CRUZAN v. DIRECTOR, MISSOURI DEPARTMENT OF HEALTH: A CLEAR AND CONVINCING CALL FOR COMPREHENSIVE LEGISLATION TO PROTECT INCOMPETENT PATIENTS’ RIGHTS

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INTRODUCTION

Significant advances in the field of medical technology now provide physicians with the ability to prolong life despite permanently debilitating illnesses and what would have been fatal injuries.¹

¹ Severns v. Wilmington Medical Center, 421 A.2d 1334, 1344 (Del. 1980). The Delaware Supreme Court appropriately articiulated the problem of defining when life ends:

[We] are on the threshold of new terrain—the penumbra where death begins, but life, in some form, continues. We have been led to it by medical miracles which now compel us to distinguish between “death,” as we know it, and death in which the body lives in some fashion, but the brain (or a significant part of it) does not.

Id. The President’s Commission for the Study of Ethical Problems in Medicine found that nearly 80% of all deaths in America take place in a hospital or nursing home and most involved a decision by someone to do or not to do something which resulted in prolonging the dying process. President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life Sustaining Treatment: A Report of the Ethical, Medical and Legal Issues in Treatment Decisions 16-18 (1983); see also D. Callahan, Setting Limits, Medical Goals in an Aging Society 52-81, 159-200 (1987) (questioning use of disproportionate share of medical resources to extend lives of elderly patients with little focus on quality of life being prolonged); Lipton, Do-Not-Resuscitate Decisions in a Community Hospital: Incidence, Implications and Outcomes, 256 J. A.M.A. 1164, 1168 (1986) (finding 70% of deaths follow decision to forgo life-sustaining treatment); U.S. Congress: Office of Technology Assessment, Life Sustaining Technologies and the Elderly 41 (1987) (positing that timing of death is now matter of choice rather than fate).

In addition, advances in medical technology place physicians in a difficult situation when their own decisions might conflict with those of the patient’s family. See Meisel, Refusing Treatment, Refusing to Talk, and Refusing to Let Go: On Whose Terms Will Death Occur?, 17 Law Med. & Health Care 221, 223-26 (1989) (stating that some doctors would prefer not to know whether patients want aggressive treatment because it may raise concerns about medical malpractice, medical ethics, or “mercy killing”); Note, I Have a Conscience, Too: The Plight of Medical Personnel Confronting the Right to Die, 65 Notre Dame L. Rev. 699, 716-30 (1990) (addressing medical professional’s right to refrain from participating in decisions to withdraw treatment for ethical reasons).

For a comprehensive analysis of the ethical, medical, and legal ramifications of medical decisionmaking, see N. Cantor, Legal Frontiers of Death and Dying (1987) [hereinafter...
Many state courts and legislatures have attempted to discern exactly what rights apply to a patient whose life depends on the implementation or maintenance of medical treatment. In the most clear-cut


cases, the issue focuses on whether a competent patient has the right to terminate or to deny medical treatment. Despite some innovative “right to die” case law, jurists are not provided with a clear basis for drawing the line for or against medical treatment.

Courts have recognized a competent patient’s right to refuse medical treatment based on an individual’s common law right to refuse consent for treatment. Courts have also upheld a patient’s right to refuse treatment based upon the right of privacy.

3. Numerous state courts have held that a competent individual may refuse life-sustaining treatment. See, e.g., Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 745, 370 N.E.2d 417, 427 (1977) (recognizing that general right of competent persons to refuse treatment must also apply to incompetents in appropriate circumstances); In re Farrell, 108 N.J. 355, 347, 529 A.2d 404, 410 (1987) (holding competent patient has right to refuse life-sustaining medical treatment); In re Peter, 108 N.J. 365, 372, 529 A.2d 419, 423 (1987) (suggesting patient does not lose right to refuse medical treatment upon incompetency); In re Conroy, 98 N.J. 321, 346-47, 486 A.2d 1209, 1222 (1985) (finding competent adult generally has right to refuse initiation or continuance of medical treatment); In re Quinlan, 70 N.J. 10, 40, 355 A.2d 647, 663 (finding right of privacy encompasses patient’s decision to decline medical treatment in certain situations), cert. denied, 429 U.S. 922 (1976); In re Westchester County Medical Center ex rel. O’Connor, 72 N.Y.2d 517, 528, 531 N.E.2d 607, 611, 534 N.Y.S.2d 886, 890 (1988) (relating that common law has traditionally held that person may decline life-sustaining treatment, absent overriding state interest); see also infra note 140 and accompanying text (discussing Supreme Court’s reiteration of competent patient’s right to refuse medical treatment).


A majority of citizens strongly believe that the right to make medical treatment decisions includes the right to forgo life-sustaining treatment, including nutrition and hydration, and that such choices are deeply personal and should remain within the family. See AMERICAN MEDICAL ASSOCIATION, PUBLIC OPINION ON HEALTH CARE—1986 (1986) (presenting results of poll indicating 73% of those surveyed favored withdrawal of any life-sustaining procedures if they or their family requested it); Collin, Planning and Drafting Durable Powers of Attorney for Health Care, 22 INST. ON EST. PLAN. ¶¶ 501.3 to .8 (1988) (discussing changes in American medical care, problems with medical decisionmaking in aging society, and development of right-to-die movement).

5. See Schloendorff v. Society of New York Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914) (holding per Judge Cardozo that “every human being of adult years and sound mind has a right to determine what shall be done with his own body, and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages”).

The doctrine of informed consent is designed to respect an individual’s right of self-determination in medical treatment matters and requires that physicians or other health care providers treat a patient only after having obtained the patient’s consent. See Collin, supra note 4, ¶ 503.1(C) (providing detailed analysis of doctrine of informed consent); Comment, The Right to Die: An Exercise of Informed Consent, Not An Extension of the Constitutional Right to Privacy, 58 U. CIN. L. REV. 1367, 1387-95 (1990) (concluding decision to refuse life-sustaining treatment soundly supported by common law doctrine).

6. See In re Quinlan, 70 N.J. 10, 40, 355 A.2d 647, 663 (holding right of privacy, found in penumbral emanating from specific guarantees of Bill of Rights and in article I, paragraph 1 of New Jersey Constitution broad enough to cover patient decisions), cert. denied, 429 U.S. 922 (1976). The New Jersey Supreme Court is at the forefront of right-to-die jurisprudence. That court’s first decision in this area was Quinlan, in which the court permitted a father to exercise his incompetent daughter’s privacy right to withdraw treatment and to compel the hospital to
v. Director, Missouri Department of Health, the United States Supreme Court considered whether an incompetent individual possesses a fundamental constitutional right to refuse life-prolonging procedures or to direct their withdrawal. The Court concluded that an incompetent patient does not have such a right. Absent clear and convincing evidence that she would have refused life-prolonging treatment if competent, Nancy Cruzan's parents could not compel withdrawal of her life-support system. Cruzan offered the Court an opportunity to expand the right of privacy to include the decision to terminate medical treatment. The majority eschewed this path, however, by deciding that Missouri's evidentiary requirement of clear and convincing proof of intent as a prerequisite to withdrawing or withholding an incompetent patient's medical treatment was not unconstitutional.

This Note examines the approach of the United States Supreme

discontinue artificial respiration. Id. at 41-42, 355 A.2d at 664. Other state courts have adopted similar privacy rights. See Satz v. Perlmutter, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978) (recognizing right of privacy allows competent individual to refuse or discontinue treatment), aff'd, 379 So. 2d 359 (Fla. 1980); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 739-40, 370 N.E.2d 417, 424 (1977) (extending right of privacy to refuse medical treatment to incompetent patient). For a discussion of the United States Supreme Court's privacy cases see Mayo, Constitutionalizing the "Right to Die", 49 Md. L. Rev. 103, 111-25 (1990) (tracing early development of right of privacy through abortion cases and noting that none establish right at issue in Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841 (1990)); Note, The Foundations of the Right to Die, 90 W. Va. L. Rev. 235, 239-59 (1987) (outlining development of right to refuse medical treatment through common law, constitutional right of privacy, and statutory authority); see also infra notes 19-20 and accompanying text (examining limitations on application of right of privacy to medical decisionmaking); infra note 21 (providing additional state decisions recognizing right of privacy as foundation for right to refuse treatment).

8. Id. at 2846; see also Mayo, supra note 6, at 149-50 (listing broad range of issues presented to Court in Cruzan).
9. Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2852 (1990) (analyzing "right to die" in terms of fourteenth amendment liberty interest and finding Missouri's heightened evidentiary standards not violative of procedural due process). For an overview of the existence of a constitutional right to die, see L. Tribe, AMERICAN CONSTITUTIONAL LAW § 15-11, at 1362-71 (2d ed. 1988) (arguing that attributing rights to patients who are irreversibly comatose or in persistent vegetative state is problematic).
10. Cruzan, 110 S. Ct. at 2853. The clear and convincing standard of proof has been defined as "proof sufficient to persuade the trier of fact that the patient held a firm and settled commitment to the termination of life supports under the circumstances like those presented." In re Westchester County Medical Center ex rel. O'Connor, 72 N.Y.2d 517, 531, 531 N.E.2d 607, 613, 534 N.Y.S.2d 886, 892 (1988). The New Jersey Supreme Court has held that clear and convincing evidence is that which:
produce[s] in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, evidence so clear, direct and weighty and convincing as to enable [the factfinder] to come to a clear conviction, without hesitancy, of the truth of the precise facts in issue.
In re Jobes, 108 N.J. 394, 407-08, 529 A.2d 434, 441 (1987) (citation omitted); see also infra notes 23-37 and accompanying text (discussing clear and convincing standard as applied by New York courts in right-to-die cases).
Court in addressing the issue of an incompetent patient's right to die. Part I traces the development of a patient's right to refuse treatment based upon the common law right of bodily integrity and the right of privacy. Part I also examines the analysis employed by courts in New York and New Jersey to resolve medical treatment decisions for incompetent patients, including application of the "clear and convincing" and "substituted judgment" standards. Part II briefly examines legislation affecting medical treatment decisions. Part III reviews the Supreme Court's analysis in Cruzan, and Part IV offers a constructive evaluation of the opinion. Finally, Part V proposes a basic framework of uniform requirements to protect the interest of individuals in refusing medical care. The Note concludes with a recommendation that state legislatures establish clear guidelines for determining when an incompetent patient may have life-sustaining treatment withheld or withdrawn.

I. DEVELOPMENT OF A GENERAL RIGHT TO DISCONTINUE LIFE-SUSTAINING TREATMENT

A. Background

Proponents of a "right to die" equate the individualized decision to control medical treatment with the Supreme Court's articulation of the right to self-determination.\textsuperscript{12} Self-determination entitles individuals to the possession and control of their bodies, and, therefore, supports the termination of medical treatment by recognizing the choice of a competent individual to refuse unwanted treatment.\textsuperscript{13} The right to self-determination and autonomy comes under considerable scrutiny, however, when invoked on behalf of incompetent patients.\textsuperscript{14} Courts faced with protecting an incompetent patient's interests have taken two distinct approaches. Courts in Maine, Missouri, and New York hold that absent a patient's in-

\begin{itemize}
\item \textsuperscript{12} See Union Pacific Ry. v. Botsford, 141 U.S. 250, 251 (1891) (holding that to force plaintiff to undergo surgery would violate plaintiff's right to maintain bodily integrity). The Botsford Court observed that no right is held more sacred or is more carefully guarded by the common law than the right of individuals to possess and control their own persons. \textit{Id.} This right is free from restraint and the interference of others, subject only to clear and unquestionable authority of law. \textit{Id.; see also Cruzan, 110 S. Ct. at 2846-47} (explaining that notion of bodily integrity is embodied in notion of informed consent).
\item \textsuperscript{13} See \textit{In re Westchester County Medical Center ex rel. O'Connor}, 72 N.Y.2d 517, 539-40, 531 N.E.2d 607, 619, 534 N.Y.S.2d 886, 898 (1988) (Simons, J., dissenting) (examining common law right of self-determination); see also \textit{supra} note 5 (discussing common law doctrine of informed consent).
\item \textsuperscript{14} See Johnson, \textit{From Medicalization to Legalization to Politicization: O'Connor, Cruzan, and Refusal of Treatment in the 1990s}, 21 CONN. L. REV. 685, 708-15 (1989) (discussing court challenges to appropriateness of right of self-determination as applied to incompetent patients); see also infra notes 180-83 and accompanying text (evaluating problems inherent in applying autonomy concept to incompetent patients).
\end{itemize}
formed refusal of medical treatment, the state's interest in preserving life prevails. The other courts, however, evaluate an incompetent patient's value system and general pattern of beliefs. The latter, "substituted judgment" approach, attempts to determine whether the patient, if competent, would have decided to implement, maintain, or terminate life-sustaining treatment.

Generally, the Supreme Court has placed limits on state intrusion into the basic areas of personal liberty, family privacy, and bodily integrity. Nevertheless, the right of privacy, as recognized by the Court in Griswold v. Connecticut, has only limited application in

15. See, e.g., Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2846, 2855 (1990) (affirming Missouri Supreme Court finding that informal statements to friend are not sufficient to meet clear and convincing standard); In re Gardner, 534 A.2d 947, 955 (Me. 1987) (applying clear and convincing standard of proof to establish that patient declared intent and desire to discontinue treatment in advance); In re Storar, 52 N.Y.2d 363, 379, 420 N.E.2d 64, 72, 438 N.Y.S.2d 266, 274 (1981) (requiring clear and convincing evidence of patient's wishes); see also Note, An Incompetent Individual's Right to Die, 17 FORDHAM URB. L.J. 303, 307-22 (1989) (examining New York's subjective intent requirement).


18. See, e.g., Griswold v. Connecticut, 381 U.S. 479, 485-86 (1965) (holding criminal law prohibiting use or aiding and abetting use of contraceptives violates constitutional right of privacy); Rochin v. California, 342 U.S. 165, 172 (1952) (finding police conduct in attempting to extract suspect's stomach contents "shocks the conscience" under due process); Skinner v. Oklahoma, 316 U.S. 535, 541-43 (1942) (prohibiting state, on equal protection grounds, from sterilizing convicts); Meyer v. Nebraska, 262 U.S. 390, 400 (1923) (recognizing right of parents to control their children's education as liberty interest).

