1993

Family Surrogate Laws: A Necessary Supplement to Living Wills and Durable Powers of Attorney

Ardath A. Hamann

Follow this and additional works at: https://digitalcommons.law.villanova.edu/vlr

Part of the Family Law Commons

Recommended Citation
Ardath A. Hamann, Family Surrogate Laws: A Necessary Supplement to Living Wills and Durable Powers of Attorney, 38 Vill. L. Rev. 103 (1993). Available at: https://digitalcommons.law.villanova.edu/vlr/vol38/iss1/2

This Article is brought to you for free and open access by the Journals at Villanova University Charles Widger School of Law Digital Repository. It has been accepted for inclusion in Villanova Law Review by an authorized editor of Villanova University Charles Widger School of Law Digital Repository.
FAMILY SURROGATE LAWS: A NECESSARY SUPPLEMENT TO LIVING WILLS AND DURABLE POWERS OF ATTORNEY

ARDATH A. HAMANN*

TABLE OF CONTENTS

I. INTRODUCTION ........................................ 104

II. CURRENT STATUS OF THE LAW ........................ 107
   A. Refusal of Medical Treatment by Competent Adults ..... 107
   B. Termination of Medical Treatment for Incompetent Adults 110
      1. The Substituted Judgment Test .................... 111
      2. The Best Interests Test .......................... 117
   C. Cruzan v. Director, Missouri Department of Health .......... 119
   D. Current Statutory Solutions .......................... 123
      1. Living Wills .................................... 125
      2. Durable Powers of Attorney for Health Care ........ 128
      3. Other Statutes .................................. 130
      4. The Patient Self-Determination Act ................ 132

III. PROBLEMS INHERENT IN JUDICIAL INVOLVEMENT IN DECISIONMAKING ...................................... 134
   A. Judges Should Not Make Personal Medical Decisions ... 137
   B. Fictional Assumptions Underlying Judicial Decisions .... 138
      1. It Is Better to Err in Favor of Preserving Life ...... 140
      2. The State Has an Interest in Preserving Life ....... 141
      3. Most People Want to Be Kept “Alive” by Machines .. 145
      4. There Is No Harm in Postponing the Decision ....... 146
      5. Youth Withdraw Medical Treatment from the Elderly 150
      6. Family Will Terminate Medical Treatment for Financial Reasons ..................................... 151
      7. Removal of Life-Sustaining Treatment Is a Step Toward Euthanasia .................................. 154
      8. Religions Oppose Termination of Life-Sustaining Treatment ............................................ 156

* Assistant Professor of Law, The John Marshall Law School. B.S. 1974, Purdue University; J.D. 1977, Marshall-Wythe School of Law, College of William and Mary; LL.M. 1986, The John Marshall Law School. The author gratefully acknowledges the assistance of her research assistants, Donna L. Marks and Patrick McMahon, in the preparation of this Article.
IV. THE CASE FOR SURROGATE DECISIONMAKERS ............ 158

A. Proposal for Family Decisionmaking ............... 158

B. Advantages of Family Decisionmaking .......... 160
   1. No One Cares More About the Person Than Family .. 160
   2. No One Knows the Person’s Religious Beliefs and
      Personal Values Better Than Family .............. 164
   3. Strangers with Political Agenda Should Not Be
      Allowed to Intervene .................................. 165
   4. Judicial Intervention in Medical Decisionmaking Is
      Costly and Unnecessarily Intrusive ............... 167

C. Disadvantages of Family Decisionmaking .......... 168
   1. The Dysfunctional Family ......................... 168
   2. Conflict Among Family Members .................. 170
   3. No Close Family ........................................ 171
   4. Family Uncomfortable Making the Decision ........ 172
   5. The Unreasonable Decision ......................... 174
   6. Right of Conscience .................................... 175

V. CONCLUSION ........................................... 176

I. INTRODUCTION

ADVANCES in medical technology are usually heralded as miraculous. In recent years, however, there has been a growing recognition that there are problems associated with these advances. With the development of medical technology such as respirators and artificial feeding techniques, physicians are now able to sustain the bodily functions of the irreversibly comatose and those in persistent vegetative states. During the 1970s, state legislatures began to deal with this issue by enacting “living will” statutes.\(^1\) Today, only three states do not have some form of living will statute.\(^2\) A more recent development is the durable power of attorney for health care.\(^3\)

---

\(^1\) For a discussion of living will statutes, see infra notes 117-32 and accompanying text.


\(^3\) For a discussion of durable powers of attorney for health care, see infra
of attorney is considerably more flexible than a living will, both documents have a major defect: they only apply to individuals who have the foresight to execute them. 4

Despite the development of these self-determination tools, studies suggest that as few as nine percent of the population have executed living wills. 5 Reasons for such a limited response vary

A recently developed alternative to living wills and durable powers of attorney is the medical directive, which is also called an advance directive. See Linda L. Emanuel & Ezekiel J. Emanuel, The Medical Directive: A New Comprehensive Advance Care Document, 261 JAMA 3288, 3288-89 (1989) (discussing problems and limitations of living wills and durable powers of attorney statutes while advocating use of medical directives); see also President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment 136-39 (1983) [hereinafter Deciding to Forego Treatment] (describing flexibility of advance directives). A medical directive typically has five sections: (1) an introduction, (2) a section in which the person chooses among medical care options in several scenarios, (3) a section designating a proxy decisionmaker, (4) a section agreeing to donate organs, and (5) a personal statement. Emanuel & Emanuel, supra, at 3289. The medical directive is essentially an amalgamation of a durable power of attorney (§ 3), an organ donation directive (§ 4) and an expanded living will (§§ 2 and 5). Although a medical directive is certainly an improvement over a simple living will, it is no better than the sum of its parts. In addition to incorporating the problems inherent in living wills and durable powers of attorney, the personal statement portion of a medical directive may be ambiguous or may conflict with the options chosen by the individual in the second section. For a discussion of the problems identified in association with living wills and durable powers of attorney, see infra notes 123-38 and accompanying text.

4. Two of the seminal cases regarding termination of health care treatment concerned young women who reached majority but had never executed either a durable power of attorney or a living will. Karen Ann Quinlan was diagnosed as being in a persistent vegetative state at 22 years of age. In re Quinlan, 355 A.2d 647, 651, 654 (N.J.), cert. denied, 429 U.S. 922 (1976). Nancy Cruzan was 25 years old when she was resuscitated by paramedics to live thereafter in a persistent vegetative state. Cruzan v. Harmon, 760 S.W.2d 408, 411 (Mo. 1988) (en banc), aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990). Because Karen Quinlan and Nancy Cruzan were so young and because the issue of health care decisionmaking had not yet reached the public consciousness, it is unlikely that either of these young women even considered drafting a living will or durable power of attorney.

5. Steven R. Steiber, Right to Die: Public Balks at Deciding for Others, Hospitals, Mar. 5, 1987, at 72, 72 (discussing poll results which indicated that although most Americans are willing to make decisions regarding their own health care "nearly 10 of 11 adults have not taken legal steps to see that their wishes are fulfilled"); see also I President's Comm'n for Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Making Health Care Decisions 49 n.11 (1982) [hereinafter Making Health Care Decisions]. The report cited a Commission survey which found that 36% of the general public have given "instructions to someone about how they would like to be treated if they become too sick to make decisions." Id. Only 23% of that 36%, however, had put their instructions in writing. Id. Thus, only approximately 8% of the total sample had put their preferences into writing.
from ignorance to procrastination. Even increased education, however, is unlikely to significantly change these figures. For example, in the analogous area of wills, only thirty percent of the population die with a valid will. All states have intestacy laws to provide for the distribution of the decedent's property without a will. A comparable alternative is needed to provide for those individuals who fail to execute a living will or a durable power of attorney.

The thesis of this Article is that decisions about medical treatment for an incompetent person should be made within the family. Judges, hospital ethics committees and other strangers to the family unit should not interfere in these very personal decisions. It is the family that knows the person's preferences about medical care. It is the family that has to live with the results of the decisions about medical care. Therefore, it should be the family that makes the decisions about medical care.

Part II of this Article reviews the current status of both case law and statutory alternatives in the area of medical care decision-making. Part III argues that judicial decisionmaking is not objective. Rather, judges make certain assumptions that are incorrect, and these assumptions distort the decisionmaking process. Finally, part IV proposes a statutory alternative that allows a surrogate decisionmaker to continue or terminate an individual's medical treatment even though that person has not executed a living will or a durable power of attorney.

A more recent survey by the American Medical Association found that 56% of those surveyed had informed family members of their wishes concerning the use of life-sustaining treatment if they entered an irreversible coma. American Medical Association, Public Opinion on Health Care Issues, at 29 (Apr. 1988) (hereinafter AMA Public Opinion Poll). According to that study, however, the number who had signed a living will was still only 15%. Id. at 29-30.

6. See, e.g., Barber v. Superior Court, 195 Cal. Rptr. 484, 489 (Cal. Ct. App. 1983) ("The lack of generalized public awareness of the statutory scheme and the typically human characteristics of procrastination and reluctance to contemplate the need for such arrangements however makes this a tool which will all too often go unused by those who might desire it.").

7. James N. Zartman, The Legacy of Cruzan, Prob. & Prop., May-June 1991, at 13, 16 (observing that although "[t]he importance of wills is continually publicized... 70% of all Americans die without a will"); cf. Steiber, supra note 5, at 72 (explaining that 52% of Americans do not have wills). The 18% discrepancy between the percentages cited by Zartman and those cited by Steiber may occur because the wills of spouses who die first owning only joint tenancy property are not probated. In any case, even the 52% cited by Steiber supports the proposition that a majority of the population may die without a valid will.

8. Marc Kaufman, 'Death with Dignity' Families Tell of Their Torment, Phila. Inquirer, Sept. 19, 1992, at B1 (observing that families of Karen Ann Quinlan, Nancy Ellen Jobes and Nancy Cruzan all "began their ordeals confident that the medical world had their best interests at heart, but ended feeling there had to be a better way").
either a living will or a durable power of attorney. These medical decisions regarding life-sustaining treatment would be made without judicial intervention even if the person were a minor or had never expressed an opinion on this issue. Thus, decisionmaking power would return to where it resided before the revolution in medical technology of the past twenty-five years—to the family.

II. CURRENT STATUS OF THE LAW

A. Refusal of Medical Treatment by Competent Adults

The right of competent adults to refuse medical treatment has two sources: the theory of informed consent and the right of privacy. The theory of informed consent originated in the tort of battery. Historically, liability for unauthorized medical treatment was included in the tort of battery. A doctor who performed surgery without the person's consent committed a battery even if the operation was successful. In recent years, this theory evolved into the doctrine of informed consent. Informed consent requires the physician to inform the person of not only the

---

9. Traditionally, the patient's next of kin has made medical decisions for an unconscious patient. Elaine B. Krasik, Comment, The Role of the Family in Medical Decisionmaking for Incompetent Adult Patients: A Historical Perspective and Case Analysis, 48 U. PITT. L. Rev. 539, 554-55 (1987). While this is the general practice, neither the common law nor statutes authorize this alternative decisionmaking.


12. Most early cases involving nonconsensual medical treatment focused on medical providers who violated explicit instructions of the patient regarding the extent of the treatment. See 1 MAKING HEALTH CARE DECISIONS, supra note 5, at 19-20. Rarely did a court deal with the obligation of the medical provider to disclose all relevant matters to the patient prior to receiving the patient's consent for treatment. Id. at 19.

In the latter part of the twentieth century, some courts began to refer to a medical provider's “duty to warn” the patient of the possible complications involved in a particular treatment, prior to receiving consent to perform the treatment. Id. at 20. This reference to a duty to warn evolved into the doctrine of informed consent which was first articulated in a 1957 California case. See Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees, 917 P.2d 170, 181 (Cal. Ct. App. 1995). The current form of the informed consent doctrine was more fully explained by the Kansas Supreme Court a few years later. See Natanson v. Kline, 350 P.2d 1093, 1099-1107 (Kan. 1960) (indicating that to assure proper consent, physician was obligated to disclose information that reasonable physician would disclose in similar circumstances). For a further discussion of the informed consent doctrine, see BARRY R. FURROW ET AL., LIABILITY AND QUALITY
risks and expected benefits of the treatment, but also the alternative treatments available.\textsuperscript{13} The logical corollary of the right of informed consent is the right to refuse some or all medical treatment.\textsuperscript{14} The right of informed consent would be meaningless if the person did not also have the option to refuse treatment.\textsuperscript{15}

The constitutional right of privacy has been evolving during the past thirty years. Although the Constitution does not explicitly mention a right of privacy, beginning with \textit{Griswold v. Connecticut}.\textsuperscript{16}

ISSUES IN HEALTH CARE 322-70 (2d ed. 1991); see also 1 Making Health Care Decisions, supra note 5, at 20-23.

\textsuperscript{13} See Canterbury v. Spence, 464 F.2d 772, 780 (D.C. Cir.), cert. denied, 409 U.S. 1064 (1972). The informed consent doctrine is based on the presumption that a patient is competent to make his own health care decisions. Two goals are inherent in the doctrine: personal well-being and self-determination. 1 Making Health Care Decisions, supra note 5, at 2-3. Under the informed consent doctrine, a competent patient must be allowed to make his own health care decisions, but the decision can be properly made only after he is fully advised of all “possible benefits, risks, costs, other consequences, and significant uncertainties surrounding any of this information.” \textit{Id.} at 2.

In promoting expanded disclosure by physicians, the President’s Commission noted that informed consent is a process requiring active participation by both physician and patient. \textit{Id}. The Commission further rejected any notion that adequate consent to medical treatment is obtained following the mere narration of the risks of a particular procedure. \textit{Id}. Finally, informed consent does not give the patient the right to demand a specific course of treatment. ROBERT ZUSSMAN, INTENSIVE CARE 82 (1992). Its primary goal is to allow patients to refuse any offered treatment. \textit{Id}. (noting that judicial recognition of patient’s right of informed consent is significant only when right of informed refusal is also recognized).

\textsuperscript{14} Barber, 195 Cal. Rptr. at 489; see also \textit{In re Conroy}, 486 A.2d 1209, 1222 (N.J. 1985) (noting that judicial recognition of patient’s right of informed consent is significant only when right of informed refusal is also recognized).

\textsuperscript{15} Apparently, doctors do not generally agree that patients have the right to make the choice of whether or not to proceed with a particular treatment. In a President’s Commission survey, physicians were asked to define informed consent. 1 Making Health Care Decisions, supra note 5, at 17-18. The survey results revealed that only certain percentages of physicians understood informed consent to encompass each of the following: “generally informing patient about condition and treatment (59%); disclosing treatment risks to patient (47%); patient understanding his condition and treatment (34%); patient giving permission for treatment (26%); and patient understanding treatment risks (23%).” \textit{Id.} at 18. Only 14\% of the physicians surveyed thought informed consent required the explanation of treatment alternatives. \textit{Id}. Finally, only 9\% thought that under the doctrine of informed consent, the patient had a right to make a choice between treatment alternatives. \textit{Id}.; accord ZUSSMAN, supra note 13, at 85 (quoting physician who stated, “I don’t think informed consent exists in an intensive care unit”); see also Raymond S. Duff & A.G.M. Campbell, Moral and Ethical Dilemmas in the Special-Care Nursery, 289 NEW ENG. J. MED. 890, 893 (1973). In discussing informed consent in the context of infants, the authors stated that “[s]ome physicians believed that parents were too upset to understand the nature of the problems and the options for care. Since they believed informed consent had no meaning in these circumstances, they either ignored the parents or simply told them that the child needed an operation.” \textit{Id}.
cut, the Supreme Court recognized that this right exists. As the New Jersey Supreme Court noted in In re Quinlan, "this right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions." Additionally, various medical professional groups have recognized that competent individuals have a right to refuse medical treatment. The American Hospital Association has stated: "Whenever possible . . . the authority to determine the course of treatment, if any, should rest with the patient," and "the right to choose treatment includes the right to refuse a specific treatment or all treatment."

Bouvia v. Superior Court is instructive on the right of a competent adult to refuse medical treatment. Elizabeth Bouvia was born with severe cerebral palsy. Because she could not retain sufficient food, doctors inserted a nasogastric tube against her will. Ms. Bouvia petitioned to have the tube removed but the trial court denied her request. The trial court found that she was not in "great physical discomfort" and that she tolerated the feeding tube "reasonably well." The California Court of Appeal reversed, holding that because Bouvia was competent, she had the absolute right to decide to terminate any type of medical treatment. The court stated unequivocally that this was neither a medical decision to be made by her physicians or a hospital ethics committee, nor a legal issue to be resolved by judges.

17. Id. at 485.
19. Id. at 663 (citing Roe v. Wade, 410 U.S. 113, 153 (1973)).
22. Id. at 299. At the time she filed suit, 28-year-old Elizabeth Bouvia was a quadriplegic, immobile except for a few fingers and some slight head movements. Id. at 299-300. She also suffered from crippling arthritis. Id. at 300. Due to the intense pain caused by her condition, periodic doses of morphine were injected through a tube permanently inserted into her chest. Id. The morphine was successful in dissipating only some of her discomfort. Id. The court found that she was mentally competent at the time of trial. Id.
23. Id. at 298. A nasogastric tube provides a mechanism through which the person can be fed a liquid, nutritionally balanced diet without the need to chew and swallow.
24. Id. at 299.
25. Id.
26. Id. at 300-01.
27. Id. at 305.
decision was Elizabeth Bouvia's alone. The appellate court particularly criticized the trial court's consideration of Bouvia's "ability to tolerate physical discomfort." 28 The court noted that it would be inhumane for a physician to force a person to accept medical treatment, perhaps for fifteen or twenty years, when her prognosis was so bleak. The court recognized that it would be Bouvia who would be living her life under these circumstances and not the physicians. 29

Both the doctrine of informed consent and the right of privacy require the same result. When a person is competent, the decision to continue or terminate treatment is the person's alone.

B. Termination of Medical Treatment for Incompetent Adults

State courts have long wrestled with the issue of when to allow families to terminate medical treatment for incompetent persons; yet, the standards vary immensely between states, and indeed between judges in a single state. 30 Two basic tests have

---

28. Id. at 299.
29. Id. at 305. Although Elizabeth Bouvia was victorious in her quest to elect to have the feeding tube removed, she decided not to do so and remains alive today. See Beverly Beyette, The Reluctant Survivor, L.A. TIMES, Sept. 13, 1992, at E1. Ms. Bouvia states she wants to die, but she believes that "now the business of dying is too physically painful." Id.
30. The New Jersey Supreme Court has been in the forefront of analyzing the issue of when to allow family members to order the removal of medical treatment for their relatives. Initially the New Jersey courts adopted the test referred to as the substituted judgment test. In re Quinlan, 355 A.2d 647, 664 (N.J.), cert. denied, 429 U.S. 922 (196). For a discussion of the substituted judgment test, see infra notes 31-50 and accompanying text. Later, the New Jersey court developed a three-part analytical framework that allowed consideration of both the substituted judgment and the best interests tests. In re Conroy, 486 A.2d 1209 (N.J. 1985). Using this framework, the first option available to the court is, in essence, a substituted judgment test. The first option can be used if there is clear evidence that the incompetent patient would have refused treatment under the circumstances. Id. at 1229-31. If clear evidence is absent, the treatment cannot be terminated under the first option. If treatment cannot be terminated under the first option, then under a second option, the "limited objective" test, the treatment can be withdrawn upon a showing of trustworthy evidence of the patient's intent coupled with a showing that the burden of maintaining life outweighs the benefit to the patient. Id. at 1232. The evidence required by this "limited objective" test would be "[e]vidence that, taken as a whole, would be too vague, casual, or remote to constitute the clear proof" of intent. Id. The balancing of burdens against the benefits means that the pain the patient is suffering "markedly outweigh[s] any physical pleasure, emotional enjoyment, or intellectual satisfaction that the patient may still be able to derive from life." Id. The third option of the framework is to be used only in the absence of any evidence of patient intent. In that case, treatment may be withdrawn when the effect of administering such treatment is inhumane due to severe, recurring and unavoidable pain. Id. The Conroy court ultimately held that the evidence at trial was inadequate to satisfy any of the three tests; the court would have refused to
emerged: the substituted judgment test and the best interests test.

