its Georgia counterpart.[334] Of course, the Kentucky law, like all DPA statutes, allows a grantor to include limiting directions. Unlike the Georgia Act, however, it does not invite them.[335]

The Kentucky law imposes only two noteworthy restrictions on the surrogate's decisionmaking power. First, the surrogate is required to "consider" both the grantor's wishes and her best interests.[336] Second, nutrition and hydration cannot be refused unless it is being artificially provided *and* either death is expected within a few days, tube-feeding cannot be assimilated or its burden outweighs its benefit.[337] Even these restrictions are not specified in the form document, however. The form is a remarkably simple, one-sentence grant, with an optional line to add an alternative surrogate and space for the document to be executed and witnessed.[338] As a result, Kentucky has created the least intimidating form DPA for healthcare, which should encourage its use. Alternatively, principals may include the grant in a general DPA, which would make the process as simple in Kentucky as it is in Washington State.[339]

Simplicity has a price, however. In crafting its Health Care Surrogate Act, the Kentucky legislature made a policy decision in favor of providing artificial nutrition and hydration in most cases. Even though this policy decision differs from prevailing medical practice and developing case law, it is not reflected in the state's

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[332] KY. REV. STAT. ANN. § 311.970(9) (Baldwin Supp. 1990).
[333] *Id.* § 311.980.
[334] *See* GA. CODE ANN. §§ 31-36-1 to 31-36-13 (Supp. 1990).
[335] KY. REV. STAT. ANN. §§ 311.976, 311.978(1).
[336] *Id.* § 311.978(1).
[337] *Id.* § 311.978(3).
[338] *Id.* § 311.980.
[339] *Id.* § 311.974(2).

simple form document. As a result, grantors may not appreciate this significant limitation in the otherwise broad powers held by their surrogates. This raises constitutional concerns. If, as the *Cruzan* Court assumed, "the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition"[340] and, as Justice O'Connor added, that right may be delegated to a surrogate,[341] then the Kentucky legislature may have exceeded its authority in limiting that right. Of course, any constitutional right to authorize a surrogate to order the termination of tube-feeding would still exist outside the statute. A problem of potentially constitutional dimensions remains, however, because grantors signing a statutory DPA in Kentucky might not know about the limitation and, therefore, would not seek to invoke their broader constitutional right through a supplementary document. This could constitute a fatal flaw in Kentucky's experiment with simplicity.

4. Minnesota. The furthest stage of evolutionary development for a basic DPA yet produced in this area of state experimentation is contained in Minnesota law.[342] That law authorizes the execution of "Health Care Declarations"[343] and prescribes a form for such declarations that must be substantially followed.[344] The form, which is addressed "[t]o my family, doctors, and all those concerned with my care," encourages the declarant to express her opinions on relevant issues. It begins by asking her "feelings" regarding healthcare, followed by spaces to explain what type of healthcare she wants and does not want. The questions then focus on right-to-die issues by asking the "kinds of life-sustaining treatment" she would and would not want if she were terminally ill, followed by spaces to express "feelings and wishes regarding artificially administered sustenance" and any other relevant thoughts, including "religious beliefs, philosophy, or other personal values."[345] At this point, the declarant is invited to designate a "proxy." This proxy is empowered to make healthcare decisions for the declarant if the declarant becomes unable to communicate in-

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[340] Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2852 (1990).
[341] *Id.* at 2857 (O'Connor, J., concurring).
[342] MINN. STAT. §§ 145B.01-145B.17 (1990).
[343] *Id.* § 145B.03.
[344] *Id.* § 145B.04.
[345] *Id.*

structions, but must make decisions consistent with the instructions in the declaration.[346]

In its experimentation, Minnesota has created a chameleon-like cross between a living will and a DPA for healthcare. If the declarant provides instructions to remove life-sustaining treatment but does not designate a proxy, then the declaration acts like a living will, and must be followed.[347] If the declarant designates a proxy but provides no other instructions, then the declaration acts like a DPA for healthcare with the sole statutory restriction that artificially administered nutrition and hydration are generally to be provided unless the declarant specifically instructs otherwise.[348] If the declarant both provides written instructions and designates a proxy, then the declaration creates a limited special DPA, somewhat similar in effect to the Georgia DPA for healthcare.[349]