19. 381 U.S. 479 (1965). No right of privacy is specifically guaranteed in the Constitution. See id. at 495 (noting that Constitution does not speak in so many words of the right of privacy); see also Coleman, Creating Therapist-Incest Offender Exception to Mandatory Child Abuse Reporting Status—When Psychiatrist Knows Best, 54 U. CIN. L. REV. 1113, 1116 n.15 (1986) (recognizing lack of specific constitutional provision guaranteeing right of privacy, but finding individual's interest in preventing disclosure of psychiatric records protected by penumbra of various rights); Fletcher, Principlist Models in the Analysis of Constitutional and Statutory Texts, 72 IOWA L. REV. 891, 905-09 (1987) (discussing distortions in constitutional interpretation exemplified by right to privacy when no specific constitutional provision directly endorses it). The Court in Griswold, however, per Justice Douglas, found a constitutional zone of privacy within the penumbra and emanations of the first, third, fourth, fifth, and ninth amendments to the Constitution. Griswold, 381 U.S. at 484. Justice Goldberg cited the ninth amendment as a specific recognition that not all rights protected by the Constitution are specifically enumerated. Id. at 487 (Goldberg, J., concurring). Justice Harlan contended that the right to marital privacy was implicit in the concept of ordered liberty. Id. at 500 (Harlan, J., concurring) (citing Palko v. Connecticut, 302 U.S. 319, 325 (1937)).

Judicial recognition of an expanded right of sexual privacy came in Eisenstadt v. Baird, when the Court struck down a Massachusetts statute prohibiting the distribution of contraceptives
other areas of personal decisionmaking. The Court has thus far rejected efforts to extend the privacy right protecting contraception and abortion choices to sexual privacy or matters of personal autonomy.\textsuperscript{20} Prior to Cruzan, the Supreme Court had never addressed the issue of whether the right of privacy extends to the termination of life-sustaining medical treatment.\textsuperscript{21} The Court's general reluctance to unmarried persons as violative of the fourteenth amendment guarantee of equal protection. Eisenstadt v. Baird, 405 U.S. 438, 447 (1972). Justice Brennan, writing for the majority, held that the equal protection clause prohibited states from discriminating between married and unmarried persons. \textit{Id}. Moreover, the distinction did not relate sufficiently to the state's objective of discouraging premarital intercourse. \textit{Id}. at 449-50.

In \textit{Roe v. Wade}, the Court overruled a Texas law prohibiting abortion except to save the life of the mother. \textit{Roe v. Wade}, 410 U.S. 113, 166-67 (1973). The Court, per Justice Blackmun, concluded that the constitutional right of privacy was broad enough to encompass a woman's decision to terminate her pregnancy. \textit{Id}. at 129-53 (surveying history of abortion and development of right of privacy). A decade later, the Court reaffirmed the principles of \textit{Roe} and refused to adopt an approach that would limit the application of strict scrutiny to state regulations which unduly burdened fundamental rights. \textit{Akron v. Akron Center for Reproductive Health}, 462 U.S. 416, 420 & n.1 (1982) (finding Akron city ordinance unconstitutional in limiting second trimester hospital procedures by requiring parental consent, requiring informed consent, imposing 24-hour waiting period, and dictating procedures for disposal of fetal remains). \textit{But see id. at 455 (O'Connor, J., dissenting) (proposing Court adopt "undue burden" standard to determine whether state regulation unduly burdens woman's right to abortion regardless of stage of pregnancy). More recently, in \textit{Webster v. Reproductive Health Services}, the Supreme Court upheld a Missouri statute that regulated the performance of abortions. \textit{Webster v. Reproductive Health Servs.}, 109 S. Ct. 3040, 3046 (1989). In a plurality opinion, joined by Justices White and Kennedy, Chief Justice Rehnquist noted that \textit{Griswold}, unlike \textit{Roe}, did not adopt a rigid framework of rules and distinctions to deal with areas of medical practice traditionally subject to state regulation. \textit{Id}. at 3045. The plurality questioned \textit{Roe}'s characterization of abortion as a fundamental right. \textit{Id}. at 3058. The \textit{Webster} plurality, by contrast, depicted abortion merely as a liberty interest protected by the due process clause. \textit{Id}.

\textsuperscript{20} See \textit{Bowers v. Hardwick}, 478 U.S. 186, 188 n.2, 190-92 (1986) (rejecting suggested fundamental right to engage in consensual homosexual sodomy). In \textit{Hardwick}, Justice White, writing for the majority, recognized that the Court's prior privacy decisions protected matters involving family, marriage, and procreation, but rejected any connection between those rights and the proposed right at issue in \textit{Hardwick}. \textit{Id}. at 190-91; \textit{see also Kelley v. Johnson}, 425 U.S. 238, 248-49 (1976) (rejecting effort to extend right of privacy to police hair-length regulation). The Supreme Court has never held that there is a constitutionally guaranteed right to live a particular lifestyle. \textit{See generally Wilkinson & White, Constitutional Protection for Personal Lifestyles}, 62 \textit{CORNELL L. REV.} 563 (1977) (examining constitutional treatment of governmental intrusion into personal preferences of domestic companionship, sexual conduct, hair style, and dress).

\textsuperscript{21} Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2851 (1990) (recognizing \textit{Cruzan} as first case to squarely present Court with "right to die" issue). Nevertheless, state courts have held or recognized that a constitutional right of privacy was a foundation for the right of a patient to forgo life-sustaining treatment. \textit{See}, e.g., \textit{Foody v. Manchester Memorial Hosp.}, 40 Conn. Supp. 127, 132, 482 A.2d 713, 717 (1984) (finding penumbral right of privacy encompasses right of patient to be free from unwanted infringements of bodily integrity); \textit{In re Severns}, 425 A.2d 156, 158-59 (Del. Ch. 1980) (finding right of incompetent person to choose, through guardian, to have artificial support discontinued is grounded in constitutional right of privacy); \textit{Satz v. Perlmutter}, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978) (recognizing constitutional right of privacy encompasses competent patient's choice to discontinue respirator), \textit{aff'd}, 379 So. 2d 359 (Fla. 1980); \textit{Superintendent of Belchertown State School v. Saikewicz}, 373 Mass. 728, 739-40, 370 N.E.2d 417, 424 (1977) (stating guardian may assist incompetent patient's right of privacy against unwanted infringements of bodily integrity); \textit{Lane v. Candura}, 6 Mass. App. 377, 378-79, 376 N.E.2d 1232, 1233 (1978) (hold-
toward extending the constitutional right of privacy in earlier cases suggested that it would not do so in *Cruzan.*

**B. In re Storar and the "Clear and Convincing" Standard**

Courts at the forefront of medical treatment issues have established different standards for protecting individual interests. In the consolidated appeals of *In re Storar* and *In re Eichner,* the New York Court of Appeals considered the rights of incompetent patients whose guardians desired to stop life-sustaining medical treatment. The court required clear and convincing proof of an incompetent person's prior instructions to withhold or withdraw life-sustaining procedures.

The resulting loss of oxygen to the surviving brain caused severe and irreversible brain damage.

The consolidated appeals in *In re Storar* addressed two sets of circumstances: one involving an individual who, while competent, made prior statements concerning his health care, and one involving a mentally handicapped individual who was never competent to consider health care decisions. *Storar,* 52 N.Y.2d at 370-75, 420 N.E.2d at 67-70, 438 N.Y.S.2d at 269-72 (providing history of Storar's medical problems). The *Eichner* appeal involved an 83-year-old patient maintained by a respirator in a persistent vegetative state. *Id.* at 370-71, 420 N.E.2d at 67, 438 N.Y.S.2d at 269. Brother Fox, a long-time member of a Catholic religious order suffered cardiac arrest while undergoing routine surgery. *Id.* The resulting loss of oxygen to Father Eichner, as Fox's guardian, sought to have the hospital remove the respirator. *Id.* In the lower court proceedings, evidence suggested that before the operation, and while competent, Fox stated that under similar circumstances he would want a respirator removed. *Id.* at 371-72, 420 N.E.2d at 67-68, 438 N.Y.S.2d at 269-70. Both the New York Supreme Court and Appellate Division concluded that evidence presented in Fox's behalf clearly established that, if competent, he would have wanted treatment stopped. *Id.* at 372, 420 N.E.2d at
The court declined to address whether the right of privacy encompassed a patient's control of the course of medical treatment. Instead, the majority relied on common law principles respecting the right of competent patients to refuse consent for medical treatment. The court concluded that proof consisting of instructions left by a previously competent person to terminate treatment procedures must be clear and convincing. Under this standard, prior directives based merely upon casual or cursory statements concerning medical treatment would be insufficient proof.

Although the court in Storar failed to expand upon the showing necessary to satisfy the clear and convincing evidentiary burden, the same court later addressed this issue in In re Westchester County

68, 438 N.Y.S.2d at 270. The New York Court of Appeals agreed, but the court modified the elaborate procedural requirements established by the Appellate Division.

The Storar appeal involved a proceeding, initiated by the director of a development center, to continue blood transfusions to an incompetent patient. Id. at 373, 420 N.E.2d at 68, 438 N.Y.S.2d at 270. The patient's mother had requested that the blood transfusions to her terminally ill son be stopped. Id. Her son, profoundly retarded since birth, was diagnosed with terminal bladder cancer. Id. Treatment required blood transfusions, but, even with the transfusions, Storar would ultimately have died of the disease. Id.

The Appellate Division determined that individuals have the right to control what will be done with their bodies, and, when a person is incompetent, this right may be exercised by another in the incompetent person's behalf. See id. at 375-76, 420 N.E.2d at 70, 438 N.Y.S.2d at 272 (affirming New York Supreme Court decision). The New York Court of Appeals, adopting a clear and convincing evidence standard, reversed. Id. at 382-83, 420 N.E.2d at 73-74, 438 N.Y.S.2d at 275-76 (concluding permission to continue transfusions should be granted).

26. Id. at 376-77, 420 N.E.2d at 70, 438 N.Y.S.2d at 272-73 (distinguishing other decisions finding medical decisionmaking protected by right of privacy).

27. Id. In Eichner, however, the court declined to decide if a substituted decision to forgo life-sustaining treatment may be exercised because the patient had clearly made the decision to terminate treatment while competent. Id. at 379, 420 N.E.2d at 72, 438 N.Y.S.2d at 274; see also supra note 5 and accompanying text (discussing common law doctrine of informed consent).


29. See id. at 379-80, 420 N.E.2d at 72, 438 N.Y.S.2d at 274 (explaining that loose, equivocal or contradictory evidence would not suffice). In the Eichner appeal, the court concluded that under this standard, the patient clearly understood the consequences of his statements, and his statements were consistent with his beliefs and life of religious devotion. Id. Moreover, the patient's reiteration of his decision shortly before hospitalization supported the seriousness of his statements. Id. In the Storar appeal, the patient was never competent. Id. at 373, 420 N.E.2d at 68, 438 N.Y.S.2d at 270. For such individuals, every medical decision must be made by another. See generally LEGAL FRONTIERS, supra note 1, at 58-82 (analyzing problems in decisionmaking criteria for incompetent patients). The court stated that the facts in Storar bear only superficial similarity to Eichner and thus the decision should turn on different principles. Storar, 52 N.Y.2d at 380, 420 N.E.2d at 73, 438 N.Y.S.2d at 275. The New York Court of Appeals held, therefore, that it would be unrealistic to attempt to discern whether a life-long incompetent individual would stop treatment if he were competent. Id. at 380, 420 N.E.2d at 72, 438 N.Y.S.2d at 275.

30. In Eichner, Brother Fox left unquestionably clear instructions as to his wishes. Id. at 371-72, 420 N.E.2d at 68, 438 N.Y.S.2d at 270. In Storar, however, the court doubted that a never-competent individual could ever establish an opinion concerning termination of treatment. Id. at 379-80, 420 N.E.2d at 72, 438 N.Y.S.2d at 274. The court, therefore, avoided the
Medical Center ex rel. O'Connor.\textsuperscript{31} In O'Connor, the court held that an individual should not be denied essential medical care absent that person's express intent to decline treatment.\textsuperscript{32} Specifically, the clear and convincing standard required proof that an incompetent person had made a previous firm commitment to a decision to terminate life-support.\textsuperscript{33} The persistence and seriousness of past statements are factors considered in evaluating the patient's commitment.\textsuperscript{34} The majority revealed some reluctance to authorize treatment decisions based upon prior statements.\textsuperscript{35} The court suggested that a possibility always exists that patients might change their minds after making a statement, or that past statements were made without appropriate reflection about the consequences.\textsuperscript{36} Nevertheless, the court determined that these subjective problems did not require abandoning the clear and convincing standard in favor of an objective substituted judgment approach.\textsuperscript{37}

\textsuperscript{31} 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988). Mary O'Connor, a 77-year-old widow, sustained serious brain damage and related disabilities after a series of strokes. \textit{Id.} at 523, 531 N.E.2d at 608, 534 N.Y.S.2d at 887. O'Connor could not swallow and was unable to care for herself. \textit{Id.} at 523-24, 531 N.E.2d at 608-09, 534 N.Y.S.2d at 887-88. Her condition continued to deteriorate and her physician determined that a nasogastric tube should be inserted to increase her intake of nourishment. \textit{Id.} at 524, 531 N.E.2d at 609, 534 N.Y.S.2d at 888. O'Connor's daughters objected to the hospital's attempts to insert a nasogastric tube. \textit{Id.} When the hospital sought to compel the treatment, the daughters claimed such action would be against their mother's expressed wishes. \textit{Id.} O'Connor's daughters and a third witness recounted times when she had discussed how patients should not be kept alive by machines when there was no hope of recovery. \textit{Id.} at 526-27, 531 N.E.2d at 610-11, 534 N.Y.S.2d at 889-90. Despite O'Connor's past concern about prolonged medical treatment, all agreed she had never discussed her thoughts on the artificial provision of food and water, or the refusal of medical treatment in a situation that would cause a painful death. \textit{Id.} at 527, 531 N.E.2d at 611, 534 N.Y.S.2d at 890.