1. The Substituted Judgment Test

The substituted judgment analysis was first applied in a right to die case by the New Jersey Supreme Court in 1976. Substituted judgment is a subjective test, unique to each individual person's desires and personal value system. The goal of substituted judgment is to determine, insofar as possible, what the incompetent person would have decided if he were competent. The question is not whether a reasonable or average person would have decided to terminate treatment, but whether this particular person would have decided to continue or terminate treatment. This analysis requires the surrogate decisionmaker to determine whether the person, prior to becoming incompetent, had expressed any views on what his decision would be under such circumstances. Allow cessation of feeding had Ms. Conroy survived the proceedings. *Id.* at 1243.

In *Conroy*, Justice Handler criticized the objective tests (second and third options) for focusing on pain as the decisive element. *Id.* at 1247 (Handler, J., concurring in part and dissenting in part). Justice Handler argued that the focus on pain eclipsed the multitude of human values that should be considered in any decision on termination of medical treatment. *Id.* (Handler, J., concurring in part and dissenting in part). Finally, he noted that medical professionals often have difficulty determining the extent of pain suffered by a patient. *Id.* (Handler, J., concurring in part and dissenting in part).

Two years later, the New Jersey Supreme Court limited the application of the third portion of the *Conroy* test, referred to as the "pure-objective" test, finding that its use was not appropriate when the patient was in a persistent vegetative state; in those cases, the substituted judgment test articulated in *Quinlan* was to be used. *In re Jobes*, 529 A.2d 434, 443 (N.J. 1987); see also *In re Peter*, 529 A.2d 419, 425 (N.J. 1987) (indicating that *Quinlan* provides test for patient in persistent vegetative state); accord *Gray v. Romeo*, 697 F. Supp. 580, 582 (D.R.I. 1988) (suggesting that third part of *Conroy* test was useless as applied to patients in vegetative states because by definition, they were unable to experience pain).

The substituted judgment analysis had long been utilized in making financial decisions for incompetent individuals. Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 431 (Mass. 1977). The doctrine has also been used to justify kidney donation by an incompetent individual for the purpose of a transplant. *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. 1969).

*Quinlan*, 355 A.2d at 664. The *Quinlan* court did not, however, refer to the test as substituted judgment at that time. Instead, the court ruled that the "guardian and family of Karen [should] render their best judgment, subject to the qualifications hereinafter stated, as to whether she would exercise it in these circumstances." *Id.* Eleven years later, the New Jersey Supreme Court noted that the approach it used in *Quinlan* is known as the substituted judgment test. *Jobes*, 529 A.2d at 444.

*Conroy*, 486 A.2d at 1229.

*Id.*
circumstances. 35

Under the substituted judgment test, the decisionmaker need not be a family member. In fact, a guardian who has never met the person may be appointed to make the decision. 36 Because the guardian may never have met the person as a competent individual, the guardian must rely on statements by family members about the person's moral and religious views as well as any statements about what the individual would have wanted in the particular situation. Typically, family members base their opinions about the person's beliefs on their prior conversations with the person about similar publicized cases or about medical treatment administered to friends or family. 37

There are two major problems inherent in the substituted judgment approach. The first problem is that it is impossible to know with certainty what decision anyone would make in a particular circumstance. On a metaphysical level, some have argued that it is impossible for anyone to know how he would feel in a situation until he has been in the situation. 38 Thus, supporters of this view maintain that courts and families are merely comforting themselves when they say that they are discontinuing life support because that is what the person would have wanted. 39

35. See Saikewicz, 370 N.E.2d at 430 (declaring that purpose of substituted judgment test is to determine wants and needs of person); see also Jobes, 529 A.2d at 444-49 (holding that patient's family, as party most familiar with patient's desires, was allowed to remove feeding tube).

36. See, e.g., In re Greenspan, 558 N.E.2d 1194, 1199-1200 (Ill. 1990) (granting public guardian standing to petition for cessation of artificial hydration and nutrition even though patient's wife and children were living).

37. See, e.g., Conroy, 486 A.2d at 1230 (listing, among other avenues of evincing intent, statements voiced by individual regarding treatment given to others); see also In re Longeway, 549 N.E.2d 292, 299 (Ill. 1989) (stating that surrogate decisionmaker should initially determine if person made any explicit statements regarding medical treatment). In Longeway, the Illinois Supreme Court adopted the substituted judgment approach and remanded the case to allow the guardian of a 76-year-old woman to demonstrate by "any reliable and relevant evidence" the patient's intent. Id. at 300.

38. Donald L. Beschle, Autonomous Decisionmaking and Social Choice: Examining the "Right to Die", 77 Ky. L.J. 319, 342-46 (1988-89) (arguing that because we cannot conceive of our own death, we cannot really make informed choice to die); see also In re Westchester County Medical Ctr., 531 N.E.2d 607, 614-16 (N.Y. 1988) (refusing to grant family's petition to prevent insertion of feeding tube because court found prior statements made by patient were not clear and convincing evidence that she would want to die in specific circumstances presented by her illness).

39. Beschle, supra note 38, at 346-50. Beschle argues that courts avoid exerting responsible judicial power by saying that they are just doing what the individual would have wanted. Id. at 346. Beschle further claims that courts and litigants avoid responsibility for their actions by stating that they are merely exercising the rights of an individual patient. Id. at 348-49.
practical level, many people never express their preferences for treatment if they were to become incompetent. In addition, there are those who were never able to express a preference, namely minors and the mentally handicapped.

This inability to know another's choice was documented in a 1988 study. The study detailed patient treatment preferences and knowledge of those preferences by the patient's doctor and spouse. In five of six treatment scenarios, the doctor's prediction of patient preference was no better than chance. While spouses were significantly more successful in determining patient preferences than doctors, their predictions were still better than chance in only half of the scenarios.

The second problem with the substituted judgment test is that different courts require different levels of proof as to the person's intent. Some states require clear and convincing evidence

40. Only a bare majority (56%) of the population have told family members their wishes concerning the use of life-sustaining treatment if they were in a coma from which doctors do not believe they could recover. AMA Public Opinion Poll, supra note 5, at 29. Adults between the ages of 18 and 34 were even less likely to have discussed their wishes with their family. Id. In any case, these expressions would probably be inadequate in light of In re Quinlan, 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976) and In re Jobes, 529 A.2d 434 (N.J. 1987). For examples of statements that courts considered inadequate, see infra notes 47-57 and accompanying text.

41. Some courts have used the substituted judgment test in situations involving children and the mentally retarded even though it is illogical to determine what one would do in a particular situation when that person has never been capable of rationally considering the issue. See, e.g., In re Minor, 434 N.E.2d 601, 609 (Mass. 1982) (stating in case involving four-month-old patient that court "must attempt to 'don the mental mantle' of the child and seek to act on the same motives and considerations as would have moved the child"); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 431-32 (Mass. 1977) (utilizing substituted judgment approach to determine that mentally retarded adult would not want chemotherapy). But see In re Storar, 420 N.E.2d 64, 73 (N.Y.), cert. denied, 454 U.S. 858 (1981). In Storar, the New York Court of Appeals recognized the limitations of the substituted judgment test in considering the situation of a 52-year-old man with a mental age of 18 months. Id. at 68. The court said it was "unrealistic to attempt to determine whether he would want to continue potentially life prolonging treatment if he were competent...[T]hat would be similar to asking whether 'if it snowed all summer would it then be winter?' " Id. at 72-73.

42. Richard F. Uhlmann et al., Physicians' and Spouses' Predictions of Elderly Patients' Resuscitation Preferences, 43 J. Gerontology: Med. Sci., M115 (1988) (discussing inaccuracy of substituted judgments, but suggesting that such decisions could be made more accurate through increased communication with patient and shared decisionmaking by both physician and family).

43. Id. at M117.

44. Id. at M117, M120. Also noteworthy was the fact that spouses were much more likely to be "uncertain" of the patient's response than the doctor, even though the doctors' predictions were less likely to be accurate. Id. at M117.

while others are satisfied with a lower standard of proof. Regardless of which standard a court has articulated, however, courts have been erratic in their determinations of what types of evidence are considered reliable. Courts look not only at the person’s words but also at the context in which the words were spoken. Among the factors that enter into the equation are: the maturity of the person at the time he made a statement, the remoteness in time of the remarks from the person’s illness, the consistency among remarks made at different times and the seriousness of the remarks. As one court noted, “an offhand remark about not wanting to live under certain circumstances made by a person when young and in the peak of health” would not be sufficient twenty years later when family members were seeking to discontinue life-sustaining treatment even if the circumstances were virtually identical. The specificity of the statements also affects the probative value of the statements. Casual statements made in general terms are usually not adequate. For example, an individual’s statement that he would not want to be artificially sustained by heroic measures if his condition were hopeless would probably be too general to support a request to discontinue treatment.

Does the comment “I wouldn’t want to live like a vegetable,” provide sufficient evidence of the individual’s intent if the comment was made after watching a news special on the topic of withdrawing treatment? Does the answer to the preceding question depend on whether the news special discussed disconnecting a respirator and not artificial nutrition? Is a college paper advocating euthanasia adequate? The answers depend on the court.

The most famous case to tackle such questions was the Quinlan case. In its opinion, the New Jersey Supreme Court did not quote the actual statements of Karen Ann Quinlan. The court simply noted that there was evidence that Karen made statements while she was competent that indicated “her distaste for continu-

---

48. Id.
49. Id. at 1231.
50. Id. at 1231 n.7.
ance of life by extraordinary medical procedures, under circum-
stances not unlike those of the present case."\(^{52}\) The statements
were made during conversations about others who were termi-
nally ill and were being subjected to similar heroic measures. The
court, however, rejected reliance on these statements because they
were "remote and impersonal" and "lacked significant proba-
tive weight."\(^{53}\) Some judges take an even more rigid position,
refusing to discontinue treatment unless the person specifically
addressed the type of treatment being received and knew all the
consequences of the specific decision.\(^{54}\) In essence, these judges
would create a standard more stringent than that required for in-
formed consent.

The New Jersey court again faced the issue of determining
the evidentiary adequacy of prior statements in *In re Jobes*.\(^{55}\) In
*Jobes*, the court heard testimony regarding several conversations
Nancy Jobes had with friends beginning in 1971.\(^{56}\) In one con-
versation she told a friend that if she were crippled with multiple
sclerosis or muscular dystrophy, she would not want to live. In
discussing the *Quinlan* case, Jobes said that she would not want to
live like Karen Ann Quinlan did after her respirator was removed.
Later, after watching a friend on a respirator suffer from amyotro-
phic lateral sclerosis, Jobes commented that she would not

\(^{52}\) Id. at 653.

\(^{53}\) Id. Nine years after *Quinlan*, however, in *Conroy*, the New Jersey
Supreme Court declared:

[W]e now believe that we were in error in *Quinlan* . . . to disregard
evidence of statements that Ms. Quinlan made to friends concerning
artificial prolongation of the lives of others who were terminally ill. . .
Such evidence is certainly relevant to shed light on whether the patient
would have consented to the treatment if competent to make the
decision.

*Conroy*, 486 A.2d at 1230.

\(^{54}\) See, e.g., *In re Westchester County Medical Ctr.*, 531 N.E.2d 607, 608
(N.Y. 1988) (refusing to allow patient's daughters to prevent artificial feeding
because "there [was] not clear and convincing proof that the patient had made a
firm and settled commitment, while competent, to decline this type of medical
assistance under circumstances such as these"); see also Brophy v. New England
*Brophy*, the dissent found no evidence that Paul Brophy ever declared his inten-
tions as to life-sustaining treatment, nor any evidence that he knew of the pain of
death after removal of treatment. *Id.* (Nolan, J., dissenting). The dissent be-
lieved that without this evidence, a successful argument could be made that
Brophy never made his own determination whether food or water should be
removed. *Id.* (Nolan, J., dissenting). For a discussion of the statements Brophy
made, see *infra* note 60.

\(^{55}\) 529 A.2d 434 (N.J. 1987).

\(^{56}\) *Id.* at 442.
want to be kept alive under those circumstances. Nonetheless, the court characterized these statements as “remote, general, spontaneous, and made in casual circumstances.” With those conclusory statements, the court dismissed Jobes' statements as unreliable.

In contrast, the New York Court of Appeals held that statements made by a Catholic Brother about the Quinlan case exhibited clear and convincing evidence of his intent to forego the use of “extraordinary life support measures.” During discussions within his religious community, Brother Fox said that “he would not want any of this ‘extraordinary business’ done for him under those circumstances.”

It is difficult to distinguish the statements made by Nancy Jobes from those of Brother Fox. Even though Jobes was young when she entered a persistent vegetative state, her prior statements were more specific and were repeated several times over a longer period of time than were the statements made by Brother Fox. Because Fox was older, was a priest and made the statements to others within his religious community, the court apparently assumed that he had thought more carefully about issues of life and death. As a practical matter, Fox's situation appears to be an anomaly. If the validity of statements were dependent on the age and circumstances of the declarant, treatment could never be discontinued for any young adult who had failed to execute a living will.

As implemented, the substituted judgment test has proved

57. Id.
58. Id. at 443.
59. Id.
60. In re Eichner, 420 N.E.2d 64, 72 (N.Y.) (decided with In re Storar) (“These were obviously solemn pronouncements and not casual remarks made at some social gathering, nor can it be said that he was too young to realize or feel the consequences of his statements...”), cert. denied, 454 U.S. 858 (1981); see also Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626, 632 n.22 (Mass. 1986). Paul Brophy had also discussed Karen Quinlan's situation with his wife and stated: "I don't ever want to be on a life support system." Id. Several years later, Brophy helped rescue a man from a burning truck. The man died from extensive burns. Brophy discarded his award for bravery and said, "I should have been five minutes later." Id. Within hours after being hospitalized with a ruptured aneurysm he said to a daughter, "If I can't sit up to kiss one of my beautiful daughters, I may as well be six feet under." Id. The court noted that "[a]lthough he never had discussed specifically whether a G-tube or feeding tube should be withdrawn in the event that he was diagnosed as being in a persistent vegetative state following his surgery,... if presently competent, Brophy would choose to forgo artificial nutrition." Id. at 632.
61. Eichner, 420 N.E.2d at 68.
unworkable for two reasons. First, it is impossible to know with any degree of certainty how an individual would want to be treated if faced with a specific illness. Second, the substituted judgment test has been inconsistently applied by judges who are uncomfortable with the idea of terminating life support. Thus, an alternative is needed for the traditional substituted judgment test.

2. The Best Interests Test

The best interests approach is an objective test. The test requires the decisionmaker to determine the course of medical care based on the goals of "relief from suffering, preservation or restoration of functioning, and quality and extent of sustained life." Courts must balance the pain the person is subjected to against the beneficial effects of the treatment. This test is primarily used when the person has never expressed any views on the issue or has never been competent to express any preference on medical treatment. The best interests approach, however, is also seriously flawed.

The first problem with the best interests approach is that it is not really an objective test. Although the courts present the illusion that they are objectively considering the circumstances, the reality is that the person is at the mercy of the judge and the judge's value system. Intimately intertwined with any decision in the best interests of the person is a value judgment as to what is "best." A best interests standard assumes a consensus that does not exist in society on the issue of whether to discontinue treatment. People have "different ideas about how the value of life is affected by the loss of brain function, the loss of cognitive abilities, bodily deterioration, or unrelievable pain."  

63. See, e.g., In re Storar, 420 N.E.2d 64, 73 (N.Y.) (approving, over patient's mother's objections, blood transfusions to profoundly retarded 52-year-old man suffering from bladder cancer because transfusions kept patient alive and were judged not excessively intrusive), cert. denied, 454 U.S. 858 (1981).
64. In In re Minor, 434 N.E.2d 601, 602 (Mass. 1982), doctors had requested a "do not resuscitate" (DNR) order for a four-month-old abandoned baby with serious cardiac problems. In granting the request, the court noted that when a young child is involved, substituted judgment (the standard in Massachusetts) was "consistent" with the best interests test because "the criteria to be examined and the basic applicable reasoning are the same." Id. at 608 n.10; cf Storar, 420 N.E.2d at 73 (stating that patient's pain was one factor but not necessarily determinative).
66. Id. at 457-58 (Handler, J., concurring).
The second problem with the best interests test is that there is rarely one correct medical solution for any health problem. For example, mild diabetes can be controlled by diet, by injectable natural insulin or by oral synthetic insulin. Doctors disagree as to whether back problems are better treated with surgery or with medication and bed rest. There is continuing controversy about whether gynecologists perform too many hysterectomies and whether obstetricians perform too many caesarean sections. It is inescapable that physicians' treatment decisions reflect their values: for example, their preference for surgery over the natural healing processes of the body. The question becomes infinitely more complex when the termination of medical treatment is involved.

The case of John Storar is instructive regarding the lack of objectivity in the best interests approach. Storar was a severely retarded individual who had lived in a state facility for forty-seven years. After being diagnosed with bladder cancer, he received radiation therapy and also required blood transfusions as his disease progressed. Even with the transfusions, however, his life expectancy was predicted to be only three to six months. Storar also received regular doses of narcotics to control his pain. Because he found the transfusions “disagreeable,” his mother re-

67. 1 Making Health Care Decisions, supra note 5, at 42.
68. Id. at 43.
69. See generally Gina Kolata, Rate of Hysterectomies Puzzles Experts, N.Y. Times, Sept. 20, 1988, at C1. The article noted that there are substantial differences in the rate of hysterectomies between different regions of the country. Id. Furthermore, the article noted that in 1988, the American College of Obstetricians and Gynecologists formed a task force to determine whether too many unnecessary hysterectomies are being performed. Id.
70. See generally U.S. Dep't of Health & Human Servs., Cesarean Childbirth (1981) (discussing concern regarding increased rate of caesareans performed, recommending steps to lower such rates and articulating diverse views on caesarean controversy).
71. 1 Making Health Care Decisions, supra note 5, at 42 (arguing that many treatment decisions are not supported by medical data or professional standards, and merely represent matter of choice).
73. Id. at 68.
74. Id. at 69.
75. Id.
76. John Storar found the transfusions so unpleasant that he had to be physically restrained during the procedure to prevent him from injuring himself by pulling the needle out of his arm. Id. at 78 (Jones, J., dissenting in part). Urination became very painful for him because of the clotting in his urine. Id. (Jones, J., dissenting in part). The pain associated with the transfusions also affected him emotionally. Id. (Jones, J., dissenting in part). He changed from being outgoing to being withdrawn. Id. (Jones, J., dissenting in part).
quested that they be discontinued.\textsuperscript{77} The New York Court of Appeals recognized that some doctors believed that treatment of bladder cancer could properly be limited to pain relievers because, at an advanced stage, transfusions only prolonged the person's suffering.\textsuperscript{78} The court, however, discounted that alternative and stated that it would not "allow an incompetent patient to bleed to death."\textsuperscript{79} This is a classic example of a situation where there were two reasonable treatment choices; yet, the court intervened and substituted its judgment for that of the patient's mother who had visited him almost every day since he had been institutionalized.

The best interests approach is inherently unworkable. It is not an objective test because judges cannot avoid interjecting their personal values into the decisionmaking process. Moreover, even physicians are incapable of reaching a consensus about treatment in many situations. In a diverse society, there is no one "best" answer. There is only a range of answers that society has deemed acceptable; within this range, the best answer is only one person's judgment. Thus, a replacement is needed for the best interests approach as well as the substituted judgment test.

C. Cruzan v. Director, Missouri Department of Health

In 1990, the United States Supreme Court had the opportunity to stabilize this area of law and provide consistent guidelines in the case of \textit{Cruzan v. Director, Missouri Department of Health}.\textsuperscript{80} Instead of providing a clear framework for addressing these difficult situations, however, the Court left the judicial determination of these private medical decisions in the hands of the individual states. As noted in the previous section, this approach resulted in a patchwork of inconsistent tests.

