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Withdrawal of Life Support: Individual Autonomy Against Alleged State Interests in Preserving Life

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Cuanto vive el hombre, por fin?
Vive mil dias o uno solo?
Una semana o varios siglos?
Por cuanto tiempo muere el hombre?[1]

I. INTRODUCTION

Nancy Cruzan is a thirty-year-old woman who lies in a permanent vegetative state, quadriplegic, spastic, and so severely brain damaged that she is wholly "oblivious to her environment except for reflexive responses to sound and perhaps to painful stimuli."[2] She lacks the cognitive or reflexive ability to swallow food or water and, therefore, is maintained by a gastrostomy tube through which nutrition and hydration are provided.[3] On November 16, 1988, the Missouri Supreme Court denied her parents' request that life support be terminated and ruled that the feedings by a gastrostomy tube must be continued.[4] According to medical experts, she could "live" in this manner for another thirty years.[5] Surprisingly, the Missouri court refused to follow long-standing policy in other ju-

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1. How much does man live, after all?
Does he live a thousand days, or one only?
For a week, or for several centuries?
How long does man spend dying?
P. NERUDA, ESTRAVAGARIO (1958).

2. Cruzan v. Harmon, 760 S.W.2d 408, 411 (Mo. 1988), *cert. granted*, 109 S. Ct. 3240 (1989).

3. *Id.*

4. *Id.* at 426.

5. *Id.*

risdictions in which families and guardians of patients in similar conditions were allowed to refuse life-sustaining treatment.[6]

The Missouri court justified its decision in *Cruzan* by asserting that various state interests compelled judicial intervention.[7] At the same time, the court also minimized the well-established individual right to refuse medical treatment.[8] Although *Cruzan* is the first modern case to hold that life support must be maintained because of a state interest in preserving life,[9] this ruling is only the logical extension of reasoning which seeks to balance an individual's right to refuse treatment against a state interest. The state's capacity to overrule a refusal of treatment is inherent even in the formulation of those decisions which did allow patients or their guardians to refuse treatment.[10]

This Article will argue that the state's role in cases involving the permanently incompetent patient should not entail the balancing of an abstract interest in preserving life against the patient's right to refuse treatment, but rather should be to ascertain whether the individual would have chosen to accept life-sustaining treatment in her[11] present situation. This argument is founded on the belief that an individual should not lose the privacy or autonomy rights of a competent person upon becoming incompetent.[12]

After a brief review of the right to refuse medical treatment, I will examine the underlying premise for state intervention in cases involving the refusal of medical treatment in general, and life support in particular, by both competent and incompetent patients. With the clarified role of the state in mind, I will explore and reconstruct the incompetent patient's right to refuse medical treat-

6. *See generally* Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 992 (1976). Cases authorizing the withdrawal of artificial nutrition and/or hydration include: Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); Corbett v. D'Alessandro, 487 So. 2d 368 (Fla. Dist. Ct. App. 1986); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); *In re* Grant, 109 Wash. 2d 545, 747 P.2d 445 (1987) (en banc).

7. *Cruzan*, 760 S.W.2d at 420.

8. *Id.* at 417.

9. *Id.* at 420.

10. *See In re* Conroy, 98 N.J. 321, 348-55, 486 A.2d 1209, 1223-26 (1985); *see also* L. TRIBE, AMERICAN CONSTITUTIONAL LAW 1365 (2d ed. 1988).

11. The use of feminine pronouns in this Article is intended to encompass both genders.

12. *See Quinlan*, wherein the court stated that Karen Quinlan's right to refuse life-prolonging treatment, which they found to be incident to the right of privacy, "should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice." *Quinlan*, 70 N.J. at 41, 355 A.2d at 664.

ment by utilizing the legal doctrine of informed consent as opposed to the constitutional right to privacy. Finally, I will suggest that the state can best fulfill its role as the guardian of individual autonomy by creating procedures which will ensure that, to the greatest possible extent, individual preferences will have been recorded prior to the development of incompetence.

II. ANALYSIS

A. The Right to Refuse Medical Treatment

The right to refuse treatment has evolved from a narrow privacy right, dependent on the type of treatment involved and on the patient's prognosis,[13] to the much broader autonomy right articulated in *Bouvia v. Superior Court*,[14] in which a competent and non-terminally ill quadriplegic woman was allowed to refuse medical treatment.[15] Although most decisions in this area involve patients who were not expected to live more than one year (with or without treatment), the judicially articulated scope of the right to refuse treatment extends beyond these factual situations. In *In re Conroy*,[16] for example, the court stated that the right to accept or refuse medical treatment does not depend on the patient's prognosis or medical condition, or on the quality of life.[17] As one commentator has noted, even though the court's point was that one should not be deprived of the right to refuse medical treatment by virtue of becoming incompetent, the argument also implies that patients should not be denied that right because they are "not debilitated enough."[18]

The landmark case involving withdrawal of life support, *In re Quinlan*,[19] held that the Constitutional right to privacy outweighed the state's interest in preserving life.[20] The *Quinlan* case and its progeny[21] relied on a broadly asserted, but ill-defined view of the privacy right, borrowed from cases involving reproductive free-

13. *See id.* ("the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims").

14. 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986).

15. *Id.* at 1137, 225 Cal. Rptr. at 300. *See infra* note 34 and accompanying text for a more detailed discussion of that case.

16. 98 N.J. 321, 486 A.2d 1209 (1986).

17. *Id.* at 355, 486 A.2d at 1226.

18. Matthews, *Suicidal Competence and the Right to Refuse Lifesaving Treatment*, 75 CAL. L. REV. 707, 718 n.100 (1987).

19. 70 N.J. 10, 355 A.2d 647 (1976).

20. *Id.* at 41, 355 A.2d at 664.

