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## Cruzan & The Right to Die Symposium (Part 1)

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## ARTICLES

### **CRUZAN AND THE CONSTITUTIONAL STATUS OF NONTREATMENT DECISIONS FOR INCOMPETENT PATIENTS**

*John A. Robertson\**

Questions of medical treatment for incompetent patients raise difficult policy issues about the meaning and value of human life. Should bedridden or minimally functional patients who suffer from the effects of a coma, a stroke, Alzheimer's disease and other ills be treated? Do they have interests that need protection? How should such choices be made?

These questions are troubling because they pit fundamental values against each other. Human life, even in severely diminished states, seems precious. We recoil at the idea that the sick and dependent will be discarded because of the inconvenience they cause.

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Yet we also believe that existence in certain marginal states may be meaningless and feel strongly that patients and their families should not be prisoners of medical technology that serves no curative purpose. How then may we chart a course that respects dependent persons and yet limits excessive medical interventions?

Physicians, ethicists, courts and legislatures have made substantial progress in answering this question since 1975, when *In re Quinlan* first put it squarely on the public agenda.<sup>1</sup> The prevailing consensus is that the ethical and legal principle of autonomy should control these decisions whenever possible. It is now widely accepted—and recognized in judicial decisions and legislation—that a competent patient's refusal of treatment or directive against treatment if he becomes incompetent should be honored.<sup>2</sup>

Treatment questions, however, are much more difficult when the patient is incompetent and has not previously issued an explicit directive against treatment. In the case of an incompetent patient, questions of the value of that patient's life inevitably arise. Should the patient be regarded as the person she was previously, with the decision most consistent with her prior beliefs and values then inferred? If such substituted judgment by family or proxy is not permitted, should the patient always be treated? Or should treatment decisions be made on the basis of the incompetent patient's mental status and current interests, with treatment withheld if the patient appears to have no substantial interest in further existence? What role should family, financial and more general societal concerns play in these choices?<sup>3</sup>

The policy choices for treatment of incompetent patients may be viewed as points on a continuum between a vitalist and a nonvitalist position. From the vitalist perspective, all human life is viewed as worthy of protection regardless of its quality or functional ability.<sup>4</sup> In the most extreme form, even competent choices to refuse

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<sup>1</sup> *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied sub nom. Garger v. New Jersey, 429 U.S. 922 (1976).

<sup>2</sup> See, e.g., PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL SCIENCE RESEARCH, FOREGOING LIFE-SUSTAINING TREATMENT (1983) [hereinafter PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS]. The precise limits of this understanding—and its constitutional status—are unclear. See *infra* Part IV(B).

<sup>3</sup> The answer usually given is that these concerns should play no role at all, although they often do in unacknowledged ways. For further discussion, see *infra* Part V(A)(3).

<sup>4</sup> Many extreme vitalists would include prenatal human life as well and require protection

treatment and competently made prior directives must be ignored due to the importance of human life.<sup>5</sup> A somewhat less extreme position would require treatment whenever a competent refusal or explicit directive against treatment was missing, regardless of the condition of the patient or wishes of the family.<sup>6</sup>

The opposite or nonvitalist pole of the continuum regards human life as worth protecting only if that life meets certain minimal standards of functional ability. Thus, prenatal life that lacks a developed brain or functional ability or postnatal life that is merely metabolic or biologic, such as the permanently comatose, need not be sustained or protected.<sup>7</sup> Nonvitalists are also prepared to assess whether conscious, noncomatose patients have meaningful interests in being treated. They accept quality of life judgments, either directly or through recognition of prior directives or proxy inferences of what the patient would have chosen.<sup>8</sup> Nonvitalists would also allow treatment to be withheld in some marginal cases to serve family, economic and societal interests.

Legal and policy issues in treatment of incompetent patients thus pose the question of where on the vitalist-nonvitalist continuum to locate public policy. As the brief discussion above shows, however, the policy question is rarely addressed directly in these terms. Instead, policy questions are usually mediated—or obscured—by a focus on personal autonomy. For example, a public policy that relies heavily on the existence of a competent patient's advance directive against treatment if she becomes incompetent may often lead to nonvitalist results, not because the incompetent

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of fertilized eggs, embryos and fetuses. In some states, anti-abortion groups have also opposed legislation allowing nontreatment of incompetent persons. See *N.Y. Times*, Jan. 26, 1991, § 1, at 12, col. 5.

<sup>5</sup> Some vitalists would find it wrong to allow competent persons to refuse medical treatment and would insist on treatment against the patient's wishes.

<sup>6</sup> A vitalist would also be skeptical about the validity of a prior directive against treatment, especially if an incompetent patient appeared to have interests in continued life. See *infra* Part IV(B)(2).

<sup>7</sup> I have argued that fetuses themselves have no rights or interests prior to viability because they lack the neural substrate upon which the very concept of having interests depends. See Robertson, *In the Beginning: The Legal Status of Early Embryos*, 76 *VA. L. REV.* 437, 441-44 (1990) [hereinafter Robertson, *In the Beginning*].

<sup>8</sup> By looking at prior choices, this position devalues the patient's current status. Nonvitalists are thus likely to demand few procedural protections for the making of a living will. They are also likely to accept prior oral statements as sufficient evidence of the patient's wishes, as the family argued in the *Cruzan* case. See *infra* note 25 and accompanying text.

patient has no interest in treatment, but because a previously expressed autonomous choice requires it. At the same time, in the absence of directives, a state may be rigidly vitalist, not because the patient's interests are thereby best served, but because the prior choice against treatment is missing.

The tendency to recast decisions about incompetent patients as questions of prior autonomy, rather than to assess directly the worth of the patient's life, is most evident when an incompetent patient has not issued a prior directive to guide current decisions. Most courts faced with this question remain wedded to personal autonomy and require that proxies determine what the patient, if competent, would have decided about the choice before her.<sup>9</sup> In many instances such substituted judgment is nonvitalist because it usually leads the proxy decisionmaker to find that the patient, if competent, would have decided against treatment.

Some courts, however, take a more vitalist approach and require that, unless there is explicit evidence of a prior directive, the patient must be treated.<sup>10</sup> Such courts usually require clear and convincing evidence that the patient would have chosen nontreatment, a burden which may often be difficult to meet. In either case, however, courts have not decided questions solely in terms of the incompetent patient's current interests, thereby avoiding direct assessments of the worth or value of the diminished life before them.<sup>11</sup>

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<sup>9</sup> *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 497 N.E.2d 626 (1987) (holding by means of substituted judgment that patient in persistent vegetative state would have, if competent, discontinued the artificial maintenance of his nutrition and hydration); *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980) (holding that probate judge, on petition of ward's wife and son, appropriately decided that treatment should be withheld because ward, if competent, would elect not to receive treatment).

<sup>10</sup> *In re Westchester County Med. Center*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988) (holding that hospital was authorized to insert nasogastric feeding tube into elderly, mentally incompetent patient who was unable to obtain food and drink without medical assistance in the absence of clear and convincing proof that patient had made firm and settled commitment, while competent, to decline assistance).

<sup>11</sup> An exception to the general rule exists, however, when the patient was never competent because a previously competent choice cannot then be inferred. Despite this difficulty, the Massachusetts Supreme Judicial Court inferred such a choice in *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977). Conversely, the New York Court of Appeals refused to do so in *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981). Although the results of these two cases differ dramatically, both cases involved mentally retarded persons who had never been competent.

The problems with eschewing a direct assessment of the patient's interest in continued living are clearest in these cases, for neither approach is satisfactory. The first approach, which usually leads to nonvitalist results, risks sacrificing the patient's current interests to the imputed choice of a previously competent self whose situation and interests have changed radically. The effect of this position is to privilege the interests and views of the family or other proxy making the substituted choice over the incompetent patient's current interests.<sup>12</sup>

On the other hand, the second, explicitly vitalistic approach refuses to acknowledge that continued existence might not be in the interest of an incompetent patient whose consciousness and ability to relate to others has deteriorated. While such vitalism ostensibly protects human life, it does so blindly and without attention to the reality of the patient's situation. A direct assessment of that situation might reveal that, given the patient's debilitated condition, her interests in further treatment are so marginal that treatment is a burden that cannot be justified.<sup>13</sup>

Unfortunately, public policy will likely continue to rely heavily on actual or inferred exercises of autonomy to determine positions on the vitalist-nonvitalist continuum. Such an approach is fundamentally flawed because it refuses to address directly the central question of how to value or respect incompetent patients as they are now. Attempts to approach the incompetent patient through the lens of autonomy ignores the reality of the incompetent patient as a nonautonomous individual. Reliance on prior directives in that situation, while not always disrespectful of the incompetent patient's current interests, risks protecting previous interests rather than current ones.<sup>14</sup> Reliance on substituted judgment in the absence of an explicit directive commits the same error, while a refusal to permit nontreatment in the absence of an explicit directive risks the error of maintaining incompetent patients whose interests would be best served by nontreatment.

In my view, the most defensible policies will result only if deci-

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<sup>12</sup> This is not to say that courts or commentators taking this position are consciously or intentionally privileging these interests over those of the incompetent patient or that nontreatment always disserves those patients' interests.

<sup>13</sup> Dresser & Robertson, *Quality of Life and Nontreatment Decisions for Incompetent Patients: A Critique of the Orthodox Approach*, 17 *LAW, MED. & HEALTH CARE* 234 (1989).

<sup>14</sup> See *infra* text accompanying notes 154-55 & 182-83.

sionmakers directly address the worth or value of severely diminished life on its own terms—that is, from the perspective of the now incompetent patient.<sup>15</sup> In other words, the key question in every case is whether the patient, from her own perspective, has interests that are best served by treatment and further life or nontreatment and her likely demise. Although implementing such an approach has its own difficulties, it has the great virtue of asking the right question because it recognizes that the decision affects the incompetent patient as she now is, not as she previously was.<sup>16</sup>

A useful way to approach these issues is through the 1990 Supreme Court decision in *Cruzan v. Director, Missouri Department of Health*, the Supreme Court's first attempt to come to terms with the issues raised by the nontreatment of incompetent patients.<sup>17</sup> In this case, the state of Missouri took an extreme vitalist position regarding the treatment of an irreversibly comatose patient who had not made an explicit directive against treatment. Missouri insisted that Nancy Cruzan's life, whatever its quality or level of functioning, be protected despite the anguish caused her family and the lack of discernible benefit to her.<sup>18</sup>

Her parents, on the other hand, took a nonvitalist position, which they articulated in the language of autonomy. Finding no benefit to Nancy Cruzan from continued maintenance in her comatose state, they claimed that when she was competent she had or would have chosen not to be maintained in that state. The case became constitutionally significant because the Cruzans argued that the state's vitalist position violated their daughter's and their own fundamental constitutional rights.

The Court rejected this claim, thus permitting the state to require continued maintenance of Nancy Cruzan in her comatose state notwithstanding her parents' objections. While recognizing constitutional limits on the state's power to override a competent

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<sup>15</sup> This approach is not without its own pitfalls, but in my judgement it is preferable to existing alternatives. See Dresser & Robertson, *supra* note 13; *infra* note 204.

<sup>16</sup> See Dresser & Robertson, *supra* note 13; *infra* text accompanying notes 154-55 & 182-83.

<sup>17</sup> 110 S. Ct. 2841 (1990).

<sup>18</sup> On December 26, 1990, Nancy Cruzan died after a Missouri judge ruled that her feeding tube could be removed based on new evidence that Nancy Cruzan would not have consented to further treatment. Lewin, *Nancy Cruzan Dies, Outlived by a Debate Over the Right to Die*, N.Y. Times, Dec. 27, 1990, § A, at 1, col. 1.

person's refusal of medical treatment, the Court gave states wide discretion to adopt vitalist policies in decisions concerning incompetent patients.<sup>19</sup> In reaching this result, the Court demonstrated many of the errors and potential flaws to which the dominant emphasis on autonomy with incompetent patients leads.

This Article analyzes the Court's decision in *Cruzan* and evaluates the constitutional limits that apply to treatment decisions for incompetent patients. Although Missouri should not have required further treatment of Nancy Cruzan, the Court acted soundly in finding that this position was constitutionally permissible. The Court, however, never recognized the conflict that might arise between the interests of the currently incompetent patient and the interests of the patient when she was competent. A direct assessment of the incompetent patient's current interests clarifies many debates about nontreatment and will lead to sounder and more honest policy results. In analyzing these questions, the value choices at stake in these agonizing situations and the constitutional limits on state, family and patient authority will become clear.

### I. THE FACTS AND LOWER COURT DECISION IN *CRUZAN*

The facts and lower court decision in *Cruzan* aid in the assessment of *Cruzan* and the role of constitutional limitations on state lawmaking for incompetent patients.

#### A. *The Facts of Cruzan*

On the night of January 11, 1983, Nancy Cruzan lost control of a car she was driving and landed in a ditch.<sup>20</sup> Paramedics found her without detectable respiratory or cardiac function, restored her breathing at the accident site and transferred her to a hospital in an unconscious state. Neurosurgeons estimated that she was without oxygen for approximately twelve or fourteen minutes, clearly more than the six minutes of anoxia that generally causes permanent brain damage.<sup>21</sup>

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<sup>19</sup> Thus, *Cruzan* is hardly a decisive defeat for a constitutional "right to die." In fact, it may turn out to be a great victory for the competent patients' rights' over the dying process. See *infra* text accompanying note 121.

<sup>20</sup> This summary of facts is taken from the Court's opinion in *Cruzan*, 110 S. Ct. at 2844-47.

<sup>21</sup> *Id.* at 2845 (noting trial court's finding that "permanent brain damage generally results after six minutes in an anoxic state").



After approximately three weeks in a coma, she progressed to an unconscious state in which she was able orally to ingest some food. In order to facilitate feeding, surgeons implanted a gastrostomy feeding and hydration tube in Cruzan with the consent of her husband. Her condition never improved. She remained in a Missouri state hospital in a persistent vegetative state: a condition in which a person exhibits motor reflexes but shows no signs of significant cognitive function.<sup>22</sup> The state of Missouri bore the cost of her care.<sup>23</sup>

After Nancy Cruzan remained comatose for many months, it became apparent that she had no chance of regaining her mental faculties. Her parents, who had been appointed her guardians, asked hospital employees to terminate the artificial hydration and nutrition procedures, an act which would have resulted in her death. When they refused to act without court approval, the Cruzans sought and received authorization from a state trial court for termination. The court found that a person in Nancy's condition had a fundamental right under the state and federal constitutions to refuse or direct the withdrawal of "death prolonging procedures."<sup>24</sup> The court also found that Nancy's "expressed thoughts at age

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<sup>22</sup> The Court quoted the following description of a persistent vegetative state by Dr. Fred Plum, the creator of the term: "Vegetative state describes a body which is functioning entirely in terms of its internal controls. It maintains temperature. It maintains heart beat and pulmonary ventilation. It maintains digestive activity. It maintains reflex activity of muscles and nerves for low level conditioned responses. But there is no behavioral evidence of either self-awareness or the surroundings in a learned manner." *In re Jobes*, 108 N.J. 394, 403, 529 A.2d 434, 438 (1987).

It is generally considered that persons in such states cannot feel pain. The Missouri Supreme Court, adopting much of the trial court's findings, however, described her condition as follows:

... (3) she suffered anoxia of the brain resulting in a massive enlargement of the cerebral ventricles filling with cerebrospinal fluid in the area where her brain has degenerated and her cerebral cortical activity is irreversible, permanent, progressive and ongoing; (4) her highest cognitive brain function is exhibited by her grimacing *perhaps in recognition of ordinarily painful stimuli, indicating the experience of pain* and apparent responses to sound; (5) she is a spastic quadriplegic; (6) her four extremities are contracted with irreversible muscular and tendon damage to all extremities.

*Cruzan v. Harmon*, 760 S.W.2d 408, 411 (Mo. 1988) (en banc) (emphasis added). If she was indeed experiencing pain, she would have had a strong interest in having treatment stopped. See *infra* note 78 and accompanying text. Because Justice Stevens was the only justice who emphasized this fact, it should not be taken as established.

<sup>23</sup> Lewin, *supra* note 18, at 1.

<sup>24</sup> *Cruzan*, 110 S. Ct. at 2846.

twenty-five in somewhat serious conversation with a housemate friend that if sick or injured she would not wish to continue her life unless she could live at least halfway normally suggests that given her present condition she would not wish to continue on with her nutrition or hydration."<sup>25</sup>

### B. *Missouri Supreme Court Decision*

The guardian *ad litem* appointed to represent Nancy in this proceeding agreed that withdrawal of nutrition and hydration was in Nancy's best interests but felt bound to bring this case of first impression to the state's highest court.