\textit{Cruzan} is a very limited decision. The only question the Court decided was whether the United States Constitution gives a

\textsuperscript{77} Id. at 69.
\textsuperscript{78} Id. at 69-70.
\textsuperscript{79} Id. at 73. The court relied on several cases where courts had authorized blood transfusions for children who were Jehovah's Witnesses even though the parents objected to transfusions as contrary to their religious beliefs. \textit{See, e.g., In re Sampson, 278 N.E.2d 918, 918-19 (N.Y. 1972) (refusing to honor parents' religious objections because transfusions were necessary part of surgery for child). The Storar court ignored a very significant distinction: in the Jehovah's Witnesses' cases, the patients were likely to recover if given the transfusions, while John Storar would merely live for three to six months while suffering intensely.}
\textsuperscript{80} 497 U.S. 261 (1990).
conservator the right to terminate life-sustaining treatment for a person in a persistent vegetative state.\textsuperscript{81} The Court concluded that the Constitution does not give a conservator such a right.\textsuperscript{82} As a practical matter, \textit{Cruzan} did not change the law in any jurisdiction. The Court merely decided that each state could make its own rules on the question of termination of life-sustaining treatment.\textsuperscript{83}

Nancy Cruzan was\textsuperscript{84} in a persistent vegetative state\textsuperscript{85} as a result of an automobile accident. Although her respiratory and circulatory systems were not being artificially maintained, she was being sustained by artificial nutrition through a gastrostomy feeding and hydration tube.\textsuperscript{86} Her parents, as guardians, sought to remove the gastrostomy tube. The Supreme Court of Missouri held that clear and convincing evidence of Ms. Cruzan's desire to have life-sustaining treatment withdrawn was required before her parents could terminate artificial feeding and nutrition.\textsuperscript{87}

The United States Supreme Court granted certiorari to consider the question of "whether Cruzan has a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment from her under these circumstances."\textsuperscript{88} In other words, the issue addressed was "whether the United States Constitution grants what is in common parlance re-

\textsuperscript{81} Id. at 269.
\textsuperscript{82} Id. at 280.
\textsuperscript{83} Id. at 285-87.
\textsuperscript{84} Nancy Cruzan died on December 26, 1990. Joyce Price, \textit{Cruzan Dies After 12 Days}, WASH. TIMES, Dec. 27, 1990, at Al. After the United States Supreme Court decision was issued, her parents returned to the trial court and presented additional evidence that Nancy would not want to be maintained in a persistent vegetative state. Id. The trial court found that this evidence satisfied the requirement of clear and convincing evidence. Id. On December 14, 1990, the court gave permission to terminate her treatment. Id.
\textsuperscript{85} In a vegetative state, only the body's internal controls are functioning. \textit{In re Jobes}, 529 A.2d 434, 438 (N.J. 1987). Heart function, digestion, low level nerve response and body temperature are all maintained. Id. The body, however, does not otherwise exhibit any awareness of the environment in which it is located. Id. A person in a vegetative state may appear to be reacting to sound or painful stimuli, but the movements are merely reflexive, not a purposeful reaction to any sensation. \textit{Cruzan}, 497 U.S. at 301 n.2 (Brennan, J., dissenting) (citing Ronald E. Cranford, \textit{The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)}, HASTINGS CENTER REP., Feb.-Mar. 1988, at 27, 28, 31). Individuals in persistent vegetative states are completely unaware of anything that may be occurring around them. Id. (Brennan, J., dissenting).
\textsuperscript{86} \textit{Cruzan}, 497 U.S. at 266.
\textsuperscript{88} \textit{Cruzan}, 497 U.S. at 269.
ferred to as a 'right to die.' ”

Chief Justice Rehnquist's opinion traced the history of the right to refuse treatment from the earliest "consent" cases to Quinlan and In re Longeway. Significantly, the Court recognized that the "common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment." The Court then noted that the Fourteenth Amendment provides a constitutionally protected liberty interest in refusing treatment. These may have been the most important statements in the case.

The inference generally drawn from prior decisions was that a competent individual had the right to refuse medical treatment. The most frequently cited of those decisions is the United States Supreme Court decision in Union Pacific Railway v. Botsford. In Botsford the Court said: "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others." Cruzan, however, was the first case in which the Supreme Court explicitly stated, although in dicta, that a competent individual has the right to decide whether to refuse medical treatment.

The Cruzan Court then discussed whether an incompetent person has the same right to refuse medical treatment as a competent person. The Court summarily dismissed the suggestion that an incompetent individual has this right because it "begs the question." The Court noted that, by definition, an incompetent...
person cannot exercise any rights. With that brief discussion of the major constitutional question, the Court abruptly concluded its discussion of whether an incompetent individual can refuse treatment.

The Court next discussed the question of whether the United States Constitution was violated by Missouri's requirement of clear and convincing evidence of the person's wishes prior to allowing termination of life support. In upholding Missouri's right to require such a stringent level of proof in a civil proceeding, the Court looked to the state interest that Missouri was attempting to protect. The Court provided examples of other non-criminal situations where clear and convincing evidence was properly required. The Court concluded that Nancy Cruzan's (and society's) interest in making such a determination was more substantial than the mere loss of money at issue in other types of civil disputes. Consequently, the Court held that the burden of proof reflected Missouri's determination "about how the risk of error should be distributed between the litigants." The Court buttressed its decision with this statement:

An erroneous decision not to terminate results in a maintenance of the status quo; the possibility of subsequent developments such as advancements in medical science, the discovery of new evidence regarding the patient's intent, changes in the law, or simply the unexpected death of the patient despite the administration of life-sustaining treatment at least create the potential that a wrong decision will eventually be corrected or its im-

99. Id. But see id. at 309 (Brennan, J., dissenting) (finding that person does not lose constitutional rights in other areas merely because he is incompetent).
100. Id. at 280. For a discussion of the four most commonly articulated state interests related to medical decisionmaking, see infra notes 195-216 and accompanying text.
101. Cruzan, 497 U.S. at 282-83 (comparing to clear and convincing evidence burden of proof in deportation, denaturalization, termination of parental rights and civil commitment proceedings).
102. Id. at 283.
103. Id. (quoting Santosky v. Kramer, 455 U.S. 745, 755 (1982)). The dissenters disagreed with the majority's reliance on the cases cited to uphold Missouri's burden. For example, Justice Brennan stated:

In the cases cited by the majority, the imbalance imposed by a heightened evidentiary standard was not only acceptable but required because the standard was deployed to protect an individual's exercise of a fundamental right, as the majority admits. In contrast, the Missouri court imposed a clear and convincing standard as an obstacle to the exercise of a fundamental right.
Id. at 319-20 (Brennan, J., dissenting) (citation omitted).
This statement drew some of the strongest objections from the dissenters. The assumptions of the Justices that underlie the majority's statement are the focus of Part III of this Article.

Except for the dicta that a competent individual has the right to refuse medical treatment and the Court's implied approval of withdrawal of food and water, *Cruzan* is not particularly important for what it mandates. Rather, the decision is important for the areas it leaves open to the states. First, a state may be constitutionally required to implement the decisions of a surrogate appointed by the person. Second, the states are free to develop other mechanisms that would allow the termination of medical treatment even though the person is incompetent. Thus, *Cruzan* does not prevent a state from taking any action. Rather, it gives states the opportunity to develop solutions to this difficult problem.

**D. Current Statutory Solutions**

In response to this issue, state legislatures have adopted three methods of addressing the problem of termination of medical treatment for incompetent persons. Living wills and durable powers of attorney, the most common solutions, are seriously flawed. These statutes are valueless for those who have not had the foresight to execute such an instrument. Moreover, the

---

104. *Id.* at 283.

105. *Id.* at 320-21 (Brennan, J., dissenting).

106. For a discussion of these assumptions, see *infra* notes 185-282 and accompanying text.


108. *Id.* at 292 (O'Connor, J., concurring). Justice O'Connor's language on an incompetent individual's right to terminate treatment is particularly noteworthy. She specifically refers to an "incompetent individual's liberty interest in refusing medical treatment." *Id.* (O'Connor, J., concurring). Thus, she recognized a right which the majority had dismissed. See *id.* at 280.

109. See, e.g., *id.* at 268-69 (indicating that Missouri Supreme Court found that state living will statute embodied state policy in favor of preserving life and state policy requiring surrogate decisionmaker to provide clear and convincing evidence of individual's desires absent presence of document satisfying statutory requirements). For a discussion of the *Cruzan* case, see *supra* notes 80-108 and accompanying text.

A similar problem is encountered in the area of wills. The majority of people do not execute a will. Society, however, does not hold property in permanent limbo or require its escheat to the state merely because the individual did not utilize good judgment and execute a will. Rather, society has statutorily des-
statutes do not benefit children, the mentally handicapped or those who have never been competent.110

The National Conference of Commissioners on Uniform State Laws has approved the Uniform Rights of the Terminally Ill Act (URTA).111 The URTA provides for declarations similar to living wills and durable powers of attorney for health care.112 It also includes an alternative procedure for individuals who have not executed a declaration.113 Only thirteen states114 have adopted the URTA, however, and all but two have made significant changes.115 Consequently, there are almost as many different versions of the URTA as there are states that have enacted it.

Seventeen legislatures have made halting steps towards solving the problem of termination of medical treatment for incompetent individuals who have not executed some written declaration.116 However, even these progressive statutes have flaws. Thus, in most jurisdictions individuals remain captives of the medical or judicial systems. The remaining portions of this


111. UNIF. RIGHTS OF THE TERMINALLY ILL ACT, 9B U.L.A. 96 (West Supp. 1992). The URTA was first approved in 1985. Id. It was superseded by the 1989 version. Id.

112. Id. § 2.

113. Id. § 7.


116. For a discussion of these statutory attempts to address the need for a more flexible approach, see infra notes 139-48 and accompanying text.
part describe the legislative steps taken to provide assistance to those making health care determination decisions.

1. Living Wills

A living will\(^{117}\) is a written statement signifying that an individual does not want life-sustaining medical treatment\(^{118}\) if the individual is suffering from a terminal injury or illness.\(^{119}\) A living will generally requests that the person be given comfort care including necessary pain relieving medications.\(^{120}\) The first living will statute was enacted by California in 1976.\(^ {121}\) Although there are substantial variations among the statutes, today forty-seven states and the District of Columbia have some version of a living will law.\(^ {122}\)

\(^{117}\) See, e.g., TENV. CODE ANN. § 32-11-103(4) (Supp. 1992) (defining “living will” as “written declaration” of person’s preferences for medical treatment). Most statutes use the terms “declaration” or “directive” to describe a living will. See, e.g., ALA. CODE § 22-8A-4 (1990) (defining declaration as written document directing “withdrawal of life-sustaining procedures in a terminal condition”); OR. REV. STAT. § 127.610 (1990) (defining directive as written document expressing individual’s wish to withhold or withdraw life-sustaining procedures).


\(^{119}\) See, e.g., OKLA. STAT. ANN. tit. 63, § 3080.2(7) (West Supp. 1993) (defining terminal illness or injury as “an incurable and irreversible medical condition that, even with the use of medical treatment, will result in death of a person”).

\(^{120}\) See, e.g., VA. CODE ANN. § 54.1-2984 (Michie Supp. 1992) (providing section on living will form allowing individual to express desire to continue medical procedures designed to give “comfort care or to alleviate pain”).


The inconsistencies among statutes have the potential for creating reciprocity problems. An individual who moves between states may find that portions of his living will are not valid in the new jurisdiction. In fact, Oregon requires that a specific statutory form be executed; no other living will is valid in that state. By contrast, a limited number of states recognize the mobility of our society and make specific provisions for living wills executed in other states. Even without the problems resulting from variations among statutes and the mobility of our society, there are two substantial problems with many of the living will statutes that limit their value even when properly executed.

The first problem, which has gained recent public attention, relates to whether artificial nutrition and hydration may be withdrawn from the permanently unconscious under a properly executed living will. Many living will statutes specifically prevent

---

123. OR. REV. STAT. § 127.610 (requiring that "directive shall be in the following form") (emphasis added).

124. See, e.g., FLA. STAT. ANN. § 765.112 (providing that "declaration executed in another state in compliance with the law of that state" is valid in Florida). The question of reciprocity has been left open in most states. A typical statute allows a declaration to be in any form so long as it "substantially complies" with the statutory form. See, e.g., KY. REV. STAT. ANN. § 311.626. The problem with interstate enforceability in these jurisdictions may turn on the question of proper execution, namely the number of witnesses and their identity.

125. The discussion is focused on the issue of nutrition and hydration because it is the current unresolved topic. Twenty years ago, as physicians began to perform organ transplants, the prevailing issue was when did death occur. DAVID J. ROTHSAN, STRANGERS AT THE BEDSIDE 156 (1991). In the mid-1970s, the issue was whether respirators should be disconnected. See, e.g., In re Quinlan...
the individual from making such a decision. The most common method of preventing the withdrawal of artificial nutrition is through the statutory definition of “life-sustaining procedures.” These statutes allow the withdrawal of life-sustaining procedures but specifically exclude artificial nutrition and hydration from the definition of life-sustaining procedures.\footnote{355 A.2d 647, 651 (N.J.), cert. denied, 429 U.S. 922 (1976). With advances in medical technology, there are already new issues on the horizon. See, e.g., Michael E. Young, Court Bars Donating Doomed Baby’s Organs, CHI. TRIB., Mar. 28, 1992, at A1 (discussing court’s refusal to allow organ transplants from anencephalic infant because she did not satisfy criteria for brain death). At the very least, the law must remain flexible to deal with advances in technology.} These statutes contrast sharply with more recent legislation providing living will forms that allow the declarant to affirmatively request the withdrawal of nutrition and hydration.\footnote{126. See, e.g., ILL. REV. STAT. ch. 110 1/2, para. 702(d) (precluding withdrawal of nutrition and hydration “if the withdrawal or withholding would result in death solely from dehydration or starvation rather than from the existing terminal condition”); MD. HEALTH-GEN. CODE ANN. § 5-602(c)(1) (excluding “administration of food and water” from those procedures to be withheld); N.H. REV. STAT. ANN. § 137-H:2(II) (excluding “sustenance” from definition of life-sustaining procedures); WIS. STAT. ANN. § 154.01(5)(b) (excluding “provision of nutrition or hydration” from definition of life-sustaining procedure).} Finally, there are those statutes that make no mention of the issue of nutrition and hydration. These statutes often provide that “comfort care” cannot be withdrawn, but they do not define the term.\footnote{127. See, e.g., ALASKA STAT. § 18.12.010(c) (containing specific provision on declaration form to allow individual to indicate whether or not he wants nutrition provided through gastric tube or intravenous mechanism). Some jurisdictions allow the withdrawal of nutrition by a back door process. The statutes provide that artificial nutrition and hydration cannot be withdrawn unless there is a specific affirmative statement to that effect included in the living will. See, e.g., GA. CODE ANN. § 31-32-3. Oklahoma has a separate statute which creates a rebuttable presumption that all incompetent patients wish to receive artificial nutrition and hydration. OKLA. STAT. ANN. tit. 63, §§ 3080.1-3080.5. This presumption can be rebutted by a living will that includes a statement to the contrary or by clear and convincing evidence of the patient’s intent. Id.} The second problem with many of these statutes is that they apply only if the person is in a “terminal condition.”\footnote{128. See, e.g., ALA. CODE § 22-8A-3(3) (excluding from life-sustaining procedures “the performance of any medical procedure deemed necessary to provide comfort or care or to alleviate pain”); FLA. STAT. ANN. § 765.101(11) (stating that “term ‘life-prolonging procedure’ does not include the administration of medication or performance of medical procedure . . . deemed necessary to provide comfort care or alleviate pain”).} A common statutory definition of a terminal condition is an “incurable condition caused by disease, illness, or injury which, regardless of the application of life-sustaining procedures, would produce...
death." Some statutes also require that death be imminent. It is the person in a terminal condition, however, who least needs the protection of a living will. Even if the person is suffering, by definition, he will die within a short period of time. The people most in need of a living will are people like Karen Ann Quinlan and Nancy Cruzan who were not in a terminal condition; they could and did live for many years in a state of permanent unconsciousness with the assistance of a respirator or artificial nutrition and hydration.

Living wills are an incomplete answer when an incompetent person is being kept alive by life-support systems. Most people will never execute a living will. Even those who do may find their living will inadequate if they move to, or even travel in, another state. Finally, if the person is not in a "terminal" condition or if the person is being kept alive by artificial nutrition, the document may be valueless.

2. **Durable Powers of Attorney for Health Care**

Thirty-two states and the District of Columbia have statutes that specifically provide for the execution of a durable power of attorney for health care. This document allows a principal to...
name an agent to make health care decisions if the principal becomes unable to communicate his desires. An agent is particularly valuable because a principal generally chooses a close relative or friend whom he trusts. Consequently, the agent knows the person's values and standards. This appointment is thus consistent with the rationale behind the substituted judgment test.134

Generally, statutes creating the durable power of attorney allow the agent to make any medical decisions that the person himself could have made if he were competent.135 As with living wills, there are many variations in durable power of attorney statutes among the states.136 Most significantly, the statutes vary on the issue of whether artificial nutrition and hydration can be withdrawn.137 The majority allow the withdrawal of nutrition and hydration.138

134. At the same time, the power of appointment eliminates the problems associated with the substituted judgment test by preventing the appointment of a guardian who is unfamiliar with the individual's desires. For a discussion of the substituted judgment test, see supra notes 31-50 and accompanying text.

135. For these statutory enactments, see supra note 133. Five states have only a brief statute that allows any power of appointment to survive disability if the power specifically so states. COLO. REV. STAT. §§ 15-14-501 to -509 (1987); HAW. REV. STAT. §§ 551D-1 to -7 (Supp. 1991); Md. EST. & TRUSTS CODE ANN. §§ 13-601 to -605 (1991); Mont. CODE ANN. §§ 72-5-501 to -502 (1991); N.M. STAT. ANN. §§ 45-5-501 to -502 (Michie 1989). These statutes do not mention medical decisionmaking but presumably could be applied in that situation.


136. Some of these variations create problems similar to those that exist under the living will statutes. For a discussion of the problems associated with living will statutes, see supra notes 122-32 and accompanying text.

137. Connecticut does not allow the withdrawal of artificial nutrition and hydration. CONN. GEN. STAT. § 1-54a. Three states make no reference to the
dration. This creates an anomaly in certain states where the living will statute specifically precludes the withdrawal of nutrition and hydration but the durable power of attorney statute allows such withdrawal.138

Durable powers of attorney for health care are in some respects better than living wills because they are more flexible. However, the most significant problems remain: they only benefit those who execute them, problems arise when a person moves to another state, and in a few states, artificial nutrition cannot be withdrawn.

3. Other Statutes

States have begun to recognize the deficiencies in living wills and durable powers of attorney for health care. Sixteen states and the District of Columbia now provide for family decisionmaking even in the absence of these two documents.139 Generally, issue of artificial nutrition. Nev. Rev. Stat. § 449.830; N.D. Cent. Code §§ 23-06.5-02 to-03; Tenn. Code Ann. § 34-6-205. Limits on the right to withdraw nutrition and hydration are included in two statutes. Ky. Rev. Stat. Ann. § 311.978(3)(c) (preventing withdrawal of nutrition unless burdens of continuing it outweigh benefits); Wis. Stat. Ann. § 155.20(4) (allowing withdrawal of nutrition unless withdrawal will cause pain or reduce comfort).