21. *See, e.g.*, *In re* Colyer, 99 Wash. 2d 114, 120, 660 P.2d 738, 742 (1983).

dom.[22] *Quinlan* limited this particular exercise of the right to privacy to cases in which the proposed treatment was invasive and the prognosis was dim.[23] However, this construction yielded a right that was vague and subjective, as it turned on the physician's medical diagnosis and the type of treatment proposed. In order for this standard to work, the medical community had to determine whether a given treatment was "extraordinary" and, therefore, could be forgone, or if the treatment was merely "ordinary," and thus mandated regardless of patient autonomy. Due to the fact that the medical community has rejected subjective distinctions based on the sophistication of the treatment at issue, coupled with the growing technological advances which lengthen the survival time for even a dim prognosis, courts have moved toward the articulation of a common law right to refuse medical treatment.[24]

The common law right to refuse treatment is inherent in the informed consent doctrine, which is older and more firmly established than the federal constitutional right to privacy.[25] The right to give informed consent, as opposed to the right to privacy, reflects an interest in preserving decisional autonomy and freedom from non-consensual bodily invasion.[26] This distinction is relevant because, while the constitutional right to privacy is limited by various state interests, the common law right to informed consent to and refusal of treatment is not.[27] If the right to refuse treatment was based on privacy grounds rather than on tort grounds, factors such as the invasiveness of the proposed procedure and the proximity of death could be used to limit its exercise.[28] However, even though courts have acknowledged the common law basis for the right to refuse treatment, they persistently have recited that the right to refuse treatment is limited by the four "countervailing state interests"[29] discussed below. Courts' adherence to a state in-

22. Two of the cases relied on were Roe v. Wade, 410 U.S. 113 (1973) and Griswold v. Connecticut, 381 U.S. 479 (1965).

23. *Quinlan*, 70 N.J. at 41, 355 A.2d at 664.

24. *See* Brophy v. New England Sinai Hosp., 398 Mass. 417, 436, 497 N.E.2d 626, 636 (1986); *see also* L. TRIBE, *supra* note 10, at 1366-67.

25. Informed consent, derived from tort law, is a conversation in which the health practitioner tells the patient the diagnosis, proposes a treatment, then discloses the risks and benefits involved in that treatment, in alternative treatments, and in foregoing treatment. Cobbs v. Grant, 8 Cal. 3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972); Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1137, 225 Cal. Rptr. 297, 300 (1986).

26. Matthews, *supra* note 18, at 723.

27. *See infra* notes 30-70 and accompanying text for a discussion of state interests.

28. L. TRIBE, *supra* note 10, at 1366.

29. *See* Bartling v. Superior Court, 163 Cal. App. 3d 186, 193, 209 Cal. Rptr. 220, 224 (1984) (court held that the right of the patient, as a competent adult, to refuse un-

terest rationale is noted particularly in cases where the withdrawal of life support is sought by patients or their guardians. Although these state interests virtually never prevail over the individual's choice, the very mention of state interests implies a limit on the patient's right to refuse treatment.

B. Defining the State's Interests in Medical Treatment Decisions

The modern articulation of the state's interest in cases involving the refusal of medical treatment is found in *Superintendent of Belchertown State School v. Saikewicz*,[30] which surveyed case law from 1840 to 1977 and distilled four elements comprising this interest: maintaining the ethical integrity of the medical profession; preventing suicide; protecting the interests of innocent third parties; and preserving life.[31] In the ensuing discussion, each element will be analyzed individually in order to clarify its meaning and to assess its impact on the right of the competent patient to refuse medical treatment. Once the state's role in treatment decisions is properly delineated, the justification for state intervention will be examined in the context of the incompetent patient.

1. Maintaining the Ethical Integrity of the Medical Profession

Until recently, judicial concern with the ethical integrity of the medical profession was commonly mentioned as the decisive factor in decisions ordering treatment over a patient's refusal.[32] For ex-

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wanted medical treatment, is outweighed by the various state and personal interests urged by the hospital); Satz v. Perlmutter, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978) (court held that the competent adult's right to privacy encompasses an expression of the sanctity of individual free choice and self-determination and that such right prevails over state interests); Brophy v. New England Sinai Hosp., 398 Mass. 417, 432-40, 497 N.E.2d 626, 634-38 (1986) (court held that although the state's interest in life must be considered, greater weight should be given to the finding that if a patient was able to do so, he would decide to discontinue the feeding tube); *In re* Conroy, 98 N.J. 321, 348-49, 486 A.2d 1209, 1223 (1985) (court denied request to withdraw feeding tube because the patient never expressed an opinion on life-sustaining treatment, the treatment was not particularly painful, and no trustworthy evidence that the patient would have refused the feeding tube was presented).

30. 373 Mass. 728, 370 N.E.2d 417 (1977). *Saikewicz* involved a severely retarded adult who was suffering from leukemia. *Id.* at —, 370 N.E.2d at 419. The court allowed the patient's guardian to refuse medical treatment on the patient's behalf. *Id.* at —, 370 N.E.2d at 435.

31. *Id.* at —, 370 N.E.2d at 425.

32. John F. Kennedy Memorial Hosp. v. Heston, 58 N.J. 576, 583, 279 A.2d 670, 673 (1971). The court concluded that the interests of the "hospital and its staff, as well as the State's interest in life warranted the transfusion of blood." *Id.* at 584, 279 A.2d at 674. Note, however, that even though the court cites this interest as the basis for its holding, it

ample, *John F. Kennedy Memorial Hospital v. Heston*[33] involved an adult Jehovah's Witness who was given a blood transfusion even though her physicians were notified of her religious opposition to transfusions.[34] The New Jersey court asserted that doctors and nurses are trained to preserve life, and that they should not be asked to compromise their professional judgment.[35] The law governing physician-patient relations has changed so dramatically since the early 1970s, however, that recent cases which deal with the refusal of medical treatment only have addressed this particular state interest in passing.[36]

In large part, the movement away from this rationale is due to the fact that physicians themselves have encouraged the recognition of patient autonomy and have rejected the notion that their professional ethics will be violated if aggressive treatment is not pursued in all cases.[37] The *Saikewicz* decision illustrates this change:

> Recognition of the right to refuse necessary treatment in the appropriate circumstances is consistent with existing medical mores; such a doctrine does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the state's interest in protecting the same.[38]

More recently, courts have started to note this change in the medical profession's view of treating the competent, non-terminal patient.[39] For example, a California court cited the policy statements of the American Medical Association and the American Hospital Association in support of its decision that a competent, non-terminal individual is entitled to hasten her death by refusing life-supporting treatment.[40]

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fails to show how patient autonomy threatened the ethical integrity of the medical profession.

33. *Id.*

34. *Id.* at 578, 279 A.2d at 671.

