

Annotated Legal Cases Involving Right-to-Die in the USA

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Keywords

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Introduction

As a matter of well-established law, a mentally competent adult patient has the legal right to refuse continuing medical treatment, even if that refusal will hasten his/her death, as discussed in detail in my essay at <http://www.rbs2.com/rrmt.pdf>.

The present essay contains annotated quotations from the major reported cases in the USA on the legal right of a patient to refuse medical care when the patient is either (1) *unable* to express his/her choice (e.g., patient in a persistent vegetative state) or (2) physically *unable* to disconnect their feeding tube or ventilator that keeps them alive (e.g., because patient is quadriplegic). The scope of this essay is limited to patients who were mentally competent adults prior to their injury/illness and excludes both children, mentally retarded adults, and inmates of prisons.

These cases — involving patients either (1) currently unable to express their choice or (2) physically unable to refuse medical treatment — are conventionally known as “right-to-die” cases, although that phrase is a misnomer.¹ Everyone is going to die sometime, and there is nothing that judges or physicians can do to prevent an ultimate death. The real legal issue is the right of adult patients to refuse continuing medical treatment, and thereby die sooner than they would with continued medical treatment.

I list the cases in chronological order in this essay, so the reader can easily follow the historical development of a national phenomenon.

I am interested in this subject for two different reasons. First, I am interested in constitutional privacy law,² which sets limits on the power of governments to intrude in personal choices and Second, I am interested in the relationship between technology and change in the law. Prior to the 1960s, people tended to die quickly. Modern medical technology can prolong life, even when the quality of life (according to the affected individual) is not worth living. People in persistent vegetative states can live for tens of years, in a meaningless and undignified existence, and consuming large amounts of money in health care expenses. The legal and religious rules that worked well prior to the 1960s are suddenly not only inadequate, but also harsh and cruel. In 1987, the New Jersey Supreme Court wrote:

Death comes to everyone. However, in our society, due to great advances in medical knowledge and technology over the last few decades, death does not come suddenly or completely unexpectedly to most people. *President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-*

¹ George J. Annas, “The ‘Right to Die’ in America: Sloganeering from Quinlan and Cruzan to Quill and Kevorkian,” 34 DUQUESNE LAW REVIEW 875, 880 (Summer 1996).

² Ronald B. Standler, *Fundamental Rights Under Privacy in the USA*, <http://www.rbs2.com/priv2.pdf> (Aug 1998).

Sustaining Treatment 15 (1983) (hereinafter *President's Commission Report*).

[footnote omitted] Instead, most people who die are under the treatment of health care professionals who are able to continue physical existence for human beings "even when most of our physical and mental capacities have been irrevocably lost." *In re Conroy*, 98 N.J. 321, 343, 486 A.2d 1209 (1985). While medical advances have made it possible to forestall and cure certain illnesses previously considered fatal, they also have prolonged the slow deterioration and death of some patients. Sophisticated life-sustaining medical technology has made it possible to hold some people on the threshold of death for an indeterminate period of time, "obfuscat[ing] the use of traditional definition of death." *In re Quinlan*, 70 N.J. 10, 27, 355 A.2d 647, cert. denied *sub nom. Garger v. New Jersey*, 429 U.S. 922, 97 S.Ct. 319, 50 L.Ed.2d 289 (1976). Questions of fate have thereby become matters of choice raising profound "moral, social, technological, philosophical, and legal questions involving the interplay of many disciplines." *Matter of Conroy*, *supra*, 98 N.J. at 344, 486 A.2d 1209; see *Perspectives on J. Katz, The Silent World of Doctor and Patient*, 9 W. New Eng.L.Rev. 1 (1987).

Matter of Farrell, 529 A.2d 404, 406 (N.J. 1987).

See also the dissent of Justice Brennan in *Cruzan*, below, beginning at page 123.

I had contemplated posting an essay on this topic since 1997, but my dismay at the legal debacle created by Theresa Schiavo's parents in April 2005 was the catalyst for posting this essay. This essay consists of long quotations from the major court cases on this topic, with my annotations. In June 2012, I added (1) more citations to the list beginning on page 9, on the underlying disease being the legal cause of death in right-to-die cases, (2) a brief discussion of the autopsy report in the Schiavo case and Senator Frist's debacle, and (3) more detail in the "advance directives" section that begins on page 11.

By presenting long quotations from the series of judicial decisions in each of these cases, I hope to show students and interested citizens the legal history of *how* judges grappled with new legal issues. I believe it is remarkable how quickly judges came to a consensus about new law in these cases. Of course, the law was not really new, it was just a new application of the right to refuse medical treatment that had existed for decades.

This essay is intended only to present general information about an interesting topic in law and is *not* legal advice for your specific problem. See my disclaimer at <http://www.rbs2.com/disclaim.htm> . Furthermore, the reader is cautioned that the law on this topic varies from state to state, and also changes with time. Therefore, reading the excerpts from court cases in this essay does *not* necessarily tell you the current law in your state.

Overview of the Law

Before reading the lengthy judicial opinions, it is worthwhile to have a terse summary of the modern law on this topic.

A mentally competent adult person has the legal right to refuse medical treatment, even if that refusal would cause his/her death, as explained in my separate essay at <http://www.rbs2.com/rrmt.pdf>. Medical treatment in this context includes artificial ventilation, and also includes a feeding tube (e.g., nasogastric tube, gastrostomy tube) for water and nutrition.³ If such a patient is conscious and able to communicate, then that patient can assert their legal rights for himself or herself.

The difficult legal issues in these cases arise when patients are unable to communicate their current wishes, typically because they are unconscious (e.g., in a persistent vegetative state). Someone else must assert the patient's wishes on behalf of the patient. There are two legal questions: (1) Who decides for the patient? and (2) How does that person decide?

1. In the early cases, a court appointed a “guardian of the person” to assert the wishes of the unconscious patient. The New Jersey Supreme Court in *Quinlan* suggested that the patient's family and physicians, together with a hospital ethics committee, routinely make end-of-life decisions by consensus, without intervention of a court.
2. There are three ways that a guardian can make the decisions.
 - A. **subjective test** The most appropriate outcome is when the guardian can determine by clear and convincing evidence what the specific individual patient would have wanted or chosen. For example, in some of the early cases, there was testimony by the friends and relatives of the unconscious patient that the patient previously expressed a wish⁴ *not* to be kept alive by artificial means.
 - B. **limited-objective test** If there is no indication of a person's personal wishes, the guardian of the person will need to infer what the patient would have wanted from the patient's conduct, the patient's religious beliefs, or other sources. Life-sustaining treatment may be withheld or withdrawn if *both* (1) “there is some trustworthy evidence that the patient would have refused the treatment” and (2) “the decision-maker is satisfied that it is clear that the burdens of the patient's continued life with the treatment outweigh the benefits of that life” for the patient. *Matter of Conroy*, 486 A.2d 1209, 1232 (N.J. 1985).

³ Although providing water and nutrition is normally *not* medical care, in patients who are unable to swallow because of neurological injury (e.g., comatose, persistent vegetative state) it is necessary to give water and nutrition by artificial means. It is the artificial means (e.g., a nasogastric tube) that constitutes medical care.

⁴ Typically, the wish was expressed while watching a television news story about Karen Quinlan or one of the other cases involving someone in a persistent vegetative state.

- C. **pure-objective test** If it appears impossible to determine what the specific unconscious patient would have wanted, then the guardian of the person must consider what a hypothetical reasonable person would have wanted. Life-sustaining treatment may be withheld or withdrawn if “the net burdens of the patient's life with the treatment should clearly and markedly outweigh the benefits that the patient derives from life.” This is the least satisfactory resolution of the issue, but is necessary to allow a humane end of life to a suffering patient who has no reasonable hope of recovery. *Matter of Conroy*, 486 A.2d 1209, 1231-1232 (N.J. 1985).

The second test (i.e., limited-objective) is known by the legal jargon “substituted judgment”, because the guardian attempts to make the same decision that the patient would make, if the patient were conscious and able to communicate. The third test (i.e., pure-objective) makes a decision according to the “best interests” of a currently incompetent person.

In determining that there is no reasonable hope of recovery, it is common for courts⁵ to require the declaration of the attending physician plus the findings of independent examinations by two other physicians, for a total of three medical opinions that concur in the conclusion that there is no reasonable hope of recovery

Courts have consistently declared administration of water and nutrition via a feeding tube to be medical treatment,⁶ which a patient may legally refuse. One needs to be careful with a technical distinction here: water and food themselves are *not* medicine; water and food are *not* extraordinary medical care. However, the administration of water and food via a nasogastric tube or via a tube implanted in the stomach *is* medical care, because a physician inserted the tube. Because the law is clear that a mentally competent adult patient has the legal right to refuse any medical treatment, classifying a feeding tube as medical treatment means that the patient has the legal right to refuse that feeding tube. Incidentally, attorneys and judges often speaking of a patient “starving”, but after removal of a feeding tube death generally occurs as a result of dehydration (i.e., renal failure).

⁵ *Matter of Welfare of Colyer*, 660 P.2d 738, 751 (Wash. 1983); *Foody v. Manchester Memorial Hosp.*, 482 A.2d 713, 721 (Conn.Super. 1984); *Matter of Farrell*, 529 A.2d 404, 415 (N.J. 1987); *In re Estate of Longeway*, 549 N.E.2d 292, 299 (Ill. 1989); *In re Guardianship of Browning*, 543 So.2d 258, 271 (Fla.App. 2 Dist. 1989), *aff'd*, 568 So.2d 4, 16 (Fla. 1990); *In re Fiori*, 673 A.2d 905, 912-913 (Pa. 1996).

⁶ *Matter of Guardianship of L.W.*, 482 N.W.2d 60, 66, n. 6 (Wis. 1992) (citing ten cases).

initial injury/disease is proximate cause of death

Judges frequently declare that the legal cause of death is *not* the withholding or withdrawal of life support (e.g., mechanical ventilator or feeding tube). Instead the legal cause of death of the patient is whatever initially caused the patient's injury or illness. There are four good reasons for this holding:

1. Whoever caused the patient's initial injury, which eventually led to the patient's death, can be prosecuted for homicide, and also sued for negligence or wrongful death. This rule of law puts the responsibility on the blameworthy person.
2. The physician(s) who withhold or remove life-support can *neither* be prosecuted criminally for homicide *nor* sued for medical malpractice or negligence. Furthermore, those who discuss and plan the withholding or withdrawal of life support can *not* be prosecuted criminally for conspiracy.
3. A patient who desires disconnection of life support is *not* committing suicide.
4. It is arguable that a patient in a persistent vegetative state is alive but *not* a person.⁷ In this view, when physicians agree that a patient in a persistent vegetative state has no reasonable hope of recovery, the *person* has already died. This view is *not* commonly asserted by conventional judges.

The rule of law that discontinuing life support is *not* the proximate cause of death is stated in a long line of cases, some of which are criminal, and others are right-to-die cases.

cites to criminal cases

- *Michigan v. Vanderford*, 258 N.W.2d 502, 503 (Mich.App. 1977) (Defendant beat victim. Victim was in coma, breathing only with ventilator. Brain death diagnosed five days later. Ventilator disconnected seven days after attack. "From the record it is clear [victim] was dead before the respirator was turned off. But even if the respirator was stopped prematurely, defendant would still be liable, since intervening medical error is not a defense to a defendant who has inflicted a mortal wound upon another.").

⁷ Joseph Fletcher, "Indicators of Humanhood: A Tentative Profile of Man," 2 *Hastings Center Report* 1 (1972); David Randolph Smith, "Legal Recognition of Neocortical Death," 71 *Cornell Law Review* 850 (May 1986) <http://www.drslawfirm.com/legaldeath.pdf>; Ronald E. Cranford and David R. Smith, "Consciousness: The Most Critical Moral (Constitutional) Standard for Human Personhood," 13 *American Journal of Law & Medicine* 233 (1987).

- *Massachusetts v. Golston*, 366 N.E.2d 744, 749-750 (Mass. 1977), *cert. den.*, 434 U.S. 1039 (1978) (Defendant hit victim on head with baseball bat. Ventilator disconnected from victim seven days after assault and at least two days after victim was “brain dead”. Court held that disconnection of ventilator was *not* proximate cause of death, and affirmed defendant’s murder conviction. The victim might have arguably been kept alive on a ventilator for more than a year and a day, thus permitting defendant to escape the murder charge.).
- *Arizona v. Fierro*, 603 P.2d 74, 76-77 (Ariz. 1979) (Victim “was shot once in the chest and four times in the head.” He was “brain dead” after leaving surgery on the day of the shooting. Life support was withdrawn four days later. The court held he was legally dead before the life support was withdrawn, and the legal cause of death was the gunshot wounds to his head.).
- *Iowa v. Inger*, 292 N.W.2d 119, 125 (Iowa 1980) (Defendant kicked victim in the head. A few days later, victim was brain dead, then his heart stopped. Finally, life support was disconnected six days after the attack. Held that defendant’s acts were proximate cause of death.).
- *Nebraska v. Meints*, 322 N.W.2d 809, 812-814 (Neb. 1982) (Victim injured in automobile accident. Victim not able to breathe and was put on a ventilator, to maintain her cardiac function. Two days after the accident, victim was found to be brain dead, and the ventilator was disconnected. A “short time” later, her heart stopped. The court affirmed the homicide conviction: “... proof of brain death is sufficient as proof of the victim’s death in a homicide case, and removal of life support systems is not an efficient intervening cause of death in such cases.”).
- *New York v. Bonilla*, 467 N.Y.S.2d 599, 608 (N.Y.A.D. 2 Dept. 1983), *aff’d sub nom. New York v. Eulo*, 472 N.E.2d 286, 297, 482 N.Y.S.2d 436, 447 (N.Y. 1984) (Victim was shot in the head. Hospital connected victim to ventilator. Victim was brain dead one day after being shot. Two days after shooting, victim’s kidneys and spleen were harvested for transplant. The respirator was then disconnected. Court held that the proximate cause of death was the bullet wound to head.).
- *Huffington v. Maryland*, 500 A.2d 272, 280 (Md. 1985) (Physician’s negligence or victim’s refusal of medical care *not* a superseding cause of death of gunshot victim.).
- *Illinois v. Caldwell*, 692 N.E.2d 448, 451-452, 454-455 (Ill.App. 4 Dist. 1998) (Defendant hit a 97 y old victim in neck with skillet, rendering her a quadriplegic dependent on a ventilator. Victim asked to be disconnected from ventilator, because “she did not want to live with complete paralysis.” Defendant was convicted of manslaughter.).
- *Michigan v. Bowles*, 607 N.W.2d 715, 717-718 (Mich. 2000) (Defendant beat victim, causing her to become comatose. Ventilator was disconnected three days after beating and she suffered cardiac arrest 8½ hours later. The court affirmed defendant’s murder conviction. The removal of the ventilator was *not* an intervening cause. “... we find in these facts only the unsuccessful efforts of the medical community to overcome the harm inflicted by the defendant, and the acceptance by the victim’s family of the reality of fatal injuries.”).
- *Iowa v. Garcia*, 616 N.W.2d 594, 596-599 (Iowa 2000) (Physician’s negligence *not* a superseding cause of death of gunshot victim.).

- *New Jersey v. Pelham*, 824 A.2d 1082, 1092 (N.J. 2003), *cert. den.*, 540 U.S. 909 (2003) (Victim of an automobile accident who was on life-support for 152 days. He died two hours after the ventilator was removed, and the intoxicated driver, Pelham, who caused the accident was then convicted of vehicular homicide. “We agree with the widely recognized principle that removal of life support, as a matter of law, may not constitute an independent intervening cause for purposes of lessening a criminal defendant's liability.”).

cites to right-to-die cases

- *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417, 426, n.11 (Mass. 1977) (“... to the extent that the cause of death was from natural causes the patient did not set the death producing agent in motion with the intent of causing his own death. Byrn, [Compulsory Lifesaving Treatment for the Competent Adult, 44 FORDHAM L.REV. 1 (1975)] at 17-18. Cantor, [A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life, 26 RUTGERS L.REV. 228 (1973)] at 255.”).
- *Matter of Quinlan*, 355 A.2d 647, 669-670 (N.J. 1976) (“We believe ... that the ensuing death would not be homicide but rather expiration from existing natural causes.”), *cert. den. sub nom., Garger v. New Jersey*, 429 U.S. 922, (1976).
- *Satz v. Perlmutter*, 362 So.2d 160, 162 (Fla.App. 4 Dist. 1978) (“As to suicide, the facts here unarguably reveal that Mr. Perlmutter would die, but for the respirator. The disconnecting of it, far from causing his unnatural death by means of a "death producing agent" in fact will merely result in his death, if at all, from natural causes, [*Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417,] 426, fn. 11. [Mass. 1977]”), *aff'd*, 379 So.2d 359 (Fla. 1980).
- *Matter of Welfare of Colyer*, 660 P.2d 738, 743 (Wash. 1983) (“A death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion nor intended by the patient.”). Quoted with approval in *In re Guardianship of Grant*, 747 P.2d 445, 451 (Wash. 1987).
- *Foody v. Manchester Memorial Hosp.*, 482 A.2d 713, 720 (Conn.Super. 1984) (“An individual's determination to cease medical treatment pursuant to his right of privacy does not constitute suicide. *In re Quinlan*, supra, 70 N.J. 51–52, 355 A.2d 647. This is so, because (1) in refusing treatment the patient may not have the specific intent to die and (2) even if he did, to the extent that death resulted from natural causes, the patient did not set the death producing agent in motion with intent to cause his own death. *Superintendent of Belchertown State School v. Saikewicz*, supra, 373 Mass. 743 n. 11, 370 N.E.2d 417.”).
- *Bartling v. Superior Court*, 209 Cal.Rptr. 220, 225-226 (Cal.App. 2 Dist. 1984) (Holding that conscious patient has legal right to order physicians to disconnect patient's ventilator, even though that would hasten the patient's death. “This is not a case, however, where real parties would have brought about Mr. Bartling's death by unnatural means by disconnecting the ventilator. Rather, they would merely have hastened his inevitable death by natural causes.”)

- *Matter of Conroy*, 486 A.2d 1209, 1224, 1226 (N.J. 1985) (At 1224: “In any event, declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury.” At 1226: “... rejecting her artificial means of feeding would not constitute attempted suicide, as the decision would probably be based on a wish to be free of medical intervention rather than a specific intent to die, and her death would result, if at all, from her underlying medical condition, which included her inability to swallow.”).
- *Bouvia v. Superior Court*, 225 Cal.Rptr. 297, 306 (Cal.App. 2 Dist. 1986) (“As a consequence of her changed condition, it is clear she has now merely resigned herself to accept an earlier death, if necessary, rather than live by feedings forced upon her by means of a nasogastric tube. Her decision to allow nature to take its course is not equivalent to an election to commit suicide with real parties [i.e., physicians and the hospital] aiding and abetting therein.”).
- *Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 638 (Mass. 1986) (citing *Saikewicz*, *Colyer*, *Bartling*, *Conroy*, and *Bouvia*.).
- *Matter of Farrell*, 529 A.2d 404, 411 (N.J. 1987) (“Courts in other jurisdictions have consistently agreed that refusal of life-supporting treatment does not amount to an attempt to commit suicide. [citing *Conroy* and 7 other cases]”).
- *Matter of Peter by Johanning*, 529 A.2d 419, 428 (N.J. 1987) (“We specifically reject the Ombudsman’s distinction that the withdrawal of artificial feeding directly causes death while the withdrawal of other forms of life-support only indirectly causes death. Just as a patient does not die because of the withdrawal of a kidney dialysis machine, but because his underlying disease has destroyed the proper functioning of his kidney, so Hilda Peter will not die from the withdrawal of the nasogastric tube, but because of her underlying medical problem, i.e., an inability to swallow. Withdrawal of the nasogastric tube, like discontinuance of other kinds of artificial treatment, merely acquiesces in the natural cessation of a critical bodily function. The cessation is the cause of death, not the acquiescence. See N. Cantor, LEGAL FRONTIERS OF DEATH AND DYING 38-45 (1987).”).
- *In re Gardner*, 534 A.2d 947, 955-956 (Me. 1987) (“Yet this coupling of his treatment decision and his ultimate death should not mask the obvious point that the cause of his death will be not his refusal of care but rather his accident and his resulting medical condition, including his inability to ingest food and water. His decision not to receive [artificial feeding], far from constituting suicide, is a choice to allow to take its course the natural dying process set in motion by his physiological inability to chew or swallow.”).
- *McConnell v. Beverly Enterprises-Connecticut*, 553 A.2d 596, 605-606 (Conn. 1989) (“... we agree with the majority of jurisdictions that have addressed this issue in holding that the removal of a gastrostomy tube is not the ‘death producing agent,’ set in motion with the intent of causing her own death. In exercising her right of self-determination, Mrs. McConnell merely seeks to be free of extraordinary mechanical devices and to allow nature to take its course. Thus, death will be by natural causes underlying the disease, not by self-inflicted injury. [citing ten cases]”).

- *Rasmussen*, 741 P.2d 674, 685 (Ariz. 1987) (quoting *Conroy* and citing *Saikewicz*, *Colyer*, and *Foody*);
- *McKay v. Bergstedt*, 801 P.2d 617, 626 (Nev. 1990) (“Other courts have consistently agreed that rejecting treatment in the form of artificial life support systems is not a euphemistic exercise in suicide. [citing 9 cases]”).
- *Deel v. Syracuse Veterans Admin. Medical Center*, 729 F.Supp. 231, 234 (N.D.N.Y. 1990) (“The cause of Mr. Deel’s death, if it were to occur upon removal of artificial respiration, would be the natural underlying disease, not a self-inflicted injury.”).
- *In re Guardianship of Browning*, 568 So.2d 4, 14 (Fla. 1990) (“... the discontinuation of life support ‘in fact will merely result in [her] death, if at all, from natural causes.’ *Satz*, 362 So.2d at 162.”).
- *Vacco v. Quill*, 521 U.S. 793, 801 (1997) (“... when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication.”).
- *Sampson v. Alaska*, 31 P.3d 88, 99 (Alaska 2001) (“In the case of a physician who honors a dying patient's request to withdraw life-sustaining medical treatment, the patient's underlying disease or pathology runs its course and causes death; the death is hastened by the physician's failure to continue treatment.”).

advance directives

To solve the problem of unconscious patients who could not express their consent to medical treatment, in 1969 attorney Luis Kutner published a proposal for a “living will” that would contain detailed instructions to physicians.⁸ A successful living will requires that the patient accurately foresee what medical treatments are available for his/her end-of-life condition. Further, many patients may not want to spend hours contemplating their death and making detailed choices.

A second kind of advance directive is for the patient to appoint an agent, and let the agent make decisions for the unconscious patient. This kind of advance directive is known as a health-care proxy, or alternatively as a “durable power of attorney for health care”.

⁸ Luis Kutner, “Due Process of Euthanasia: The Living Will, a Proposal,” 44 INDIANA LAW JOURNAL 539, 550-554 (Summer 1969); George J. Annas, “The Health Care Proxy and the Living Will,” 324 NEW ENGLAND JOURNAL OF MEDICINE 1210 (25 April 1991) (citing Kutner).

Both a living will or a health-care proxy are intended to avoid litigation⁹ seen in some of the cases discussed in this essay. Unfortunately, these documents have been popular only with affluent older people, so we can expect that many people in persistent vegetative states will *not* have these documents.

In 1975, the trial court in *Quinlan* was one of the first judicial opinions in the USA to mention a living will. *Matter of Quinlan*, 348 A.2d 801, 819, n.10 (N.J.Super.Ch. 1975) (citing law review article: “Kutner, ‘The Living Will — Coping With The Historical Event of Death,’ 27 BAYLOR LAW REV. 1, 39 (1975).”).

In 1976, California passed its Natural Death Act, and became the first state in the USA to recognize a living will. The original version of this statute had two serious flaws: it only applied to patients whose death is “imminent”,¹⁰ thus providing no relief to patients in either persistent vegetative states or quadriplegic patients; and there was no penalty for physician(s) who dishonored the living will.

In 1987, the New Jersey Supreme Court listed statutes in 38 states that authorized a living will, mostly copied from the Uniform Rights of the Terminally Ill Act. *Matter of Farrell*, 529 A.2d 404, 407, n.2 (N.J. 1987).

In 1988, the Missouri Supreme Court tersely summarized the history:

At the end of life, this State maintains its policy strongly favoring life. In response to the dilemmas which attend the increasing ability of medical science to maintain life where death would have come quickly in former days, legislatures across the country adopted so-called “Living Will” statutes. These permit a competent person to decree in a formal document that she would refuse death prolonging medical treatment in the event of terminal illness and an accompanying inability to refuse such treatment as a result of incompetency.

The Uniform Rights of the Terminally Ill Act (URITA) provided the basis for many of these acts. Missouri's statute, Sections 459.010, et seq., RSMo 1986, is modeled after URITA, but with substantial modifications which reflect this State's strong interest in life. *Cruzan*, 760 S.W.2d 408, 419 (Mo. 1988) (At 420: Nancy Cruzan had *not* executed a living will.). When *Cruzan* reached the U.S. Supreme Court, Justice O'Connor in her concurring opinion made the first mention of living will and health-care proxies at the U.S. Supreme Court. *Cruzan*, 497 U.S. 261, 290-291 (1990) (O'Connor, J., concurring).

⁹ Such litigation is agonizing for family and friends of a patient. Such litigation can delay the end-of-life decision by several years, nine years in the case of Theresa Schiavo. And despite all of the money spent on legal fees, after the litigation is finished, there is still *not* a consensus that the judicial order did the right thing, according to the wishes of the patient.

¹⁰ Chris Beraldo, Comment, “Give Me Liberty and Give Me Death: The Right To Die and the California Natural Death Act,” 20 SANTA CLARA LAW REVIEW 971, 989 (1980).

From these few citations, it is clear that the right-to-die cases were responsible for the enactment of state statutes about living wills and health-care proxies.

Effective Dec 1991, a federal statute requires that hospitals, nursing facilities, home health agencies, and hospices that are paid by either Medicare or Medicaid give *all* adult patients written information about their right to “refuse medical or surgical treatment and the right to formulate advance directives”. 42 U.S.C. § 1395cc(f)(1)(A). In 1997, another federal statute clarified that there was no right to either “assisted suicide, euthanasia, or mercy killing”. 42 U.S.C. § 14406.

physician-assisted suicide

A related, but distinctly different, set of legal issues arise when a mentally competent adult patient wishes to have a physician prescribe drugs that the patient can use to end the patient’s life. While it is legal in most states for an individual to commit suicide, the law in most of the USA is clear that it is illegal for anyone, including a physician, to assist a suicide. See my separate essay at <http://www.rbs2.com/pas.pdf> .

Quinlan

- ***Matter of Quinlan*, 348 A.2d 801 (N.J.Super.Ch. 10 Nov 1975), modified and remanded, 355 A.2d 647 (N.J. 31 Mar 1976), cert. denied sub nom. Garger v. New Jersey, 429 U.S. 922 (1 Nov 1976).**

Quinlan, 348 A.2d 801 (N.J.Super.Ch. 1975), is the first case in the Westlaw database to mention the phrase “persistent vegetative state”.¹¹ Although some points of law in this case have been subsequently modified in later cases, the *Quinlan* case is of great historical importance and is still cited by courts.

medical facts

The trial court summarized the facts:

On the night of April 15, 1975 friends of Karen summoned the local police and emergency rescue squad, and she was taken to Newton Memorial Hospital. The precise events leading up to her admission to Newton Memorial Hospital are unclear. She apparently ceased breathing for at least two 15-minute periods. Mouth-to-mouth resuscitation was applied by her friends the first time and by a police respirator the second time. The exact amount of time she was without spontaneous respiration is unknown.

¹¹ The phrase “persistent vegetative state” first appeared in the medical literature in 1972. Multi-Society Task Force on PVS, “Medical Aspects of the Persistent Vegetative State,” 330 New England Journal of Medicine 1499, 1499 (26 May 1994) (citing B. Jennett and F. Plum, “Persistent Vegetative State After Brain Damage: a syndrome in search of a name,” 1 Lancet 734 (1972)).

Upon her admission to Newton Memorial urine and blood tests were administered which indicated the presence of quinine, aspirin, barbiturates in normal range and traces of valium and librium. The drugs found present were indicated by Dr. Robert Morse, the neurologist in charge of her care at St. Clare's, to be in the therapeutic range, and the quinine consistent with mixing in drinks like soda water.

The cause of the unconsciousness and periodic cessations of respiration is undetermined. The interruption in respiration apparently caused anoxia — insufficient supply of oxygen in the blood — resulting in her present condition.

Hospital records at the time of admission reflected Karen's vital signs to be normal, a temperature of 100, pupils unreactive, unresponsivity to deep pain, legs rigid and curled up, with decorticate brain activity. Her blood oxygen level was low at the time. She was placed upon a respirator at Newton Hospital.

At 10 p.m. on April 16, 1975 Dr. Morse examined Karen at the request of her then attending physician. He found her in a state of coma, with evidence of decortication indicating altered level of consciousness. She required the respirator for assistance. She did not trigger the respirator, which means that she did not breathe spontaneously nor independently of it at any time during the examination. Due to her decorticate posturing, no reflexes could be elicited.

In the decorticate posturing the upper arms are drawn into the side of the body. The forearms are drawn in against the chest with the hands generally at right angles to the forearms, pointing towards the waist. The legs are drawn up against the body, knees are up, feet are in near the buttocks and extended in a ballet-type pose.

Matter of Quinlan, 348 A.2d 801, 806-807 (N.J.Super.Ch. 1975).

Subsequent tests and examinations did not further the establishment of the precise location and cause of Karen's comatose condition.

Dr. Morse testified concerning the treatment of Karen at St. Clare's. He averred she receives oral feedings since intravenous feeding is insufficient to sustain her. She is fed a high caloric nutrient called 'Vivenex,' which she receives through a small nasal gastro tube inserted in her gastro-intestinal system. He asserts this is necessary to keep her 'viable.' She has apparently lost considerable weight, being described as emaciated by most of the examining experts, who also indicate her weight condition to be good under the circumstances.

Matter of Quinlan, 348 A.2d 801, 808 (N.J.Super.Ch. 1975).

Dr. Javed indicated that efforts were made to wean or remove Karen from the respirator. The hospital records support this. Dr. Javed testified that for weaning to be successful, the patient must have a stable respiratory pattern. Karen was taken off the respirator for short periods of time. Each time, her respiratory rate, rate of breathing, went up and the volume of air intake would decrease. He indicated her breathing rate would more than double in intensity while her 'tidal volume' or air intake would drop 50%. The longest period of time she was off the respirator was one-half hour. He further indicated that during removal from the respirator her pO₂ dropped. He stated that the respiratory problem is secondary to the neurological problem, and without improvement in the latter she cannot be removed from the respirator since she would be unable to maintain her vital processes without its assistance.

Dr. Morse's hospital notes indicate there is no neurological improvement from the time of her admission to St. Clare's to date. He testified that Karen changed from a sleeping comatose condition to a sleep-awake type comatose condition but described this as normal in comatose patients and not any indication of improvement. During the awake cycle she is still unconscious.

Matter of Quinlan, 348 A.2d 801, 809 (N.J.Super.Ch. 1975).

Dr. Morse, in reflecting on the prognosis, notes Karen's absence of awareness of anything or anyone around her. In response to a direct question he noted she is not suffering from locked-in syndrome in which a patient is conscious but so totally paralyzed that communications can be made only through a complex system of eye or eyelid movements.

Dr. Morse states Karen Quinlan will not return to a level of cognitive function (I.e., that she will be able to say 'Mr. Coburn I'm glad you are my guardian.') What level or plateau she will reach is unknown. He does not know of any course of treatment that can be given and cannot see how her condition can be reversed, but is unwilling to say she is in an irreversible state or condition. He indicated there is a possibility of recovery but that level is unknown, particularly due to the absence of pre-hospital history.

Karen Ann Quinlan was examined by several experts for the various parties. All were neurologists with extensive experience and backgrounds. Some had done research in the area of brain injury, conscious and comatose behavior. The qualifications of all were admitted.

On October 2, 1975 Dr. Stuart Cook, Dr. Eugene Loesser and Dr. Fred Plum, in the presence of Doctors Morse, Javed and others, examined Karen. Each reviewed the medical and hospital records and talked with the attending physicians. The examination consisted in part of Karen's removal from the respirator for a 3- minute and 45-second interval and an EEG.

Their testimonies did not vary significantly. Some gave in greater detail than others. A general synopsis of their testimonies indicates they found Karen comatose, emaciated and in a posture of extreme flexion and rigidity of the arms, legs and related muscles which could not be overcome, with her joints severely rigid and deformed. During the examination she went through awake and sleep periods but mostly awake. The eyes moved spontaneously. She made stereotyped cries and sounds and her mouth opened wide when she did so. Cries were evoked when there was noxious stimulation. She reflexed to noxious stimuli. Her pupils reacted to light and her retinas were normal. Her reflex activity, deep tendon reflexes and plantar stimulation of soles of her feet could not be elicited because of the severe flexion contractures. She triggered the respirator during the entire examination except for the interval of removal. When she was removed from the respirator, with an oxygen catheter inserted through the tracheostomy, she breathed spontaneously and her blood gases were in a normal range. Her EEG showed normal electrical activity for a sedated person. (She was sedated for the EEG). She does not have the locked-in syndrome.