\textsuperscript{32} \textit{Id.} at 530-31, 531 N.E.2d at 613, 534 N.Y.S.2d at 892 (citing \textit{In re Storar}, 52 N.Y.2d 363, 379, 420 N.E.2d 64, 72, 438 N.Y.S.2d 266, 274, \textit{cert. denied}, 454 U.S. 858 (1981)). The court determined that O'Connor's past statements did not amount to clear and convincing evidence of her choice to terminate treatment under these circumstances. \textit{Id.} at 532-34, 531 N.E.2d at 614-15, 534 N.Y.S.2d at 893-94.

\textsuperscript{33} \textit{Id.} at 531, 531 N.E.2d at 613, 534 N.Y.S.2d at 892; \textit{see also supra} note 10 (providing general definition of clear and convincing standard).

\textsuperscript{34} \textit{Ex rel. O'Connor}, 72 N.Y.2d at 531, 531 N.E.2d at 613, 534 N.Y.S.2d at 892. Although O'Connor made many statements concerning termination of medical treatment, the court held they were insufficient to meet the clear and convincing standard. \textit{Id.} at 534, 531 N.E.2d at 615, 534 N.Y.S.2d at 894. The court reasoned that it would be highly speculative to consider O'Connor's statements anything more than immediate reactions to the unsettling experience of caring for her relatives. \textit{Id.} at 532, 531 N.E.2d at 614, 534 N.Y.S.2d at 893. O'Connor's daughters undoubtedly knew her wishes better than anyone, but O'Connor's statements alone did not establish the seriousness of purpose required to satisfy the evidentiary burden. \textit{Id.} at 532-34, 531 N.E.2d at 614-15, 534 N.Y.S.2d at 893-94.

\textsuperscript{35} \textit{See id.} (suggesting any error should be made on side of sustaining life).

\textsuperscript{36} \textit{Id.}

\textsuperscript{37} \textit{Id.} at 530, 531 N.E.2d at 613, 534 N.Y.S.2d at 891 (rejecting latter approach as unacceptable because of inconsistency with commitment to notion that no person or court should substitute its judgment as to acceptable quality of life of another) (citation omitted). Simi-
C. The New Jersey Supreme Court: In re Quinlan, the Right of Privacy, and Substituted Judgment

The New Jersey Supreme Court began to craft a significant body of law involving an incompetent patient’s right to terminate treatment in In re Quinlan. The court concluded in Quinlan that the right of privacy is broad enough to encompass medical treatment decisions and, in certain circumstances, supersedes the state’s interest in the preservation of human life. Nine years later, in In re Conroy, the New Jersey Supreme Court reestablished that the right of privacy is not lost upon incompetency, and set forth procedures to decide when an incompetent individual’s right to forgo medical treatment may be exercised by a surrogate decisionmaker. In In re Farrell, In re Peter, and In re Jobes, the same court refined its application of the substituted judgment doctrine and applied it in three distinct treatment situations.

1. The case of Karen Ann Quinlan

In Quinlan, the New Jersey Supreme Court unanimously held that the right of privacy articulated by the United States Supreme Court presumably was broad enough to encompass a patient’s decision to decline medical treatment. The court recognized that the state regularly, other courts have declined to follow an objective approach to substituted judgment. See Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 749-51, 370 N.E.2d 417, 429-31 (1977) (preferring subjective inquiry into intent of particular patient to objective assessment of what majority of people would do in similar circumstances).


Karen Ann Quinlan stopped breathing for an extended period of time. Quinlan, 70 NJ. at 22-34, 355 A.2d at 653-60 (providing background of Quinlan’s medical problems). The resulting loss of oxygen to her brain caused her to slip into what is considered a persistent vegetative state. Id. at 24, 355 A.2d at 654. Quinlan’s father sought to be appointed guardian “of the person and property of his daughter,” and expressly requested that the letters of guardianship authorize the discontinuance of all extraordinary medical procedures. Id. at 18, 355 A.2d at 651. The Superior Court denied Mr. Quinlan authorization to terminate the life-support system. In re Quinlan, 137 NJ. Super. 227, 266, 348 A.2d 801, 824 (Ch. Div. 1975). Mr. Quinlan’s appeal and the cross-appeal by the Attorney General of New Jersey presented the court with two issues: (1) whether the right of privacy extends to choices involving medical treatment, and (2) whether an incompetent’s right of choice may be asserted on her behalf. Quinlan, 70 N.J. at 40-42, 355 A.2d at 663-64.
tains an interest in the preservation and sanctity of human life. The court concluded, however, that the state's interests wane and an individual's right of privacy grows as the degree of bodily intrusion increases and the likelihood of recovery diminishes. A patient's right to choose is normally based on the competency to assert it. With incompetent patients, however, no means exist by which they may independently exercise the right to terminate treatment. The New Jersey Supreme Court concluded that, under these circumstances, Quinlan's right of privacy could be asserted on her behalf by her guardian.

Additionally, the court in Quinlan addressed whether the court should resolve issues when provided with minimal pre-existing legislative guidance. The opinion stressed that courts have the power "to protect those under disability," and, as such, may impose particular medical decisions by applying the doctrine of substituted judgment. The New Jersey Supreme Court refused, however, to endorse a general practice of enlisting the court to validate a decision to withdraw life-sustaining treatment from a patient.

2. The case of Clair C. Conroy

As did the New York Court of Appeals' decision in Storar, the New Jersey Supreme Court, in Quinlan, took an approach toward medical treatment decisions for incompetent patients that did not provide clear guidance for applying the standard to other individuals. The New Jersey Supreme Court clarified its position in In re Conroy. The court in Conroy articulated both substantive and procedural guidelines to be followed in deciding whether to allow withholding or withdrawal of treatment from incompetent nursing home pa-

47. Quinlan, 70 N.J. at 40, 355 A.2d at 663.
48. Id. at 41, 355 A.2d at 664.
49. Id.
50. Id.
51. Id.
52. Id. at 42-51, 355 A.2d at 664-69 (noting paucity of judicial or legislative guidance and evaluating decision in light of prevailing medical standards).
53. Id. at 44, 355 A.2d at 666 (citing Hart v. Brown, 29 Conn. Supp. 368, 369-71, 376-78, 289 A.2d 386, 387-88, 390-91 (Sup. Ct. 1972) (permitting parents to authorize kidney donation from one seven-year-old identical twin to the other) and Strunk v. Strunk, 445 S.W.2d 145, 147-48 (Ky. 1969) (allowing mother to authorize removal of kidney from incompetent son for benefit of other son)).
54. See id. at 46-51, 355 A.2d at 666-69 (warning that court should not encroach upon medical practice).
tients. The court expanded the situations in which withdrawal or withholding of life-sustaining treatment could be authorized for nursing home patients. In addition, the court determined that applied only to patients in a "chronic, persistent vegetative or comatose state." Accordingly, the Conroy court enunciated standards by which an incompetent individual, although not in a persistent vegetative state such as Karen Quinlan, may exercise a right to self-determination. These standards attempt to best effec-

56. Claire Conroy was an 84-year-old nursing home patient with serious and irreversible physical and mental impairments. In re Conroy, 98 N.J. 321, 335-42, 486 A.2d 1209, 1216-19 (1985) (describing Claire Conroy's medical condition and likelihood of short lifespan). Conroy received nutrition through a nasogastric tube; removal of the tube would cause her to die within one week. Id. at 338, 486 A.2d at 1217. Conroy's guardian had refused to consent to a prior operation and now sought permission to remove the nasogastric tube, because, in his opinion, Conroy "would not have allowed [the nasogastric tube] to be inserted in the first place." Id. at 340, 486 A.2d at 1218. The doctors' opinions were divided regarding whether it was an appropriate medical practice to remove the tube. Id. at 398-99, 486 A.2d at 1217. One physician did not consider it acceptable medical practice to remove the tube, yet another stated that if he were the treating physician, and the case had not gone to court, he would have removed the tube with the consent of Conroy's family. Id. at 399, 486 A.2d at 1217-18.

The trial court determined that the tube could be removed. In re Conroy, 188 N.J. Super. 523, 529-30, 457 A.2d 1232, 1236 (Ch. Div. 1983). The lower court reasoned that the inquiry should focus on determining whether Conroy's life had become "impossibly burdensome." Id. at 528, 457 A.2d at 1235. The court noted that removal of the tube would lead to starvation within several days and acknowledged that it might be painful. Id. at 529-30, 457 A.2d at 1236. The court justified removal, however, based on Conroy's severely limited intellectual capacity and the possibility that in her condition she may not feel pain. Id.

The New Jersey Appellate Division reversed, concluding that the ultimate issue was whether Conroy's right of privacy outweighed the State's interest in preserving life. In re Conroy, 190 N.J. Super. 453, 460, 464 A.2d 303, 306-07 (App. Div. 1983). Although Conroy died pending appeal, the Appellate Division heard the case because cases of this type were "capable of repetition yet evading review." Id. at 459-60, 464 A.2d at 306 (citing Roe v. Wade, 410 U.S. 113, 124-25 (1973) (stating pregnancy provides classic justification for non-mootness)).

The court limited the right to terminate life-sustaining treatment, based upon a guardian's judgment, to incurably and terminally ill patients who were brain dead, irreversibly comatose, or in a persistent vegetative state and thus not able to benefit from further medical treatment. Conroy, 190 N.J. Super. at 460, 464 A.2d at 310 (requiring also that patient gain no medical benefits from continued treatment). As an alternative basis for reversing the trial court, the Appellate Division distinguished withholding nourishment from other forms of medical treatment. Id. But see infra notes 151, 199-95, 212 and accompanying text (providing conclusions of Cruzan and other authorities that no such distinction may be maintained). Thus, the court equated withdrawal of the nasogastric tube to depriving Conroy of the necessities of life. Conroy, 190 N.J. Super. at 475, 464 A.2d at 312. Such action would be tantamount to active euthanasia and, therefore, ethically impermissible. Id. Subsequently the New Jersey Supreme Court granted Conroy's guardian's petition for certification. In re Conroy, 95 N.J. 195, 470 A.2d 418 (1983).

57. In re Conroy, 98 N.J. 328, 486 A.2d 1209 (1985). Although the court recognized both common law and constitutional support for an individual's right to decline medical treatment, the court declined to decide whether the right of privacy extended to this case. Id. Instead, the court relied on the common law right to self-determination as the basis for a qualified right to decline life-sustaining treatment. Id. at 347-48, 486 A.2d at 1223 (citing Storar as example of court declining to reach constitutional issue where decision was appropriately based upon common law principles).


59. Specifically, the court addressed cases involving formerly competent nursing home
tuate the choice the individual would have made in this situation.  

   a. The subjective test

A decisionmaker for an incompetent individual must seek to reach, to the extent possible, the decision that the individual would have made if competent. To enable a surrogate decisionmaker to exercise the right to withhold or withdraw medical treatment, the court in Conroy formulated a subjective test that focuses solely on determining whether the particular patient, if competent, would have refused treatment. To satisfy the test, an individual must have unequivocally expressed an intent to forgo future life-sustaining intervention. Absent clear proof of a patient's prior choice, no court, doctor, or relative may cite the patient's right to self-determination as justification for a substituted judgment.

   b. The limited-objective and pure-objective tests

The court in Conroy did not foreclose the possibility of withholding or withdrawing life-sustaining treatment from incompetent individuals suffering from painful and terminal illnesses who had never expressed their intentions. Through the state's parens patriae power, courts may allow decisions to be made on behalf of an incompetent person despite the absence of any prior directives. Ac-

residents who, unlike Karen Quinlan, remained conscious, but whose mental and physical capacities were seriously impaired, and whose life expectancy was relatively short. See Conroy, 98 N.J. at 358-59, 486 A.2d at 1228-29. Despite these limitations, the standards presented in Conroy provide a basis for the law applied later by the New Jersey Supreme Court in In re Farrell, In re Peter, and In re Jobes. See infra notes 76-98 and accompanying text (discussing these cases).

60. See LEGAL FRONTIERS, supra note 1, at 68-76 (discussing standards whereby medical treatment decisions may be designed to best reflect the interests of incompetent patients).

61. In re Conroy, 98 N.J. 321, 360-61, 486 A.2d 1209, 1229 (1985); see LEGAL FRONTIERS, supra note 1, at 63-67 (discussing substituted judgment approach and Conroy subjective test).


63. See id. at 361-62, 486 A.2d at 1229-30 (defining evidence of expression sufficient to satisfy subjective test). The court elaborated upon several types of evidence which would exhibit clear intent under its subjective test: a written document such as a living will; oral directives to a relative, friend, or health care provider; a durable power of attorney or health care proxy authorizing another to make decisions on the patient's behalf should the patient become incompetent; a person's religious beliefs; and a patient's consistent prior conduct with regard to medical decisions. Id.

64. Id. at 364, 486 A.2d at 1231 (citing In re Storar, 52 N.Y.2d 363, 378-80, 420 N.E.2d 64, 72-73, 438 N.Y.S.2d 266, 274-75, cert. denied, 454 U.S. 858 (1981)).