35. *Id.* at 582, 279 A.2d at 673.

36. *See Bartling*, 163 Cal. App. 3d at 195, 209 Cal. Rptr. at 225; *Satz*, 362 So. 2d at 163; *Brophy*, 398 Mass. at 438-39, 497 N.E.2d at 638; *Saikewicz*, 373 Mass. at —, 370 N.E.2d at 427.

37. *See generally* PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *Deciding to Forego Life-Sustaining Treatment* (U.S. Gov't Printing Office 1983).

38. *Saikewicz*, 373 Mass. at —, 370 N.E.2d at 426-27.

39. *See Brophy*, 398 Mass. at 439, 497 N.E.2d at 638; *Saikewicz*, 373 Mass. at —, 370 N.E.2d at 426.

40. Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1143, 225 Cal. Rptr. 297, 305 (1986). In reality, it seems that physicians have not fully ceded decision-making to the patient because cases in this area arise when physicians insist on treating patients over the opposition of either the patient or her family. Rhoden, *Litigating Life and Death*, 102

2. Protecting the Interest of Innocent Third Parties

The second asserted state interest, like the first, fails to focus on the well-being of the patient. In the context of the refusal of medical treatment, the state has claimed an interest in protecting innocent third parties that "is exemplified when the refusal of treatment and subsequent death results in the abandonment of minor children."[41] In such cases, the state intervenes as *parens patriae*[42] in order to protect the health and welfare of a child.[43] In essence, the state is "solely concerned with seeing to it that minor children are cared for and are not abandoned."[44]

The cases which deal with the interest of innocent third parties are few, but the facts are usually the same: the patient is a competent woman who is a practicing Jehovah's Witness and who is also either pregnant or the mother of minor children.[45] The state's intervention in these cases is not easily justified, especially since a parent who finds herself unable to care for her child is allowed to turn the child over to the state for foster care or adoption. If the state cannot force a woman to be a parent, then it follows that the state should not force a woman to accept medical treatment because of her status as a parent. Also troubling is the fact that all of

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HARV. L. REV. 375, 429 (1988). What has changed is that because the medical community recognizes the individual's right to refuse treatment, a judge can no longer premise a decision to override a patient's refusal of treatment on the medical profession's ethical mandate to treat. *Id.* at 420.

41. St. Mary's Hosp. v. Ramsey, 465 So. 2d 666, 668 (Fla. Dist. Ct. App. 1985)(citing Satz v. Perlmutter, 362 So. 2d 160, 162 (Fla. Dist. Ct. Ap. 1978)). *See also In re* President and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964).

42. *See infra* note 53 and accompanying text for a discussion of the *parens patriae* doctrine.

43. Annotation, *Power of Court or Other Public Agency to Order Medical Treatment over Parental Religious Objections for Child Whose Life Is Not Immediately Endangered*, 52 A.L.R.3D 1118 (1973); 42 AM. JUR. 2D *Infants* § 16 (1969).

44. Wons v. Public Health Trust, 500 So. 2d 679, 688 (Fla. Dist. Ct. App. 1987).

45. *See* Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537, *cert. denied* 377 U.S. 985 (1964) (court held that the state's concern for the welfare of the unborn child justified a blood transfusion over the objection of the pregnant woman, a Jehovah's Witness); *In re* Application of Jamaica Hosp., 128 Misc. 2d 1006, 491 N.Y.S.2d 898 (Sup. Ct. 1985) (court held that although a pregnant woman in critical condition has an important interest in exercising her religious beliefs, she could not refuse a blood transfusion because of the state's interest in protecting the unborn child); *In re* Winthrop Univ. Hosp., 128 Misc. 2d 804, 490 N.Y.S.2d 996 (Sup. Ct. 1985) (court held that under the doctrine of *parens patriae*, the state's interest in protecting minor children from abandonment prevailed over the competent mother's refusal to consent to the administration of blood or blood products). *See also* Rhoden, *Cesareans and Samaritans*, 15 L. MED. & HEALTH CARE 118, 118-25 (1987) (while the reported cases are few, the incidence of court-ordered cesarean sections is as high as several thousand each year).

the cases of forced treatment occur with female patients, thus raising the concern that women are not being allowed the same autonomy and freedom of religion that is granted to men.[46]

Similarly, in addressing the issue of compelling women to undergo cesarean sections, one commentator noted that the entire legal premise of forcing medical treatment on patients for the benefit of third parties lacks merit.[47] In addition to abandoning their children, "parents take health risks, such as hang gliding, sky diving, or joining the U.S. army, that could potentially result in their children being orphaned."[48] That commentator sees "no good reason why here, but not elsewhere, parenthood should obliterate personal autonomy."[49]

Regardless of whether one supports the forced treatment of the competent and curably ill patient on the grounds that such patient has minor children, this basis for intervention is seldom pursued in cases involving the withdrawal of life support. It is difficult to apply the justification of preventing the abandonment of minor children to a mother in a permanent vegetative state.

3. Prevention of Suicide

The third focus of state concern is the prevention of suicide. Theoretically, the state interest in preventing suicide should be triggered whenever a patient's refusal of medical treatment would lead to her death. In cases involving the refusal of medical treatment, however, courts generally avoid this issue by distinguishing between committing suicide (actively causing one's own death) and

46. For example, a Florida trial court recently ordered a transfusion for a woman who was a married mother of two minor children. Wons v. Public Health Trust, 500 So. 2d 679, 680-81 (Fla. Dist. Ct. App. 1987). The court, in distinguishing this case from one decided in the same state two years earlier in which the father of a minor child was allowed to refuse treatment, St. Mary's Hosp. v. Ramsey, 465 So. 2d 666 (Fla. Dist. Ct. App. 1985), held that "the right of these two children to be reared by two parents is an overriding reason [for ordering treatment]." *Wons*, 500 So. 2d at 683. The appellate court reversed, reasoning that because they have a father, "Mrs. Wons' probable, but not certain, demise . . . will not result in an abandonment of her two minor children." *Id.* at 688.