Even though other DPA-for-healthcare statutes contain different provisions from those found in the four laws discussed in this part, they are all variations on a theme. The range of state experimentation is reflected in these four acts. Washington State's law reflects minimal deviation from general DPAs.[350] Georgia's variation is significant for the complex, but possibly forbidding, precautions developed to ensure that the principal's intentions are followed.[351] Kentucky's effort produced a convenient, though perhaps deceptively simple, form.[352] Only Minnesota's experiment with mixing living wills and DPAs creates a decisionmaker who becomes almost unrecognizable as a DPA agent when bound merely to carry out lengthy instructions. But even this "proxy" reverts to the DPA form when the proxy designation is made without limiting instructions.[353] As will be discussed more fully below, the modest results of this experimentation may not justify the inconvenience and confusion of having so many different forms in a highly mobile coun-

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[346] *Id.* § 145B.06(2).

[347] *Id.* § 145B.04.

[348] *Id.* § 145B.03(2)(b)(2).

[349] To consider these similarities, compare *id.* §§ 145B.04, 145B.06(2) with GA. CODE ANN. § 31-36-10 (Supp. 1990).

[350] Compare WASH. REV. CODE ANN. § 11.94.010(3) (Supp. 1991) with *id.* § 11.94.010(1) to identify slight differences between general DPA and DPA for healthcare in Washington.

[351] See *supra* notes 321-27 and accompanying text for a discussion of these precautions.

[352] For an example of the form, see KY. REV. STAT. ANN. § 311.980 (Baldwin Supp. 1990).

[353] See *supra* notes 345-46 and accompanying text for a discussion of Minnesota's experimental Health Care Declaration.

try, especially where few state statutes expressly recognize the authority of out-of-state DPAs for healthcare—even for a nonresident hospital patient.[354]

B. *Statutory Surrogates*

Despite the intense legislative experimentation with living wills and DPAs for healthcare, few Americans have executed such documents.[355] Despite recent evidence that nearly all patients want advance treatment directives for themselves, a 1988 survey found only a small fraction of those polled had signed living wills.[356] As a result, most Americans have no legislatively sanctioned declaration to guide their terminal healthcare. Decisions to withhold or withdraw life-sustaining treatment from incapacitated patients largely have been left to court-appointed guardians or to an informal process involving the patient's family and physicians.[357] To clarify and expedite this process, some states have enacted statutes authorizing certain relatives to make such decisions when the patient has not executed a living will or DPA for healthcare.[358] In effect, these laws provided statutory surrogates power to make terminal healthcare decisions.

Only a few states have provided these back-up decisionmaking procedures, and all these laws are quite similar. Maine's statute is both typical and particularly significant because it was adapted from the recently revised Uniform Rights of the Terminally Ill Act, which is likely to be enacted elsewhere.[359] The Maine law empow-

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[354] Among the four statutes discussed at length in the text, only Minnesota's law provides that declarations executed in other states are effective, and then only if they substantially comply with the Minnesota act. *Id.* § 145B.16.

[355] *See* Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2857 (1990) (O'Connor, J., concurring).

[356] *Advance Directives*, *supra* note 229, at 890-91 (post-*Cruzan* survey of patients found 93% desired some form of advanced treatment directives); AMA, SURVEYS OF PHYSICIANS AND PUBLIC OPINION ON HEALTH CARE 29-30 (1988) (pre-*Cruzan* survey of public found 15% of those polled had living wills). A study published simultaneously with the post-*Cruzan* survey suggested that advance directives have limited actual impact on treatment practices in the typical hospital or nursing-home setting, however. Danis, Sutherland, Garrett, Smith, Hielema, Pickard, Egner & Patrick, *A Prospective Study of Advance Directives for Life Sustaining Care*, 324 N. ENG. J. MED. 884-85 (1991).

[357] B. MISHKIN, *supra* note 272, at 4.