65. Id.

66. Id. at 364-65, 486 A.2d at 1231. The parens patriae doctrine is an equitable concept under which courts or the state may exercise power to protect the welfare of those unable to do so themselves. See Custer, The Origins of the Doctrine of Parens Patriae, 27 EMORY L. REV. 195, 195-96 (1978) (tracing parens patriae doctrine to English 13th-century wardship over "all natural fools and idiots"); see also Weinberg, supra note 17, at 125-30 (analyzing best interests standards, self-determination, and parens patriae doctrine).
Accordingly, the court in Conroy concluded that the state may terminate or deny life-sustaining treatment if either of two “best-interest” tests are satisfied.\textsuperscript{67}

Under the limited-objective test, if patients leave some “trustworthy” evidence that they would have refused treatment, the substitute decisionmaker may withdraw life-sustaining treatment if the burdens imposed upon the patient outweigh the benefits.\textsuperscript{68} The pure-objective test applies when there is insufficient trustworthy evidence of an incompetent patient’s wishes.\textsuperscript{69} The pure-objective test allows withdrawal of treatment only if “the net burdens of the patient’s life with the treatment . . . clearly and markedly outweigh the benefits that the patient derives from life” or if continued treatment would be “inhumane.”\textsuperscript{70}

In sum, the subjective test mandates clear proof that the incompetent patient would choose to refuse treatment if able to do so.\textsuperscript{71} The limited-objective test is met when some trustworthy evidence exists to show that the patient would have refused treatment, and where the burden of the patient’s pain and suffering outweigh the benefits of continued life.\textsuperscript{72} Finally, the pure-objective test is satisfied when no evidence supporting the patient’s treatment decision exists, but the effect of directing or continuing treatment would be inhumane due to severe and unavoidable pain.\textsuperscript{73} In each of these cases, the substitute decision maker must determine whether the burdens of the patient’s life with the treatment clearly and markedly outweigh the benefits that the patient derives from life.

\textsuperscript{67} In re Conroy, 98 N.J. 321, 365, 486 A.2d 1209, 1232 (1985).

\textsuperscript{68} Id. (permitting withdrawal of life-sustaining treatment if trustworthy evidence that patient would refuse such treatment is presented and “it is clear that the burdens of the patient’s continued life with the treatment outweigh the benefits of that life for him”). Trustworthy evidence represents prior expression by the patient that proves insufficient to satisfy the clear standard required by the subjective test. Id. at 366, 486 A.2d at 1232. The court indicated that the patient’s prior reactions to other people’s medical situations would be insufficient to satisfy the subjective test, but may represent trustworthy evidence under the limited-objective test. Id.; see also Legal Frontiers, supra note 1, at 68-76 (discussing best interest standards and evaluating their application).

\textsuperscript{69} Conroy, 98 N.J. at 365, 486 A.2d at 1232 (describing pure-objective test and its application); Legal Frontiers, supra note 1, at 69.

\textsuperscript{70} Conroy, 98 N.J. at 366, 486 A.2d at 1292 (finding that treatment may be inhumane if it causes “recurring unavoidable and severe pain to patient”).

\textsuperscript{71} Id. at 360, 486 A.2d at 1229.

\textsuperscript{72} Id. at 365, 486 A.2d at 1232.

\textsuperscript{73} Id. at 366, 486 A.2d at 1232. The New Jersey Supreme Court determined that Conroy’s past conduct, statements, and religious beliefs did not satisfy the subjective test. Id. at 385, 486 A.2d at 1242-43. Evidence that Conroy would have refused treatment, however, was sufficient to meet the lower showing of intent required under the limited-objective test. Id., 486 A.2d at 1242. Nevertheless, the court found insufficient evidence concerning the benefits or burdens of treatment on Conroy’s life to satisfy either the limited-objective or pure-objective tests. Id. at 386, 486 A.2d at 1243. Ultimately, the court determined that if Conroy had not died before final disposition of the case, her guardian would have been required to explore the benefits and burdens of either withdrawing or continuing treatment. See id. at 387, 486 A.2d at 1243 (noting such issues should be explored fully and any decision should be cautious and deliberate).
tests, once the appropriate standard is satisfied, a substituted judgment may be made on behalf of the incompetent individual.

D. The New Jersey Supreme Court Clarifies Its Position

Despite its expansion of the right to die beyond persistent vegetative state patients at issue in *Quinlan*, the court in *Conroy* only provided guidance for cases involving incompetent, elderly, nursing home patients.74 The New Jersey Supreme Court elaborated upon the right of patients to withdraw or withhold medical treatment under other circumstances in three concurrent decisions.75

1. In re Farrell

*In re Farrell* reaffirmed the right of an informed and competent patient to decline life-sustaining treatment.76 As a guide for future patients, families, and doctors, the court set forth procedures for competent patients living at home to seek withdrawal of medical treatment.77 First, patients must establish that they are competent and informed of their prognosis, alternative treatments, and the

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74. *Conroy*, 98 N.J. at 342, 486 A.2d at 1219-20 (limiting scope of decision to incompetent nursing home residents suffering from painful and terminal illness).


76. *In re Farrell*, 108 N.J. 335, 358-59, 529 A.2d 404, 416 (1987). The court reiterated that both the common law right to self-determination and a federal and state constitutional right of privacy support this principle. *Id.* at 347-48, 529 A.2d at 410.

Kathleen Farrell was a 37-year-old competent, but terminally ill patient. *Id.* at 344-45, 529 A.2d at 408-09. Farrell suffered from a fatal nervous system disorder that ultimately renders a patient's muscles inoperative, but does not impair the patient's mental faculties. *Id.* at 344, 529 A.2d at 408. She remained confined to her home where she lay connected to a respirator, requiring constant medical attention. *Id.* at 345, 529 A.2d at 409. Farrell informed her husband she wanted to have the respirator disconnected. *Id.* Mr. Farrell sought to be appointed guardian with the specific authority to disconnect the respirator. *Id.* The trial court concluded that Ms. Farrell's choice was informed and made with a full understanding of the consequences. *Id.* Farrell testified that she had made the decision with her husband, their children, her parents, her sister, and her psychologist. *Id.* Farrell's psychologist testified that Farrell's choice was "not the result of a mere whim or casual decision." *Id.* The court determined that no countervailing state interest outweighed Farrell's common law and constitutional right to withdraw medical treatment. *See id.* at 348-53, 529 A.2d at 410-13 (concluding that state interests in preserving life, preventing suicide, safeguarding integrity of medical profession, and protecting innocent third-parties were not compelling in this case).

77. *Id.* at 353, 529 A.2d at 413. The court noted, however, that a competent patient's right to refuse treatment does not change solely because the patient remains at home rather than in a medical institution. *Id.* at 354, 529 A.2d at 413-14.
risks involved in terminating treatment. To ensure that a patient is actually competent and informed, two non-attending physicians must participate in this initial stage. Second, the patient must show that the choice to terminate or decline treatment was voluntary and not coerced. Finally, a court must determine that the patient’s informed and voluntary decision to withdraw treatment outweighs the state’s interest in preserving life, preventing suicide, safeguarding the integrity of the medical profession, and protecting innocent third parties. Presumably, no state interest could outweigh the informed decision of a competent individual.

2. In re Peter

In re Peter addressed the withdrawal of life-sustaining treatment from a patient in a persistent vegetative state who had clearly expressed her wishes with regard to such a decision. The patient executed a power of attorney several years prior to her incompetency specifically authorizing a friend to make all her health care decisions, including consent to treatment. The New Jersey

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78. Farrell, 108 N.J. at 354, 529 A.2d at 413.
79. Id. at 356, 529 A.2d at 415.
80. Id. at 354, 529 A.2d at 413.
82. Farrell, 108 N.J. at 354, 529 A.2d at 413 (concluding that competent patient’s right to sovereignty over own body generally outweighs any state interest).
83. In re Peter, 108 N.J. 365, 370, 529 A.2d 419, 421-22 (1987). Ms. Peter was a 65-year-old nursing home patient maintained in a persistent vegetative state, without hope of recovery, but not expected to die in the near future. Id.
84. Id. at 370-71, 529 A.2d at 422. The power of attorney authorized her friend: to make all decisions with respect to [her] health, as if he were next of kin; to hire physicians, nurses or other medical personnel if any, and all medical treatment which [she] require[s], and to be authorized to consent to any medical treatment, operation or medical procedure [she] might require, to be given full and complete authority to manage and direct [her] medical care. Id. at 371, 529 A.2d at 422.

The trial court appointed Peter’s friend as her guardian, but ordered that he not make any decisions to withhold or withdraw medical treatment without informing and obtaining approval from the Office of the Ombudsman for the Institutionalized Elderly. Id. The Ombudsman concluded that, although Peter would not have wanted to be kept alive by mechanical means, the court’s opinion in Conroy prevented the office from authorizing re-
Supreme Court distinguished Peter from Conroy, because, unlike the conscious patient at issue in Conroy, Peter remained in a persistent vegetative state. Application of either the limited-objective or objective standard was, therefore, inappropriate. The court concluded that when a persistent vegetative state patient leaves clear and convincing evidence of intentions regarding medical treatment decisions, courts must employ the guidelines and procedures enunciated by the Conroy subjective test in order to best enforce those wishes. If such a patient leaves no directives concerning life-sustaining treatment or if the evidence is unclear, the guidelines and procedures of Quinlan control.

3. In re Jobes

In the third companion case, the court considered a situation alluded to in Peter, the validity of surrogate decisionmaking on behalf of a persistent vegetative state patient when there is no clear evidence of the patient's medical wishes. In re Jobes involved a patient who suffered severe loss of oxygen to her brain during surgery. Unlike Peter, however, Jobes had not previously expressed her desire not to be sustained in a persistent vegetative state.

The New Jersey Supreme Court granted her guardian's application for direct certification in order to clarify the court's position on the withdrawal or withholding of treatment from patients in a persistent vegetative state. The court reasoned that because Peter was in a vegetative state, the weighing of benefits and burdens required by the Conroy limited-objective and pure-objective tests was impossible. Stressing that these objective tests were not designed for patients in a persistent vegetative state, the court concluded that guidance for such cases should come from Quinlan. Under Quinlan, where the guardian concludes the persistent vegetative state patient would not want life-sustaining treatment, the guardian may seek to terminate the treatment on the patient's behalf. The court found that Peter left clear evidence of her intent not to be sustained by medical treatment and accordingly applied the Conroy subjective test. In contrast, Jobes required the court to set guidelines and procedures for a patient who left no clear directives while competent.

86. Peter, 108 N.J. at 374, 529 A.2d at 424 (finding Peter's status more analogous to situation at issue in Quinlan than in Conroy).
87. Id. The court reasoned that because Peter was in a vegetative state, the weighing of benefits and burdens required by the Conroy limited-objective and pure-objective tests was impossible. Id. at 376-77, 529 A.2d at 425. Stressing that these objective tests were not designed for patients in a persistent vegetative state, the court concluded that guidance for such cases should come from Quinlan. Id. at 377, 529 A.2d at 425. Under Quinlan, where the guardian concludes the persistent vegetative state patient would not want life-sustaining treatment, the guardian may seek to terminate the treatment on the patient's behalf. In re Quinlan, 70 N.J. 10, 41-42, 355 A.2d 647, 654, cert. denied, 429 U.S. 922 (1976). The court found that Peter left clear evidence of her intent not to be sustained by medical treatment and accordingly applied the Conroy subjective test. Peter, 108 N.J. at 377, 529 A.2d at 425.
88. Id. at 384-85, 529 A.2d at 429.
89. Id. at 385, 529 A.2d at 429.
91. Id. at 401, 529 A.2d at 437. Doctors treated Ms. Jobes, who was more than four months pregnant, for injuries sustained in an automobile accident. Id. The oxygen loss occurred during an attempt to remove the fetus which had been destroyed in the accident. Id.
92. Id. at 399, 529 A.2d at 436. Peter set guidelines and procedures for withdrawing treatment from an elderly nursing home patient in a persistent vegetative state who, while competent, had clearly expressed her desire to discontinue life-sustaining treatment in this condition. See Peter, 108 N.J. at 484-85, 529 A.2d at 429 (summarizing doctrinal conclusions mandating application of Conroy subjective test to persistent vegetative state patient who clearly enunciated her wishes). In contrast, Jobes required the court to set guidelines and procedures for a patient who left no clear directives while competent. See Jobes, 108 N.J. at 412, 529 A.2d at 443 (characterizing patient's prior statements regarding her medical care as "remote, general, spontaneous, and made in casual circumstances").
Under the Conroy subjective test, as applied in Peter, courts must weigh the probative value of a patient's prior expression of medical preferences by considering the "remoteness, consistency, and thoughtfulness" of the statements or acts, as well as the maturity of the person at the time of the statements or acts. The court in Jobes concluded that, despite testimony by the patient's friends and relatives, evidence of her intent was not sufficiently clear and convincing to satisfy the subjective test. Following its mandate in Peter, the Jobes court turned to Quinlan for guidance and held that a surrogate decisionmaker may implement the decision the incompetent person would have made if competent. When an incompetent patient's wishes are not clearly expressed, the substituted judgment doctrine requires that the surrogate decisionmaker consider the patient's personal value system, past reactions to medical issues, and all aspects of the patient's personality to "extrapolate what course of medical treatment the patient would choose." Jobes recognized family members as the most appropriate parties to make a substituted medical decision on behalf of an incompetent patient. As such, the court authorized Jobes' husband to implement removal of the life-sustaining food and nutrition from his comatose wife.

93. See Conroy, 98 N.J. at 362, 486 A.2d at 1230 (citing In re Colyer, 99 Wash. 2d 114, 131, 660 P.2d 738, 748 (1983), modified, In re Hamlin, 102 Wash. 2d 810, 689 P.2d 1372 (1984)). Peter concluded that the Conroy subjective test is applicable to all surrogate refusal of treatment cases, regardless of the patient's life expectancy or medical status. Peter, 108 N.J. at 377, 529 A.2d at 425.


95. See Jobes, 108 N.J. at 413-15, 529 A.2d at 444 (outlining substituted judgment doctrine developed in Quinlan). The court applied its conclusion in Peter to Jobes and held that neither the life-expectancy test nor the balancing test set forth in Conroy may be applied to cases involving persistently vegetative patients. Id. at 413, 529 A.2d at 443.

96. Id. at 414-15, 529 A.2d at 444. The court suggested the surrogate also consider the patient's philosophical, theological, and ethical values. Id.

97. See id. at 415-20, 529 A.2d at 444-47 (discussing court's view of family members as proper parties to effect substituted medical judgments for incompetent patients). The Jobes court noted that:

Family members are the best qualified to make substituted judgments for incompetent patients not only because of their peculiar grasp of the patient's approach to life, but also because of their special bonds with him or her. Our common human experience informs us that family members are generally most concerned with the welfare of a patient. It is they who provide for the patient's comfort, care, and best interests, and who treat the patient as a person, rather than as a symbol of a cause.