47. Rhoden, *supra* note 45, at 120.

48. *Id.*

49. *Id.* A troubling new trend has emerged recently, in which pregnant drug abusers are being charged with child abuse by virtue of their drug use during pregnancy, and such abusers are losing custody of their newborns. Along the same lines, certain judges have recently given longer than ordinary prison sentences to drug-abusing pregnant convicts in order to keep them under state supervision. (Given the notorious levels of drug abuse within our prisons, one might well question the effectiveness of such an strategy, if not its legality). *See The Pregnancy Police, on Patrol*, U.S. NEWS & WORLD REP., Feb. 6, 1989, at 50.

simply allowing a disease to run its natural course.[50]

In *Cruzan*, the Missouri court confronted the weakness of this distinction by noting that if the patient's right to refuse treatment is as broad as present case law indicates, it would always override the state's interest in preserving life, regardless of the patient's prognosis or medical condition.[51] In other words, a patient whose death could be prevented by medical treatment may refuse this treatment and thereby choose to die. The court concluded that this judicial standard would not only reveal the absence of a state interest in preventing suicide, but would actually "lead[ ] to the judicial approval of suicide."[52]

Although the court plainly disapproved of the subordination of the state interest in preventing suicide to the individual right to refuse treatment, it did not develop its analysis of the state's interest into a mandate for judicial intervention in all refusals of "medically necessary treatment."[53] Instead, the court focused on the

50. For example, Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986) involved the refusal of medical treatment by a patient who had attempted suicide several times and had indeed asserted in her first pleading that she wanted to die. *Id.* at 1144, 225 Cal. Rptr. at 306. The trial court concluded that the patient could not refuse life support because her real goal was to commit suicide. *Id.* at 1144, 225 Cal. Rptr. at 305. The appellate court rejected this, declaring that she did not wish to die, but had merely "resigned herself to accept an earlier death, if necessary, rather than live by feedings forced upon her by means of a nasogastric tube." *Id.* at 1144, 225 Cal. Rptr. at 306 (citing Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984); Lane v. Candura, 6 Mass. App. 377, 376 N.E.2d 1232 (1978)). The concurring opinion rejected the claim that Bouvia did not seek to commit suicide, and instead decried both the plaintiff's need to "stultify her position before this court by disavowing her desire to end her life," and the fact that "even the majority opinion here must necessarily dance around the issue." *Id.* at 1147, 225 Cal. Rptr. at 307 (Compton, J., concurring).

51. *Cruzan*, 760 S.W.2d at 417-18.

52. *Id.* at 422 (citing L. TRIBE, *supra* note 10, at 1367).

53. Such an argument would have been difficult to sustain. As *Saikewicz* and its progeny make clear, the state maintains an interest in preventing suicide. *Saikewicz*, 373 Mass. at —, 370 N.E.2d at 425. However, the law no longer treats suicide as a crime, but rather, views it as an expression of mental illness. *In re* Joseph G., 34 Cal. 3d 429, 433, 667 P.2d 1176, 1178, 194 Cal. Rptr. 163, 165 (1983). This view shapes the nature of the state response to suicide and suicide attempts. A recent article lists two justifications for this state interest: the state's *parens patriae* power to protect individuals, and the harm to the general welfare which a suicide may engender. Bloch, *The Role of Law in Suicide Prevention: Beyond Civil Commitment — A Bystander Duty to Report Suicide Threats*, 39 STAN. L. REV. 929, 935 (1987). The *parens patriae* doctrine refers to the government's power of guardianship over incompetent persons, and requires that the state ascertain the competence of the decision-maker. BLACK'S LAW DICTIONARY 1269 (5th ed. 1979). Although the law presumes that those attempting suicide are incompetent, it would seem that one who was competent, yet chose to die (*e.g.*, by refusing medically necessary treatment) would not trigger the state's *parens patriae* power. Indeed, this was the result reached in *Bouvia*. *See supra* note 15.

As an example of the potential harm to the general welfare, Bloch notes the contagious

other justifications for state intervention, and found a more suitable anchor in the state interest in preserving life.[54]

4. The State Interest in Preserving Life

While the preservation of life would seem to be the core of the state's power to intervene in cases involving the refusal of medical treatment, in practice it is a relatively weak, ambiguous concern. Indeed, until *Cruzan*, none of the cases ordering treatment did so based on this factor alone.[55] Both the basis for and the meaning of this state interest are elusive. In the context of the incurable patient refusing treatment, *Saikewicz* defined this general interest as "[t]he interest of the state in prolonging a life."[56] Rather than explaining the source and nature of this interest, however, the court simply stated that such an interest is very high "where the affliction is curable," but that the state may not order that an incurable affliction be prolonged through treatment.[57]

Like the court in *Saikewicz*, the *Cruzan* court discussed the existence of a state interest in preserving life, without explaining its source or defining its scope.[58] But the *Cruzan* court's interpretation of this interest was broader than that described by *Saikewicz*, and the court used this broadly drawn interest to mandate treatment in a case in which there was no hope of a cure.[59]

The fact pattern in *Cruzan* differed from *Saikewicz* in that while Nancy Cruzan's condition was not curable, her present vegetative condition was not considered "terminal."[60] However, a careful

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effect of suicide, seen especially among adolescents. Bloch, *supra*, at 937. Though troublesome, this potential harm does not explain the state's interest in preventing suicide by competent adults. Rather, it simply asserts that the state should get involved because of the risk that more individuals will choose to end their lives. In any case, this reasoning is not persuasive when applied to individuals refusing medical treatment because these deaths are highly unlikely to cause or to result from such an effect. *Id.* at 938 n.63.

54. For an excellent analysis of suicide and the right to refuse lifesaving treatment, see Matthews, *supra* note 18, which proposes a redefinition of the state interest in preventing suicide so as to make it a substantial factor to be weighed in refusal of treatment cases.

55. Even the relatively early case, *John F. Kennedy Memorial Hospital v. Heston*, justified its order for medical intervention on "the interest of the hospital and its staff, as well as the State's interest in life." *Heston*, 58 N.J. at 584, 279 A.2d at 674.

56. *Saikewicz*, 373 Mass. at —, 370 N.E.2d at 425.

57. *Id.* at —, 370 N.E.2d at 426.

58. *Cruzan*, 760 S.W.2d at 419.

59. *Id.* at 412, 422.