In that proceeding, the Missouri Supreme Court reversed by a divided vote.<sup>26</sup> While finding a common-law right to refuse medical treatment, the court declined to find a broad right of privacy in either the state or federal constitution that would cover the situation before it. Finding a strong state policy in favor of the preservation of life, whatever its quality, the court found that Nancy Cruzan's statements to her roommate were "unreliable for the purpose of determining her intent . . . and thus insufficient to support the co-guardians' claim to exercise substituted judgment on her behalf."<sup>27</sup> It rejected the argument that Cruzan's parents were entitled to order the termination of her medical treatment, concluding that "no person can assume that choice for an incompetent in the absence of the formalities required under Missouri's living will statutes or the clear and convincing, inherently reliable evidence absent here."<sup>28</sup>

The United States Supreme Court granted certiorari to consider whether the Missouri court's requirements and decision violated Cruzan's constitutional rights:<sup>29</sup> did she have a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment from her under these circumstances?

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<sup>25</sup> *Id.*

<sup>26</sup> *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (en banc).

<sup>27</sup> *Id.* at 424-26.

<sup>28</sup> *Id.* at 425.

<sup>29</sup> *Cruzan v. Director, Missouri Dep't of Health*, 109 S. Ct. 3240 (1989).

## II. UNITED STATES SUPREME COURT DECISION

In a 5-4 decision the Supreme Court affirmed the lower court ruling.<sup>30</sup> Justice Rehnquist, in an opinion for five members of the Court, defined the issue as whether the Constitution allows Missouri to require that a patient's competent wish to have treatment stopped be shown by the clear and convincing evidence which the Missouri court had found lacking on the record before it.

A. *Majority Opinion*

In finding that Missouri's rule was constitutional, the majority appeared to share the dissent's and the petitioner's assumptions about the right of competent persons to refuse treatment and to issue advance directives against treatment when incompetent. The Court noted that "the principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."<sup>31</sup> The Court recognized that this liberty interest must be balanced against relevant state interests. Without deciding how the balancing would come out if a competent adult refused nutrition and hydration, the Court stated that, "for purposes of this case, we assume that the . . . Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition."<sup>32</sup>

The situation in *Cruzan*, however, did not involve a competent adult who was asking that treatment be withheld. The Court rejected the claim that "an incompetent person should possess the same right in this respect as is possessed by a competent person," noting that "an incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right."<sup>33</sup> "Such a 'right' must be exercised for her, if at all, by some sort of surrogate."<sup>34</sup>

Missouri permitted the surrogate to decide for the incompetent

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<sup>30</sup> *Cruzan v. Director, Missouri Dep't of Health*, 110 S. Ct. 2841, 2841 (1990).

<sup>31</sup> *Id.* at 2851.

<sup>32</sup> *Id.* at 2852.

<sup>33</sup> *Id.*

<sup>34</sup> *Id.* The question of whether an incompetent patient has the right to have a surrogate make a decision for her if she has given no specific instructions or otherwise appointed the surrogate or whether she merely has the right to have her interests in her incompetent situation protected is discussed *infra* text accompanying notes 92-95.

patient only if the surrogate's decision "conforms as best it may to the wishes expressed by the patient while competent."<sup>35</sup> To that end, the state required that "evidence of the incompetent's wishes as to the withdrawal of treatment be proved by clear and convincing evidence," a burden which the Cruzans were not able to meet.<sup>36</sup>

The Court upheld this requirement because of Missouri's legitimate interest "in the protection and preservation of human life," an interest long recognized in laws against homicide and assisting suicide.<sup>37</sup> Moreover, the Court indicated that the state's interest is more particular than merely protecting life. Since the choice between life and death is "a deeply personal decision of obvious and overwhelming finality . . . Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements."<sup>38</sup>

Because some incompetent patients may not have family available to serve as surrogates and because some families have competing interests in that role, the Court held that a state is entitled "to guard against abuses in such a situation."<sup>39</sup> Moreover, the state may impose procedural or evidentiary requirements to protect its interest and the patient's inferred interest in life because even a judicial proceeding to determine an incompetent patient's wishes

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<sup>35</sup> *Cruzan*, 100 S. Ct. at 2852.

<sup>36</sup> *Id.* This standard assumes that the decision should be based on what the patient had chosen when competent but sets a heavy standard for determining that choice. A different approach would require determining which decision will serve the patient's interests or welfare as she now exists. See *infra* Part V(A)(2).

<sup>37</sup> *Cruzan*, 110 S. Ct. at 2852-53. The Court stated: "We do not think that a State is required to remain neutral in the face of an informed and voluntary decision by a physically-able adult to starve to death." *Id.* In this passage, Chief Justice Rehnquist appears to address Justice Scalia's claim that the liberty interest or right recognized by the Court would allow a physically able person to commit suicide by starving himself to death. See *infra* text accompanying note 55; see also *In re Caulk*, 125 N.H. 226, 232, 480 A.2d 93, 97 (1984) (rejecting inmate's claim that he had a constitutional right to die where he was not facing death from illness). As noted below, the Court's asserted distinction with starvation would not distinguish cases of refusing medical care where a physically able person can be restored to a normal, healthy existence. See *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 581-87, 279 A.2d 670, 672-73 (1971) (ordering transfusion where failure to administer blood transfusion would have resulted in patient's death and where patient's mother rejected transfusion on religious grounds).

<sup>38</sup> *Cruzan*, 110 S. Ct. at 2852-53. The Court noted, "the Due Process clause protects an interest in life as well as an interest in refusing life-saving medical treatments." *Id.* at 2853.

<sup>39</sup> *Id.* at 2853.

may not be truly adversarial.<sup>40</sup> In any event, the State is not required to make judgments about the quality of life of individual patients and may "simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual."<sup>41</sup>

The Court then found that Missouri "permissibly sought to advance these interests through the adoption of a 'clear and convincing' standard of proof to govern proceedings to determine what the patient had chosen when competent."<sup>42</sup> Given the importance of the interests at issue, the state acts reasonably in nontreatment cases when it requires a higher degree of confidence than it does in an ordinary civil dispute involving the transfer of money. The Court noted:

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 maintenance of the status quo . . . . An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction.<sup>43</sup>

The Court found that the evidence adduced at trial regarding Nancy Cruzan's prior wishes did not meet the state's clear and convincing standard. Although the trial court had found that the evidence "suggested that Nancy would not have desired to continue such measures," that court had not assessed the evidence under a clear and convincing standard.<sup>44</sup> Given that this evidence

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<sup>40</sup> *Id.* at 2854.

<sup>41</sup> *Id.* at 2853.

<sup>42</sup> *Id.* at 2853-54. The Missouri position assumes, of course, that the only ground for withholding treatment from an incompetent patient is a prior, competent clear expression of a wish against treatment. This position overlooks the possibility of nontreatment that is necessary to advance or serve the patient's current interests. For a discussion of the constitutionality of such a position, see *infra* Part IV(C).

<sup>43</sup> *Cruzan*, 110 S. Ct. at 2854. The Court bolstered this point by noting that most states forbid oral testimony in certain contract cases, which are of lesser importance than a decision to terminate a patient's life. Thus, the parol evidence rule and statute of frauds in wills might also frustrate the wishes of decedents, just as this one might "have frustrated the effectuation of the not-fully expressed desires of Nancy Cruzan." *Id.* One could argue, however, that in Nancy Cruzan's case the fundamental right at stake was of greater personal significance than the liberty interest in making contracts.

<sup>44</sup> *Id.* at 2855. The trial court did not know that a clear and convincing standard of cer-

did not address nutrition and hydration and the remarks were made in conversation to a housemate, it was not clear constitutional error for the Missouri Supreme Court to find that the clear and convincing test was not satisfied.

The final point the Court addressed was the claim that Missouri must accept the "substituted judgment of close family members even in the absence of substantial proof that their views reflect the views of the patient."<sup>45</sup> The Court rejected this claim. Cases such as *Parham*<sup>46</sup> and *Michael H.*<sup>47</sup> allow states to rely on family decisionmaking, but they do not require that family choice always controls.<sup>48</sup> Thus, the Constitution does not require the "State to repose judgment in these matters with anyone but the patient herself."<sup>49</sup> Indeed, the Court recognized the possibility of inaccurate or conflicting assessments of the patient's wishes by the family:

Close family members may have a strong feeling—a feeling not at all ignoble or unworthy, but not entirely disinterested, either—that they do not wish to witness the continuation of the life of a loved one which they regard as hopeless, meaningless, and even degrading. But there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had she been confronted with the prospect of her situation while competent . . . . [T]he State may choose to defer only to the patient's wishes rather than confide the decision to close family members.<sup>50</sup>

In sum, the Court held that the state may choose decisionmak-

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tainty was required because the Missouri Supreme Court announced this standard after appeal of the trial court's decision. When the Cruzans reopened the case, the court found that the evidence of Nancy Cruzan's prior wishes did meet this standard. *See supra* note 18.

<sup>45</sup> *Cruzan*, 110 S. Ct. at 2855.

<sup>46</sup> *Parham v. J.R.*, 442 U.S. 584 (1979) (holding that the risk of error inherent in parental decision to leave child institutionalized for mental health care is sufficiently great that some kind of inquiry should be made by a neutral "factfinder" to determine whether statutory requirements for admission are satisfied).

<sup>47</sup> *Michael H. v. Gerald D.*, 491 U.S. 110 (1989) (stating that state's interest in protecting the integrity of the family outweighed petitioner's right to demonstrate his paternity of a child born into a marriage), *reh'g denied*, 110 S. Ct. 22 (1989).

<sup>48</sup> *Cruzan*, 110 S. Ct. at 2855.

<sup>49</sup> *Id.*

<sup>50</sup> *Id.* at 2855-56.

ing procedures for incompetent, comatose patients that require clear evidence of the wishes of the patient when she was competent.<sup>51</sup> Such a rigorous showing does not violate a competent patient's right to refuse treatment nor does treatment harm the comatose patient. Additionally, the family possesses no independent right to decide the matter. Thus, the state may constitutionally choose to protect even vegetative human life because doing so, as illustrated by *Cruzan*, violates no one's constitutional rights.

### B. Concurring Opinions

Justices O'Connor and Scalia joined the opinion of the Court but added their own views. Justice O'Connor's concurrence articulated two points. She discussed more fully why refusal of medical treatment, including nutrition and hydration, is a protected liberty interest.<sup>52</sup> She also noted that the right to refuse medical treatment should logically include the right to appoint surrogate decisionmakers who can refuse treatment for incompetent patients.<sup>53</sup>

Justice Scalia wrote separately to argue that any constitutional pronouncement is likely to confuse state legislative efforts because neither the Constitution nor the Justices have any special insight into these matters.<sup>54</sup> He strongly criticized the Court's conclusion that the liberty clause protects a competent adult's right to refuse necessary medical care. He equated such a right with a right to commit suicide, a right not "historically and traditionally protected against state interference."<sup>55</sup> Scalia's concurring opinion placed no limits on a state's rejection of a patient's refusal of artificial feeding and nutrition.<sup>56</sup>

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<sup>51</sup> Because *Cruzan* involved an incompetent, comatose patient, it is not clear that the holding would extend to incompetent, noncomatose patients. As noted below, such a position could violate the rights of such patients when they have present interests in nontreatment, regardless of prior directives against treatment. See *infra* Part IV(C).

<sup>52</sup> *Id.* at 2856 (O'Connor, J., concurring) (citing *Rochin v. California*, 342 U.S. 165, 172 (1952)).

<sup>53</sup> *Id.* at 2857 (citing Areen, *The Legal Status of Consent Obtained from Families of Adult Patients to Withhold or Withdraw Treatment*, 258 J. AM. MED. ASS'N 229, 230 (1987)).

<sup>54</sup> *Cruzan*, 110 S. Ct. at 2859 (Scalia, J., concurring).

<sup>55</sup> *Id.* at 2860.

<sup>56</sup> *Id.* at 2861-63.

### C. *Dissenting Opinions*

In *Cruzan*, Justices Brennan and Stevens wrote long dissenting opinions. Their arguments are briefly summarized here, and their substantive points are more fully discussed in the analysis of *Cruzan* that follows.

1. *Justice Brennan's Dissent.* Justice Brennan's dissent, joined by Justices Marshall and Blackmun, started with the assumption that patients who do not want a life sustained only by technology have a right to "die with dignity" free of such technology.<sup>57</sup> If competent, they have a fundamental right to refuse medical technology that would keep them alive, subject only to state restrictions that satisfy the demands of strict scrutiny.<sup>58</sup>

Incompetency does not deprive a person of fundamental rights.<sup>59</sup> The fact of incompetency, however, may "adjust the manner" in which rights are exercised by those "unable to exercise choice freely and rationally," for example, by requiring that they be exercised by agents "acting with the best interests of their principals in mind."<sup>60</sup>

Justice Brennan made several different arguments for halting treatment of Nancy Cruzan. He argued that when she was competent, she had in fact decided against treatment, a fact which the state's unreasonably high and biased standard of clear and convincing evidence prevented from being recognized.<sup>61</sup> Even if she had not issued a prior directive, she had a right not to be treated if her family found that she would have chosen to forgo treatment when competent.<sup>62</sup> While recognizing that she lacked any meaning-

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<sup>57</sup> *Cruzan*, 110 S. Ct. at 2863 (Brennan, J., dissenting) (quoting *Rasmussen v. Fleming*, 154 Ariz. 207, 211, 741 P.2d 674, 678 (1987) (en banc)).

<sup>58</sup> *Id.* at 2864. Justice Brennan gave the right to refuse medical care a much firmer foundation than the majority and would extend it to incompetent patients. He noted that, if there is a liberty interest to be free of unwanted medical care, then it must be part of a fundamental right against unwanted bodily intrusions. Moreover, he noted that this right exists, even if serious consequences such as death result from its exercise. Delivery of artificial nutrition and hydration is merely a form of intrusive medical treatment which a person has a constitutional right to refuse.

<sup>59</sup> *Id.* at 2867.

<sup>60</sup> *Id.* at 2867 (quoting *Thompson v. Oklahoma*, 487 U.S. 815 (1988)).

<sup>61</sup> *Id.* at 2869-71.

<sup>62</sup> *Id.* at 2877. He would grant the family, rather than the state, the power to decide when the choice that the patient "would make" cannot be determined. In that case "a state must generally either repose the choice with the person whom the patient himself would most likely have chosen as proxy or leave the decision to the patient's family." *Id.* at 2877-78.



ful interests in continued life, Justice Brennan also argued that maintaining her by gastrostomy feeding may have actually hurt her.<sup>63</sup> Finally, his dissent questioned whether the state's interest in preservation of life is legitimate in a case where the patient has only a metabolic existence, devoid of "thought, emotion and sensation."<sup>64</sup> He noted:

[T]he state has no legitimate general interest in someone's life, completely abstracted from the interest of the person living that life, that could outweigh the person's choice to avoid medical treatment . . . . Thus, the state's general interest in life must accede to Nancy Cruzan's particularized and intense interest in self-determination in her choice of medical treatment.<sup>65</sup>

2. *Justice Stevens' Dissent.* Justice Stevens wrote a long dissent full of philosophical reflections that paid less attention to prior directives and the standards by which they are established than they paid to Nancy Cruzan's best interests. He argued repeatedly that treatment in these circumstances violated her rights because a decision to treat her ignored her best interests.<sup>66</sup> At times, Stevens based this judgment on the finding of the guardian *ad litem* and the trial judge that withdrawing treatment would be in her best interests.<sup>67</sup> At other times, he argued that her interests included "how she will be thought of after her death by those whose opinions mattered to her."<sup>68</sup>

Justice Stevens also criticized the state's claimed interest in the preservation of life. He argued that the state was actually defining

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<sup>63</sup> *Id.* at 2868-69 (describing the damage that can occur to the patient's body as a result of the delivery of artificial nutrition and hydration through a gastrostomy tube).

<sup>64</sup> *Id.* at 2868.

<sup>65</sup> *Id.* at 2870.

<sup>66</sup> *Cruzan*, 110 S. Ct. at 2882, 2891 (Stevens, J., dissenting).

<sup>67</sup> *Id.* at 2882. Justice Stevens extensively quoted Missouri Supreme Court Justice Blackmar's dissenting opinion in support of the contention that she may have been in pain: "There is evidence that Nancy may react to pain stimuli. If she has any awareness of her surroundings, her life must be a living hell." *Id.* If she is truly comatose, however, it is difficult to understand how she can feel pain or have any interests at all. *See infra* text accompanying notes 78-81.