Id. at 416, 529 A.2d at 445 (citation omitted); see also In re Farrell, 108 N.J. 335, 355, 529 A.2d 404, 414 (1987) (recognizing importance of family involvement in medical decisionmaking for incompetent patients); Rhoden, Litigating Life and Death, 102 HARV. L. REV. 375, 437-45 (1988) (supporting family decisionmaking for incompetent patients and setting forth applicable guidelines).

II. LEGISLATIVE ACTION REGARDING LIFE-SUSTAINING TREATMENT AND MEDICAL DECISIONMAKING

The application of the clear and convincing standard by the New York Court of Appeals in *Storar* and *O'Connor*, and the New Jersey Supreme Court’s development of substituted judgment standards in *Quinlan*, *Conroy*, *Farrell*, *Peter*, and *Jobes*, represent two judicial frameworks designed to address the problem of medical decision-making for incompetent patients.99 The courts developed both approaches without the aid of specific legislation addressing the termination of medical care for incompetent patients who have not clearly expressed their intent regarding such treatment.100 A brief summary of the various legislative schemes currently in place provides a foundation for an analysis of the Supreme Court’s decision in *Cruzan v. Director, Missouri Department of Health*.

The National Conference of Commissioners on Uniform State Laws drafted model legislation to address specific problems relating to terminal patients and the medical decisions that affect them.101 Specifically, the Uniform Rights of the Terminally Ill Act (URTIA)102 provides that a competent person may make a declaration governing the withdrawal or withholding of life-sustaining medical treatment.103 The patient’s prior directives only become

99. *See supra* notes 23-37 and accompanying text (describing clear and convincing standards proposed by New York Court of Appeals in *Storar*); *supra* notes 53-73 and accompanying text (discussing New Jersey Supreme Court substituted judgment doctrine and various tests employed to ratify surrogate decisionmaking).

100. *See, e.g.*, Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 755 n.18, 370 N.E.2d 417, 432 n.18 (1977) (declining invitation to formulate comprehensive guidelines applicable to emergency medical situations involving incompetent patients because this decision is better left to legislature); *In re Farrell*, 108 N.J. 355, 360-62, 529 A.2d 404, 416-17 (1987) (O’Hern, J., concurring) (stating that trial courts may not cite absence of clear legislative guidance as excuse to avoid ruling on such issues); *In re Conroy*, 98 N.J. 321, 345, 486 A.2d 1209, 1221 (1985) (noting absence of specific legislation governing termination of life-sustaining treatment); *In re Storar*, 52 N.Y.2d 363, 382-83, 420 N.E.2d 64, 73-74, 438 N.Y.S.2d 266, 276 (1981) (concluding that courts may declare rights under existing law, but recognizing that enlarging role of court in cases involving termination of life-sustaining treatment should come from legislature).


102. *Uniform Rights of the Terminally Ill Act*, 9B U.L.A. 68 (Supp. 1990) (URTIA); *see Chapman, supra* note 101, at 347-49 (discussing development of URTIA). In 1983, an appointed twelve-member committee of the Uniform Law Commissioners (ULC) began drafting the new law. *See id.* at 347-48 (providing details of drafting procedure). A majority of states present, but no fewer than 20, was required to approve the draft before it was officially adopted by the ULC. *Id.* at 349. The URTIA was approved in August of 1985 with 37 states voting in favor of the Act and 10 against. *See Marzen, The “Uniform Rights of the Terminally Ill Act”: A Critical Analysis, 1 Issues L. & Med. 441, 441 n.1 (1986)* (listing states voting for or against approval). Two states abstained and three states failed to vote. *Id.*

103. Section 2 of the URTIA provides:
operative when they are communicated to the attending physician and that doctor determines that the patient is in a terminal condition and is no longer capable of making decisions regarding life-sustaining treatment. The URTIA, however, is limited in scope and provides no guidance for situations involving significant categories of patients. The URTIA does not encompass minors, persons who have not executed a declaration before becoming ill, adults who have never been capable of executing medical directives, and non-terminal patients who will never regain consciousness. The URTIA fails, therefore, to address the problem raised in Storar, O'Connor, Quinlan, Conroy, and Jobs: the failure to enunciate substantive and procedural guidelines for courts to follow when a patient has not executed a prior declaration concerning the withholding or withdrawal of medical treatment.

Living will laws are designed to protect patient choice by permitting individuals to execute a document expressing their own wishes regarding life-sustaining treatment. Living wills describe patients' treatment choices in specific situations should they become

(a) An individual of sound mind and [18] or more years of age may execute at any time a declaration governing the withholding or withdrawal of life-sustaining treatment. The declarant may designate another individual of sound mind and [18] or more years of age to make decisions governing the withholding or withdrawal of life-sustaining treatment. The declaration must be signed by the declarant, or another at the declarant's direction, and witnessed by two individuals.

(b) A declaration directing a physician to withhold or withdraw life-sustaining treatment may but need not be in the following form:

DECLARATION

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


104. Id. § 3, at 73.

105. See Chapman, supra note 101, at 350 (indicating URTIA fails to address rights of substantial number of patients).

106. Id.


For example, the form created by the Society for the Right to Die provides:

A Living Will

I, ——, being of sound mind, make this statement as a directive to be followed if I become permanently unable to participate in decisions regarding my medical care. These instructions reflect my firm and settled commitment to decline medical treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw treatment that serves only
incapable of expressing their views at the time a decision must be made. 108 Living will statutes often define the conditions under which such documents become effective. These statutes typically conclude that the patient must be in a "terminal condition." 109 The URTIA defines terminal condition as a permanent medical condition requiring provision of life-sustaining treatment to prevent imminent death. 110 The URTIA leaves to individual statutes the responsibility for listing specific medical procedures included within the definition of life-sustaining treatment, as well as specifying witness procedures and immunity provisions for health care providers who follow the directives of the living will. 111 Notwithstanding the availability of statutorily delineated procedures, many individuals do not have the foresight or desire to set forth their personal treatment to prolong the process of my dying, if I should be in an incurable or irreversible mental or physical condition with no reasonable expectation of recovery.

These instructions apply if I am (a) in a terminal condition; (b) permanently unconscious, or (c) if I am conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing treatment.

While I understand that I am not legally required to be specific about future treatments, if I am in the condition(s) described above I feel especially strongly about the following forms of treatment:

I do not want cardiac resuscitation.
I do not want mechanical respiration.
I do not want tube feeding.
I do not want antibiotics.
I do not want maximum pain relief.

Other directions (insert personal instructions):

These directions express my legal right to refuse treatment under the law of New York State. I intend my instructions to be carried out, unless I have rescinded them in a new writing or by clearly indicating that I have changed my mind.

Signed:___________Date:__________
Witness:________________________
Address:________________________
Witness:________________________
Address:________________________


Although the sample provided applies to New York law, currently 40 states and the District of Columbia have living will statutes. See supra note 2 (enumerating living will statutes); McMillion, The Right to Terminate Care, A.B.A.J., Oct. 1990, at 134 (reviewing legislative initiatives involving medical treatment decisions). The Society's will has no statutory basis under any state law. Collin, supra note 4, at ¶ 504.1. It may, however, provide important guidance to a surrogate decisionmaker exercising substituted judgment and provide clear and convincing evidence of an incompetent patient's intent. Id.

108. J. Murphy, supra note 107, ch. 20, § A2, at 20-5 (discussing living will forms).
109. See URTIA § 3, 9B U.L.A. 68, 73 (Supp. 1990) (providing uniform requirements after which living wills become effective including confirmation of patient's terminal status).
110. Id. § 1, at 68. The URTIA defines "terminal condition" as "an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physicians, result in death within a relatively short time." Id.
111. See generally J. Murphy, supra note 107, § C (discussing contents of health care directives and providing forms for protecting patient choice in medical treatment cases).
decisions in a living will. Treatment decisions are therefore limited not only by the narrow scope of living will laws, which are generally applicable only to patients facing imminent death or terminal illness, but also by the fact that many individuals will not have executed a living will prior to an event rendering them incompetent.

The limitations of living wills have caused many state legislatures to enact specific durable power of attorney statutes to protect health care decisions. A Durable Power of Attorney for Health Care (DPAHC) allows a competent individual to appoint another person to make decisions regarding life-sustaining treatment should the person become incompetent. While a living will itself provides

112. It appears that only 15 to 20% of adult Americans have written a living will. Schultz, Ruling Draws the Worried to 'Living Wills', Wall St. J., June 29, 1990, at Cl, col. 3 (citing American Medical Association estimate); McCrory & Botkin, Hospital Policy on Advance Directives: Do Institutions Ask Patients About Living Wills?, 262 J. A.M.A. 2411, 2411 (1989) (reporting poll indicating that while 56% of respondents had expressed preferences to their families, only 15% claimed to have completed living wills).


114. See Collin, supra note 4, ¶ 500.1 (indicating that all 50 states and District of Columbia have general durable power of attorney statutes); see also McMillion, supra note 107, at 134 (stating that in past two years, 32 states have enacted specific health care power of attorney laws in response to living will statutory limitations); Katzeff, States Go to Work After Cruzan, Nat'l LJ., Sept. 24, 1990, at 16, col. 1 (contending that number of states enacting such durable power of attorney acts has doubled in past year). Unlike durable powers of attorney, traditional powers of attorney become invalid when the maker of the power of attorney becomes incapacitated. See Collin & Meyers, Using a Durable Power of Attorney for the Authorization of Withdrawal of Medical Care, 11 EST. PLAN. 282, 282 (1984) (advocating use of durable power of attorney to authorize withdrawal of medical treatment).

the decision on medical treatment for the patient, a DPAHC designates another individual to dictate medical treatment decisions for the patient. As with the URTIA and living wills, a DPAHC is only useful when an individual has decided to execute it. Several states have reacted to this deficiency by including surrogate decision-making provisions in their statutes that authorize certain individuals to make health care decisions on behalf of incompetent patients.


116. See Katzeff, supra note 114 (noting differences between living wills and durable powers of attorney). The durable power of attorney is seen as politically preferable to living wills because right to die opponents believe the power of attorney may better protect individual patients' rights from abuse. Id.; see also Collin, supra note 4, §§ 504-504.3 (discussing differences between advance directives, living wills, and durable power of attorney for health care).

State courts have supplemented these statutory rights by specifically addressing whether an incompetent individual may have life-sustaining treatment withheld or withdrawn without any previously-initiated directive by the patient. Nevertheless, clear legislative guidance protecting an individual’s interests, in the absence of clear expression of intent, remains absent.

III. Cruzan v. Director, Missouri Department of Health

A. Factual Background and Lower Court Holdings

On January 11, 1983, Nancy Beth Cruzan was severely injured in an automobile accident. After transporting her to the hospital, doctors diagnosed Cruzan as suffering from severe brain damage resulting from the impact of the collision and lack of oxygen to the brain. To aid in her recovery and to provide nourishment, doc-

medical directive); Virginia Natural Death Act, Va. Code Ann. § 54.1-2986 (1988) (providing procedure in absence of declaration for surrogate health care decisionmaking); see also URTIA § 7, 9B U.L.A. 68, 76-77 (Supp. 1990) (outlining requirements for valid consent by others for withdrawal or withholding of treatment). These statutory surrogate provisions provide a procedure by which an attending physician may obtain consent to withhold or withdraw life-sustaining treatment in the absence of an effective declaration by the incompetent patient. Id. § 7 comment, at 77. Moreover, these statutes guide the attending physician or other health care provider in determining who should be contacted for consent to withdraw or withhold life-sustaining treatment. Id.

118. See supra notes 65-70 and accompanying text (setting forth illustrative case law in Conroy).

119. Cruzan v. Harmon, 760 S.W.2d 408, 410-11 (Mo. 1988) (en banc) (noting accident caused Cruzan’s vehicle to overturn and throw her 35 feet from vehicle), aff’d, Cruzan v. Director, Mo. Dep’t of Health, 110 S. Ct. 2841 (1990).

120. Id. at 411. The trial court made the following factual findings about Nancy Cruzan:

1. That her respiration and circulation are not artificially maintained and within essentially normal limits of a 30-year-old female with vital signs recently reported as BP 130/80; pulse 78 and regular; and respiration spontaneous at 16 to 18 per minute.

2. That she is oblivious to her environment except for reflexive responses to sound and perhaps to painful stimuli.

3. That she has suffered anoxia of the brain resulting in massive enlargement of the ventricles filling with cerebro-spinal fluid in the area where the brain has degenerated. This cerebral cortical atrophy is irreversible, permanent, progressive, and ongoing.

4. That her highest cognitive brain function is exhibited by her grimacing perhaps in recognition of ordinary painful stimuli, indicating the experience of pain and her apparent response to sound.

5. That she is a spastic quadriplegic.

6. That she has contractures of her four extremities which are slowly progressive with irreversible muscular and tendon damage to all extremities.

7. That she has no cognitive or reflexive ability to swallow food or water to maintain her daily essential needs. That she will never recover her ability to swallow sufficient [sic] to satisfy her needs.

tors inserted a gastrostomy tube.\textsuperscript{121} Cruzan remained in a coma for three weeks and then showed some signs of improvement. Further rehabilitative efforts failed, however, and her condition ultimately required that all nutrition and hydration be administered through the gastrostomy tube.\textsuperscript{122}

Nearly five years after her accident, Cruzan's parents, as her appointed guardians, sought court approval to discontinue further nutrition and hydration to their daughter.\textsuperscript{123} The trial court emphasized that, before a person may be declared incapacitated and have a guardian appointed, both the due process clause of the United States Constitution and the Missouri living will statute require clear and convincing evidence of physical and mental incapacitation.\textsuperscript{124} Thus, this standard is the minimum showing required for the court to authorize the guardians to discontinue life-sustaining nutrition and hydration of their ward.\textsuperscript{125}

The court concluded that the Cruzans met this standard.\textsuperscript{126} Public policy, however, as enunciated by the Missouri legislature, prohibited withholding or withdrawing nutrition or hydration.\textsuperscript{127} Nevertheless, the trial court determined that there is a fundamental "right to liberty" expressed in the Missouri constitution which permits an individual to refuse or direct withdrawing or withholding artificial medical treatment.\textsuperscript{128} To deny Cruzan's guardians the authority to withdraw her nutrition and hydration would deprive

\textsuperscript{121} Cruzan v. Harmon, 760 S.W.2d 408, 411 (Mo. 1988) (en banc), aff'd, Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841 (1990).