[358] *See, e.g.*, ME. REV. STAT. ANN. tit. 18-A, § 707 (Supp. 1990).

[359] In 1990, Maine became the first, and so far the only, state to enact the 1989 amended Uniform Rights of the Terminally Ill Act. *Significant Gains*, *supra* note 243, at 2.

ers specified relatives to give written consent to withholding or withdrawing treatment for incompetent, terminally ill individuals who did not leave valid living wills or DPAs.[360] Because "terminal condition" is defined the same for this provision and for living wills, these surrogate decisionmaking powers become effective at the same point as living wills[361]—which typically occurs at a much later stage in a degenerative illness than the simple incapacity that activates a DPA. Under Maine's law, this decisionmaking power passes first to the patient's spouse, then to her available adult children acting by majority vote, then to her parents, then to her available adult siblings acting by majority vote and finally to her nearest other available adult relative.[362] Other statutes provide a similar prioritized list, though some give express precedence to a court-appointed guardians.[363]

A statutory surrogate's power is not as broad as it may initially appear. First, it only takes effect when the patient has lapsed into a terminal condition, which is narrowly defined by Maine law.[364] Second, the Maine statute requires that decisions "must be made in the best interest of the individual, consistent with the individual's desires, if known, and in good faith."[365] Third, any persons with "a significant personal relationship" to the patient may challenge a surrogate's decision in court.[366] Finally, any patient may disqualify one or more potential surrogates from later acting in her behalf by naming them in an advance written statement.[367] With these restrictions, Maine's law does little more than formalize, clarify and legitimate prevailing practices. Given the stresses and difficulties typically involved in making terminal treatment decisions for a close relative, however, this can be quite important.

Living will and DPA legislation has no effect unless the patient acts prior to becoming incompetent. To date, only a small percentage of our population has executed one or both of these docu-

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[360] ME. REV. STAT. ANN. tit. 18-A, § 5-707 (Supp. 1990).

[361] *Id.* §§ 5-703, 5-707(a)(1).

[362] *Id.* § 5-707(b).

[363] *E.g.*, FLA. STAT. § 765.07(1) (1989). Under this Florida statute, a court-appointed guardian takes precedence over even a designated DPA agent.

[364] *See* ME. REV. STAT. ANN. tit. 18-A, § 5-701(9) (Supp. 1990).

[365] *Id.* § 5-707(d).

[366] *Id.* § 5-707(f).

[367] *Id.* § 5-707(g).

ments. The statutory surrogate fills the void present in most cases where the incompetent patient has executed neither a living will nor DPA. The hierarchy of legislatively sanctioned surrogates offers a "default" decisionmaking structure for the patient who fails to leave a directive. Such statutes go far in answering judicial pleas for a comprehensive legislative solution to right-to-die issues. The statutes clearly identify who can decide and, less clearly, offer general standards for decisionmaking.[368] Statutory surrogate legislation may be inspired as much by a concern for efficiency as for patient self-determination. The statutory surrogate is efficient in that it provides a clear chain of decisionmakers without the need for court-appointed guardians. It is arguably consistent with patient self-determination because it applies only when the patient has failed to act. Thus, it allows patients the first option to control their own treatment. Moreover, the family hierarchy of surrogate decisionmakers may be presumed by lawmakers to generally reflect the patient choice as to who should make treatment decisions on her behalf. This may not always be true, however. For example, some patients may prefer entrusting such decisions to a close friend rather than a distant relative. This potential deviation from patient self-determination is partially addressed in Maine's law by allowing any individual, regardless of competency, to "disqualify others from consenting to the withdrawal or withholding of life-sustaining treatment . . . by *any* writing, signed by the individual, which designates those disqualified."[369] Of course, this still leaves those individuals who fail (whether out of ignorance of the law or inaction) to disqualify a relative whose decisions would not reflect the individual's choices. Statutory surrogate legislation makes it all the more important that such individuals execute living wills or DPAs.

VI. Conclusion: An Invitation Accepted

Much of the state constitutional, common-law and statutory experimentation with the right to die described in this Article occurred prior to the Supreme Court decision in *Cruzan*. The Court could have drawn on this experimentation to formulate uniform national standards founded on the Constitution, much like it did

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[368] *See id.* § 5-707.