<sup>68</sup> *Cruzan*, 110 S. Ct. at 2885-86 (Stevens, J., dissenting). Many other similar statements are found throughout the opinion: "How she dies will affect how [she] is remembered," *id.* at 2886; "an interest in having their memories of her filled predominately with thoughts about her past vitality rather than her current condition," *id.* at 2892.

the meaning of life, rather than attempting to preserve its sanctity, when decisions regarding this definition should be left to the privacy of patient or family.<sup>69</sup> He emphasized the point that the patient's best interests, including her right to be remembered as a person of vitality, must control. Stevens wrote: "[T]he meaning and completion of her life should be controlled by persons who have her best interests at heart—not by a state legislature concerned only with the 'preservation of human life.'"<sup>70</sup> He thus viewed the state as trying to make an example of Nancy Cruzan and ignoring her own well-being:

However commendable may be the State's interest in human life, it cannot pursue that interest by appropriating Nancy Cruzan's life as a symbol for its own purposes. Lives do not exist in abstraction from persons, and to pretend otherwise is not to honor but to desecrate the State's responsibility for protecting life.<sup>71</sup>

### III. EVALUATION OF THE DECISION: CRUZAN WAS CORRECTLY DECIDED

*Cruzan* involved a family caught in an agonizing situation that cried out for relief. The Cruzans' daughter's life had effectively ended, even though she could have remained curled in a comatose position in a state institution for years. Except for Missouri, every state that had considered the matter would have allowed medical treatment, including artificial nutrition and hydration, to be withheld from an irreversibly comatose patient.<sup>72</sup> The vast majority of people, no doubt, would support the family's decision in these circumstances.<sup>73</sup>

Despite these compelling circumstances, Missouri law did not allow medical treatment to be terminated when there is no clear evi-

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<sup>69</sup> *Id.* at 2886-87.

<sup>70</sup> *Id.* at 2892.

<sup>71</sup> *Id.*

<sup>72</sup> See, e.g., *Gray v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988); *Foody v. Manchester Memorial Hosp.*, 40 Conn. Sup. 127, 482 A.2d 713 (1984); *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 Conservatorship of Torres*, 357 N.W.2d 332 (Minn. 1984).

<sup>73</sup> The exception is persons who hold strong right-to-life views and connect this situation with the debate over abortion. See *infra* note 174.

dence that the patient had issued a directive against treatment when competent because of its policy to protect all human life, regardless of its quality or functional ability.<sup>74</sup>

Missouri's extreme vitalist posture toward Nancy Cruzan cannot be justified as a matter of ethics or policy. She had lost the capacity to have interests and thus gained nothing from continued life, while treatment caused her family continual suffering.<sup>75</sup> Withholding artificial nutrition and hydration from comatose patients like Nancy Cruzan has few symbolic costs. It would not diminish respect for human life and poses little threat of a slippery slope to more extreme nonvitalist scenarios.

Notwithstanding the fact that Missouri's position was ethically questionable, the Supreme Court's decision upholding this posture was correct as a matter of constitutional law. A vitalist position toward comatose patients in Nancy Cruzan's circumstances cannot easily be shown to violate the patient's or her family's constitutional rights.

In justifying this conclusion, I examine several grounds offered to justify the claim that Missouri's requirement of gastrostomy feeding violated Nancy's or her parents' fundamental constitutional rights. I first examine the claim that the state violated Nancy's rights and then discuss the rights of the family to have treatment discontinued.

#### A. *Nancy Cruzan's Fundamental Rights Were Not Violated*

The question here is whether requiring gastrostomy feeding of an irreversibly comatose patient who has no cognitive life violates that patient's fundamental rights. This question might be rephrased: does an irreversibly comatose patient have a right not to be treated or a right to die when she has not made an explicit directive against treatment? The Cruzans and various *amici curiae* claimed that treatment directly violated Nancy Cruzan's right to refuse medical treatment—or her right to die—because it ignored her best interests. Consideration of the several strands of this claim will demonstrate that the Court correctly rejected these claims.

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<sup>74</sup> See *supra* note 28 and accompanying text.

<sup>75</sup> The Missouri policy did not serve her interests because she no longer had interests to be served, even if she would not have been hurt by continued treatment.

1. *She Was Not Refusing Treatment.* The strongest support for a claim that a state requirement of treatment violates a patient's fundamental rights—including the patient's right to die—arises when a competent adult refuses the present administration of life-saving treatment. The basis for such a right and its scope are discussed in detail below.<sup>76</sup> For present purposes, it is sufficient to note that Nancy Cruzan was not competent and had not refused gastrostomy feeding or other medical treatment because her comatose condition rendered her incapable of refusing treatment or exercising choice in any way.

2. *Gastrostomy Feeding Did Not Harm Her.* Treatment of an incompetent patient might also be unconstitutional if it harmed the patient, for example by injuring her or reducing her interests significantly without sufficient justification.<sup>77</sup> The petitioners argued that gastrostomy feeding harmed Nancy Cruzan. In Justice Stevens' words, Missouri's action was unconstitutional because it hurt or overwhelmed "her own best interests."<sup>78</sup>

The difficulty with this argument is that it appears to have no application to irreversibly comatose patients such as Nancy Cruzan. Irreversibly comatose patients, by definition, have no interests in their present condition, because they lack the mental substrate essential to the possession of interests. As Justice Brennan noted, Nancy Cruzan had a metabolic existence only, with no emotion, sensation or consciousness: "She is oblivious to her surroundings and will remain so. Her body twitches only reflexively, without consciousness. The areas of her brain that once thought, felt, and experienced sensations have degenerated badly and are continuing to do so."<sup>79</sup> As the petitioners and dissenting Justices noted, a person in such a diminished state has no interest in continued treatment, no matter how benign, because she has no interest in life.<sup>80</sup> Indeed, they base their claim for nontreatment on the fact that Nancy Cruzan's life had effectively ended. Nontreatment leading to total brain death would not deprive her of anything of

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<sup>76</sup> See *infra* Part IV(A).

<sup>77</sup> See *infra* Part IV(C).

<sup>78</sup> *Cruzan*, 110 S. Ct. at 2879, 2882 (Stevens, J., dissenting).

<sup>79</sup> *Cruzan*, 110 S. Ct. at 2863 (Brennan, J., dissenting). He made no claim that treatment was causing her pain. If pain were shown, see *supra* note 22, then a strong argument would exist for discontinuing treatment because continuing treatment would impair her interests.

<sup>80</sup> *Cruzan*, 110 S. Ct. at 2863, 2867-70 (Brennan, J., dissenting).

value to her because she had already lost the experiences and capacities that make life a good for persons. Her personal life was already over, though she was not yet dead under prevailing definitions of brain death, a position consistent with court decisions denying a comatose person damages for loss of enjoyment of the activities of life which her comatose state now prevents her from experiencing.<sup>81</sup>

If she had no interest in further living, however, it does not necessarily follow that she also had an interest in dying. If allowing her to die cannot harm her because she no longer has interests in any meaningful sense, then she cannot be harmed by further maintenance either. Nancy Cruzan simply had no further interests in being treated or not being treated. In the absence of interests, treatment cannot violate any interest or harm her in her permanently comatose state. Moreover, even if treatment might, in some circumstances, harm incompetent patients, it cannot harm the irreversibly comatose because they lack interests altogether.

How valid are the concerns about the indignity and humiliation which result from being sustained artificially which animate the dissenting opinions of Justices Brennan and Stevens? Justice Brennan wrote eloquently about the desire for a "quiet, proud death, bodily integrity intact" and the avoidance of an "ignoble end, steeped in decay" with submission of the most private bodily functions to the attention of others, resulting in the "debilitating effects of a long drawn out death on family members."<sup>82</sup> Justice Stevens was especially concerned about the patient's interest in "how she will be thought of after her death by those whose opinions mattered to her."<sup>83</sup>

For patients who are contemplating future situations of dependency or who are dependent and aware of their plight, these are real concerns which deserve respect. They are also real concerns for persons afraid that they or friends or family will become as dependent and debilitated as Nancy Cruzan. These concerns, how-

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<sup>81</sup> Brain death requires total cessation of all brain function, including brain stem functions which continue when a person is in a persistent vegetative state. See *infra* notes 201-02 and accompanying text. For decisions denying recovery of damages for loss of enjoyment by comatose persons, see *McDougal v. Garber*, 73 N.Y.2d 246, 536 N.E.2d 372, 538 N.Y.S.2d 937 (1989); *Nussbaum v. Gibstein*, 73 N.Y.2d 912, 536 N.E.2d 618, 539 N.Y.S.2d 289 (1989).

<sup>82</sup> *Cruzan*, 110 S. Ct. at 2868-69 (Brennan, J., dissenting).

<sup>83</sup> *Cruzan*, 110 S. Ct. at 2885-86 (Stevens, J., dissenting).

ever, cannot matter to the comatose patient, who lacks awareness of her situation and its impact on her family.<sup>84</sup> None of Justice Brennan's and Justice Stevens' concerns could have mattered to Nancy Cruzan after she had irretrievably lost awareness. Thus, because the patient was not capable of feeling the indignity or humiliation which may result from artificial treatment, these concerns do not show that gastrostomy feeding harmed Nancy Cruzan.

3. *Incompetent Patients Must Be Treated Equally.* The petitioners' claim in *Cruzan* that treatment violated Nancy Cruzan's right to decide against treatment also takes a form that combines aspects of the two claims just considered. They claim—and the dissent and many state supreme courts agree—that equal treatment of incompetents requires that they have the same right to refuse treatment that the competent patient has.<sup>85</sup> Otherwise incompetent patients would be treated unequally solely because of their incompetency. Accordingly, equal respect for incompetent patients requires that they have a right to have a proxy refuse treatment on their behalf.

Resolution of this issue is key to many ethical and policy questions concerning incompetent patients. It is a key point of difference between the majority and three dissenting justices in *Cruzan*.<sup>86</sup> If incompetent patients have a right to be treated as if they are competent decisionmakers and a corresponding right to have surrogates infer their choices, then states will be much more limited in the choices that they can make for incompetent patients.

Proponents of this view, however, make a conceptual error. It is true that incompetent persons may have a constitutional right to be treated with respect; they do not lose all rights just because they are incompetent. It does not follow, however, that they have

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<sup>84</sup> The distinction between how others view an incompetent patient and to what extent, if any, that patient may herself be experiencing the situation of illness and dependency is a crucial one that is often overlooked in discussions of these issues. Obviously if the patient were aware of her condition, one could make a strong argument in favor of withholding treatment to prevent her suffering.

<sup>85</sup> See Dresser & Robertson, *supra* note 13, at 236.

<sup>86</sup> The majority held that clear and convincing evidence of a patient's own expressed intent to withhold life-sustaining treatment will suffice. *Cruzan*, 110 S. Ct. at 2349. In contrast, the dissenters argued that a state must either repose the choice with the person whom the patient would have chosen as proxy or leave the decision to the patient's family. *Id.* at 2877 (Brennan, J., dissenting).

exactly the same rights as competent patients because the existence of certain rights necessarily depends upon a minimal level of mental functioning.

The majority recognizes this point when it points out that the claim of equality begs the question: "an incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right. Such a 'right' must be exercised for her, if at all, by some sort of surrogate."<sup>87</sup> An incompetent person cannot herself exercise the right to refuse treatment because the exercise of this right requires the mental capacity to be aware of the situation, to understand the alternatives and to make a choice. Thus, it is not meaningful to speak of an incompetent patient's possession of the same right to *refuse* treatment that a competent person possesses.

The majority's point is correct. Clearly, incompetent persons do not lose all constitutional protection merely because they are incompetent.<sup>88</sup> They do not, however, retain the same constitutional rights that competent persons enjoy. Certain rights necessarily require a minimum degree of mental functioning, while others may exist at lower functional levels. For example, a severely retarded person may lack the ability to vote, though she retains an interest in life. Thus her right to vote cannot be violated, but her right to life could be.<sup>89</sup> Similarly, the right to consent to or refuse medical care is also dependent on some minimum degree of mental functioning. Unless a person has the capacity to recognize alternatives and make choices, a claim that she has the right to refuse treatment makes no sense.

Indeed, Justice Brennan inadvertently supported the very claim

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<sup>87</sup> *Cruzan*, 110 S. Ct. at 2852.

<sup>88</sup> Although Justice Stevens mistakenly identified what the interests of a permanently comatose patient are, he correctly noted that "Our Constitution presupposes a respect for the personhood of every individual . . .," 110 S. Ct. at 2892 (Stevens, J., dissenting), thereby denying the claim "that chronically incompetent persons have no constitutionally cognizable interests at all, and so are not persons within the meaning of the Constitution." *Id.* at 2891.

<sup>89</sup> The same point could be made about the right to read or to reproduce. If the minimum mental ability to exercise these rights is missing, then it is nonsense to speak of that person as having such rights. See Ellman, *Cruzan v. Harmon and the Dangerous Claim That Others Can Exercise an Incapacitated Patient's Right to Die*, 29 JURIMETRICS J. 389, 395-96 (1989). The great difficulties that some persons—even lawyers—have with this point is evident in the responses to Ellman by Alan Meisel and Lois Snyder, *Letters*, 20 HASTINGS CENTER REP. 48-49 (1990) (arguing that Nancy Cruzan, though comatose, had a right to refuse medical treatment).

that he attempted to refute. He noted: "The right to be free of unwanted medical attention is a right to evaluate the potential benefit of treatment and its possible consequences according to one's own values and to make a personal decision whether to subject oneself to intrusion."<sup>90</sup> Such a right cannot be held by someone who utterly lacks the capacity to distinguish between benefits and burdens and express preferences. Such a person cannot have a right to refuse treatment because the notion of choice is irrelevant to her in her present condition, just as the idea that she has a right to vote for President is irrelevant.

Justice Brennan's assertion that "the fact that Nancy Cruzan is now incompetent [does not] deprive her of her fundamental rights" is not apposite because he fails to distinguish between the fundamental rights that one loses by incompetency and those that one retains.<sup>91</sup> Incompetent persons may retain fundamental rights of life and liberty to the extent that these concepts have meaning for them, but it does not follow that they also have fundamental rights to speak, vote, read or make medical decisions when they lack the capacity or awareness essential to the exercise of those rights.

Equal treatment of incompetent patients requires that their interests, to the extent that they exist, be respected. With regard to medical treatment, those interests may require either that treatment be provided or that it be withheld, depending on the benefits and burdens of a proposed treatment.<sup>92</sup> In some cases, the incompetent patient will have a strong interest in receiving medical treatment to make continued living possible. In other cases, the treatment may be so burdensome and the resulting life may be so marginal, that the patient's interests are best served by withholding treatment.<sup>93</sup> When the patient is irreversibly comatose, however, neither treatment nor its absence serves her interests because

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<sup>90</sup> *Cruzan*, 110 S. Ct. at 2867-68 (Brennan, J., dissenting).

<sup>91</sup> *Id.* at 2867. Of course a comatose patient may lose all rights because she no longer has any interests which could be protected by the recognition of any rights. For a discussion of whether the state could classify comatose patients as dead, see *infra* Part V(B)(3).

<sup>92</sup> See *infra* notes 192-93 and accompanying text.

<sup>93</sup> See *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977) (upholding probate judge's determination that, in a case involving a 68-year-old severely retarded leukemia patient, the "negative factors of treatment exceeded the benefits" and that therefore treatment could be withheld).



the patient lacks the mental capacity to have any interests whatsoever.<sup>94</sup>

If this claim is precisely understood, it is not inaccurate to say that incompetent patients have a "right" to have a surrogate or proxy decide for them. If they cannot make decisions for themselves, then someone else will have to make decisions for them. Traditionally, a guardian has been appointed to make decisions for incompetent persons, but the appointment of a guardian is not necessary if the incompetent patient's interests are otherwise protected. Moreover, the guardian or surrogate has no duty to determine what the person had or would have chosen when competent. Rather, respect for the incompetent patient merely requires that her current interests and welfare be respected, not that previously held interests, which no longer apply to her incompetent situation, be protected.

The incompetent patient thus does not have a right to have a surrogate decide for her according to what she previously wanted or according to the surrogate's substituted judgment concerning what the incompetent patient would have chosen if she were competent. States may be free to adopt such an approach, but it is not constitutionally required to protect the incompetent patient's interests.<sup>95</sup> If she does have present interests, for example if she is not comatose, those interests could be protected directly or by a surrogate decision designed to protect her current interests.

4. *No Prior Directive Against Treatment.* Treatment of Nancy Cruzan did not violate a right to have competently made advance directives against treatment enforced after she became incompetent.<sup>96</sup> If such a right exists, it is a right to direct that treatment

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<sup>94</sup> It does not follow that they have a right to die or that there is an obligation not to treat them. If they lack interests in being alive, similarly, they have no interest in dying. Justice Brennan thus contradicts himself (as do the Cruzans) on this point. If withholding treatment from Nancy Cruzan does not harm her because she has only metabolic function, then treating her over her family's wishes cannot harm her either. Furthermore, other actions done to her without her or her family's consent, such as using her as an organ source or as a subject of medical experimentation, would not harm her. If these actions are "too brave a new world" for Justice Brennan and "for our Constitution," it must be because of their impact on others and not because of demonstrable harm to the comatose person's interests. 110 S. Ct. at 2869 n.13 (Brennan, J., dissenting).