\textsuperscript{122} Id.


\textsuperscript{124} Id. at A96-A97. The fourteenth amendment provides:

\begin{quote}
No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.
\end{quote}

U.S. CONST. amend. XIV, § 1 (emphasis added).

\textsuperscript{125} App. to Petition for Cert. at A97, Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988) (No. 70813) (Mar. 13, 1989).

\textsuperscript{126} Id. The court reasoned that Cruzan's serious thoughts expressed to a friend prior to her accident, in which she related that if she were sick or injured she would not wish to continue her life, suggested that in her present condition she would not wish to continue treatment. Id. at A97-A98.

\textsuperscript{127} Id. at A98; see Mo. ANN. STAT. §§ 459.10(3) (West Supp. 1990) (excluding procedures involving nutrition or hydration from death-prolonging procedures that may be withheld or withdrawn).

\textsuperscript{128} App. to Petition for Cert. at A98-A99, Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988) (No. 70813) (Mar. 13, 1989) (citing Mo. CONST. art I, §§ 2, 10). The court rationalized that such death-prolonging procedures may only be withheld where no injury to innocent third parties occurs, no homicide or suicide results, and good ethical standards in the medical
Nancy Cruzan of equal protection of the law. The court, therefore, directed the hospital to honor the family’s request.129

The Missouri Supreme Court reversed.130 In a divided decision, the court held that the guardians did not have the authority to order withdrawal of Cruzan’s nutrition and hydration, primarily because the right of privacy under the state constitution did not allow refusal of treatment in every case.131 Similarly, the court found no such right under the United States Constitution.132

The majority reasoned that the right to refuse medical treatment must be balanced against appropriate state interests, and that the Missouri living will statute embodies a strong state policy favoring the preservation of life.133 Since Cruzan was not terminally ill, had a life-expectancy of thirty more years, and was not in physical pain, the court held that the burden of her treatment did not outweigh the state’s vital interest in sustaining her life.134 The Missouri Supreme Court found that Cruzan’s statements to a friend regarding her desire to die under certain circumstances were informal reactions to the medical treatment or conditions of others and did not constitute a clear and convincing expression of her intent.135 Absent inherently reliable evidence that an incompetent person would want nutrition and hydration discontinued, the court held that no other person could compel such a choice.136 Finding no legal basis for the Cruzans to terminate Nancy’s medical care, and given the strong state policy favoring life, the court denied the Cruzans the right to disconnect her artificial nutrition and hydration.137 The United States Supreme Court granted certiorari to consider whether the Constitution permitted patients or their guardians to direct the

professions are maintained. Id. at A98. The court found no such problems present in this case. Id.

129. Id. at A99-A100.
131. Id. at 417.
132. Id. at 418 (noting Supreme Court has not extended right of privacy to permit patient or guardian to direct withdrawal of nutrition and hydration).
133. See id. at 419-20 (regarding state’s interest in life as unqualified without regard to quality of life); see also supra note 81 (discussing general state interests usually weighed against right to forgo life-sustaining treatment). See generally Mo. Ann. Stat. §§ 459.010 to .055 (West Supp. 1990) (providing text of Missouri act).
134. See Cruzan v. Harmon, 760 S.W.2d 408, 424 (Mo. 1988) (en banc) (characterizing state’s interest in life as immense), aff’d, Cruzan v. Director, Mo. Dep’t of Health, 110 S. Ct. 2841 (1990).
135. Id. at 424 (citing In re Jobes, 108 N.J. 394, 412-13, 529 A.2d 434, 443 (1987), to demonstrate probative value of prior statements offered to prove intent).
136. Id. at 426.
137. Id. (recognizing necessity for comprehensive legislation on right-to-die issue and declining to inject court into legislative arena by formulating piecemeal guidelines).
withholding or withdrawal of medical treatment.¹³⁸

B. The Decision of the Supreme Court of the United States

1. The majority decision

The United States Supreme Court affirmed the decision of the Missouri Supreme Court.¹³⁹ The majority found that a competent person has a constitutionally protected liberty interest in refusing life-sustaining nutrition and hydration.¹⁴⁰ Nevertheless, the Court rejected the assertion that an incompetent person should possess the same right and concluded that the United States Constitution did not preclude Missouri from requiring clear and convincing evidence of an incompetent patient's prior directives concerning withholding or withdrawing medical treatment.¹⁴¹

¹⁴⁰. Id. at 2852 (reading this conclusion with prior decisions, including Jacobson v. Massachusetts, 197 U.S. 11, 24-30 (1905) (balancing individual's liberty interest in declining smallpox treatment against state's interest in preventing disease)). The Court discussed a substantial body of state case law that based the right to refuse treatment on the common law doctrine of informed consent, a constitutional right of privacy, or statutory authority. See id. at 2846-51 (tracing common law basis for right not to consent to treatment and analyzing right to refuse treatment decisions). The majority opinion acknowledged that at common law, the mere touching of an individual by another without consent and without legal justification constituted battery. Id. at 2846 (citing W. KEETON, D. DOBBs, R. KEETON & D. OWEN, PROSSER AND KEETON ON THE LAW OF TORTS, § 9, at 39-42 (5th ed. 1984 & Supp. 1988). The court reasoned that the notion of bodily integrity, embodied in the doctrine of informed consent, includes a patient's right not to consent, i.e., to refuse medical treatment. Id. at 2846-47.

The majority thereafter surveyed a significant body of cases involving the right to refuse treatment. Id. at 2847-51; see, e.g., Conservatorship of Drabick, 200 Cal. App. 3d 185, 208, 245 Cal. Rptr. 840, 854-55 (finding statutory basis for removal of nasogastric feeding tube), cert. denied, 488 U.S. 958 (1988); In re Estate of Longeway, 153 Ill. 2d 33, 49-51, 549 N.E.2d 292, 299-300 (1989) (opting for substituted judgment standard rather than rigid expressed intent standard, and thus allowing consideration of other clear and convincing evidence of patient's intent); Superintendent of Belchertown State School v. Saikewicz, 375 Mass. 122, 370 N.E.2d 417, 424 (1977) (basing decision to permit withholding of treatment on right of privacy and right of informed consent and determining that incompetent individual's rights must be protected by substituted judgment standard); In re Conservatorship of Torres, 357 N.W.2d 332, 337-38 (Minn. 1984) (authorizing removal of incompetent patient's respirator as supported by constitutional and statutory authority and in patient's best interest); In re Conroy, 98 N.J. 321, 348, 361-68, 486 A.2d 1209, 1223, 1229-33 (1985) (recognizing federal right of privacy might apply, but basing decision to remove feeding tube on common law right to self-determination and informed consent and setting forth subjective and objective "best interest" analyses to protect patient's rights); In re Quinlan, 70 N.J. 10, 38-42, 355 A.2d 647, 662-64, cert. denied, 429 U.S. 922 (1976) (recognizing qualified right to privacy grounded in federal Constitution to terminate treatment); In re Westchester County Medical Center ex rel. O'Connor, 72 N.Y.2d 517, 530, 531 N.E.2d 607, 613, 534 N.Y.S.2d 886, 892 (1988) (rejecting substituted judgment approach and requiring clear and convincing evidence of patient's expressed intent to withhold or withdraw treatment); In re Storar, 52 N.Y.2d 363, 376-77, 420 N.E.2d 64, 70, 438 N.Y.S.2d 266, 272 (declining to base right to refuse medical treatment on constitutional right to privacy, and instead requiring clear and convincing evidence of prior statements made by patient regarding withdrawal of medical treatment), cert. denied, 454 U.S. 858 (1981).

The Court accepted Missouri's reliance on its interest in the protection and preservation of human life as support for implementing the clear and convincing standard. The Court noted that where the choice between life and death would be made on behalf of the incompetent patient, Missouri could legitimately impose a higher evidentiary standard to protect the personal element of choice. The Court further held that a state may decline to assess the quality of life an individual might enjoy and may assert an unqualified interest in the preservation of life to be weighed against the constitutionally protected liberty interest of the individual.

The Court determined that Missouri permissibly sought to advance its interests by adopting the clear and convincing standard of proof for treatment termination inquiries. This standard reflects the seriousness of the proceeding and places the burden of avoiding an erroneous decision upon those seeking to terminate an incompetent individual's life-sustaining treatment. The Court agreed with the Missouri Supreme Court's conclusion that the evidence offered at trial—that Cruzan would not have wanted her nutrition and hydration to continue—was insufficient to satisfy the clear and convincing standard.

The majority also concluded that the due process clause of the Constitution does not require a state to accept the substituted judgment of close family members on behalf of an incompetent patient. The Court reasoned that no assurance exists that the views

Rehnquist authored the opinion in which Justices White, O'Connor, Scalia, and Kennedy joined.

142. Cruzan, 110 S. Ct. at 2852.
143. Id. at 2852-53. The majority added that not all incompetent patients will have a surrogate decisionmaker acting in their best interests and the state may guard against potential abuses. See id. (citing In re Jobes, 108 N.J. 394, 419, 529 A.2d 434, 447 (1987) (noting these exceptional circumstances mandate appointment of guardian)).
144. Id. at 2853. See generally Procaccino, Life v. Quality of Life: The Dilemma of Emerging Medical-Legal Standards, 29 MED. TRIAL TECH. Q. 45 (1983) (analyzing ethical, medical, and legal problems in weighing quality of life as measure for life worthy of protection).
145. Id. at 2853.
146. See id. at 2854 (citing Santosky v. Kramer, 455 U.S. 745, 755 (1982)) (suggesting that minimum standard of proof tolerated by due process clause reflects not only weight of private and public interests affected, but also acts as societal judgment about how risk of error should be distributed between litigants).
147. Cruzan, 110 S. Ct. at 2855.
148. Id. at 2855. The Court rejected claims by the Petitioner that Michael H. v. Gerald D.,
of the substitute decisionmaker would necessarily reflect those of the patient's. The due process clause does not require the state to place the decision to withhold or withdraw medical treatment on anyone other than the individual; thus, Missouri's clear and convincing standard effectuates this scheme.

2. The concurring opinions

In a concurring opinion, Justice O'Connor agreed that individuals possess a protected liberty interest in refusing medical treatment and that this interest encompasses the right to refuse nutrition and hydration. Justice O'Connor added, however, that it is likely the state would be constitutionally required to give effect to the decisions of a surrogate decisionmaker. Justice O'Connor reiterated that *Cruzan* does not foreclose this determination, nor does it prevent states from developing and implementing other approaches for protecting an incompetent individual's liberty interest in refusing medical treatment. Most importantly, Justice O'Connor noted that the Court decided only that Missouri's procedure does not violate the Constitution and that further responsibility for developing appropriate procedures for protecting incompetent individuals' liberty interests resides with the states.

In a separate concurrence, Justice Scalia agreed with the Court's...
analysis, but expressed concern that the majority opinion would only confuse future legislators trying to draft statutes to resolve the problem of medical decisionmaking for incompetent patients. Justice Scalia added that under American law states have always had the power to prohibit suicide, and, even if clear and convincing evidence demonstrates that a patient no longer desired life-sustaining treatment, elected representatives of Missouri should decide whether to honor that choice. Justice Scalia specifically asserted that the issue raised in Cruzan was not set forth in the due process clause and the Court, therefore, lacked any authority to inject itself into this field.

3. The dissenting opinions

Justice Brennan, in a dissent joined by Justices Marshall and Blackmun, argued that the liberty interest in refusing medical treatment is fundamental because it “involves one of the basic civil rights of man,” and is “deeply rooted in this nation’s history and tradition.” The dissent insisted that Cruzan’s incompetence did not deprive her of fundamental rights. Although Justice Brennan asserted that the right to refuse unwanted medical treatment is not absolute, he concluded that no state interest could outweigh the individual rights of a person in Cruzan’s condition. Brennan concluded that the state’s general interest in the preservation of life should yield to Cruzan’s “particularized and intense interest in self-determination in her choice of medical treatment.”

Justice Brennan rejected the majority’s conclusion that Missouri’s clear and convincing standard advanced substantive state inter-

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155. Cruzan, 110 S. Ct. at 2859 (Scalia, J., concurring). Justice Scalia suggested the Court’s approach was “poised to confuse that enterprise as successfully as [it had] confused the enterprise of legislating concerning abortion.” Id.

156. See id. at 2859-62 (Scalia, J., concurring). The petitioner maintained that Cruzan’s case could be distinguished from ordinary suicide: Cruzan remained permanently incapacitated and in pain; she would bring about her death not by any affirmative act but by merely declining nourishment; and, preventing her from effectuating her presumed wish to die violated her bodily integrity. Id. at 2860 (Scalia, J., concurring). Justice Scalia found none of these distinctions sufficient. Id. at 2860-62 (Scalia, J., concurring).

157. Id. at 2859 (Scalia, J., concurring).

158. Id. at 2863 (Scalia, J., concurring).


160. Id. at 2867 (Brennan, J., dissenting).

161. Id. at 2869 (Brennan, J., dissenting) (stating that Missouri does not claim that society as whole would be benefited, that any other party’s situation would be improved, or that harm to third parties would be averted by continuing Cruzan’s treatment).

162. Id. at 2870 (Brennan, J., dissenting).
He criticized the Missouri procedure for discounting the evidence offered in support of terminating treatment and questioned the exclusion of relevant evidence of her intent. Moreover, Brennan added, the majority did not specifically detail what evidence would be sufficient to satisfy the clear and convincing standard and thereby upheld an evidentiary procedure that will often impede the right of most patients to forgo life-sustaining treatment.