All agree she is in a persistent vegetative state. She is described as having irreversible brain damage; no cognitive or cerebral functioning; chances for useful sapient life or return of discriminative functioning are remote. The absence of knowledge on the events precipitating the condition, and the fact that other patients have been comatose for longer periods of time and recovered to function as a human, made Dr. Cook qualify his statement as to the return to discriminative functioning. All agree she is not brain-dead by present-known medical criteria and that her continued existence away from the respirator is a determination for a pulmonary internist.

Matter of Quinlan, 348 A.2d 801, 811-812 (N.J.Super.Ch. 1975).

In March 1976, the New Jersey Supreme Court wrote:

Karen remains in the intensive care unit at Saint Clare's Hospital, receiving 24-hour care by a team of four nurses characterized, as was the medical attention, as 'excellent.' She is nourished by feeding by way of a nasal-gastro tube and is routinely examined for infection, which under these circumstances is a serious life threat. The result is that her condition is considered remarkable under the unhappy circumstances involved.

Karen is described as emaciated, having suffered a weight loss of at least 40 pounds, and undergoing a continuing deteriorative process. Her posture is described as fetal-like and grotesque; there is extreme flexion-rigidity of the arms, legs and related muscles and her joints are severely rigid and deformed.

From all of this evidence, and including the whole testimonial record, several basic findings in the physical area are mandated. Severe brain and associated damage, albeit of uncertain etiology, has left Karen in a chronic and persistent vegetative state. No form of treatment which can cure or improve that condition is known or available. As nearly as may be determined, considering the guarded area of remote uncertainties characteristic of most medical science predictions, she can *never* be restored to cognitive or sapient life. Even with regard to the vegetative level and improvement therein (if such it may be called) the prognosis is extremely poor and the extent unknown if it should in fact occur.

She is debilitated and moribund and although fairly stable at the time of argument before us (no new information having been filed in the meanwhile in expansion of the record), no physician risked the opinion that she could live more than a year and indeed she may die much earlier. Excellent medical and nursing care so far has been able to ward off the constant threat of infection, to which she is peculiarly susceptible because of the respirator, the tracheal tube and other incidents of care in her vulnerable condition. Her life accordingly is sustained by the respirator and tubal feeding, and removal from the respirator would cause her death soon, although the time cannot be stated with more precision.

Matter of Quinlan, 355 A.2d 647, 655-656 (N.J. 1976).

trial court

Karen was injured on 15 April 1975. Just 107 days later, on 31 July 1975, the parents formally asked Dr. Morse to discontinue the ventilator. However, Dr. Morse refused, because “medical tradition” required continuing life support. Karen’s father then filed litigation in New Jersey Chancery Court seeking to be appointed guardian of Karen and seeking declaratory judgment that he could order her ventilator discontinued. Other parties (e.g., Karen’s physicians, hospital, and the County prosecutor¹², and Karen’s guardian ad litem) were added to this case. All of these other parties disagreed with the discontinuation of ventilation advocated by Karen’s parents.

The decision to request removal of their daughter from the respirator, understandably came tortuously, arduously to the Quinlans. At the outset they authorized Dr. Morse to do everything he could to keep her alive, believing she would recover. They participated in a constant vigil over her with other family members. They were in constant contact with the doctors, particularly Dr. Morse, receiving day-by-day reports concerning her prognosis which, as time passed, became more and more pessimistic and more and more discouraging to them.

Mrs. Quinlan and the children were the first to conclude Karen should be removed from the respirator. Mrs. Quinlan, working at the local parish church, had ongoing talks with

¹² “... the Prosecutor of Morris County (he being charged with responsibility for enforcement of the criminal law), to enjoin him from interfering with, or projecting a criminal prosecution which otherwise might ensue in the event of, cessation of life in Karen resulting from the exercise of such extraordinary authorization were it to be granted to the guardian.” 355 A.2d. at 651 (N.J. 1976).

Father Trapasso, who supported her conclusion and indicated that it was a permissible practice within the tenets of Roman Catholic teachings.

Mr. Quinlan was slower in making his decision. His hope for recovery continued despite the disheartening medical reports. Neither his wife nor Father Trapasso made any attempt to influence him. A conflict existed between letting her natural body function control her life and the hope for recovery. Precisely when he came to a decision is not clear. By his testimony he indicated early September, but he signed a release to the hospital dated July 31, 1975, hereafter referred to, which makes it reasonably inferrable that the decision was made in July. Once having made the decision, he sought Father Trapasso's encouragement, which he received. *Matter of Quinlan*, 348 A.2d 801, 812-813 (N.J.Super.Ch. 1975).

The judicial opinion then quotes a statement by Pope Pius XII on 24 Nov 1957 that the declaration of death “cannot be deduced from any religious and moral principle” but Catholics believe that “human life continues for as long as its vital functions — distinguished from the simple life of organs — manifest themselves spontaneously or even with the help of artificial processes.”

Father Trapasso acknowledges it is not a sinful act under the church teachings or the Papal Allocutio to either continue extraordinary treatment or discontinue it. It is acknowledged to be a matter left optional to a Roman Catholic believer. Mr. Quinlan indicates that had Roman Catholic traditions and morals considered it a sin, he would not be seeking termination of the respiratorial support. Mr. Quinlan avers Karen's natural bodily functions should be allowed to operate free of the respirator. He states that then, if it is God's will to take her, she can go on to life after death, and that is a belief of Roman Catholics. He asserts he does not believe or support the concept of euthanasia.

Once having made the determination, the Quinlans approached hospital officials to effectuate their decision. Father Paschal Caccavalle, chaplain of St. Clare's, at a meeting between hospital representatives and the Quinlans, read the Papal Allocutio of November 1957.

The Quinlans on July 31, 1975 signed the following:

We authorize and direct Doctor Morse to discontinue all extraordinary measures, including the use of a respirator for our daughter Karen Quinlan.

We acknowledge that the above named physician has thoroughly discussed the above with us and that the consequences have been fully explained to us. Therefore, we hereby RELEASE from any and all liability the above named physician, associates and assistants of his choice, Saint Clare's Hospital and its agents and employees.

The Quinlans, upon signing the release, considered the matter decided. Dr. Morse, however, felt he could not and would not agree to the cessation of the respirator assistance. He testified — characterizing the issue of extraordinary treatment and the termination of it as something brought up suddenly in July — that he advised the Quinlans prior to the time of the release that he wanted to check into the matter further before giving his approval. After checking on other medical case histories he concluded that to terminate the respirator would be a substantial deviation from medical tradition, that it involved ascertaining 'quality of life,' and that he would not do so.

Karen Quinlan is quoted as saying she never wanted to be kept alive by extraordinary means. The statements attributed to her by her mother, sister and a friend are indicated to

have been made essentially in relation to instances where close friends or relatives were terminally ill. In one instance an aunt, in great pain, was terminally ill from cancer. In another instance the father of a girl friend was dying under like circumstances. In a third circumstance a close family friend was dying of a brain tumor. Mrs. Quinlan testified that her daughter was very full of life, that she loved life and did not want to be kept alive in any way she would not enjoy life to the fullest.

Matter of Quinlan, 348 A.2d 801, 813-814 (N.J.Super.Ch. 1975).

Note that the first mention of what Karen would have wanted occurs about halfway through a long judicial opinion, and *after* the judge's recitation of what her parents wanted. Modern law would make Karen's wishes paramount.

After a long discussion, the trial judge found Dr. Morse's refusal to disconnect the ventilator was more persuasive than Karen's expressed desire not to be kept alive by artificial means. Further, the trial judge found that removing her from the ventilator would be homicide, if it caused her death.

None of the doctors testified there was *no* hope. The hope for recovery is remote but no doctor talks in the absolute. Certainly he cannot and still be credible, in light of the advancements medical science has known and the inexactitudes of medical science.

There *is* a duty to continue the life-assisting apparatus, if, within the treating physician's opinion, it should be done. Here Dr. Morse has refused to concur in the removal of Karen from the respirator. It is his considered position that medical tradition does not justify that act. There is no mention, in the doctor's refusal, of concern over criminal liability, and the court concludes that such is not the basis for his determination. It is significant that Dr. Morse, a man who demonstrated strong empathy and compassion, a man who has directed care that impressed all the experts, is unwilling to direct Karen's removal from the respirator.

The assertion that Karen would elect, if competent, to terminate the respirator requires careful examination.

She made these statements at the age of 20. In the words of her mother, she was full of life. She made them under circumstances where another person was suffering, suffering in at least one instance from severe pain. While perhaps it is not too significant, there is no evidence she is now in pain. Dr. Morse describes her reacting to noxious stimuli — pain — as reflex but not indicative that she is sensing the pain as a functioning human being does. The reaction is described as stereotyped, and her reflexes show no adjustment that would indicate she mentally experiences pain.

The conversations with her mother and friends were theoretical ones. She was not personally involved. They were not made under the solemn and sobering fact that death is a distinct choice. See *In re Estate of Brooks*, 32 Ill.2d 361, 205 N.E.2d 435 (1965). Karen Quinlan, while she was in complete control of her mental faculties to reason out the staggering magnitude of the decision not to be 'kept alive,' did not make a decision. This is not the situation of a 'living will' which is based upon a concept of informed consent. [omitted footnote to 1975 law review article on living wills]

While the repetition of the conversations indicates an awareness of the problems of terminal illness, the elements involved — the vigor of youth that espouses the theoretical good and righteousness, the absence of being presented the question as it applied to her — are not persuasive to establish a probative weight sufficient to persuade this court that Karen Quinlan would elect her own removal from the respirator.

The breadth of the power to act and protect Karen's interests is, I conclude, controlled by a judicial conscience and morality which dictate that the determination whether or not Karen

Ann Quinlan be removed from the respirator is to be left to the treating physician. It is a medical decision, not a judicial one. I am satisfied that it may be concurred in by the parents but not governed by them. This is so because there is always the dilemma of whether it is the conscious being's relief or the unconscious being's welfare that governs the parental motivation.

It is also noted the concept of the court's power over a person suffering under a disability is to *protect* and aid the best interests. As pointed out, the *Hart* and *Strunk* cases¹³ deal with protection as it relates to the future life of the infants or incompetent. Here the authorization sought, if granted, would result in Karen's death. The natural processes of her body are not shown to be sufficiently strong to sustain her by themselves. The authorization, therefore, would be to permit Karen Quinlan to die. This is not protection. It is not something in her best interests, in a temporal sense, and it is in a temporal sense that I must operate whether I believe in life after death or not. The single most important temporal quality Karen Ann Quinlan has is life. This court will not authorize that life to be taken from her.

As previously indicated, equity follows the law. When positive statutory law exists, an equity court cannot supersede or abrogate it. The common law concept of homicide, the unlawful killing of one person by another, is reflected in our codified law. N.J.S.A. 2A:113-1, 2 and 5. The intentional taking of another's life, regardless of motive, is sufficient grounds for conviction. *State v. Ehlers*, 98 N.J.L. 236, 240--241, 119 A. 15 (E. & A. 1922); see *People v. Conley*, 64 Cal.2d 310, 49 Cal.Rptr. 815, 411 P.2d 911 (Sup.Ct.1966). Humanitarian motives cannot justify the taking of a human life. See *State v. Ehlers*, supra, 98 N.J.L. at 240--241, 119 A. 15. The fact that the victim is on the threshold of death or in terminal condition is no defense to a homicide charge. *State v. Mally*, 139 Mont. 599, 366 P.2d 868, 873 (Sup.Ct. 1961).

New Jersey has adopted the principles of the common law against homicide. While some of the afocited decisions are from other jurisdictions, they are reflections of the common law and therefore dispositive of the manner in which this State would treat like circumstances. It is a reasonable construction that the law of this State would preclude the removal of Karen Quinlan from the respirator. As such, a court of equity must follow the positive statutory law; it cannot supersede it.[footnote omitted]

A significant amount of the legal presentation to the court has involved whether the act of removing Karen from the respirator constitutes an affirmative act, or could be considered an act of omission.[footnote omitted] An intricate discussion on semantics and form is not required since the substance of the sought-for authorization would result in the taking of the life of Karen Quinlan when the law of the State indicates that such an authorization would be a homicide.

Matter of Quinlan, 348 A.2d 801, 818-820 (N.J.Super.Ch. 1975).

The trial judge then considered the U.S. Supreme Court cases on privacy, and decided that there was *no* constitutionally protected right-to-die that Karen's parents could assert on her behalf.

The 'right of privacy,' identified as such, was first recognized in *Griswold v. Connecticut*, 381 U.S. 479, 85 S.Ct. 1678, 19 L.Ed.2d 510 (1965). The source of this right has various explanations. *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1972). Justice Blackmun, writing for the court in *Wade*, indicated

¹³ "The doctrine has been extended in other jurisdictions to the personal affairs of incompetents and others suffering under disability. *Strunk v. Strunk*, 445 S.W.2d 145, 147-148 (Ky.Ct.App. 1969), *Hart v. Brown*, 29 Conn.Super. 368, 289 A.2d 386 (Super.Ct. 1972)." *Matter of Quinlan*, 348 A.2d. at 816.

The Constitution does not explicitly mention any right of privacy. * * * (T) he Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution. In varying contexts, the Court or individual Justices have, indeed, found at least the roots of that right in the First Amendment * * *; in the Fourth and Fifth Amendments * * *; in the penumbras of the Bill of Rights, * * *; in the Ninth Amendment * * *; or in the concept of liberty guaranteed by the first section of the Fourteenth Amendment, * * *.

*. These decisions make it clear that only personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty,' * * * are included in this guarantee of personal privacy.

(410 U.S. at 152, 93 S.Ct. at 726, 35 L.Ed.2d at 176; citations omitted)

Plaintiff suggests, citing *Griswold* in concert with *Union Pacific Railway Co. v. Botsford*, 141 U.S. 250, 11 S.Ct. 1000, 35 L.Ed. 734 (1891), that the right of self-determination and right of privacy are synonymous.[footnote omitted] He also suggests the right is exercisable by a parent for his child.

It is not significant to this opinion whether the right of self-determination is within the scope of the right of privacy. What is significant is the extent to which it is subject to a compelling state interest, *Roe v. Wade*, supra, and whether the right can be exercised by the parent for his child.

The majority of cases dealing with the refusal of an individual to accept treatment which created an exposure to death involved mature, competent adults. *U.S. v. George*, 239 F.Supp. 752 (D.Conn. 1965); *In re Osborne*, 294 A.2d 372 (D.C.Ct.App.1972); *In re Brooks Estate*, supra; *In re Yetter*, 62 Pa.D. & C.R.2d 619 (C.P. 1973); *John F. Kennedy Memorial Hospital v. Heston*, supra [279 A.2d 670 (N.J. 1971)] (the competency of the adult to make the decision at the specific instance was questionable because of her condition of shock).¹⁴ None, however, dealt with an incompetent adult, as here, totally unaware of the problem.

The disability places the court in a *Parens patriae* circumstance, significantly different from the instance of a competent adult's effort to control his body. This is true in spite of the prior statements of Karen Quinlan concerning dispensing with extraordinary care. For, as indicated, the proofs do not meet a standard clear enough to have the probative weight sufficient to convince the court that Karen Quinlan, in full command of the facts, would favor death.

The judicial power to act in the incompetent's best interest in this instance selects continued life, and to do so is not violative of a constitutional right.

The majority of the right-of-privacy cases, *Roe v. Wade*, supra (abortion); *Eisenstadt v. Baird*, 405 U.S. 438, 92 S.Ct. 1029, 31 L.Ed.2d 349 (1972) (contraception); *Griswold v. Connecticut*, supra (contraception); *Stanley v. Georgia*, 394 U.S. 557, 89 S.Ct. 1243, 22 L.Ed.2d 542 (1969) (possession of obscene films for own personal viewing, involved a claim which asserted a Life practice for the individual involved).¹⁵ The compelling state interest found lacking in *Wade*, *Baird*, *Griswold* and *Stanley* is appropriate here in the State's interest

¹⁴ Note that *JFK Memorial Hospital v. Heston* was overruled by *Matter of Conroy*, 486 A.2d 1209, 1224 (N.J. 1985).

¹⁵ It is *not* convincing to cite cases involving access to contraception or abortion to justify creating a constitutional right to refuse medical treatment. In *Cruzan*, the first U.S. Supreme Court case to consider the issue, the majority opinion did not establish such a constitutional right. However, five justices of the U.S. Supreme Court did find such a constitutional right exists. See below at page 123.

in preservation of life and the extension of the court's protection to an incompetent. *John F. Kennedy Memorial Hospital v. Heston*, supra.

The power of the parents to exercise the constitutional right is found lacking on several grounds: First, the only cases where a parent has standing to pursue a constitutional right on behalf of an infant are those involving continuing life styles. *Wisconsin v. Yoder*, infra; *Pierce v. Society of Sisters*, 268 U.S. 510, 45 S.Ct. 571, 69 L.Ed. 1070 (1925); *Meyer v. Nebraska*, 262 U.S. 390, 43 S.Ct. 625, 67 L.Ed. 1042 (1923). Second, the parents urged Dr. Morse to do everything at the outset to save Karen's life. The parents now ask him to abandon his conscience and allow her life to end. In *Roe v. Wade*, the court refused to hold that the right of privacy included the unlimited right to body control. In a like manner, the right to privacy, being urged through a parent, must be fettered when in conflict with a doctor's duty to provide life-giving care.[footnote omitted]

There is no constitutional right to die that can be asserted by a parent for his incompetent adult child.

Matter of Quinlan, 348 A.2d 801, 821-822 (N.J.Super.Ch. 1975).

The trial judge then briefly considered two arguments that continue thirty years later to be made by pro-life advocates: (1) discontinuing life support is a violation of a person's First Amendment right to free exercise of religion and (2) discontinuing life support is cruel and unusual punishment under the Eighth Amendment. The trial judge tersely rejected both arguments: (1) "The temporal world is what the Free Exercise Clause deals with not the hereafter." and (2) "The Eighth Amendment has no applicability to this civil action." *Matter of Quinlan*, 348 A.2d at 822-824 (N.J.Super.Ch. 1975).

Finally, the trial court refused to appoint either of Karen's parents as the guardian of her person, because each of the parents had expressed a wish to discontinue the respirator. The court continued the appointment of its guardian ad litem for Karen, then concluded:

The responsibility of the guardian over the person of the incompetent is to make the decisions, in this instance, that relate to her welfare, insofar as those decisions are within the person's control. I have ruled that it is a medical decision whether or not Karen should be removed from the respirator. Just as that decision is a medical one, the continued care and treatment of Karen is a medical one. There will be, however, from time to time medical decisions relating to further treatment that will require a guardian's counsel, advice and concurrence. This is reflected by the testimony of Dr. Morse.

Matter of Quinlan, 348 A.2d 801, 824 (N.J.Super.Ch. 1975).

New Jersey Supreme Court

The father of Karen Quinlan appealed and the New Jersey Supreme Court took the case directly, without passing through the lower-level appellate court. Chief Justice Hughes wrote the opinion. In the review of the history of the case, the New Jersey Supreme Court wrote:

After certification the Attorney General filed as of right (R. 2:3-4) a cross-appeal [FN3.1] challenging the action of the trial court in admitting evidence of prior statements made by Karen while competent as to her distaste for continuance of life by extraordinary medical procedures, under circumstances not unlike those of the present case. These quoted statements were made in the context of several conversations with regard to others terminally

ill and being subject to like heroic measures. The statements were advanced as evidence of what she would want done in such a contingency as now exists. She was said to have firmly evinced her wish, in like circumstances, not to have her life prolonged by the otherwise futile use of extraordinary means. Because we agree with the conception of the trial court that such statements, since they were remote and impersonal, lacked significant probative weight, it is not of consequence to our opinion that we decide whether or not they were admissible hearsay.¹⁶

FN3.1. This cross-appeal was later informally withdrawn but in view of the importance of the matter we nevertheless deal with it.

Matter of Quinlan, 355 A.2d 647, 653 (N.J. 1976).

The New Jersey Supreme Court noted that the Quinlan family, including Karen, were devout Catholics. The Court quoted from the amicus curiae brief submitted by the “New Jersey Catholic Conference, essentially the spokesman for the various Catholic bishops of New Jersey”.

So it was that the Bishop Casey statement validated the decision of Joseph Quinlan:

Competent medical testimony has established that Karen Ann Quinlan has no reasonable hope of recovery from her comatose state by the use of any available medical procedures. The continuance of mechanical (cardiorespiratory) supportive measures to sustain continuation of her body functions and her life constitute extraordinary means of treatment. *Therefore, the decision of Joseph * * * Quinlan to request the discontinuance of this treatment is, according to the teachings of the Catholic Church, a morally correct decision.* (Emphasis in original)

Matter of Quinlan, 355 A.2d 647, 658-659 (N.J. 1976).

The New Jersey Supreme Court then presented the three issues before the Court.

It is from this factual base that the Court confronts and responds to three basic issues:

1. Was the trial court correct in denying the specific relief requested by plaintiff, I.e., authorization for termination of the life-supporting apparatus, on the case presented to him? Our determination on that question is in the affirmative.
2. Was the court correct in withholding letters of guardianship from the plaintiff and appointing in his stead a stranger? On that issue our determination is in the negative.
3. Should this Court, in the light of the foregoing conclusions, grant declaratory relief to the plaintiff? On that question our Court's determination is in the affirmative.

This brings us to a consideration of the constitutional and legal issues underlying the foregoing determinations.

Matter of Quinlan, 355 A.2d 647, 660 (N.J. 1976).

¹⁶ Later, the New Jersey Supreme Court found they were admissible. *Matter of Conroy*, 486 A.2d 1209, 1230, n. 6 (N.J. 1985) (“None of these forms of evidence need be excluded as hearsay from a court proceeding, if there be one, since oral and written expressions of a person's reactions or desires fit within the ‘existing state of mind’ exception to the hearsay rule.”). Also see page 59 below. Further, *Matter of Conroy*, 486 A.2d 1209, 1230 (N.J. 1985) (“... we now believe that we were in error in *Quinlan*, ... 355 A.2d 647,[653, 664 (NJ 1976)] to disregard evidence of statements that Ms. Quinlan made to friends concerning artificial prolongation of the lives of others who were terminally ill. Such evidence is certainly relevant to shed light on whether the patient would have consented to the treatment if competent to make the decision.”).

The New Jersey Supreme Court held that the father had standing to raise the issues.

The father of Karen Quinlan is certainly no stranger to the present controversy. His interests are real and adverse and he raises questions of surpassing importance. Manifestly, he has standing to assert his daughter's constitutional rights, she being incompetent to do so.

Matter of Quinlan, 355 A.2d 647, 661 (N.J. 1976).

The New Jersey Supreme Court affirmed the trial court's holding that religious freedom under the First Amendment was not implicated in this case.

We think ... that, ranged against the State's interest in the preservation of life, the impingement of religious belief, much less religious 'neutrality' as here, does not reflect a constitutional question, in the circumstances at least of the case presently before the Court. Moreover, like the trial court, we do not recognize an independent parental right of religious freedom to support the relief requested.

Matter of Quinlan, 355 A.2d 647, 661-662 (N.J. 1976).

The New Jersey Supreme Court affirmed the trial court's holding that the Constitutional prohibition against "cruel and unusual punishment" was not applicable to this case.

Similarly inapplicable to the case before us is the Constitution's Eighth Amendment protection against cruel and unusual punishment which, as held by the trial court, is not relevant to situations other than the imposition of penal sanctions. A deprivation, forfeiture or penalty arising out of a civil proceeding or otherwise cannot be 'cruel and unusual punishment' within the meaning of the constitutional clause.

Matter of Quinlan, 355 A.2d 647, 662 and n. 6 (N.J. 1976).

The New Jersey Supreme Court then focused on the Constitutional right of privacy.

III. The Right of Privacy

It is the issue of the constitutional right of privacy that has given us most concern, in the exceptional circumstances of this case. Here a loving parent, Qua parent and raising the rights of his incompetent and profoundly damaged daughter, probably irreversibly doomed to no more than a biologically vegetative remnant of life, is before the court. He seeks authorization to abandon specialized technological procedures which can only maintain for a time a body having no potential for resumption or continuance of other than a 'vegetative' existence.

We have no doubt, in these unhappy circumstances, that if Karen were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death. To this extent we may distinguish *Heston*, supra, which concerned a severely injured young woman (Delores Heston), whose life depended on surgery and blood transfusion; and who was in such extreme shock that she was unable to express an informed choice (although the Court apparently considered the case as if the patient's own religious decision to resist transfusion were at stake), but most importantly a patient apparently salvable to long life and vibrant health; — a situation not at all like the present case.

We have no hesitancy in deciding, in the instant diametrically opposite case, that no external compelling interest of the State could compel Karen to endure the unendurable, only to vegetate a few measurable months with no realistic possibility of returning to any

semblance of cognitive or sapient life. We perceive no thread of logic distinguishing between such a choice on Karen's part and a similar choice which, under the evidence in this case, could be made by a competent patient terminally ill, riddled by cancer and suffering great pain; such a patient would not be resuscitated or put on a respirator in the example described by Dr. Korein, and a fortiori would not be kept *against his will* on a respirator.

Although the Constitution does not explicitly mention a right of privacy, Supreme Court decisions have recognized that a right of personal privacy exists and that certain areas of privacy are guaranteed under the Constitution. *Eisenstadt v. Baird*, 405 U.S. 438, 92 S.Ct. 1029, 31 L.Ed.2d 349 (1972); *Stanley v. Georgia*, 394 U.S. 557, 89 S.Ct. 1243, 22 L.Ed.2d 542 (1969). The Court has interdicted judicial intrusion into many aspects of personal decision, sometimes basing this restraint upon the conception of a limitation of judicial interest and responsibility, such as with regard to contraception and its relationship to family life and decision. *Griswold v. Connecticut*, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965).

The Court in *Griswold* found the unwritten constitutional right of privacy to exist in the penumbra of specific guarantees of the Bill of Rights 'formed by emanations from those guarantees that help give them life and substance.' 381 U.S. at 484, 85 S.Ct. at 1681, 14 L.Ed.2d at 514. Presumably this right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions. *Roe v. Wade*, 410 U.S. 113, 153, 93 S.Ct. 705, 727, 35 L.Ed.2d 147, 177 (1973).

Nor is such right of privacy forgotten in the New Jersey Constitution. N.J.Const. (1947), Art. I, par. 1.

The claimed interests of the State in this case are essentially the preservation and sanctity of human life and defense of the right of the physician to administer medical treatment according to his best judgment. In this case the doctors say that removing Karen from the respirator will conflict with their professional judgment. The plaintiff answers that Karen's present treatment serves only a maintenance function; that the respirator cannot cure or improve her condition but at best can only prolong her inevitable slow deterioration and death; and that the interests of the patient, as seen by her surrogate, the guardian, must be evaluated by the court as predominant, even in the face of an opinion *Contra* by the present attending physicians. Plaintiff's distinction is significant. The nature of Karen's care and the realistic chances of her recovery are quite unlike those of the patients discussed in many of the cases where treatments were ordered. In many of those cases the medical procedure required (usually a transfusion) constituted a minimal bodily invasion and the chances of recovery and return to functioning life were very good. We think that the State's interest *Contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest. It is for that reason that we believe Karen's choice, if she were competent to make it, would be vindicated by the law. Her prognosis is extremely poor, — she will never resume cognitive life. And the bodily invasion is very great, — she requires 24 hour intensive nursing care, antibiotics, the assistance of a respirator, a catheter and feeding tube.

Our affirmation of Karen's independent right of choice, however, would ordinarily be based upon her competency to assert it. The sad truth, however, is that she is grossly incompetent and we cannot discern her supposed choice based on the testimony of her previous conversations with friends, where such testimony is without sufficient probative weight.¹⁷ 137 N.J.Super. at 260, 348 A.2d 801. Nevertheless we have concluded that

¹⁷ *Matter of Conroy*, 486 A.2d 1209, 1230 (N.J. 1985) ("... we now believe that we were in error in *Quinlan*, ... 355 A.2d 647,[653, 664 (NJ 1976)] to disregard evidence of statements that Ms. Quinlan made to friends concerning artificial prolongation of the lives of others who were terminally ill.

Karen's right of privacy may be asserted on her behalf by her guardian under the peculiar circumstances here present.

If a putative decision by Karen to permit this non-cognitive, vegetative existence to terminate by natural forces is regarded as a valuable incident of her right of privacy, as we believe it to be, then it should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice. The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment, subject to the qualifications hereinafter stated, as to whether she would exercise it in these circumstances. If their conclusion is in the affirmative this decision should be accepted by a society the overwhelming majority of whose members would, we think, in similar circumstances, exercise such a choice in the same way for themselves or for those closest to them. It is for this reason that we determine that Karen's right of privacy may be asserted in her behalf, in this respect, by her guardian and family under the particular circumstances presented by this record.

Regarding Mr. Quinlan's right of privacy, we agree with Judge Muir's conclusion that there is no parental constitutional right that would entitle him to a grant of relief *In propria persona*. *Id.* at 266, 348 A.2d 801. Insofar as a parental right of privacy has been recognized, it has been in the context of determining the rearing of infants and, as Judge Muir put it, involved 'continuing life styles.' [citations omitted] Karen Quinlan is a 22 year old adult. Her right of privacy in respect of the matter before the Court is to be vindicated by Mr. Quinlan as guardian, as hereinabove determined.

IV. The Medical Factor

Having declared the substantive legal basis upon which plaintiff's rights as representative of Karen must be deemed predicated, we face and respond to the assertion on behalf of defendants that our premise unwarrantably offends prevailing medical standards. We thus turn to consideration of the medical decision supporting the determination made below, conscious of the paucity of pre-existing legislative and judicial guidance as to the rights and liabilities therein involved.

A significant problem in any discussion of sensitive medical-legal issues is the marked, perhaps unconscious, tendency of many to distort what the law is, in pursuit of an exposition of what they would like the law to be. Nowhere is this barrier to the intelligent resolution of legal controversies more obstructive than in the debate over patient rights at the end of life. Judicial refusals to order lifesaving treatment in the face of contrary claims of bodily self-determination or free religious exercise are too often cited in support of a preconceived 'right to die,' even though the patients, wanting to live, have claimed no such right. Conversely, the assertion of a religious or other objection to lifesaving treatment is at times condemned as attempted suicide, even though suicide means something quite different in the law. (Byrn, 'Compulsory Lifesaving Treatment For The Competent Adult,' 44 *Fordham L.Rev.* 1 (1975)).

Perhaps the confusion there adverted to stems from mention by some courts of statutory or common law condemnation of suicide as demonstrating the state's interest in the preservation of life. We would see, however, a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support or radical surgery, for instance, in the face of irreversible, painful and certain imminent death. The contrasting situations mentioned are analogous to those continually faced by the medical profession. When does the institution of life-sustaining procedures, ordinarily mandatory, become the subject of medical discretion in the context of administration to persons *In extremis*? And when does the withdrawal of such procedures, from such persons already supported by them,

Such evidence is certainly relevant to shed light on whether the patient would have consented to the treatment if competent to make the decision.”).

come within the orbit of medical discretion? When does a determination as to either of the foregoing contingencies court the hazard of civil or criminal liability on the part of the physician or institution involved?

The existence and nature of the medical dilemma need hardly be discussed at length, portrayed as it as in the present case and complicated as it has recently come to be in view of the dramatic advance of medical technology. The dilemma is there, it is real, it is constantly resolved in accepted medical practice without attention in the courts, it pervades the issues in the very case we here examine. The branch of the dilemma involving the doctor's responsibility and the relationship of the court's duty was thus conceived by Judge Muir:

Doctors * * * to treat a patient, must deal with medical tradition and past case histories. They must be guided by what they do know. The extent of their training, their experience, consultation with other physicians, must guide their decision-making processes in providing care to their patient. The nature, extent and duration of care by societal standards is the responsibility of a physician. The morality and conscience of our society places this responsibility in the hands of the physician. What justification is there to remove it from the control of the medical profession and place it in the hands of the courts?

(137 N.J.Super. at 259, 348 A.2d at 818).

Such notions as to the distribution of responsibility, heretofore generally entertained, should however neither impede this Court in deciding matters clearly justiciable nor preclude a re-examination by the Court as to underlying human values and rights. Determinations as to these must, in the ultimate, be responsive not only to the concepts of medicine but also to the common moral judgment of the community at large. In the latter respect the Court has a nondelegable judicial responsibility.

Put in another way, the law, equity and justice must not themselves quail and be helpless in the face of modern technological marvels presenting questions hitherto unthought of. Where a Karen Quinlan, or a parent, or a doctor, or a hospital, or a State seeks the process and response of a court, it must answer with its most informed conception of justice in the previously unexplored circumstances presented to it. That is its obligation and we are here fulfilling it, for the actors and those having an interest in the matter should not go without remedy.

Courts in the exercise of their *Parens patriae* responsibility to protect those under disability have sometimes implemented medical decisions and authorized their carrying out under the doctrine of 'substituted judgment.' *Hart v. Brown*, 29 Conn.Sup. 368, 289 A.2d 386, 387-88 (Super.Ct. 1972); *Strunk v. Strunk*, 445 S.W.2d 145, 147-48 (Ky. 1969). *Matter of Quinlan*, 355 A.2d 647, 662-666 (N.J. 1976).

The New Jersey Supreme Court then began to resolve this case.

The medical obligation is related to standards and practice prevailing in the profession. The physicians in charge of the case, as noted above, declined to withdraw the respirator. That decision was consistent with the proofs below as to the then existing medical standards and practices.

Under the law as it then stood, Judge Muir was correct in declining to authorize withdrawal of the respirator.