138. See, e.g., Ill. Rev. Stat. ch. 110 1/2, para. 702(d) (living will; preventing withdrawal of nutrition if death would result solely from dehydration or starvation rather than from existing terminal condition); id. para. 804-10 (durable power; allowing withdrawal of nutrition unless benefits of treatment outweigh burdens).

these statutes provide that if a person who is incapable of making medical decisions has not named an agent to make health care decisions, a family member may make such decisions on the person's behalf. Each statute includes a list of family members who may consent, sometimes in order of priority.140 Some statutes give a court-appointed guardian priority in making medical decisions141 and others only allow the guardian to make medical decisions if no family member is available.142 Some extend to all relatives, even distant ones,143 others allow friends to make deci-

document, physician can remove "maintenance medical treatment" if all family members who can be contacted agree in good faith that patient would have foregone treatment; N.C. Gen. Stat. § 90-322 (1990) (providing that "extraordinary means" to sustain life can be withdrawn by patient's guardian, spouse or majority of relatives of first degree); Or. Rev. Stat. § 127.635 (1990) (providing that patient's spouse, guardian, adult child or parent can request that life-sustaining procedures be withdrawn if physicians agree); S.C. Code Ann. § 44-66-30 (Law Co-op. Supp. 1992) (allowing spouse, parent, adult child, adult sibling, grandparents, adult grandchild or other relative to make health care decision for patient unable to consent and allowing for judicial intervention if two persons of equal priority disagree); Tex. Health & Safety Code Ann. § 672.009 (West 1992) (giving authority to make decision to withdraw life-sustaining procedures to patient's spouse, majority of available adult children, parents or other relative); Utah Code Ann. § 75-2-1107 (1992) (allowing physician to consult with patient's spouse, parent or adult children in deciding whether to withdraw life-sustaining procedures); Va. Code Ann. § 54.1-2986 (Michie Supp. 1992) (allowing patient's spouse, adult child, parent, sibling or other living relative to make health care decisions).

One of these states, Louisiana, does not have a statute authorizing durable powers of attorney for health care. Thus, in Louisiana, an individual is limited to the statutorily named decisionmaker even if that is not the person he would have chosen. This is particularly difficult for non-traditional couples where there is strong disagreement with the individual's family. For a discussion of litigation between an incompetent patient's parents and her lesbian partner, see infra note 325.

Five additional states have general medical consent statutes. Idaho Code § 39-4303 (1985) (outlining generally who "may give consent to care for others"); Miss. Code Ann. § 41-41-3 (Supp. 1992) (allowing any adult patient and various other people, including spouses, emancipated minors and guardians to consent to medical procedures); Mo. Rev. Stat. § 431.061 (1992) (indicating who can give consent to medical treatment and under what circumstances); N.D. Cent. Code § 23-12-13 (1991) (setting forth those persons who can make health care decisions for incapacitated patients); W. Va. Code § 16-5B-8a (Supp. 1992) (listing those persons who can consent for incapacitated patient in long-term care facility). While these statutes could be construed expansively to allow the family members to withdraw or withhold medical treatment, they were designed to give family members the power to approve the medical treatment recommended by the attending physician.

140. For a description of these statutory lists, see supra note 139.
sions if no family member is available, and two allow a religious superior to make the decision for a member of a religious order.

As is true of both living wills and durable powers of attorney, there are many variations among the statutes. The two most troublesome variations center around the issue of consensus. Illinois and Utah require that at least one physician agree with the named family member before life-sustaining treatment can be terminated. Consequently, the family can make the decision only if the medical establishment approves.

The other variation is that some states require unanimity or majority agreement among family members who are in the same class of priority, e.g. the person's adult children. If there are a substantial number of class members, the objection of one could frustrate the intent of the person. One particularly egregious example is New Mexico which requires the agreement of the spouse and adult children, thus preventing the spouse from acting alone. This may be a significant barrier when the spouse is from a second marriage and the children are from a first marriage.

4. The Patient Self-Determination Act

To date the most significant federal legislative response in the area of health care decisionmaking is the Patient Self-Determination Act (PSDA). The PSDA applies to health care provid-

144. See, e.g., ARIZ. REV. STAT. ANN. § 36-3231; FLA. STAT. ANN. § 765.401.
145. D.C. CODE ANN. § 21-2210(5A) (allowing religious superior to make health care decisions for patient if patient is member of religious order); IND. CODE § 16-8-12-4(3) (same; requiring, however, that individual does not have guardian or guardian does not act before authority can be given to religious superior).
146. ILL. REV. STAT. ch. 110 1/2, para. 851-20(c) (requiring certification by two physicians); UTAH CODE ANN. § 75-2-1107 (requiring written concurrence of two physicians).
147. LA. REV. STAT. ANN. § 40:1299.58.5A(1)(g) (requiring that all members of defined class consent to withholding or withdrawal of life-sustaining procedure); N.C. GEN. STAT. § 90-322(b)(iii) (requiring majority of relatives of first degree to agree when patient has no spouse or guardian); VA. CODE ANN. § 54.1-2986 (requiring agreement of majority of defined class of family members).
148. N.M. STAT. ANN. § 24-7-8.1.
ers including hospitals, nursing homes and other inpatient and outpatient care providers receiving federal funding under the Medicaid or Medicare programs.\textsuperscript{150} Under the PSDA, these health care providers must: (1) give written information to all adult patients explaining their rights under state law to make medical care decisions; (2) establish policies and procedures within the health care facility to implement patients' advance directives\textsuperscript{151} and provide all patients with information about such policies; (3) ask each patient if they have executed such an advance directive; (4) develop mechanisms to ensure compliance with state law related to medical care decisionmaking; and (5) educate hospital staff members about advance directives.\textsuperscript{152}

The reaction of health care providers to the legislation has been positive.\textsuperscript{153} The federal act also stimulated increased state legislative activity in the area of living will and durable power of attorney legislation.\textsuperscript{154} A common criticism of the PSDA, however, is that the time of admission to a health care facility is not the ideal time for a person to be informed of his rights regarding withdrawal of medical treatment.\textsuperscript{155} Nonetheless, the PSDA is generally considered an appropriate step towards encouraging the return of decisionmaking power to individuals.\textsuperscript{156}

\textsuperscript{150} See Schlesinger & Scheiner, \textit{supra} note 2, at 144.

\textsuperscript{151} An advance directive under the PSDA is defined as "a written instruction, such as a living will or durable power of attorney for health care, recognized under a state statute or by the courts of the state as relating to health care when the individual giving the instruction becomes incapacitated." \textit{Id.} at 145.

\textsuperscript{152} \textit{Id.} at 144-45.

\textsuperscript{153} See Bruce Weber, \textit{Positive Reaction Greets 'Living Will' Law}, N.Y. TIMES, Dec. 2, 1991, at B3 (stating that "reaction among patients and staff members at hospitals in the metropolitan region [to the PSDA] was largely one of relief").

\textsuperscript{154} See, e.g., Erich H. Loewy, \textit{Advance Directives and Surrogate Laws; Ethical Instruments or Moral Cop-Out?}, 152 ARCHIVES INTERNAL MED. 1973, 1973 (1992) (noting that PSDA "spawned a rash of legislation in the several states"). Moreover, Loewy asserts that state legislation is not only supporting the PSDA but is also expanding to protect patients from being at the mercy of "crass medical or crass legal paternalism." \textit{Id.}

\textsuperscript{155} See, e.g., \textit{id.} at 1974-75 (expressing concern that PSDA and advance directive laws are not enough; that in order for patients to make informed choices physicians must spend time discussing options and educating patients); Kevin M. McIntyre, \textit{Shepherding the Patient's Right to Self-Determination; The Physician's Dawning Role}, 152 ARCHIVES INTERNAL MED. 259, 259 (1992) (recognizing that although providing such information at time of admission to hospital may be most practical, it is still far from ideal method of disseminating such information to public); see also Joanna S. Abramson, \textit{Guardianship Petitions 'Swamp' State Courts}, MICH. LAW. WKLY., Nov. 25, 1991, at 1 (noting that in response to PSDA, Michigan nursing homes refused to accept new incompetent patients unless they had executed durable power of attorney or had guardian).

\textsuperscript{156} McIntyre, \textit{supra} note 155, at 259 (asserting that PSDA "will very likely increase the use [of advance directives] by bringing a national face to [them]").
The PSDA and the various state statutes described above are a major step toward removing from limbo those individuals who have not executed a durable power of attorney or a living will; but, current statutes are an incomplete answer. Physicians should not be allowed to interfere in family medical decisions and impose their own values. Moreover, the requirement of unanimity has the effect of creating a presumption against termination of treatment. This imposition of values and the current presumption against termination of treatment are the focus of the following part.

III. PROBLEMS INHERENT IN JUDICIAL INVOLVEMENT IN DECISIONMAKING

Judicial involvement in medical decisionmaking is a relatively recent phenomenon.157 Until the late 1950s and early 1960s, medical decisionmaking was exercised almost exclusively by the patient's personal physician.158 Not only were judges and hospital ethics committees not part of the decisionmaking process, but frequently, not even the patient and his family were consulted.159 By the mid-1970s, however, the entire decisionmaking process had changed. Physicians, patients, family members, hospital ethics committees and the judiciary were all involved.160

Several events were critical in causing these changes. First, public concern was aroused about abuses in human experimentation.161 In the notorious Tuskegee study, men with syphilis were left untreated in order to study the effects of the disease.162 Such abuses led to increasing public distrust in allowing physicians to exercise full control in health care decisionmaking. The second

157. ROTHMAN, supra note 125, at 1 (noting that "[w]ell into the post-World War II period, decisions at the bedside were the almost exclusive concern of the individual physician").
158. Id.
159. Id. at 2. For example, as recently as the early 1960s, almost 90% of physicians stated that it was their usual policy not to inform a patient of a cancer diagnosis. Id. at 147.
160. Id. at 2.
162. ROTHMAN, supra note 125, at 183. Rothman discusses how for over 30 years until the early 1970s, investigators from the United States Public Health Service had studied, but not treated, black men suffering from secondary syphilis in rural Alabama. Id.
lightning rod was the 1969 death of a Down's syndrome baby born with a digestive abnormality. The child died fifteen days after birth because surgery was not performed. At the same time, the abortion issue was becoming heated, culminating with the decision in Roe v. Wade. Thus, public distrust expanded to include parents who were believed to be colluding with the physicians.

The final event which galvanized this area was the case of Karen Ann Quinlan. Karen entered a persistent vegetative state in 1975 from an unknown cause and required mechanical ventilation to sustain her respiratory function. Karen's father requested the removal of the respirator, but the doctors refused. Because the medical profession would not comply with his request, Joseph Quinlan turned to the legal profession. Thus began the involvement of the judiciary in medical decisionmaking.

In general, society has benefitted from the public attention to medical decisionmaking. People have been forced to grapple with major medical, ethical and religious issues. Families are now involved in decisions affecting their lives rather than leaving these personal decisions to the unsupervised control of individual physicians. The pendulum, however, has swung past the middle to the opposite extreme. The government, through the courts, has

---

163. Id. at 191.
164. Id. The infant's intestinal blockage could have been repaired through surgical intervention but the parents refused to consent. Id.
167. Id. at 654.
168. Id. at 656-57.
169. The New Jersey Supreme Court granted Joseph Quinlan the authority to withdraw Karen's life support system by appointing him as her guardian. Id. at 672.
170. Rothman, supra note 125, at 190-91, 210-12. See generally Robert Stinson & Peggy Stinson, The Long Dying of Baby Andrew (1983). This book was written by parents whose child was born prematurely, suffering from serious birth defects. It discusses the parents' frustration when their child was transferred to a teaching hospital and given treatment against their wishes. Medical ethicist David Rothman suggests that the doctors' initial treatment really was not that far off the mark. Rothman, supra note 125, at 218. However, there should have been a termination of treatment later on. Unfortunately, the perspective of doctors in a neonatal unit—that with maximum treatment, children have a chance to survive—prevented the termination of treatment in Andrew's case. Rothman asserts that the fact "[t]hat Andrew lost does not support the case for parents' rights, any more than does the fact that other infants have won buttress the case for doctors." Id. at 219.
merely replaced the physicians as the decisionmaker.\footnote{171}

Before the \textit{Quinlan} case, physicians, outside of the glare of
the public spotlight, discontinued treatment “when they believed
that a patient’s death was imminent and irreversible,” and hospi-
tals allowed the physicians to make those decisions without the
interference of regulations and committees.\footnote{172} Even today, it is
acknowledged that many physicians continue to quietly turn off
machines when further treatment is futile.\footnote{173} Not all hospitals,
however, will allow this informal decisionmaking. Moreover,
some physicians are unwilling to take this responsibility.\footnote{174} The

\footnote{171. \textit{Rothman}, supra note 125, at 228. The problem of the government as
the decisionmaker is particularly acute in the area of neonatal care. In 1984, the
Reagan Administration promulgated regulations which require the treatment of
infants under virtually all circumstances without regard to the severity of their
disabilities or prognosis for life. \textit{See 45 C.F.R. § 84.55} (1992). In some in-
stances, the result may be essentially human experimentation. \textit{Paul Ramsey,
Ethics at the Edges of Life} 208-10 (1978) (recognizing that infants may be
treated not because they are expected to survive but rather to experiment with
new medical procedures).

\footnote{172. \textit{Rothman}, supra note 125, at 160.}

\footnote{173. \textit{Id.} at 228; \textit{see also In re Storar, 420 N.E.2d} 64, 75 (N.Y.) (Jones, J.,
noted that for many years physicians and family members had turned off the life
support systems of incurably ill patients without the intervention of the legal
system. \textit{Id.} (Jones, J., dissenting in part). In a 1975 opinion piece in the \textit{New
that the \textit{[Quinlan]} case ‘is in court at all. Each day, hundreds, perhaps thousands,
of similar dilemmas present themselves. . . . The decisions are difficult, often
agonizing, but they are reached in hospital corridors and in waiting rooms, not
courts.’” \textit{Rothman}, supra note 125, at 228 (quoting Michael Halberstam, \textit{Other

\footnote{174. The most commonly expressed reason for a physician’s hesitation in
terminating life support is the fear of criminal liability or malpractice suits. Only
one case involved criminal charges against the physicians, however, and that in-
dictment was dismissed on the pleadings. \textit{Barber v. Superior Court, 195 Cal.
Rptr. 484, 486} (Cal. Ct. App. 1983). There are no reported cases involving mal-
practice and such cases are not likely. Only immediate family members would
have standing to sue, and they will not sue if the doctors have terminated treat-
ment in accordance with their wishes.

Despite the dearth of prosecutions of physicians for removing a respirator
from one whose death is imminent and unavoidable, there still exists a perva-
sive, even hysterical, fear of liability in the medical world. \textit{See John J. Paris &
Richard A. McCormick, Living-Will Legislation, Reconsidered}, \textit{Am.}, Sept. 5, 1981, at
86, 86. This hysteria is not completely unfounded. For example, litigation was
required in the \textit{Eichner} case because of the Nassau County District Attorney’s
insistence on the continued respiratory treatment of Brother Fox. \textit{See In re
Eichner, 420 N.E.2d} 64, 67-68 (N.Y.), \textit{cert. denied}, 454 U.S. 858 (1981). Furth-
ermore, in 1977, the Attorney General of the State of Washington issued an opin-
ion on the subject of withdrawal of life support from a dying patient which stated
that “[u]nder the present law, an attempt to bring about death by the removal of
a life sustaining mechanism would constitute homicide, first degree.” \textit{Paris &
McCormick, supra, at 88.}
result is that a patient's rights depend on the personal views of his physician and the policies of the hospital he has selected.175

These historical changes have had an enormous impact on individual lives and on medical decisionmaking. The following sections focus on the impact of judicial intervention on family decisionmaking. Specifically, these sections focus on the value system that is inherent in any medical decisionmaking and the impossibility of discovering any objective approach to the question of whether to terminate life-sustaining medical treatment.

A. Judges Should Not Make Personal Medical Decisions

The issue of termination of medical treatment does not belong in court. Judges have no special expertise that allows them to make the decision to terminate medical treatment. Many courts recognize that decisions made by courts concerning withdrawal of medical treatment are not inherently better than decisions made by doctors or families.176

Justice Stevens, recognizing the difficulty of deciding these essentially private questions, stated in 

Cruzan: "It is not within the province of secular government to circumscribe the liberties of the people by regulations designed wholly for the purpose of establishing a sectarian definition of life."177 Justice Jones stated in his dissent in 

Storar that "we approach, and even may be

175. In a study of intensive care units (ICU) at two teaching hospitals, there was a dramatic difference in the percentage of patients for whom treatment was limited. Zussman, supra note 13, at 131. At one hospital, physicians limited treatment for approximately one-third of the patients while at the other hospital, treatment was limited for fewer than one-sixth of the patients. Id. The difference is particularly striking because both hospitals used the same standard in limiting treatment: the patient had to be terminal. Id. at 132. The difference in treatment was the result of the subjective application of the standard.

A patient's rights may also be affected by who is paying for the medical care, particularly when the patient is receiving public assistance. Nancy Cruzan and Elizabeth Bouvia were in public hospitals; their care was being paid with public funds. Cruzan v. Harmon, 760 S.W.2d 408, 411 n.2 (Mo. 1988) (en banc), aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990); Bouvia v. Superior Court, 225 Cal. Rptr. 297, 299-300 (Cal. Ct. App. 1986). The Attorney General of the State of Missouri prosecuted the appeal in 

Cruzan and county attorneys opposed the petition in 

Bouvia. Cruzan, 760 S.W.2d at 410; Bouvia, 225 Cal. Rptr. at 298.

176. See, e.g., In re Lawrance, 579 N.E.2d 32, 42 (Ind. 1991); see also In re Jobes, 529 A.2d 434, 451 (N.J. 1987). In Jobes, the court asserted: "Courts are not the proper place to resolve the agonizing personal problems that underlie these cases. Our legal system cannot replace the more intimate struggle that must be borne by the patient, those caring for the patient and those who care about the patient." Id.

thought by some to trespass on, the domain of Providence. Few areas of judicial activity present such awesome questions or demand greater judicial wisdom and restraint.'178 Our adversary system is designed to settle disputes between parties with conflicting claims. For example, courts determine whether contracts are valid or whether individuals are negligent. Courts were not designed to make personal family decisions such as whether a child should attend a parochial school or whether a person should be treated by a chiropractor. Except in the area of divorce, when two people who are incapable of agreeing have equal right to decide such issues, a court is not an appropriate forum. These questions are infused with moral, ethical and theological elements. Courts, for good reason, have stayed out of this area in the past.

As courts began to enter the arena of medical care decision-making they attempted to be objective, trying to make the best decision. The problem is that there is no one best decision. In their attempts to decide these questions, judges have made many assumptions that have often had the effect of preordaining the outcome. These assumptions will be examined in the following section.

B. Fictional Assumptions Underlying Judicial Decisions

There are two fundamental problems with *Cruzan* and most of the decisions involving termination of life-sustaining treatment. The first problem is that medical technology has progressed beyond our knowledge of life and death. For generations, a bright line divided life and death. When a person stopped breathing or his heart stopped functioning, he was dead. The development of respirators, heart-lung machines, and more recently, artificial feeding techniques has blurred this line and destroyed the medical and societal consensus as to when a person dies.

The second problem is societal distrust of family decision-
making. In recent years, the government has increasingly intervened in private lives when children are involved. The goal of protecting children from abuse certainly is desirable. Even from the outset, however, problems arose because children from poor households have always been more likely to be characterized as abused and to be placed in foster homes than children from middle-class families.  

This concern for abused children evolved into a tendency of courts to second-guess decisions that in the past were private. For example, during the past ten years, courts have frequently ordered caesarean sections for women who have refused to consent to the procedure. A particularly tragic case involved Angela Carder. Angela Carder suffered from cancer, but was in remission when she became pregnant in 1987. Twenty-five weeks into the pregnancy her doctor discovered that the cancer had spread. Angela Carder, her husband, her parents and one of her doctors decided against an emergency caesarean, but George Washington University Hospital petitioned the Superior Court to seek “a judicial determination of its legal obligations.” The trial judge ordered a caesarean section and the court of appeals refused to issue a stay. The infant died two hours after birth. Angela Carder died two days later. 