Justice Brennan further noted that Missouri is essentially the only state to institute a system of safeguarding the interests of incompetent patients in which the likelihood of accurately determining those interests is actually lessened. He disagreed with the proposition that when it is impossible to determine an incompetent patient's choice, the state's role as parens patriae permits the state to make the decision itself. Rather, he asserted, the due process clause requires that if an incompetent individual's medical treatment intentions are unclear, the state must either delegate the choice to the person the patient would have most likely appointed as proxy or leave the decision to the patient's family.

In a separate dissent, Justice Stevens asserted that the Constitution...
tion requires Missouri to provide Cruzan with care that respects her own "best interests." Justice Stevens found that Missouri unreasonably intruded upon traditionally private matters encompassed within the liberty interest protected by the due process clause. The majority limited the right to refuse unwanted medical care to individuals with the foresight to make an unambiguous expression of their decisions while competent. According to Justice Stevens, the Missouri procedure failed to bear a reasonable relationship to any legitimate state concern because it attempted to define rather than to protect life. Finally, he concluded that the meaning and completion of Cruzan's life "should be controlled by persons who have her best interests at heart—not by a state legislature concerned only with the 'preservation of human life.'"

IV. AN EVALUATION OF CRUZAN v. DIRECTOR, MISSOURI DEPARTMENT OF HEALTH

A. Cruzan and Patients' Rights

1. The "right of privacy" and incompetent patients

Had the United States Supreme Court chosen to overrule the Missouri decision, Cruzan v. Harmon, the Court would have been required to find that the United States Constitution compelled Missouri to order Nancy Cruzan's physicians to follow the instructions of her family. The Court has never held, however, that a generalized right of privacy under the Constitution encompasses the right to refuse treatment. In Cruzan, the Court acknowledged that state courts have often applied constitutional privacy arguments as well as common law doctrine to resolve treatment decision

169. Cruzan, 110 S. Ct. at 2879 (Stevens, J., dissenting).
170. Id. at 2882 (Stevens, J., dissenting) (agreeing with Judge Blackmar's dissent in Missouri Supreme Court's decision in Cruzan v. Harmon).
171. Id. at 2883 (Stevens, J., dissenting).
172. Id. at 2886 (Stevens, J., dissenting). Justice Stevens argued that a state may not "circuit the liberties of the people by regulations designed wholly for the purpose of establishing a sectarian definition of life." Id. at 2888 (Stevens, J., dissenting) (citing Webster v. Reproductive Health Servs., 109 S. Ct. 3040, 3082-85 (1989) (Stevens, J., dissenting)).
173. Id at 2892 (Stevens, J., dissenting).
174. See id. at 2852 (analyzing Petitioner's argument that incompetent person who is unable to make choice to exercise right to refuse treatment must have such right exercised through surrogate). The Missouri Supreme Court considered this argument but rejected it. See Cruzan v. Harmon, 760 S.W.2d 408, 417-18 (Mo. 1988) (en banc) (finding no such right under state constitution and expressing doubts whether it exists under federal Constitution), aff'd, Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841 (1990).
175. Mayo, supra note 6, at 111-25 (tracing early development of right of privacy and concluding Court's decisions do not provide basis for extending privacy protection to medical decisionmaking). Numerous state courts, however, have held that the federal Constitution supports such a conclusion. See Rasmussen ex rel. Mitchell v. Fleming, 154 Ariz. 207, 215 n.8, 741 P.2d 674, 682 n.8 (1987) (listing cases holding constitutional right applicable).
cases. The Court, nevertheless, declined to endorse the privacy approach and analyzed the issue of medical treatment decisions in terms of an individual's fourteenth amendment liberty interest. The Court's conclusion should not have been entirely unexpected, given its hesitancy to extend the right of privacy beyond the sphere of marriage, procreation, and family.

The validity of the Court's decision rests upon whether an incompetent patient should possess the same rights regarding medical decisionmaking as a competent patient. Although recognizing that a competent person may refuse medical treatment, the Court refused to assign similar protections to an incompetent person. The Court's conclusion is justified because there is no way to protect an incompetent patient's right to refuse treatment in the absence of the patient's intent other than by resorting to a legal fiction designed to assess what the incompetent person would have done if competent. Any constitutional claim arising from the theory of personal autonomy has no application, therefore, to the incompetent patient. Missouri avoids this legal fiction by establishing a procedural requirement that an incompetent patient's statements


177. See id. at 2851 n.7 (citing Bowers v. Hardwick, 478 U.S. 186, 194-95 (1986)) (exhibiting Court's reluctance to take expansive view of its authority to find new fundamental rights); see also Comment, supra note 5, at 1387-95 (concluding constitutional right of privacy does not protect patient's right to refuse life-supporting medical treatment).

178. See supra notes 18-22 and accompanying text (discussing Court's development of right of privacy and noting limits of privacy right); see also Bowers v. Hardwick, 478 U.S. 186, 194 (1986) (expressing specific reluctance to discover new fundamental rights within fourteenth amendment due process clause).

179. Cruzan, 110 S. Ct. at 2852 (explaining that constitutionally protected right to refuse life-saving treatment is contingent upon "informed and voluntary choice," however, an incompetent person is incapable of making such a choice).

180. See Taylor, Muddling Through Medicine, Legal Times, Jul. 23, 1990, at S27, col. 1 (discussing "conceptual corner" into which dissent's argument leads). Taylor noted an apparent inconsistency in Justice Stevens' argument that Cruzan no longer had a constitutionally protected interest in life, because she was practically dead, yet her liberty interest in freedom from unwanted treatment inexplicably survived. Id.

The legal fiction concept is best illustrated by Superintendent of Belchertown State School v. Säkewicz, which involved an individual who was severely retarded since birth. Superintendent of Belchertown State School v. Säkewicz, 373 Mass. 728, 750-53, 370 N.E.2d 417, 430-32 (1977). Although someone in Säkewicz's condition could never have the capacity to express any views regarding medical care, the court nonetheless extended the general right to refuse medical treatment to the mentally incompetent patient. Id. at 745, 370 N.E.2d at 427. The court applied a substituted judgment analysis designed to give effect to the decision that would be made by the incompetent if competent; an analogy which, in reality, is clearly impossible. Id. at 750-53, 370 N.E.2d at 430-31. But see In re Storar, 52 N.Y.2d 363, 380-83, 420 N.E.2d 64, 72-74, 438 N.Y.S.2d 266, 274-76 (rejecting judicial self-deception present in Säkewicz), cert. denied, 454 U.S. 858 (1981).

concerning the withdrawal or withholding of medical treatment be proved by clear and convincing evidence. The Supreme Court correctly resisted the temptation to find that autonomy encompasses an incompetent patient's right to refuse treatment, thereby avoiding the judicial self-deception that occurs when a third party exercises autonomy on behalf of the incompetent patient. In so doing, the Court did not preclude all incompetent patients from having their decisions respected. The Court merely concluded that Cruzan's prior statements did not meet the standard established by Missouri to protect its interest in preserving life, and that, as applied, the standard was constitutional.

2. What is left of substituted judgment?

The substituted judgment approach has been applied to encompass treatment decisions on behalf of incompetent patients. The Supreme Court, however, did not accept the premise that Missouri must accede to the substituted judgment of close family members in the absence of substantial proof that the family members' decisions reflect the views of the patient. The Court correctly stated that the due process clause places the decision to terminate treatment solely with the patient. The majority, however, found no assurance that the views of close family members would be the same as those of the patient had the patient made a treatment decision while competent. A more appropriate alternative would require courts to adopt a presumption in favor of family choice and to place the burden of showing the unreasonableness of the family decision upon the attending physician.

182. See Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. at 2841, 2852 (1990) (holding federal Constitution does not bar establishment of clear and convincing standard as safeguard).

183. See Bradley, Does Autonomy Require Informed and Specific Refusal of Life-Sustaining Treatment?, 5 Issues L. & Med. 301, 304 (1989) (stating autonomy often used as legal fiction to shield from view true bases of courts' decisions). For example, courts attempt to transform a decision by a surrogate to end the life of the patient into an exercise of the patient's autonomy. Id. at 305; see Ellman, supra note 181, at 396-99 (arguing courts should avoid legal fiction that others are actually vindicating patient's own rights when they decide to terminate treatment for patient). Professor Ellman asserts that the interests of incompetent patients are actually threatened, not advanced, when others are given a constitutional right to decide on the incompetent patient's care. Id.; see also Johnson, supra note 14, at 708-09 (noting inherent limitations of applying self-determination or autonomy as model for medical treatment decisionmaking for incompetent patients).

184. See supra notes 38-98 and accompanying text (reviewing substituted judgment approach as applied by New Jersey Supreme Court); supra notes 115, 117 (listing statutes designed to effectuate surrogate decisionmaking for incompetent patients).

185. Cruzan, 110 S. Ct. at 2855-56.

186. Id. at 2855.

187. Id. at 2856.

188. See Rhoden, supra note 97, at 437-45 (advocating strong case for family discretion).
In her concurring opinion, Justice O'Connor sought to clarify the Court's position concerning substituted judgment. Justice O'Connor emphasized that the Court did not foreclose a later determination that the due process clause compels a state to give effect to the decisions of a substitute decisionmaker. Her opinion emphasizes the limited scope of the Court's decision and clearly addresses the need for further legislative action to ensure that surrogate decisions for the incompetent patient are allowed and followed.

B. What the Cruzan Decision Did Not Do

First, the Court did not eliminate the "right to die." Cruzan presented the Court with an incompetent patient who had not left clear and convincing evidence establishing her intent to terminate treatment. Many state legislatures may reach, or have already reached, a different conclusion than Missouri, and may support an incompetent patient's right to refuse medical treatment. Cruzan does not eliminate a more expansive right to die in these other states. Nor does the decision prevent other states from applying a lower standard of proof to determine a patient's intent or merely deferring to the decisions of close family members.

Second, the Court did not distinguish between administered nutrition and hydration and other life-sustaining measures such as artificial respiration. The Missouri Supreme Court previously found a moral and legal difference between care provided by artificial hy-
dration and nutrition and other medical care.\textsuperscript{194} Although this distinction was not at issue in \textit{Cruzan}, the Supreme Court’s remarks regarding nutrition and hydration as indistinguishable from other forms of treatment may deter the passage of legislation maintaining such a distinction.\textsuperscript{195}

Finally, \textit{Cruzan} does not prevent incompetent patients who have expressed their intent in advance from having their constitutionally protected liberty interest in refusing unwanted medical treatment enforced.\textsuperscript{196} The Court’s conclusion in \textit{Cruzan}, however, should alert state legislatures that standards enumerated in their own statutes must be reevaluated and, if necessary, amended to protect the interests of incompetent patients who may not have provided clear expressions of their decisions regarding medical care.

Justice Stevens, in his dissent, insisted that the majority’s conclusions should have compelled the Court to require that Cruzan’s caretaker respect her own best interests.\textsuperscript{197} He articulated two cogent arguments. First, no basis existed for the state to insist upon continued treatment if Cruzan had no interest in continued treatment. The termination of her treatment had no impact on third parties, and there was no reason to doubt the good faith of her guardians.\textsuperscript{198} Second, the best interests of the individual, especially

\begin{itemize}
  \item \textsuperscript{194} See Cruzan v. Harmon, 760 S.W.2d 408, 423-24 (Mo. 1988) (en banc) (weighing conflicting arguments on distinguishing artificial hydration and nutrition from other life-sustaining measures), aff’d, Cruzan v. Director, Mo. Dep’t of Health, 110 S. Ct. 2841 (1990).
  \item \textsuperscript{195} See Coyle, \textit{Is the Court Avoiding the Big Question?}, Nat’l L.J., July 9, 1990, at 24, col. 4 (discussing how \textit{Cruzan} decision bolstered position of right to die advocates by equating artificial nutrition and hydration with other forms of medical treatment). The Court did not specifically strike down the portion of the Missouri statute which distinguishes artificial nutrition and hydration from other “death-prolonging” procedures. See Mo. Ann. Stat. § 459.010 (Vernon Supp. 1990) (maintaining distinction). It is unclear how the Court would rule on this question. See Belkin, \textit{States Are a Patchwork Of Life-and-Death Laws}, N.Y. Times, June 26, 1990, at A19, col. 1 (analyzing state-to-state differences on types of treatment which may be terminated); see also Fluery, \textit{Cruzan Ruling To Shape N.J. Living Will Ban}, 126 N.J.L.J. 3, 3 (July 5, 1990) (suggesting Supreme Court’s ruling in \textit{Cruzan} may provide legal ground for dropping distinction between providing intravenous fluids and nutrition from other medical procedures under New Jersey law).
  \item \textsuperscript{196} See supra notes 101-17 and accompanying text (discussing legislation designed to protect incompetent patients’ interests by respecting prior directives of patient).
  \item \textsuperscript{197} Cruzan v. Director, Mo. Dep’t of Health, 110 S. Ct. 2841, 2879 (1990) (Stevens, J., dissenting). Justice Stevens argued that the Court Ironically permitted the state’s abstract interest in the preservation of life to overwhelm the best interests of Cruzan. \textit{Id.} (Stevens, J., dissenting). He insisted that the majority’s findings: that a competent individual’s decision to refuse life-sustaining treatment is a protected liberty interest, \textit{id.} at 2851-52; that upon a proper evidentiary showing, a duly appointed guardian may exercise such decisions on behalf of an incompetent ward, \textit{id.} at 2854-55; and that in resolving this tragic case the Court must “not . . . attempt, by any general statement, to cover every possible phase of the subject, \textit{id.} at 2851 (citing Twin City Bank v. Nebeker, 167 U.S. 196, 202 (1897)), mandated that Nancy Cruzan’s liberty to refuse treatment be evaluated in light of her particular circumstances. \textit{Id.} at 2879 (Stevens, J., dissenting).
  \item \textsuperscript{198} \textit{Id.} at 2880-81, 2891 (Stevens, J., dissenting); see \textit{id.} at 2870 (Brennan, J., dissenting) (positing that state’s general interest in life must accede to Cruzan’s particularized and in-
when supported by the interests of all other parties involved, should prevail over a general state policy that ignores those interests.\footnote{199} This alternative approach, if applied in Cruzan’s case, would have allowed her family to exercise the deeply personal decision to terminate her artificial nutrition and hydration.