<sup>95</sup> See *supra* Part III(A)(3) for a discussion of the patient's interests and how they are to be protected.

<sup>96</sup> For a discussion of whether there is such a right, see *infra* Part IV(B)(2).

not occur at a future time when the person is incompetent. Such a right would protect the interest of competent persons in directing their future and in gaining assurance that certain undesirable outcomes will not occur.

These interests exist only if the patient in fact contemplated the future situation and chose a particular outcome, for example issuing a directive that certain interventions not occur. Thus, a state requirement for treatment of an incompetent patient would violate a right to refuse treatment by advance directive only if the person, when competent, had in fact directed that treatment not occur. Inferences or guesses that the patient would have issued such a directive if she had thought of it are not equivalent to making a directive.

In *Cruzan* there was no claim that, when Nancy Cruzan was competent, she had issued a written directive against treatment if she became incompetent. Whether she issued an oral directive was in dispute.<sup>97</sup> If she had not issued an explicit written or oral directive against treatment, however, the state did not violate a right to make such directives when it required that she be treated.

5. *Clear and Convincing Evidence Test for Prior Directives.* The petitioners claimed that the state ignored evidence that Nancy Cruzan issued oral directives against being medically sustained in a comatose state. Although she did not formally sign a living will or orally specify that no gastrostomy feeding should occur, they claimed that she made statements to friends and family that constitute an advance directive against treatment.<sup>98</sup> The state found the evidence of a prior directive insufficient because the family did not meet the clear and convincing standard of proof for establishing such directives. The question for the Court was whether this standard violated a person's right to refuse medical care by advance directive.

The majority's conclusion that the state may legitimately require a high degree of certainty that a prior directive against treatment has been made is neither irrational nor unjustifiably obstructive of

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<sup>97</sup> This was a major evidentiary point of difference, upon which the case turned.

<sup>98</sup> See *Comatose Woman's Lawyer Seeks to Reopen Death Issue*, N.Y. Times, Sept. 1, 1990, § 1, at 8, col. 3. The article reported that the family has "new evidence that she would not want to continue living in her condition." The family's petition stated that "three witnesses had come forward to tell of 'specific discussions with Nancy Cruzan regarding her wishes about life-sustaining medical treatment.'" *Id.*

such choices. If there is a right to refuse medical care in advance, state requirements to ensure that the right has in fact been exercised serve legitimate state interests in protecting life and in preventing erroneous determinations about what the patient had chosen when she was competent.

If a directive is binding and thus determines whether the incompetent patient will live or die, it is not unreasonable or unduly burdensome to require that the directive be knowingly and clearly expressed. The clear and convincing standard of proof ensures that the choice was in fact made and protects against termination of treatment when the patient had not in fact so directed.

If the right to make a binding advance directive is based on the importance to a person of knowing that she is directing the future and thus avoiding certain situations, then requiring that she consider that situation specifically and issue her directive in some explicit manner would seem to be consistent with that right. Although some procedural hurdles might violate the right to make such directives, requiring a clear showing that the person exercised prior choice is reasonable.

The state's interests in protecting life and preventing erroneous determinations are legitimate and important. The real import of an advance directive arises when treatment would actually serve the incompetent patient's interests, yet the directive is against treatment.<sup>99</sup> Honoring the directive would deprive the incompetent patient of treatment that would serve her present interest. If autonomous competent choices are to be privileged over the incompetent person's current interests, it is reasonable to require a clear showing that the competent person did indeed freely and knowingly issue a directive that trumps the incompetent patient's current interests. Thus, contrary to Justice Brennan's claims,<sup>100</sup> the

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<sup>99</sup> This conflict is seldom noted. Most people think that the directive is a way to have treatment withheld when treatment would not be deemed to be in the patient's interests and there is no other way to establish that point.

<sup>100</sup> Justice Brennan's argument goes as follows: The biased nature of the Missouri rule is most evident in "its categorical exclusion of relevant evidence" of Nancy's wishes. *Cruzan*, 110 S. Ct. at 2871-74 (Brennan, J., dissenting). Finding that her statements to family and friends were unreliable indicators of what she would want, the Missouri court seemed to suggest that "only a living will or equivalently formal directive from the patient when competent would meet this standard." *Id.* at 2875. Since few people actually issue such directives or think about the matter beforehand, requiring such specific evidence of the competent person's wishes ignores much relevant evidence of "what the patient's choice would be"

clear and convincing standard does not bias or skew the decision toward life; it merely ensures that a decision in favor of death is not inappropriately reached.

A requirement that the existence of a prior directive be clearly shown does not prevent persons from making such directives and legitimately protects incompetent patients. Because the interest in making enforceable prior directives is based on the importance to the individual of exercising autonomy and gaining certainty about future outcomes, requiring that the person clearly exercise choice to that end is legitimate. A presumed or inferred exercise of autonomy, or an unthinking or casual exercise, does not involve the exercise of autonomy that is so central to persons that it can override their later interests. In addition, it shifts control to the evidence about the prior choice proffered by persons who may have their own competing interests in a given outcome.

Critics of this position point to the burdens or obstacles that such requirements place in the way of persons seeking to issue prior directives against treatment.<sup>101</sup> These critics argue that people are not able to exercise their right of advance choice because they may not have known about the specific requirements necessary to that exercise. Furthermore, they argue, this requirement discriminates against the young, the poor and minorities who do not have access to legal advice and the means to make such directives.

This criticism is unpersuasive. If the right concerns the considered exercise of autonomy, then one simply must exercise it in a considered way. It is not unreasonable to require that the exercise in fact occur and that it be documented in writing or be made ex-

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and "evinces a disdain for her own right to choose." *Id.* The Missouri rule thus "skews the result away from a determination that as accurately as possible reflects the individuals' own preferences and beliefs." *Id.* at 2876. It is a rule that transforms human beings into passive subjects of medical technology." *Id.*

Although he finds the Missouri rule invalid, Justice Brennan would recognize safeguards that are "genuinely aimed at ensuring decisions commensurate with the will of the patient and . . . [which are] reliable as instruments to that end," such as mandatory judicial review of family or surrogate decisions. *Id.* The states have much leeway here, as long as the state "is seeking in a reliable manner to discover what he patient would want," without skewing the decision in some way. *Id.*

<sup>101</sup> *A Limited Right to Die*, TIME, July 9, 1990, at 59. Of course, such persons should not always be treated when they have not clearly issued a prior directive. For example, if treatment and further existence does not serve their current interests, treatment should be withheld regardless of an explicit prior directive. See *infra* Part IV(c).

plicit in some other manner to provide proof that it was exercised, just as written contracts are required for certain other autonomous decisions. A less restrictive position might lead to erroneous determinations and premature death of incompetent patients who possess interests in treatment.<sup>102</sup>

6. *Do What the Incompetent Patient Would Have Chosen If Competent.* A crucial difference between the majority and the dissents in *Cruzan* concerns decisionmaking when the patient has not clearly made a prior directive against treatment, that is, when proof of the directive does not meet the clear and convincing standard. In this situation, Justice Brennan and other critics of the decision argue that the incompetent patient has a right to have a proxy make a treatment decision consistent with the decision the patient herself, if competent, would have chosen.<sup>103</sup> In effect, critics claim that an incompetent patient has a right to loose substituted judgment—to have a proxy decide the matter according to how the proxy thinks that the person would have decided at a previous time when she was competent.

This contention raises another major public policy issue regarding incompetent patients. If a patient has not previously issued a clear directive against treatment, should the patient be treated solely in terms of her present interests, or should treatment decisions attempt to approximate what the patient would have chosen if she were competent and endowed with her previous interests and values?

As an ethical matter, arguments for each position can be asserted. Those who support treating the patient as she was speak of the trajectory of a life and emphasize that the incompetent patient's long prior history should not be ignored.<sup>104</sup> The opposing view emphasizes that respect for the incompetent patient requires that she be regarded as she now is and not as she previously was.<sup>105</sup>

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<sup>102</sup> The state could also require that an informed choice is be made because the very nature of the interest being protected is autonomy. Perhaps the state could also require that persons making such directives are aware of certain important features of the choice, such as the fact that future interests may be very different or that decisions might be made on some other acceptable basis.

<sup>103</sup> *Cruzan*, 110 S. Ct. at 2875-77 (Brennan, J., dissenting).

<sup>104</sup> Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375 (1988).

<sup>105</sup> Dresser & Robertson, *supra* note 13; Dresser, *Relitigating Life and Death*, 51 OHIO ST. L.J. 425 (1990).

State courts have varied on the issue. For example, Massachusetts has adopted a very loose substituted judgment approach, allowing the family to determine treatment according to their view of what the patient would have chosen if she were competent.<sup>106</sup> New York and New Jersey, on the other hand, appear to require treatment.<sup>107</sup>

As a constitutional matter, however, it is difficult to see how the result urged by the dissent follows. The incompetent patient has a right to have her interests and present welfare respected to the extent that she has interests.<sup>108</sup> Her present welfare is served by treating her in terms of her current interests, not in terms of interests that she previously had but which are no longer relevant. Indeed, treating her in terms of her previous interests could hurt her because it could lead to nontreatment when her current interests would be served by treatment. In addition, allowing the proxy to determine what the patient would have chosen if she were competent—an ambiguous standard open to several competing meanings—risks having the proxy choose what competent persons generally would choose or what the proxy would want for herself.<sup>109</sup> Evidence of what the patient would have chosen is often lacking. If it does exist, it may show no awareness of the fact that a person's interests may change significantly once she becomes incompetent.<sup>110</sup>

If the concern is the welfare and interests of the incompetent patient, that welfare is not served by treating the patient in terms of what she would want if she were still competent and endowed with her prior interests and values. To treat the incompetent patient according to her past values is to ignore the welfare of the incompetent patient as she now is. Thus, the loose substituted

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<sup>106</sup> See *Guardianship of Linda*, 401 Mass. 783, 519 N.E.2d 1296 (1988) (enumerating six inquiries relevant to the court-adopted substituted judgment test).

<sup>107</sup> See *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987) (holding that there must be clear and convincing evidence that incompetent patient would have refused treatment before guardian may force hospital to discontinue treatment); *In re Westchester County Medical Center*, 72 N.Y.2d 517, 534 N.Y.S.2d 886, 531 N.E.2d 607 (1988) (holding that there must be clear and convincing evidence of a prior directive against treatment before patient's daughters could require hospital to discontinue treatment).

<sup>108</sup> See *infra* notes 187-93 and accompanying text.

<sup>109</sup> The perils of substituted judgment are discussed in Dresser & Robertson, *supra* note 13, at 242-43.

<sup>110</sup> There could also be cases where it is in the interest of the patient not to be treated, but the loose substituted judgment doctrine allows an extremely vitalist family to have the patient treated against her wishes.

judgment test cannot be constitutionally required because it does not protect the interests of the incompetent patient.<sup>111</sup>

Nor can adopting this test be constitutionally required due to a right of competent persons to be treated as they would have chosen to be treated when they were competent if they ever become incompetent. If competent persons have a constitutional right to make enforceable directives against future medical care, that right is grounded in the importance to them of making such a directive. That importance, however, exists only if the competent person contemplates the situation and actually chooses to forgo future treatment. If the competent person has not made such a choice, there is no interest in any particular exercise of autonomy. Being treated as one might have chosen, when one has not made a choice, cannot be required out of respect for the competent person's autonomy.

Thus, the basis for such a right is very weak: people will be reassured knowing that in the future they will be treated in accordance with their past values and interests despite the fact that their future situation is very different than their past situation and that they have not issued an explicit directive about future treatment. It is equally plausible that people will be reassured knowing that they will be treated in accordance with their interests in their future situations rather than in accordance with what they, when competent, might have predicted their interests to be if they became incompetent. A constitutional right of incompetent patients who have not issued prior directives to be treated according to what a proxy thinks they might have chosen when they were competent cannot rest on such a weak rationale.

A corollary of the majority's position is that an incompetent patient has no right to have a particular proxy decide for her or to have a proxy decide according to what the patient would have chosen if she were competent. The incompetent person has a right to be treated with respect—that is to say, to have her current interests protected—but a particular proxy is not necessary to protect the incompetent patient's interests as long as those interests are otherwise being protected. Similarly, a proxy who is best situated

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<sup>111</sup> Whether the substituted judgment test is constitutionally permissible despite the fact that it might override the interests of incompetent patients, is discussed *infra* text accompanying notes 185-86.

to determine what the incompetent patient would have chosen if she were competent is not required to protect those interests. The incompetent patient merely has a right to have her interests protected as she is now, not as she was previously.<sup>112</sup>

### B. *The Family's Right to Determine Treatment for Incompetent Patients*

The Cruzans argued that they had an independent right to decide about Nancy's treatment as part of a fundamental right of family autonomy or privacy in intimate family matters. The majority rejected this claim without extensive discussion.<sup>113</sup>

As a constitutional matter, the Court was correct to reject this claim. The right to make decisions about intimate matters, such as whether to have children and how to rear them, are constitutionally protected aspects of family autonomy.<sup>114</sup> Cases involving handicapped newborns, however, demonstrate that family privacy has never included a right to withhold necessary medical care or to decide which medical care is necessary.<sup>115</sup> Moreover, although state grants of family discretion over a child's mental healthcare have been upheld, those cases did not turn on whether the parents had the right to make such choices.<sup>116</sup> Medical decisions pose the risk

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<sup>112</sup> Whether there is a right to appoint a proxy who will have binding authority to decide for the incompetent patient is discussed *infra* notes 182-86 and accompanying text.

<sup>113</sup> The family's claim has been articulated most succinctly by Professor Peggy Davis in a letter to the *New York Times*:

The Court's opinion gave virtually no acknowledgment of the traditionally recognized right of healthy families to maintain a realm of decision-making with respect to intensely personal moral issues . . . [L]egislatively determined ideology may well trump the judgments we would have made and the judgments of those bound to us by blood, trust and affection, leaving us in irreversible states that are less than conscious life. This is helplessness in a sense that is both profound and profoundly at war with the faith in individual dignity and private choice that animates our system of ordered liberty.

*Right-to-Die Ruling Curtails Individual Liberty*, *N.Y. Times*, July 12, 1990, § A, at 20, col. 4. The Court rejected this claim. It distinguished cases that had upheld family autonomy over the medical treatment of children by noting that it had involved a challenge of a state grant of discretion to the family and thus did not hold that such discretion was constitutionally required. *Cruzan*, 110 S. Ct. at 2855.

<sup>114</sup> See, e.g., *Parham v. J.R.*, 442 U.S. 584 (1979); *Moore v. East Cleveland*, 431 U.S. 494 (1977); *Wisconsin v. Yoder*, 406 U.S. 205 (1972).

<sup>115</sup> See generally, Robertson, *The Rights of Critically Ill Children*, in *THE RIGHTS OF THE CRITICALLY ILL* 80-97 (1983).

<sup>116</sup> *Cruzan*, 110 S. Ct. at 2855; *Parham v. J.R.*, 442 U.S. 584 (1979).



of conflicting family interests. As the majority noted in *Cruzan*: "Close family members may have a strong feeling . . . that they do not wish to witness the continuation of the life of a loved one which they regard as hopeless, meaningless and even degrading."<sup>117</sup>

Should the sphere of family autonomy be expanded to include such decisions? Many people think that parents of handicapped newborns should have the right to make decisions regarding the children's treatment, at least in cases where the children do not reasonably appear to have interests in being treated and staying alive. A similar argument may apply to treatment decisions for a family member who is comatose or otherwise severely incompetent. The family is closest to the incompetent patient, has been caring for her and is deeply affected. It would seem to be within the bounds of family life that the family have the authority to determine when treatment should end. On this view, the family's wishes should be overridden only where they are inconsistent with the patient's current interest in being treated.<sup>118</sup>

As a policy matter, this position is appealing as long as there are sufficient safeguards to ensure that family desires do not unreasonably subordinate the interests of the patients. Whether such a posture is constitutionally required, however, is another matter. The family may be very burdened emotionally, but psychological burden alone is insufficient to give rise to a fundamental right.<sup>119</sup> Nor is there an established tradition of having family members make such choices to ground a fundamental right, as there is with reproduction, education and choice of residence. Indeed, in most states, family members have no right to make treatment decisions for incompetent patients unless they have been appointed guardian. As guardian, their duty is to protect the ward's best interests, not to promote their own.