Society justifies interference with family decisionmaking on the basis that children must be protected from abuse or neglect or under the theory that family members have a conflict of interest because the death of the loved one will relieve them of their emo-


183. See In re A.C., 573 A.2d 1235, 1241 (D.C. 1990). The family argued to the trial judge that a caesarean section would inflict unjustified pain upon Ms. Carder in her last moments of life because the child might be born with birth defects and might not survive. Greenhouse, supra note 181, at A15. Experts for the hospital testified, however, that the 26-week-old fetus had a 50-60% probability of survival and a less than 20% chance of substantial impairment if delivered at that point. In re A.C., 573 A.2d at 1239.

184. In re A.C., 573 A.2d at 1241.
tional and/or financial burdens. Instead, society concludes, the omniscient and impartial outsider should make the decision. This conclusion is fundamentally flawed. Only God is omniscient and there is no absolute truth that impartial judges can apply. There are only individual preferences based in individual morality.

In the following sections, the most frequently expressed assumptions will be examined. Judges use these rationales as the underpinnings for decisions in which they refuse to allow the termination of medical treatment in the absence of a written declaration or other clear and convincing evidence of the person's desire to terminate life-sustaining treatment.

1. It Is Better to Err in Favor of Preserving Life

The first assumption is that it is better for judges to err in favor of preserving life.¹⁸⁵ Implicit in this statement is the conclusion that permanent unconsciousness¹⁸⁶ is "life." For example, in In re Barry, an infant had only brain stem activity; yet, the state's attorney tried to prevent the termination of treatment in order to protect the infant's "life."¹⁸⁷ Additionally, in In re Colyer, although the court noted that there was no likelihood that Bertha Colyer would ever again have a meaningful existence, two justices dissented from the majority opinion allowing termination of treatment.¹⁸⁸ A few courts have modified this assumption by drawing a distinction between "biological life"¹⁸⁹ and "cognitive or sapient life."¹⁹⁰

If "biological life" is the accepted standard, the question is: why is it best to err in favor of preserving life? Why not err in

¹⁸⁶. "Permanent unconsciousness" is a general term that includes many subgroups of "irremediable unawareness." SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS 11 (1987) [hereinafter LIVING WILL LAWS]. Two of these subgroups are irreversible coma and persistent vegetative state. Id. An irreversible coma is a "condition in which the patient appears permanently asleep." Id. Persistent vegetative state is a condition in which a patient appears to have cycles of sleeping and wakefulness. Id. These terms are frequently, and improperly, used interchangeably.
¹⁸⁸. In re Colyer, 660 P.2d 738, 743 (Wash. 1983) (en banc) (suffering from anoxic brain damage, patient was unable to breathe on her own and was in persistent vegetative state).
¹⁸⁹. In re Quinlan, 355 A.2d 647, 659 (N.J.) (distinguishing "human life" from "biological life in a merely vegetative state"), cert. denied, 429 U.S. 922 (1976); see also In re Conroy, 486 A.2d 1209, 1248 (N.J. 1985) (Handler, J., concurring in part and dissenting in part) (characterizing biological life as "life at its most rudimentary level").
¹⁹⁰. Quinlan, 355 A.2d at 663; Colyer, 660 P.2d at 751.
favor of relieving suffering? Why not err in favor of allowing individuals to die quickly and easily of natural causes? Are we sustaining life or prolonging death?\footnote{191} There are approximately 10,000 people who are permanently unconscious in hospitals and nursing homes in this country.\footnote{192} No legislators have debated the issue of whether these individuals are "alive." The populace has not expressed a preference for keeping the permanently unconscious "alive" indefinitely.\footnote{193} The statement that it is best to err in favor of preserving life is not a universal truth. It is an assumption that has allowed a handful of state court judges to decide whether comatose patients will be able to die naturally or will be kept "alive" with respirators and feeding tubes.

The corollary to this assumption is that withdrawal of nutrition is the equivalent of starving the person to death.\footnote{194} The assumption here is that provision of artificial nutrition is the same as feeding a conscious person. A more apt analogy is the withdrawal of a respirator. Even though a person can no longer breathe after disconnection of a respirator, removal of the respirator is not the same as suffocating a conscious individual. Similarly, removing the feeding tube from a permanently unconscious person is very different from depriving a conscious individual of food.

Whether a court's rationale is that it will not allow the person to starve to death or that it is best to err in favor of life, the question remains the same: does a permanently unconscious person have a life to preserve? That question can only be answered by each person's family based on their own moral beliefs.

2. \textit{The State Has an Interest in Preserving Life}

The second assumption is that there is a legitimate state in-


interest in preserving life. This is axiomatic. The state's interest is generally subdivided into four factors: (1) the preservation of life, (2) the protection of the interests of innocent third parties, (3) the prevention of suicide and (4) the maintenance of the ethical integrity of the medical profession. On this basis, courts consistently hold that the right to refuse medical treatment is not absolute. Courts balance these four factors against the right of an individual to refuse medical treatment. When a person is competent, these state interests are rarely used to override the competent person's decision. When the person is not competent, however, these factors are used as a presumption against termination of medical treatment.

The first factor, the state's interest in preserving life, embraces "two separate but related concerns: an interest in preserving the life of a particular person, and an interest in preserving the sanctity of all life." While the state's interest in preserving life is significant, standing alone it usually will not prevent a competent person from declining treatment. The state's interest is indirect and abstract and therefore generally must yield to the competent person's more personal interest in his own life. This factor becomes more complex when the person is not competent. The state's interest, however, should still weaken when treatment only prolongs the life of an individual suffering from an incurable condition.

There is a fundamental problem with the assumption that the

---

195. *Cruzan*, 497 U.S. at 280 (stating that there is "no gainsaying" state's interest in protecting and preserving life).
197. *Conroy*, 486 A.2d at 1223 (noting that "[i]n some cases, [the right to refuse] may yield to countervailing societal interests in sustaining the person's life").
198. *Conroy*, 486 A.2d at 1225 (concluding that individual's right to self-determination will generally outweigh any contrary state interest, even though enforcing person's right to terminate treatment may result in death).
199. *Id. at 1223; see also Rasmussen v. Fleming*, 741 P.2d 674, 683 (Ariz. 1987) (en banc).
200. *Id.* at 1223; *see also Conroy*, 486 A.2d at 1225 (observing that "the life that the state is seeking to protect in such a situation is the life of the same person who has competently decided to forego the medical intervention").
201. *Id.* at 1223; *see also In re Colyer*, 660 P.2d 738, 743 (Wash. 1983) (en banc) (indicating that although state's interest in preserving life should prevail in cases requiring life
The state has an interest in preserving life. Although the state should protect an individual from the loss of his life by the act of another as in the case of homicide, the state has no interest in interfering with an individual's decision about his own life. As Justice Brennan noted in his dissent in Cruzan: "[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."204 This is true whether or not the individual is competent.

The second factor, protection of the interests of innocent third parties, is the basis on which courts occasionally order treatment of even competent persons. When the person's decision could adversely affect the health, safety or welfare of third parties, the person's right to refuse continued treatment must give way to the protection of those third parties.205 A typical example is when the person has dependent children.206 The interests of third parties may be relevant in the situation where a blood transfusion will save a person's life and allow him to return to a meaningful relationship with his children. No third party, however, benefits by maintaining the pulse and respiration of a person who is permanently unconscious or is in a terminal condition.

The third factor, the prevention of suicide, is really a subset of the state's general interest in preserving life.207 The basis for the state interest in preventing suicide is the prevention of "irrational self-destruction."208 When a person refuses medical treatment, the disease is simply allowed to take its natural course. The death which occurs is a result of the underlying disease and is not that of a self-inflicted injury.209 Suicide is really a question of in-
tent; it requires an intent to die\textsuperscript{210} not just an unwillingness to continue the fight to live.\textsuperscript{211} Thus, the state's interest in preventing suicide is not relevant in cases involving the withdrawal of medical treatment.

The fourth factor, maintenance of the integrity of the medical profession, is perhaps the least important interest. Even the American Medical Association recognizes that medical treatment need not be provided in every situation.\textsuperscript{212} This factor is obviously irrelevant if the physician does not object.\textsuperscript{213} Even the physician's objection, however, should not be the final answer on this question.\textsuperscript{214} The person should not give up his right to self-determination when he chooses a physician. When a person rejects his doctor's advice, he is accepting responsibility for his medical

\textsuperscript{210} Wayne R. LaFave & Austin W. Scott, Jr., Criminal Law § 7.8, at 649 (2d ed. 1986); see also Bouvia v. Superior Court, 225 Cal. Rptr. 297, 306 (Cal. Ct. App. 1986) (stating that patient's desire "to allow nature to take its course is not equivalent to an election to commit suicide with real parties aiding and abetting").

\textsuperscript{211} In Cruzan, the focus of Justice Scalia's concurrence is that refusal of medical treatment is suicide. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 292 (1990) (Scalia, J., concurring). Justice Scalia would prevent a person from refusing medical treatment no matter how painful or oppressive the illness or how brief the extension of life if the result of the refusal would be acceleration of death. Such a radical position would give carte blanche to the medical profession to make all decisions on patient treatment without interference by the patient.

Noting that state statutes, not the Constitution, prohibit suicide, Justice Scalia argues that Justice Brennan's and Justice Stevens' dissents advocate allowing suicide. \textit{id.} at 299-300 (Scalia, J., concurring). This characterization, however, stretches their language to an unintended extreme and twists the obvious intent of Justice Brennan and Justice Stevens, which is to protect the patient's liberty interest in choosing to accept or reject particular medical treatments.

Justice Scalia has oversimplified the problem to two choices: the acceptance of all medical treatment no matter how small the benefit or the refusal of all treatment no matter how significant the benefit. The result of Justice Scalia's opinion would be to replace decisionmaking by the individual with decisionmaking by the medical establishment.

\textsuperscript{212} See AMA Council on Ethical and Judicial Affairs, Withholding or Withdrawing Life Prolonging Medical Treatment (Mar. 15, 1986), quoted in Rasmussen v. Fleming, 741 P.2d 674, 684 (Ariz. 1987) (en banc); see also Saikewicz, 370 N.E.2d at 426 (observing that "[p]revailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances"); Conroy, 486 A.2d at 1224 (stating that "[m]edical ethics do not require medical intervention in disease at all costs").

\textsuperscript{213} Rasmussen, 741 P.2d at 684; see also Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626, 638 (Mass. 1986) (concluding that integrity of medical profession is not violated if hospital does not take part in termination of patient's medical treatment).

\textsuperscript{214} For a discussion of the right of conscience, see infra notes 341-46 and accompanying text.
treatment decisions. The person’s right to informed consent would have no meaning if it must always give way when the person’s decision conflicts with the advice of his doctor or even the conclusions of the medical profession as a whole.

3. Most People Want to Be Kept “Alive” by Machines

The third assumption is that most people would prefer to be kept alive with mechanical devices. This assumption is implicit in virtually all decisions involving refusal of medical treatment. Courts begin with the presumption that the person wants treatment. The petitioner must then prove that the person does not want to continue treatment. The presumption, however, is erroneous. Most people would rather die than be kept alive on machines. In 1986, the Gallup organization surveyed approximately one thousand adults. These adults were asked whether they would want life support systems disconnected if they were in an irreversible coma. Seventy percent were “very willing” to have their own life support system disconnected in that circumstance. The number increased to a dramatic eighty-two percent when the category “somewhat willing” was added. This public opinion poll was confirmed by a more sophisticated empirical study aimed at determining patient preferences. Patients with some current health problems were asked whether they wished to receive cardiopulmonary resuscitation (CPR) or CPR and a ventilator if they suffered cardiac arrest in each of three situations: after suffering a stroke, while suffering from chronic lung disease or in their current condition. CPR and a ventilator were only requested by fourteen percent of the participants in the case of stroke, twenty-one percent in the case of chronic lung disease, and twenty-three percent in the case of current health. The request for CPR alone was significantly higher for chronic lung disease (sixty-one percent) and current health (seventy-five percent).

216. Id. For a discussion of the informed consent doctrine, see supra notes 12-15 and accompanying text.
217. Steiber, supra note 5, at 72.
218. Id.
219. Id.
220. Id.
221. Id. supra note 42, at M115.
222. Id.
223. Id. at M118 tbl. 2. The percentages of those requesting designated treatment included those persons responding “definitely yes” and “probably yes.” Id.
percent), but not for stroke (twenty-one percent). The dramatic increase in the number requesting only CPR in comparison to CPR and a ventilator evidences a desire for treatment if a person can live a somewhat normal life but a rejection of long term total incapacitation in a hospital or nursing facility.

There appears to be a very clear consensus that people do not want to be kept alive when life means unconsciousness or maintenance on machines. In addition, people apparently do not want treatment if no real benefit will result. It is time for courts to change the presumption to one reflecting the public's desire not to be kept "alive" by machines.

4. There Is No Harm in Postponing the Decision

Perhaps the most insidious assumption is that there is no harm in delaying a decision to terminate medical treatment. The Supreme Court adopted the similar view that it was better to err on the side of caution in terminating medical treatment because a mistake in that direction could later be corrected while a decision to terminate treatment could never be reversed. While the irreversibility of the decision to terminate treatment is obvious, the Court showed a surprising lack of appreciation for the continued suffering and degradation resulting from a decision not to terminate treatment. Justice Brennan recognized this harm in his dissent in *Cruzan*. He explained:

An erroneous decision not to terminate life support, however, robs a patient of the very qualities protected by the right to avoid unwanted medical treatment. His own degraded existence is perpetuated; his family's suffering is protracted; the memory he leaves behind becomes more and more distorted.

Even a later decision to grant him his wish cannot undo the intervening harm.

The risk of error is often the basis of a court's refusal to dis-

---

224. *Id.*
226. Some courts have recognized the danger inherent in a decision either to terminate or to continue treatment. *See, e.g.*, *In re Conroy*, 486 A.2d 1209, 1220 (N.J. 1985) (stating that either way, mistaken decision would be disastrous).
227. *Cruzan*, 497 U.S. at 320 (Brennan, J., dissenting); *see also id.* at 252-53 (Stevens, J., dissenting) (discussing harm in ignoring Nancy Cruzan's wishes and prolonging her death).
The risk of error, however, is inherent in the entire legal system. There are no certainties in the law. Damages are imposed in most civil cases based on a mere preponderance of the evidence standard. Even in the criminal law, the standard of beyond a reasonable doubt leaves room for error. A person can even be executed without absolute certainty. In no other area does risk of error freeze the courts into inaction. Thus, the mere chance that a decision may be erroneous should not be the basis to continue treatment.

It is unrealistic to expect that judges will ever be certain of the correctness of their decisions. Moreover, it is impossible for a physician to state to a level of moral certainty that the diagnosis that a person's situation is hopeless is correct. To require such a level of proof would effectively preclude the termination of treatment.

Additionally, it is overly simplistic to suggest that adopting a "wait and see" attitude toward these decisions is merely maintaining the status quo. In the case of Nancy Cruzan, the status quo only existed because medical personnel initiated life support. If paramedics had not begun artificial respiration or if hospital personnel had not surgically inserted the gastrostomy tube, the status quo would have been her death in 1983 from the injuries sustained in the automobile accident. The status quo for Nancy Cruzan was "to a large extent a predictable, yet accidental confluence of technology, psyche, and inertia." Once treat-

---

228. See, e.g., In re Longeway, 549 N.E.2d 292, 305 (Ill. 1989) (Ward, J., dissenting) (discussing substituted judgment standard and chances of error under that approach).

229. In re Minor, 434 N.E.2d 601, 610 (Mass. 1982) (noting that "[t]o require judges in reviewing medical judgments to reach a level of moral certainty ... would cause those terminally ill patients involved to suffer unnecessary pain and loss of dignity" (citation omitted).

230. Id.

231. Cruzan, 497 U.S. at 266; see also Ramsey, supra note 171, at 271. In discussing the Quinlan case, Ramsey noted:

If there had been reliable information, when Karen was brought to the hospital, as to how she became comatose, how long she was in a state of respiratory distress, and what degree of anoxia her brain had suffered, Karen might not have been placed on a respirator in the first place. Not knowing why or how long Karen had been comatose, the doctors rightly began curative treatment. But having rightly begun curative treatment, the physicians then found they could not in conscience stop.

232. Cruzan, 497 U.S. at 320 n.17 (Brennan, J., dissenting).

233. Id. (Brennan, J., dissenting) (quoting Nancy K. Rhoden, Litigating Life and Death, 102 Harv. L. Rev. 375, 433 (1988)); see also Ramsey, supra note 171, at 272 (concluding that treatments which had potential for saving Karen Ann
ment began, no one was willing to take responsibility for stopping it. It was medical technology run amuck. The judgment call of a paramedic or an emergency room doctor should not be allowed to determine whether an individual will be allowed to die a natural death or be attached to machines in an unconscious state for many years.

When a decisionmaker refuses to act and adopts a wait and see attitude, the decision is often cushioned in language that suggests that the person will actually benefit from the decision. The court often frames its opinion in language that suggests that a future medical discovery may save the person's life. This is one of the most pernicious rationales; it cloaks an unwillingness to make a hard choice in the language of altruism.

A refusal to terminate treatment because a future discovery may save the person reflects "an extraordinary optimism about the prospects of innovation." The probability of such a discovery is infinitesimal. Years pass between an initial discovery and the creation of technology sufficient to make effective treatment available to the public at large.

Quinlan's life became means by which her life was needlessly prolonged. Ramsey suggests that it may be a "routinized conscience" that prevents physicians from terminating treatment after it becomes apparent that a patient will not recover. Id. See Cruzan, 497 U.S. at 283.

The reluctance of some physicians to make hard choices regarding the termination of medical treatment is similar to the attitude of some judges in refusing to allow the termination of treatment. Rothman, supra note 125, at 66. In discussing the analogous relationship between government regulators and research scientists, Rothman stated that government officials sometimes hesitated to intervene in research because they assumed that experiments were likely to prove successful and the drugs under investigation would turn out to be therapeutic wonders. . . . They measured the impact of regulation not by calculating risks but by exaggerating benefits. Fantasies, not nightmare cases, ruled: the researcher who had a miracle cure for a deadly disease or who could awaken the comatose patient ought not to be burdened or bridled with administrative regulations. Id.

For example, in the area of cancer research, the National Cancer Institute has spent over $20 billion during the past twenty years and the American Cancer Society now raises over $330 million each year. Samuel S. Epstein & Ralph W. Moss, Have We Lost the War on Cancer?, Chi. Trib., Dec. 12, 1991, at C27. Five year survival rates for many types of cancer have remained generally unaffected by the large investment in research. Id. For example, a bone marrow transplant costs $100,000 and has a low chance of success. Id. Epstein and Moss argue that efforts should be more properly focused on the need for prevention through avoidance of carcinogenic agents rather than on seeking a cure once the cancer has developed. Id.

See, e.g., Epstein & Moss, supra note 236, at C27 (observing that despite massive influx of cancer research dollars "our ability to treat and cure cancer has
Moreover, Justice Brennan noted in his dissent in *Cruzan* that the majority misconceived the relevance of possible medical advances.238 He argued that possible advances should not be used as a reason to force a person to accept medical treatment against his will. "The possibility of a medical miracle is indeed part of the calculus, but it is part of the patient's calculus."259 Thus, the possibility of future advances in medicine should not be used as a justification for denying an incompetent person the right to die naturally.

Opponents of the right to die often cite to medical miracles in support of the proposition that medical treatment should not be terminated. On rare occasions, individuals who were comatose for extended periods regained consciousness, but the evidence is primarily anecdotal.240 This fantasy has been promoted in popular culture by the movie *Awakenings*.241 The reality, however, is that the actual incidence of recovery from a coma diagnosed as permanent has been infinitesimal. In *Brophy*, a neurologist testified that he was aware of only two cases in the

---

238. *Cruzan*, 497 U.S. at 321 (Brennan, J., dissenting). This is particularly true for individuals in persistent vegetative states from anoxic brain injury, because the focus of research and treatment advances is on responding more quickly at the time of injury to minimize damage, not on reversing existing damage. See, e.g., Mark C. Rogers & Jeffrey R. Kirsch, *Current Concepts in Brain Resuscitation*, 261 JAMA 3143 (1989) (reviewing current treatments given to brain-injured patients, all initiated as soon as possible following precipitating event); Dixie Farley, *Head Injuries Require Quick, Skilled Care*, FDA CONSUMER, Sept. 1990, at 8 (describing emergency response systems in place to treat head injury and need for immediate diagnosis and treatment to limit long-term effects).