60. *Id.* at 412. While subtle, there is a significant difference between focusing on the terminal diagnosis and focusing on the ability of medicine to cure the ailment. The former refers only to a status which, as Karen Quinlan showed by surviving for eight years after her respirator was removed, is approximate at best. *See also* B. SIEGEL, LOVE,

reading of the *Saikewicz* ruling reveals that the decision turned not on the "terminal" nature of Joseph Saikewicz's cancer, but rather on whether the proposed treatment would cure him.[61] Because all parties to *Cruzan* agreed that present treatment only maintained Nancy's life, and could not cure her,[62] the court was clearly wrong when it cited *Saikewicz* and its predecessors as legal authority for the proposition that "the state's interest in prolonging life is particularly valid in Nancy's case . . . [because] Nancy will continue a life of relatively normal duration if allowed basic sustenance."[63]

Putting aside the dispute over terminal versus incurable illness, the task remains one of justifying the state's interest in prolonging life in the first place. In a different context, one court has held that the state has a "substantial and compelling" interest in a "strong, healthy, robust, taxpaying citizenry," and that it has "a right to protect a person from himself and to demand that he protect his own life."[64] Inherent in this holding is a conception of governmental authority that is "at odds with the ideal of individual freedom that guides American jurisprudence."[65] Why should the state have a right to force a competent individual to accept medical treatment when its refusal poses no identifiable threat of harm to others?[66]

One might argue that courts do not explain or justify the state interest in prolonging life because that interest stems from deep-seated convictions about the role of the government in protecting and defending its citizens. When the patient refusing treatment is competent, however, the state's intervention is designed not to defend the individual's choice, but rather to impose a choice of its

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MEDICINE, AND MIRACLES (chronicling the recoveries of patients diagnosed as terminally ill). By focusing on curability, one can assess the patient's options, asking what medicine can do, and what benefit such actions afford to the patient. A condition might be incurable, yet not terminal. The question then is whether or not the patient wishes to continue living, given that her present condition cannot be ameliorated.

61. *Saikewicz*, 373 Mass. at —, 370 N.E.2d at 425-26.

62. *Id.* at —, 370 N.E.2d at 422.

63. *Cruzan*, 760 S.W.2d at 419.

64. State *ex rel.* Swann v. Peck, 527 S.W.2d 99, 113 (Tenn. 1975), *cert. denied*, 424 U.S. 954 (1976) (barring a man from handling poisonous snakes in a religious ritual).

65. Matthews, *supra* note 18, at 730. Moreover, even if this concept of authority is justifiable, such a justification is irrelevant when applied to the vegetative patient on life support who lacks the ability to produce tangible social benefits such as tax dollars. *Id.*

66. Economic justifications for forcing certain behaviors spring to mind. However, even these are often premised on harm to others. For example, the state can force motorcycle riders to wear helmets not because that will prevent them from dying, but because the costs of injuries arising from accidents associated with motorcycles are often borne by society. *See* L. TRIBE, *supra* note 10, at 1372. Such justifications do not apply to the refusal of medical treatment, where the economic costs of forcing a patient to accept treatment are clearly higher than those of allowing a patient to forego treatment.

own. This outcome conflicts with the view of the government as the ultimate protector of its citizens, unless a presumption is made that all citizens who refuse treatment are incompetent and require the state's intervention. However, even that assumption does not mandate a decision to prolong life in all cases, as the state's role is to act in the best interests of one who is unable to make decisions for herself.

Because of these difficulties in articulating the basis for a state interest in prolonging life, the Missouri Supreme Court chose to rest its decision in *Cruzan* on an aberrant legal twist of the state interest: "the interest in the sanctity of life itself."[67] Without citing any authority (legal or otherwise) for the proposition, the court asserted that this concern "rests on the principle that life is precious and worthy of preservation without regard to its quality."[68]

While such a moral principle may stem from the underpinnings of our society, as a legal imperative it lacks definition. In order to convert such a maxim into a rule of law, its scope and the limitations it imposes on individual rights must be clear. The court did not address this definition because it perceived the principle as manifest. It was on the basis of this unsubstantiated state interest that the Missouri court mandated ongoing treatment for Nancy Cruzan:

> The state's concern with the sanctity of life . . . is especially important when considering a person who has lost the ability to direct her medical treatment. In such a circumstance, we must tread carefully, with due regard for those incompetent persons whose wishes are unknowable but who would, if able, choose to continue life-sustaining treatment.[69]

It is noteworthy that the court's decision to focus solely on refusals of treatment on behalf of incompetent patients frees it from the difficult task of reconciling its assertion of a state interest in the sanctity of life with the right of the competent, informed patient to refuse treatment. Instead, the argument rests on the claim that it is impossible to know what the incompetent patient would choose to do in this precise situation and, therefore, the court must "provide shelter for those who would choose to live — if able to choose."[70] The broad reasoning of *Cruzan* would ban virtually all refusals of life supporting treatment on behalf of incompetent patients.

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67. *Cruzan*, 760 S.W.2d at 419.
68. *Id.*
69. *Id.*
70. *Id.*

C. *Redefining the State Interest in Preserving Life*

The *Cruzan* decision brings one no closer to understanding the state's interest in preserving life in the context of the refusal of medical treatment. Centuries ago, a government might have premised a right to intervene either on the need for a larger population or perhaps on the need for money, but relations between the state and its citizens have undergone great changes in the last 200 years. When addressing the right to refuse treatment, courts regularly quote John Stuart Mill, crediting him with establishing the modern conception of individual rights vis-a-vis the state:

> The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or to forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise or even right.[71]

The principle of autonomy limits the state's control over the competent individual and it appears throughout American legal history. In 1914, Justice Cardozo stated that: "[E]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages."[72] No mention is made of a state interest limiting this right. In 1928, Justice Brandeis echoed this sentiment: "The makers of our Constitution . . . sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations. They conferred, as against the government, the right to be let alone — the most comprehensive of rights and the right most valued by civilized man."[73]

Given this understanding of the primacy of individual autonomy, I propose that the state's interest in the preservation of life is not a general mandate for government intervention whenever an individual's act puts her life in potential jeopardy, but rather, constitutes a state duty to protect the autonomy or the right of the competent individual to choose to live. When an individual refuses medical treatment, the state's first concern should be whether that individual is competent to make medical decisions. If there is no

71. J. MILL, ON LIBERTY 68 (G. Himmelfarb ed. 1974).

72. Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914).