Establishing such a right to help the Cruzans would have ramifications—and dangers—in many other situations. Apart from any questions regarding the definition of "family," would the scope of

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<sup>117</sup> *Cruzan*, 110 S. Ct. at 2855-56.

<sup>118</sup> This is in essence Rhoden's position, though it is based on the family's own interests, not on the notion that it best serves the patient's interests. See Rhoden, *supra* note 104, at 379.

<sup>119</sup> For example, the family's psychological burden does not permit them to have treatment withheld from an infant born prematurely as the result of an induced abortion or from handicapped children. See *supra* note 115 and accompanying text.

this liberty extend to nontreatment for children, adults and parents?<sup>120</sup> Would the family thus have a right to have treatment withheld from elderly relatives in nursing homes as well as from handicapped newborns? Families are well-meaning, but families are also cruel. The risk that their decisions will serve the family's own interest instead of the interests of the incompetent patient is too great to be ignored. In addition, every state law concerning guardianship or substituted judgment for incompetent persons would be subject to constitutional attack as an interference with family privacy.

The conclusion that the sphere of constitutionally protected family autonomy does not extend this far is defensible because of the unprecedented nature and potentially dangerous scope of such a view of family autonomy. As a practical matter, the family is claiming a right to cause the patient's death. Clearly, the state has the power to determine when death occurs notwithstanding contrary views. Similarly, the state should have the ultimate power to decide whether the incompetent patient has interests worthy of protection. People may differ over whether there is a vitalist interest here, but the state is not required to adopt the family's view as to whether an incompetent person's life is worth protecting merely because of the burden that the person's continued life may impose on the family.<sup>121</sup>

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<sup>120</sup> Difficult questions would arise about the definition of "family": Is it biological or social? Is unanimity or a majority vote sufficient? Establishing a family's right to make proxy decisions would require that these questions be answered as a matter of constitutional law.

<sup>121</sup> Some critics of *Cruzan*, as well as Justice Stevens in his dissent, argue that the state inappropriately deprived the family of control over the body of Nancy Cruzan. *Cruzan*, 110 S. Ct. at 2881-82 (Stevens, J., dissenting). Since the state's requirement is based on vitalist interests—interests in protecting and preserving human life for its own sake even when benefit to the patient cannot be shown—the question of whether its vitalism is inappropriate depends upon whether its policies impose on the protected interests of others. As we have seen, because Nancy Cruzan was comatose, the requirement did not interfere with her interests or violate her rights.

Nor did it violate her family's right to determine whether she was dead or worth protecting. The state, not the family, is the final arbiter of what constitutes death and protectible life, that is unless the state is utterly irrational and arbitrary. The state is not required to equate cognitive death with death, and the state may adopt a whole brain definition of death despite the family's objections. See *infra* notes 201-03 and accompanying text.

Even when a patient is dead, it would not follow that the family has the right to dispose of the body as they wish. Although the family has traditionally had the right to decide on form of burial, as opposed to the doctor, hospital or funeral home, it does not follow that they have a fundamental right against the state in this regard. Thus, the state may prevent

#### IV. CONSTITUTIONAL LIMITS ON STATE VITALISM TOWARD NONCOMATOSE PATIENTS

*Cruzan* upheld a state policy of extreme vitalism because no constitutional rights had been violated in the situation before the Court. An important question after *Cruzan* is whether there are constitutional limits to state vitalism in treatment situations that do not involve comatose patients. In order to preserve human life, may the state require that competent persons also be treated? May it refuse to enforce a prior directive against treatment? May it require that all noncomatose, incompetent patients be maintained in order to protect human life?

The clearest limits on state vitalism arise in cases where there are competently made choices against treatment or where treatment would clearly harm the incompetent patient. This section discusses constitutional limits on state vitalism toward noncomatose patients.

##### A. *The Competent Patient's Right to Refuse Treatment*

Although widespread support for honoring competent refusals of medical care exists, state attempts to override such choices to protect human life will undoubtedly occur. Such conflicts could arise when adults refuse medical care necessary to keep them alive, and physicians or family seek judicial approval to treat them. Conflicts could also arise when a competent patient wishes to commit suicide, seeks the assistance of others in suicide or requests active euthanasia.

Although these issues did not directly arise in *Cruzan*, both the majority and the dissenters agreed that competent patients have some constitutional right to refuse necessary medical treatment.<sup>122</sup> There are important differences, however, between the majority and the dissenters regarding the nature and scope of such a right.

The majority noted that "the principle that a competent person

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families from burying cadavers of loved ones on their property or from storing them in a freezer. It may also require that autopsies be done and presumably could require that organs and tissue be donated for transplant or research after death. For example, constitutional attacks on laws allowing postmortem use of corneas without the family's consent have not succeeded. See *State v. Powell*, 497 So. 2d 1188 (Fla. 1986), cert. denied, 481 U.S. 1059 (1987); *Tillman v. Detroit Receiving Hosp.*, 138 Mich. App. 683, 360 N.W.2d 275 (1984).

<sup>122</sup> Only Justice Scalia did not accept such a right. *Cruzan*, 110 S. Ct. at 2859, 2863 (Scalia, J., concurring).

has a constitutionally protected liberty interest in refusing unwanted medical treatment" could be inferred from previous cases.<sup>123</sup> The majority, however, was careful not to discuss this "interest" either as a fundamental right subject to strict scrutiny or as an interest "encompassed by a generalized constitutional right of privacy."<sup>124</sup> In addition, the majority said nothing about the method of "balancing . . . liberty interests against the relevant state interests" in cases involving refusals of medical care.<sup>125</sup>

Justice O'Connor described the "liberty interest" in forced medical treatment more fully than the majority and noted that unwanted nutrition and hydration would implicate that interest. Imposition of medical treatment on an unwilling, competent adult "necessarily involves some form of restraint and intrusion."<sup>126</sup> She noted that "a seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures or other medical interventions."<sup>127</sup> Accordingly, the "liberty guaranteed by the Due Process clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water."<sup>128</sup> Her apparently firm commitment to this liberty interest included no clues about the standard of scrutiny that she would apply to conflicts between the state and this liberty interest.

Justice Brennan, on the other hand, noted the majority's avoidance of "discussing either the measure of that liberty interest or its application" and explicitly stated that the liberty interest under discussion is a "fundamental right" deeply rooted in American law and jurisprudence.<sup>129</sup> The tradition of informed consent in tort law is evidence that the "inviolability of the person is "so rooted in the traditions and conscience of our people as to be ranked as fundamental."<sup>130</sup> Accordingly, the state would have to show compelling

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<sup>123</sup> *Cruzan*, 110 S. Ct. at 2851.

<sup>124</sup> *Id.* at 2851 n.7.

<sup>125</sup> *Id.* at 2852.

<sup>126</sup> *Id.* at 2856 (O'Connor, J., concurring).

<sup>127</sup> *Id.* Does her comment about the interest of a seriously ill or dying patient indicate that she would not find a "liberty interest" with a less seriously ill patient, who might also feel that he is "a captive of machinery"? *Id.*

<sup>128</sup> *Id.* at 2857.

<sup>129</sup> *Cruzan*, 110 S. Ct. at 2865 (Brennan, J., dissenting).

<sup>130</sup> *Id.* at 2865. Justice Stevens characterizes the right as one of privacy founded on the important interest in bodily integrity and human dignity. *Cruzan*, 110 S. Ct. at 2884-85

reasons for interfering with refusals of treatment.<sup>131</sup>

Although they are not significant in *Cruzan* itself, these differences in the articulation of the right of a competent person to refuse medical treatment may be significant in other situations. The majority's use of the term "liberty interest" rather than "right" is a significant move in the Court's ongoing debate about the derivation of unwritten rights from the open-textured clauses of the Constitution. By calling it a fourteenth amendment "liberty interest" rather than a privacy right, the majority avoids acknowledging the existence of fundamental, unenumerated rights of privacy. Justice Brennan, on the other hand, sees this right as consistent with the Court's tradition of enumerating substantive rights under the due process clause.

This move, however, is not merely symbolic; it could substantially affect the standard of scrutiny that state restrictions on treatment refusals must meet. By avoiding "fundamental right" language, the Court may implicitly allow states to restrict this "liberty interest" upon a lesser showing of need than it would require if that interest were characterized as a fundamental right, thereby requiring the state to meet the rigorous standard of scrutiny traditionally applied to violations of fundamental rights.<sup>132</sup>

Given the majority's terminology, the extent to which states may interfere with competent refusals of medical care remains undetermined. A standard of scrutiny less strict than compelling state in-

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(Stevens, J., dissenting).

<sup>131</sup> The state action limiting it "cannot be upheld unless it is supported by sufficiently important state interests and is closely tailored to effectuate only those interests." *Cruzan*, 110 S. Ct. at 2864 (Brennan, J., dissenting).

<sup>132</sup> For example, calling termination of pregnancy a "liberty interest" in *Webster v. Reproductive Health Services*, 109 S. Ct. 3040, 3058 (1989), indicated that the interest at stake was less firmly protected than a fundamental right because any reasonable state interest, or at least one which does not impose an "undue burden," would justify state interference with that liberty. See also *Mathews v. Eldridge*, 424 U.S. 319 (1976) (holding that deprivation of disability benefits, a liberty or property interest, without an evidentiary hearing did not violate due process).

As in the abortion case, Justice O'Connor may again be the "swing vote." Her apparent commitment to this "liberty interest" will be tested by what she counts as "undue burdens" on its exercise. If she would require a complainant to demonstrate an "undue burden," as it appears to be in abortion, *Webster*, 109 S. Ct. at 3062 (O'Connor, J., concurring), then the state will have greater room to override patient choice than if a compelling interest standard were imposed. If this were the case, she would be less protective of this right than her rhetoric in *Cruzan* suggests.

terest, such as no undue burden or significant state interest, might permit a state to override a competent patient's refusal of medical treatment when the treatment is minimally intrusive or would restore the patient to a functional existence, as in cases involving blood transfusions for patients who are religiously opposed to them or other cases involving potential cures.<sup>133</sup> If preservation of life is a legitimate interest and intervention will restore the person to a reasonably functional life, then medical treatment might be viewed as not imposing an "undue burden" on the competent patient. If this interpretation is correct, the state will have the power in many situations to preserve life over the wishes of competent patients.<sup>134</sup>

The standard of scrutiny will also be crucial in determining whether the fourteenth amendment liberty interest protects individual autonomy in situations beyond refusal of medical treatment, such as suicide, assisted suicide and active euthanasia.

A strong case can be made for extending the liberty interest recognized in *Cruzan* to suicide by passive means—a refusal to eat or to accept medical care generally or after a suicide attempt. If the interest in bodily integrity permits one to refuse medical care when one is ill, it should also permit one to refuse food or treatment in other circumstances, such as suicide by starvation or the refusal of medical care after a failed suicide attempt, if competency can be established.

Indeed, Justice Scalia's argument against recognizing a right to refuse medical care is based on his perception that suicide by refusal of food or treatment cannot be distinguished from other refusals of necessary medical care.<sup>135</sup> Because suicide even by passive means has not been considered a fundamental right, there should be no right to cause one's death by refusal of medical treatment.<sup>136</sup>

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<sup>133</sup> See *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971); *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 42 N.J. 421, 201 A.2d 537 (1964), *cert. denied*, 377 U.S. 985 (1964).

<sup>134</sup> Even if the right here were recognized as a fundamental right, there may be some situations in which the patient's refusal might be overridden, such as cases where the intrusion is minimal and the patient will be restored to a normal, healthy life.

<sup>135</sup> *Cruzan*, 110 S. Ct. at 2860-62 (Scalia, J., concurring). Recall Chief Justice Rehnquist's response to this point: "We do not think a State is required to remain neutral in the face of an informed and voluntary decision by an adult to starve to death." *Cruzan*, 110 S. Ct. at 2852.

<sup>136</sup> *Id.* at 2860-61 (Scalia, J., concurring). Justice Scalia, however, overlooked the possibility that the person's interests in living are different in each case.

As he noted, attempts to distinguish Nancy Cruzan's case from the ordinary suicide do not work. Permanent incapacitation or pain would not justify or require that a person be allowed to commit suicide.<sup>137</sup> Nor does an active versus passive distinction properly distinguish the cases because starving oneself to death is as intentional a killing of oneself as using a gun.<sup>138</sup> If the state may interfere with the active killing of oneself, it should also be able to interfere with passively causing death.<sup>139</sup> Moreover, the interference with attempted suicide may involve as much of an intrusion on bodily integrity as overriding a competent refusal of medical treatment. If a state may use force to prevent a person from slashing his wrists, to administer a blood transfusion after a suicide attempt or to pump an overdose of barbiturates from his stomach, it should also be able to prevent him from killing himself by refusing necessary medical care.<sup>140</sup>

If the Court applied the logic of personal autonomy and found that the fourteenth amendment's liberty interest includes a right to kill oneself by active or passive means in nonmedical situations, the Court's standard for interfering with that liberty interest might reinstate prohibitions on suicide. That is, if only a rational basis or undue burden for interferences with that right must be shown, then the state's interest in preventing mistakes and protecting life might easily satisfy a standard of scrutiny less than a compelling state interest standard.

The same problem arises with a competent person's claim of a constitutional right to active suicide, assisted suicide or consensual active euthanasia in situations of terminal or chronic illness. One can make a cogent argument that the logic of a right to refuse necessary medical care necessarily entails these extensions. For example, if the competent patient has a right to cause her death pas-

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<sup>137</sup> *Id.* at 2860.

<sup>138</sup> *Id.* at 2861.

<sup>139</sup> *Id.* at 2862.

<sup>140</sup> Justice Scalia noted:

To raise up a constitutional right here we would have to create out of nothing (for it exists neither in text nor tradition) some constitutional principle whereby, although the state may insist that an individual come in out of the cold and eat food, it may not insist that he take medicine; and although it may pump his stomach empty of poison he has ingested, it may not fill his stomach with food he has failed to ingest.

*Id.* at 2863.

sively by refusing medical care, then her right to kill herself by active means should logically follow as should her right to have the assistance of others in pursuing that end. State prohibitions on suicide or assisted suicide may be viewed as imposing bodily burdens—by preventing their removal—just as forcing unwanted treatment on a competent patient imposes bodily burdens. Suicide enables the patient to avoid the bodily burdens of severe illness and a life no longer worth living, just as the refusals of medical care do. This logic would also make consensual active euthanasia a constitutional right of a competent patient unable to cause her own death.<sup>141</sup>

Even if active steps to cause one's death were found to be protected as a liberty interest under the fourteenth amendment, the weak standard of scrutiny would remain an obstacle to the assertion of such a right by competent patients. State restrictions on assisted suicide or active euthanasia to prevent mistakes, to preserve life and to protect the role of physicians might easily satisfy a less strict standard of scrutiny.<sup>142</sup>

#### *B. May the State Refuse to Enforce Advance Directives Against Medical Treatment?*

A state's vitalist policies might also come into conflict with directives made by competent persons against treatment if they become incompetent. For example, a state may refuse to honor living wills altogether, in cases of nonterminal conditions or in cases involving the withdrawal of artificial food and water. It may do so because it wishes to preserve human life whenever possible, be-

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<sup>141</sup> If one sees the underlying right as encompassing the dignity to decide when one dies or the dignity in not being bound to a state of burdensome life as judged by the person herself, then the right should extend to having the assistance of others, either to provide the means or to perform the act when she has no other means of accomplishing it. The right in question would be the right to be free of state interference—prohibition or subsequent punishment—in a person's efforts to rid herself of a life that she finds burdensome. Although courts will not easily recognize such rights, the pressure to do so will increase as more physicians assist patients to commit suicide and state laws pose barriers to the practice. See, e.g., Altman, *Doctor Says He Agonized but Gave Drug for Suicide*, N.Y. Times, Mar. 7, 1991, at 1.

<sup>142</sup> A primary objection to consensual, active euthanasia is the assumption that physicians will necessarily be the agents who cause death, as is the practice in the Netherlands. See Singer & Siegler, *Euthanasia—A Critique*, 322 N. ENG. J. MED. 1881, 1883 (1990). However, active euthanasia practices need not depend upon physician involvement.



cause it thinks that the incompetent patient's interests deserve protection or because it doubts whether such directives are knowingly made.

This possibility is not merely theoretical. Although living wills are widely supported, explicit legal recognition is variable and usually substantively limited in some respect.<sup>143</sup> For example, many states specifically authorize advance directives only for narrowly defined "terminal conditions."<sup>144</sup> Some states do not recognize directives if the incompetent patient is pregnant or if artificial food and water is at issue.<sup>145</sup> Only thirteen states explicitly recognize a person's right to appoint a healthcare proxy, leaving unclear the effect of durable power of attorney in many circumstances.<sup>146</sup>

May the state refuse to honor directives that fall outside specific statutory authority? Or does the competent patient's liberty interest in refusing medical care include a right to refuse treatment in advance through written or oral directives or through the appointment of a health care proxy? The answer to these questions will affect the power of the state to adopt vitalist policies when competent persons decide otherwise.