[369] *Id.* (emphasis added).

for indigents' right to counsel in *Gideon v. Wainwright*.[370] That would have likely curtailed future state experiments with the right to die because all states would then be governed by a common constitutional standard. Instead, by merely suggesting that there may be constitutional parameters to the right to die while upholding Missouri's particular evidentiary standards, *Cruzan* invited further state experimentation in this area.[371] The preliminary response to *Cruzan* by state courts, legislatures and the people suggest that the Court's invitation has been accepted.

At least three different state supreme courts confronted right-to-die cases in the months following the Supreme Court's decision in *Cruzan*.[372] Although all three rulings continued the pre-*Cruzan* trend of affirming the right to refuse treatment, they differed on some fundamental points. In *In re Estate of Greenspan*,[373] the Illinois Supreme Court recognized a common-law right to terminate life-sustaining nutrition and hydration for a stroke victim who had survived on feeding tubes in a "chronic vegetative state" for five years with "no reasonable hope" of recovery.[374] Greenspan had not executed an advance treatment directive, but there was overwhelming evidence from his family and friends that he would have wanted to terminate treatment.[375] The *Greenspan* court found a common-law right to end tube-feeding so long as "clear and convincing evidence of the patient's intent"[376] existed and "death would be imminent in *the absence of* the feeding tube."[377]

The Florida Supreme Court reached a strikingly similar result on different legal grounds in *In re Browning*.[378] Browning was also an elderly stroke victim who had survived on feeding tubes in a

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[370] 372 U.S. 335 (1963).

[371] Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2859 (1990) (O'Connor, J., concurring) (stating "task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to 'laboratory' of the states").

[372] *Cf. In re* Busalacchi, No. 59582, 1991 Mo. App. Lexis 315 (March 5, 1991) (reversing and remanding for further proceedings the decision of a probate judge that would have enabled the father and guardian of a 20-year-old vegetative daughter to transfer her to a healthcare facility in Minnesota where the law governing the removal of feeding tubes from vegetative patients is less strict).

[373] 137 Ill. 2d 1, 558 N.E.2d 1194 (1990).

[374] *Id.* at 4-5, 558 N.E.2d at 1196.

[375] *Id.* at 8-10, 558 N.E.2d at 1197-98.

[376] *Id.* at 18, 558 N.E.2d at 1202.

[377] *Id.* at 20, 558 N.E.2d at 1203 (emphasis added).

[378] 568 So. 2d 4, 7-8 (Fla. 1990).

"persistent vegetative state" for several years with "virtually no chance of recovery."[379] She had executed a written advance directive requesting the end of tube-feeding if she suffered from a terminal condition and death was imminent, but the state's living-will statute did not authorize the termination of sustenance.[380] Nevertheless, the Florida high court found a state constitutional right to end tube-feeding[381] where there was "clear and convincing evidence of the patient's wishes."[382] Death was found to be imminent, as required by Browning's declaration, where there was "clear and convincing evidence" that death would occur within four to nine days *without* treatment.[383]

The Nevada Supreme Court reached a somewhat different result in *McKay v. Bergstedt*.[384] Kenneth Bergstedt was, much like Larry McAffee, "a non-terminal, competent, adult quadriplegic" who sought court confirmation of his right to refuse medical treatment.[385] Relying heavily on *Cruzan*, the court confirmed this right on the basis of "an individual's liberty interest in refusing medical treatment" under the federal and Nevada State constitutions.[386] Using this basis for the decision, however, led the court to decree that there must be a judicial balancing of the patient's interests in refusing treatment against relevant state interests in providing treatment whenever the patient is not terminally ill,[387] which was defined to include anyone with a life expectancy in excess of six months *with or without* treatment.[388]

These few post-*Cruzan* decisions have yielded some important differences as well as points of agreement. The cases reflect the ongoing uncertainty of the source of the right to refuse treatment. The Illinois Supreme Court based its decision on common law.[389]

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[379] *Id.* at 9.