240. See *In re Colyer*, 660 P.2d 738, 754 n.1 (Wash. 1983) (en banc) (Dore, J., dissenting). In *Colyer*, Justice Dore discussed Dr. Lev Landau, 1962 Nobel Prize winner in physics, who suffered severe brain damage as the result of an automobile accident. *Id.* (Dore, J., dissenting). Dr. Landau was comatose for an extended period, he required ventilatory support for seven weeks and had a "flat EEG" reading for 100 days. *Id.* (Dore, J., dissenting). Later, he miraculously recovered and resumed his research. *Id.* (Dore, J., dissenting).

Anecdotes such as this, however, should not be used as the basis for preventing all families from terminating treatment when a patient is in a coma. Recovery after seven weeks in a coma is certainly unusual; however, seven weeks is a considerably shorter period of time than the comatose period for most of the individuals whose families are seeking to terminate treatment. For examples of the length of time patients remained in comas, see infra note 328.

241. *Awakenings* (Columbia Pictures Industries, Inc. 1990). Even in *Awakenings*, however, the patients' recovery was not permanent. *Id.*
medical literature where the person recovered cognitive awareness after one month in a persistent vegetative state. Neither of the individuals described by the neurologist recovered completely. Thousands of people should not be doomed to spend decades in comas because a handful may recover consciousness.

5. Youth Withdraw Medical Treatment from the Elderly

Another assumption relied on by some judges is that medical treatment is more quickly withdrawn from the elderly. The suspicion, however, that healthy young and middle-aged people are waiting to terminate medical treatment to rid the world of sick and aging individuals is unfounded. Although this is a frequently articulated assumption, there is no documented case law that supports the perception that the young readily withdraw treatment from the elderly that the elderly would have wanted. In contrast, a survey conducted by Gallup indicated that older individuals are more willing to have treatment terminated than younger individuals and that only forty-six percent of those surveyed would be “very willing” to even consider withdrawing treatment from a family member. Additionally, in a more formal research study performed by Uhlmann, the persons surveyed were all over sixty-five years old and had at least one chronic health problem. Yet, in all three scenarios presented to the respondents,

243. Id. (noting that “[t]hey were left in a state . . . worse than the vegetative state”); see also Bonnie Steinbock, Recovery from Persistent Vegetative State?: The Case of Carrie Coons, HASTINGS CENTER REP., July-Aug. 1989, at 14. Mrs. Coons had a massive stroke in October 1988, and her condition deteriorated. Id. In November, a gastrostomy tube was surgically inserted and she was diagnosed in a persistent vegetative state. Id. In January 1989, the sister with whom she had lived asked that the tube be removed. Id. On April 4, 1989, a New York Supreme Court judge ruled that the tube could be removed. Id. On April 9, she regained consciousness and was able to eat a small amount of food and speak with those around her. Id. Her recovery, however, was very limited. Id. at 15. Her doctor characterized her as “more or less communicative,” but her responses to questions were often inconsistent. Id. She was not competent and might at any time, lapse back into a vegetative state. Id.
244. There are cases that suggest that courts do consider this assumption. See, e.g., In re Moorhouse, 593 A.2d 1256, 1257 (N.J. Super. 1991) (allowing sister of elderly woman with Down’s syndrome in persistent vegetative state to become patient’s guardian because sister had sincere interest in patient’s welfare and had no improper motives in requesting withdrawal of treatment); In re Peter, 529 A.2d 419, 425 n.6 (N.J. 1987) (requiring one-year life expectancy test to be applied in addition to other considerations when withdrawal request is for elderly senile patients).
245. Steiber, supra note 5, at 72.
246. Uhlmann et al., supra note 42, at M115.
only fourteen to twenty-three percent of these elderly individuals stated they would want the treatment of CPR and a ventilator if they suffered a cardiac arrest. In other words, contrary to the hysteria that the healthy youth will attempt to deprive the elderly of desired medical care, it is the elderly, themselves facing the threat of incompetence, who wish to terminate their own medical treatment even if it results in death.

This hysteria arises on occasion when someone in public life suggests that there should be anything less than extraordinary medical treatment for all persons regardless of their prognosis or wishes. Colorado Governor Richard Lamm discovered this when he discussed the problem of limited medical resources at a meeting of the Colorado Health Lawyers Association. He created an uproar when he stated: “Like leaves which fall off a tree forming the humus in which other plants can grow, we’ve got a duty to die and get out of the way with all of our machines and artificial hearts, so that our kids can build a reasonable life.”

During the next generation, hard choices will need to be made in the allocation of medical resources. Encompassed within the issue of allocation is whether life-sustaining measures should be applied or continued when a person’s prognosis is poor. This difficult issue should not be further complicated by those who would require treatment under all circumstances. The elderly themselves generally oppose continued treatment when the prospects for a meaningful existence are limited. Their choice should be respected.

6. Family Will Terminate Medical Treatment for Financial Reasons

One common assumption articulated in support of the need for decisionmaking by a neutral party is that family members may have a conflicting interest in relieving themselves of financial or emotional burdens. The family members who are forced to make life and death decisions for an incompetent person are generally the same people who will inherit if the person dies. Moreover, if a person is kept on life support for an extended period of time, his estate may be drained by the substantial cost, leaving little for the survivors to inherit. It is these substantial financial concerns that raise suspicions about a family’s motivation for terminating life

247. Id. at M118 tbl. 2. For a more detailed discussion of the Uhlmann study, see supra notes 221-24 and accompanying text.

support. In point of fact, however, these are rarely the prime motivating factors behind a decision to cease treatment.

People are uncomfortable making life and death decisions for others. In the Gallup survey, when asked whether they would be willing to terminate life support for a family member, the percentage dropped significantly from those who would be willing to terminate their own life support. Only forty-six percent were "very willing" to disconnect machines for someone else in comparison to seventy percent who were "very willing" to disconnect their own machines.249 Even when "somewhat willing" was added, only seventy-two percent were willing to disconnect another's machines, a ten percent drop from the number willing to disconnect their own life support systems.250 Similarly, in the Uhlmann study, individuals consistently overestimated their spouse's resuscitation preferences.251

A family member should not be disqualified from making the decision to withdraw treatment simply because he or she will benefit from the person's will.252 In Colyer, the court recognized that "[i]n most instances, the familial relationship will strengthen, and not undermine, the guardian's best judgment in exercising the personal rights of the incompetent."253 Courts look for greed even where none exists. Yet, in no case, from Quinlan to the recent decision in Lawrance,254 was there any evidence that the families were motivated by financial considerations. Nevertheless, courts often mention this issue and occasionally rely on it as a basis for their decision. For example, the Illinois Supreme Court in Longeway required a court order before treatment could be discontinued "to guard against the remote, yet real possibility that greed may taint the judgment of the surrogate decision-maker."255

Additionally, it is not only the family members who may have

249. Steiber, supra note 5, at 72.
250. Id.
251. Uhlmann et al., supra note 42, at M117.
253. Id.; see also In re Conroy, 486 A.2d 1209, 1218 (N.J. 1985). In Conroy, the patient's nephew was her only surviving blood relative. Id. He visited his aunt once a week for four to five years in the years preceding her incapacitation. Id. The court concluded that the inheritance that the nephew might receive created no conflict of interest to cause the court to question his intentions. Id.
255. In re Longeway, 549 N.E.2d 292, 300 (Ill. 1989). The holding in Longeway could more accurately be referred to as the full-employment-for-lawyers ruling.
a financial stake in the outcome. The hospitals, nursing homes and, to a lesser extent, even the doctors will be financially affected by the outcome. 256 Whether the person's bills are being paid by insurance, Medicare or Medicaid, the payments will cease if treatment is terminated and the person dies. 257

Finally, if the family's goal in terminating treatment is to be relieved of the financial and emotional hardships associated with the person's illness, they have a much easier way out. They can just walk away. For example, Mr. and Mrs. Cruzan could have deserted their daughter like Nancy's husband did. 258 They chose to fight in the courts, however, because they believed that it was what their daughter wanted. When a family tries to terminate treatment, they do it out of love, because in many cases the family has no financial responsibility for the person's care. 259

There is no question that in many family decisions, family members have conflicting interests. There is no evidence, however, that families are allowing financial concerns to override the best interests of the person when making medical care decisions. 256 See Grace Plaza of Great Neck, Inc. v. Elbaum, 588 N.Y.S.2d 853 (N.Y. App. Div. 1992). In Grace Plaza, a nursing home did not inform a patient's family at the time of the patient's admission of its policy refusing to remove feeding tubes. Id. at 867 (Rosenblatt, J., concurring in part and dissenting in part). The patient was admitted conditioned on her husband's agreement to pay for her care. Id. at 854. One year after she was admitted, her husband requested that her feeding tube be withdrawn. Id. at 855. When the nursing home refused, her husband refused to pay the charges. Id. During the next two years more than $110,000 in fees accrued. See Cerisse Anderson, Fees Held Due to Nursing Home, N.Y. L.J., Sept. 24, 1992, at 1. The Appellate Division held that the patient's husband was liable for fees incurred after the nursing home refused to withdraw artificial nutrition. Grace Plaza, 588 N.Y.S.2d at 854. Even the majority conceded the dissent's contention that health care providers have a financial incentive to prolong the lives of comatose patients over the objections of their families. Id. at 860. 257 See, e.g., Peter Kerr, Treating of Severe Brain Injuries Is Profitable, But Not for Patients, N.Y. TIMES, Mar. 16, 1992, at A1.

258 I use the term "desert" advisedly but with reservations. The Missouri Supreme Court makes reference to the fact that Nancy's husband was granted a divorce in 1984, after two years of marriage and one year after the accident. Cruzan v. Harmon, 760 S.W.2d 408, 431 (Mo. 1988) (en banc) (Higgins, J., dissenting) (quoting trial court opinion), aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990); id. at 427 n.1 (Blackmar, J., dissenting) (noting that "[t]his circumstance alone indicates a relativity of values"); see also Bouvia v. Superior Court, 225 Cal. Rptr. 297, 300 (Cal. Ct. App. 1986) (patient lived with parents until told by father that family could no longer provide care); In re Minor, 434 N.E.2d 601, 602 (Mass. 1982) (child abandoned at birth by mother); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 420 (Mass. 1977) (patient's only relatives were two sisters who did not want to be involved).

259 For example, in Cruzan, the costs of long-term care were borne by the state. Cruzan, 760 S.W.2d at 411 n.2.
In the absence of more than pure speculation, this perceived conflict of interest should not be used as a basis for removing family decisionmaking authority from those who know the person best, who care most for the person and who the person would probably want to make the decision.

7. **Removal of Life-Sustaining Treatment Is a Step Toward Euthanasia**

Judges occasionally give voice to another insidious assumption—that if persons on life support are allowed to die, the next step on the "slippery slope" will be active euthanasia of the handicapped and elderly. For example, Justice Schreiber, writing for the majority in Conroy stated: "More wide-ranging powers to make decisions about other people's lives, in our view, would create an intolerable risk for socially isolated and defenseless people suffering from physical or mental handicaps." "Right-to-life" groups paint a dismal portrait of a future in which all individuals who are mentally retarded or physically handicapped will be denied medical treatment. One dissent has even drawn an analogy to the war crimes in Nazi Germany. This analogy is

---

262. The situation of the physically handicapped in particular is a red herring. The physically handicapped are competent and, therefore, make their own medical decisions. Under decisions like *Bouvia*, these individuals have the right to refuse medical treatment. See *Bouvia*, 225 Cal. Rptr. at 300-01 (discussing right of competent individuals to make medical treatment decisions). The only limitation is the right of the state to prevent suicide. For a discussion of the state's interest in preventing suicide, see supra notes 207-11 and accompanying text.
263. See, e.g., Nancy M. Czerwiec, *Surrogate Law*, CHI. TRIB., Oct. 7, 1991, at C10 (letter to editor by director of The Human Life Resource Center attacking living wills and durable powers of attorney for health care and alleging that "these two legal documents are part of the strategic plan of action of euthanasia leaders in America").
264. *In re Longeway*, 549 N.E.2d 292, 313 (Ill. 1989) (Clark, J., dissenting). In Longeway, Justice Clark quoted Dr. Leo Alexander, a medical consultant at the Nazi war crimes trials:

> Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived.

*Id.* (Clark, J., dissenting) (quoting Dr. Alexander). After making the parallel to doctors in Nazi Germany, Justice Clark then denied that he was drawing the analogy saying that he was not "equat[ing] the decision before this court in any manner to the horror of decisions and actions made before and during the war." *Id.* (Clark, J., dissenting); see also Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969, 1030-36 (1958) (mak-
inaccurate and unwarranted. Proponents of the “right-to-die” do not suggest, explicitly or implicitly, that the mentally handicapped do not have the right to live and should therefore be euthanized.\textsuperscript{265}

The use of terms such as “quality of life” and “degrading” obscure the issue.\textsuperscript{266} Although a competent quadriplegic may have a lower quality of life than a mobile individual, given the choice, most quadriplegics would prefer to continue living as is evidenced by the paucity of cases similar to \textit{Bouvia}.\textsuperscript{267} Similarly, while severely retarded individuals may not appreciate the world in the same manner as most others, they are conscious and enjoy life on their own terms. Families with children burdened with severe mental disabilities recognize this and consequently continue to love and care for their disabled children.\textsuperscript{268}

The cases involving termination of life-sustaining treatment generally involve individuals who were mentally competent but because of accident or illness have lost \textit{all} mental capacity. For example, Nancy Cruzan was “oblivious to her environment except for reflexive responses to sound and perhaps painful stimuli.”\textsuperscript{269} Much of her brain had deteriorated and had been replaced by fluid.\textsuperscript{270} After seven years in a vegetative state, she had no chance of regaining consciousness.\textsuperscript{271} Her case was not atypical. Even in a situation in which the withdrawal of treatment petition was for a mentally handicapped person, the family did not seek to deny medical treatment merely to be rid of the

\textsuperscript{1993] SURROGATE DECISIONMAKING 155}

\textsuperscript{265} See, \textit{e.g.}, \textit{Deciding to Forego Treatment}, supra note 3, at 29 (cautioning that “slippery slope arguments are themselves subject to abuse in social and legal policy debate”).

\textsuperscript{266} “[T]here is no intrinsic reason why a quality-of-life standard must remain any more vague and undefined than a standard that includes pain.” \textit{In re Conroy}, 486 A.2d 1209, 1249 (N.J. 1985) (Handler, J., concurring in part and dissenting in part).


\textsuperscript{268} See, \textit{e.g.}, \textit{In re Lawrance}, 579 N.E.2d 32, 35 (Ind. 1991) (family cared for retarded child for 33 years); \textit{In re Storar}, 420 N.E.2d 64, 68 (N.Y.) (observing that patient’s elderly mother lived near facility and visited her severely retarded son almost daily), cert. denied, 454 U.S. 858 (1981).

\textsuperscript{269} \textit{Cruzan v. Director, Mo. Dep’t of Health}, 497 U.S. 261, 266 n.1 (1990).

\textsuperscript{270} \textit{Id.} at 321 n.18 (Brennan, J., dissenting).

\textsuperscript{271} \textit{Id.} at 266. In the medical literature of the past 20 years, only three persons in a persistent vegetative state due to oxygen deprivation have even partially recovered. \textit{Id.} at 309 n.8 (Brennan, J., dissenting) (quoting Brief of American Medical Association as Amici Curiae at 11-12, \textit{Cruzan v. Director, Mo. Dep’t of Health}, 497 U.S. 261 (1990) (No. 88-1503)).
A decision to terminate life-supporting treatment is only a
decision to allow nature to take its course. It is not a first step on
the road to euthanasia of the handicapped.

8. Religions Oppose Termination of Life-Sustaining Treatment

The final assumption is that religious opposition to the termi-
nation of life-sustaining treatment precludes such withdrawal. 
Other than religious based “right to life” groups, however, there
is little religious opposition to terminating life-sustaining treat-
ment. Although religious reasons are often cited by those who
wish to force continuation of apparently futile treatment, organ-
ized religion does not generally oppose termination of treatment.

For example, the Catholic Church has been described as op-
posed to withdrawal of treatment. But, in the seminal Quinlan
case, the family's priest and the New Jersey Catholic Conference
supported the parents' position to terminate care. Additionally, the Catholic Conference of Illinois, comprised of Cardinal 
Bernadin and the other Catholic bishops in Illinois, supported the 
Illinois Health Care Surrogate Act, which allows a surrogate to
terminate artificial nutrition and hydration.

The Roman Catholic Church has stated that there is no need
to artificially prolong life. Specifically, the 1980 Vatican Declara-
tion on Euthanasia stated:

When inevitable death is imminent in spite of the
means used, it is permitted in conscience to take the de-
cision to refuse forms of treatment that would only se-
cure a precarious and burdensome prolongation of life,
so long as the normal care due the sick person in similar

---

272. See Lawrance, 579 N.E.2d at 34.
(1976); see also In re Conroy, 486 A.2d 1209, 1218 (N.J. 1985) (referring to
priest's testimony that removal of feeding tube was consistent with teachings of
church).
275. Id.; see also ILL. 87TH GEN. ASSEMBLY H.R. TRANSCRIPTION DEBATE 1
(June 28, 1991) (statement of Rep. Dunn). There appears to be a split, however,
among the church hierarchy on this issue; Cardinal O'Connor, Archbishop of
New York, has opposed termination of artificial nutrition and hydration. Id. at 3-
4 (statement of Rep. McCracken); see also Matters of Life or Death Are Also Questions
of Ethics and Morals, L.A. TIMES, Apr. 4, 1992, at B4 (discussing split of opinion
between Catholic bishops regarding withdrawal of artificial nutrition and hydra-
tion from individuals in persistent vegetative states).
In this context, the church recognized that “it is very important to protect, at the moment of death, both the dignity of the human person and the Christian concept of life against a technological attitude that threatens to become an abuse.”

In the area of living will legislation, Catholic groups have frequently been in the forefront of the opposition. Catholic authors, however, have suggested that the reasons for the opposition do not include disagreement with the generalized right to refuse medical treatment. Instead, the concerns which prompt Catholic groups to oppose living will legislation arise from the fear that these bills will move society toward acceptance of euthanasia. Two Catholic theologians who previously opposed living will legislation now support it, in part because the position of some of “the more radical right-to-life advocates threatens the traditional Catholic position on the sanctity of life and the rights of the individual, in the Vatican’s phrasing, ‘to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life.’”

Although specific religious groups may oppose termination of life-support treatment even when there is no chance for recovery, organized religion itself does not oppose such termination. Its opposition is often based on a different political agenda that includes opposition to abortion and euthanasia. In any case, religious opposition should not be an underlying assumption used to defeat surrogate decisionmaking in our diverse society, particularly in light of the First Amendment.

---

277. Id.
279. Id. at 86.
280. Ramsey, supra note 171, at 319. In earlier years, Catholic leaders had opposed defining brain death because they were concerned that the next type of legislation might legalize abortion. Rothman, supra note 125, at 164-65.
281. Theologians Paris and McCormick objected to living will legislation because
   [t]here is no need for it; the potential for misunderstanding about the proper locus of decision making in the patient-physician relationship; the danger that those without a living will are presumed to want all possible treatments; the exclusion of the family from participation in decision-making; and the possibility that the state, construing the right to refuse treatment as a conferral rather than a natural right—one with inherent moral limitations—could also confer the right to be killed.
Paris & McCormick, supra note 174, at 87.
282. Id.
The previous eight subsections have discussed the presumptions that underlie judicial decisions on whether to terminate life-support treatment. These presumptions inaccurately represent what most people believe and how they wish treatment decisions were made. The following proposal reverses these presumptions and allows families to make the critical and very personal decision about when treatment should be withdrawn.