The constitutional status of prior directives against treatment was not directly addressed in *Cruzan*. Nevertheless, statements in several opinions suggest that a majority of the Court would find some fourteenth amendment protection for advance refusals of medical care.<sup>147</sup> This section analyzes the arguments for and against constitutional recognition of prior directives against medical care.

1. *The Argument for Constitutional Recognition.* The argument for constitutional recognition of competently made, prior directives

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<sup>143</sup> See generally Gelfand, *Living Will Statutes: The First Decade*, 1987 Wis. L. Rev. 737.

<sup>144</sup> *Id.* at 740-47.

<sup>145</sup> *Id.* at 750-53 (discussing statutes under which food, water, comfort-care and pain-reduction techniques cannot be withdrawn), 778-80 (discussing the effect of pregnancy on the effectiveness of a living will in states which have considered this issue).

<sup>146</sup> Justice O'Connor lists these statutes in her concurring opinion, *Cruzan*, 110 S. Ct. at 2857-58 n.2 (O'Connor, J., concurring). For her listing of general durable power of attorney statutes and living will statutes that allow the appointment of a health care proxy, see *id.* at 2858 nn.3-4.

<sup>147</sup> If Justice O'Connor's statement that the Court's decision "does not preclude a future determination that the Constitution requires the states to implement the decisions of a patient's duly appointed surrogate," *id.* at 2858, indicates her support of such a decision, then her opinion combined with the four dissenting justices totals five votes in favor of the right to make advance decisions regarding medical care.

is based on personal autonomy and the importance to individuals of directing their future. If a competent person is free to reject medical treatment now, she should also be free to reject it in the future. As Justice O'Connor noted in her concurring opinion, such recognition "may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment."<sup>148</sup> Both present and future refusals involve the exercise of autonomy. Advance directives also provide certainty that treatment scenarios that burden family members and keep the patient alive in an undignified and humiliating state will not occur.<sup>149</sup>

In this view, competently made prior directives should receive the same constitutional protection that current refusals of medical treatment receive. Presumably this respect would extend to written or oral directives as well as to the decisions of an agent designated for healthcare decisions. State refusals to honor directives would then have to meet the same standard of justification that state attempts to override current refusals of medical treatment must meet. If a competent patient may refuse treatment for nonterminal conditions, food and water and treatment during pregnancy, she would then also have the right to make advance, enforceable directives against treatment if she is incompetent in those situations.<sup>150</sup>

Competently made prior directives would thus be an important check on state vitalism because they give control to the competent patient who is concerned about treatment in future situations of incompetency. States may set reasonable standards for establishing

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<sup>148</sup> *Id.* at 2857. She emphasizes that this question remains unresolved, suggesting that it might be recognized in a case directly raising the issue. Because few persons in fact make explicit oral or written directives concerning medical treatment when they become incompetent, she also appeared inclined to recognize the choices of a proxy appointed by the patient. Thus the Court's decision in *Cruzan* "does not preclude a future determination that the Constitution requires the States to implement the decisions of a patient's duly appointed surrogate." *Id.* at 2858. But if a surrogate may be appointed, a written or oral directive should also be constitutionally protected as well, even though she does not mention that right.

<sup>149</sup> It is also widely thought that an advance directive provides the best indication of what a patient would want in those circumstances. This is a misconception because, when she is incompetent, she is no longer capable of choice. It does, however, indicate what she would want contemplating her future situation.

<sup>150</sup> One could thus argue on the basis of *Cruzan* that state living will laws that do not permit advance directives for the withholding of artificial nutrition and hydration are unconstitutional.

the existence of the directive and for assuring that it is knowingly and freely made, but they would not be able to privilege life or other interests over the substantive content of the competently made prior directives.

2. *Arguments Against Constitutional Recognition of Prior Directives.* The argument against a constitutional right to refuse treatment in advance distinguishes between current and advance refusals of medical care and denies that the latter has the same importance as an exercise of individual autonomy as the former does.

First, because of differences in immediacy, constitutional recognition of a right to refuse medical care in advance does not necessarily follow from the recognition of a right to refuse care in the present. The interest in refusing medical care is an interest in avoiding immediate bodily burdens that will clearly pose burdens to the patient refusing treatment. The interest in refusing medical treatment in advance is an interest in exercising control and in being reassured that certain, speculative situations of medical maintenance will not occur.

The interest in making a binding prior directive is thus a present interest in avoiding a future condition that may never occur. In contrast to present refusals of treatment, if incompetency does occur, the person may be unaware of the burdens of the medical treatment at issue. Moreover, the incompetent patient's interests may be very different than they appear to a competent person projecting the future. Indeed, adhering to the advance directive could harm the incompetent patient because her needs and interests could be significantly different than the person making the directive predicted.<sup>151</sup>

Second, the satisfaction and certainty that arises from controlling one's future in this way is not so central to personal autonomy and identity that it deserves fundamental right status. Because of the hypothetical nature of the concern, it hardly seems to have the

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<sup>151</sup> Dresser, *supra* note 105, at 431-32 (offering the two examples discussed in the text).

If a right—or liberty interest—in making an enforceable prior directive were recognized, questions concerning the standard of scrutiny for restricting that right would still arise. If the standard of scrutiny is relatively weak, recognition of such a right would not have as great an impact, and states would remain free to restrict or regulate prior directives to protect the present interests of incompetent patients. See *supra* note 134 and accompanying text.

importance to individuals that decisions over reproduction, education of children, religious affiliation, speech and other constitutional rights have. It is simply not so important to individual identity that it should have protected constitutional status. Thus, a competent person's interest in controlling future situations of incompetency lacks the centrality to current interests and identity that warrants recognition as a fundamental right.

3. *Implications of Recognition of Such a Right.* Although the existence of constitutional rights should not necessarily depend on the consequences of their recognition, it is interesting to examine the consequences that would follow from constitutional recognition of a right to make advance directives against medical treatment.

a. *State Living Will Policy*

If there is a constitutional right to refuse treatment in advance, then state restrictions on advance refusals will receive the higher degree of scrutiny accorded to constitutional rights.<sup>152</sup> States would be presumptively barred from refusing recognition of directives that apply to nonterminal situations, pregnancy and nutrition and hydration. They would also be barred from penalizing physicians, hospitals and others who acted in reliance on what appeared to be competently made, prior directives against treatment, regardless of the incompetent patient's condition. All other restrictions in state living will and durable power of attorney statutes would be subject to constitutional challenge for improperly limiting the exercise of that right. While such constraints may sometimes be arbitrarily imposed and lead to treatment of incompetent patients whose best interests are served by nontreatment, constitutional constraints might also impair the ability of the state to protect incompetent patients from improvidently making advance choices against treatment that end up hurting incompetent patients.<sup>153</sup>

The problem with such an outcome is that the state may be impaired in its ability to protect incompetent patients who should be

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<sup>152</sup> States would be required to meet a heavier burden than rational basis to limit that right. At the very least, a state would have to show that its regulation did not impose an "undue burden" on the exercise of the right. In fact, it is possible that a more restrictive scrutiny would also apply. See *supra* note 132 and accompanying text.

<sup>153</sup> Thus, constitutional status may also lead policymakers to conclude that they must treat indefinitely incompetent patients who have issued directives in favor of treatment, even if there is no discernible benefit to the patient. See *infra* note 198.

treated, for example, in situations where treatment is in the incompetent patient's interest. Advance directives serve the interests of competent persons concerned about their future, not the interests of patients who are incompetent.<sup>154</sup> Thus, they risk projecting the competent person's interests into a situation of incompetency, a situation in which the patient's interests and needs are very different than those previously contemplated. Honoring the directive could thus harm the incompetent patient, whose situation is now very different than the person making the directive imagined.

Constitutionalizing advance refusals of medical care could thus impair efforts by the state to assure that nontreatment does not harm the incompetent patient's interests. It could lead states to make no efforts to protect incompetent patients from improvidently made prior directives because the state perceived no conflicting interest. Alternatively, it could lead to the invalidation of statutes that permit physicians to refuse to honor directives that they think conflict with the incompetent patient's interests.

Constitutionalizing prior directives might also limit the procedures which the state requires for the making of directives to ensure informed consent, minimize mistakes and prevent fraud and abuse. Similar issues with durable power of attorney statutes would arise: is it enough to designate a proxy with full power or can the maker be required to specify the circumstances under which the designated proxy is to act? In what circumstances will the state be permitted to regulate such proxy decisions? In short, there will be confusion and an absence of clear guidelines governing permissible state action. This confusion may only delay the adoption of state policies for controlling future medical care through prior directives.<sup>155</sup>

### *b. Implications Beyond Advance Refusal of Medical Care*

If one has a right to refuse medical care in advance, then one could argue that one also has a right to exercise other constitu-

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<sup>154</sup> Only if the incompetent patient would be treated in the absence of a living will and such treatment would harm his interests, would enforcement of the prior directive actually serve the incompetent patient's interests.

<sup>155</sup> Note the reverse question: Whether giving the right to have treatment withheld in the future is actually unconstitutional because it violates the right of the incompetent patient to have his interests protected once he is incompetent. See *supra* notes 14-16 (discussing previous interests versus current interests).

tional rights in advance as well. The interest in autonomy and certainty about the future is identical, whatever the particular object of the directive. Any present right of a competent person should then be subject to exercise by an advance directive.

If this premise is accepted, two other categories of enforceable advance directives would arise. The first category involves advance consent to activities other than treatment refusal in future situations of incompetency. Thus, a person could give advance consent to being a subject in medical experimentation, a live donor of bone marrow or other tissue or organs or even active euthanasia (if active euthanasia were legally permitted). The only issue would be whether the advance consent is given to an activity that is itself constitutionally protected when the patient is competent. If so, there is no way to distinguish advance refusals of treatment from these other activities.<sup>156</sup>

The second category of expanded advance directives include advance control of later situations where the person remains competent. The autonomy interest in present control of future situations will exist even though the future situation does not involve incompetency. Although one will be able to exercise choice at that future time, it may often be advantageous and meaningful to exercise that control in advance. Thus, the interest in exercising control and acquiring certainty may be equally strong whether or not the directive takes effect at a time of competency or incompetency.

If this observation is true, then people should have a constitutional right to make enforceable directives or contracts regarding abortion, reproduction, childrearing, surgery and frozen embryos. The most obvious example is a woman's advance directive, in the form of a surrogate mother contract, to relinquish custody of a child she bears for an infertile couple.<sup>157</sup> Another example is a surrogate mother's advance agreement not to abort the pregnancy or

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<sup>156</sup> Advance directives for postmortem organ donation, autopsy and disposition of property also serve the interests of competent persons in exercising autonomy and gaining certainty about future situations. A crucial difference, however, in these situations, unlike in cases involving medical treatment, is that at the time that the directive becomes applicable, the maker will no longer have interests to be protected.

<sup>157</sup> The argument that enforcement of such contracts may be constitutionally required on grounds of the procreative liberty of the infertile couple is presented in Robertson, *Embryos, Families and Procreative Liberty: The Legal Structure of the New Reproduction*, 59 S. CAL. L. REV. 939, 1011-15 (1986).

to abort it if there is a serious genetic defect.<sup>158</sup> The disposition of frozen embryos in case of divorce or death is another subject that could be agreed upon by an advance directive or contract between the parties.<sup>159</sup> Finally, women who are in high-risk pregnancies might find it advantageous to give advance consent to performance of a cesarean section in the event that the physician determines that the operation is appropriate during labor.<sup>160</sup>

The question of enforcement of advance directives in these reproductive situations differs from advance refusals of medical treatment in that the subject of the directive is competent at the time the directive is to take effect. Indeed, the issue of enforceability will arise when the maker of the directive wants to be relieved of its terms because she later finds the burdens and benefits of the situation to be different from those she had previously anticipated. Like Ulysses at the mast, she wants to be free of her previous commitment in order to pursue a different goal.<sup>161</sup> A strong argument for enforcement remains, however, if the Constitution protects the right to have advance directives for situations of incompetency enforced.

In order for competent persons to gain the certainty that they wish from advance directives, including the participation of others, they will have to accept that they will be binding in the applicable situation, even if they subsequently change their minds. In exchange, others who rely on their commitment will be willing to enter into the transaction which the maker finds to be important. Indeed, the reliance by the other party on the directive makes enforcement especially compelling because the other party will have relied on it and, as a result, may have incurred heavy costs.<sup>162</sup>

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<sup>158</sup> *Id.*

<sup>159</sup> Robertson, *Prior Agreements for Disposition of Frozen Embryos*, 51 OHIO ST. L.J. 407 (1990).

<sup>160</sup> A physician might ask a woman to agree in advance to undergo a cesarean section if she deems it necessary, even if the pregnant woman later refuses. See Dresser, *Ulysses and the Psychiatrists: A Legal and Policy Analysis of the Voluntary Commitment Contract*, 16 HARV. C.R.-C.L. L. REV. 777 (1982).

<sup>161</sup> Unlike the situation of Ulysses at the mast, however, the person is not arguably incompetent to overrule her prior directive as Ulysses was when he heard the siren's song.

<sup>162</sup> One example is the couple that entrusts their embryo to a gestational surrogate in reliance on her promise to return it at birth. If the surrogate is to have opportunities to be a surrogate, she will have to agree to give up custody at a later time and be willing to have her agreement enforced. Similarly, enforcing prior agreements for the disposition of frozen embryos gives each party the power to control eventual disposition, even if there is the risk

4. *Should States Recognize Living Wills?* The fact that the principle underlying the enforcement of advance refusals of medical care has the above implications should cause one to reconsider whether a right to refuse treatment in advance should be recognized when the autonomy interest is less compelling than it is in a present refusal of medical care. If such a right follows from the right to refuse treatment, then it is difficult to distinguish advance exercise of many other constitutional rights. The problem that arises—that the person's interests may be very different than she previously anticipated and therefore she should not be bound by the prior directive—also arises with advance refusal of medical treatment. Once the anticipated situation occurs, the patient's interests may be very different than previously envisaged. This situation is most clearly presented when the maker is later competent and objects, but it may also be true when she is incompetent because her interests may be very different than previously imagined. Enforcing advance exercises of other constitutional rights thus shows the problem with the claim that advance refusals of medical care should be honored.

The most desirable outcome is to avoid constitutionalizing advance refusals of medical care, so that states will be able to exercise discretion in setting both procedural and substantive limits on their use. The most desirable compromise between present control of the future and the future needs of incompetent patients has no clear constitutional answer. If a constitutional right is not at stake with every living will, states can take full account of the possible discrepancies that arise between prior directives and the actual needs of incompetent patients and fashion a policy that best serves the needs of each.<sup>163</sup>

### C. *The Incompetent Patient's Interest in Nontreatment*

A third possible constraint on vitalist state policies would arise in the absence of a present or past competent refusal of medical treatment. If no obstacle to treatment based on the patient's au-

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that they will change their minds and have the agreement enforced against their later wishes. See *supra* note 159 and accompanying text.

<sup>163</sup> In doing so, states will have to confront the issue of whether to adopt the best interests test or some other test and respect the incompetent patient's interest in treatment or nontreatment, as the situation demands.



tonomy can be raised, there is still the question of whether the mandated treatment harms the incompetent patient.

Unlike Nancy Cruzan, who had no interest in living or dying after lapsing into a comatose state, conscious incompetent patients may have substantial interests in how they are treated. A vitalist policy may often serve their interests in continued life, but when the treatment is very burdensome and the resulting benefits marginal, vitalist policies may actually harm the patient.<sup>164</sup>

In those cases, one could argue that state interventionist policies are unconstitutional violations of the incompetent patient's liberty. Incompetent patients retain fourteenth amendment rights to life and liberty.<sup>165</sup> If they are conscious and capable of suffering, state policies that require burdensome treatments with little corresponding benefit would deny them liberty. This situation might arise where an incompetent patient's death is imminent or where the patient has no interactive existence. Those policies would force them to undergo procedures that impose great burdens and produce little benefit.<sup>166</sup>

This question is most likely to arise when a state requires that incompetent patients who have not issued explicit prior directives against treatment always be treated, such as occurs in states that reject either a loose substituted judgment test or a current best interests test.<sup>167</sup> Such policies eschew an inquiry into whether treatment actually serves the patient's current interests; therefore, physicians, hospitals and courts may conclude that they have no choice under state law other than to treat the patient. In that case, family or proxy should argue that the state's vitalist policy is un-

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<sup>164</sup> The vitalist policy could take the form of a direct prohibition on nontreatment or a delegation to family of discretion where the family is excessively vitalist. It would also arise if a state took an extreme vitalist position and required that all patients be treated if there were no explicit prior directive against treatment, like Missouri did in *Cruzan*. *Cruzan v. Harmon*, 760 S.W.2d 408, 419 (Mo. 1988) (en banc), *aff'd sub nom. Cruzan v. Director, Missouri Dep't of Health*, 110 S. Ct. 2841 (1990).