However, in relation to the matter of the declaratory relief sought by plaintiff as representative of Karen's interests, we are required to reevaluate the applicability of the medical standards projected in the court below. The question is whether there is such internal consistency and rationality in the application of such standards as should warrant their

constituting an ineluctable bar to the effectuation of substantive relief for plaintiff at the hands of the court. We have concluded not.

In regard to the foregoing it is pertinent that we consider the impact on the standards both of the civil and criminal law as to medical liability and the new technological means of sustaining life irreversibly damaged.

The modern proliferation of substantial malpractice litigation and the less frequent but even more unnerving possibility of criminal sanctions would seem, for it is beyond human nature to suppose otherwise, to have bearing on the practice and standards as they exist. The brooding presence of such possible liability, it was testified here, had no part in the decision of the treating physicians. As did Judge Muir, we afford this testimony full credence. But we cannot believe that the stated factor has not had a strong influence on the standards, as the literature on the subject plainly reveals. (See footnote 8, *Infra*). Moreover our attention is drawn not so much to the recognition by Drs. Morse and Javed of the extant practice and standards but to the widening ambiguity of those standards themselves in their application to the medical problems we are discussing.

The agitation of the medical community in the face of modern life prolongation technology and its search for definitive policy are demonstrated in the large volume of relevant professional commentary.[FN8]

FN8. See, e.g., Downing, *Euthanasia and the Right to Death* (1969); St. John-Stevas, *Life, Death and the Law* (1961); Williams, *The Sanctity of Human Life and the Criminal Law* (1957); Appel, 'Ethical and Legal Questions Posed by Recent Advances in Medicine,' 205 *J.A.M.A.* 513 (1968); Cantor, 'A Patient's Decision To Decline Life-Saving Medical Treatment: Bodily Integrity Versus The Preservation Of Life,' 26 *Rutgers L.Rev.* 228 (1973); Claypool, 'The Family Deals with Death,' 27 *Baylor L.Rev.* 34 (1975); Elkington, 'The Dying Patient, The Doctor and The Law,' 13 *Ill.L.Rev.* 740 (1968); Fletcher, 'Legal Aspects of the Decision Not to Prolong Life,' 203 *J.A.M.A.* 65 (1968); Foreman, 'The Physician's Criminal Liability for the Practice of Euthanasia,' 27 *Baylor L.Rev.* 54 (1975); Gurney, 'Is There A Right To Die?--A Study of the Law of Euthanasia,' 3 *Cumb.-Sam.L.Rev.* 235 (1972); Mannes, 'Euthanasia vs. The Right to Life,' 27 *Baylor L.Rev.* 68 (1975); Sharp & Crofts, 'Death with Dignity and The Physician's Civil Liability,' 27 *Baylor L.Rev.* 86 (1975); Sharpe & Hargest, 'Lifesaving Treatment for Unwilling Patients,' 36 *Fordham L.Rev.* 695 (1968); Skegg, 'Irreversibly Comatose Individuals: 'Alive' or 'Dead?', 33 *Camb.L.J.* 130 (1974); Comment, 'The Right to Die,' 7 *Houston L.Rev.* 654 (1970); Note, 'The Time Of Death--A Legal, Ethical and Medical Dilemma,' 18 *Catholic Law.* 243 (1972); Note, 'Compulsory Medical Treatment: The State's Interest Re-evaluated,' 51 *Minn.L.Rev.* 293 (1966).

The wide debate thus reflected contrasts with the relative paucity of legislative and judicial guides and standards in the same field. The medical profession has sought to devise guidelines such as the 'brain death' concept of the Harvard Ad Hoc Committee mentioned above. But it is perfectly apparent from the testimony we have quoted of Dr. Korein, and indeed so clear as almost to be judicially noticeable, that humane decisions against resuscitative or maintenance therapy are frequently a recognized *De facto* response in the medical world to the irreversible, terminal, painridden patient, especially with familial consent. And these cases, of course, are far short of 'brain death.'

We glean from the record here that physicians distinguish between curing the ill and comforting and easing the dying; that they refuse to treat the curable as if they were dying or ought to die, and that they have sometimes refused to treat the hopeless and dying as if they were curable. In this sense, as we were reminded by the testimony of Drs. Korein and Diamond, many of them have refused to inflict an undesired prolongation of the process of dying on a patient in irreversible condition when it is clear that such 'therapy' offers neither human nor humane benefit. We think these attitudes represent a balanced implementation of a profoundly realistic perspective on the meaning of life and death and that they respect the

whole Judeo-Christian tradition of regard for human life. No less would they seem consistent with the moral matrix of medicine, 'to heal,' very much in the sense of the endless mission of the law, 'to do justice.'

Yet this balance, we feel, is particularly difficult to perceive and apply in the context of the development by advanced technology of sophisticated and artificial life-sustaining devices. For those possibly curable, such devices are of great value, and, as ordinary medical procedures, are essential. Consequently, as pointed out by Dr. Diamond, they are necessary because of the ethic of medical practice. But in light of the situation in the present case (while the record here is somewhat hazy in distinguishing between 'ordinary' and 'extraordinary' measures), one would have to think that the use of the same respirator or like support could be considered 'ordinary' in the context of the possibly curable patient but 'extraordinary' in the context of the forced sustaining by cardio-respiratory processes of an irreversibly doomed patient. And this dilemma is sharpened in the face of the malpractice and criminal action threat which we have mentioned.

We would hesitate, in this imperfect world, to propose as to physicians that type of immunity which from the early common law has surrounded judges and grand jurors, See e.g., *Grove v. Van Duyn*, 44 N.J.L. 654, 656--57 (E. & A. 1882); *O'Regan v. Schermerhorn*, 25 N.J.Misc. 1, 19--20, 50 A.2d 10 (Sup.Ct. 1940), so that they might without fear of personal retaliation perform their judicial duties with independent objectivity. In *Bradley v. Fisher*, 60 U.S. (13 Wall.) 335, 347, 20 L.Ed. 646, 649 (1872), the Supreme Court held:

(I)t is a general principle of the highest importance to the proper administration of justice that a judicial officer, in exercising the authority vested in him, shall be free to act upon his own convictions, without apprehension of personal consequences to himself.

Lord Coke said of judges that 'they are only to make an account to God and the King (the State).' 12 Coke Rep. 23, 25, 77 Eng.Rep. 1305, 1307 (S.C. 1608).

Nevertheless, there must be a way to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their dying patients. We would hope that this opinion might be serviceable to some degree in ameliorating the professional problems under discussion.

A technique aimed at the underlying difficulty (though in a somewhat broader context) is described by Dr. Karen Teel, a pediatrician and a director of Pediatric Education, who writes in the *Baylor Law Review* under the title 'The Physician's Dilemma: A Doctor's View: What The Law Should Be.' Dr. Teel recalls:

Physicians, by virtue of their responsibility for medical judgments are, partly by choice and partly by default, charged with the responsibility of making ethical judgments which we are sometimes ill-equipped to make. We are not always morally and legally authorized to make them. The physician is thereby assuming a civil and criminal liability that, as often as not, he does not even realize as a factor in his decision. There is little or no dialogue in this whole process. The physician assumes that the judgment is called for and, in good faith, he acts. Someone must and it has been the physician who has assumed the responsibility and the risk.

I suggest that it would be more appropriate to provide a regular forum for more input and dialogue in individual situations and to allow the responsibility of these judgments to be shared. Many hospitals have established an Ethics Committee composed of physicians, social workers, attorneys, and theologians, * * * which serves to review the individual circumstances of ethical dilemma and which has provided much in the way of assistance and safeguards for patients and their medical caretakers. Generally, the authority of these committees is primarily restricted to the hospital setting and their official status is more that of an advisory body than of an enforcing body.

The concept of an Ethics Committee which has this kind of organization and is readily accessible to those persons rendering medical care to patients, would be, I think, the most promising direction for further study at this point. * * * * * (This would allow) some much needed dialogue regarding these issues and (force) the point of exploring all of the options for a particular patient. It

diffuses the responsibility for making these judgments. Many physicians, in many circumstances, would welcome this sharing of responsibility. I believe that such an entity could lend itself well to an assumption of a legal status which would allow courses of action not now undertaken because of the concern for liability.

(27 Baylor L.Rev. 6, 8--9 (1975)).

The most appealing factor in the technique suggested by Dr. Teel seems to us to be the diffusion of professional responsibility for decision, comparable in a way to the value of multi-judge courts in finally resolving on appeal difficult questions of law. Moreover, such a system would be protective to the hospital as well as the doctor in screening out, so to speak, a case which might be contaminated by less than worthy motivations of family or physician. In the real world and in relationship to the momentous decision contemplated, the value of additional views and diverse knowledge is apparent.

We consider that a practice of applying to a court to confirm such decisions would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome. Such a requirement is distinguishable from the judicial overview traditionally required in other matters such as the adjudication and commitment of mental incompetents. This is not to say that in the case of an otherwise justiciable controversy access to the courts would be foreclosed; we speak rather of a general practice and procedure.

And although the deliberations and decisions which we describe would be professional in nature they should obviously include at some stage the feelings of the family of an incompetent relative. Decision-making within health care if it is considered as an expression of a primary obligation of the physician, *Primum non nocere*, should be controlled primarily within the patient-doctor-family relationship, as indeed was recognized by Judge Muir in his supplemental opinion of November 12, 1975.

If there could be created not necessarily this particular system but some reasonable counterpart, we would have no doubt that such decisions, thus determined to be in accordance with medical practice and prevailing standards, would be accepted by society and by the courts, at least in cases comparable to that of Karen Quinlan.

The evidence in this case convinces us that the focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of that biological vegetative existence to which Karen seems to be doomed.

In summary of the present Point of this opinion, we conclude that the state of the pertinent medical standards and practices which guided the attending physicians in this matter is not such as would justify this Court in deeming itself bound or controlled thereby in responding to the case for declaratory relief established by the parties on the record before us.

Matter of Quinlan, 355 A.2d 647, 666-669 (N.J. 1976).

The New Jersey Supreme Court then rejected the possibility of criminal liability for homicide, if Karen's ventilator were disconnected and thereby caused her death.

Having concluded that there is a right of privacy that might permit termination of treatment in the circumstances of this case, we turn to consider the relationship of the exercise of that right to the criminal law. We are aware that such termination of treatment would accelerate Karen's death. The County Prosecutor and the Attorney General maintain that there would be criminal liability for such acceleration. Under the statutes of this State, the unlawful killing of another human being is criminal homicide. N.J.S.A. 2A:113--1, 2, 5. We conclude that there would be no criminal homicide in the circumstances of this case. We believe, first, that the ensuing death would not be homicide but rather expiration from existing natural causes. Secondly, even if it were to be regarded as homicide, it would not be unlawful.

These conclusions rest upon definitional and constitutional bases. The termination of treatment pursuant to the right of privacy is, within the limitations of this case. Ipsa facto lawful. Thus, a death resulting from such an act would not come within the scope of the homicide statutes proscribing only the unlawful killing of another. There is a real and in this case determinative distinction between the unlawful taking of the life of another and the ending of artificial life-support systems as a matter of self-determination.

Furthermore, the exercise of a constitutional right such as we have here found is protected from criminal prosecution. See *Stanley v. Georgia*, supra, 394 U.S. at 559, 89 S.Ct. at 1245, 22 L.Ed.2d at 546. We do not question the State's undoubted power to punish the taking of human life, but that power does not encompass individuals terminating medical treatment pursuant to their right of privacy. See *id.* at 568, 89 S.Ct. at 1250, 22 L.Ed.2d at 551. The constitutional protection extends to third parties whose action is necessary to effectuate the exercise of that right where the individuals themselves would not be subject to prosecution or the third parties are charged as accessories to an act which could not be a crime. *Eisenstadt v. Baird*, supra, 405 U.S. at 445-46, 92 S.Ct. at 1034-35, 31 L.Ed.2d at 357-58; *Griswold v. Connecticut*, supra, 381 U.S. at 481, 85 S.Ct. at 1679-80, 14 L.Ed.2d at 512-13. And, under the circumstances of this case, these same principles would apply to and negate a valid prosecution for attempted suicide were there still such a crime in this State.[FN9]

FN9. An attempt to commit suicide was an indictable offense at common law and as such was indictable in this State as a common law misdemeanor. 1 Schlosser, *Criminal Laws of New Jersey* § 12.5 (3d ed. 1970); See N.J.S.A. 2A:85--1. The legislature downgraded the offense in 1957 to the status of a disorderly persons offense, which is not a 'crime' under our law. N.J.S.A. 2A:170--25.6. And in 1971, the legislature repealed all criminal sanctions for attempted suicide. N.J.S.A. 2A:85--5.1. Provision is now made for temporary hospitalization of persons making such an attempt. N.J.S.A. 30:4--26.3a. We note that under the proposed New Jersey Penal Code (Oct. 1971) there is no provision for criminal punishment of attempted suicide. See Commentary, § 2C:11--6. There is, however, an independent offense of 'aiding suicide.' § 2C:11--6b. This provision, if enacted, would not be incriminatory in circumstances similar to those presented in this case.

Matter of Quinlan, 355 A.2d 647, 669-670 (N.J. 1976).

The New Jersey Supreme Court reversed the trial court's refusal to appoint Karen's father as the guardian of her person.

The statute creates an initial presumption of entitlement to guardianship in the next of kin, for it provides:

In any case where a guardian is to be appointed, letters of guardianship shall be granted * * * to the next of kin, or if * * * it is proven to the court that no appointment from among them will be to the best interest of the incompetent or his estate, then to such other proper person as will accept the same.

(N.J.S.A. 3A:6--36. See *In re Roll*, 117 N.J.Super. 122, 124, 283 A.2d 764, 765 (App.Div. 1971)).

The trial court was apparently convinced of the high character of Joseph Quinlan and his general suitability as guardian under other circumstances, describing him as 'very sincere, moral, ethical and religious.' The court felt, however, that the obligation to concur in the medical care and treatment of his daughter would be a source of anguish to him and would distort his 'decision-making processes.' We disagree, for we sense from the whole record before us that while Mr. Quinlan feels a natural grief, and understandably sorrows because of the tragedy which has befallen his daughter, his strength of purpose and character far outweighs these sentiments and qualifies him eminently for guardianship of the person as

well as the property of his daughter. Hence we discern no valid reason to overrule the statutory intendment of preference to the next of kin.

Matter of Quinlan, 355 A.2d 647, 670-671 (N.J. 1976).

Finally, the New Jersey Supreme Court granted the declaratory relief and concluded:

DECLARATORY RELIEF

We thus arrive at the formulation of the declaratory relief which we have concluded is appropriate to this case. Some time has passed since Karen's physical and mental condition was described to the Court. At that time her continuing deterioration was plainly projected. Since the record has not been expanded we assume that she is now even more fragile and nearer to death than she was then. Since her present treating physicians may give reconsideration to her present posture in the light of this opinion, and since we are transferring to the plaintiff as guardian the choice of the attending physician and therefore other physicians may be in charge of the case who may take a different view from that of the present attending physicians, we herewith declare the following affirmative relief on behalf of the plaintiff. Upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital 'Ethics Committee) or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital or others. [FN10] We herewith specifically so hold.

FN10. The declaratory relief we here award is not intended to imply that the principles enunciated in this case might not be applicable in divers other types of terminal medical situations such as those described by Drs. Korein and Diamond, *Supra*, not necessarily involving the hopeless loss of cognitive or sapient life.

CONCLUSION

We therefore remand this record to the trial court to implement (without further testimonial hearing) the following decisions:

1. To discharge, with the thanks of the Court for his service, the present guardian of the person of Karen Quinlan, Thomas R. Curtin, Esquire, a member of the Bar and an officer of the court.
2. To appoint Joseph Quinlan as guardian of the person of Karen Quinlan with full power to make decisions with regard to the identity of her treating physicians.

We repeat for the sake of emphasis and clarity that upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital 'Ethics Committee' or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital or others.

By the above ruling we do not intend to be understood as implying that a proceeding for judicial declaratory relief is necessarily required for the implementation of comparable decisions in the field of medical practice.

Matter of Quinlan, 355 A.2d 647, 671-672 (N.J. 1976).

Given the controversy on abortion, which is allegedly another end-of-life situation, I find it remarkable that the seven judges of the New Jersey Supreme Court unanimously issued their opinion in *Quinlan*.

In May 1976, after the New Jersey Supreme Court's decision, Karen was weaned from the ventilator. Instead of promptly dying, as predicted by her physicians, she lived for approximately nine years. Karen Quinlan died on 11 June 1985 of pneumonia.

Brother Fox

- ***Application of Eichner*, 423 N.Y.S.2d 580 (N.Y.Sup. 6 Dec 1979), modified sub nom. *Eichner v. Dillon*, 426 N.Y.S.2d 517 (N.Y.A.D. 2 Dept. 27 Mar 1980), mod. sub nom. *Matter of Storar*, 420 N.E.2d 64, 438 N.Y.S.2d 266 (N.Y. 31 Mar 1981), cert. den. sub nom. *Storar v. Storar*, 454 U.S. 858 (5 Oct 1981).**

Joseph Charles Fox had been a Brother in the Membership of the Society of Mary, a religious congregation in the Roman Catholic Church, since 1912, when Fox was 16 y of age. At age 83 y in 1979, Brother Fox lapsed into a persistent vegetative state following a routine surgical operation for a hernia. Father Philip K. Eichner, a priest of the Roman Catholic Church, and Director of the Society of Mary at Chaminade, filed a petition in court on 22 Oct 1979 to become a "committee of the person" (i.e., guardian) and then to discontinue life support from Brother Fox. The District Attorney opposed discontinuation of life support.

medical facts

Fr. Eichner's petition alleged the following facts:

On October 1, 1979, Brother Fox reentered the hospital and, at about 10:00 A.M. on the following day, underwent hernia surgery. Brother Fox never regained consciousness after the surgery.

Accompanying the petition were affidavits from three physicians, including two neurosurgeons, describing the medical condition of Brother Fox. Dr. Edward Kelly, a surgeon and Brother Fox's treating physician, stated that, during the surgery on October 2, at about 11:10 A.M., Brother Fox suffered a severe cardio-respiratory arrest. Despite extensive and heroic resuscitative measures, Brother Fox was afflicted with a diffuse cerebral and brain stem anoxia as a consequence of the arrest.

As a result of the anoxia, Brother Fox had remained in a coma without spontaneous respiration and had been maintained by a mechanical respirator. His responses to stimuli were minimal, his right pupil was pinpoint and he was afflicted with myoclonic volleys, which are in the nature of spasmodic movements of the body. Various brain tests, including

an electroencephalogram, indicated "minimal activity." The conclusion of the physicians was that, despite some subsequent changes, Brother Fox is in a deep coma with loss of respiratory function and is in "a permanent vegetative state" with a prognosis of "lethalis."

Application of Eichner, 423 N.Y.S.2d 580, 583 (N.Y.Sup. 1979) [citations to Petition omitted]

The trial court found the following facts:

From all the evidence presented in this case, this Court makes the following findings about Brother Fox's medical condition. As a result of diffuse cerebral and subcortical anoxia brought on by cardiac arrest suffered on October 2, 1979, Brother Fox lost the ability to then respire spontaneously and fell into a comatose, vegetative state in which he has since been maintained through use of a respirator. Although certain alterations for the better were detected on October 17 and November 6, 1979, Brother Fox's condition has since deteriorated. He is in a chronic vegetative and akinetic mute state as a result of which only certain lower vegetative functions operate. The higher functions of the brain, the so-called cognitive and sapient functions, have been lost and it is highly improbable that they will ever return. To the extent that any further improvements may occur, they will relate only to Brother Fox's vegetative functioning and will occur within the persisting clinical framework of a vegetative state. It was the unanimous conclusion of the physicians who testified in this case, that, to a reasonable degree of medical certainty, there is no reasonable possibility that Brother Fox will ever return from the state he is now in to a condition in which the cognitive and sapient powers of the brain the ability to feel, see, think, sense, communicate, feel emotions and the life operate. The prognosis is that Brother Fox, whether on or off the respirator, will die.

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trial court

In contrast to many other cases with similar issues, in the case of Brother Fox it was relatively easy to determine what Fox would have wanted in this situation.

The Chaminade community discussed the case of Karen Ann Quinlan on repeated occasions in 1976. Concerned about the appropriate moral and spiritual response to the dilemmas posed by the case, the community had occasion to discuss at length the position taken by Pope Pius XII in 1957 in a well-known allocution to a group of anaesthesiologists. The Pope concluded that it was morally and spiritually proper for adherents of the Roman Catholic Church to direct that use of extraordinary life-support systems be terminated when there is no longer reasonable hope of recovery. The community also discussed the statement of Lawrence B. Casey, Bishop of Paterson, in the Quinlan case. Bishop Casey, applying the principles set forth by Pope Pius XII, concluded that continued use of a respirator for Karen constituted extraordinary means of treatment, given the fact that there was no reasonable hope of recovery, and that termination of the treatment was morally sound. Being members of a religious group, the Chaminade community frequently discussed life, death and life after death and how properly to integrate the life of this world with that of the next. The Chaminade community was particularly concerned about the moral and spiritual issues raised by the Quinlan case because of the community's function as a teacher of religious and ethical principles. After these discussions, the community unanimously agreed with the position of Bishop Casey. Brother Fox was an active participant in these discussions, especially inasmuch as various community members read to him articles on the subject which his eye affliction prevented him from reading himself. During these discussions of the Quinlan case,

Brother Fox not only repeatedly expressed agreement with the Church's teaching on the subject of the withdrawal of extraordinary life-support systems but also stated that he personally would not want any of this "extraordinary business" done for him under such circumstances. (The Court notes that the moral and spiritual position which underlines the view of the Chaminade community has recently been approved by John R. McGann, Bishop of Rockville Centre. In a message relating specifically to the condition of Brother Fox, Bishop McGann stated that if mechanical life-support systems will not result in any appreciable benefit, they would cause an unnecessary prolongation of the natural process of dying and can rightly be called extraordinary. Such extraordinary means can properly be withdrawn said the Bishop. (Statement of Bishop John R. McGann on the Condition of Brother Joseph C. Fox, S.M., November 17, 1979, submitted as part of the Memorandum of Amicus Curiae, The Catholic Lawyers Guild of Rockville Centre).)

On a Saturday morning two months prior to his entry into the hospital, Brother Fox discussed the subject of withdrawing extraordinary life-support systems with Father Keenan. On that occasion, he reiterated that he would not want such treatment if his condition were hopeless and would not wish the process of death to be prolonged. Brother Fox also told Norbert Mechenbier that being alive to him was more than the simple vegetative process of respiration. In his investigation Mr. Minion found nothing to cast even the slightest doubt upon the accuracy of these statements.

The position taken by Brother Fox in regard to extraordinary life-support systems is consistent with other views held by him. As a member of the Society of Mary, he has believed throughout his long adult life in an afterlife which is a reward for proper conduct in this life. In fact, on prior trips to the hospital he had so fully prepared himself for death that he told his fellows in the community where everything was in his room and gave away some possessions. Similarly, it is the custom of the Chaminade community to read aloud at a morning religious service the names of members of the Society who had previously died on that date and Brother Fox was very concerned that that custom always be observed because he looked forward to joining them.

From observation during the course of the hearing and from a studied review of the testimony of Father Eichner, Father Keenan, Norbert Mechenbier and Robert C. Minion, this Court finds that Brother Fox opposed the continued use of life-supporting systems like respirators when the chance of recovery from a persistent vegetative state is largely nonexistent and, were he competent at this moment, he would order a termination of the life-supporting respirator. The evidence, which was unchallenged at every turn and unimpeachable in its sincerity, compels this conclusion.

Application of Eichner, 423 N.Y.S.2d 580, 586-587 (N.Y.Sup. 1979) [citations to trial transcript omitted]. Later in the opinion of the trial court, Fox's expression of his opinion was characterized in the following way.

These discussions were plainly not offhand theoretical remarks, but serious examinations of issues of the utmost meaning and significance to Brother Fox and his religious brothers. At the time, Brother Fox, although in generally good health, was 80 years old and obviously, unlike Karen Quinlan, nearing the end of his life. He had seriously prepared himself for death on other occasions and was looking forward to his reward in an afterlife for his sacrifices and good works in this world. He had reiterated his view on the subject as recently as two months before entering the hospital, at a time when he was 83 years of age.

Furthermore, Brother Fox's expressions were not general and vague so as to give rise to doubt about the application of those expressions to the specific facts here present. The discussions in the Chaminade community involved a consideration of Karen Ann Quinlan's situation and the position of Bishop Casey with regard thereto. The focus was thus upon

precisely the illness and the treatment at issue here a chronic vegetative state maintained by a respirator. Whatever Brother Fox may have wanted under other circumstances, he clearly expressed his intentions about the situation that now afflicts him.

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The trial judge appointed Fr. Eichner as the committee of the person for the now incompetent Brother Fox. 423 N.Y.S.2d at 588. Normally the committee of the person would be the next-of-kin, but an exception was made in this case, because Brother Fox had lived all of his adult life in this religious community and Fr. Eichner had personally known Brother Fox since 1953.

The court then considered whether the law would permit Fr. Eichner to stop the life support of Brother Fox. The trial court first considered the right of privacy, which has been used by the New Jersey Supreme Court in the earlier *Quinlan* case.

Father Eichner argues that this Court should authorize the termination of the "extraordinary life support systems" which are now maintaining Brother Fox's life. The legal basis offered for this argument is "that to maintain the life support system of an unwilling patient is an invasion of his constitutionally guaranteed right of privacy."

The Constitution of the United States does not explicitly provide protection for privacy as such. Certain explicit guarantees do insure the integrity and security of the individual from governmental intrusion, particularly the First Amendment, the Fourth Amendment and the self-incrimination clause of the Fifth Amendment, but the right claimed by the petitioner does not find distinct expression in these guarantees. However, in *Griswold v. Connecticut*, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965) the Supreme Court found that a right of privacy was encompassed within the penumbras or peripheries of certain provisions of the Bill of Rights.

The right of privacy was more clearly elucidated in *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973). There, the court extracted from prior cases, including *Griswold*, a recognition of a constitutional right of privacy. The basis for this right was held to be the concept of liberty secured by the Fourteenth Amendment. This right of privacy, the Court held, is not absolute but may be curtailed upon the demonstration of a "compelling state interest."

Petitioner urges that this right of privacy "is broad enough to encompass a patient's decision to decline medical treatment." In support of this proposition, petitioner relies upon *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976) and *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977).

Quinlan involved Karen Ann Quinlan, an unfortunate young woman 20 years of age, who, for reasons that were unclear, ceased breathing for at least two periods of 15 minutes each. As a result, she suffered severe brain damage and lapsed into a comatose condition which was characterized by her physicians as a "chronic persistent vegetative state." For an extended period of time, she was maintained on a respirator without the aid of which the physicians believed she would die. (355 A.2d at 654-55.) The evidence indicated that no form of treatment known to medicine could alleviate or even improve her tragic state. (355 A.2d at 655.) The father of the victim petitioned the Superior Court for an adjudication of Karen's incompetency and for appointment as guardian for her person and property. Mr. Quinlan sought express power to authorize the discontinuance of all "extraordinary medical procedures" being used to keep his daughter alive. (355 A.2d at 651.)

The New Jersey Supreme Court recognized the constitutional right of privacy referred to above and concluded that this right is presumably "broad enough to encompass a patient's

decision to decline medical treatment under certain circumstances." (355 A.2d at 663.) The court also recognized that the State has contrary interests, principally the preservation and sanctity of all human life. Balancing these interests, the court concluded:

"We think that the State's interest Contra weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest. It is for that reason that we believe Karen's choice, if she were competent to make it, would be vindicated by the law. Her prognosis is extremely poor she will never resume cognitive life. And the bodily invasion is very great * * *."

(355 A.2d at 664.)

In *Superintendent of Belchertown*, authorities of a Massachusetts mental health facility petitioned a court to appoint a guardian for Joseph Saikewicz, a person mentally retarded from birth who was suffering from leukemia and in need of prompt medical treatment. A guardian ad litem was appointed who reported his findings to the court wherein he found that Mr. Saikewicz's illness was incurable and invariably fatal. Although the appropriate medical treatment for the illness was chemotherapy, the guardian recommended against it on the ground that the adverse side effects and discomfort which it would cause outweighed the limited extension of life that might possibly result. After a hearing, the court essentially accepted the recommendation of the guardian ad litem. On appeal, the Supreme Judicial Court of Massachusetts agreed. (370 N.E.2d at 420.) Approximately two months later, Mr. Saikewicz died of a complication of the leukemia. (370 N.E.2d at 422.)

The Massachusetts court followed the same approach as the Quinlan court with regard to the question of a constitutional right of privacy, referring to it as "the unwritten constitutional right of privacy (found) in the penumbra of specific guarantees of the Bill of Rights." Relying on Quinlan, the court concluded that "this constitutional guaranty * * * encompasses the right of a patient to preserve his or her right to privacy against unwanted infringements of bodily integrity in appropriate circumstances." (370 N.E.2d at 424.) The same court recognized the countervailing interest of the State in the preservation of human life but qualified that interest as follows:

"There is a substantial distinction in the State's insistence that human life be saved where the affliction is curable, as opposed to the State interest where, as here, the issue is not whether but when, for how long, and at what cost to the individual that life may be briefly extended. Even if we assume that the State has an additional interest in seeing to it that individual decisions on the prolongation of life do not in any way tend to 'cheapen' the value which is placed in the concept of living * * * we believe it is not inconsistent to recognize a right to decline medical treatment in a situation of incurable illness. The constitutional right to privacy, as we conceive it, is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice."

(370 N.E.2d at 425-26.)

The court also recognized State interests in protecting third parties, especially children, against the harmful results which might flow from the decision of a competent adult to refuse life-sustaining treatment and in maintenance of the ethical integrity of the medical profession. The former interest was inapplicable in the Saikewicz case and the latter was held consistent with the apparently prevailing medical practice to recognize that comfort is often more important for the dying than treatment. The court relied upon *Quinlan* as support for the second of these conclusions. (370 N.E.2d at 426-27.)

Although urged by petitioner to do so, this Court will not pass upon the applicability of the constitutional Right of privacy to the circumstances of this case. Petitioner and the authorities upon which he relies do not confront several considerations which appear relevant to the issue posed. First, a variety of activities which may be characterized as private may nevertheless not be automatically incorporated into the constitutional right. (See Cantor, Quinlan, Privacy, and the Handling of Incompetent Dying Patients, 30 Rutgers L.Rev. 243, 245-48 (1977).) More importantly, if the constitutional right of privacy may be said to encompass the decision to terminate life-sustaining medical treatment, there are evidently certain prerequisites to the establishment of that right to which petitioner has not referred. For example, because the right of privacy is protected by the "Fourteenth Amendment's concept of personal liberty and restrictions upon state action" (*Roe v. Wade*, supra, 410 U.S. at 153, 93 S.Ct. at 727), is it not necessary to the establishment of a violation of that right that "state action" be involved? (See *Schlein v. Milford Hospital, Inc.*, 561 F.2d 427 (2nd Cir.); *Robinson v. Price*, 553 F.2d 918 (5th Cir.); *Greco v. Orange Memorial Hospital Corp.*, 513 F.2d 873 (5th Cir.), cert. den. 423 U.S. 1000, 96 S.Ct. 433, 46 L.Ed.2d 376 (1975).) Petitioner has not shown the inapplicability of this principle, nor has he demonstrated that Nassau Hospital is a state institution or so imbued with state concerns that its actions satisfy the "state action" requirement. The specification of these two areas of concern to this Court is not intended to be an exhaustive survey but rather to illustrate the reasons that motivate the determination not to adopt the constitutional right of privacy advanced by petitioner.

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Instead, the trial court decided to grant relief under common-law grounds that a person has the right to control, and reject, medical treatment.

The resolution of the awesome question posed by this case, literally one of life and death for Brother Fox, may hereafter profoundly affect all citizens of this State. No one can foresee the nature of future petitions seeking to apply the conclusion reached here. This consideration also underlines this Court's determination not to base a conclusion on the claim of a right of privacy that is insufficiently defined but nevertheless so attractively worded as to invite unrestrained applications made in its name. Only the petition on behalf of Brother Fox seeks disposition here. (See Byrn, Compulsory Lifesaving Treatment for the Competent Adult, 44 Fordham L.Rev. 1, 8-9 (1975).)

However, the petition must be viewed in the light of existing and relevant common law rights. The common law has long reflected a concern for the individual's right of self-determination. In *Union Pacific Railway Co. v. Botsford*, 141 U.S. 250, 251, 11 S.Ct. 1000, 1001, 35 L.Ed. 734 (1891), the court stated that "(n)o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." Where medical treatment is concerned, the common law has recognized a civil action for damages for treatment in the absence of the patient's informed consent. As Judge Cardozo said, "(e)very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages." (*Schloendorff v. Society of the New York Hospital*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914).) (*Accord Fogal v. Genesee Hospital*, 41 A.D.2d 468, 344 N.Y.S.2d 552, 559 (1973); *Darrah v. Kite*, 32 A.D.2d 208, 301 N.Y.S.2d 286, 290 (1969).) The law clearly requires that the consent be Informed, based upon all information necessary under the circumstances. (*Abril v. Syntex Laboratories, Inc.*, 81 Misc.2d 112, 364 N.Y.S.2d 281, 283 (1975); *Barnette v. Potenza*, 79 Misc.2d 51, 359 N.Y.S.2d 432, 436 (1974).) The statutory

and administrative law of this State embodies the same concern for self-determination on the part of the patient. (See Public Health Law, § 803-c.) It is required by 10 N.Y.Code, Rules & Regs., § 405.25(a)(5) and (6) that hospitals establish written policies which afford each patient, among other things, the right to "receive from his physician information necessary to give informed consent * * * " and the right to "refuse treatment to the extent permitted by law * * * ."