73. Olmstead v. United States, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).

doubt as to competency, then the state must respect and defend the individual's autonomous choice. If, however, the individual is permanently incompetent, the state does not, as the *Cruzan* decision suggested, suddenly gain an overriding interest in preserving life. Rather, the state is obligated to aid in effectuating the choice that individual would have made had she been able to do so.

Courts facing the dilemma of ascertaining the wishes of an incompetent patient have been troubled by the inherent uncertainty in making treatment decisions.[74] To that end, they have posited that "[t]he only practical way to prevent destruction of the right (to privacy) is to permit the guardian and family . . . to render their best judgment . . . as to whether she would exercise it in these circumstances."[75] This standard is known as the substituted judgment test, and it is probably the most influential decision-making tool in this entire line of cases.[76]

The *Cruzan* court rejected the rationale of substituted judgment as ill-conceived because even when there is evidence of the patient's attitudes toward life support in the abstract, that evidence cannot be considered an informed refusal of treatment.[77] The *Cruzan* court's solution to this problem with substituted judgment was to assert a state interest which could easily be expanded to negate the right to refuse treatment for all patients:

> Given the fact that Nancy is alive and that the burdens of her treatment are not excessive for her, we do not believe that her right to refuse treatment . . . outweighs the immense, clear fact of life in which the state maintains a vital interest.[78]

Hiding behind an abstract, unfounded state interest, the *Cruzan* court has revoked the incompetent patient's right to self-determination and sidestepped the ugly reality of its mandate of years of what Justice Cardozo would call an on-going battery for the permanently vegetative individual on life support.[79] Decisions of this type, in which an individual's fate is entirely in the court's hands, demand an outcome which is grounded in carefully reasoned legal principles, rather than dictated by political niceties and unsubstantiated state interest.

Determining an individual's wishes in regard to treatment will

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74. L. TRIBE, *supra* note 10, at 1368.

75. *In re* Quinlan, 70 N.J. 10, 41, 355 A.2d 647, 664, *cert. denied*, 429 U.S. 992 (1976).

76. Rhoden, *supra* note 40, at 384.

77. *Cruzan*, 760 S.W.2d at 417.

78. *Id.* at 424.

79. *See supra* note 72 and accompanying text.

be easy in some cases, such as when the adult patient anticipated her demise and left prior treatment directives, and harder in others, such as when the patient is a mentally retarded adult. Despite the occasional difficulty of the task, courts cannot retreat from it by following *Cruzan*. The remainder of this Article will address this problem of decision-making for the incompetent patient, given the state's duty to respect and defend individual autonomy.

III. Refusal of Treatment for the Permanently Incompetent Patient

Substituted judgment, the legal doctrine by which courts presently attempt to effectuate the incompetent person's desires, involves one of three scenarios.[80] First, the patient, when competent, may have unequivocally indicated the decision she would make in the event of her incompetency, and in such circumstances courts generally follow those wishes.[81] Second, where the patient has not given an explicit indication of her wishes or views regarding life support, but a close friend or relative can attest to the patient's likely decision, that person may be allowed to decide in the patient's name.[82] Third, if there is no basis for ascertaining the patient's preferences, a decision will be made "according to what would be in the patient's 'best interests' as defined by the court, by the patient's family, or by a court-appointed guardian."[83]

A. Consent, Informed Consent, and the Right to Refuse Treatment

Cruzan openly objected to the first two of these three practices.[84] The court's argument was based on the doctrine of informed consent, which empowers a patient to accept or reject medical treatment.[85] To give informed consent, the patient must have the capacity to reason and make judgments, the decision must be made voluntarily, and the patient must understand the risks and benefits

80. The following remarks draw heavily from L. Tribe, *supra* note 10, at 1368-70.

81. *See In re* Conroy, 98 N.J. 321, 360, 486 A.2d 1209, 1229 (1985); *In re* Storar, 52 N.Y.2d 363, 376-80, 420 N.E.2d 64, 70-72, 438 N.Y.S.2d 266, 272-74 (1981).

82. *See In re* Colyer, 99 Wash. 2d 114, 131-32, 660 P.2d 738, 748 (1983).

83. *Conroy*, 98 N.J. at 363-68, 486 A.2d at 1231-33; *see also In re* Guardianship of Barry, 445 So. 2d 365, 371 (Fla. Dist. Ct. App. 1984); *In re* Hamlin, 102 Wash. 2d 810, 820, 689 P.2d 1372, 1378 (1984).

84. *Cruzan*, 760 S.W.2d at 417.

85. *Id.*

of the treatment alternatives and of non-treatment.[86] "In the absence of these three elements," the *Cruzan* court claimed, "neither consent nor refusal can be informed. Thus, it is definitionally impossible for a person to make an informed decision — either to consent or to refuse — under hypothetical circumstances . . . ."[87] Because Nancy Cruzan was unable to consent, the court concluded that the state's interest in preserving life dictated continued treatment.[88]

From the above discussion of *Cruzan*, one understands that the court's arguments as to the state's interest in preventing suicide and preserving life are flawed.[89] A second flaw is seen in the *Cruzan* court's application of the informed consent doctrine in the case of an incompetent patient. The relevant legal theory in *Cruzan* is that of consent, not informed consent, because the issue is not how much information must be given to the patient in order to enable her to make a treatment decision, but whether treatment should be provided given that the patient is unable to consent. Treatment absent consent, even if perfectly performed and beneficial, is a battery.[90]

In contrast, the one occasion on which treatment may be rendered absent the incompetent patient's (or her guardian's) consent is in the event of an emergency. This occurs when a patient is unconscious or otherwise incapable of consenting and the harm threatened by the failure to treat is imminent and outweighs any harm threatened by proposed treatment.[91] It is important to note that the legal rationale for the involuntary treatment in such cases is not the state's interest in preserving life, but the assumption that a reasonable person would consent to treatment under these circumstances. In other words, consent is implied for the duration of the emergency.[92] Thus, if the patient were to awaken and choose to discontinue all ongoing treatment, this choice would be respected.[93]

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86. *Id.*

87. *Id.*

88. *Id.* at 419.

89. *See supra* notes 74-88 and accompanying text.

90. Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 105 N.E. 92 (1914).