[380] *Id.*

[381] Drawing upon the right to privacy granted each citizen by the Florida Constitution, the court found that "[a] competent individual has the constitutional right to refuse medical treatment regardless of his or her medical condition." *Id.* at 10.

[382] *Id.* at 16.

[383] *Id.* at 17.

[384] 801 P.2d 617 (Nev. 1990).

[385] *Id.* at 620.

[386] *Id.* at 622.

[387] *Id.*

[388] *Id.* at 630.

[389] *In re* Estate of Greenspan, 137 Ill. 2d 1, 16, 558 N.E.2d 1194, 1201 (1990).

The Florida Supreme Court relied primarily on state constitutional law.[390] Nevada invoked both state and federal constitutional law.[391] While all three cases purported to deal with patients suffering a "terminal condition," there is some divergence in how to measure nearness of death. The Nevada Supreme Court referred to death occurring within six months *if treatment is continued.*[392] The Illinois and Florida courts referred to death occurring within a week or nine days *if treatment is withdrawn.*[393] There are important points of agreement, however. All three courts made no distinction between the artificial administration of nutrition and hydration and other forms of life-sustaining treatment.[394] Perhaps the most telling point is the ultimate result—every petitioner was allowed to die.

Statutory experimentation with the right-to-die has also continued since *Cruzan*, albeit at a moderate pace. This pace may reflect the timing of *Cruzan*, which appeared after most state legislatures had adjourned for the year, and the fact that forty-six states already had right-to-die statutes in force.[395] One of the key holdouts, New York, enacted a broad DPA for healthcare statute on July 22, 1990,[396] with legislators citing *Cruzan* as an impetus.[397] Even though the new act contains many standard provisions, it also incorporates distinct provisions reflecting the three-year pitched battle over its enactment.[398] The federal Congress also intervened

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[390] *In re* Browning, 568 So. 2d 4, 10 (Fla. 1990).

[391] *McKay*, 801 P.2d at 622. *See also*, Norwood Hosp. v. Munoz, 564 N.E.2d 1017, 1021 (Mass. 1991) (recognizing federal and state constitutional right of Jehovah's Witness to refuse blood transfusion).

[392] *McKay*, 801 P.2d at 630.

[393] *Greenspan*, 137 Ill. 2d at 22, 558 N.E.2d at 1204 ("death is imminent when expected within a week"); *Browning*, 568 So. 2d at 17 (finding death within four to nine days to be imminent).

[394] *But cf.* Farnam v. CRISTA Ministries, 116 Wash. 2d 659, 683-88, 807 P.2d 830 (1991) (Dore, J., concurring), in which one justice in a post-*Cruzan* state supreme court opinion interpreted the Supreme Court's decision in *Cruzan* as supporting a distinction between discontinuing nutrition or hydration and other medical treatment while the rest of the court did not address that issue.

[395] This number includes states with living-will, DPA-for-healthcare statutes or both. The exceptions were Nebraska, New Jersey, New York and Pennsylvania.

[396] N.Y. PUBLIC HEALTH LAW §§ 2980-2994 (McKinney Supp. 1991).

[397] *See Legislation Roundup*, CONCERN FOR DYING/SOC'Y RIGHT TO DIE NEWSL., Fall 1990, at 2.

[398] For example, the New York statute includes a unique compromise on the tube-feeding issue by providing that

when, following *Cruzan*, it included language in the annual budget act requiring all hospitals receiving any federal funds (including medicare and medicaid payments) to advise patients of their rights under state law to make out living wills.[399] This is likely to encourage activity in this area, as hospitals and hospital attorneys grapple with the applicable law.