As the Supreme Court indicated in *Union Pacific Railway Co. v. Botsford*, supra, this right to self-determination is, like other rights, not without its limitations. The question of whether or not the right extends to the rejection of life-sustaining medical treatment by a competent adult has been considered in a number of cases, with a variety of results.

In *Erickson v. Dilgard*, 44 Misc.2d 27, 252 N.Y.S.2d 705 (1962) Mr. Justice Meyer of this Court (now Judge Meyer of the Court of Appeals) was faced with an application by the county hospital for an order authorizing administration of a blood transfusion to a patient. The evidence disclosed that the hospital had advised the patient, who had been admitted voluntarily, to submit to an operation to stop gastro-intestinal bleeding, along with a blood transfusion. The patient did not object to the operation but did refuse to submit to a blood transfusion. The hospital contended that the operation was necessary, that there was a considerable chance that the patient would not recover without the blood, and that the patient's decision to forego the transfusion was equivalent to suicide, in violation of the Penal Law. Justice Meyer rejected this argument, stating that it is always a question of judgment whether a medical opinion is correct or not. The court concluded that the application should be denied:

"(I)t is the individual who is the subject of a medical decision who has the final say * * * . (T)his must necessarily be so in a system of government which gives the greatest possible protection to the individual in the furtherance of his own desires."

(44 Misc.2d at 28, 252 N.Y.S.2d at 706.)

In *Palm Springs General Hospital Inc. v. Martinez* (Civil No. 71-12687 (Dade County Cir. Ct., filed July 2, 1971), discussed in Byrn, *Supra*, 44 Fordham L.Rev. 1 at 13-14), a 72-year old woman was suffering from a terminal illness. She refused transfusions and an operation even though death was certain without treatment because she did not want anyone to "torture" her any longer with further surgery. Upon application by her physician for clarification of his duty, the court ruled that the woman could not be forced to undergo the surgery. She died shortly thereafter. Mrs. Martinez based her objection to the treatment proposed not on any religious belief but evidently upon a simple desire to die in peace. The court accepted her decision, which was made competently and with knowledge of the inevitable consequences. Said the court:

"Based upon (her) debilitated physical condition * * * and the fact that performance of surgery * * * and administration of further blood transfusions would only result in the painful extension of her life for a short period of time, it is not in the interest of justice for this Court of Equity to order that she be kept alive against her will.

A conscious adult patient who is mentally competent has the right to refuse medical treatment, even when the best medical opinion deems it essential to save her life."

In *In re Long Island Jewish-Hillside Medical Center*, 73 Misc.2d 395, 342 N.Y.S.2d 356 (1973), a hospital sought authorization for the amputation of the left leg of an 84-year old man afflicted with gangrene. As a result of arteriosclerotic heart disease, the patient was incompetent to decide whether or not he wished to submit to this treatment, which was immediately necessary in order to save his life. Although the case involved incompetency, it is nevertheless clear that, had the patient been competent to decide upon the course of treatment, the court would have accepted his decision. (See 73 Misc.2d at 397-398, 342 N.Y.S.2d at 359-60.)

Courts have also reached similar conclusions when the patient has asserted that the treatment proposed would conflict with his religious beliefs. In *In re Estate of Brooks*, 32 Ill.2d 361, 205 N.E.2d 435 (1965), a lower court appointed a conservator of the person of a competent adult woman for the purpose of consenting to blood transfusions. She was in the hospital for a peptic ulcer but declined to undergo transfusions because she adhered to religious notions which forbade them. The lower court appointed the conservator and the transfusions were successfully performed. On appeal, the Supreme Court of Illinois concluded that the lower court had violated the woman's constitutional right to practice her religious beliefs. (205 N.E.2d at 442.) (See also *In re Melideo*, 88 Misc.2d 974, 390 N.Y.S.2d 523; *Holmes v. Silver Cross Hospital*, 340 F.Supp. 125 (N.D.Ill. 1972).) The court did, however, recognize that the right to exercise one's religious beliefs by declining medical treatment which would violate them is not unlimited. (205 N.E.2d at 439-41.)

Other cases have rejected the right to refuse treatment in particular situations on the ground that State interests prevailed. For example, one court permitted a blood transfusion to be given over a patient's religious objections because of State interests in protecting the patient's minor children from abandonment, protecting the desire of physicians to act to save life and preventing suicide where the patient could readily be restored to life. (*Application of President & Directors of Georgetown College, Inc.*, 118 U.S.App.D.C. 80, 331 F.2d 1000 (D.C. Cir.), cert. den. 377 U.S. 978, 84 S.Ct. 1883, 12 L.Ed.2d 746 (1964).) (See also *John F. Kennedy Memorial Hospital v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971).) In *United States v. George*, 239 F.Supp. 752 (D.Conn. 1965), the court ordered a transfusion for a father of four who had refused the transfusion for religious reasons. The court emphasized the importance of permitting physicians to follow their consciences.

From all of the foregoing, it is clear that there is a common law right to bodily self-determination, which includes the right of a competent adult to refuse life-sustaining medical treatment. This general right is, however, subject to being overridden by State interests in appropriate circumstances. Among the State interests which must be weighed are interests in [1] the protection of third parties, such as minor children, [2] the maintenance of latitude for physicians and hospitals to fulfill their ethical obligations and, [3] by far the most important, the preservation of all human life.

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There is also a state interest in [4] preventing suicide, see below at page 68.

The trial court then considered these four state interests.

The protection of third parties is not at issue here. The State interest in the preservation of life is applicable and is troubling. This State concern encompasses an interest in the preservation of particular life, and, beyond that, an interest in insuring against the cheapening of life in general as a result of individual decisions. (See *Superintendent of Belchertown State School v. Saikewicz*, supra, 370 N.E.2d at 426.) It is unnecessary, and, given the limited judicial role of this Court, inappropriate to attempt to set forth a test by which the rights should generally be balanced. Similarly, the Court need not and does not suggest what decision ought to be reached in different cases under other circumstances. All that is concluded is that Brother Fox, having been afflicted at his very advanced age with the most severe physical ailments with irreversible brain damage which has destroyed all of the higher functions of the mind and which has left him suspended in a purely vegetative condition (and that only with the aid of machines) is entitled to decline treatment.

The State interest in the preservation of life should not, under these most extreme of circumstances, require that Brother Fox be made, against his will, to submit to treatment which cannot serve any medical purpose and which in this situation merely interferes with the

natural process of dying. The State interest in the preservation of Brother Fox's life is, in view of the extreme conditions affecting him, insufficiently strong to override the right of Brother Fox to choose for himself whether or not to submit to continued treatment. Balancing of the State interest in the preservation of all life, the interest, that is, in insuring that life does not lose its inviolability or become cheapened, is more problematic. However, acknowledging Brother Fox's right to choose in these extreme circumstances will not undermine this State interest. It must be recalled that Brother Fox is in his present predicament because medical science, in conformance with its duty to do its utmost to preserve life, has brought a variety of artificial means to bear in an effort to restore Brother Fox to health. These exertions having failed and the patient being now maintained by machines in a hopeless condition, Brother Fox should not be barred from ending a treatment which, in these circumstances, serves only more or less briefly to extend the process of dying. To recognize Brother Fox's right to decide to terminate an artificial life-sustaining treatment in these narrow and extreme circumstances does not undermine the State's interest. Indeed, the courts of this State have already recognized the right to decline life-preserving treatment even though the patients' reasons for doing so were, by normal standards, irrational. (See *Erickson v. Dilgard*, supra; *In re Melideo*, supra.) Here, by contrast, the right is raised under such circumstances that its exercise would be entirely rational and understandable.

This Court is aware of the concern of the medical profession to provide to all patients the fullest medical attention possible in accordance with the ancient obligations of the profession. The Court notes that the physicians who have testified in this case have demonstrated a devotion to these obligations which is to be applauded. However, the medical testimony is convincing that the State's interest in affording the medical profession full opportunity to carry out its functions should not outweigh Brother Fox's right to choose. In this regard, it might well be noted that it is important that the law not create a disincentive to the fullest treatment of patients by making it impossible for them in at least some extreme circumstances to choose to end treatment which has proven unsuccessful.

If this Court were to conclude that Brother Fox's right to self-determination should be exercised in accordance with his wishes, the question arises whether the exercise of the right would constitute suicide. (*John F. Kennedy Memorial Hospital v. Heston*, supra, 279 A.2d at 672, and *Application of the President & Directors of Georgetown College, Inc.*, Supra, 118 U.S.App.D.C. 88-89, 331 F.2d at 1008-09, held that the refusal of life-preserving medical treatment on religious grounds would constitute suicide.) New York Penal Law, § 125.15(3) provides that a person is guilty of manslaughter in the second degree if he intentionally causes or aids another person to commit suicide.

In a scholarly article, Professor Robert M. Byrn of Fordham Law School analyzed the issue of suicide in this context and discussed, *Inter alia*, the *Georgetown College* and *Heston* cases. (Byrn, Supra, 44 Fordham L.Rev. 1 at 16-24.) As Professor Byrn notes, suicide at common law required that an individual "purposefully set in motion a death-producing agent with the specific intent of effecting his own destruction, or, at least, serious injury." (Byrn, Supra, 44 Fordham L.Rev. 1 at 16.) Neither of the patients in *Georgetown College* and *Heston* satisfied this standard. In each instance, the patient did not have a specific intent of effecting his own destruction, nor had the patient set a death-producing agent in motion. The same is overwhelmingly true of Brother Fox. If it could be determined that Brother Fox desired that life-preserving treatment be ended under the circumstances present here, that desire would fall well short of the necessary specific intent. Similarly, it could not be said that Brother Fox had set a death-producing agent in motion. As Professor Byrn states:

"(He would) not claim a right of affirmative self-destruction but a right, in a sense, to allow 'nature' to take its course. It is not (he), but the natural progress of (his) ills, which will destroy (his life). (His) conduct manifests a kind of pacifism, a

fatalistic attitude far removed from the 'extreme forms of aggression' of the suicidal person who makes war on his own life."

(Byrn, supra, 44 Fordham L Rev 1 at 20.)

Furthermore, no criminal responsibility would attach to persons authorized by this Court to withdraw the respirator. The District Attorney concedes that New York Penal Law, § 35.05(1) provides for such a result, although he argues that no such authorization would in fact be proper here. Thus, if this Court were to find that the respirator could be withdrawn because of Brother Fox's desire to decline such treatment under the circumstances present here, that cessation of treatment would not give rise to criminal responsibility on the part of those authorized to effect it.

In sum, this Court concludes

- (a) that the common law right of bodily self-determination permits a competent adult to refuse life-sustaining medical treatment but that this right is subject to certain State interests;
- (b) that the State interests, especially the interest in the preservation of life, do not outweigh Brother Fox's right of self-determination in the circumstances present here;
- (c) that exercise of the right of Brother Fox to decline medical treatment in these circumstances would not give rise to civil liability on the part of those providing medical treatment to him; and
- (d) that implementation of Brother Fox's choice would not constitute a suicide or give rise to criminal responsibility for homicide or assisting another to commit suicide.

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The trial court then found that Fr. Eichner could act on behalf of Brother Fox, to effectuate decisions that Fox could no longer make for himself.

Because Brother Fox is, at present, incompetent and unable to express his desires, the petitioner seeks authorization to exercise the right of bodily self-determination on his behalf. Essentially, petitioner relies once again upon *In re Quinlan* and *Superintendent of Belchertown State School v. Saikewicz* in support of this aspect of the relief requested.

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The trial court judge distinguished *Quinlan* and *Saikewicz* from the case of Brother Fox, but noted that the justification for ending life support was stronger in Fox's case than in either *Quinlan* or *Saikewicz*.

In view of the magnitude of the power involved here and the serious implications for the future, this Court is constrained to reject the analyses of *Quinlan* and *Saikewicz*. However, on the facts of this case, this conclusion does not require the rejection of the relief requested.

As has been found above, Brother Fox had clearly indicated that, under the circumstances and conditions that presently surround and inflict him, he would not consent to continuation of the life-supporting respirator. If Father Eichner, his committee, were to request the termination of the respirator, then that request would be the decision of Brother Fox which Father Eichner would merely pass on as a conduit. Unlike *Quinlan* and *Saikewicz*, no fiction is created nor is the judgment of Father Eichner substituted for that of Brother Fox.

Application of Eichner, 423 N.Y.S.2d 580, 597 (N.Y.Sup. 1979).

In view of later cases (e.g., *Conroy*) we would now say that Brother Fox is an example of a subjective test, *Quinlan* is an example of a limited-objective test, and *Saikewicz* is an example of a pure objective test.

The trial court then issued an Order that authorized Fr. Eichner to disconnect the ventilator from Brother Fox on the following conditions:

¶4.(a) Before directing a removal of the respirator from those life-supporting systems presently sustaining Brother Joseph Charles Fox, he secure from a physician or physicians of his choice an opinion that the condition of Brother Joseph Charles Fox continues in a chronic vegetative state with no reasonable medical possibility that he will ever regain any sapient or cognitive function or capability. This Court will not designate the physician or physicians to be selected by the Committee but does commend both Dr. Edward Kelly and Dr. Nicolas Poloukhine whose medical qualifications and whose experience with Brother Joseph Charles Fox's condition were persuasively demonstrated by their testimony during the hearing in this proceeding;

¶4.(b) In scheduling the physical examination described immediately above, the Committee shall provide the office of the District Attorney of Nassau County with at least forty-eight hours' notice in advance of the date and time of the examination of Brother Joseph Charles Fox in order to provide the District Attorney with an opportunity to have a representative or representatives present for the purpose of observing what transpires. While this Court will not designate the physicians, if any, to be selected by the District Attorney, should he decide to avail himself of the opportunity to be represented, the Court does commend both Dr. Eli Goldensohn and Dr. Richard Beresford whose qualifications and whose experience with the condition of Brother Joseph Charles Fox were persuasively demonstrated during the hearing in this proceeding;

¶5. That if, upon compliance with the conditions described above, the respirator is removed from the life-support systems of Brother Joseph Charles Fox by termination of its use, such action shall not give rise to either civil or criminal liability on the part of any participant, whether Committee, physician, hospital or others;

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first appeal

The trial court issued its opinion on 6 Dec 1979, just 65 days after Fox became unconscious. Denis Dillon, the district attorney appealed. On 24 Jan 1980, Brother Fox died of congestive heart failure, while still on the ventilator. The appellate court decided to hear the case, despite the death of Fox.

... we recognize that, because the profound and difficult issues which underlie this proceeding transcend the tragedy which befell Brother Fox, they have not perished with him. We are therefore unwilling to rely on the fact of his death to avoid the task and indeed the responsibility of defining the role of the judicial system in circumstances such as those originally presented to us. It is important at the outset to address ourselves to the issue of jurisdiction and to state our conclusion that Brother Fox's death neither renders the case moot nor ousts this court of jurisdiction to decide it.

Since the controversy here is one likely to recur and may in the future again evade review, the issues presented are plainly not moot (see *United States v. New York Tel. Co.*, 434 U.S. 159, 165, n.6, 98 S.Ct. 364, 368, n.6, 54 L.Ed.2d 376, quoting *Southern Pacific Terminal Co. v. ICC*, 219 U.S. 489, 515, 31 S.Ct. 279, 283 ... [1911]; see, also, *Roe v. Wade*, 410 U.S. 113, 125, 93 S.Ct. 705, 712, 35 L.Ed.2d 147; *East Meadow Community Concerts Assn. v. Board of Educ.*, 18 N.Y.2d 129, 135, 272 N.Y.S.2d 341, 346, 219 N.E.2d 172, 175). *Eichner v. Dillon*, 426 N.Y.S.2d 517, 523 (N.Y.A.D. 1980).

There are several notable holdings in this first appellate opinion. First, the court recognized the well-established legal right of a mentally competent adult to refuse medical treatment, subject to some exceptions.

Turning our attention to the substantive legal problems, we begin by recognizing that, while the right of an incompetent patient to refuse medical treatment or to have it withdrawn may be subject to some controversy, by contrast, the right of a competent patient to do so is not. There exists a solid line of case authority recognizing the undeniable right of a terminally ill but competent individual to refuse medical care, even if it will inexorably result in his death. The underlying motive for the patient's decision is irrelevant. Its legal underpinnings have been carefully considered and variously described. The Court of Appeals has affirmed that "(e)very human being of adult years and sound mind has a right to determine what shall be done with his own body" (*Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (CARDOZO, J.)). Similarly, it has been stated that "it is the individual who is the subject of a medical decision who has the final say and that this must necessarily be so in a system of government which gives the greatest possible protection to the individual in the furtherance of his own desires" (*Matter of Erickson v. Dilgard*, 44 Misc.2d 27, 28, 252 N.Y.S.2d 705, 706 (MEYER, J.)). In this regard, one United States District Court, in considering whether the terminally ill had a right to elect unconventional methods of treatment such as the use of the drug Laetrile, remarked that it was "uncontrovertible that a patient has a right to refuse cancer treatment altogether" (*Rutherford v. United States*, 438 F.Supp. 1287, 1299, remanded 582 F.2d 1234, rev'd. 442 U.S. 544, 99 S.Ct. 2470, 61 L.Ed.2d 68; accord *Union Pacific Ry. v. Botsford*, 141 U.S. 250, 251, 11 S.Ct. 1000, 1001, 35 L.Ed. 734; *Matter of Melideo*, 88 Misc.2d 974, 975, 390 N.Y.S.2d 523, 524 (LAZER, J.); *Long Island Jewish-Hillside Med. Center v. Levitt*, 73 Misc.2d 395, 397, 342 N.Y.S.2d 356, 359; *Matter of Nemser*, 51 Misc.2d 616, 273 N.Y.S.2d 624; *Satz v. Perlmutter*, supra; *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d at p. 424, supra; *Lane v. Candura*, Mass.App., 376 N.E.2d 1232, 1236; *Matter of Osborne*, 294 A.2d 372 (D.C.); *Matter of Estate of Brooks*, 32 Ill.2d 361, 205 N.E.2d 435; *Palm Springs Gen. Hosp. v. Martinez*, Dade County Cir.Ct., July 2, 1977, Civ. No. 71-12687; *Matter of Yetter*, 62 Pa.D. & C.2d 619; see, also, Note, "Last Rights": Hawaii's Law on the Right to Choice of Therapy for Dying Patients, 1 Hawaii L.Rev. 144, 153-157; Note, The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State, 51 N.Y.U.L.Rev. 285, 306-308; Bryn, Compulsory Lifesaving Treatment for the Competent Adult, 44 Fordham L.Rev. 1, 2-16). Essentially, it was this right of a competent patient to refuse medical care that Special Term recognized, denominating it the "right of bodily self-determination".

In some cases, however, the right to refuse medical treatment may be overridden by countervailing "compelling State interests." Thus, for example, an individual may not refuse to be vaccinated where his refusal presents a threat to the community at large. (See *Jacobson v. Massachusetts*, 197 U.S. 11, 25 S.Ct. 358, 49 L.Ed. 643.)¹⁸ Moreover, the State's general interest in the preservation of life, coupled with its responsibility to act as *parens patriae* for minors or incompetents, may sometimes require that treatment be accepted. Thus, in *Long Island Jewish-Hillside Med. Center v. Levitt*, 73 Misc.2d 395, 398, 342 N.Y.S.2d 356, 359, supra the court, asserting its power of *parens patriae*, ordered a life-saving operation for an 84-year-old man who had become confused and unable to consent for himself (accord, *Matter of Sampson*, 65 Misc.2d 658, 317 N.Y.S.2d 641, aff'd. 37 A.D.2d 668, 323 N.Y.S.2d 253,

¹⁸ Technically, the statute at issue in *Jacobson* does not compel vaccination. That statute only fined people \$ 5 who failed to be vaccinated. Therefore, people were free to refuse vaccination.

aff'd. 29 N.Y.2d 900, 328 N.Y.S.2d 686, 278 N.E.2d 918; Matter of Weberlist, 79 Misc.2d 753, 756, 360 N.Y.S.2d 783, 786, supra; John F. Kennedy Mem. Hosp. v. Heston, 58 N.J. 576, 279 A.2d 670; State v. Perricone, 37 N.J. 463, 181 A.2d 751, cert. den. 371 U.S. 890, 83 S.Ct. 189, 9 L.Ed.2d 124; Holmes v. Silver Cross Hosp. of Joliet, D.C., 340 F.Supp. 125; cf. Roe v. Wade, 410 U.S. 113, 152-156, 93 S.Ct. 705, 726-728, 35 L.Ed.2d 147, supra (state's interest in potential life allowed it to proscribe abortions in third trimester of pregnancy); see, also, Cantor, Quinlan, Privacy and the Handling of Incompetent Dying Patients, 30 Rutgers L.Rev. 243, 248-250). The interests of the State are also strongly implicated where the patient is responsible for the support of minor children and where refusal to accept treatment threatens to bring about their "abandonment". Thus, in Application of President & Director of Georgetown Coll., D.C.Cir., 331 F.2d 1000, 1008, treatment was ordered over the refusal of the 25-year-old mother of a seven-month-old child (see, also, United States v. George, 239 F.Supp. 752). It has also been said that the State has a compelling interest in maintaining the ethical integrity of the medical profession by protecting physicians against the compelled violation of their professional standards and against exposure to the risk of civil or criminal liability (see, e. g., Application of President & Director of Georgetown Coll., supra; United States v. George, supra, p. 754; Bryn, Compulsory Lifesaving Treatment for the Competent Adult, 44 Fordham L.Rev. 1, 29-33). And, lastly, it has long been recognized that the State has an interest in discouraging irrational and wanton acts of self-destruction which violate fundamental norms of society (see Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d at p. 426, n. 11, supra; Application of President & Director of Georgetown Coll., supra; Annas, Reconciling Quinlan and Saikewicz: Decision Making for the Terminally ill Incompetent, 4 Amer.J.L. & Med. 367, 373-374, n.19; Note, Suicide and the Compulsion of Lifesaving Medical Procedures: An Analysis of the Refusal of Treatment Cases, 44 Brooklyn L.Rev. 285; Byrn, Compulsory Lifesaving Treatment for the Competent Adult, supra, citing, inter alia, Hales v. Petit, 75 Eng.Rep. 387 (C.B. 1562)).

Eichner v. Dillon, 426 N.Y.S.2d 517, 536-537 (N.Y.A.D. 1980).

The trial court held that there was no state action in this case, but the first appellate court disagreed, because of the possibility of criminal prosecution for homicide if Fox's ventilator were disconnected. 426 N.Y.S.2d at 540. While agreeing with the trial court that this common-law right to refuse medical treatment was adequate to justify the decision in the matter of Brother Fox, the appellate court found that Fox's constitutional right of privacy was more important.

It seems clear that predicated upon the foregoing principles of common law, had Brother Fox been fully competent after surgery and had he refused the assistance of a respirator, his wishes would have had to be honored, absent any countervailing compelling State interest. We believe, however, that his right to refuse treatment when competent rests on a far more fundamental principle of law: the constitutional right to privacy.[FN16] In the landmark decision of *Roe v. Wade*, 410 U.S. 113, 117-118, 93 S.Ct. 705, 709, 35 L.Ed.2d 147, supra, a pregnant woman challenged the constitutionality of the Texas criminal abortion statute which permitted abortions only when necessary to save the life of the mother. In striking the statute, the Supreme Court recognized that the right of personal privacy encompassed the decision to abort, subject only to the triggering of State interest in protecting "potential life" at some point in its development (410 U.S. at 154, 162-163, 93 S.Ct. at 731). Addressing that issue, the court declared (p. 152, 93 S.Ct. p. 726):

"The Constitution does not explicitly mention any right of privacy. In a line of decisions, however, going back to *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251 (11 S.Ct.

1000, 1001, 35 L.Ed. 734) (1891), the Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution."

FN16. The petitioner specifically did not seek withdrawal of the respirator based upon the exercise of Brother Fox's First Amendment right to religious freedom. Since it has long been recognized that the First Amendment does not necessarily shield freedom of actions undertaken in the exercise of religion, as opposed to freedom of belief or thought (see *Reynolds v. United States*, 98 U.S. 145, 25 L.Ed. 244 (practice of polygamous marriages forbidden); *Lawson v. Commonwealth*, 291 Ky. 437, 441-442, 164 S.W.2d 972 (practice of snake handling forbidden)) resort to such a theory might well have posed difficult legal problems (see *Matter of Quinlan*, 355 A.2d 647, 661-662; Byrn, Compulsory Lifesaving Treatment for the Competent Adult, 44 Fordham L.Rev. 1, 7).

This right has been discerned within the penumbras of the Bill of Rights, and from the language of the First, Fourth, Fifth, Ninth and Fourteenth Amendments to the Constitution (id.).[FN17] However, "only personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty,' *Palko v. Connecticut*, 302 U.S. 319, 325 (58 S.Ct. 149, 152, 82 L.Ed. 288) (1937), are included in this guarantee of personal privacy" (*Roe v. Wade*, supra, p. 152, 93 S.Ct. p. 726). While the parameters of this right are still not certain, the Supreme Court has focused on "matters relating to marriage, procreation, contraception, family relationships, and child rearing and education" (*Paul v. Davis*, 424 U.S. 693, 713, 96 S.Ct. 1155, 1166, 47 L.Ed.2d 405). Mr. Justice DOUGLAS, speaking of the constitutional right of privacy, declared that "the freedom to care for one's health and person " falls within its purview (*Doe v. Bolton*, 410 U.S. 179, 213, 93 S.Ct. 739, 758, concurring opn.), adding that the "right of privacy has no more conspicuous place than in the physician-patient relationship" (id., p. 219, 93 S.Ct., p. 761). We believe that the essence of this right is autonomy over matters of personal integrity, including control over one's body, and that such a right is fundamental within the meaning of the Fourteenth Amendment (see *Doe v. Bolton*, 410 U.S. at p. 219, 93 S.Ct. at p. 761, supra, DOUGLAS, J., concurring; *Kelley v. Johnson*, 425 U.S. 238, 251, 96 S.Ct. 1440, 1447, 47 L.Ed.2d 708, MARSHALL, J., dissenting; see, also, Beardsley, Privacy: Autonomy and Selective Disclosure, as reprinted in *Privacy, Nomos XIII* 56-57 (Pennock & Chapman ed., 1971); Note, On Privacy: Constitutional Protection for Personal Liberty, 48 N.Y.U.L.Rev. 670, 700; G. Hughes, The Conscience of the Courts: Law and Morals in American Life, 71). Indeed, such a right is simply one facet of the right "to be let alone" (*Olmstead v. United States*, 277 U.S. 438, 478, 48 S.Ct. 564, 572, 72 L.Ed. 944, BRANDEIS, J., dissenting), and is consistent with the Supreme Court's observation that " 'outside areas of plainly harmful conduct, every American is left to shape his own life as he thinks best, do what he pleases, go where he pleases' " (*Kent v. Dulles*, 357 U.S. 116, 126, 78 S.Ct. 1113, 1118, 2 L.Ed.2d 1204). *Roe* acknowledges that pregnancy and its termination so fundamentally affect the integrity of a woman's body that the constitutional right to privacy necessarily extended to her "decision whether or not to terminate her pregnancy" subject only to countervailing compelling state interests (*Roe v. Wade*, 410 U.S. at p. 153, 93 S.Ct. at p. 727, supra). By parity of reasoning, the constitutional right to privacy, we believe, encompasses the freedom of the terminally ill but competent individual to choose for himself whether or not to decline medical treatment where he reasonably believes that such treatment will only prolong his suffering needlessly, and serve merely to denigrate his conception of the quality of life. The decision by the incurably ill to forego medical treatment and allow the natural processes of death to follow their inevitable course is so manifestly a "fundamental" decision in their lives, that it is virtually inconceivable that the right of privacy would not apply to it. Individuals have an inherent right to prevent "pointless, even cruel, prolongation of the act of dying" (*Matter of Dinnerstein*, 380 N.E.2d at 137, supra). Stated in simpler and more

fundamental terms, as a matter of constitutional law, a competent adult who is incurably and terminally ill has the right, if he so chooses, not to resist death and to die with dignity (see *Rutherford v. United States*, 438 F.Supp. 1287, 1299, supra; *Satz v. Perlmutter*, 362 So.2d 160, 162, supra; *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d at p. 426, supra; *Matter of Quinlan*, 355 A.2d at p. 663, supra; see, also, Cantor, A Patient's Decision to Decline Life-saving Medical Treatment: Bodily Integrity versus the Preservation of Life, 26 Rutgers L.Rev. 228; Paris, Compulsory Medical Treatment and Religious Freedom: Whose Law Shall Prevail?, 10 U.San.Fran.L.Rev. 1; Note, The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State, 51 N.Y.U.L.Rev. 285, 294).

FN17. Indications of the right to privacy can be found at various places in the Bill of Rights and Amendments to the Constitution: The First Amendment: *NAACP v. Alabama*, 357 U.S. 449, 462, 78 S.Ct. 1163, 1172, 2 L.Ed.2d 1488 ("freedom to associate and privacy in one's associations" is contemplated within the First Amendment). See, also, *Stanley v. Georgia*, 394 U.S. 557, 564, 89 S.Ct. 1243, 1247, 22 L.Ed.2d 542. Fourth and Fifth Amendments: *Terry v. Ohio*, 392 U.S. 1, 8-9, 88 S.Ct. 1868, 1873, 20 L.Ed.2d 889 (the "right of personal security belongs as much to the citizen on the streets of our cities as to the homeowner closeted in his study to dispose of his secret affairs"); *Katz v. United States*, 389 U.S. 347, 350, 88 S.Ct. 507, 510, 19 L.Ed.2d 576 (Fourth Amendment "protects individual privacy against certain kinds of governmental intrusion"); *Boyd v. United States*, 116 U.S. 616, 630, 6 S.Ct. 524, 532, 29 L.Ed. 746 (Fourth and Fifth Amendments protect against governmental invasions "of the sanctity of a man's home and the privacies of life"). In the penumbras of the Bill of Rights, *Griswold v. Connecticut*, 381 U.S. 479, 485-486, 85 S.Ct. 1678, 1682, 14 L.Ed.2d 510 (use of contraceptives "concerns a relationship lying within the zone of privacy created by several fundamental constitutional guarantees." Searching for signs of use "is repulsive to the notions of privacy surrounding the marriage relationship.") See, also, *Eisenstadt v. Baird*, 405 U.S. 438, 453, 92 S.Ct. 1029, 1038, 31 L.Ed.2d 349 (right of privacy "is the right of the individual * * * to be free from unwarranted governmental intrusion into matters * * * fundamentally affecting a person"). Ninth Amendment: *Griswold v. Connecticut*, 381 U.S. 479, 486-487, 85 S.Ct. 1678, 1683, 14 L.Ed.2d 510, GOLDBERG, J., concurring. Fourteenth Amendment: *Meyer v. Nebraska*, 262 U.S. 390, 399, 43 S.Ct. 625, 626, 67 L.Ed. 1042 (liberty "denotes not merely freedom from bodily restraint but also the right of the individual * * * to enjoy those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men"). The right of privacy has been used in the context of the right to marry (*Loving v. Virginia*, 388 U.S. 1, 12, 87 S.Ct. 1817, 1823, 24 L.Ed.2d 428), the right to have children (*Skinner v. Oklahoma*, 316 U.S. 535, 541-542, 62 S.Ct. 1110, 1113, 86 L.Ed. 1655), and the right to educate one's children (*Pierce v. Society of Sisters*, 268 U.S. 510, 45 S.Ct. 571, 69 L.Ed. 1070). See, also *Doe v. Bolton*, 410 U.S. 179, 209-215, 93 S.Ct. 739, 756-759, 35 L.Ed.2d 201, DOUGLAS, J., concurring; Cantor, Quinlan, Privacy, and the Handling of Incompetent Dying Patients, 30 Rutgers L.Rev. 243, 245-248). *Eichner v. Dillon*, 426 N.Y.S.2d 517, 537-539 (N.Y.A.D. 1980).

Accordingly we conclude that, were Brother Fox competent, he could refuse medical treatment not only as an exercise of his common-law right to bodily self-determination, but also pursuant to his constitutional right to privacy. Although the two are quite clearly equivalent in effect since they compel the same result, the difference between them is something more than mere semantics. Common-law rights can be abrogated by statute in the exercise of the State's police powers subject only to due process requirements (see McKinney's Cons.Laws of N.Y., Book 1, Statutes, § 301 et seq.; cf. *Penn. Cent. Transp. Co. v. New York City*, 438 U.S. 104, 123-124, 98 S.Ct. 2646, 2659, 57 L.Ed.2d 631; *Spears v. Berle*, 48 N.Y.2d 254, 261- 262, 422 N.Y.S.2d 636, 638-639, 397 N.E.2d 1304, 1306-1307; *Matter of Subway-Surface Supervisors Assn. v. New York City Tr. Auth.*, 44 N.Y.2d 101, 109-110, 404 N.Y.S.2d 323, 327-328, 375 N.E.2d 384, 388-389; *Modjeska Sign Studios v. Berle*, 43 N.Y.2d 468, 473-475, 402 N.Y.S.2d 359, 362-363, 373 N.E.2d 255, 257-258; *Suffolk Outdoor Adv. Co. v. Hulse*, 43 N.Y.2d 483, 489, 402 N.Y.S.2d 368, 370, 373 N.E.2d 263, 265). Constitutional rights on the other hand cannot be so abrogated (see *Roe v. Wade*,

410 U.S. 113, 155, 93 S.Ct. 705, 727, 35 L.Ed.2d 147 supra ; *Kramer v. Union Free School District*, 395 U.S. 621, 627, 89 S.Ct. 1886, 1889, 23 L.Ed.2d 583; *Shapiro v. Thompson*, 394 U.S. 618, 634, 89 S.Ct. 1322, 1331, 22 L.Ed.2d 600). It suffices for purposes of this analysis, however, that these two rights function in a complimentary manner, simultaneously affording the incurably ill the right to determine at what point aggressive therapy should cease. *Eichner v. Dillon*, 426 N.Y.S.2d 517, 540-541 (N.Y.A.D. 1980).