91. AMERICAN COLLEGE OF LEGAL MEDICINE, LEGAL MEDICINE: LEGAL DYNAMICS OF MEDICAL ENCOUNTERS 197 (1988) [hereinafter LEGAL MEDICINE]. *See also* Dunham v. Wright, 423 F.2d 940 (3d Cir. 1970); Pratt v. Davis, 224 Ill. 300, 79 N.E. 562 (1906); Berlinger v. Lackner, 331 Ill. App. 591, 73 N.E.2d 620 (1st Dist. 1947).

92. LEGAL MEDICINE, *supra* note 91.

93. *See In re* Quinlan, 70 N.J. 10, 41, 355 A.2d 647, 664, *cert. denied*, 429 U.S. 992 (1976).

While an incompetent person receiving life support may originally enter the hospital as an emergency patient, obviating the initial need for express consent, consent can no longer be implied once the patient has been stabilized. At this point, a guardian must be appointed to give informed consent to or refusal of ongoing and additional treatment.[94] This consent process varies depending upon the extent to which the patient's attitude toward life support is known.

B. Informed Consent and the Permanently Incompetent Patient

1. Incompetent Patients with Prior Treatment Directives

If the presently incompetent patient anticipated her incompetency by leaving explicit instructions (*e.g.*, refusing life support), the traditional informed consent doctrine can be applied rather easily.[95] Such instructions are found in oral requests made by patients suffering from degenerative diseases,[96] in written living wills, or through the execution of a durable power of attorney granting a guardian the right to refuse treatment on one's behalf. The court's reasoning in *Cruzan* dictates that informed consent is not truly possible in any of these scenarios because a patient cannot foresee her future medical condition and is thus rejecting or consenting to hypothetical treatment only.[97] Setting aside the fact that this objection is not true for those patients suffering from slow, degenerative diseases whose processes are fairly well understood, this reasoning is ill-founded in a more general sense.

Because patients typically are not medical experts, the treatment decisions they make in the informed consent scenario can be viewed as quality of life assessments. The physician explains the risks and benefits inherent in various solutions to their problem. The patient then decides whether to live with the problem as it is, or to follow the physician's recommended course of treatment, in spite of the risks, in the hopes of improving her quality of life. From the patient's perspective, the means, or proposed treatment, cannot be evaluated independently of the end.

For many patients, that end is often a constant: to remain alive and to regain or maintain one's health. However, for some pa-

94. LEGAL MEDICINE, *supra* note 91.

95. L. TRIBE, *supra* note 10, at 1368.

96. See *In re* Requena, 213 N.J. Super. 475, 517 A.2d 886 (1986), in which a woman suffering from ALS (amyotrophic lateral sclerosis, also known as "Lou Gehrig's disease") indicated that once she lost her ability to swallow, she did not wish to be intubated.

97. *Cruzan*, 760 S.W.2d at 417.

tients, these twin goals are not feasible, and while they may remain alive through treatment, they will never regain their health. When this is the case, a patient may choose to articulate her convictions regarding life with a diminished capacity and death. When she signs a living will or gives orders regarding her treatment in the event of future incapacity, she is stating that a given goal (such as simply maintaining her body once she no longer has any cognitive brain function), is not important enough to her to permit treatment. In essence, because she would rather die than live that way, no treatment short of a cure or an improved quality of life will be acceptable.

2. Incompetent Patients with Unknown Treatment Preferences

Given that the purpose of the right to give informed consent is to allow a patient to determine what will be done to her body, there are no reasonable grounds for denying such a right to one who has made that determination ahead of time.[98] Unfortunately, not all permanently incompetent patients have known wishes regarding medical treatment. Aside from incompetent patients who have clearly indicated their future treatment desires, there are two other types of incompetent patients: those for whom there is either weak oral testimony or a family/friend's testimony as to their desires, and those whose wishes are not known. Normally, the informed consent doctrine requires the court to use an objective standard in cases where a patient's desires are unclear.[99] In an emergency, as noted above, treatment is given because a reasonable person would consent to life-saving treatment. This approach is problematic in two respects: first, the permanently incompetent patient is not permanently in an emergency condition; second, courts have little idea what treatment the reasonable person would consent to, given an incurable condition.[100]

98. The court in *In re Conroy* held that "[t]he right of an adult who, like Claire Conroy, was once competent, to determine the course of her medical treatment remains intact even when she is no longer able to assert that right or to appreciate its effectuation." *In re* Conroy, 98 N.J. 321, 359-60, 486 A.2d 1209, 1229 (1985).

99. *See generally* L. TRIBE, *supra* note 10, at 1369.

100. It is interesting to note that in its 1976 decision permitting the withdrawal of life support to a permanently incompetent patient, the *Quinlan* court speculated that the "overwhelming majority . . . would, we think, in similar circumstances, exercise such a choice in the same way for themselves or for those closest to them." *Quinlan*, 70 N.J. at 41-42, 355 A.2d at 664. A 1988 Roper Poll, surveying 1,982 people, found that 58% of Americans answered positively when asked if a physician should be able to lawfully end the life of a terminally ill patient who requests it. Roper Organization of New York City, A Roper Poll (1988).

Cruzan's solution to this dilemma is to force treatment on all permanently incompetent patients because there is always the possibility that a patient might choose to live in these circumstances.[101] Given the frequency of litigation on the withdrawal of treatment and the popularity of natural death acts and the hospice movement, it is simply wrong to presume that all such patients would choose to remain alive. Even the *Cruzan* court does not make this claim, since its argument is based on the possibility that one such person might choose to accept treatment.[102] The prospect of negating the right to refuse treatment for an entire class of patients because of the speculative desires of a few is troublesome. Such a practice relegates those who would have chosen to exercise their right to refuse treatment to months, if not years of technology-dependent existence, with no hope for recovery, no meaningful interaction with their environments, unknown amounts of physical pain, and the psychological pain of becoming a tremendous financial and emotional burden to their families and society.