IV. THE CASE FOR SURROGATE DECISIONMAKERS

This part of the Article offers a proposal for family decision-making that reverses the assumptions made in the previous section. It gives an order of priority for determining which family member will make medical treatment decisions, identifies those who have standing to contest the decisionmaker’s choice and reverses the burden of proof. This part then discusses the advantages of family decisionmaking. The advantages include returning exclusive control over medical decisions to those who best know the person’s wishes and care most about the person. At the same time, outsiders with political agenda are deprived of the opportunity to capitalize on a family’s misfortune. Following this proposal would also help to avoid the cost, time and additional trauma involved in judicial intervention.

Finally, this part discusses the disadvantages of family decisionmaking. Most of the problems identified also exist under the status quo. The proposed system cannot avoid court involvement when a person is part of a dysfunctional family, when a person’s family cannot agree or when a person does not have close family members. The only disadvantage unique to the proposal is defining the narrow circumstances under which a court should be allowed to deprive the family of the right to decide. This part concludes with a brief discussion of the right of conscience.

A. Proposal for Family Decisionmaking

A statute naming a surrogate decisionmaker would become applicable when: (1) a person has not executed a durable power of attorney for health care, and (2) a person is incapable of making medical decisions.

283. Only a durable power of attorney for health care obviates the need for a statutory surrogate decisionmaker. A living will only provides evidence of what an individual would want in certain, often narrow, circumstances. Someone must still make the decision. Thus, a living will would not replace the surrogate decisionmaker.
The proposed statute would provide a list of family members who would have the power to act as a surrogate decisionmaker. No court appointment would be necessary to exercise the power. The order of priority would be: spouse, parents, adult children, adult grandchildren, siblings, a close friend or relative and a court-appointed guardian. Thus, for example, if the spouse of the person were living and competent, the spouse would be the surrogate decisionmaker; if the person were not married, the person's parents would be the surrogate decisionmakers.

The surrogate decisionmaker would have the power to make all medical decisions on behalf of the person. This power would include the power to terminate or to continue medical treatment. The power would include termination of respirators, artificial nutrition and hydration as well as other technologies that have not yet been developed.

A rebuttable presumption would be created that the surrogate decisionmaker's decision is in the best interests of the individual. The only parties with standing to attack the decision of the surrogate decisionmaker would be other family members, close friends, or in the case of abuse, the state.

The standard for an attack on the decision by one with standing would be that the surrogate's decision is contrary to the expressed wishes of the person. This essentially reverses the burden of proof in the substituted judgment test; instead of requiring evidence of the person's desires in order to terminate treatment, clear and convincing evidence of the person's desires would be required to overturn the decision of the surrogate.

For the state to attack the surrogate's decision, it must show that, in the past, the surrogate abused the person or that the particular decision constitutes abuse. Abuse would be defined to mean that no responsible physician would implement the choice; it must be outside the boundaries of acceptable medical practice.\textsuperscript{284} Physicians and hospitals would no longer have the right

\textsuperscript{284} As discussed \textit{infra} text accompanying notes 303-06, this definition of abuse would allow termination of treatment if the decision is reasonable in light of the patient's personal or religious views even though the decision might be unreasonable to the vast majority of people. For example, a patient's family could refuse a blood transfusion for a critically ill patient on basis that the incompetent patient is a Jehovah's Witness and such a transfusion violates the tenets of the religion.

The standard of "abuse" has some parallels to Nancy Rhoden's standard of unreasonableness. Nancy K. Rhoden, \textit{Litigating Life and Death}, 102 \textit{Harv. L. Rev.} 375, 437 (1988). She defines reasonableness as "turning on the question whether the patient retains any capacity to experience and enjoy life." \textit{Id.} One
to challenge a decision merely because they do not agree with the decision.

B. Advantages of Family Decisionmaking

Life and death decisions about medical care are family decisions that should be made without the expensive and time consuming interference of the courts. As discussed in Part III, people generally do not want life-sustaining medical treatment if they have no chance for recovery. Thus, the basic goal of the proposal is to put the decisionmaking power back with the family where it belongs. Treatment should not be imposed when it is not wanted, and it should not be denied when it is desired. Family members who know the person’s desires and who care about him should make the decision.

1. No One Cares More About the Person Than Family

Medical decisionmaking for an incompetent person should rest with the person’s family because no one loves the person more than his own family. Traditionally, certain decisions were made solely within the confines of the family. Society respected the family’s decisions in these areas and did not even attempt to determine whether the decision made was the best decision. Justice Douglas, in his concurrence in *Roe v. Wade*, enumerated some of the areas within this zone of family privacy: marriage, divorce, procreation, contraception and the education and upbringing of children. For example, in *Pierce v. Society of Sisters*, the Supreme Court upheld the right of parents to educate their children in a religious school. Significantly, the Court recognized that “those who nurture him and direct his destiny

of the differences between my thesis and that of Rhoden, however, is that she would allow the physician to challenge the decision on the basis of reasonableness. *Id.*

285. See, e.g., *Barber v. Superior Court*, 195 Cal. Rptr. 484, 493 n.2 (Cal. Ct. App. 1983) (indicating that some family members were at hospital nearly around the clock).

286. See *In re Jobes*, 529 A.2d 434, 445 (N.J. 1987) (noting that “law has traditionally respected the private realm of family life which the state cannot enter” (quoting *In re Farrell*, 529 A.2d 404, 414 (N.J. 1987))). The *Jobes* court stated that the “tradition of respect for and confidence in the family” should be the basis for judicial restraint in the area of medical treatment. *Id.* (quoting *In re Farrell*, 529 A.2d 404, 414 (N.J. 1987)).

287. See *Doe v. Bolton*, 410 U.S. 179, 209 (1973) (Justice Douglas stated that his opinion also applied to *Roe v. Wade*, 410 U.S. 113 (1973)).

288. *Id.* at 211-15.

289. 268 U.S. 510 (1925).
have the right, coupled with the high duty, to recognize and prepare him for additional obligations." 290

It is impossible for anyone to determine exactly what is right and what is wrong in these withdrawal of treatment situations. Personal values are inextricably bound with what is in the best interests of the person. The question thus becomes: who should make the decision? There are really only two choices: family or strangers.

Some might suggest that there are two additional choices: physician decisionmaking and joint decisionmaking by some combination of family, physician, hospital ethics committee and judge. These additional decisionmaker options, however, are really subsets of the class of strangers. In our mobile society, it is now rare for an individual's physician to be a family practitioner who has known the person both personally and professionally for many years. Thus, the doctor is generally a stranger. 291 This is even more true if the person is in an intensive care unit as is often the situation in cases involving the removal of life-sustaining treatment. In such a setting, the patient is surrounded by specialists whom he has probably never met. 292 The physician may be a stranger with specialized knowledge and good motives, but he is a stranger nonetheless. The joint decisionmaker is also essentially a stranger. Although the family is involved in the process, if there is disagreement, it is still the stranger, either a judge or a hospital ethics committee, who makes the decision.

Over the past decade, society has gradually shifted away from the doctrine of family autonomy as the basis for medical decisionmaking to the view that the state is the best decisionmaker. There is a fundamental problem, however, with replacing the family as the decisionmaker with a stranger—even a well-meaning stranger is incapable of caring for the person as much as the person's fam-

290. Id. at 535.
291. Physicians have become a social group apart from their patients. Rothman, supra note 125, at 108. "It is not romanticizing the past practice of medicine to observe that in the pre-World War II period, physicians were more closely connected both to their patients and their community." Id. at 109.
292. Because specialists generally have no acquaintance with their patients prior to the initial consultation, the specialist was not chosen by the patient based on common religious or social views. Id. at 128-29. This reinforces the argument that the family and not the doctor should make the decision, particularly if the goal is substituted judgment. Additionally, in the ICU setting, the physicians may be more likely to provide treatment even a competent patient would not want. See Zussman, supra note 13, at 83 (observing that ICU physicians frequently persist in providing treatment, even in face of patient's explicit refusal).
ily. There are four basic reasons that families are inherently better decisionmakers than strangers.

First, families generally exhibit more concern about the welfare of the person than anyone else. Families spend time with the person at the hospital and assist the medical personnel in caring for and in comforting him. Family members often advise and counsel the person faced with treatment decisions. One study noted that families ask the medical staff more questions about the individual's condition and prognosis than even the competent person does. As a result, family members often become advocates for persons who, although competent, find it difficult to assert themselves in their weakened condition.

Second, and even more importantly, it is the family that has to live with the decision. Much discussion has focused on the argument that families may wish to terminate treatment in order to relieve themselves of the emotional and financial burdens associated with caring for the person. That argument neglects the fact that guilt and the fear of making the wrong decision for a loved one may actually cause the family to continue treatment even if it is contrary to the person's best interests.

Third, contrary to common belief, physicians are not impar-
terial observers. They also may face conflicts of interest. For example, when infants are involved, they are frequently transferred to hospitals with neonatal intensive care units. The resident physicians may have a vested interest in aggressively treating a dying child. Physicians' interests in advancing their own training or advancing the state of research in the field may conflict with the interest of individual infants and their families.

Finally, a person's family is adversely affected by his incapacitation. When the family considers the adverse impact of the person's illness on the family unit, it is considering exactly what the person himself would consider. Most persons do not want to become a burden to their families. Few want the fruits of their life's labors decimated by a futile attempt to treat the last stages of a painful terminal illness, or worse, to be kept alive in a coma for years.

Even when infants are involved it is overly simplistic and self-righteous to argue that all possible treatment should be provided no matter what the prognosis. Living with a severely handicapped child is a family affair. There are limits to what a family

298. See, e.g., Harold E. Bronheim, Medical Views of Capacity to Make Health Care Decisions, in Handling Your First Health Care Proxy, Living Will, and Durable Power of Attorney, supra note 2, at 443. Dr. Bronheim stated:

For the physician, too, there is a negative incentive not to institute treatment. First, a determination not to institute treatment involves painstaking discussion with the family, patient, and staff. Everybody's anxiety must be allayed that everything possible has been considered and the best course of action is to let death take its natural course. This effort requires many hours of deliberation and consultation, none of which will be reimbursed. Our third party payor system rewards doctors for providing treatments, not for comforting patients and families and withholding treatment. It is much easier to spend 15 minutes ordering an intravenous line with antibiotics which can maintain a dying patient for weeks, who can then be followed daily with examinations all of which is reimbursable, than it is to spend eight hours consulting everybody involved to allow the patient to die peacefully, all of which is not reimbursed.

Id. at 452.


300. Id. (noting fear of some physicians that loss of infant through lack of treatment would deprive medical profession of "teaching material" and compromise training of medical professionals).

301. Id. Duff and Campbell discussed the experience of the special care nursery of Yale-New Haven Hospital during the period 1970-1972. Id. at 890. In one case, a five-month-old child with chronic pulmonary disease still required 40% oxygen to survive after much treatment. Id. at 891. All persons involved were very attached to this child and did not want to see the child die, making it very difficult to terminate treatment. Id. The financial and emotional burdens on the family were thought to be threatening the marriage and sibling relationships. Id. Treatment was eventually stopped and the baby died within hours.
can and should have to bear. Furthermore, is society any better today because doctors can “save” a child who would have died if he had been born only ten or twenty years ago.\textsuperscript{302}

The question is not whether the person can be kept alive by medical technology but whether he should be kept alive. Outsiders who will walk away once the medical treatment has been completed cannot make that decision. Only the family members who have to live with results of the treatment can make that decision. Thus, because the family cares about the person as an individual human being and not as one more patient or case study, the family should make the decision about whether to continue life-sustaining treatment.

2. No One Knows the Person’s Religious Beliefs and Personal Values Better Than Family

Knowledge of a person’s wishes is critical to any decision about life-sustaining treatment, and no one knows the person’s wishes better than close family or friends. Courts developed the theory of substituted judgment in an attempt to reach a result consistent with the person’s desires.\textsuperscript{303} The problem with the substituted judgment test is that the person often has not expressed his desires in language that satisfies evidentiary stan-

\textit{Id.} at 891-92. The baby’s death seemed to correct the family’s problems, and 18 months later, they had another healthy baby. \textit{Id.} at 892. This situation raises the question of who has the right to determine whether a child should be aggressively treated indefinitely despite his prognosis and the effects on the remainder of the family? The thesis of this Article is that only the family has the right to choose.

\textsuperscript{302} See, e.g., Anthony Shaw, Dilemmas of “Informed Consent” in Children, 289 NEW ENG. J. MED. 885, 889 (1973). Dr. Shaw effectively summarizes the problem with saving the lives of permanently disabled children when he states: All pediatric surgeons, including myself, have “triumphs”—infants who, if they had been born 25 or even five years ago, would not have been salvageable. Now . . . we can wind up with “viable” children three and four years old, well below the third percentile in height and weight, propped up on a pillow, marginally tolerating an oral diet of sugar and amino acids and looking forward to another operation.

\textit{Id.}

There is also the question few are willing to discuss: should a severely handicapped infant be saved if the child will face life in an institution? Institutionalization has an adverse, usually disastrous affect on healthy children. Duff & Campbell, supra note 15, at 892. Are we a more humane society because we have “saved” a severely handicapped child from death when the child’s life will be spent in an institution? \textit{See generally} STINSON & STINSON, supra note 170 (discussing authors’ experiences as parents of premature child who suffered from serious birth defects and who was treated against parents’ wishes).

\textsuperscript{303} For a discussion of the substituted judgment test, see \textit{supra} notes 31-50 and accompanying text.
However, what is unclear to the judge, who is a stranger, may be obvious to a family member who understands the person's attitudes towards medical care and general view of life and the world. The family knows "the motives and considerations that would control the patient's medical decisions." There is a special bond between family members based on their shared experience that allows them to understand each other much better than those outside the family understand them. Nonetheless, this knowledge is often intuitive, causing difficulties when family members attempt to translate this knowledge into evidence to be presented at a hearing.

Although there are substantial flaws with the substituted judgment test, the problems are in the implementation of the test, not the goal of the test. The person's beliefs and opinions should be the focus of the medical treatment decision. There may be no way to present objective evidence of the person's preferences; however, close family members generally have a sense of what a person would have wanted. They know how the person lived his life and how person's religious and personal values affected the his decisionmaking.

The burden of proof currently rests on family members to prove that the person would want treatment terminated. This burden should be shifted to require the one challenging the family's decision to terminate treatment to prove that the person would have wanted the treatment to continue. The resulting decision, although not infallible, will more closely approximate the person's intent. It will be based on knowledge of the person's desires not limited by artificial rules of evidence.

3. Strangers With Political Agenda Should Not Be Allowed to Intervene

In recent years, there has been a proliferation of "right to life" groups. These groups no longer focus solely on abortion; they are also active in opposing the termination of medical treatment. For example, these groups were instrumental in convincing the Reagan Administration to issue regulations preventing the termination of treatment for neonates. Today they invariably appear as amicus against a family that seeks to have life sup-

304. For examples of language that courts have found inadequate to satisfy the substituted judgment test, see supra notes 47-59 and accompanying text.
306. Id.
port equipment or feeding tubes removed from a dying family member. These groups do not see the patient as a person but as a symbol of a cause.

For example, in *Lawrance*, a group called the Christian Fellowship with the Disabled sought guardianship of a person who was permanently unconscious.\(^{308}\) Amazingly, not only did the trial court allow them standing, it appointed the group’s attorney as the guardian of Sue Ann Lawrance.\(^{309}\) Unfortunately, this is not an isolated incident. For example, when a Missouri father recently sought to move his daughter to a private hospital that was willing to disconnect her feeding tube, an unrelated anti-abortion activist was granted a temporary restraining order to prevent the move.\(^{310}\) This type of interference is unacceptable because it allows an incompetent person to become the pawn of special interest groups that should be lobbying the legislature rather than interfering in a family tragedy.

In *In re Greenspan*,\(^{311}\) both the guardian ad litem, appointed by the court to represent the person’s interests for purposes of the litigation, and the public guardian agreed that artificial nutrition and hydration should be terminated. The guardian ad litem informed the court that he was unable to find a physician to testify in favor of continuing treatment.\(^{312}\) The court then allowed Americans United for Life Legal Defense Fund to appear as a party to argue against the family.\(^{313}\)

Judges are so accustomed to the adversary nature of most legal proceedings that they sometimes search to find a party with a contrary view even when that party is a stranger to the litigation and is using the litigation to forward its own agenda. Intervention of such lobbying groups does not benefit the person and should not be allowed to continue. By changing the legal presumption to favor family decisionmaking, political groups will be prevented from turning private tragedies into political soapboxes.

---

\(^{308}\) *In re Lawrance*, 579 N.E.2d 32, 36 (Ind. 1991).

\(^{309}\) *Id.* One week after appointing Patti Mullins as guardian, the court appointed Daniel Avila, an attorney with the National Legal Center for the Medically Disabled and Dependent, as successor guardian. *Id.*

\(^{310}\) *See* Staci D. Kramer, *Father Regains Control in Right-to-Die Case*, CHI. TRIB., Feb. 20, 1993, at N2 (indicating that once Missouri courts had dismissed case, thereby allowing father of comatose patient to move daughter, unrelated third party was allowed to intervene in attempt to block move).

\(^{311}\) 558 N.E.2d 1194, 1199 (Ill. 1990).

\(^{312}\) *Id.* at 1197.

\(^{313}\) *Id.* at 1199.
4. Judicial Intervention in Medical Decisionmaking Is Costly and Unnecessarily Intrusive

Family decisionmaking also allows families to avoid the burdens of litigation. Litigation is expensive. Many, perhaps most, families facing high medical expenses do not also have the resources to pay an attorney. Hospitals and nursing homes, on the other hand, typically have substantial resources. Thus, if a hospital wishes to oppose the family’s petition, it has the financial ability to fight a long court battle, including any lengthy appeals process.\(^{314}\)

Even when the hospital does not object, a state requirement that a court order must be obtained before terminating medical treatment may pose an overwhelming obstacle for some families.\(^ {315}\) Complex medical, legal and ethical situations are commonplace for health care providers, hospital administrators and lawyers. The vast majority of the population, however, faced with

\(^{314}\) See Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626, 627 (Mass. 1986) (hospital and physicians opposed termination of nutrition and hydration); see also In re Storar, 420 N.E.2d 64, 75 (N.Y.) (Jones, J., dissenting in part), cert. denied, 454 U.S. 858 (1981). In Storar, the administrator of the residential facility where the patient lived petitioned to continue the blood transfusions. Id. at 69. Justice Jones, in dissent, argued that the case should have been dismissed based on the hospital’s lack of standing. Id. at 77 (Jones, J., dissenting in part). “Medical care providers have at best only a tangential interest in the outcome of the litigation and can have no legitimate individual stake in the institution (or continuation) or the discontinuance of the medical procedure.” Id. (Jones, J., dissenting in part).

\(^{315}\) On April 26, 1989, Rudy Linares used a gun to keep hospital personnel from interfering while he disconnected the mechanical ventilator that was maintaining the life of his 15-month-old son, Sammy, who was in a coma. Gilbert M. Goldman et al., What Actually Happened: An Informed Review of the Linares Incident, 17 LAW, MED. & HEALTH CARE 298, 303 (1989) (article written to respond to criticism of hospital’s actions). During the first week following the infant’s injury, when it became obvious that there was extensive neurologic damage, the Linares family requested that the ventilator be removed. Id. at 300. The hospital refused, although it did agree to record a DNR status. Id. The family was advised that a court order was required to discontinue the ventilator. Id. at 302. Even the authors admit that the family was not initially encouraged to seek such an order because the medical personnel believed that the child would succumb to various complications. Id. The authors further admit that the family may not have understood what was involved in the legal process or the costs of such an action. Id. Although the hospital offered pastoral, social and counseling services to the family, there is no indication that the family was advised about legal processes. Id. at 301. The authors concede that the hospital should have provided the family with legal counsel at the hospital’s expense, and in fact, since the incident, it has done so for at least one other family. Id. at 305. The authors note that the father refused counseling services, may have had alcohol and drug abuse problems, and had an arrest record, and that the mother was involved in welfare fraud. Id. at 302-03. These facts are not relevant, however, to the issue of the hospital’s actions (or inaction).
an emotionally draining illness and unschooled in law or medicine, may be incapable of taking the steps necessary to resolve the dilemma.