The first appellate court noted that the same legal right to refuse medical treatment ought to apply to both competent and incompetent individuals.

We further conclude that by standards of logic, morality and medicine the terminally ill should be treated equally, whether competent or incompetent. Can it be doubted that the "value of human dignity extends to both"? (see *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d at pp. 423, 427, 428, supra ; cf. *Matter of Brown v. Ristich*, 36 N.Y.2d 183, 191-192, 366 N.Y.S.2d 116, 123-124, 325 N.E.2d 533, 538-539, supra ; Mental Hygiene Law, § 33.01). What possible societal policy objective is vindicated or furthered by treating the two groups of terminally ill differently ? What is gained by granting such a fundamental right only to those who, though terminally ill, have not suffered brain damage and coma in the last stages of the dying process? The very notion raises the spectre of constitutional infirmity when measured against the Supreme Court's recognition that incompetents must be afforded all their due process rights; indeed any State scheme which irrationally denies to the terminally ill incompetent that which it grants to the terminally ill competent patient is plainly subject to constitutional attack (see *O'Connor v. Donaldson*, 422 U.S. 563, 574-575, 95 S.Ct. 2486, 2493, 45 L.Ed.2d 396; *McNeil v. Director, Patuxent Institution*, 407 U.S. 245, 249, 92 S.Ct. 2083, 2086, 32 L.Ed.2d 719; *Jackson v. Indiana*, 406 U.S. 715, 727, 730, 92 S.Ct. 1845, 1852, 1854, 32 L.Ed.2d 435; *Humphrey v. Cady*, 405 U.S. 504, 508, 92 S.Ct. 1048, 1051, 31 L.Ed.2d 394; *Baxstrom v. Herold*, 383 U.S. 107, 111-113, 86 S.Ct. 760, 762- 763, 15 L.Ed.2d 620; *Matter of Torsney*, 47 N.Y.2d 667, 674-675, 420 N.Y.S.2d 192, 196-197, 394 N.E.2d 262, 265-266, supra; *People ex rel. Henig v. Commissioner of Mental Hygiene*, 43 N.Y.2d 334, 338, 401 N.Y.S.2d 462, 464, 372 N.E.2d 304, 306; cf. *Addington v. Texas*, 441 U.S. 418, 426, 99 S.Ct. 1804, 1809, 60 L.Ed.2d 323; see also, Note, *Developments in the Law of Civil Commitment of the Mentally Ill*, 87 Harv.L.Rev. 1190). *Eichner v. Dillon*, 426 N.Y.S.2d 517, 542-543 (N.Y.A.D. 1980).

The first appellate court considered the four state interests and agreed with the trial court that none of them precluded disconnection of the ventilator from Brother Fox. 426 N.Y.S.2d at 543-544.

The first appellate court then considered the minimum level of proof necessary.

The necessary medical criteria for the activation of the patient's right are self-apparent: he must be terminally ill; he must be in a vegetative coma characterized by the physician as "permanent", "chronic" or "irreversible"; he must lack cognitive brain function; and the probability of his ever regaining cognitive brain function must be extremely remote. The State's interest in protecting the sanctity of life will tolerate no less stringent medical standard than this (see *Matter of Quinlan*, 355 A.2d at p. 669, supra). In this regard, however, the District Attorney has raised the issue of the burden of proof necessary to satisfy this medical standard. He argues that nothing less than proof beyond a reasonable doubt will suffice to establish the appropriate medical criteria. This contention is based on the assumption that the termination of a human life should rest upon a determination necessitating the "strongest level of proof"; moreover, since in all likelihood death will result, the District Attorney contends

that the proceeding is analogous to the "imposition of death" in a criminal proceeding requiring the beyond a reasonable doubt standard. We decline to apply this standard. Proceedings under the Mental Hygiene Law including incompetency proceedings are civil in nature (cf. *Matter of Torsney*, 47 N.Y.2d 667, 673, 420 N.Y.S.2d 192, 195, 394 N.E. 262, 265, supra) and the "beyond a reasonable doubt" standard historically has been reserved for criminal cases" (*Addington v. Texas*, 441 U.S. 418, 428, 99 S.Ct. 1804, 1810, 60 L.Ed.2d 323, supra). Under the circumstances present herein, by no stretch of the imagination can the State be deemed to be "taking life" in a manner analogous to the imposition of a death penalty in a criminal action. This judicial proceeding is not directed towards the imposition of a penalty for criminal activity but, rather, towards the furtherance of the best interests of the comatose and terminally ill patient. By the same token, however, we cannot abide by the suggestion that a "preponderance of the credible evidence" standard, common to most civil proceedings, would be sufficient here. Rather, we elect the middle tier standard of proof, that of "clear and convincing evidence." As recently discussed by the *Addington* court, this standard is appropriate where the "interests at stake * * * are deemed to be more substantial than mere loss of money * * *." Similarly, * * * the 'clear, unequivocal and convincing' standard of proof (is used) to protect particularly important individual interests in various civil cases. See, e. g., *Woodby v. INS*, (385 U.S. 276), 285, 87 S.Ct. (483,) 487, 17 L.Ed.2d 362" (*Addington v. Texas*, supra, p. 424, 99 S.Ct. p. 1808).[FN21] The exercise of the right to refuse treatment by the terminally ill comatose individual clearly falls within such "particularly important individual interests", and demands that a judicial finding be supported by the "clear and convincing" quantum of proof. While the qualitative meaning of the phrase, "clear and convincing evidence" has been variously described (see, e. g., *Amend v. Hurley*, 293 N.Y. 587, 595, 59 N.E.2d 416, 419; *Porter v. Commercial Cas. Ins. Co.*, 292 N.Y. 176, 181, 54 N.E.2d 353, 355; *Christopher & Tenth St. R.R. Co. v. Twenty-Third St. Ry. Co.*, 149 N.Y. 51, 58, 43 N.E. 538, 539; *Commissioner of Public Welfare of City of N.Y. v. Ryan*, 238 App.Div. 607, 608, 265 N.Y.S. 286, 287), we believe it requires a finding of high probability and we are content to rest upon a recent observation by the Court of Appeals: "(T)he evidentiary requirement 'operate(s) as a weighty caution upon the minds of all judges, and it forbids relief whenever the evidence is loose, equivocal or contradictory' " (*Backer Mgt. Corp. v. Acme Quilting Co.*, 46 N.Y.2d 211, 220, 413 N.Y.S.2d 135, 139, 385 N.E.2d 1062, 1066, quoting *Southard v. Curley*, 134 N.Y. 148, 151, 31 N.E. 330, 331). In the case at bar, there can be no dispute that the requisite standard of proof has been met.

FN21. That the "clear and convincing evidence" standard is utilized only where the "interests at stake" are deemed more significant than ordinary is borne out by those other causes of action where the standard also applies: reformation of a contract (see *Ross v. Food Specialties*, 6 N.Y.2d 336, 189 N.Y.S.2d 857, 160 N.E.2d 618); for a charge of fraud (*United States v. American Bell Tel. Co.*, 167 U.S. 224, 17 S.Ct. 809, 42 L.Ed. 144); a filiation proceeding (*Commissioner of Public Welfare of City of N.Y. v. Ryan*, 238 App.Div. 607, 265 N.Y.S. 286); an action based upon a claim against a deceased (*Matter of Cady*, 211 App.Div. 373, 207 N.Y.S. 385). (See *Richardson*, *Evidence* (Prince, 10th ed.), § 97, p. 75; 9 *Wigmore*, *Evidence* (3d ed.), § 2498, subd. (3), pp. 329-335.) In addition, the Federal courts require this proof in denaturalization proceedings (*Schneiderman v. United States*, 320 U.S. 118, 16 S.Ct. 1333, 87 L.Ed. 1796) and deportation proceedings (*Woodby v. Immigration and Naturalization Serv.*, 385 U.S. 276, 286, 87 S.Ct. 483, 488, 17 L.Ed.2d 362). *Eichner v. Dillon*, 426 N.Y.S.2d 517, 545-546 (N.Y.A.D. 1980).

The District Attorney argued that the testimony about Brother Fox refusing to be kept alive by extraordinary and artificial means was inadmissible hearsay. The first appellate court disagreed with the District Attorney.

The District Attorney argues that these expressions were merely theoretical and, in any event, hearsay which must be disregarded. This argument is untenable. Statements demonstrating the declarant's state of mind are admissible when relevant. When a declaration is offered to establish the state of mind, rather than the truth of any objectively verifiable underlying fact, then that declaration, although technically hearsay, is admissible as part of the *res gestae* [citations omitted].

Eichner v. Dillon, 426 N.Y.S.2d at 547 (N.Y.A.D. 1980).

The first appellate court reversed ¶4 of the trial court's order (see page 42 above) and specified a different legal procedure for withdrawing life support.

Accordingly, we hold that the following procedure shall be applicable to the proposed withdrawal of extraordinary life-sustaining measures from the terminally ill and comatose patient. The physicians attending the patient must first certify that he is terminally ill and in an irreversible, permanent or chronic vegetative coma, and that the prospects of his regaining cognitive brain function are extremely remote. Thereafter, the person to whom such certification is made, whether a member of the patient's family, someone having a close personal relationship with him, or an official of the hospital itself, may present the prognosis to an appropriate hospital committee. If the hospital has a standing committee for such purposes, composed of at least three physicians, then that committee shall either confirm or reject the prognosis. If the hospital has no such standing committee, then, upon the petition of the person seeking relief, the hospital's chief administrative officer shall appoint such a committee consisting of no fewer than three physicians with specialties relevant to the patient's case. Confirmation of the prognosis shall be by a majority of the members of the committee, although lack of unanimity may later be considered by the court.

Upon confirmation of the prognosis, the person who secured it may commence a proceeding pursuant to article 78 of the Mental Hygiene Law for appointment as the Committee of the incompetent, and for permission to have the life-sustaining measures withdrawn. The Attorney-General and the appropriate District Attorney shall be given notice of the proceeding and, if they deem it necessary, shall be afforded an opportunity to have examinations conducted by physicians of their own choosing. Additionally, a guardian ad litem shall be appointed to assure that the interests of the patient are indeed protected by a neutral and detached party wholly free of self-interest.

Where this procedure is complied with, and where the court concludes, consistent with the principles announced herein, that the extraordinary life-sustaining measures should be discontinued, no participant either medical or lay shall be subject to criminal or civil liability as a result of the termination of such life-sustaining measures. Should death occur, its proximate cause shall be deemed to be whatever caused the patient to lapse into the coma in the first instance.

Eichner v. Dillon, 426 N.Y.S.2d 517, 550 (N.Y.A.D. 1980).

These formal legal procedures were later deleted by the New York Court of Appeals, as described below at page 52. These procedures are in stark contrast with the approach of the New Jersey Supreme Court in *Quinlan* of allowing the patients' family and physicians to make the decision for patients in a hospital.

New York Court of Appeals

The District Attorney then appealed to the highest court in New York State, the Court of Appeals. That Court combined the *Eichner* case with *Storar*, a case involving a mentally retarded and terminally ill adult cancer patient. As the *Storar* case is outside the scope of this essay, I only discuss the New York Court of Appeals holdings that applies to *Eichner*.

The Court of Appeals affirmed the decision to decide the case, although Brother Fox had already died. 420 N.E.2d at 67.

The Court of Appeals agreed with the trial court that the common-law right to refuse medical treatment justified the Order to disconnect the ventilator.

In the *Eichner* case the Supreme Court properly granted the petition. At common law, as CARDOZO noted, every person "of adult years and sound mind has a right to determine what should 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 * * *. This is true except in cases of emergency where the patient is unconscious and where it is necessary to operate before consent can be obtained" (*Schloendorff v. Society of N. Y. Hosp.*, 211 N.Y. 125, 129-130, 105 N.E. 92; see, also, *Pearl v. Lesnick*, 20 A.D.2d 761, 247 N.Y.S.2d 561, aff'd. 19 N.Y.2d 590, 278 N.Y.S.2d 237, 224 N.E.2d 739; *Garziona v. Vassar Bros. Hosp.*, 36 A.D.2d 390, 320 N.Y.S.2d 830, aff'd. 30 N.Y.2d 857, 335 N.Y.S.2d 293, 286 N.E.2d 731; 2 Harper and James, Law of Torts, 61 [1968 Supp.]; Patient's Right to Refuse Treatment Allegedly Necessary to Sustain Life, Ann., 93 A.L.R.3d 67). Even in emergencies, however, it is held that consent will not be implied if the patient has previously stated that he would not consent (Restatement Torts 2d, § 62, Illustration 5; Powell, Consent to Operative Procedures, 21 Md.L.Rev. 189, 199; Bryn, Compulsory Life Saving Treatment for the Competent Adult, 44 Fordham L.Rev. 1, 15, n.64). The basic right of a patient to control the course of his medical treatment has been recognized by the Legislature (see Public Health Law, 2504, 2805-d; CPLR 4401-a).

Father Eichner urges that this right is also guaranteed by the Constitution, as an aspect of the right to privacy. Although several courts have so held (see, e. g., *Matter of Quinlan*, 70 N.J. 10, 355 A.2d 647, *supra*; *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417), this is a disputed question (see, e. g., Bryn, *op. cit.*, pp. 5- 9), which the Supreme Court has repeatedly declined to consider (see Note, The "Living Will": The Right to Death With Dignity?, 26 Case Western Reserve L.Rev. 485, 501, n.76; see, also, *Garger v. New Jersey*, 429 U.S. 922, 97 S.Ct. 319, 50 L.Ed.2d 289, *supra*). Neither do we reach that question in this case because the relief granted to the petitioner, *Eichner*, is adequately supported by common-law principles. *Matter of Storar*, 420 N.E.2d 64, 70 (N.Y. 1981).

The District Attorney urged the Court of Appeals to find a state interest in preserving life, but the Court refused.

The District Attorney urges that the patient's right to decline medical treatment is outweighed by important State interests when the treatment is necessary to preserve the patient's life. We recognize that under certain circumstances the common-law right may have

to yield to superior State interests, as it would even if it were constitutionally based (*Roe v. Wade*, 410 U.S. 113, 154-155, 93 S.Ct. 705, 727-28, 35 L.Ed.2d 147; *Doe v. Bolton*, 410 U.S. 179, 93 S.Ct. 739, 35 L.Ed.2d 201). The State has a legitimate interest in protecting the lives of its citizens. It may require that they submit to medical procedures in order to eliminate a health threat to the community (see, e. g., *Jacobson v. Massachusetts*, 197 U.S. 11, 25 S.Ct. 358, 49 L.Ed. 643). It may, by statute, prohibit them from engaging in specified activities, including medical procedures which are inherently hazardous to their lives (*Roe v. Wade, supra*, 410 U.S. pp. 150, 154, 93 S.Ct. pp. 725, 727). In this State, however, there is no statute which prohibits a patient from declining necessary medical treatment or a doctor from honoring the patient's decision. To the extent that existing statutory and decisional law manifests the State's interest on this subject, they consistently support the right of the competent adult to make his own decision by imposing civil liability on those who perform medical treatment without consent, although the treatment may be beneficial or even necessary to preserve the patient's life (see, e. g., *Schloendorff v. Society of N. Y. Hosp.*, 211 N.Y. 125, 105 N.E. 92, *supra*; *Matter of Erickson v. Dilgard*, 44 Misc.2d 27, 252 N.Y.S.2d 705; *Matter of Melideo*, 88 Misc.2d 974, 390 N.Y.S.2d 523; Public Health Law, 2504, 2805-d; CPLR 4401-a). The current law identifies the patient's right to determine the course of his own medical treatment as paramount to what might otherwise be the doctor's obligation to provide needed medical care. A State which imposes civil liability on a doctor if he violates the patient's right cannot also hold him criminally responsible if he respects that right. Thus a doctor cannot be held to have violated his legal or professional responsibilities when he honors the right of a competent adult patient to decline medical treatment. [FN6]

FN6. In other cases the State may be able to assert additional interests, such as, prevention of suicide or, perhaps, protection of minor children or dependents. Those concerns are inapplicable here. Brother Fox' condition was not self-inflicted (see e. g., Bryn, *op. cit.*, pp. 16-24) and he has no children or dependents.

Matter of Storar, 420 N.E.2d 64, 71 (N.Y. 1981).

The Court of Appeals affirmed that "clear and convincing evidence" is the proper level of proof.

The District Attorney's arguments underscore the very sensitive nature of the question as to whether, in case of incompetency, a decision to discontinue life sustaining medical treatment may be made by some one other than the patient (see, also, Kamisar, Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation, 42 Minn.L.Rev. 969; Collester, Death, Dying and the Law: A Prosecutorial View of the Quinlan Case, 30 Rutgers L.Rev. 304). However, that issue is not presented in this case because here Brother Fox made the decision for himself before he became incompetent. The Supreme Court and the Appellate Division found that the evidence on this point, as well as proof of the patient's subsequent incompetency and chances of recovery was "clear and convincing." We agree that this is the appropriate burden of proof and that the evidence in the record satisfies this standard.

Although this is a civil case in which a preponderance of the evidence is generally deemed sufficient, the District Attorney urges that the highest burden of proof beyond a reasonable doubt should be required when granting the relief may result in the patient's death. But that burden, traditionally reserved for criminal cases where involuntary loss of liberty and possible stigmatization are at issue (*Addington v. Texas*, 441 U.S. 418, 428, 99 S.Ct. 1804, 1810, 60 L.Ed.2d 323), is inappropriate in cases where the purpose of granting the relief is to give effect to an individual's right by carrying out his stated intentions. However, we agree with the courts below that the highest standard applicable to civil cases should be required. There is more involved here than a typical dispute between private litigants over a sum of

money. Where particularly important personal interests are at stake, clear and convincing evidence should be required (*Addington v. Texas, supra*, p. 424, 99 S.Ct. p. 1808). It is constitutionally required in cases of involuntary civil commitments (*Addington v. Texas, supra*) and we have recognized the need for the higher standard in exceptional civil matters (see, e. g., *Ross v. Food Specialties*, 6 N.Y.2d 336, 189 N.Y.S.2d 857, 160 N.E.2d 618; *Amend v. Hurley*, 293 N.Y. 587, 59 N.E.2d 416; *Porter v. Commercial Cas. Ins. Co.*, 292 N.Y. 176, 54 N.E.2d 353). Clear and convincing proof should also be required in cases where it is claimed that a person, now incompetent, left instructions to terminate life sustaining procedures when there is no hope of recovery. This standard serves to "impress the factfinder with the importance of the decision" (*Addington v. Texas*, 441 U.S. 418, 427, 99 S.Ct. 1804, 1810, 60 L.Ed.2d 323 *supra*) and it "forbids relief whenever the evidence is loose, equivocal or contradictory" (*Backer Mgt. Corp. v. Acme Quilting Co.*, 46 N.Y.2d 211, 220, 413 N.Y.S.2d 135, 385 N.E.2d 1062).

In this case the proof was compelling. There was no suggestion that the witnesses who testified for the petitioner had any motive other than to see that Brother Fox' stated wishes were respected. The finding that he carefully reflected on the subject, expressed his views and concluded not to have his life prolonged by medical means if there were no hope of recovery is supported by his religious beliefs and is not inconsistent with his life of unselfish religious devotion. These were obviously solemn pronouncements and not casual remarks made at some social gathering, nor can it be said that he was too young to realize or feel the consequences of his statements (cf. *Matter of Quinlan*, 70 N.J. 10, 355 A.2d 647, *supra*). That this was a persistent commitment is evidenced by the fact that he reiterated the decision but two months before his final hospitalization. There was, of course, no need to speculate as to whether he would want this particular medical procedure to be discontinued under these circumstances. What occurred to him was identical to what happened in the *Karen Ann Quinlan* case, which had originally prompted his decision. In sum, the evidence clearly and convincingly shows that Brother Fox did not want to be maintained in a vegetative coma by use of a respirator.

Matter of Storar, 420 N.E.2d 64, 71-72 (N.Y. 1981).

The Court of Appeals concluded:

Accordingly, the order of the Appellate Division should be ... modified, without costs, in the *Eichner* case by deleting everything but the authorization to the petitioner to discontinue use of the respirator.

Matter of Storar, 420 N.E.2d 64, 74 (N.Y. 1981).

This means that the elaborate legal procedure quoted above, beginning on page 49, was *not* affirmed.

Five of the seven judges on the New York Court of Appeals agreed with the majority opinion in *Eichner*, one judge concurred in the result, and one judge believed the case should have been dismissed for mootness.

Colyer

- *Matter of Welfare of Colyer*, 660 P.2d 738 (Wash. 10 Mar 1983).

medical facts

The Supreme Court of Washington state mentioned the following facts:

On March 8, 1982, Bertha Colyer, age 69, sustained a cardiopulmonary arrest; her heart stopped beating. Although she was resuscitated by paramedics, her body was without oxygen for approximately 10 minutes, resulting in massive brain damage.

After being taken to St. Luke's Hospital in Bellingham, she was kept alive by artificial life support mechanisms. She required a respirator in order to breathe, and she remained in a comatose state, unresponsive to pain or verbal stimuli. In short, she was unable to breathe on her own and remained in a persistent vegetative state.

The prognosis for any sort of meaningful existence was zero, according to the findings. Weeks elapsed without any signs of neurological improvement or lightening of her coma. Two physicians, a cardiologist and a neurologist, agreed that the likelihood of Bertha Colyer recovering any significant amount of brain function was extremely small. They also agreed that she would probably expire within a short period if removed from the respirator. Even their most optimistic prognosis was that she might be able to breathe on her own, but would persist in a very infantile state, unable to speak or communicate and requiring maintenance of all bodily functions.

Matter of Welfare of Colyer, 660 P.2d 738, 740 (Wash. 1983).

Washington Supreme Court

Bertha's husband petitioned a trial court to be appointed guardian of Bertha. The state Supreme Court summarized the case:

Bertha Colyer's husband was appointed guardian over Bertha's person and estate; he petitioned the Superior Court to authorize removal of the life support systems. The husband's affidavit in support of the petition stated in part:

It is very painful for me and Bertha's family to see her in her current condition.

We all love her very much and would like for her to be able to live her final days and pass through this life with dignity, rather than being maintained by artificial means.

A guardian ad litem was appointed to represent the interests of Bertha Colyer. After a hearing, which included testimony from the two physicians and Bertha Colyer's husband and sisters, the Superior Court judge ruled that the "life support systems presently in place and sustaining Bertha Colyer shall be withdrawn and terminated forthwith." He based his ruling on the patient's right of privacy, the testimony from her family that it would be Bertha's wish to have the life support systems removed, and the medical testimony that there was no hope for her recovery to a sapient state. The trial court stayed its order, however, to provide the opportunity for review by this court.

On April 1, 1982, after hearing oral argument, we affirmed the trial court's order. Bertha Colyer died peacefully soon after the life support systems were removed.

Matter of Welfare of Colyer, 660 P.2d 738, 740 (Wash. 1983).

The opinion of the trial court (i.e. Superior Court) was not published, so the opinion of the Washington Supreme Court is the only published opinion in this case.

At the time the Washington Supreme Court decided *Colyer*, there had been only a few similar cases reported nationwide. Note that while the trial court in *Conroy* (discussed below, beginning at page 61) had issued its opinion about one month before the Washington Supreme Court decision in *Colyer*, the decision of the New Jersey Supreme Court in *Conroy* was almost two years in the future.

As this is a case of first impression in Washington, we look to other jurisdictions for information and guidance. Five other states have addressed the issue of an incompetent's right to have life sustaining treatment withheld or withdrawn. See *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied, 429 U.S. 922, 97 S.Ct. 319, 50 L.Ed.2d 289 (1976); *Superintendent of Belchertown State Sch. v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977) (hereinafter *Saikewicz*); *Leach v. Akron Gen. Med. Ctr.*, 68 Ohio Misc. 1, 22 O.O.3d 49, 426 N.E.2d 809 (1980); *Severns v. Wilmington Med. Ctr., Inc.*, 421 A.2d 1334 (Del. 1980); *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981). All of these courts have recognized the right of a patient to refuse life sustaining treatment in appropriate circumstances. This right has been premised on a constitutional right of privacy, *Quinlan*, supra, or, alternatively, on a common law right to be free from invasions of one's bodily integrity. *In re Storar*, supra.

A. Right of Privacy

The United States Supreme Court has identified a right of privacy emanating from the penumbra of the specific guarantees of the Bill of Rights and from the language of the First, Fourth, Fifth, Ninth and Fourteenth Amendments. *Griswold v. Connecticut*, 381 U.S. 479, 484, 85 S.Ct. 1678, 1681, 14 L.Ed.2d 510 (1965); *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973). In *Roe*, the United States Supreme Court determined that the right of privacy was a personal right "broad enough to encompass a woman's decision whether or not to terminate her pregnancy", subject only to countervailing, compelling state interests. *Roe v. Wade*, supra, 410 U.S. at 153, 93 S.Ct. at 727. While the perimeters of this right have not been defined, the "freedom to care for one's health and person" falls within its purview. *Doe v. Bolton*, 410 U.S. 179, 213, 93 S.Ct. 739, 758, 35 L.Ed.2d 201 (1973) (Douglas, J., concurring).

From these holdings, our sister states have reasoned that the privacy right is "broad enough to encompass a patient's decision to decline medical treatment under certain circumstances". *In re Quinlan*, supra at 40, 355 A.2d 647; see also *Leach*, supra, 426 N.E.2d at 813; *Storar*, supra, 420 N.E.2d at 71, 438 N.Y.S.2d at 273; *Saikewicz*, supra at 740, 370 N.E.2d 417.

The decision by the incurably ill to forego medical treatment and allow the natural processes of death to follow their inevitable course is so manifestly a "fundamental" decision in their lives, that it is virtually inconceivable that the right of privacy would *not* apply to it. *In re Eichner*, 73 A.D.2d 431, 459, 426 N.Y.S.2d 517, (1980), *aff'd sub nom. In re Storar*, supra (hereinafter *Eichner*); see also Cantor, *A Patient's Decision To Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 Rutgers L.Rev. 228 (1973); Comment, *Roe v. Wade and In Re Quinlan: Individual Decision and the Scope of Privacy's Constitutional Guarantee*, 12 U.S.F.L.Rev. 111 (1977).

In Washington, we have previously recognized this right of privacy in the context of an abortion decision. *State v. Koome*, 84 Wash.2d 901, 530 P.2d 260 (1975). In harmony with other jurisdictions, we now hold that an adult who is incurably and terminally ill has a constitutional right of privacy that encompasses the right to refuse treatment that serves only to prolong the dying process, given the absence of countervailing state interests. Support for this holding is also found in our state constitution. Const. art. 1, 7.

This privacy right, if founded on the federal constitution and applied to the states through the Fourteenth Amendment, extends only to situations where state action exists. *United States v. Stanley*, 109 U.S. 3, 11, 3 S.Ct. 18, 21, 27 L.Ed.2d 835 (1883), *Long v. Chiropractic Soc'y*, 93 Wash.2d 757, 613 P.2d 124 (1980). Other jurisdictions have approached this limitation by presuming state action is involved without expressly addressing the issue. See *Saikewicz, supra* at 739, 370 N.E.2d 417; *Quinlan, supra* at 40, 355 A.2d 647. The one court directly addressing the issue found an implied state presence sufficient to constitute state action. *Eichner, supra* at 460-61, 426 N.Y.S.2d 517.

The existence of "state action" for constitutional purposes depends on "whether there is a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself." *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 351, 95 S.Ct. 449, 453, 42 L.Ed.2d 477 (1974). Here, the presence of the state is manifested by its capability of imposing criminal sanctions on the hospital and its staff (RCW 9A.32.030), by its licensing of physicians (RCW 18.71.020), by the required involvement of the judiciary in the guardianship appointment process (see Part V(A) and (D)) and by the State's *parens patriae* responsibility to supervise the affairs of incompetents. RCW 11.88.010; *Cf. Parham v. J.R.*, 442 U.S. 584, 99 S.Ct. 2493, 61 L.Ed.2d 101 (1978). Taken together, these factors show a sufficient nexus between the state and the prohibitions against withholding or discontinuance of life sustaining treatment to call into play the constitutional right of privacy.

B. Right to be Free from Bodily Invasion

The common law right to be free from bodily invasion is an alternative basis for the right to refuse life sustaining treatment. See *Saikewicz, supra*; *Storar, supra*. Historically, an operation without authorization constituted an assault and battery, as well as malpractice. *Physician's & Dentists' Business Bur. v. Dray*, 8 Wash.2d 38, 111 P.2d 568 (1941).

This right to be free from nonconsensual invasions of one's bodily integrity is the basis for the doctrine of informed consent which requires physicians to disclose to a patient all material facts and risks concerning the patient's condition, thus enabling the patient to make an informed choice regarding the proposed treatment. *Gates v. Jensen*, 92 Wash.2d 246, 595 P.2d 919 (1979); RCW 7.70.050. Such information must include the possibility of alternative treatment or no treatment at all. *ZeBarth v. Swedish Hosp. Med. Ctr.*, 81 Wash.2d 12, 499 P.2d 1, 52 A.L.R.3d 1067 (1972); RCW 7.70.050(3)(d). Thus, freedom of choice with respect to medical treatment encompasses the right to refuse life sustaining treatment in certain circumstances.

C. State Interests

This right to refuse treatment, be it founded on constitutional or common law precepts, is not absolute, for the state has an interest in protecting the sanctity of the lives of its citizens. See *Saikewicz, supra*; *Quinlan, supra*. This state interest has been identified in four areas: (1) the preservation of life; (2) the protection of interests of innocent third parties; (3) the prevention of suicide; and (4) maintenance of the ethical integrity of the medical profession. *Saikewicz, supra* at 741, 370 N.E.2d 417 [425 (Mass. 1977)].

The most significant state interest, the preservation of life, has prevailed to require *lifesaving* treatment for nonconsenting patients. See *In re President & Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C.Cir.) *cert. denied*, 377 U.S. 978, 84 S.Ct.

1883, 12 L.Ed.2d 746 (1964); *John F. Kennedy Mem. Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971). This interest weakens, however, in situations where continued treatment serves only to prolong a life inflicted with an incurable condition. See *Quinlan*, *supra* at 41, 355 A.2d 647; *Saikewicz*, *supra* at 742, 370 N.E.2d 417; Note, *In re Quinlan: One Court's Answer to the Problem of Death With Dignity*, 34 Wash. & Lee L.Rev. 285, 297 (1977).

In *Quinlan*, the court balanced the degree of bodily invasion against the state's interest in preserving life. *Quinlan*, *supra* at 40-41, 355 A.2d 647. For Karen Quinlan, the degree of bodily invasion was great, since she required a respirator, an intravenous feeding apparatus, a catheter, and intensive nursing care. The court concluded that Karen's privacy right outweighed the state's interest.

Matter of Welfare of Colyer, 660 P.2d 738, 741-743 (Wash. 1983).

The Supreme Court of Washington applied the above-quoted survey of law to the facts of this case.

Similar intrusive care was required for Bertha Colyer. Therefore, applying the *Quinlan* balancing test, we conclude that Bertha Colyer's privacy right was greater than the state's interest in preserving her life.

The other identified state interests do not mandate a different conclusion. Bertha Colyer had no children and her immediate family, consisting of her sisters, joined in her husband's request to remove the life sustaining mechanisms. Hence, no third party interests needed to be protected. Compare *In re President & Directors of Georgetown College, Inc.*, *supra* (blood transfusion ordered for mother of small child) with *In re Osborne*, 294 A.2d 372 (D.C. 1972) (refusal of lifesaving treatment by competent adult upheld where provisions were made for the children). Nor was prevention of suicide a pertinent consideration here. A death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion nor intended by the patient. See *Saikewicz*, *supra* at 743 n. 11, 370 N.E.2d 417; Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 Fordham L.Rev. 1 (1975).

Finally, the state's interest in the maintenance of the ethical integrity of the medical profession is not at odds with this result.

[T]he prevailing ethical practice seems to be to recognize that the dying are more often in need of comfort than treatment. Recognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores; such a doctrine does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the State's interest in protecting the same. It is not necessary to deny a right of self-determination to a patient in order to recognize the interests of doctors, hospitals, and medical personnel in attendance on the patient.

Saikewicz, *supra* at 743-44, 370 N.E.2d 417[426-427 (Mass. 1977)]. Thus, we conclude there were no compelling state interests opposing the removal of life sustaining mechanisms from Bertha Colyer that outweighed her right to refuse such treatment.

Matter of Welfare of Colyer, 660 P.2d 738, 743-744 (Wash. 1983).

The Supreme Court of Washington considered who may exercise the right to refuse medical treatment.

The next issue is who may exercise this right. A competent patient may refuse treatment under the informed consent doctrine. RCW 7.70.050. Moreover, a competent patient may

ensure with a directive that life sustaining treatment will be withheld or withdrawn, should he or she subsequently become incompetent. RCW 70.122.