<sup>165</sup> Justice Stevens made this point in his dissent. He noted that "[o]ur Constitution presupposes a respect for the personhood of every individual," *Cruzan*, 110 S. Ct. at 2892 (Stevens, J., dissenting), and when he strongly disagreed with the proposition "that chronically incompetent persons have no constitutionally cognizable interests," *id.* at 2891.

<sup>166</sup> Justice Stevens and others, however, mistakenly viewed gastrostomy feeding as harming Nancy Cruzan's interests, when her permanent coma prevented her from having interests in being treated or not being treated. See *supra* note 81 and accompanying text.

<sup>167</sup> Missouri and New York, among other states, take this position. See *In re Westchester County Med. Center*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988).

constitutional because it deprives the incompetent patient of her liberty interest in being free of nonbeneficial, burdensome medical intrusions.

This argument asserts that the fourteenth amendment requires states to adopt a current interests test for determining whether treatment must be provided to incompetent patients who have not issued explicit directives against treatment. Whether or not reliance on prior explicit or implied wishes is constitutional, the state is not free to interfere with the bodily integrity of an incompetent patient in order to preserve life without any corresponding benefit. It must treat that patient with respect, which means determining whether she truly has interests in treatment and continued life. If she does not, the state violates the incompetent patient's liberty when it subjects her to burdensome medical treatment. The state may not appropriate the body or person of an incompetent conscious patient to make a symbolic statement about the importance of human life when doing so harms the incompetent patient.<sup>168</sup>

#### D. *Constitutional Limits on Prenatal Vitalism*

The state's power to take a vitalist position at the end of life may be contrasted with its power to do so at the beginning of life. The abortion debate concerns the state's power to protect or preserve all prenatal forms of human life—to take a vitalist position toward fetuses over the objections of pregnant women. In its most extreme form, prenatal state vitalism views fertilized eggs, embryos and fetuses as persons or legal subjects and requires that they be protected, regardless of the impact on pregnant women and others.<sup>169</sup>

Current constitutional limits on prenatal state vitalism mirror the limits on state vitalism at the end of life. Under *Roe v. Wade*, the state is limited in its prenatal vitalist policies by the woman's right of bodily integrity—her right to be free of unwanted preg-

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<sup>168</sup> See *Cruzan*, 110 S. Ct. at 2892 (Stevens, J., dissenting). Unlike *Cruzan*, the patient in this case has real interests in nontreatment that are being violated. Nor does the family's interest in life justify imposing treatment on an incompetent patient whose best interests are served by nontreatment.

<sup>169</sup> Extreme prenatal vitalism is found in Missouri, Louisiana and Minnesota, which regard the fertilized egg and early embryo as a person or legal subject for many purposes outside of abortion. See Robertson, *In the Beginning*, *supra* note 7, at 452 n.7.

nancy.<sup>170</sup> Only when the fetus has reached the advanced stage of viability (and thus has interests in its own right) may state vitalism subordinate the woman's interest in bodily integrity. On the other hand, if prenatal human life is outside the woman's body, thus not implicating her bodily integrity, such as embryos created by *in vitro* fertilization, then the state is relatively free to take a very protective position.<sup>171</sup> The interest in avoiding genetic offspring *tout court* (biological reproduction without any contact or rearing role with offspring) may not rise to the level of a fundamental right, which trumps state vitalism.

This position shares the commitment to bodily integrity that limits state vitalism at the end of life. As we have seen, a patient's objection to present or future medical care precludes the state from imposing on her body. If she is incompetent, her interests still take priority over state vitalism. The state may adopt vitalistic policies for chronically ill or dying patients only when it does not violate their right to bodily integrity, a position similar to the state's power with regard to prenatal human life.<sup>172</sup>

Thus, *Cruzan* portends nothing about the future of *Roe v. Wade* and abortion.<sup>173</sup> State vitalism in *Cruzan* is consistent with *Roe's* right to end pregnancy because gastrostomy feeding did not intrude upon the choice, bodily integrity or other interests of a permanently comatose patient. One hopes that the Court would have ruled differently if the state insisted on treating a conscious incompetent patient whose best interests were clearly served by nontreatment.<sup>174</sup>

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<sup>170</sup> 410 U.S. 113 (1973), *reh'g denied*, 410 U.S. 959 (1973).

<sup>171</sup> Robertson, *In the Beginning*, *supra* note 7, at 497-501.

<sup>172</sup> Of course, there may be disputes about whether the incompetent patient has any interests at all.

<sup>173</sup> In its recognition of a "liberty interest" rather than privacy, *Cruzan* is consistent with *Webster v. Reproductive Health Services*, 109 S. Ct. 3040 (1989). Moreover, as in *Webster*, Justice O'Connor's views about the requisite standard of scrutiny and what is entailed by "undue burden" will determine the extent to which the state may interfere with the choice of competent persons to refuse necessary medical treatment. See *supra* note 132-34 and accompanying text.

<sup>174</sup> Johnson, *Foes of Abortion View "Right to Die" as Second Battle Over Life and Death*, N.Y. Times, July 31, 1990 § A, at 8, col. 1. Abortion foes also oppose the right to die, at least as far as it concerns active euthanasia or the withholding of feeding tubes, even in the presence of an explicit directive. They recognize that nontreatment decisions often allow some other interest to take priority over human life, and that the roots of the right are found in an unwritten right of privacy in the fourteenth amendment, which implicitly legiti-

## V. CONSTITUTIONAL LIMITS ON NONVITALIST POLICIES

The discussion has focused on the constitutional limitations on state policies of vitalism—policies that protect human life regardless of its quality or impact on other interests.<sup>175</sup> The state has wide discretion to adopt vitalist policies, except where a competent patient's wishes against present or arguably future treatment conflict or it could be clearly shown that the policy hurts the patient's current interests.<sup>176</sup>

Many states, however, reject strict vitalism and adopt policies toward severely ill, incompetent persons that are decidedly nonvitalist. Nonvitalist policies may be direct or indirect, and may run the gamut from prohibitions on funding to broad grants of discretion to families to have treatment withheld.

In the current stage of policy development, policies that are directly nonvitalist are rare and generally disapproved. For example, no state authorizes active euthanasia for incompetent patients, explicitly permits or requires private and public insurers to withhold funds from incompetent patients or gives families authority to determine treatment on the basis of the family's need.

On the other hand, state policies that are indirectly nonvitalist are widespread. The most common examples are laws or court rulings that permit families or proxies to have treatment withheld from incompetent patients on the basis of their judgment of what the patient would have chosen if competent.<sup>177</sup> These rules grant broad discretion to families, while appearing to serve the interests of the patient when competent.<sup>178</sup> In fact, in some cases, they lead to decisions against treatment that may not clearly be in the patient's interest.<sup>179</sup>

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mates or shares the premises of *Roe v. Wade*, as Geoffrey Stone notes. *Id.*

<sup>175</sup> A main appeal of vitalism is, of course, that in many instances the patient benefits from the vitalist policy because she has an interest in further living, which the vitalist policy protects.

<sup>176</sup> This statement is a summary of constitutional limits on state vitalism. Although I think that courts should adopt this analysis in deciding cases, the statement is not yet a positive description of what courts in fact do.

<sup>177</sup> See *supra* note 9 and cases cited therein.

<sup>178</sup> Supporters of loose substituted judgment may not even be aware of the nonvitalist import of the test, sincerely believing that they are doing what best serves the patient's welfare by having family or proxy decide that the patient would have chosen nontreatment and death if competent.

<sup>179</sup> See *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980) (allowing hospital to discon-

An important public policy question is whether there are constitutional limits on nonvitalist policies involving incompetent patients. Nonvitalist policies based on present or past competent refusals of treatment may be justified in terms of autonomy. These policies are clearly constitutionally permissible and may also be constitutionally required. If no exercise of autonomy has occurred, however, can nonvitalism be squared with the respect due incompetent patients? Does nonvitalism serve their interests or violate their rights? To answer these questions, it is important to distinguish between nonvitalist policies that affect conscious, incompetent patients and those nonvitalist policies that affect comatose patients.

#### A. *Policies Affecting Conscious Incompetent Patients*

State nonvitalist policies may lead to the termination of necessary medical care for conscious but incompetent patients, thereby causing their deaths. Since conscious, incompetent patients retain fourteenth amendment rights to life and liberty, an important question is whether such policies violate those rights.

The question could be easily answered if the policies took a form that directly denigrated the life of incompetent patients, for example, denying demented patients medical care, defining them as dead or authorizing active euthanasia of them. Since conscious, incompetent patients would appear to retain interests in treatment and further life, such policies would ordinarily deny them their right to life or liberty. Justifications based on their dependence or lack of value would not suffice because such justifications would deny them respect as persons.

But such direct devaluation of incompetent patients is ordinarily deemed abhorrent and is strictly avoided. Instead, nonvitalist policies toward conscious incompetent patients take a less direct form. They operate under the guise of proxy decisions made on the basis of substituted judgment or best interests. It is important, therefore, to address the constitutionality of these approaches as they relate to decisionmaking for incompetent patients who have not issued explicit directives against treatment.<sup>180</sup>

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tinue kidney dialysis from conscious patient who was suffering from senility and kidney disease).

<sup>180</sup> The assumption is that a nonvitalist outcome based on a competently made prior di-

1. *Substituted Judgment Loosely Construed.* A significant body of ethical and legal opinion argues that the most appropriate decisionmaking procedure for incompetent patients who have not explicitly issued prior directives against treatment is to permit the family to decide for the patient based on its view of what the patient, if competent, would have wanted. This loose substituted judgment approach, it is argued, is justified by the protective regard and special knowledge of the patient's values and interests that families have.<sup>181</sup> In addition, what the patient would have chosen is usually thought to be the best indicator of what would now best serve the patient's interests.

While some courts and commentators have questioned the desirability of such an approach, it has generally been assumed that loose substituted judgment is a policy option that states may, if they choose, adopt for these decisions. Indeed, the petitioners in *Cruzan* argued unsuccessfully that such a test was constitutionally required to protect the incompetent patients constitutional rights.<sup>182</sup>

Loose substituted judgment, however, presents several threats to the welfare of incompetent patients which call its constitutionality into question. The threats concern the very issues that led the Court to reject the test as constitutionally required in *Cruzan*. Deciding whether an incompetent patient lives or dies on the basis of a proxy judgment about what she would have chosen if she were competent has two major defects. The first defect is that it ignores the patient's current interests in favor of what she might have decided previously but never in fact did decide. The second defect is that it gives the proxy no guidance in how to infer the patient's choice when previously competent, thus making it likely that the substituted decision will serve the proxy's own interests rather than the patient's interests.

Regarding the first charge, as noted above, the patient's previous values and interests are no longer relevant to her because her situation has changed so drastically. Deciding for the incompetent pa-

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rective is constitutionally permissible. For further discussion of this issue, see *supra* Part IV(B)(1).

<sup>181</sup> The term "loose" is used because there is no requirement of an actual oral or written expression of views. See *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 497 N.E.2d 626 (1987); *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980).

<sup>182</sup> *Cruzan*, 110 S. Ct. at 2855.

tient on that basis ignores her interests. Indeed, the incompetent patient's current interests are subordinated not according to a prior directive, but according to a conception of what she *might* have chosen. Since her current situation is so different from her previous state, it cannot be convincingly claimed that treating her as if she were still competent respects her as she is now.

The second defect resides in the method by which loose substituted judgment is implemented. Assuming that prior values and interests are relevant, the test is not well-structured to discover them. The family is asked to decide what the patient would have chosen if she were competent but is given no guidance in choosing among the several meanings that that capacious phrase might have.<sup>183</sup> As a result, the proxy may decide according to what the proxy would have chosen, to what other competent people might choose or to what decision would serve the proxy's own interests. No requirement of actual evidence of past wishes is needed. Moreover, even if some evidence of prior choice exists, it is not clear how that evidence would be used.

The constitutional challenge arises because a loose substituted judgment rule gives the family or other proxy the power to decide whether the patient is treated and lives or whether she is not treated and dies, without providing for any meaningful check to ensure that the resulting decisions respect the incompetent patient's current interests. Indeed, by its very terms, the test shifts attention to what the patient wanted when she was competent despite the fact that a different set of interests and needs now exist. There are no or few constraints on how to make this choice.<sup>184</sup>

Two justifications which are often offered for the test are not persuasive. Proponents cannot claim that the test allows the person's wishes when she was competent to control because the test does not require actual evidence that the person had previously

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<sup>183</sup> See Dresser & Robertson, *supra* note 13, at 238-39. For example, the Texas Natural Death Act allows making a nontreatment choice "based on knowledge of what the patient would desire, if known." TEX. HEALTH & SAFETY CODE § 672.009(c) (1989).

<sup>184</sup> Nor is there any constraint on how the family or proxy should approach determining what the patient, when competent, wanted. Essentially, it is the proxy's guess and may easily be confused with what she would want if competent and considering the situation, what a reasonable person in those circumstances would want or what will serve the family's interests. The *Spring* case is an example of how in the guise of determining what the patient would have wanted, if competent, the family may actually be privileging their own or other interests. See *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980).

chosen this outcome. The fact that she might have chosen it is not proof that she had chosen it. Moreover, treating her as if she were still competent is not respectful of her because she is now so different.

Nor can they persuasively claim that the family's own interest in deciding these questions justifies depriving the patient of life—life which would be provided if she never had been competent. The family of course wants closure and decisional authority, but these interests hardly seem sufficient to deprive an incompetent patient of life. If they were, the rule should be stated explicitly that family discretion is controlling, regardless of the patient's interest in treatment. That, however, is not the claim made on behalf of substituted judgment. Indeed, many persons object to family discretion in order to protect the patient from the family's own competing interests in the outcome.<sup>185</sup>

How will constitutional challenges to loose substituted judgment arise? In many cases application of the rule will not be an unconstitutional violation of patient rights because the patient's interests, in fact, require nontreatment. A challenge will arise only when the proxy concludes that, if the patient were competent, she would have rejected treatment, and that conclusion conflicts with the patient's current interest in being treated. A challenge is thus likely only when an interested person, such as a healthcare provider, friend or family member, disagrees with a proxy's substituted judgment against treatment. At that point the interested party could argue that the substituted judgment test ignores the incompetent patient's current interests in being treated and thus deprives her of her life or liberty without due process of law. Essentially, the party could assert that a best interests determination is constitutionally required because substituted judgment ignores the incompetent patient's interests in treatment.<sup>186</sup>

Whether or not this claim of unconstitutionality can be raised judicially, state courts and legislatures confronting policy choices for incompetent patients should heed the conflict between current

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<sup>185</sup> Such a statute would probably be unconstitutional because it ignores the interests of the incompetent patient and thus deprives her of life or liberty.

<sup>186</sup> They can argue that the patient would have chosen to be treated if competent. In other words, they could argue that substituted judgment actually is best interest. See Robertson, *Organ Donations By Incompetents and the Substituted Judgment Doctrine*, 76 COLUM. L. REV. 48, 68-73 (1976).



interests and substituted judgment. Given the difficulties in applying substituted judgment and its irrelevancy to the incompetent patient, they should adopt policies that directly serve the incompetent patient's interests. If doing so imposes high costs on families and society, then this conflict should be addressed directly rather than resolved *sub rosa* in favor of families through the substituted judgment test.

2. *Best Interests Test*. An alternative test for these decisions would be to focus on the present interests of the incompetent patient, viewed from her current perspective. Under this test the substantive criterion for decision would be not what the patient wanted when she was competent or what a reasonable person would have wanted, but what serves this patient's interests in her current situation of illness and permanent incompetency.

The courts have been reluctant to adopt such an approach either because they have been lured astray by the homage that substituted judgment appears to pay to autonomy or because they are troubled by possible consequences of directly assessing patient interests.<sup>187</sup> The test, however, has wide support when the patient never was previously competent but a decision must be made, as occurs with pediatric patients and patients who have always been retarded.<sup>188</sup> It has also received limited recognition from the New Jersey Supreme Court in *In re Conroy*.<sup>189</sup> That court gave impetus to the test in a case where clear evidence of previous wishes against treatment was lacking, permitting nontreatment in the absence of a prior directive to occur only if treatment involved unremitting pain, a very strict standard indeed.<sup>190</sup>

It is likely that some form of the best interest test or other objective test will be increasingly adopted, particularly as the pitfalls

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<sup>187</sup> See, e.g., *Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977) (refusing to talk directly about best interests or quality of life, yet finding nontreatment not to be in patient's interest under the substituted judgment doctrine); see also *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

<sup>188</sup> PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS, *supra* note 2, at 217-20.