Some recent statutes have been designed to avoid the necessity of a court decision before allowing termination of medical treatment.316 These statutes, however, generally provide that termination without court intervention cannot occur if the physicians do not agree with the family.317 Thus, many of these cases still end up in court.318 Only by depriving hospitals, nursing homes and medical personnel of standing will families be spared the burdens of litigation.

C. Disadvantages of Family Decisionmaking

The proposed surrogate decisionmaking statute will simplify most medical treatment decision situations. There are five situations, however, where this proposal may not be as effective. Four of these potential problem areas already exist under the current systems. When a family is dysfunctional, when there is conflict among family members, when a person has no close family members or when the family is unwilling or unable to make the decisions, judicial intervention may still be necessary to determine whether to continue medical treatment for an incompetent person. The problem unique to this proposal is determining what mechanism should be used when outsiders believe the family's decision is unreasonable. The final topic in this area, titled the right of conscience, addresses the problem of medical personnel who refuse to defer to the wishes of the person's family.

1. The Dysfunctional Family

One disadvantage with giving families exclusive authority to

316. See, e.g., ILL. REV. STAT. ch. 110 1/2, paras. 851-1 to -55 (Supp. 1992) (clarifying process for implementing decisions to forego life-sustaining medical treatment); IND. CODE § 16-8-12-4 (1992) (authorizing family members as primary decisionmakers).

317. For a discussion of these statutes, see supra notes 139-48 and accompanying text.

318. The court in Jobes established a common-law rule that allowed termination without judicial review after two neurologists had certified that "the patient is in a persistent vegetative state and that there is no reasonable possibility that the patient will ever recover to a cognitive, sapient state." In re Jobes, 529 A.2d 434, 448 (N.Y. 1987). The court then issued this warning: "We specifically disapprove any interpretations . . . which allow[ ] 'a hospital, nursing home, [or] treating physician[ . . .] to apply for the appointment of a special medical guardian to consent to emergency treatment when a patient is unable to give consent, that would frustrate the tenor of this opinion.'" Id. at 449 n.16.
make a person's medical treatment decisions is that some families are dysfunctional.\textsuperscript{319} The experience of the past fifteen years, however, indicates that a dysfunctional family is unlikely to be involved in this type of case.\textsuperscript{320} In fact, in none of the cases from \textit{Quinlan}\textsuperscript{321} to \textit{Cruzan}\textsuperscript{322} have the family members been anything less than loving and devoted to the individual.

The dissent in \textit{Jobes} criticized the majority for basing its decision to allow the termination of treatment on the fact that the family was intact.\textsuperscript{323} Justice O'Hern argued that a substantive principle of law should not be based upon the fact that the family is intact.\textsuperscript{324} All abuse and neglect laws, however, are based on the dysfunctional status of the family.

Under the proposal made in this Article, if there is an allegation of abuse, the government would have standing to intervene to prevent the termination of medical treatment. The rebuttable presumption that family members act in the person's best interest allows the rare cases involving abuse to be litigated.

Similarly, some persons may not get along with their families or may have parents who disapprove of their lifestyle. In those cases, it may be necessary for a close friend or other surrogate decisionmaker to seek court appointment as the surrogate to make the decision.\textsuperscript{325}

\begin{itemize}
\item \textsuperscript{319} By dysfunctional, I mean families in which there has been abuse or neglect. That abuse may either be physical or emotional.
\item \textsuperscript{320} Perhaps the most likely explanation for the fact that dysfunctional families have not been involved in these cases is that these families do not wish to draw attention to themselves. The families are more likely to accede to the wishes of the physician rather than instigate conflict with the medical professionals. Moreover, if the patient has been the victim of abuse by the decisionmaker, the decisionmaker may encourage maximum treatment to assuage any personal guilt.
\item \textsuperscript{321} In re \textit{Quinlan}, 355 A.2d 647 (N.J.), \textit{cert. denied}, 429 U.S. 922 (1976).
\item \textsuperscript{322} \textit{Cruzan} v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990).
\item \textsuperscript{323} In re \textit{Jobes}, 529 A.2d 434, 464 (N.Y. 1987) (O'Hern, J., dissenting).
\item \textsuperscript{324} Id. (O'Hern, J., dissenting).
\item \textsuperscript{325} An even better choice than a friend approaching the court on his own would obviously be for the individual to designate the friend as agent through the use of a durable power of attorney for health care. Failing this, however, the court should take into account the dynamics of the family and appoint the friend as the surrogate decisionmaker.
\end{itemize}

A particularly tragic example involved the conflict between a lesbian partner and the patient's parents. In re \textit{Kowalski}, 478 N.W.2d 790 (Minn. Ct. App. 1991). For eight years, the parents and partner litigated the guardianship issue. \textit{Id.} at 791-92. For one period of more than three years, the partner was pre-
In the final analysis there will always be problems when the person's family is dysfunctional or when the person was involved in a non-traditional relationship. These problems will be no greater when the presumption is in favor of family decision-making than under the current system. Consequently, the existence of dysfunctional families is no real disadvantage to the proposal.

2. Conflict Among Family Members

A second disadvantage with giving families authority to make decisions regarding a person's medical treatment is that family members may disagree about the treatment that should be provided to the person. The most obvious situation occurs when the person is an unmarried child and the statutory surrogate decisionmakers are the person's divorced parents who are unable to agree. Similarly the person may be an elderly individual whose statutory surrogate decisionmakers are his adult children who are unable to agree. In these cases, the courts will probably be forced to make the decision whether to terminate or to continue treatment.

None of the litigated cases to date have involved such family disagreements. Perhaps this is because litigation of this nature requires such an emotional commitment that families who disagree do not even begin the process, but rather reach a decision without involving the courts. A decision to terminate treatment is not reached quickly or without much soul-searching. The decision to withdraw treatment is not made immediately after arrival at the hospital by the first relative or friend whom the doctor can find. Petitions to terminate treatment generally are not filed

326. But see Chris Conway, A Family Divided Over Life and Death As Ted Smerdon Lies in a Coma, Relatives Are Fighting His Wife to Decide his Fate, PHILA. INQUIRER, Mar. 23, 1992, at B1. In the Smerdon controversy, the wife of a man who has been in a persistent vegetative state for over ten years has asked the New Jersey courts to appoint her as guardian so that she can withdraw the artificial nutrition and hydration sustaining her husband. Id. Her petition is being challenged by her husband's mother and some of his siblings, who accuse the wife of "infidelity and financial opportunism." Id. The court will need to decide the controversy through the guardianship appointment process. See also Dolores Kong, Patient Proxy Laws Face Hitches, BOSTON GLOBE, Dec. 3, 1992, at 29 (describing family conflict in which brother, who disagreed with decision made by sister appointed proxy by their mother, unsuccessfully petitioned probate court to have himself named proxy).

327. Illinois legislators expressed this concern during the debate about a
until families have lost all hope of recovery, sometimes several years after the brain injury occurred. This may also explain why families sometimes wait for so many years before seeking termination: some family members may not have been willing to agree to terminate treatment at an earlier time. Thus, the problem of conflict among family members is not a serious disadvantage, and it certainly is not unique to the proposal.

3. No Close Family

A third disadvantage with giving families exclusive authority to decide on a person’s medical treatment is that some individuals do not have close family members. Many of these individuals are elderly and live in nursing homes where the average age is eighty-two. Furthermore, among nursing home residents, more than half have no living descendants. Consequently, it is unrealistic to expect caring family members to be involved in decisionmaking in every situation.

When a person has no close family member, however, it still may be possible to resolve the dilemma without court interven-
tion. For example, a close friend could act as the surrogate decisionmaker. Admittedly, even today, close friends can seek court appointment as a guardian, although, with the cost and difficulty of these proceedings, few are willing to commit to this undertaking. The proposed priority of decisionmakers should include a final category of close friends. Then, so long as the physician knows that the person has no close family members and the physician knows that this person was a close friend of the person, the physician should follow the direction of the friend acting as a surrogate decisionmaker.

4. Family Uncomfortable Making the Decision

Another problem present under the current systems that will still be present under the proposal is that some family members may feel uncomfortable, or may be unwilling to make surrogate medical decisions for a family member. As discussed previously, polls indicate that some people are more willing to make such decisions for themselves than for other family members.\(^{332}\) In addition, research studies reveal that family members are not always able to accurately predict the resuscitation and medical care decision preferences of other family members.\(^{333}\)

Frequently, such reluctance on the part of family members arises from a lack of knowledge regarding the medical care preferences of their loved ones.\(^{334}\) The best way to eliminate such reluctance is the encouragement of communication between families on the topic of medical decisionmaking.\(^{335}\)

\(^{332}\) See Steiber, supra note 5, at 72.

\(^{333}\) See, e.g., Ezekiel J. Emanuel & Linda L. Emanuel, Proxy Decision Making for Incompetent Patients: An Ethical and Empirical Analysis, 267 JAMA 2067 (1992) (discussing research done in area of surrogate decisionmaking and noting that such research indicates failure of proxy decisionmaking to promote patient preferences); Jan Hare et al., Agreement Between Patients and Their Self-Selected Surrogates on Difficult Medical Decisions, 152 ARCHIVES INTERNAL MED. 1049 (1992) (revealing that although surrogates and patients made similar decisions regarding withdrawal of life-sustaining treatment, their decisions were affected by different factors); Uhlmann et al., supra note 42, at M115-18 (finding that spouses were better predictors of patient resuscitation preferences than physicians but still overestimated patient resuscitation preferences to statistically significant level).

\(^{334}\) Hare et al., supra note 333, at 1049-50; Uhlmann et al., supra note 42, at M120.

\(^{335}\) See, e.g., McIntyre, supra note 155, at 260 (stating that best way for advance directives to be effective is for patient to develop comprehensive written expression of medical care preferences or designate proxy who knows and understands patient’s preferences); Uhlmann et al., supra note 42, at M120 (concluding that “discussions between surrogate decisionmakers and patients would enhance the accuracy of substituted judgments by allowing surrogates to better understand patients’ values”).
medical communities can assist in this task by providing educational and support services to accomplish this goal. The Patient Self-Determination Act is an appropriate beginning. Its effectiveness, however, is limited because under the Act, information regarding medical care decisionmaking is provided to patients at the time of admission to a health care facility, a time of stress and concern when patients and their families may not be able to adequately cope with the need to have such discussions.

The ultimate success of legislative enactments, such as existing living will and durable power of attorney statutes, lies in the development of mechanisms to educate the public regarding this right of self-determination.

In the situation where the family is uncomfortable making medical care decisions, as in the previous three problem areas discussed, the concerns with the proposed family decisionmaking statute are really no greater than under the current system. Moreover, the proposed statute has the advantage of allowing decisions to be made free from judicial intervention in some circumstances when court intervention would be necessary in most jurisdictions today.

336. See Loewy, supra note 154, at 1974. Dr. Loewy states:
Advance directives, properly used to foster true patient autonomy, have much to recommend them. Among other things, they can (1) stimulate patients to think about such issues; (2) allow patients to speak about their preferences with their physician, their relatives, and their friends; (3) permit patients either to express their wishes or to select a trusted other who can make choices for them; and (4) help resolve some of the fears of entrapment by the medical system. All of these advantages, however, imply leadership by health care professionals who must carefully inform, discuss, listen to, and ultimately counsel and advise patients and their families.

Id. Patients and their families would welcome such information and the encouragement of such discussions. See F. Russell Kellogg et al., Life-Sustaining Interventions in Frail Elderly Persons; Talking About Choices, 152 ARCHIVES INTERNAL MED. 2317 (1992) (reporting positive reactions by frail, homebound, elderly respondents to physician-initiated discussions concerning need of patients to consider medical care preferences); Villaire, supra note 295, at 84-86 (describing success of foundation started by Cruzan family to provide information to public regarding advance directives).

Educational and support services should also be provided to the families of patients in persistent vegetative states who must navigate the current medical and legal systems. See id. at 86; Richard W. Carlson et al., Development of a Comprehensive Supportive Care Team for the Hopelessly Ill on a University Hospital Medical Service, 259 JAMA 378 (1988) (describing program developed to meet all needs of patient in persistent vegetative state, not just medical needs).

337. For a discussion of the Patient Self-Determination Act, see supra notes 149-56 and accompanying text.
5. The Unreasonable Decision

Perhaps the most difficult problem posed by the proposal is when a decision by the surrogate appears to be unreasonable, favoring either continuation\(^3\) or discontinuation of treatment. In a diverse society, a wide range of alternative decisions regarding medical treatment should be acceptable. Sometimes these choices are made based on personal views and at other times based on religious beliefs. For example, Jehovah’s Witnesses refuse to submit to blood transfusions. Some legislatures have recognized this diversity of choice in statutes that authorize durable powers of attorney for health care. For example, under the Illinois statute, an individual can direct his agent to refuse amputations or blood transfusions on his behalf.\(^3\) Although most of society probably views refusal of a blood transfusion as an unacceptable decision, this refusal should be within the range of acceptable decisions.

There may be instances, however, when a decision is so unreasonable that it should not be enforced. In response to this problem, the standard that the court should use in reviewing a statutory surrogate’s decision should be a higher barrier than merely “best interests.” This deference to the decisionmaker is certainly not unique to this proposal. Appellate courts routinely defer to trial courts’ factual determinations. Courts also defer to administrative agencies in their factual determinations. These examples of deference are based on the fact that the record often does not convey the subtle nuances of testimony on which fact finders judge credibility. Similarly, courts should defer to family decisions in the area of medical care because family impressions of a person’s desires often are not easily translated into testimony.

A significant problem arises if hospitals are allowed to take the lead in objecting to termination of treatment. Because an institution’s resources are significant, it can challenge decisions with which the administration does not agree. The doctor or hos-

---

\(^3\) See also Judge Rules Parents May Keep Comatose Child Alive, CHI. TRIB., Oct. 18, 1991, at C4 (noting doctors’ argument that keeping child alive was child abuse).

hospital administrator should be required to convince a prosecuting attorney that the family's decision constitutes abuse before the case can be litigated. A hospital or doctor should also be required to transfer the patient if they do not agree with the surrogate decisionmaker's treatment choice. If another doctor or hospital will comply, then *prima facie* the treatment choice is not unreasonable.

6. **Right of Conscience**

The final problem with this proposal to allow family decision-making is called, for lack of a better term, the right of conscience. The right of conscience first arose in the area of abortion. Both federal and state statutes exist that allow medical personnel to refuse to perform or to assist in performing abortions if doing so is contrary to their religious or moral beliefs. Some courts have created a similar right of conscience in the right to die area. For example, in *Brophy*, the Massachusetts court ruled that while the patient had the right to have the gastrostomy tube removed, the hospital and its agents were not required to remove it. The hospital only had to transfer the patient pursuant to the family's request.

It is not always practical to merely require that the hospital

---

340. One problem that cannot be avoided is the prosecuting attorney with a personal agenda. Such an attorney may choose to intervene alleging abuse even where such intervention is inappropriate. William Webster, the Attorney General of the State of Missouri, fought for years to decide the course of Nancy Cruzan's treatment instead of allowing her parents to make treatment choices. See Price, *supra* note 84, at A1.

More recently, Christine Busalacchi, a severely brain damaged woman, was kept alive by a feeding tube in the same hospital as Nancy Cruzan. Kramer, *supra* note 310, at N2. Busalacchi was injured in an automobile accident in 1987. *Id.* In December 1990, her father attempted to move her to a Minnesota hospital where a neurologist had agreed to take her case. The State of Missouri intervened to prevent the transfer. See Missouri Court Rejects Move for Comatose Woman, N.Y. Times, Mar. 6, 1991, at A18 (noting that court of appeals refused to allow father of 20-year-old to move daughter to state where families "have more discretion in making decisions about the removal of feeding tubes and other extraordinary medical treatment"). Only when the new Attorney General, Jay Nixon, was sworn in did the state dismiss its appeal in the case. Kramer, *supra* note 310, at N2; see also *In re Rosebush*, 491 N.W.2d 633 (Mich. Ct. App. 1992). In *Rosebush*, staff members at a hospital convinced a county prosecutor to seek a temporary restraining order preventing a transfer of a patient whose family was seeking to terminate life support. *Id.* at 678. The prosecutor intervened after the hospital bio-ethics committee had approved the transfer. *Id.*


transfer the patient. For example, Elizabeth Bouvia was an indigent patient in a public hospital. Consequently, the California Court of Appeal required the hospital to comply with her request.\textsuperscript{343} Even when the patient is not on public assistance, it may not be fair or practical to force the patient's family to find a facility willing to care for the patient.\textsuperscript{344}

When a person is admitted to a hospital or nursing home, the person does not surrender the right to choose among medical treatment alternatives.\textsuperscript{345} Although requiring medical personnel to continue to care for an individual in this situation may be burdensome, the personnel are not being compelled to perform acts contrary to their conscience. It is not like requiring a nurse to participate in an abortion; it is more closely analogous to a nurse being required to care for a person after a botched illegal abortion.

It is a doctor's duty to provide the necessary medical facts, and it is the person's right to make the treatment decision based on his interpretation of those facts.\textsuperscript{346} A person's right to choose should not be frustrated simply because the doctor or hospital disagrees with the choice. To allow a doctor to continue to provide certain treatment in the face of the person's objection merely because the doctor believes it should be done would render the concept of informed consent meaningless.

V. Conclusion

Although cases involving the termination of medical treatment have "many layers and contexts, legal, medical, theological, ethical, and popular, the heart" of these cases is elementary: who

\textsuperscript{343} Bouvia v. Superior Court, 225 Cal. Rptr. 297, 306 (Cal. Ct. App. 1986) (holding that public hospital "may not deny her relief from pain and suffering merely because she has chosen to exercise her fundamental right to protect what little privacy remains to her").

\textsuperscript{344} Nursing homes may refuse to take a patient for the sole purpose of removing tubes for artificial nutrition and hydration. See, e.g., Grace Plaza of Great Neck, Inc. v. Elbaum, 588 N.Y.S.2d 853, 855 (N.Y. App. Div. 1992) (noting that when nursing home attempted to find another facility to take comatose patient whose husband had requested removal of feeding tube, "those facilities which were contacted 'would not admit the patient for the purpose of removing the tube'").

\textsuperscript{345} See In re Jobes, 529 A.2d 434, 450 (N.J. 1987). The nursing home apparently did not inform Nancy Jobes' family about its treatment termination policy at the time of admission. Id. Furthermore, the court found no evidence that the hospital's policy regarding termination had ever been formalized. Id.

\textsuperscript{346} In re Conroy, 486 A.2d 1209, 1222 (N.J. 1985).
rules at the person's bedside?347 "Strip away the rhetoric and the symbols," and these cases are "contest[s] between physicians, on the one hand, and patients and their legal advocates on the other."348 The problem is that in the very first case in this area, the Quinlans made a pact with the devil. In the process of freeing themselves from the domination of the medical profession, they became enslaved to the judiciary.

In the judicial arena, the pendulum has been swinging. It has swung from a laissez faire attitude towards the poor, the ill and the neglected, to the position that the state as parent knows best and should make all medical treatment decisions.349 The time has now come for the pendulum to return to the middle. Families must be allowed to control the destinies of their own members. Only when there is reason to question the family's motivation, not the decision, should the courts be allowed to intervene.

347. Rothman, supra note 125, at 223.
348. Id.
349. See generally David J. Rothman, The State as Parent: Social Policy in the Progressive Era, in Gaylin et al., supra note 179, at 67-96 (analyzing consequences of treating state as if it were parent).