An incompetent's right to refuse treatment should be equal to a competent's right to do so. No court has denied an individual this right because of incompetency to exercise it:

[H]er right of privacy ... should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice.

In re Quinlan, 70 N.J. 10, 41, 355 A.2d 647, *cert. denied*, 429 U.S. 922, 97 S.Ct. 319, 50 L.Ed.2d 289 (1976).

The recognition of that [privacy] right must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both. *Superintendent of Belchertown State Sch. v. Saikewicz*, 373 Mass. 728, 745, 370 N.E.2d 417 (1977). The question is, therefore, who may exercise an incompetent's right to refuse life sustaining treatment if no directive exists and the incompetent is unable to do so.

On this issue, the opinions from other jurisdictions diverge. On the one hand, the *Quinlan* court held that, to prevent destruction of the privacy right because of incompetency, the guardian, Karen's father, was to render *his best judgment* as to whether Karen would have exercised the right if she were able. *Quinlan, supra* at 41, 355 A.2d 647. As a foundation for this conclusion, the court examined the character and general suitability of the father as a guardian. Evidence of the high degree of familial love between father and daughter, and the "very sincere, moral, ethical and religious" character of Mr. Quinlan convinced the court that he was eminently qualified for guardianship over his daughter. *Quinlan*, at 29-30, 53, 355 A.2d 647. This then led to the conclusion that the guardian's best judgment concerning the patient's choice to exercise her privacy right would, in this circumstance, best preserve this right.

While not abdicating jurisdiction over justiciable controversies, the *Quinlan* court maintained that, as a general practice, such decisions "should be controlled primarily within the patient-doctor-family relationship". *Quinlan*, at 50, 355 A.2d 647.

....

Saikewicz, supra, is the leading case in the other camp, those jurisdictions requiring judicial intervention in every case involving the withdrawal or withholding of life sustaining treatment from an incompetent. *See also Severns v. Wilmington Med. Ctr. Inc.*, 421 A.2d 1334 (Del. 1980); *Leach v. Akron Gen. Med. Ctr.*, 68 Ohio Misc. 1, 22 O.O.3d 49, 426 N.E.2d 809 (1980). This approach has been labeled "substituted judgment," for the court determines, based on the evidence presented, what treatment the incompetent would have chosen. *Saikewicz, supra*. A judicial standard of clear and convincing proof of the patient's desire to refuse treatment has usually been required. *Leach, supra*.

Both *Saikewicz* and *Quinlan* have been the subject of numerous articles in both legal and medical journals. While aspects of both opinions have been criticized, the *Saikewicz* opinion has been more harshly condemned. Many fear that routine court involvement will disrupt the work of doctors in ways that will detrimentally affect the treatment given to patients generally. *See Relman, The Saikewicz Decision: Judges as Physicians*, 298 New Eng.J.Med. 508 (1978). In truth, medical treatment of the terminally ill in Massachusetts in the aftermath of *Saikewicz* has been in a state of general confusion. *See Annas, Reconciling Quinlan and Saikewicz: Decision Making for the Terminally Ill Incompetent*, 4 Am.J.L. & Med. 367, 387-94 (1979). [footnote omitted]

At least one author has attempted to reconcile the seemingly divergent views in *Quinlan* and *Saikewicz*. *Annas, supra*. His thesis is that the factual differences between the two cases explain the different procedural requirements established in each. In *Saikewicz*, the

patient was a 67-year-old mentally retarded man with leukemia; the issue was whether chemotherapy treatment could be withheld. These facts presented the *Saikewicz* court with issues very different from those in the *Quinlan* case. As Mr. Saikewicz had always been severely retarded, there was no way for a guardian to ascertain what his choice would have been, were he competent. Therefore, the concept of a guardian using his best judgment to exercise the patient's personal choice was inapplicable. Also, the *Saikewicz* court was asked to reach an unusual result; most people elect chemotherapy treatment. Therefore, the court was required to find special reasons why Mr. Saikewicz would choose to refuse the treatment. [FN2] In contrast, the *Quinlan* court found that the majority of society, if in Karen's position, would have chosen to have the life support systems withdrawn. *Quinlan, supra* at 41-42, 355 A.2d 647. Finally, the decision in *Saikewicz* involved the refusal of life *prolonging* treatment, for chemotherapy offered a reasonable chance of temporary remission of the disease. Thus, the issue was not one of artificially sustaining a life for an indefinite period. Recognizing these differences, the perceived need for judicial intervention in *Saikewicz* is not surprising.

FN2. This they did with reference to his age, his inability to understand and cooperate with the treatment, the probable side effects and suffering, and the low probability of remission. *Saikewicz, supra* at 753-54, 370 N.E.2d 417.

We are not faced with facts similar to those in *Saikewicz*, however. Bertha Colyer's situation is much more akin to that of Karen Quinlan: she had been competent prior to her heart attack, she had close family members who were familiar with her character and her beliefs, and her treatment was of a life sustaining nature. Therefore, under these circumstances, we choose a course similar to that in *Quinlan* and hold that judicial intervention in every decision to withdraw life sustaining treatment is not required.

While we do not accept the *Quinlan* court's view that judicial intervention is an encroachment upon the medical profession, we do perceive the judicial process as an unresponsive and cumbersome mechanism for decisions of this nature. This fact is borne out by a number of the leading cases in which arguments were heard and opinions written long after the patient had died. See *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981); *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980). Obviously, the court system could not respond in a timely manner to the relief sought in those situations. Moreover, the formalities of a legal determination might chill a guardian's resolve to assert the rights of his ward. See Note, *In re Quinlan: One Court's Answer to the Problem of Death with Dignity*, 34 Wash. & Lee L.Rev. 285, 307 (1977).

In cases where physicians agree on the prognosis and a close family member uses his best judgment as a guardian to exercise the rights of the incompetent, intervention by the courts would be little more than a formality. Therefore, as a general principle, we hold that a decision to terminate life sustaining treatment, under the circumstances presented here, does not require judicial intervention. [footnote omitted] We in no way abdicate, however, the authority of the courts to hear and decide any such case brought before it. Nor do we maintain that judicial intervention would not be required under facts similar to *Saikewicz*; such is not the issue before us now.

Matter of Welfare of Colyer, 660 P.2d 738, 744-746 (Wash. 1983).

The Supreme Court of Washington considered whose values should be used when a guardian makes a end-of-life decision for an incompetent person.

Once appointed, the guardian's duty is to use his best judgment in deciding whether or not to assert the *personal* right of the incompetent to refuse life sustaining treatment. The

guardian's familiarity with the incompetent's character and personality, prior statements, and general attitude towards medical treatment will assist in making that judgment.

The probative value of prior statements by the incompetent regarding refusal of life sustaining treatment has been treated differently by different courts. In *Quinlan*, the court found that Karen's statements to friends to the effect that she would not want to be kept alive on a life sustaining system were without sufficient probative weight. *In re Quinlan*, 70 N.J. 10, 41, 355 A.2d 647, cert. denied 429 U.S. 922, 97 S.Ct. 319, 50 L.Ed.2d 289 (1976). On the other hand, another court considered similar statements, made by the patient while competent, to be probative. *In re Eichner*, 73 A.D.2d 431, 471-72, 426 N.Y.S.2d 517 (1980), aff'd sub nom. *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981). [FN5]

FN5. The *Eichner* court rejected hearsay objections, declaring that such statements fell under the state of mind exception.¹⁹

These positions may be reconciled by their facts, however. Because of her youth and the casual nature of her conversations, Karen Quinlan's statements were logically regarded as having little probative weight in determining what her choice would have been given her situation. In contrast, Brother Fox, the patient in *Eichner*, had expressed his opinion during discussions focusing on the Karen Quinlan situation, and he reiterated these views upon learning that he was in need of the operation that ultimately rendered him incompetent. *Eichner*, at 471, 426 N.Y.S.2d 517. We conclude that prior statements may be probative in determining the wishes of an incompetent patient, with the age and maturity of the patient, the context of the statements, and the connection of the statements to the debilitating event being factors to be weighed by the guardian.

There is no evidence that Bertha Colyer explicitly expressed her desire to refuse life sustaining treatment. Nevertheless, her husband and her sisters agreed that Bertha Colyer was a very independent woman, that she disliked going to doctors, and, if able to express her views, that she would have requested the treatment be withdrawn. Given the unanimity of the opinions expressed by Bertha's closest kin, together with the absence of any evidence of any ill motives, we are satisfied that Bertha's guardian was exercising his best judgment as to Bertha's personal choice when he requested the removal of the life support system.

Matter of Welfare of Colyer, 660 P.2d 738, 747-748 (Wash. 1983).

Finally, the Supreme Court of Washington considered whether disconnecting life support (i.e., disconnecting the ventilator) was homicide, and cautioned that the Court was *not* endorsing euthanasia.

A final issue that must be addressed is the potential criminal liability of those involved in the decision to terminate life sustaining support. [footnote omitted] Under Washington's criminal code, homicide is "the killing of a human being by the act, procurement or omission of another" (RCW 9A.32.010), and it is murder in the first degree when, "[w]ith a premeditated intent to cause the death of another person, [one] causes the death of such person". RCW 9A.32.030(1)(a). Thus, the potential for criminal liability for withdrawing

¹⁹ *Eichner v. Dillon*, 426 N.Y.S.2d at 547 (N.Y.A.D. 1980). Later, the New Jersey Supreme Court agreed. *Matter of Conroy*, 486 A.2d 1209, 1230, n. 6 (N.J. 1985) ("None of these forms of evidence need be excluded as hearsay from a court proceeding, if there be one, since oral and written expressions of a person's reactions or desires fit within the 'existing state of mind' exception to the hearsay rule.").

life sustaining mechanisms appears to exist. We conclude, however, that such action, if in good faith compliance with the procedure set forth above, would not be criminal.

The *Quinlan* court reached this same conclusion based on two alternative theories: (1) that the ensuing death would not be caused by the removal of the treatment, but rather by expiration from existing natural causes, hence it would not be homicide; or (2) even if it were homicide, it would not be unlawful because the action would be based on the exercise of a constitutional right and, as such, would be protected from criminal prosecution. *In re Quinlan*, 70 N.J. 10, 51-52, 355 A.2d 647, cert. denied, 429 U.S. 922, 97 S.Ct. 319, 50 L.Ed.2d 289 (1976); see *Stanley v. Georgia*, 394 U.S. 557, 89 S.Ct. 1243, 22 L.Ed.2d 542 (1969). We concur in this reasoning.

In addition, Washington's Natural Death Act excludes from criminal liability those who act in good faith and in accordance with a directive complying with the statutory requirements. RCW 70.122.060. It further states that acts in accordance with a directive are not deemed suicide, they should have no effect on life or health insurance policies, and the cause of death shall be that which placed the patient in a terminal condition. RCW 70.122.070 and . 080. We believe that the same principles should apply when the patient's right to refuse life sustaining treatment is exercised in accordance with this opinion.

As a concluding note, the limitations of this opinion will be delineated. The issue before us is the removal of life sustaining systems from an incurable patient. The technical term for this is antidysthanasia. Hyland & Baime, *In Re Quinlan: A Synthesis of Law and Medical Technology*, 8 Rut.-Cam.L.Rev. 37, 52-53 (1976). Nothing in this opinion is intended to authorize or condone euthanasia, the unnatural termination of a patient's life. Nor do we reach the question today of the propriety of withdrawing or withholding life prolonging or curative treatment from an incompetent patient, even if the patient is terminally ill. We defer these issues to the Legislature or to the time when they are squarely before us.

Matter of Welfare of Colyer, 660 P.2d 738, 751-752 (Wash. 1983).

Seven of the nine judges on the Washington Supreme Court agreed with the majority opinion in *Colyer*, while two judges dissented.

Conroy

- *Matter of Conroy*, 457 A.2d 1232 (N.J.Super.Ch. Feb 02, 1983),
rev'd, 464 A.2d 303 (N.J.Super.A.D. Jul 08, 1983),
rev'd, 486 A.2d 1209 (N.J. Jan 17, 1985).

medical facts

The trial court described the patient's condition and the facts of this case.

Claire Conroy was adjudicated incompetent in 1979. Her nephew, Thomas C. Whittemore, plaintiff in the present action, was appointed as her guardian. Since 1979 the patient has been a resident of Parklane Nursing Home in Bloomfield, New Jersey. In July 1982 the patient was admitted to Clara Maas Memorial Hospital, Newark, because of a severe infection of her left foot. Her left foot was diagnosed as being gangrenous. Her physicians recommended amputation of her left leg above the knee. The physicians believed that death could occur within two weeks if the leg was not amputated. In the belief that the amputation was not in the best interests of his aunt, the guardian refused permission. The physicians declined to press the issue. The leg was not amputated, but the patient did not die. The patient was discharged from the hospital back to the nursing home on November 17, 1982. At present the lower left leg is wasted and rotted. However, the infection has been contained and the leg does not presently pose a threat to the patient's life. The leg does not now seem to be a source of major pain.

Claire Conroy suffers from severe organic brain syndrome, necrotic decubitus ulcers on her left foot, left leg and left hip, urinary tract infection, arteriosclerotic heart disease, hypertension and diabetes mellitus. Except for minor movements of her head, neck, arms and hands, she is unable to move. She does not speak. She lies in bed in a fetal position. She sometimes follows people with her eyes, but often simply stares blankly ahead. Her general physical appearance is very withered. Although she moans when moved or touched upon some portions of her body, medical testimony is inconclusive as to whether she is capable of experiencing pain. The patient has sufficient brain functioning to regulate certain internal bodily functions. However, except for use of her hands for scratching, she seems incapable of useful external bodily activity. All the testimony in the case and my own direct observation of the patient convince me that she has no cognitive or volitional functioning. There is no reasonable expectation that the patient's condition will ever improve.

During her recent hospitalization a nasogastric tube was inserted through the patient's nose, down her throat and into her stomach. Several times a day water, a nutrient formula, vitamins and medicine are poured through the tube. The patient is unable to swallow. Nurses would not be able to feed her by hand. Without the tube the patient would probably die of starvation and dehydration within a few days. With the tube the patient will probably be able to live for some months, perhaps even a year or more.

Claire Conroy never married. Her siblings are all dead. Her only surviving relative is plaintiff, who is her nephew and guardian. Plaintiff testifies that his aunt never saw a physician or received medical treatment at any time prior to her becoming incompetent in 1979. She scorned medicine. Her nephew believes that she would not willingly accept the tube and the treatment she is now receiving. The guardian wishes to have the tube removed and to allow his aunt to die. The patient's treating physician, Dr. Ahmed Kazemi, will not consent to the removal of the tube. The nursing home has been following the physician's

wishes. However, the home is essentially neutral on the issue of removal of the tube and will not oppose any order entered by the court. The nephew/guardian has brought this action to obtain a judicial declaration that he has the right to have the tube removed.

The guardian filed a complaint on January 24 [1983]. On that date I appointed John J. De Laney, Jr., an attorney, as guardian *ad litem* of Claire Conroy. I heard testimony on January 31 and February 1. This opinion is being issued on February 2. The witnesses have been Dr. Ahmed Kazemi, the treating physician, Dr. Bernard Davidoff, a physician called by the guardian *ad litem*, Catherine C. Rittel, a registered nurse who is the nursing home administrator, Thomas C. Whittemore, the nephew/guardian, and Rev. Joseph Kukura, a Roman Catholic priest who is a member of the medical ethics committee at four hospitals and an associate professor of Christian ethics at Immaculate Conception Seminary.

The physicians agree on the medical condition of the patient. So does the nurse. It is obvious to any person seeing the patient that she is desperately sick. It is also obvious that her mental functioning is primitive. Dr. Kazemi thinks it would be a violation of medical ethics to remove the tube. Dr. Davidoff believes that, with the consent of the patient's guardian, the tube should be removed. Nurse Rittel would be reluctant to see the tube removed. The guardian thinks it is wrong to keep his aunt alive through use of the tube. Father Kukura thinks that under all of the circumstances of this case removal of the tube is morally appropriate. The guardian *ad litem* argues strongly against removal.

I think it fair to say that everyone involved in this case wishes that this poor woman would die. This wish does not flow from any lack of concern for Claire Conroy. On the contrary, it flows from a very deep sympathy for her sad plight. The disagreement among the participants involves differences in perception about what helping this patient means under the circumstances of this case.

Matter of Conroy, 457 A.2d 1232, 1233-34 (N.J.Super.Ch. 1983).

trial court

The trial judge granted permission to remove the nasogastric tube, which was providing water and nutrition to Claire. I find the judge's remarks eloquent and straightforward, so I am quoting them here:

Every sick human being is entitled to loving care, but there comes a time in the loving care of some patients when the proper decision is to let nature take its course, to allow the patient to die.

Even when we decide that it is proper to withhold active treatment, it would be wrong to act directly to terminate life or to withdraw nourishment, fluids, shelter or normal supportive care such as washing and body positioning. When I say that it would be wrong to withdraw nourishment or fluids, I mean that it would be wrong to refuse to give them to the patient if she could take them herself or with the manual assistance of others. It would also be wrong to withhold medications which would reduce pain without unduly prolonging life. I conclude that these things would be wrong because I perceive a need in this area of decision making (1) to recognize the limitations of our understanding of life, suffering and death, (2) to continue a fundamental respect for life even in the most dire human circumstances and (3) to keep in place some fairly simple conceptual controls designed to give some measure of protection against ill-informed or badly motivated decisions.

In this case plaintiff's counsel has argued that the tube should be removed because it constitutes an extraordinary means of treatment. I know that the distinction between "extraordinary" and "ordinary" means of treatment is frequently made in this area of concern,

but I must say that I do not find this terminology particularly helpful. It seems to me that the critical factor is the condition of the patient. I mean here both the present condition and the reasonably predictable future condition. If the patient can be restored by treatment to some meaningful level of intellectual functioning and to some acceptable level of comfort, then the full range of medical knowledge, skill and technology which is available should be brought into action as a matter of ordinary routine. Conversely, if the clear prognosis is that the patient will never return to some meaningful level of intellectual functioning and to some acceptable level of pain, then virtually every act of treatment other than the simple care mentioned in the preceding paragraph is inappropriate and is extraordinary. The focus of inquiry should be upon whether the life of the patient has become and is likely to remain impossibly burdensome to the patient. If the patient's life has become impossibly and permanently burdensome, then we simply are not helping the patient by prolonging her life, and active treatment designed to prolong life becomes utterly pointless and probably cruel. (I hasten to add that I know that persons who advocate active treatment under these circumstances do not intend to be cruel. They are, of course, acting with the intention to help the patient.)

I know that people sometimes say that physicians frequently and courts less frequently "play God" in this area of decision making. There is a sense in which that statement is true, but it seems to me that the implied criticism it contains is not valid. This is not an area where mere mortals are presumptuously reaching out to make decisions beyond their legitimate capabilities. Until fairly recently in the course of human history, nature solved many of our problems without our having much to say about it. With the rapid recent development of medical knowledge, skill and technology has come a broadly expanding ability to intervene in what would otherwise be the normal flow of nature and to prolong life significantly for many human beings. This is generally a good thing. However, it is not an unqualifiedly good thing. Presently available knowledge, skills and technology (to say nothing of what the future may hold) now give us the ability to prolong some lives which ought not be prolonged. We cannot mindlessly and indiscriminately act to prolong all lives, by all means, under all circumstances. We must make some choices.

Of course, once we human beings start making choices we start making mistakes. It is inevitable that we will allow some people to die when we could have and should have prolonged their lives. But we cannot let this fear of error force us into abdicating our basic human responsibility to make choices. The fear of error should be used constructively as an incentive to make our choices carefully and soundly.

I am firmly convinced by the evidence in this case that Claire Conroy's intellectual functioning has been permanently reduced to an extremely primitive level. She suffers from all of the medical problems mentioned above. The general state of her health is very poor and will remain so. Her life has become impossibly and permanently burdensome for her. Prolonging her life would not help her. It would be a wrong to her. The nasogastric tube should be removed, even though that will almost certainly lead to death by starvation and dehydration within a few days, and even though that death may be a painful one for the patient.

Some Misgivings

The nasogastric tube involved in this case is a very simple device. It is so simple that when I first started to think about removing it, I worried that I was getting perilously close to a straightforwardly wrongful refusal to feed a fellow human being. However, I think that there is a real difference between failing to feed a patient who could take nourishment by herself, or with the manual assistance of others, and failing to keep a nasogastric tube in a patient who has permanently lost the ability to swallow. For one thing, I think that the permanent loss of the ability to swallow is often reflective of a vast impairment of brain functioning. For

another, I think that nature may be telling us something about a patient when the ability to swallow is permanently lost.

I have also had some misgivings about an inappropriate impact that a decision such as the present one might have on the treatment of elderly senile persons or on the treatment of retarded persons of all ages. Sometimes people incorrectly evaluate the meaningfulness of the lives of the senile or the retarded. As viewed by some, a decision such as the present one might lead to a wrongful withholding of treatment for the senile or the retarded. Here, I can only say that careful distinctions have to be made. The present patient is functioning at a virtually zero intellectual level. Most people who are suffering from organic brain syndrome and are broadly thought of as being senile operate at an appreciably higher mental level, although their intellect is markedly impaired. They are capable of loving and of responding to love. They are not in the same category as this poor woman. If they become injured or ill, active treatment is mandatory. I am sure that the same is true for most retarded persons. When we think about the problems of the elderly senile and the retarded, we know that we have to be very careful about premature and wrongful withdrawal of treatment.

Judicial Involvement

In the *Quinlan* case the New Jersey Supreme Court indicated that judicial involvement in this area of decision making is not necessary in every case, and, indeed, might sometimes be inappropriate. See *In re Quinlan, supra*, 70 N.J. at 38-55, 355 A.2d 647. That view is clearly a sound one. As often as possible, the patient, the family and the physicians involved should make these decisions for themselves.

However, fairly frequently judicial involvement is necessary. Sometimes the patient is incompetent and has not prior to her incompetency given any clear indication of what her desires might be. (This is so in the present case.) Sometimes the family is divided in its views. Sometimes physicians differ among themselves or with members of the family. (This is so in the present case.) When one or more of these factors are present, judicial involvement is indicated.

It should also be noted that the kind of medical ethics committee envisioned by the *Quinlan* case as being available in the typical hospital is not, in fact, in place in many New Jersey hospitals. Such a committee is not available in the typical nursing home. Thus, the kind of solid private institutional support and monitoring of decisions contemplated by the New Jersey Supreme Court in *Quinlan* is frequently not a reality. This means more judicial involvement than would otherwise be the case.

I might also note that I would have some misgivings about a plaintiff such as the present one making basic decisions about termination of treatment without being subject to some kind of judicial scrutiny. Mr. Whittemore is an intelligent and decent man. He is the legal guardian of the patient. He certainly means well for the patient. I believe that in this case he has, in fact, reached the right decision about the nasogastric tube. However, he is only a nephew of the patient, and is, thus, not a particularly close relative. He does not stand in the same relationship to her as would a parent, a spouse, a sibling or a child. Hence, his views are perhaps somewhat less relevant than would be those of a closer relative.

There is a need for some public monitoring of the trend of decisions in this area. Physicians have a technical expertise, a frequent contact and a professional moral sensitivity which entitle their views to great deference. However, they do not have the public perception and the public responsibility which courts have. Judicial involvement from time to time is, I think, helpful to the integrity and validity of decision making in this area.

Matter of Conroy, 457 A.2d 1232, 1235-1237 (N.J.Super.Ch. 1983).

The trial court noted it issued the judgment on 2 Feb 1983, "but before the nasogastric tube could be removed, the patient died" on 15 Feb 1983.

first appeal

The guardian ad litem appealed, and the appellate court considered this case because it presented "issues of great public importance or is based upon a controversy capable of repetition, yet evading review because of the short duration of any single plaintiff's interest." 464 A.2d at 306.

The appellate court reversed, noting that Claire was aware of her environment and could respond to simple commands, and unlike a patient in a persistent vegetative state.

We reverse the judgment here entered because in our view we regard [withdrawal of life-sustaining nourishment from this patient] as the authorization of euthanasia.

Matter of Conroy, 464 A.2d 303, 306-307 (N.J.Super.A.D. 1983).

We are also troubled by the trial judge's framing of the issue as whether the patient will return "to some meaningful level of intellectual functioning." Put simply, to allow a physician or family member to discontinue life-sustaining treatment to a person solely because that person's lack of intellectual capacity precludes him from enjoying a meaningful quality of life would establish a dangerous precedent that logically could be extended far beyond the facts of the case now before us. In our view, the right to terminate life-sustaining treatment based on a guardian's substituted judgment should be limited to incurable and terminally ill patients who are brain dead, irreversibly comatose or vegetative and who would gain no medical benefit from continued treatment. *A fortiori*, there can be no justification for withholding nourishment, which is really not "treatment" at all (*see* IIB below), from a patient who does not meet these criteria. Any further extension of the *Quinlan* rule would place into the hands of physicians, family members and judges the determination of whose quality of life is so slight that he should not be kept alive. [footnote omitted]

Matter of Conroy, 464 A.2d 303, 310 (N.J.Super.A.D. 1983).

New Jersey Supreme Court

The New Jersey Supreme Court framed the issues in this moot appeal.

This case requires us to determine the circumstances under which life-sustaining treatment may be withheld or withdrawn from an elderly nursing-home resident [FN1] who is suffering from serious and permanent mental and physical impairments, who will probably die within approximately one year even with the treatment, and who, though formerly competent, is now incompetent to make decisions about her life-sustaining treatment and is unlikely to regain such competence. Subsumed within this question are two corollary issues: what substantive guidelines are appropriate for making these treatment decisions for incompetent patients, and what procedures should be followed in making them.

FN1. Our holding is restricted to nursing-home residents because they are governed by a number of state statutes that do not apply to elderly persons in other settings. *See infra* at 1238 - 1240.

Matter of Conroy, 486 A.2d 1209, 1219-1220 (N.J. 1985).

The New Jersey Supreme Court reviewed the common-law legal right to refuse medical treatment.

The starting point in analyzing whether life-sustaining treatment may be withheld or withdrawn from an incompetent patient is to determine what rights a competent patient has to accept or reject medical care. It is therefore necessary at the outset of this discussion to identify the nature and extent of a patient's rights that are implicated by such decisions.

The right of a person to control his own body is a basic societal concept, long recognized in the common law:

No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law. As well said by *Judge Cooley*, "The right to one's person may be said to be a right of complete immunity: to be let alone." *Cooley on Torts*, 29.

Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251, 11 S.Ct. 1000, 1001, 35 L.Ed. 734, 737 (1891) (refusing to compel personal injury plaintiff to undergo pretrial medical examination).

Accord Perna v. Pirozzi, 92 N.J. 446, 459-65, 457 A.2d 431 (1983). Judge Cardozo succinctly captured the essence of this theory as follows: "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." *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914).

The doctrine of informed consent is a primary means developed in the law to protect this personal interest in the integrity of one's body. "Under this doctrine, no medical procedure may be performed without a patient's consent, obtained after explanation of the nature of the treatment, substantial risks, and alternative therapies." Cantor, "A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life," 26 *Rutgers L.Rev.* 228, 237 (1973) (footnote omitted); see also *Perna v. Pirozzi*, *supra*, 92 N.J. at 461, 457 A.2d 431 ("Absent an emergency, patients have the right to determine not only whether surgery is to be performed on them, but who shall perform it.").

The doctrine of informed consent presupposes that the patient has the information necessary to evaluate the risks and benefits of all the available options and is competent to do so. Cf. Wanzer, Adelstein, Cranford, Federman, Hook, Moertel, Safar, Stone, Taussig & Van Eys, "The Physician's Responsibility Toward Hopelessly Ill Patients," 310 *New Eng. J. Med.* 955, 957 (1984) ("There are three basic prerequisites for informed consent: the patient must have the capacity to reason and make judgments, the decision must be made voluntarily and without coercion, and the patient must have a clear understanding of the risks and benefits of the proposed treatment alternatives or nontreatment, along with a full understanding of the nature of the disease and the prognosis."). In general, it is the doctor's role to provide the necessary medical facts and the patient's role to make the subjective treatment decision based on his understanding of those facts. Cf. *Hilfiker*, *supra*, 308 *New Eng. J. Med.* at 718 (acknowledging that "our ability [as doctors] to phrase options, stress information, and present our own advice gives us tremendous power").

The patient's ability to control his bodily integrity through informed consent is significant only when one recognizes that this right also encompasses a right to informed refusal. Note, "Informed Consent and the Dying Patient," 83 *Yale L.J.* 1632, 1648 (1974). Thus, a competent adult person generally has the right to decline to have any medical treatment initiated or continued. See *Superintendent of Belchertown State School v. Saikewicz*, 373 *Mass.* 728, 738, 370 N.E.2d 417, 424 (1977); *In re Quackenbush*, 156 N.J.Super. 282, 290, 383 A.2d 785 (Cty.Ct.1978); cf. *Bennan v. Parsonnet*, 83 N.J.L. 20, 22-23, 26-27, 83 A. 948

(Sup.Ct.1912) (acknowledging common-law rule that patient is "the final arbiter as to whether he shall take his chances with the operation or take his chances of living without it," but holding that surgeon had implied consent while patient was unconscious to perform necessary surgical operation).

Matter of Conroy, 486 A.2d 1209, 1221-1222 (N.J. 1985).

The New Jersey Supreme Court briefly reviewed constitutional privacy law as an alternative basis for allowing a patient to refuse medical treatment.

The right to make certain decisions concerning one's body is also protected by the federal constitutional right of privacy. The Supreme Court first articulated the right of privacy in *Griswold v. Connecticut*, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965), which held that married couples have a constitutional right to use contraceptives. The Court in *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973), further extended its recognition of the privacy right to protect a woman's decision to abort a pregnancy although the woman's right to choose abortion directly conflicted with the state's legitimate and important interest in preserving the potentiality of fetal life. Finally, in *Quinlan, supra*, 70 N.J. at 40, 355 A.2d 647, we indicated that the right of privacy enunciated by the Supreme Court "is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances," even if that decision might lead to the patient's death. Accord *Saikewicz, supra*, 373 Mass. at 738, 370 N.E.2d at 424; *Quackenbush, supra*, 156 N.J.Super. at 289-90, 383 A.2d 785. While this right of privacy might apply in a case such as this, we need not decide that issue since the right to decline medical treatment is, in any event, embraced within the common-law right to self-determination. Accord *In re Storar*, 52 N.Y.2d 363, 376-77, 420 N.E.2d 64, 70, 438 N.Y.S.2d 266, 272-73, cert. denied, 454 U.S. 858, 102 S.Ct. 309, 70 L.Ed.2d 153 (1981); Note, "Live or Let Die; Who Decides an Incompetent's Fate? *In re Storar* and *In re Eichner*," 1982 B.Y.U.L.Rev. 387, 390-92.

Matter of Conroy, 486 A.2d 1209, 1222-1223 (N.J. 1985).

The New Jersey Supreme Court reviewed the case law and found four important state interests that might justify refusal of an individual rights.

Whether based on common-law doctrines or on constitutional theory, the right to decline life-sustaining medical treatment is not absolute. In some cases, it may yield to countervailing societal interests in sustaining the person's life. Courts and commentators have commonly identified four state interests that may limit a person's right to refuse medical treatment: [1] preserving life, [2] preventing suicide, [3] safeguarding the integrity of the medical profession, and [4] protecting innocent third parties. *See, e.g., Satz v. Perlmutter, supra*, 362 So.2d at 162; *In re Spring*, 380 Mass. 629, 640, 405 N.E.2d 115, 123 (1980); *Commissioner of Correction v. Myers*, 379 Mass. 255, 261, 399 N.E.2d 452, 456 (1979); *Saikewicz, supra*, 373 Mass at 728, 370 N.E.2d at 425; *In re Torres*, 357 N.W.2d 332, 339 (Minn. 1984); *In re Colyer*, 99 Wash.2d 114, 121, 660 P.2d 738, 743 (1983); *President's Commission Report, supra*, at 31-32; Note, "In re Storar: The Right to Die and Incompetent Patients," 43 *U.Pitt.L.Rev.* 1087, 1092 (1982).²⁰

The state's interest in preserving life is commonly considered the most significant of the four state interests. *See, e.g., Spring, supra*, 380 Mass. at 633, 405 N.E.2d at 119; *Saikewicz, supra*, 373 Mass. at 740, 370 N.E.2d at 425; *President's Commission Report, supra*, at 32. It may be seen as embracing two separate but related concerns: an interest in preserving the life of the particular patient, and an interest in preserving the sanctity of all life. Cantor, "Quinlan, Privacy, and the Handling of Incompetent Dying Patients," 30 *Rutgers L.Rev.* 239, 249 (1977); *see* Annas, "In re Quinlan: Legal Comfort for Doctors," *Hastings Center Rep.*, June 1976, at 29.

While both of these state interests in life are certainly strong, in themselves they will usually not foreclose a competent person from declining life-sustaining medical treatment for himself. This is because the life that the state is seeking to protect in such a situation is the life of the same person who has competently decided to forego the medical intervention; it is not some other actual or potential life that cannot adequately protect itself. *Cf. Roe v. Wade, supra*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (authorizing state restrictions or proscriptions of woman's right to abortion in final trimester of pregnancy to protect viable fetal life); *State v. Perricone*, 37 N.J. 463, 181 A.2d 751, *cert. denied*, 371 U.S. 890, 83 S.Ct. 189, 9 L.Ed.2d 124 (1962) (affirming trial court's appointment of guardian with authority to consent to blood transfusion for infant over parents' religious objections); *Muhlenberg Hosp. v. Patterson*, 128 N.J.Super. 498, 320 A.2d 518 (Law Div. 1974) (authorizing blood transfusion to save infant's life over parents' religious objections).