In fact, if it could be shown that the majority of persons would not accept life support if they were faced with a permanently vegetative existence, then requiring treatment in all cases would be tantamount to a wholesale rejection of the right to autonomy for incompetent persons. While the majority's will is not always determinative in our constitutional framework, the interests of the minority are allowed to prevail over those of the majority only when a specific harm, unique to the minority, can be shown. Granted, the harm that results from withdrawing treatment from one who would choose to live is obvious and irrevocable. Equally compelling, however, is the harm done by forcing the majority to accept treatment; an act which raises the specter of the constitutional prohibitions against cruel and unusual punishment and slavery.[103]

In her recent article considering this dilemma, Nancy Rhoden proposed that families be given the presumptive authority to make treatment decisions for their incompetent relatives.[104] She argued that substitute judgment evidentiary standards are too stringent,

101. *Cruzan*, 760 S.W.2d at 427.

102. *Id.* at 419.

103. U.S. CONST. amends. VIII, XIII. Note that petitioners raised this argument in the *Quinlan* case, but it was rejected as irrelevant to situations other than the imposition of penal sanctions. *Quinlan*, 70 N.J. at 37-38, 355 A. 2d at 662. At that time, however, the extent to which "life" could be prolonged via life support was uncertain and more limited, so that a decision to maintain treatment was not tantamount (as it is today) to a "life sentence."

104. Rhoden, *supra* note 40, at 379.

and that families should be permitted to decide simply because they have the best ability to anticipate the patient's desires.[105] While her argument is persuasive, it will not entirely resolve the problem because there always will be incompetent patients who lack family and friends to make such a determination for them. Therefore, it is necessary to develop an objective standard to assist courts and guardians in making decisions on behalf of those permanently incompetent, vegetative patients whose attitudes toward life support are simply not known.

IV. ENCOURAGING AND ALLOWING SELF-DETERMINATION: THE ROLE OF THE COURTS AND THE ROLE OF SOCIETY

It is less than ideal to be forced to use an objective standard to determine whether to use life support for an incompetent patient. Several alternatives are available to minimize the frequency with which courts or guardians will be faced with this dilemma.

First, courts should relax the evidentiary standard by which they evaluate the less-than-explicitly expressed treatment desires of those now incompetent. Because young, healthy people seldom have occasion to make formal declarations about their feelings regarding life-support in the event of sudden and irreversible damage, more weight should be given to casual remarks made to family and friends. For example, the trial court in the *Cruzan* case "found that Nancy expressed 'in somewhat serious conversation,' that if sick or injured, she would not want to continue her life unless she could live 'halfway normally.' "[106] The court dismissed this statement, stating that " 'informally expressed reactions to other people's medical condition and treatment do not constitute clear proof of a patient's intent.' "[107] In doing so, it condemned

105. *Id.* at 437.

106. *Cruzan*, 760 S.W.2d at 411.

107. *Id.* at 424 (quoting *In re* Jobes, 108 N.J. 394, 412, 529 A.2d 434, 443 (1987)). This is by no means an ideal solution to the problem. While one could argue that such evidence is the best indication we have of a patient's desires, and that there is little incentive for the patient to be other than truthful, courts are wary of such testimony for good reason. Because the individual does not truly anticipate future misfortunes, such comments are not offered as serious instructions, but rather as general remarks. One cannot be sure that the individual would still feel the same when the actual choice was upon her. The same holds true for all testimony by family and friends regarding the incompetent individual's values, way of life, and inferred attitudes toward life support. While there may be no reason to doubt the sincerity of those speaking on behalf of the incompetent patient, the possibility of error or uncertainty will always remain. L. TRIBE, *supra* note 10, at 1369. Moreover, even if courts were to rely more heavily on testimonial evidence, there would still be cases in which no reliable evidence is available.

her to thirty years of an existence she most likely does not want.

To assist the courts, all competent persons must be encouraged to make known their wishes regarding life-support and other medical treatment in the event of future incompetency. This would require a far greater legislative effort than that seen in this area to date.[108] The scope of the Natural Death Acts would have to be expanded so that they would apply to medical treatment in general, regardless of the diagnosis and prognosis.

Further, the public must be urged to complete living wills. Encouragement could be effected along the lines of current organ donor transplant stickers placed on the backs of drivers' licenses. Yet, because the stakes for the individual are higher in the case of authorizing or not authorizing life support, and because the point at which different individuals would cease treatment will vary, a sticker might be too simplistic an approach. Another problem with this system is that only those who have driver's licenses will be eligible for determining their fate in the event of incompetency. Therefore, living wills could be completed for example along with annual income tax returns. These wills could be kept on file and amended as desired. While such a proposal might seem preposterous and costly, it is certainly no more costly than the alternative of prolonging death via life support, at a cost of millions of tax dollars for each patient.

Progress toward the same goal could be made if physicians require each of their patients to make a written declaration regarding life support. Such documents would become part of a patient's permanent medical record, and could be amended at subsequent visits. In the alternative, hospitals could require the same of all patients admitted to the facility. While this would certainly heighten patient anxiety, it would ensure a current and serious consideration of the subject.

Given that the foregoing suggestions will not entirely eliminate the problem of uncertainty in prolonging the life of incompetent persons via life support, formal efforts to assess society's attitudes toward life support in various contexts must be made. While courts have made judgments based on the "reasonable person" standard for hundreds of years without ever bothering to consult social scientists, or even to make their own surveys, this is an occasion where outside expert input is needed. Once there are reliable indications of the majority's attitudes toward life-sustaining treat-

108. L. TRIBE, *supra* note 10, at 1370.

ment given various physical and mental complications, courts will have the evidence they need to support a decision to order or to refuse treatment. An informed decision has the great advantage of being based not on the assertion of an irrelevant state interest, but rather on the standard consistent with American law regarding all medical treatment: the response of the competent person, where available and, where not, the response that would be given by a "reasonable person."

V. CONCLUSION

To date, instead of attempting to determine whether a reasonable person would choose to live under severely compromised conditions, courts rely on subjective determinations of the patient's "best interests."[109] This generally mandates continuing life support. While it is understandable that judges are uncomfortable determining if life under certain conditions is actually worse than death, a great injustice is done to the incompetent patient by avoiding the question. The artificial maintenance of Nancy Cruzan's body against the wishes of her parents and to the extent we can discern, against her wishes as well,[110] is a testament to this injustice.

Technology, in its relentless progress toward greater postponement of death, will leave us each year with more and more individuals suspended in a twilight existence. There is a more sane, more humane response to them, and to us, than to force them to wait out the limits of technology.

109. L. TRIBE, *supra* note 10, at 1369.
110. *Cruzan*, 760 S.W.2d at 411.