<sup>189</sup> 98 N.J. 321, 365, 486 A.2d 1209, 1232 (1985) (holding that one of two possible tests for determining when treatment could be withheld included the decisionmaker's satisfaction that burdens of patient's continued life with treatment outweigh benefits of life for him).

<sup>190</sup> Dresser & Robertson, *supra* note 13, at 241 (criticizing the holding in *In re Conroy* for failing to consider those patients who lack awareness and relational capability but do not suffer pain).

of the loose substituted judgment test and the rigidities of extreme vitalism become clear. A best interests approach is the most honest approach and the one which is most respectful of incompetent patients. Accordingly, it should inform all aspects of policy for incompetent patients.<sup>191</sup>

There can be no doubt that a best interests test is constitutional.<sup>192</sup> It aims to protect the interests of the present incompetent patient, rather than to serve other interests. Indeed, it may be plausibly claimed that this test is constitutionally required. It aims to protect the life and liberty of incompetent patients by focusing on their present interests. In some cases this will require that treatment be withheld; in others, it will require that treatment be provided. The decision in each case, however, will be driven by respect for the patient, rather than for other interests.

However, one might raise constitutional objections to particular ways of implementing the best interests test. For example, one could challenge a procedure which allowed the proxy to determine treatment solely on her view of the patient's best interests because it is too prone to erroneous determination of that interest. That challenge, however, goes to implementation, not to the substantive standard being applied. As long as the implementing procedure is reasonably designed to determine and protect the patient's interests, it should be constitutional.<sup>193</sup>

3. *Privileging Other Interests Over Those of the Patient.* The most difficult policy questions will arise in situations involving conscious, incompetent patients who have some slight interest in further treatment but where treatment would be burdensome for the patient's family, taxpayers or others. The advantage of loose substituted judgment is that it permits nontreatment to occur without confronting this conflict. On the other hand, if a best interests test

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<sup>191</sup> *Id.* at 242-43.

<sup>192</sup> Justice Stevens' comments in his dissent about how "chronically incompetent persons have . . . constitutionally cognizable interests . . ." support this idea and even suggest that protecting the best interests of incompetent patients may be constitutionally required. *Cruzan*, 110 S. Ct. at 2891 (Stevens, J., dissenting).

<sup>193</sup> Rhoden's recommendation that the family have the presumptive right to decide, unless the physician challenges their decision, is partially helpful. See Rhoden, *supra* note 104. Her position, however, is based on the family's deciding according to what the patient would have chosen if competent, not the patient's current best interests. Furthermore, this position gives too much discretion to the family.

is followed, the conflict will inevitably arise.<sup>194</sup>

One can make a strong policy argument that, in marginal or close cases, interests of other people may take priority over the interests of the incompetent patient.<sup>195</sup> Strictly speaking, the patient has some interest in treatment, such as in cases where further treatment is not harmful and she gains some additional, conscious life. If the additional life is of very marginal quality and the burdens to family and others are great, however, one could reasonably accept a nonvitalist outcome. The explicit judgment would be that human life in such a diminished state need not be maintained if there are significant costs involved. Indeed, many people might share this view, even if they are reluctant to enshrine this opinion in statutory criteria.

Would such a policy be constitutional? That is, does an incompetent patient with marginal interests in living have a constitutional right to life and liberty that would require that treatment continue, regardless of burdens on others? In defining the constitutional rights of incompetent persons, the courts should allow states some leeway for such valuation if a state wishes to adopt such a nonvitalist approach. Only where the interests in further living are very clear and substantial should the state be prevented from withholding treatment in such marginal cases.<sup>196</sup> While this is hardly a definitive answer and may pose other problems, it is a place to start the debate over the principles and policy that this issue raises. Ultimately we must confront the value of greatly diminished human life relative to other interests and the question of whether a patient-centered approach, even in marginal cases, must always be strictly followed.

### *B. Nonvitalist Policies When the Patient Is Irreversibly Comatose*

Nonvitalist policies are much less likely to be found unconstitu-

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<sup>194</sup> Thus, economic considerations could lead to restricting public and private insurance payments for such patients when their interests are truly marginal. If the state, however, had a strong interest in continued life, the state would not be able to enact "a policy designed to ensure quick and comfortable deaths by denying treatment to categories of marginal hopeless cases" out of concern for quality of life. *Cruzan*, 110 S. Ct. at 2891 (Stevens, J., dissenting).

<sup>195</sup> Dresser & Robertson, *supra* note 13, at 241-42.

<sup>196</sup> In that case the rights of the incompetent patient would take priority.

tional when they are applied to irreversibly comatose patients. Such policies could take the form of allowing family or proxy to decide about treatment on any basis, including their own interest; in having state or private insurers withhold payment for maintenance of such patients; or adopting a cognitive death definition of brain death.

The constitutionality of these policies depends upon whether irreversibly comatose patients are still considered persons under the Constitution, and if they are, whether they have interests that require respecting their right to life. A reasonable position would be to find that they are legal persons but lack interests that need protection from state nonvitalist positions.

1. *Nontreatment of Irreversibly Comatose Patients.* The most likely nonvitalist policy with regard to comatose patients are state rules that allow treatment to be withheld from them when the family requests it. Except for Missouri, most states that have dealt with the issue have permitted nontreatment.<sup>197</sup> This position is likely to enjoy the wide support of ethical and legal commentators.

Whether based on loose substituted judgment, the patient's current best interests or the discretion of families alone, such state policies would appear to be constitutional because they do not deprive the comatose patient of an interest in continued life or liberty. When all cognitive and sapient function is irretrievably lost, it is a reasonable judgment that the patient has lost the capacity to have interests at all. As argued above, neither sustaining the comatose patient through treatment or causing her death through nontreatment harms the patient. Permanently comatose means that the patient is permanently past the ability to be harmed. This judgment should be constitutionally permissible even if there is no prior directive for that result.

2. *Withholding Public or Private Insurance.* State policies that deny irreversibly comatose patients welfare benefits or publicly funded medical care or that permit private insurers to withhold such funds should also be constitutional. Although no state has yet taken this position, it is likely eventually to be discussed as a money-saving option for public policy.

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<sup>197</sup> See, e.g., *Conservatorship of Drabick*, 200 Cal. App. 3d 195, 245 Cal. Rptr. 840, (1988); *McConnell v. Beverly Enter.-Conn., Inc.*, 209 Conn. 692, 553 A.2d 596 (1989); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied sub nom. *Garger v. New Jersey*, 429 U.S. 922 (1976).

Consider an equal protection challenge to such laws by a family that holds strong vitalist views and wants their comatose daughter maintained as long as possible. Would denial of funds violate the comatose patient's right to equal protection or the family's right to have their needy children protected to the same extent as other dependent persons?<sup>198</sup>

The equal protection challenge should fail because the state is trying to conserve its medical funds on the rational ground that comatose patients no longer have interests to be protected. Since the state may refuse to fund certain medical procedures when there is a rational ground of difference, it should be able to withhold funds from permanently comatose patients because they have no meaningful interest in life.<sup>199</sup> The comatose patient's lack of interest in further treatment would appear to be a rational ground of difference. If comatose patients can be denied treatment altogether because they lack interests in treatment, they could be denied public funds for that treatment as well.

Just as the patient has no right to publicly funded treatment, the family does not have any inherent right to publicly funded treatment for their comatose relative. They merely have a right to have the state make rational distinctions, in its funding decisions. A state's judgment that comatose patients have no interest in further living, despite their family's objections, is rationally based—if it were not, then comatose patient's could never have treatment withheld.<sup>200</sup> Thus the state may adopt a nonvitalist policy with re-

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<sup>198</sup> A variation on this problem has arisen in the *Wanglie* case in Minneapolis, in which the family of an 87-year-old woman in a persistent vegetative state has opposed efforts of the physicians and hospital to terminate all treatment for her on the ground that it is futile. Although the issue is not presented as one of state policy concerning medical funding, but rather whether the patient has a right to be treated at all on the basis that the family believes treatment is what she would choose, if competent, the issue is similar. See Belkin, *As Family Protests, Hospital Seeks an End to Woman's Life Support*, N.Y. Times, Jan. 10, 1991, § A, at 1, col. 1.

<sup>199</sup> *Harris v. McRae*, 448 U.S. 297 (1980) (upholding constitutionality of the Hyde Amendment, Pub. L. No. 96-123, § 109, 93 Stat. 926 (1980), which allowed states to choose not to fund certain medically necessary abortions), *reh'g denied*, 448 U.S. 917 (1980); *Poelker v. Doe*, 432 U.S. 519 (1977) (denying right to publicly financed hospital services for nontherapeutic abortions), *reh'g denied*, 434 U.S. 888 (1977); *Maher v. Roe*, 432 U.S. 464 (1977) (denying right to Medicaid funds for nontherapeutic abortions).

<sup>200</sup> If it is not rational to withhold funding from them, then it is not rational to withhold other forms of treatment. Either they have an interest in living or they do not. If they do not, then they need not be funded. If they do, then treatment must be provided as well as

gard to public and private funding of treatment for permanently vegetative patients.

3. *Defining Irreversible Coma as Brain Death.* Finally, a state might choose to define the irreversibly comatose as brain dead. Current definitions of brain death require that there be total cessation of all brain activity, including brain stem function.<sup>201</sup> Thus comatose patients are not brain dead. Although they lack cortical functioning and thus have no cognitive or sapient ability, they still have lower or brain stem activity.

Some persons have argued that cortical death is the death of the person and thus should be included within the definition of brain death.<sup>202</sup> What would be the implications of a state's adopting this approach, choosing to regard cortical death as death for all purposes? Whatever the policy arguments against such a position, it is difficult to see that it would be unconstitutional. If permanently comatose patients lack interests in treatment and living, then it matters little whether we deem them dead or whether we permit nontreatment to bring about total brain death (though it might have implications for the many situations in which a clear moment of death is crucial). The outcome is the same for the patient. Therefore, a definitional approach to the irreversibly comatose would be within state power despite strong policy reasons against adopting such a position.<sup>203</sup>

#### CONCLUSION

Public policy for treatment of incompetent patients ultimately concerns the choice of a location on the vitalist-nonvitalist contin-

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equal access to public funding made available for other dependent persons. The only exception would be if an explicit prior directive against treatment were permitted to take over the incompetent—in this case, comatose—patient's interests. See *supra* note 197.

<sup>201</sup> PRESIDENT'S COMMISSION, *DEFINING DEATH: MEDICAL, LEGAL & ETHICAL ISSUES IN THE DETERMINATION OF DEATH* (1981).

<sup>202</sup> Green & Wikler, *Brain Death and Personal Identity*, 9 *PHIL. & PUBL. AFFAIRS* 105 (1980); Veatch, *The Whole-Brain Oriented Concept of Death: An Out-moded Philosophical Formulation*, 3 *J. THANATOLOGY* 13 (1975).

<sup>203</sup> As a corollary, the comatose patient could be used as a source of organs or as a subject of experimentation because she would have no interests to be harmed, though there are symbolic and other policy objections to such a practice. The controversy over the use of anencephalic infants as organ donors before they are brain dead raises similar issues. See Robertson, *Relaxing the Death Standard for Organ Donation in Pediatric Situations*, in *ORGAN SUBSTITUTION TECHNOLOGY: ETHICAL, LEGAL AND PUBLIC POLICY ISSUES* 69-76 (D. Mathieu ed. 1988).

uum of respect for human life. That choice, however, is mediated by concerns with autonomy, family interests and other factors. Rarely is it addressed directly.

The *Cruzan* case is significant because it indicated some of the constitutional constraints that attend decisional policies for incompetent patients. In requiring gastrostomy feeding of an irreversibly comatose woman against her parents' wishes, Missouri took an extreme vitalist position. Although the symbolic benefits sought from such a position do not, in my view, justify the costs to her family, the case was correctly decided as a matter of constitutional law. Because the patient was irreversibly comatose and had not clearly issued a prior directive against treatment, Missouri's extreme vitalism was within the constitutional power of the state.

Limits on state vitalism, however, would arise if state policies conflict or interfere with the considered choices of competent individuals or injure incompetent patients who have no clear interest in the treatment at issue. They may also interfere with a right to issue advance directives against medical care when incompetent, if such a right is recognized.<sup>204</sup> The state is free to adopt vitalist policies as long as those policies do not directly harm patients or override competently made choices.

States which take a less vitalist approach also face constitutional constraints when they permit incompetent persons to be denied medical treatment essential to serve their interests. Such limits would arise if state policies allow nontreatment of incompetent patients based on the interests of family and proxy, or on a determination of what the patient might have chosen if she were competent, and the patient's current interests clearly require treatment. On the other hand, nonvitalist policies toward irreversibly comatose patients face few constitutional limits because such patients have no meaningful interests that can be harmed.

This analysis of *Cruzan* has thus brought us to questions of state vitalism beyond those presented in that case. The first issue was whether a comatose patient such as Nancy Cruzan had interests

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<sup>204</sup> I have argued against recognition of a constitutional right to have advance directives enforced. See *supra* Part IV(B)(2). If a state nevertheless chooses to respect prior directives (as most no doubt will), it should be aware of the possible conflicts that can arise with the needs of incompetent patients and design advance directive laws to take account of those risks.

that were violated by continued treatment. The conclusion that she had no present interests in the treatment decision raised a second question: whether the state was obligated to treat her according to how she might have preferred to be treated when she was competent. Such an obligation would exist, if at all, only if she had explicitly directed that treatment be stopped if she were incompetent—a decision not clearly established in the *Cruzan* record.

The investigation thus led to an analysis of what the rights and interests of incompetent patients are more generally and, by implication, the rights of competent persons in controlling future situations of incompetency. Although irreversibly comatose patients have no interests, conscious, incompetent patients do have interests, which, depending on the circumstances, may require that treatment be provided or that treatment be withheld. A key point of this Article is that respect for incompetent persons requires focusing on their present interests and welfare, not on the interests and values they had when they were competent. To allow inferences about previous values to control, when the person's situation has changed so radically, risks denying incompetent patients the respect to which they are entitled.

This focus on the present interests of incompetent patients thus calls into question the common tendency to treat the incompetent patient in terms of what she previously had or would have chosen, rather than in terms of her current state. Whatever the reasons for this distortion, the critical point is the fact that a conflict may arise between current interests and previous interests or choices.

When current interests conflict with an explicit prior directive, the choice lies between the competent person's wish to exercise control over the future and the person's interests when incompetent. When a directive has not been issued and a proxy is inferring what the patient may have chosen if she had thought about it, then a competent person's interest in exercising autonomy is not at issue. Autonomy has not been exercised. The argument for ignoring the patient's current interests is weak when there is no explicit prior directive.

This Article thus argues that a best interests test for assessing treatment decisions for conscious, incompetent patients offers them the greatest respect, while substituted judgment, particularly its loose version, risks denying them respect by ignoring their present interests. It follows then that the current best interests test is



both constitutionally permissible and constitutionally required, at least where substituted judgment or other approaches ignore substantial current interests in treatment. Other approaches would be unconstitutional if they deny incompetent patients the treatment or nontreatment to which respect for their current welfare entitles them.

This conclusion leaves us with the problem of determining whether conscious, incompetent patients have substantial (or, indeed, any) interests in treatment. How can the interests of conscious, incompetent patients be determined? Is there a presumption that any conscious life is in their interests, or must more be shown, such as actual interactive experiences with others? Should family or proxy make this choice? What checks on the the assessment of patient interests are needed?<sup>205</sup>

These questions bring us to the crux of the matter: what is the meaning or value of diminished human life to the incompetent patient, and how is it to be determined? This is the normative issue that arises in every treatment decision for incompetent patients. Only by facing this question directly can it be adequately answered.<sup>206</sup>

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<sup>205</sup> Respect for the incompetent patient's interests may require substantial procedural protections in assessing those choices. See Kamisar, *When is There a Constitutional "Right to Die"?* *When is There No Constitutional "Right to Live"?*, 25 GA. L. REV. 1203 (1991).

<sup>206</sup> Although I conclude this Article without showing how one might approach answering this question, it is not unanswerable. Indeed, there is probably a large area of consensus about certain very diminished states of existence which do not serve the patient's interests, while there is disagreement over many others. The task now is to begin to try to answer that question, as I hope to do in subsequent work. For an account of how one might begin to deal with these questions, see Dresser & Robertson, *supra* note 13, at 240-43.