Matter of Conroy, 486 A.2d 1209, 1223 (N.J. 1985).

The New Jersey Supreme Court discussed the preservation of life and prevention of suicide, and concluded:

... declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury. *See Satz v. Perlmutter, supra*, 362 So.2d

²⁰ My own legal research traces these four state interests back to *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417, 425 (Mass. 1977). These four state interests were cited with approval by the U.S. Supreme Court in *Cruzan by Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 271 (1990).

at 162; *Saikewicz, supra*, 373 Mass. at 743 n. 11, 370 N.E.2d at 426 n. 11; *Colyer, supra*, 99 Wash.2d at 121, 660 P.2d at 743; see also *President's Commission Report, supra*, at 38 (summarizing case law on the subject). But cf. *In re Caulk*, N.H., 480 A.2d 93, 96-97 (1984) (stating that attempt of an otherwise healthy prisoner to starve himself to death because he preferred death to life in prison was tantamount to attempted suicide, and that the state, to prevent such suicide, could force him to eat). In addition, people who refuse life-sustaining medical treatment may not harbor a specific intent to die, *Saikewicz, supra*, 373 Mass. at 743, n. 11, 370 N.E.2d at 426 n. 11; rather, they may fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs, and without protracted suffering, see *Satz v. Perlmutter, supra*, 362 So.2d at 162-63 ("The testimony of Mr. Perlmutter * * * is that he really wants to live, but [to] do so, God and Mother Nature willing, under his own power.").

Recognizing the right of a terminally ill person to reject medical treatment respects that person's intent, not to die, but to suspend medical intervention at a point consonant with the "individual's view respecting a personally preferred manner of concluding life." Note, "The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State," 51 *N.Y.U.L.Rev.* 285, 310 (1976). The difference is between self-infliction or self-destruction and self-determination. See Byrn, "Compulsory Lifesaving Treatment for the Competent Adult," 44 *Fordham L.Rev.* 1, 16-23 (1975). To the extent that our decision in *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 581- 82, 279 A.2d 670 (1971), implies the contrary, we now overrule it.

Matter of Conroy, 486 A.2d 1209, 1224 (N.J. 1985).

The New Jersey Supreme Court wrote two paragraphs about the need to protect the integrity of the medical profession:

The third state interest that is frequently asserted as a limitation on a competent patient's right to refuse medical treatment is the interest in safeguarding the integrity of the medical profession. This interest, like the interest in preventing suicide, is not particularly threatened by permitting competent patients to refuse life-sustaining medical treatment. Medical ethics do not require medical intervention in disease at all costs. As long ago as 1624, Francis Bacon wrote, "I esteem it the office of a physician not only to restore health, but to mitigate pain and dolours; and not only when such mitigation may conduce to recovery, but when it may serve to make a fair and easy passage." *F. Bacon, New Atlantis, quoted in Mannes, "Euthanasia vs. The Right to Life," 27 Baylor L.Rev.* 68, 69 (1975). More recently, we wrote in *Quinlan, supra*, 70 N.J. at 47, 355 A.2d 647, that modern-day "physicians distinguish between curing the ill and comforting and easing the dying; that they refuse to treat the curable as if they were dying or ought to die, and that they have sometimes refused to treat the hopeless and dying as if they were curable." Indeed, recent surveys have suggested that a majority of practicing doctors now approve of passive euthanasia and believe that it is being practiced by members of the profession. See sources cited in *Storar, supra*, 52 N.Y.2d at 385-386 n. 3, 420 N.E.2d at 75-76 n. 3, 438 N.Y.S.2d at 277-78 n. 3 (Jones, J., dissenting), and in Collester, "Death, Dying and the Law: A Prosecutorial View of the *Quinlan* Case," 30 *Rutgers L.Rev.* 304, n. 3, 312 & n. 27.

Moreover, even if doctors were exhorted to attempt to cure or sustain their patients under all circumstances, that moral and professional imperative, at least in cases of patients who were clearly competent, presumably would not require doctors to go beyond advising the patient of the risks of foregoing treatment and urging the patient to accept the medical intervention. *Storar, supra*, 52 N.Y.2d at 377, 420 N.E.2d at 71, 438 N.Y.S.2d at 273; see *Colyer, supra*, 99 Wash.2d at 121-23, 660 P.2d at 743-44, citing *Saikewicz, supra*, 373 Mass. at 743-44, 370 N.E.2d at 417. If the patient rejected the doctor's advice, the onus of that

decision would rest on the patient, not the doctor. Indeed, if the patient's right to informed consent is to have any meaning at all, it must be accorded respect even when it conflicts with the advice of the doctor or the values of the medical profession as a whole.

Matter of Conroy, 486 A.2d 1209, 124-1225 (N.J. 1985).

The fourth and final state interest, the protection of innocent third-parties, was discussed by the New Jersey Supreme Court in one paragraph.

The fourth asserted state interest in overriding a patient's decision about his medical treatment is the interest in protecting innocent third parties who may be harmed by the patient's treatment decision. When the patient's exercise of his free choice could adversely and directly affect the health, safety, or security of others, the patient's right of self-determination must frequently give way. Thus, for example, courts have required competent adults to undergo medical procedures against their will if necessary to protect the public health, *Jacobson v. Massachusetts*, 197 U.S. 11, 25 S.Ct. 358, 49 L.Ed. 643 (1905) (recognizing enforceability of compulsory smallpox vaccination law); to prevent a serious risk to prison security, *Myers, supra*, 379 Mass. at 263, 265, 399 N.E.2d at 457, 458 (compelling prisoner with kidney disease to submit to dialysis over his protest rather than acquiescing in his demand to be transferred to a lower-security prison); *accord Caulk, supra*, 480 A.2d at 96; or to prevent the emotional and financial abandonment of the patient's minor children, *Application of President & Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1008 (D.C.Cir.), cert. denied, 377 U.S. 978, 84 S.Ct. 1883, 12 L.Ed.2d 746 (1964) (ordering mother of seven-month-old infant to submit to blood transfusion over her religious objections because of the mother's "responsibility to the community to care for her infant"); *Holmes v. Silver Cross Hosp.*, 340 F.Supp. 125, 130 (N.D.Ill. 1972) (indicating that patient's status as father of minor child might justify authorizing blood transfusion to save his life despite his religious objections).

On balance, the right to self-determination ordinarily outweighs any countervailing state interests, and competent persons generally are permitted to refuse medical treatment, even at the risk of death. Most of the cases that have held otherwise, unless they involved the interest in protecting innocent third parties, have concerned the patient's competency to make a rational and considered choice of treatment.

Matter of Conroy, 486 A.2d 1209, 1225 (N.J. 1985).

Such considerations might be important if a patient had minor children and there was reasonable hope that the patient would recover after treatment. In most of the right-to-die cases considered by courts one observes that both (1) the patient has no minor children, and (2) recovery of the patient is unlikely, even with aggressive treatment (i.e., further treatment is futile).

The New Jersey Supreme Court then applied this law to the facts of this case.

In view of the case law, we have no doubt that Ms. Conroy, if competent to make the decision and if resolute in her determination, could have chosen to have her nasogastric tube withdrawn. Her interest in freedom from nonconsensual invasion of her bodily integrity would outweigh any state interest in preserving life or in safeguarding the integrity of the medical profession. In addition, rejecting her artificial means of feeding would not constitute attempted suicide, as the decision would probably be based on a wish to be free of medical intervention rather than a specific intent to die, and her death would result, if at all, from her underlying medical condition, which included her inability to swallow. Finally, removal of her feeding tube would not create a public health or safety hazard, nor would her death leave any minor dependents without care or support.

It should be noted that if she were competent, Ms. Conroy's right to self-determination would not be affected by her medical condition or prognosis. Our Legislature has recognized that an institutionalized, elderly person, whatever his physical and mental limitations and life expectancy, has the same right to receive medical treatment as a competent young person whose physical functioning is basically intact. See *N.J.S.A. 52:27G-1* (declaring "that it is the public policy of this State to secure for elderly patients, residents and clients of health care facilities serving their specialized needs and problems, *the same civil and human rights guaranteed to all citizens* ") (emphasis added). Moreover, a young, generally healthy person, if competent, has the same right to decline life-saving medical treatment as a competent elderly person who is terminally ill. Of course, a patient's decision to accept or reject medical treatment may be influenced by his medical condition, treatment, and prognosis; nevertheless, a competent person's common-law and constitutional rights do not depend on the quality or value of his life.

More difficult questions arise in the context of patients who, like Claire Conroy, are incompetent to make particular treatment decisions for themselves. Such patients are unable to exercise directly their own right to accept or refuse medical treatment. In attempting to exercise that right on their behalf, substitute decision-makers must seek to respect simultaneously both aspects of the patient's right to self-determination — the right to live, and the right, in some cases, to die of natural causes without medical intervention.

Matter of Conroy, 486 A.2d 1209, 1226-1227 (N.J. 1985).

The New Jersey Supreme Court quoted from its decision in *Quinlan* and addressed the problem of making decisions for mentally incompetent persons.

The *Quinlan* decision dealt with a special category of patients: those in a chronic, persistent vegetative or comatose state. [footnote omitted] In a footnote, the opinion left open the question whether the principles it enunciated might be applicable to incompetent patients in "other types of terminal medical situations * * *, not necessarily involving the hopeless loss of cognitive or sapient life." *Quinlan*, 70 N.J. at 54 n. 10, 355 A.2d 647. We now are faced with one such situation: that of elderly, formerly competent nursing-home residents who, unlike Karen Quinlan, are awake and conscious and can interact with their environment to a limited extent, but whose mental and physical functioning is severely and permanently impaired and whose life expectancy, even with the treatment, is relatively short. The capacities of such people, while significantly diminished, are not as limited as those of irreversibly comatose persons, and their deaths, while no longer distant, may not be imminent. Large numbers of aged, chronically ill, institutionalized persons fall within this general category.

Such people (like newborns, mentally retarded persons, permanently comatose individuals, and members of other groups with which this case does not deal) are unable to speak for themselves on life-and-death issues concerning their medical care. This does not mean, however, that they lack a right to self-determination. The right of an adult who, like Claire Conroy, was once competent, to determine the course of her medical treatment remains intact even when she is no longer able to assert that right or to appreciate its effectuation. *John F. Kennedy Memorial Hosp., Inc. v. Bludworth*, 452 So.2d 921, 924 (Fla. 1984). As one commentator has noted:

Even if the patient becomes too insensate to appreciate the honoring of his or her choice, self-determination is important. After all, law respects testamentary dispositions even if the testator never views his gift being bestowed.

Cantor, *supra*, 30 *Rutgers L.Rev.* at 259.

Any other view would permit obliteration of an incompetent's panoply of rights merely because the patient could no longer sense the violation of those rights. [*Id.* at 252.]

Since the condition of an incompetent patient makes it impossible to ascertain definitively his present desires, a third party acting on the patient's behalf often cannot say with confidence that his treatment decision for the patient will further rather than frustrate the patient's right to control his own body. *Cf.* Smith, "*In re Quinlan: Defining the Basis for Terminating Life Support Under the Right of Privacy*," 12 *Tulsa L.J.* 150, 161 (1976) (arguing that permitting a guardian to make personal medical decisions for an incompetent patient actually interferes with the patient's right of privacy). Nevertheless, the goal of decision-making for incompetent patients should be to determine and effectuate, insofar as possible, the decision that the patient would have made if competent. Ideally, both aspects of the patient's right to bodily integrity — the right to consent to medical intervention and the right to refuse it — should be respected.

Matter of Conroy, 486 A.2d 1209, 1228-1229 (N.J. 1985).

The New Jersey Supreme Court then stated the major holding in this case.

In light of these rights and concerns, we hold that life-sustaining treatment may be withheld or withdrawn from an incompetent patient when it is clear that the particular patient would have refused the treatment under the circumstances involved. The standard we are enunciating is a subjective one, consistent with the notion that the right that we are seeking to effectuate is a very personal right to control one's own life. The question is not what a reasonable or average person would have chosen to do under the circumstances but what the particular patient would have done if able to choose for himself.

Matter of Conroy, 486 A.2d 1209, 1229 (N.J. 1985).

Two years later, the New Jersey Supreme Court reiterated this holding:

Medical choices are private, regardless of whether a patient is able to make them personally or must rely on a surrogate. They are not to be decided by societal standards of reasonableness or normalcy. Rather, it is the patient's preferences — formed by his or her unique personal experiences — that should control.

Matter of Peter by Johanning, 529 A.2d 419, 423 (N.J. 1987).

Our constant goal is to insure that patients' medical preferences are respected. Therefore, the *Conroy* subjective test is applicable in every surrogate-refusal-of-treatment case, regardless of the patient's medical condition or life-expectancy. Under this test, life-sustaining treatment may be withdrawn or withheld whenever there is clear and convincing proof that if the patient were competent, he or she would decline the treatment. Once the subjective test is met, the patient's life expectancy and the balance between the benefits and burdens of continued treatment are no longer important. The patient's right to self-determination simply overrides these objective standards.

Matter of Peter by Johanning, 529 A.2d 419, 425 (N.J. 1987).

The New Jersey Supreme Court explained the kinds of evidence that would be relevant in determining what an individual patient would have wanted.

The patient may have expressed, in one or more ways, an intent not to have life-sustaining medical intervention. Such an intent might be embodied in a written document, or "living will," stating the person's desire not to have certain types of life-sustaining treatment administered under certain circumstances. [FN5] It might also be evidenced in an oral directive that the patient gave to a family member, friend, or health care provider. It might consist of a durable power of attorney or appointment of a proxy authorizing a particular

person to make the decisions on the patient's behalf if he is no longer capable of making them for himself. See *N.J.S.A.* 46:2B-8 (providing that principal may confer authority on agent that is to be exercisable "notwithstanding later disability or incapacity of the principal at law or later uncertainty as to whether the principal is dead or alive"). It might take the form of reactions that the patient voiced regarding medical treatment administered to others. See, e.g., *Storar, supra*, 52 *N.Y.2d* 363, 420 *N.E.2d* 64, 438 *N.Y.S.2d* 266 (withdrawal of respirator was justified as an effectuation of patient's stated wishes when patient, as member of Catholic religious order, had stated more than once in formal discussions concerning the moral implications of the *Quinlan* case, most recently two months before he suffered cardiac arrest that left him in an irreversible coma, that he would not want extraordinary means used to keep him alive under similar circumstances). [FN6] It might also be deduced from a person's religious beliefs and the tenets of that religion, *id.* at 378, 420 *N.E.2d* at 72, 438 *N.Y.S.2d* at 274, or from the patient's consistent pattern of conduct with respect to prior decisions about his own medical care. Of course, dealing with the matter in advance in some sort of thoughtful and explicit way is best for all concerned.

FN5. The Legislature has not enacted a statute recognizing the validity of living wills or prescribing the means to execute such wills. See *supra* at 15-16 note 2 for pending legislation. Whether or not they are legally binding, however, such advance directives are relevant evidence of the patient's intent. *John F. Kennedy Memorial Hosp., Inc. v. Bludworth*, 452 *So.2d* 921, 926 (Fla. 1984).

FN6. None of these forms of evidence need be excluded as hearsay from a court proceeding, if there be one, since oral and written expressions of a person's reactions or desires fit within the "existing state of mind" exception to the hearsay rule. *Evid.R.* 63(12); see *State v. Ready*, 78 *N.J.L.* 599, 609, 75 *A.* 564 (E. & A. 1910) (testator's oral statements admissible to show his testamentary design); *Woll v. Dugas*, 104 *N.J.Super.* 586, 592-93, 250 *A.2d* 775 (Ch.Div. 1969) (decedent's statements to lawyer about testamentary intent may fall within "state of mind" exception to hearsay rule), *aff'd*, 112 *N.J.Super.* 366, 271 *A.2d* 443 (App.Div. 1970); *D. Meyers, supra*, at 282 n. 65; *Smith, supra*, 12 *Tulsa L.J.* at 163.

Any of the above types of evidence, and any other information bearing on the person's intent, may be appropriate aids in determining what course of treatment the patient would have wished to pursue. In this respect, we now believe that we were in error in *Quinlan, supra*, 70 *N.J.* at 21, 41, 355 *A.2d* 647, to disregard evidence of statements that Ms. Quinlan made to friends concerning artificial prolongation of the lives of others who were terminally ill. See criticism of this portion of *Quinlan* opinion in Collester, *supra*, 30 *Rutgers L.Rev.* at 318; *Smith, supra*, 12 *Tulsa L.J.* at 163; and *D. Meyers, supra*, at 282 n. 65. Such evidence is certainly relevant to shed light on whether the patient would have consented to the treatment if competent to make the decision.

Although all evidence tending to demonstrate a person's intent with respect to medical treatment should properly be considered by surrogate decision-makers, or by a court in the event of any judicial proceedings, the probative value of such evidence may vary depending on the remoteness, consistency, and thoughtfulness of the prior statements or actions and the maturity of the person at the time of the statements or acts. *Colyer, supra*, 99 *Wash.2d* at 131, 660 *P.2d* at 748. Thus, for example, an offhand remark about not wanting to live under certain circumstances made by a person when young and in the peak of health would not in itself constitute clear proof twenty years later that he would want life-sustaining treatment withheld under those circumstances. In contrast, a carefully considered position, especially if written, that a person had maintained over a number of years or that he had acted upon in comparable circumstances might be clear evidence of his intent.

Another factor that would affect the probative value of a person's prior statements of intent would be their specificity. Of course, no one can predict with accuracy the precise circumstances with which he ultimately might be faced. Nevertheless, any details about the level of impaired functioning and the forms of medical treatment that one would find tolerable should be incorporated into advance directives to enhance their later usefulness as evidence.

Medical evidence bearing on the patient's condition, treatment, and prognosis, like evidence of the patient's wishes, is an essential prerequisite to decision-making under the subjective test. The medical evidence must establish that the patient fits within the Claire Conroy pattern: an elderly, incompetent nursing-home resident with severe and permanent mental and physical impairments and a life expectancy of approximately one year or less. In addition, since the goal is to effectuate the patient's right of informed consent, the surrogate decision-maker must have at least as much medical information upon which to base his decision about what the patient would have chosen as one would expect a competent patient to have before consenting to or rejecting treatment. Such information might include evidence about the patient's present level of physical, sensory, emotional, and cognitive functioning; the degree of physical pain resulting from the medical condition, treatment, and termination of treatment, respectively; the degree of humiliation, dependence, and loss of dignity probably resulting from the condition and treatment; the life expectancy and prognosis for recovery with and without treatment; the various treatment options; and the risks, side effects, and benefits of each of those options. Particular care should be taken not to base a decision on a premature diagnosis or prognosis. See *Colyer, supra*, 99 Wash.2d at 143-45, 660 P.2d at 754-55 (Dore, J., dissenting).

We recognize that for some incompetent patients it might be impossible to be clearly satisfied as to the patient's intent either to accept or reject the life-sustaining treatment. Many people may have spoken of their desires in general or casual terms, [FN7] or, indeed, never considered or resolved the issue at all. In such cases, a surrogate decision-maker cannot presume that treatment decisions made by a third party on the patient's behalf will further the patient's right to self-determination, since effectuating another person's right to self-determination presupposes that the substitute decision-maker knows what the person would have wanted. Thus, in the absence of adequate proof of the patient's wishes, it is naive to pretend that the right to self-determination serves as the basis for substituted decision-making. See *Storar, supra*, 52 N.Y.2d at 378-380, 420 N.E.2d at 72-73, 438 N.Y.S.2d at 274-75; Veatch, "An Ethical Framework for Terminal Care Decisions: A New Classification of Patients," 32(9) *J.Am. Geriatrics Soc'y* 665, 666 (1984).

FN7. For example, someone may have said orally or in writing merely that he would not want to be "artificially sustained" by "heroic measures" if his condition was "hopeless," or that he would not want to have doctors apply life-sustaining procedures "that would serve only to artificially prolong the dying process" if he were "terminally ill." Such a general statement might not in itself provide clear guidance to a surrogate decision-maker in all situations. See *Cantor, supra*, 30 *Rutgers L.Rev.* at 262; *Hilfiker, supra*, 308 *New Eng.J.Med.* at 718.

Matter of Conroy, 486 A.2d 1209, 129-1231 (N.J. 1985).

The New Jersey Supreme Court addressed the possibility of having no evidence about the wishes of an individual patient, such as Claire Conroy.

We hesitate, however, to foreclose the possibility of humane actions, which may involve termination of life-sustaining treatment, for persons who never clearly expressed their desires about life-sustaining treatment but who are now suffering a prolonged and painful death. An incompetent, like a minor child, is a ward of the state, and the state's *parens patriae* power supports the authority of its courts to allow decisions to be made for an incompetent that serve

the incompetent's best interests, even if the person's wishes cannot be clearly established. This authority permits the state to authorize guardians to withhold or withdraw life-sustaining treatment from an incompetent patient if it is manifest that such action would further the patient's best interests in a narrow sense of the phrase, even though the subjective test that we articulated above may not be satisfied. We therefore hold that life-sustaining treatment may also be withheld or withdrawn from a patient in Claire Conroy's situation if either of two "best interests" tests — a limited-objective or a pure-objective test — is satisfied.

Under the limited-objective test, life-sustaining treatment may be withheld or withdrawn from a patient in Claire Conroy's situation when there is some trustworthy evidence that the patient would have refused the treatment, and the decision-maker is satisfied that it is clear that the burdens of the patient's continued life with the treatment outweigh the benefits of that life for him.²¹ By this we mean that the patient is suffering, and will continue to suffer throughout the expected duration of his life, unavoidable pain, and that the net burdens of his prolonged life (the pain and suffering of his life with the treatment less the amount and duration of pain that the patient would likely experience if the treatment were withdrawn) markedly outweigh any physical pleasure, emotional enjoyment, or intellectual satisfaction that the patient may still be able to derive from life. This limited-objective standard permits the termination of treatment for a patient who had not unequivocally expressed his desires before becoming incompetent, when it is clear that the treatment in question would merely prolong the patient's suffering.

Medical evidence will be essential to establish that the burdens of the treatment to the patient in terms of pain and suffering outweigh the benefits that the patient is experiencing. The medical evidence should make it clear that the treatment would merely prolong the patient's suffering and not provide him with any net benefit. Information is particularly important with respect to the degree, expected duration, and constancy of pain with and without treatment, and the possibility that the pain could be reduced by drugs or other means short of terminating the life-sustaining treatment. The same types of medical evidence that are relevant to the subjective analysis, such as the patient's life expectancy, prognosis, level of functioning, degree of humiliation and dependency, and treatment options, should also be considered.

This limited-objective test also requires some trustworthy evidence that the patient would have wanted the treatment terminated. This evidence could take any one or more of the various forms appropriate to prove the patient's intent under the subjective test. Evidence that, taken as a whole, would be too vague, casual, or remote to constitute the clear proof of the patient's subjective intent that is necessary to satisfy the subjective test — for example, informally expressed reactions to other people's medical conditions and treatment — might be sufficient to satisfy this prong of the limited-objective test.

In the absence of trustworthy evidence, or indeed any evidence at all, that the patient would have declined the treatment, life-sustaining treatment may still be withheld or withdrawn from a formerly competent person like Claire Conroy if a third, pure-objective test is satisfied. Under that test, as under the limited-objective test, the net burdens of the patient's life with the treatment should clearly and markedly outweigh the benefits that the patient

²¹ Note that Claire Conroy was *not* in a persistent vegetative state. Later, the New Jersey Supreme Court clarified this test in *Matter of Peter by Johannig*, 529 A.2d 419, 425 (N.J. 1987) (“While a benefits-burdens analysis is difficult with marginally cognitive patients like Claire Conroy, it is essentially impossible with patients in a persistent vegetative state. By definition such patients, like Ms. Peter, do not experience any of the benefits or burdens that the *Conroy* balancing tests are intended or able to appraise. Therefore, we hold that these tests should not be applied to patients in the persistent vegetative state. [¶] Rather, for those patients we look to *Quinlan* for guidance.”).

derives from life. Further, the recurring, unavoidable and severe pain of the patient's life with the treatment should be such that the effect of administering life-sustaining treatment would be inhumane. Subjective evidence that the patient would not have wanted the treatment is not necessary under this pure-objective standard. Nevertheless, even in the context of severe pain, life-sustaining treatment should not be withdrawn from an incompetent patient who had previously expressed a wish to be kept alive in spite of any pain that he might experience.

Although we are condoning a restricted evaluation of the nature of a patient's life in terms of pain, suffering, and possible enjoyment under the limited-objective and pure-objective tests, we expressly decline to authorize decision-making based on assessments of the personal worth or social utility of another's life, or the value of that life to others. We do not believe that it would be appropriate for a court to designate a person with the authority to determine that someone else's life is not worth living simply because, to that person, the patient's "quality of life" or value to society seems negligible. The mere fact that a patient's functioning is limited or his prognosis dim does not mean that he is not enjoying what remains of his life or that it is in his best interests to die. *But cf. In re Dinnerstein*, 6 Mass.App.Ct. 466, 473, 380 N.E.2d 134, 138 (1978) (indicating, in reference to possible resuscitation of half-paralyzed, elderly victim of Alzheimer's disease, that prolongation of life is not required if there is no hope of return to a "normal, integrated, functioning, cognitive existence"); *see also President's Commission Report, supra*, at 135 (endorsing termination of treatment whenever surrogate decision-maker in his discretion believes it is in the patient's best interests, defined broadly to "take into account such factors as the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of life sustained"). More wide-ranging powers to make decisions about other people's lives, in our view, would create an intolerable risk for socially isolated and defenseless people suffering from physical or mental handicaps.

We are aware that it will frequently be difficult to conclude that the evidence is sufficient to justify termination of treatment under either of the "best interests" tests that we have described. Often, it is unclear whether and to what extent a patient such as Claire Conroy is capable of, or is in fact, experiencing pain. Similarly, medical experts are often unable to determine with any degree of certainty the extent of a nonverbal person's intellectual functioning or the depth of his emotional life. When the evidence is insufficient to satisfy either the limited-objective or pure-objective standard, however, we cannot justify the termination of life-sustaining treatment as clearly furthering the best interests of a patient like Ms. Conroy.

The surrogate decision-maker should exercise extreme caution in determining the patient's intent and in evaluating medical evidence of the patient's pain and possible enjoyment, and should not approve withholding or withdrawing life-sustaining treatment unless he is manifestly satisfied that one of the three tests that we have outlined has been met. *Cf. In re Grady*, 85 N.J. 235, 266, 426 A.2d 467 (1981) (requiring that evidence be clear and convincing before a court would approve sterilization of an incompetent, mentally retarded adult). When evidence of a person's wishes or physical or mental condition is equivocal, it is best to err, if at all, in favor of preserving life. *See Osborne, supra*, 294 A.2d at 374 (stating in dictum that when a patient is "suffering impairment of capacity for choice, it may be better to give weight to the known instinct for survival"); Dyck, "Ethical Aspects of Care for the Dying Incompetent," 32(9) *J.Am. Geriatrics Soc'y* 661, 663 (1984) ("[S]ituations in which [decision-makers] are uncertain about what is best should be resolved in favor of extending life where possible."). Or, as one writer has said as a justification for requiring a high degree of safety and certainty of diagnosis in the determination of brain death: "[I]f there is a lot to lose by being wrong, it is generally better to stick to the safer, known way in the absence of the highest probability for proceeding otherwise." *D. Walton, Ethics of Withdrawal of Life-Support Systems: Case Studies on Decision Making in Intensive Care* 82 (1983).

Matter of Conroy, 486 A.2d 1209, 1231-1233 (N.J. 1985).

The New Jersey Supreme Court stressed the need to avoid playing games with words.

We emphasize that in making decisions whether to administer life-sustaining treatment to patients such as Claire Conroy, the primary focus should be the patient's desires and experience of pain and enjoyment — not the type of treatment involved. Thus, we reject the distinction that some have made between actively hastening death by terminating treatment and passively allowing a person to die of a disease as one of limited use in a legal analysis of such a decision-making situation.

Characterizing conduct as active or passive is often an elusive notion, even outside the context of medical decision-making.

Saint Anselm of Canterbury was fond of citing the trickiness of the distinction between "to do" (*facere*) and "not to do" (*non facere*). In answer to the question "What's he doing?" we say "He's just sitting there" (positive), really meaning something negative: "He's not doing anything at all."

D. Walton, supra, at 234 (footnote omitted).

The distinction is particularly nebulous, however, in the context of decisions whether to withhold or withdraw life-sustaining treatment. In a case like that of Claire Conroy, for example, would a physician who discontinued nasogastric feeding be actively causing her death by removing her primary source of nutrients; or would he merely be omitting to continue the artificial form of treatment, thus passively allowing her medical condition, which includes her inability to swallow, to take its natural course? See *President's Commission Report, supra*, at 65-66. The ambiguity inherent in this distinction is further heightened when one performs an act within an over-all plan of non-intervention, such as when a doctor writes an order not to resuscitate a patient. *Id.* at 67.

Consequently, merely determining whether what was done involved a fatal act or omission does not establish whether it was morally acceptable. * * * [In fact, a]ctive steps to terminate life-sustaining interventions may be permitted, indeed required, by the patient's authority to forego therapy even when such steps lead to death. [*President's Commission Report, supra*, at 67, 72.]

For a similar reason, we also reject any distinction between withholding and withdrawing life-sustaining treatment. Some commentators have suggested that discontinuing life-sustaining treatment once it has been commenced is morally more problematic than merely failing to begin the treatment. See Clouser, "Allowing or Causing: Another Look," 87 *Annals Internal Med.* 622, 624 (1977) ("To stop [therapy] * * * seems different in principle from refusing to initiate a therapy in response to a new crisis."). Discontinuing life-sustaining treatment, to some, is an "active" taking of life, as opposed to the more "passive" act of omitting the treatment in the first instance. In the words of one writer, "[T]he difference between taking away that which one has come to count on as normal support for life and not instituting therapy when a new crisis begins * * * fits nicely a basic moral distinction throughout life — we are not morally obligated to help another person, but we are morally obligated not to interfere with his life-sustaining routines." *Id.*

This distinction is more psychologically compelling than logically sound. As mentioned above, the line between active and passive conduct in the context of medical decisions is far too nebulous to constitute a principled basis for decisionmaking. Whether necessary treatment is withheld at the outset or withdrawn later on, the consequence — the patient's death — is the same. Moreover, from a policy standpoint, it might well be unwise to forbid persons from discontinuing a treatment under circumstances in which the treatment could permissibly be withheld. Such a rule could discourage families and doctors from even

attempting certain types of care and could thereby force them into hasty and premature decisions to allow a patient to die. See Lynn & Childress, "Must Patients Always Be Given Food and Water?," 13 *Hastings Center Rep.* 17, 19-20 (1983).

We also find unpersuasive the distinction relied upon by some courts, commentators, and theologians between "ordinary" treatment, which they would always require, and "extraordinary" treatment, which they deem optional. See generally *Barber v. Superior Court*, 147 *Cal.App.3d* 1006, 1018, 195 *Cal.Rptr.* 484, 491 (1983); *D. Walton, supra*, at 222-28; *Sacred Congregation for the Doctrine of the Faith*, "Declaration on Euthanasia" (official declaration of the Roman Catholic Church, approved by Pope John Paul II on May 5, 1980) [hereinafter cited as "Declaration on Euthanasia"], reprinted in *President's Commission Report, supra*, at 300-07. The terms "ordinary" and "extraordinary" have assumed too many conflicting meanings to remain useful. To draw a line on this basis for determining whether treatment should be given leads to a semantical milieu that does not advance the analysis See *President's Commission Report, supra*, at 87.

The distinction between ordinary and extraordinary treatment is frequently phrased as one between common and unusual, or simple and complex, treatment, *President's Commission Report, supra*, at 84; "extraordinary" treatment also has been equated with elaborate, artificial, heroic, aggressive, expensive, or highly involved or invasive forms of medical intervention, *id.* at 84; *D. Walton, supra*, at 222-23. Depending on the definitions applied, a particular treatment for a given patient may be considered both ordinary and extraordinary. *President's Commission Report, supra*, at 84. Further, since the common/unusual and simple/complex distinctions among medical treatments "exist on continuums with no precise dividing line," *ibid.*, and the continuum is constantly shifting due to progress in medical care, disagreement will often exist about whether a particular treatment is ordinary or extraordinary. In addition, the competent patient generally could refuse even ordinary treatment; therefore, an incompetent patient theoretically should also be able to make such a choice when the surrogate decision-making is effectuating the patient's subjective intent. In such cases, the ordinary/extraordinary distinction is irrelevant except insofar as the particular patient would have made the distinction.

The ordinary/extraordinary distinction has also been discussed in terms of the benefits and burdens of treatment for the patient. If the benefits of the treatment outweigh the burdens it imposes on the patient, it is characterized as ordinary and therefore ethically required; if not, it is characterized as extraordinary and therefore optional. See *President's Commission Report, supra*, at 84-85 & n. 122; "Declaration on Euthanasia," *supra*. This formulation is extremely fact-sensitive and would lead to different classifications of the same treatment in different situations. Thus, for example, we stated in *Quinlan, supra*, 70 *N.J.* at 48, 355 *A.2d* 647: "[T]he use of the same respirator or like support could be considered 'ordinary' in the context of the possibly curable patient but 'extraordinary' in the context of the forced sustaining by cardio-respiratory processes of an irreversibly doomed patient." Moreover, while the analysis may be useful in weighing the implications of the specific treatment for the patient, essentially it merely restates the question: whether the burdens of a treatment so clearly outweigh its benefits to the patient that continued treatment would be inhumane. As the President's Commission noted: "The claim, then, that the treatment is extraordinary is more of an expression of the conclusion than a justification for it." *President's Commission Report, supra*, at 88.