\section*{C. Post-Cruzan Developments}

In \textit{In re Estate of Greenspan},\footnote{200} the first state high court ruling on the controversial right-to-die issue after \textit{Cruzan}, the Illinois Supreme Court held that food and water may be withheld from terminally ill patients as long as certain medical and legal requirements are met.\footnote{201} The medical requirements are that the incompetent patient’s attending physician and at least two other consulting physicians diaganose the patient as terminally ill and irreversibly comatose. The legal requirements are that, in the absence of an overriding state interest, the court receive clear and convincing evidence of what the incompetent would have decided if competent. The court explained that the testimony of doctors, family members, coworkers, and clergy would be sufficient evidence to establish that the incompetent patient’s “decision” would have been to withdraw medical treatment.\footnote{202} On remand, the trial court found that the tense interest in self-determination in her choice of medical treatment). The state has nothing to be gained by superceding her decision. \textit{Id.} (Brennan, J., dissenting); \textit{see also supra} note 81 (finding general interests of state should be balanced against individual’s right to refuse treatment).

\footnote{199} \textit{Cruzan}, 110 S. Ct. at 2889 (Stevens, J., dissenting). The majority erred, according to Stevens, by resolving Cruzan’s case in the abstract. \textit{See id.} (Stevens, J., dissenting) (proposing that Nancy Cruzan’s protected liberty interest must be understood in light of facts and circumstances particular to her).

\footnote{200} 137 Ill. 2d 1, 558 N.E.2d 1194 (1990).

\footnote{201} \textit{See In re Estate of Greenspan}, 137 Ill. 2d 1, 17-18, 558 N.E.2d 1194, 1202 (1990) (approving application of substituted judgment theory if plaintiff establishes clear and convincing evidence of patient’s intent to withdraw nutrition and hydration).

\footnote{202} \textit{See id.} at 4-10, 558 N.E.2d at 1196-98 (evaluating evidence on record). The Illinois court reiterated that:

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  \item pending any constitutionally permissible modification of the common law by the legislature, a surrogate can exercise the right for an incompetent only if:
  \begin{itemize}
    \item (1) the incompetent is terminally ill . . . i.e., the patient’s condition is incurable and irreversible so that death is imminent and the application of death-delaying procedures serves only to prolong the dying process;
    \item (2) the incompetent has been diagnosed as irreversibly comatose or in a persistent vegetative state;
    \item (3) the incompetent’s attending physician and at least two other consulting physicians have concurred in the diagnosis;
    \item (4) the incompetent’s right outweighs any interest of the State, as it normally does;
    \item (5) it is ascertained, by an appropriate means—e.g., by the procedure of substituted judgment on the basis of clear and convincing evidence . . . what the incompetent presumably would have decided, if competent, in the circumstances; and
    \item (6) a court enters an order allowing the surrogate to exercise the incompetent’s right to refuse the treatment.
  \end{itemize}
\end{itemize}
family had presented clear and convincing evidence that Sidney Greenspan would have refused life-sustaining treatment, if he were able, and permitted removal of the feeding tube.\textsuperscript{203} The Illinois court's ruling was consistent with the United States Supreme Court's holding in Cruzan that the decision to terminate medical care may be made contingent upon such a showing.

V. RECOMMENDATIONS

In Cruzan, the United States Supreme Court refused to create a fundamental constitutional right to die.\textsuperscript{204} Presumably, this refusal has alerted legislatures to the significant state-to-state differences between the types of treatment that may be discontinued and those that may not, and under what conditions an incompetent patient may have medical care withheld or withdrawn.\textsuperscript{205} The following proposals incorporate the substituted judgment theory, the best interest standards, and portions of the URTIA to meet the needs of incompetent patients. Alone, each approach fails to provide a fair process to protect the rights of the incompetent patient. Together, they provide a framework of uniform requirements that ensure a fair and practical means of protecting the liberty interest of individuals to refuse unwanted medical care. Legislatures should adopt statutory provisions that fulfill the objective of the following proposals.

First, a competent person is presumed to have a constitutionally

\textsuperscript{Id.} at 16, 558 N.E.2d at 1201 (citing In re Estate of Longeway, 133 Ill. 2d 33, 47-53, 549 N.E.2d 292, 298-301 (1989) (granting guardian of incompetent patient in irreversible coma right to refuse artificial nutrition and hydration on behalf of patient)).

\textsuperscript{203}. In re Estate of Greenspan, No. 67903 (Oct. 3, 1990) (unreported opinion).

\textsuperscript{204}. Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2852 (1990) (shifting focus away from “right to die” issue by conceding United States Constitution would grant competent individuals “a constitutionally protected right to refuse lifesaving hydration and nutrition”). The Court avoided the right to die issue by focusing on the constitutionality of Missouri's clear and convincing evidence standard required to terminate life-sustaining treatment of an incompetent patient. Id. at 2852-55. Justice Scalia, in his concurring opinion, forcefully articulated a desire to avoid the right to die issue. Id. at 2859-63 (Scalia, J., concurring). Justice Scalia maintains that:

the federal courts have no business in this field; that American law has always accorded the State the power to prevent, by force if necessary, suicide—including suicide by refusing to take appropriate measures necessary to preserve one’s life; that the point at which life becomes ‘worthless,’ and the point at which the means necessary to preserve it become ‘extraordinary’ or ‘inappropriate,’ are neither set forth in the Constitution nor known to the nine Justices of this Court any better than they are known to nine people picked at random . . . it is up to the citizens . . . to decide, through their elected representatives, whether [the decision to refuse life-sustaining treatment] will be honored.

Id. at 2859 (Scalia, J., concurring); see Mayo, supra note 6, at 151-55 (arguing that no such right should be recognized under federal constitutional law and opting instead for continued state sovereignty over issue).

\textsuperscript{205}. See Belkin, supra note 195, at A19, col. 1 (discussing regulations regarding termination of medical treatment).
protected right to refuse life-prolonging treatment. 206

Second, a person adjudged to be incompetent should be provided a surrogate decisionmaker who will make the final decision on the patient's behalf. Any prior designation of a surrogate by that individual, made while competent and by way of a living will, durable power of attorney, or other means designated by the state, should be given effect. 207

Third, to protect the interests of the incompetent patient, the surrogate decisionmaker should apply the following standards to best reflect the individualized treatment decisions required by the patient's particular circumstances:

If the patient leaves evidence, either by means of a living will, durable power of attorney, or other verifiable source sufficient to establish what the patient would have chosen if competent, the individual's wishes should be given effect under the substituted judgment theory. 208

If the patient has not provided sufficient evidence regarding intent as to medical care, the health care decision should be based on the patient's best interest. 209 This determination should consider the patient's family, friends, moral and religious values,

206. Both the common law right of self-determination and autonomous choice and the Supreme Court's recent conclusion that this interest is protected under the fourteenth amendment support this right to refuse treatment. See Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2851-52 (1990) (recognizing right to refuse treatment); In re Conroy, 98 N.J. 321, 355, 486 A.2d 1209, 1226 (1985) (holding competent adults have right to refuse any medical treatment, including life-sustaining treatment, regardless of age, medical condition, or prognosis); see also supra note 3 (citing cases recognizing competent individual's right to refuse unwanted medical treatment).

The procedures of the New Jersey Supreme Court in In re Farrell may be applied to ensure that individuals are competent and informed of their prognosis, any alternative treatments, and the risks involved, and to determine that the choice was voluntary and not coerced. See supra notes 76-82 and accompanying text (outlining procedures applicable to competent patient seeking to terminate treatment). This procedure involves an assessment of the individual's competency and the voluntariness of the decision by two non-attending physicians. In re Farrell, 108 N.J. 335, 354-56, 529 A.2d 404, 413-15 (1987).

207. See supra notes 101-17 and accompanying text (setting forth basic guidelines for surrogate decisionmaking under URTIA, living wills, and other health care proxies); see also supra notes 96-97 and accompanying text (summarizing how courts apply substituted judgment to surrogate decisionmaking).

208. Evaluation of the sufficiency of evidence from other verifiable sources may be made under a clear and convincing standard, or any lesser standard designed to ensure that the evidence actually reflects the incompetent patient's intent. See supra notes 23-37, 141-47 and accompanying text (discussing application of clear and convincing standard in Storar, O'Connor, and Cruzan); see also supra note 63 (elaborating on evidence sufficient to verify intent of incompetent patient).

209. See supra notes 65-70, 72-73 and accompanying text (discussing best interest approach in Conroy); see also Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2879, 2883, 2889 (1990) (Stevens, J., dissenting) (advocating procedure that requires general state interest in life to accede to particularized best interests of incompetent); Cantor, Conroy, Best Interests, and the Handling of Dying Patients, 37 Rutgers L. Rev. 543, 570-77 (1985) (advocating best interests standard to protect incompetent patients' rights).
medical prognosis, and any other factors relevant to the particular patient's set of circumstances.210

Fourth, in the absence of clear and convincing evidence to the contrary, the health care decisions of a close family member should be presumed to have been made in good faith.211

Fifth, these standards apply to all life-sustaining treatment, including any medical procedure or intervention which, when administered to a patient, serves to prolong the process of dying.212

Sixth, by implementing the decision of a substitute decisionmaker on behalf of the incompetent patient, the physician or other health care provider should not be subject to civil or criminal liability, provided this action is in accord with reasonable medical standards and professional judgment.213

These proposals incorporate standards enumerated in many state court decisions, prevailing state legislation, and the Supreme Court's decision in Cruzan. They attempt to minimize judicial involvement in difficult, personal decisions to withdraw or withhold medical treatment. The proposals do not seek to be exhaustive, but offer a more reasonable method of evaluating an incompetent pa-


211. See Rhoden, supra note 97, at 439-45 (advocating scheme favoring family decisions on behalf of incompetent and suggesting procedures to prevent abuse); see also In re Farrell, 108 N.J. 335, 355, 529 A.2d 404, 414 (1987) (arguing in favor of family involvement in medical decisionmaking for incompetent relative); In re Jobes, 108 N.J. 394, 416, 529 A.2d 434, 445 (1987) (concluding family members are best qualified to make substituted judgment for incompetent relative); Areen, The Legal Status of Consent Obtained from Families of Adult Patients to Withhold or Withdraw Treatment, 258 J. A.M.A. 229, 234 (1987) (suggesting that protection of incompetent patients from ignorant or bad faith decisions should be provided institutionally, using courts only as last resort); Comment, The Role of the Family in Medical Decisionmaking for Incompetent Adult Patients: A Historical Perspective and Case Analysis, 48 U. Prrr. L. REV. 539, 618 (1987) (positing that ethics committee within health care institution offers reasonable solution to protect against possible abuses of private decisionmaking for incompetent patients); supra note 97 and accompanying text (examining family decisionmaking approach in In re Jobes).

212. This definition is adopted primarily from the URTIA. URTIA § 1(4), 9B U.L.A. 68, 68 (Supp. 1990). The proposal follows the conclusion of the Supreme Court that no distinction should be maintained between artificial nutrition and hydration and other forms of medical treatment. See Cruzan, 110 S. Ct. at 2852 (equating nutrition and hydration with administration of medical treatment); id. at 2857 (O'Connor, J., concurring) (discussing medical consensus rejecting any such distinction); id. at 2866-67 (Brennan, J., dissenting) (relating same); see also J. MURPHY, supra note 107, ch. 20, § C4(b) (adding no legal distinction exists between withholding or withdrawing treatment); Johnson, supra note 14, at 698-704 (stating consensus among policy organizations, professional medical associations, and courts is that provision of nutrition and hydration does not differ from other forms of medical treatment).

213. See URTIA §§ 9(a)-(b), at 78 (providing immunities for persons acting in accordance with URTIA); see also J. MURPHY, supra note 107, ch. 20, § G2(b) (dispelling misconception that health care providers are likely to face civil litigation).
tient's circumstances as a whole so that the incompetent patient may, under appropriate circumstances, be granted the right to die.

**Conclusion**

In *Cruzan v. Director, Missouri Department of Health*, the Supreme Court upheld Missouri's requirement that an incompetent patient's intent to refuse life-sustaining medical treatment be proved by clear and convincing evidence. The Court's ruling allowed the state of Missouri to sustain Nancy Cruzan's life because her family did not present clear and convincing evidence that she would have wanted treatment stopped. This decision represents a defeat, not only for Nancy Cruzan and her family, but for all other individuals and families in the same unfortunate situation. Although the Court correctly found no constitutionally protected, fundamental right to die, the decision to terminate treatment for a loved one remains one of the most personal and private decisions a family member must make. The Court's conclusion in *Cruzan* mandates that legislatures reevaluate existing statutes and enact comprehensive legislation that respects these decisions and protects the rights of incompetent individuals.

**Postscript**

On December 14, 1990, a Jasper County probate judge ruled that Nancy Cruzan's parents had presented clear and convincing evidence of their daughter's intent during a second hearing five months after the United States Supreme Court's decision. Her feeding tube was removed the next day, and on December 26, 1990,
Nancy Cruzan found peace through death. Nearly eight years after her fateful accident and after three years of litigation, the Cruzans' ordeal ended. Nevertheless, the resolution of their case does not begin to clarify sufficiently the legal standards required to terminate life-sustaining treatment for incompetent individuals. Hopefully, each state legislature will establish clear guidelines to protect not only those who have provided clear and convincing evidence of their medical treatment decisions, but also those who have not.

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218. See Gladwell, supra note 217, at A3, col. 1 (relating key events and developments throughout Cruzan's legal battle).

219. See Malcolm, supra note 217, at A10, col. 1. The story quoted Arthur Caplan, director of the Center for Biomedical Ethics at the University of Minnesota. Caplan asserted that "the legislatures need to clarify our social policies so that future families and their delicate decisions are not left to the whim of a county prosecutor somewhere." Id.

220. The Missouri legislature stands poised to wage a new debate over the right to die. Wash. Post, Dec. 30, 1990, at A3, col. 5. State Senator Robert Johnson plans to sponsor a "health care surrogate bill" which would allow designation of a health care proxy to make decisions when a person becomes incapacitated. Id. Johnson failed to get similar legislation passed last session. Id.