Perhaps the greatest response to *Cruzan* has been by the general public. The most dramatic single example of this occurred in Washington State. In the months immediately following the *Cruzan* decision, the Hemlock Society secured enough signatures to place before the voters an initiative to the legislature amending the state's living-will statute. This initiative has three main features. First, it would resolve an ongoing legal dispute by specifying that "artificially administered nutrition and hydration" could be terminated under a Washington State living will.[400] Second, it authorizes the termination of treatment for persons who have been "determined in writing by two physicians has having no reasonable probability of recovery from an irreversible coma or persistent vegetative state."[401] Third, in the most radical state experiment with living wills to date, it would direct physicians to provide "aid-in-dying," or active euthanasia, to mentally competent, terminally ill persons who so request.[402]

Although it remains unclear whether Washington State voters will approve this next step in right-to-die lawmaking, the episode exemplifies the intense public response to *Cruzan*. This response typically took the form of increased interest in living wills and DPAs. This was to be expected. The decision all but invites adults

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> the agent shall make healthcare decisions: (a) in accordance with the principal's wishes, including the principal's religious and moral beliefs; or (b) if the principal's wishes are not reasonably known and cannot with reasonable diligence be ascertained, in accordance with the principal's best interests; provided, however, that if the principal's wishes regarding the administration of artificial nutrition and hydration are not reasonably known and cannot with reasonable diligence be ascertained, the agent shall not have the authority to make decisions regarding these measures.

N.Y. PUBLIC HEALTH LAW § 2982(2) (McKinney Supp. 1991).

[399] Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206 (1990) (relevant portion of Act is "Patient Self-Determination Act").

[400] Wash. Initiative No. 119, § 2(4) (1991). This ongoing dispute is discussed in *supra* note 259.

[401] *Id.* § 2(7).

[402] *Id.* § 2(9).

to leave clear and convincing evidence of their terminal treatment decisions. The popular press made this invitation explicit. For example, in a next-day editorial praising the *Cruzan* decision, the *New York Times* urged individuals to make advance treatment directives.[403] "The Cruzan decision puts a premium on foresight," the *Times* commented. "The possibility of suffering a fate like Nancy Cruzan's where state law demands a clear and convincing statement makes it foolish not to consider a living will . . . , a durable power of attorney or other device."[404] To assist readers, the *Times* included a sample living will suitable for execution.[405] The leading advocacy group in this field, Concern for Dying and Society for the Right to Die, reported a 500% jump in living-will requests following *Cruzan*.[406] This was precisely the response urged by Justice O'Connor in her concurring opinion.[407]

Yet increased public acceptance of living wills and DPAs for healthcare, which Justice O'Connor invites, aggravates the cost of state experimentation with the right-to-die, which she also invites. We have shown how interstate diversity in the form and substance of living wills and DPAs for healthcare may create problems in a highly mobile society. Most state living-will statutes do not recognize out-of-state living wills as valid.[408] Even statutes that recognize foreign living wills, such as Maine's act, do not specify which state's substantive law prevails.[409] Should an individual who signed an advance treatment directive in Georgia (perhaps under the expectation that Georgia's statutory and common law would control) be subjected to having that document enforced according to Florida's quite different law simply because she was dying in a hospital or nursing home across the border from her prior residence? Alternatively, could a Florida institution be expected to enforce advance treatment directives in accordance with foreign law or should the

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[403] *Doing Justice to Life*, N.Y. Times, June 27, 1990, at A22, col. 1.

[404] *Id.*

[405] *Id.*

[406] *"Living Will Fever" Remains High in Cruzan Aftermath*, CONCERN FOR DYING/SOC'Y RIGHT TO DIE NEWSL., Fall 1990, at 1.

[407] *See* Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2857 (1990) (O'Connor, J., concurring) (indicating that "[d]elegating the authority to make medical decisions to a family member or friend is becoming a common method of planning for the future.").

[408] *See* Comment, *supra* note 274, at 114.

[409] *See* ME. REV. STAT. ANN. tit. 18-A, § 5-713 (Supp. 1990).

document simply be ignored? No option is wholly satisfactory. One solution would be uniform federal legislation. That, of course, would curtail experimentation with the right-to-die in the laboratory of the state, but whether this is good or bad depends on the purpose of the experimentation. If it seeks to tailor rights and responsibilities in this field to differing state conditions and expectations, then a uniform national statutory or constitutional standard should be avoided. If it seeks to use state experiments as a basis for discovering the optimal national standard, however, then there must come a time when the experiments end and the standard is adopted.