Matter of Conroy, 486 *A.2d* 1209, 1233-1235 (N.J. 1985).

The New Jersey Supreme Court distinguished artificial means (e.g., a nasogastric tube) of providing water and food from swallowing naturally.

Some commentators, as indeed did the Appellate Division here, 190 *N.J.Super.* at 473, 464 A.2d 303, have made yet a fourth distinction, between the termination of artificial feedings and the termination of other forms of life-sustaining medical treatment. See, e.g., *E. Healy, Medical Ethics* 66 (1956); *J. Piccione, Last Rights: Treatment and Care Issues in Medical Ethics* 23, 38 (1984). According to the Appellate Division:

If, as here, the patient is not comatose and does not face imminent and inevitable death, nourishment accomplishes the substantial benefit of sustaining life until the illness takes its natural course. Under such circumstances nourishment always will be an essential element of ordinary care which physicians are ethically obligated to provide. [190 *N.J.Super.* at 473, 464 A.2d 303.]

Certainly, feeding has an emotional significance. As infants we could breathe without assistance, but we were dependent on others for our lifeline of nourishment. Even more, feeding is an expression of nurturing and caring, certainly for infants and children, and in many cases for adults as well.

Once one enters the realm of complex, high-technology medical care, it is hard to shed the "emotional symbolism" of food. See *Barber, supra*, 147 *Cal.App.3d* at 1016, 195 *Cal.Rptr.* at 490. However, artificial feedings such as nasogastric tubes, gastrostomies, and intravenous infusions are significantly different from bottle-feeding or spoonfeeding — they are medical procedures with inherent risks and possible side effects, instituted by skilled health-care providers to compensate for impaired physical functioning. Analytically, artificial feeding by means of a nasogastric tube or intravenous infusion can be seen as equivalent to artificial breathing by means of a respirator. Both prolong life through mechanical means when the body is no longer able to perform a vital bodily function on its own. *Ibid.*

Furthermore, while nasogastric feeding and other medical procedures to ensure nutrition and hydration are usually well tolerated, they are not free from risks or burdens; they have complications that are sometimes serious and distressing to the patient. *Caulk, supra*, 480 A.2d at 99 (Douglas, J., dissenting); Lo & Dornbrand, "Sounding Board: Guiding the Hand that Feeds: Caring for the Demented Elderly," 311 *New Eng.J.Med.* 402, 403 (1984); Lynn & Childress, *supra*, 13 *Hastings Center Rep.* at 18, 20; Paris & Fletcher, "Infant Doe Regulations and the Absolute Requirement to Use Nourishment and Fluids for the Dying Infant," 11 *Law, Med. & Health Care* 210, 211-13 (1983); Zerwekh, "The Dehydration Question," 13 *Nursing* 83 47, 49 (1983). Nasogastric tubes may lead to pneumonia, cause irritation and discomfort, and require arm restraints for an incompetent patient. Lo & Dornbrand, *supra*, 311 *New Eng.J.Med.* at 403; Lynn & Childress, *supra*, 13 *Hastings Center Rep.* at 17-18. The volume of fluid needed to carry nutrients itself is sometimes harmful. Zerwekh, *supra*, 13 *Nursing* 83 at 51.

Finally, dehydration may well not be distressing or painful to a dying patient. For patients who are unable to sense hunger and thirst, withholding of feeding devices such as nasogastric tubes may not result in more pain than the termination of any other medical treatment. See Lynn & Childress, *supra*, 13 *Hastings Center Rep.* at 19, 20; Paris & Fletcher, *supra*, 11 *Law, Med. & Health Care* at 211. Indeed, it has been observed that patients near death who are not receiving nourishment may be more comfortable than patients in comparable conditions who are being fed and hydrated artificially. See Zerwekh, *supra*, 13 *Nursing* 83 at 51; Lynn & Childress, *supra*, 13 *Hastings Center Rep.* at 19. Thus, it cannot be assumed that it will always be beneficial for an incompetent patient to receive artificial feeding or harmful for him not to receive it. See Wanzer, Adelstein, Cranford,

Federman, Hook, Moertel, Safar, Stone, Taussig & Van Eys, *supra*, 310 *New Eng.J.Med.* at 959 ("If [a severely and irreversibly demented] patient rejects food and water by mouth, it is ethically permissible to withhold nutrition and hydration artificially administered by vein or gastric tube. Spoon feeding should be continued if needed for comfort.").

Under the analysis articulated above, withdrawal or withholding of artificial feeding, like any other medical treatment, would be permissible if there is sufficient proof to satisfy the subjective, limited-objective, or pure-objective test. A competent patient has the right to decline any medical treatment, including artificial feeding, and should retain that right when and if he becomes incompetent. In addition, in the case of an incompetent patient who has given little or no trustworthy indication of an intent to decline treatment and for whom it becomes necessary to engage in balancing under the limited-objective or pure-objective test, the pain and invasiveness of an artificial feeding device, and the pain of withdrawing that device, should be treated just like the results of administering or withholding any other medical treatment.

Matter of Conroy, 486 A.2d 1209, 1235-1237 (N.J. 1985).

The New Jersey Supreme Court in *Quinlan* had urged that end-of-life decisions be made by a hospital ethics committee. Here, in *Conroy*, the Court made a separate rule of law for patients in a nursing home.

The decision-making procedure for comatose, vegetative patients suggested in *Quinlan*, namely, the concurrence of the guardian, family, attending physician, and hospital prognosis committee, is not entirely appropriate for patients such as Claire Conroy, who are confined to nursing homes. There are significant differences in the patients, the health-care providers, and the institutional structures of nursing homes and hospitals.

Matter of Conroy, 486 A.2d 1209, 1237 (N.J. 1985).

Because of the special vulnerability of mentally and physically impaired, elderly persons in nursing homes and the potential for abuse with unsupervised institutional decision-making in such homes, life-sustaining treatment should not be withdrawn or withheld from a nursing-home resident like Claire Conroy in the absence of a guardian's decision, made in accordance with the procedure outlined below, that the elements of the subjective, limited-objective, or pure-objective test have been satisfied. A necessary prerequisite to surrogate decision-making is a judicial determination that the patient is incompetent to make the decision for himself and designation of a guardian for the incompetent patient if he does not already have one.

Substitute decision-making by a guardian is not permissible unless the patient has been proven incompetent to make the particular medical treatment decision at issue. *See* Veatch, "An Ethical Framework for Terminal Care Decisions: A New Classification of Patients," 32(9) *J. Am. Geriatrics Soc'y* 665, 668 (1984) ("[O]ne cannot simply presume that a patient is incompetent. There must be some sort of due process, and if the patient has not been adjudicated to be incompetent, he must be treated as * * * competent * * *"). A patient may be incompetent because he lacks the ability to understand the information conveyed, to evaluate the options, or to communicate a decision. Medical evidence bearing on these capabilities should be furnished to a court by at least two doctors with expertise in relevant fields who have personally examined the patient. *See* R. 4:83-2(b). The proof must be clear and convincing that the patient does not have and will not regain the capability of making the decision for himself. *Cf. Grady, supra*, 85 *N.J.* at 265, 426 A.2d 467 (requiring clear and convincing proof of incompetence of mentally retarded adult before allowing guardian to consent to sterilization of such incompetent person).

Matter of Conroy, 486 A.2d 1209, 1240-1241 (N.J. 1985).

After a guardian has been appointed for a patient in a nursing home,

We hold that to determine whether withholding or withdrawing life-sustaining treatment from an elderly nursing-home resident who is incompetent to make the decision for himself is justified under any of the three tests articulated above, the following procedure is required. A person who believes that withholding or withdrawing life-sustaining treatment would effectuate an incompetent patient's wishes or would be in his "best interests" should notify the Office of the Ombudsman²² of the contemplated action. Such notification may be undertaken by the patient's guardian, or by another interested party, such as a close family member, an attending physician, or the nursing home in which the patient resides. Any person who believes the contrary, that is, who has reasonable cause to suspect that withholding or withdrawing the life-sustaining treatment would be an abuse of that patient, should also report such information to the ombudsman.

We believe the ombudsman should be involved in the process at this stage. The ombudsman should treat every notification that life-sustaining treatment will be withheld or withdrawn from an institutionalized, elderly patient as a possible "abuse." Under *N.J.S.A. 52:27G-7.2a*, the ombudsman would then be required to investigate the situation and to report it within twenty-four hours to the Commissioner of Human Services and to any other government agency that regulates or operates the facility.

Evidence concerning the patient's condition should be furnished by the attending physician and nurses. Two other physicians, unaffiliated with the nursing home and with the attending physician, should then be appointed to confirm the patient's medical condition and prognosis. We recommend that the ombudsman exercise his discretionary authority under *N.J.S.A. 52:27G-5b* to appoint the physicians. In the event that the ombudsman chooses not to exercise his authority in this regard, application may be made to the assignment judge of the appropriate vicinage for designation of the two physicians. Depending upon the circumstances of a particular case, the physicians may be compensated by the patient's estate, the guardian, the family, or the nursing home. If the funds from these sources are insufficient, the guardian may seek reimbursement from the ombudsman or possibly from Medicare.

Provided that the two physicians supply the necessary medical foundation, the guardian, with the concurrence of the attending physician, [footnote omitted] may withhold or withdraw life-sustaining medical treatment if he believes in good faith, based on the medical evidence and any evidence of the patient's wishes, that it is clear that the subjective, limited-objective, or pure-objective test is satisfied. In addition, the ombudsman must concur in that decision. This role would be consonant with his legislative responsibilities. Finally, if the limited-objective or pure-objective test is being used, the family — that is, the patient's spouse, parents, and children, or, in their absence, the patient's next of kin, if any — must also concur in the decision to withhold or withdraw life-sustaining treatment.

Matter of Conroy, 486 A.2d 1209, 1241-1242 (N.J. 1985).

The New Jersey Supreme Court reaffirmed its decision in *Quinlan* that there was no civil and no criminal liability for good faith attempts to make end-of-life decisions.

In the absence of bad faith, no participant in the decision-making process shall be civilly or criminally liable for actions taken in accordance with the procedures set forth in this opinion. *Cf. Quinlan, supra*, 70 N.J. at 54, 355 A.2d 647 (providing for complete civil and criminal immunity for guardians, physicians, hospitals, and others, who, after complying with

²² New Jersey Statute 52:27G (enacted 1977) (creates Ombudsman for residents of nursing homes); New Jersey Statute 30:13 (enacted 1976) (bill of rights for residents of nursing homes).

the procedures articulated in *Quinlan*, participate in a decision to withhold life support treatment). However, the decision-making procedure that we have outlined does not necessarily immunize its participants entirely from judicial oversight. As previously noted, the ombudsman can refer cases of questionable criminal abuse to the county prosecutor. *N.J.S.A. 52:27G-7.2d*.

Matter of Conroy, 486 A.2d 1209, 1242 (N.J. 1985).

The New Jersey Supreme Court noted the absence in the trial record of factual findings of what Claire Conroy would have wanted.

The record in this case did not satisfy those standards. The evidence that Claire Conroy would have refused the treatment, although sufficient to meet the lower showing of intent required under the limited-objective test, was certainly not the "clear" showing of intent contemplated under the subjective test. More information should, if possible, have been obtained by the guardian with respect to Ms. Conroy's intent. What were her ethical, moral, and religious beliefs? She did try to refuse initial hospitalization, and indeed had "scorned medicine." 188 *N.J.Super.* at 525, 457 A.2d 1232. However, she allowed her nephew's wife, a registered nurse, to care for her during several illnesses. It was not clear whether Ms. Conroy permitted the niece to administer any drugs or other forms of medical treatment to her during these illnesses. Although it may often prove difficult, and at times impossible, to ascertain a person's wishes, the Conroy case illustrates the sources to which the guardian might turn. For example, in more than eight decades of life in the same house, it is possible that she revealed to persons other than her nephew her feelings regarding medical treatments, other values, and her goals in life. Some promising avenues for such an inquiry about her personal values included her response to the illnesses and deaths of her sisters and others, and her statements with respect to not wanting to be in a nursing home.

Moreover, there was insufficient information concerning the benefits and burdens of Ms. Conroy's life to satisfy either the limited-objective or pure-objective test. Although the treating doctor and the guardian's expert testified as to Claire Conroy's condition, neither testified conclusively as to whether she was in pain or was capable of experiencing pain or thirst. There was medical agreement that removal of the tube would have caused pain during the period of approximately one week that would have elapsed before her death, or at least until she were to lapse into a coma. On the other hand, there was little, if any, evidence of the discomfort, suffering, and pain she would endure if she continued to be fed and medicated through the tube during her remaining life — contemplated to be up to one year. Apparently her feedings sometimes occasioned moaning, but it remains unclear whether these were reflex responses or expressions of discomfort. Moreover, although she tried to remove the tube, it is not clear that this was intentional, and there was little evidence that she was in distress. Her treating physician also offered contradictory views as to whether the contractures of her legs caused pain or whether, indeed, they might be the result of pain, without offering any evidence on that issue. The trial court rejected as superfluous the offer to present as an expert witness a neurologist, who might have been able to explain what Ms. Conroy's reactions to the environment indicated about her perception of pain.

The evidence was also unclear with respect to Ms. Conroy's capacity to feel pleasure, another issue as to which the information supplied by a neurologist might have been helpful. What was known of her awareness of the world? Although Ms. Conroy had some ability to smile and scratch, the relationship of these activities to external stimuli apparently was quite variable.

The trial transcript reveals no exploration of the discomfort and risks that attend nasogastric feedings. A casual mention by the nurse/administrator of the need to restrain the

patient to prevent the removal of the tube was not followed by an assessment of the detrimental impact, if any, of those restraints. Alternative modalities, including gastrostomies, intravenous feeding, subcutaneous or intramuscular hydration, or some combination, were not investigated. Neither of the expert witnesses presented empirical evidence regarding the treatment options for such a patient.

It can be seen that the evidence at trial was inadequate to satisfy the subjective, the limited-objective, or the pure-objective standard that we have set forth. Were Claire Conroy still alive, the guardian would have been required to explore these issues prior to reaching any decision. Guardians — and courts, if they are involved — should act cautiously and deliberately in deciding these cases. The consequences are most serious — life or death. *Matter of Conroy*, 486 A.2d 1209, 1242-1244 (N.J. 1985).

In reversing the decision of the lower appellate court, the New Jersey Supreme Court did not remand the case to the trial court, because Claire Conroy had already died.

Six of the seven judges on the New Jersey Supreme Court joined the majority opinion in *Conroy*, while one judge dissented.

A recent New Jersey case involved a victim of an automobile accident who was on life-support for 152 days. He died two hours after the ventilator was removed, and the intoxicated driver, Pelham, who caused the accident was then convicted of vehicular homicide. *New Jersey v. Pelham*, 824 A.2d 1082, 1087-1089 (N.J. 2003), *cert. den.*, 540 U.S. 909 (2003) (“... the public policy of this State, as developed by case law and through legislative enactment, clearly recognizes that an individual has the right to refuse devices or techniques for sustaining life, including the withholding of food and the removal of life support.”).

Bouvia

- *Bouvia v. Superior Court*, 225 Cal.Rptr. 297 (Cal.App. 2 Dist. 16 Apr 1986), review denied, (5 June 1986).

The *Bouvia* case is different from the cases involving unconscious patients (e.g., patients in a persistent vegetative state) and is also different from cases involving a conscious patient with a terminal illness. Bouvia was severely disabled, but she was definitely a person and she had an estimated 15 to 20 years of life remaining. The key fact is that *she* believed her quality of life was so poor that she wanted to die now.

medical facts

Elizabeth Bouvia sought a court order in 1983 to be allowed to die from dehydration or starvation while in a hospital, and while receiving morphine to relieve the pain of that suicide. A trial court denied her request on 16 Dec 1983 and she did not appeal. In 1986, she voluntarily admitted herself to a hospital. That hospital inserted a feeding tube in her without her consent, to increase the amount of nutrition delivered to her. Bouvia sought an injunction ordering the removal of the feeding tube. A trial court denied the injunction. She appealed and a state court of appeals in California granted the injunction.²³ The appellate court characterized the facts in the following way:

Petitioner is a 28-year-old woman. Since birth she has been afflicted with and suffered from severe cerebral palsy. She is quadriplegic. She is now a patient at a public hospital maintained by one of the real parties in interest, the County of Los Angeles. Other parties are physicians, nurses and the medical and support staff employed by the County of Los Angeles. Petitioner's physical handicaps of palsy and quadriplegia have progressed to the point where she is completely bedridden. Except for a few fingers of one hand and some slight head and facial movements, she is immobile. She is physically helpless and wholly unable to care for herself. She is totally dependent upon others for all of her needs. These include feeding, washing, cleaning, toileting, turning, and helping her with elimination and other bodily functions. She cannot stand or sit upright in bed or in a wheelchair. She lies flat in bed and must do so the rest of her life. She suffers also from degenerative and severely crippling arthritis. She is in continual pain. Another tube permanently attached to her chest automatically injects her with periodic doses of morphine which relieves some, but not all of her physical pain and discomfort.

She is intelligent, very mentally competent. She earned a college degree. She was married but her husband has left her. She suffered a miscarriage. She lived with her parents until her father told her that they could no longer care for her. She has stayed intermittently with friends and at public facilities. A search for a permanent place to live where she might

²³ Stanley S. Herr, Barry A. Bostrom, Rebecca S. Barton, "No Place to Go: Refusal of Life-Sustaining Treatment by Competent Persons with Physical Disabilities," 8 Issues Law Medicine 3, 8 (Summer 1992).

receive the constant care which she needs has been unsuccessful. She is without financial means to support herself and, therefore, must accept public assistance for medical and other care.

She has on several occasions expressed the desire to die. In 1983 she sought the right to be cared for in a public hospital in Riverside County while she intentionally "starved herself to death." A court in that county denied her judicial assistance to accomplish that goal. She later abandoned an appeal from that ruling. Thereafter, friends took her to several different facilities, both public and private, arriving finally at her present location. Efforts by the staff of real party in interest County of Los Angeles and its social workers to find her an apartment of her own with publicly paid live-in help or regular visiting nurses to care for her, or some other suitable facility have proved fruitless.

Petitioner must be spoon fed in order to eat. Her present medical and dietary staff have determined that she is not consuming a sufficient amount of nutrients. Petitioner stops eating when she feels she cannot orally swallow more, without nausea and vomiting. As she cannot now retain solids, she is fed soft liquid-like food. Because of her previously announced resolve to starve herself, the medical staff feared her weight loss might reach a life-threatening level. Her weight since admission to real parties' facility seems to hover between 65 and 70 pounds. Accordingly, they inserted the subject tube against her will and contrary to her express written instructions. [FN2]

FN2. Her instructions were dictated to her lawyers, written by them and signed by her by means of her making a feeble "x" on the paper with a pen which she held in her mouth.

Bouvia v. Superior Court, 225 Cal.Rptr. 297, 299-300 (Cal.App. 1986).

At bench the trial court concluded that with sufficient feeding petitioner could live an additional 15 to 20 years;

Bouvia v. Superior Court, 225 Cal.Rptr. 297, 304 (Cal.App. 1986).

A different set of facts about Elizabeth Bouvia have been presented by disability rights advocates, for example:

This is a woman who operated a power wheelchair and was on her way to a master's degree and a career in social work. This is a woman who married, made love with her husband and planned to become a mother. This is a woman who aimed at something more significant than mere physical self-sufficiency. She struggled to attain self-determination, but she was repeatedly thwarted in her efforts by discriminatory actions on the part of government, her teachers, her employers, her parents, and her society.

Paul K. Longmore, "Elizabeth Bouvia, Assisted Suicide and Social Prejudice," 3 *Issues in Law & Medicine* 141, 158 (Fall 1987).

In fact, she was never bedridden until four years ago [i.e., 1983], when, in her depressed state, she refused to get out of bed. She has been allowed to languish there ever since. When this case began, her lawyers told the court and the public that she required constant care. In fact, her in-homes aides were never on duty more than six hours a day. [three footnotes omitted] *Ibid.* at 157.

Bouvia could continue to lead a relatively active life if given appropriate rehabilitation and psychiatric and medical treatment.²⁴ Her husband had attested that she could eat by herself and was not nearly as disabled as her lawyers professed. [two footnotes omitted] Stanley S. Herr, Barry A. Bostrom, Rebecca S. Barton, "No Place to Go: Refusal of Life-Sustaining Treatment by Competent Persons with Physical Disabilities," 8 Issues Law Medicine 3, 10 (Summer 1992).

The *Bouvia* case raises extraordinarily difficult issues. On one hand, a mentally competent person has the legal right to commit suicide. That right should not be diminished because the person is physically paralyzed. On the other hand, a person who acts irrationally (e.g., seeking suicide because of a temporary depression) needs to be protected from harming herself.

trial court

Bouvia petitioned a court for a preliminary injunction ordering the removal of the nasogastric tube in her, which was keeping her alive. The trial court, in an unpublished opinion, found that Bouvia's weight loss was life threatening and denied her request. Bouvia appealed and sought a writ of mandamus that would compel the trial court to issue the preliminary injunction, without the need for a full trial on the issues.

appellate court

The appellate court had no hesitance in determining that Bouvia had a legal right to refuse medical treatment, and that right included refusing medical treatment that was necessary to keep her alive.

"[A] person of adult years and in sound mind has the right, in the exercise of control over his own body, to determine whether or not to submit to lawful medical treatment." (*Cobbs v. Grant* (1972) 8 Cal.3d 229, 242, 104 Cal.Rptr. 505, 502 P.2d 1.) It follows that such a patient has the right to refuse *any* medical treatment, even that which may save or prolong her life. (*Barber v. Superior Court* (1983) 147 Cal.App.3d 1006, 195 Cal.Rptr. 484; *Bartling v. Superior Court* (1984) 163 Cal.App.3d 186, 209 Cal.Rptr. 220.) In our view the foregoing authorities are dispositive of the case at bench. Nonetheless, the County and its medical staff contend that for reasons unique to this case, Elizabeth Bouvia may not exercise the right available to others. Accordingly, we again briefly discuss the rule in the light of real parties' contentions.

The right to refuse medical treatment is basic and fundamental. It is recognized as a part of the right of privacy protected by both the state and federal constitutions. (Calif.Const., art. I, 1; *Griswold v. Connecticut* (1965) 381 U.S. 479, 484, 85 S.Ct. 1678, 1681, 14 L.Ed.2d 510; *Bartling v. Superior Court, supra*, 163 Cal.App.3d 186, 209 Cal.Rptr. 220.) Its exercise requires no one's approval. It is not merely one vote subject to being overridden by medical opinion.

In *Barber v. Superior Court, supra*, 147 Cal.App.3d 1006, 195 Cal.Rptr. 484, we considered this same issue although in a different context. Writing on behalf of this division, Justice Compton thoroughly analyzed and reviewed the issue of withdrawal of life-support

²⁴ In fact, she *did* live for at least six more years, see page 93 below.

systems beginning with the seminal case of the *Matter of Quinlan* (N.J.1976) 355 A.2d 647, *cert. den.* 429 U.S. 922, 97 S.Ct. 319, 50 L.Ed.2d 289, and continuing on to the then recent enactment of the California Natural Death Act (Health & Saf. Code. § 7185-7195). His opinion clearly and repeatedly stresses the fundamental underpinning of its conclusion, i.e., the patient's right to decide: 147 Cal.App.3d at page 1015, 195 Cal.Rptr. 484 "In this state a clearly recognized legal right to control one's own medical treatment predated the Natural Death Act. A long line of cases, approved by the Supreme Court in *Cobbs v. Grant* (1972) 8 Cal.3d 229 [104 Cal.Rptr. 505, 502 P.2d 1] ... have held that where a doctor performs treatment in the absence of an informed consent, there is an actionable battery. The obvious corollary to this principle is that *a competent adult patient has the legal right to refuse medical treatment*" (emphasis added); 147 Cal.App.3d at page 1019, 195 Cal.Rptr. 484, "[T]he *patient's interests and desires are the key ingredients of the decision-making process*" (emphasis added); at page 1020, 195 Cal.Rptr. 484, "Given the general standards for determining when there is a duty to provide medical treatment of debatable value, the question still remains as to who should make these vital decisions. Clearly, the medical diagnoses and prognoses must be determined by the treating and consulting physicians under the generally accepted standards of medical practice in the community and, *whenever possible, the patient himself should then be the ultimate decisionmaker*" (emphasis added); at page 1021, 195 Cal.Rptr. 484, "The authorities are in agreement that any surrogate, court appointed or otherwise, ought to be guided in his or her decisions first by his knowledge of *the patient's own desires and feelings, to the extent that they were expressed before the patient became incompetent.*" (Emphasis added.)

Bartling v. Superior Court, supra, 163 Cal.App.3d 186, 209 Cal.Rptr. 220 [Cal.App. 1984], was factually much like the case at bench. Although not totally identical in all respects, the issue there centered on the same question here present: i.e., "May the patient refuse even life continuing treatment?" Justice Hastings, writing for another division of this court, explained:

In this case we are called upon to decide whether a competent adult patient, with serious illnesses which are probably incurable but have not been diagnosed as terminal, has the right, over the objection of his physicians and the hospital, to have life-support equipment disconnected despite the fact that withdrawal of such devices will surely hasten his death.

[*Bartling v. Superior Court, supra*, 163 Cal.App.3d] at p. 189, 209 Cal.Rptr. [at 220-221]. [Before making its ruling on petitioners' request for an injunction, the trial court made several factual findings, including:] (1) Mr. Bartling's illnesses were serious but not terminal, and had not been diagnosed as such; (2) although Mr. Bartling was attached to a respirator to facilitate breathing, he was not in a vegetative state and was not comatose; and (3) Mr. Bartling was competent in the legal sense.

[The court relied substantially on *Matter of Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), which held that life-support systems could be withdrawn from a patient in a comatose, vegetative state should his or her attending physicians conclude that there was no reasonable possibility of the patient ever emerging from that state.] The court below concluded that as long as there was some potential for restoring Mr. Bartling to a 'cognitive, sapient life,' it would not be appropriate to issue an injunction in this case.

We conclude that the trial court was incorrect when it held that the right to have life-support equipment disconnected was limited to comatose, terminally ill patients, or representatives acting on their behalf.

[*Bartling v. Superior Court, supra*, 163 Cal.App.3d] at p. 193, 209 Cal.Rptr. [at 223].

The description of Mr. Bartling's condition fits that of Elizabeth Bouvia. The holding of that case applies here and compels real parties to respect her decision even though she is not "terminally" ill. The trilogy of *Cobbs v. Grant*, *supra*, 8 Cal.3d 229, 104 Cal.Rptr. 505, 502 P.2d 1, *Barber v. Superior Court*, *supra*, 147 Cal.App.3d 1006, 195 Cal.Rptr. 484, and *Bartling v. Superior Court*, *supra*, 163 Cal.App.3d 186, 209 Cal.Rptr. 220, with their thorough explanation and discussion, are authority enough and in reality provides a complete answer to the position and assertions of real parties' medical personnel.

But if additional persuasion be needed, there is ample. As indicated by the discussion in *Bartling* and *Barber*, substantial and respectable authority throughout the country recognize the right which petitioner seeks to exercise. Indeed, it is neither radical nor startlingly new. It is a basic and constitutionally predicated right. More than seventy years ago, Judge Benjamin Cardozo observed: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body...." (*Schloendorff v. Society of New York Hospital* (1914) 211 N.Y. 125, 105 N.E. 92, 93.)

Matter of Spring (1980) 380 Mass. 629, 405 N.E.2d 115; *Lane v. Candura* (1978) 6 Mass.App. 377, 376 N.E.2d 1232; *Matter of Quackenbush* (Morris County Ct. 1978), 156 N.J.Super. 282, 383 A.2d 785; *Matter of Conroy* (1985) 98 N.J. 321, 486 A.2d 1209, *Satz v. Perlmutter* (Fla.1980) 379 So.2d 359, *affg.* 362 So.2d 160 (Fla.App.1978); *In re Osborne* (D.C.1972) 294 A.2d 372; and *Superintendent of Belchertown School v. Saikewicz* (1977) 373 Mass. 728, 370 N.E.2d 417, are but a few examples of the decisions that have upheld a patient's right to refuse medical treatment even at risk to his health or his very life.

Further recognition that this right is paramount to even medical recommendation, is evidenced by several declarations of public and professional policy which were noted in both the *Barber* and *Bartling* cases.

For example, addressing one part of the problem, California passed the "Natural Death Act," Health and Safety Code sections 7185 et seq. Although addressed to terminally ill patients, the significance of this legislation is its expression as state policy "that adult persons have the fundamental right to control the decisions relating to the rendering of their own medical care...." (Health & Saf. Code, § 7186.) Section 7188 provides the method whereby an adult person may execute a directive for the withholding or withdrawal of life-sustaining procedures. Recognition of the right of other persons who may not be terminally ill and may wish to give other forms of direction concerning their medical care is expressed in section 7193: "Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner. In such respect the provisions of this chapter are cumulative."

Moreover, as the *Bartling* decision holds, there is no practical or logical reason to limit the exercise of this right to "terminal" patients. The right to refuse treatment does not need the sanction or approval by any legislative act, directing how and when it shall be exercised.

In large measure the courts have sought to protect and insulate medical providers from criminal and tort liability. (E.g., *Barber v. Superior Court*, *supra*, 147 Cal.App.3d 1006, 195 Cal.Rptr. 484.) The California Natural Death Act also illustrates this approach. Nonetheless, as indicated it too recognizes, even if inferentially, the existence of the right, even in a non-terminal patient, which overrides the concern for protecting the medical profession. *Bouvia v. Superior Court*, 225 Cal.Rptr. 297, 300-303 (Cal.App. 1986).

At the beginning of this opinion, the appellate court notes the urgency of granting Bouvia's request.

Real parties' counsel therefore argue that the normal course of trial and appeal provide a sufficient remedy. But petitioner's ability to tolerate physical discomfort does not diminish her right to immediate relief. Her mental and emotional feelings are equally entitled to respect. She has been subjected to the forced intrusion of an artificial mechanism into her body against her will. She has a right to refuse the increased dehumanizing aspects of her condition created by the insertion of a permanent tube through her nose and into her stomach.

To petitioner it is a dismal prospect to live with this hated and unwanted device attached to her, through perhaps years of the law's slow process. She has the right to have it removed immediately. This matter constitutes a perfect paradigm of the axiom: "Justice delayed is justice denied."

By refusing petitioner the relief which she sought, the trial court, with the most noble intentions, attempted to exercise its discretion by issuing a ruling which would uphold what it considered a lawful object, i.e., keeping Elizabeth Bouvia alive by a means which it considered ethical. Nonetheless, it erred for it had no discretion to exercise. Petitioner sought to enforce only a right which was exclusively hers and over which neither the medical profession nor the judiciary have any veto power. The trial court could but recognize and protect her exercise of that right.

In explanation of its ruling, the trial court stated that it considered petitioner's "motives" to be indicative of an attempt to commit suicide with the State's help rather than a bona fide exercise of her right to refuse medical treatment. No evidence supports this conclusion.

As previously noted, the legal remedies available to petitioner through the normal course of trial and appeal are wholly inadequate. Therefore, a prompt resolution, even though based upon a provisional ruling, is justified, particularly when it will probably completely resolve this tragic case.

Bouvia v. Superior Court, 225 Cal.Rptr. 297, 299 (Cal.App. 1986).

The appellate court considered the familiar four state interests (see above at page 68) that might prevail over the legal right of a competent adult to refuse medical treatment.

As in *Bartling* the real parties in interest, a county hospital, its physicians and administrators, urge that the interests of the State should prevail over the rights of Elizabeth Bouvia to refuse treatment. Advanced by real parties under this argument are the State's interests in (1) preserving life, (2) preventing suicide, (3) protecting innocent third parties, and (4) maintaining the ethical standards of the medical profession, including the right of physicians to effectively render necessary and appropriate medical service and to refuse treatment to an uncooperative and disruptive patient. Included, whether as part of the above or as separate and additional arguments, are what real parties assert as distinctive facts not present in other cases, i.e., (1) petitioner is a patient in a public facility, thereby making the State a party to the result of her conduct, (2) she is not comatose, nor incurably, nor terminally ill, nor in a vegetative state, all conditions which have justified the termination of life-support system in other instances, (3) she has asked for medical treatment, therefore, she cannot accept a part of it while cutting off the part that would be effective, and (4) she is, in truth, trying to starve herself to death and the State will not be a party to a suicide.

Nearly all of these arguments are answered by the discussion and reasoning in the *Bartling* and *Barber* cases. Nonetheless, we address ourselves briefly to some of the asserted factual differences between Mr. Bartling or patients in the other cited cases and Mrs.

Bouvia. We conclude they are insufficient to deny her the right to refuse medical treatment afforded others.

At bench the trial court concluded that with sufficient feeding petitioner could live an additional 15 to 20 years; therefore, the preservation of petitioner's life for that period outweighed her right to decide. In so holding the trial court mistakenly attached undue importance to the *amount of time* possibly available to petitioner, and failed to give equal weight and consideration for the *quality* of that life; an equal, if not more significant, consideration.

All decisions permitting cessation of medical treatment or life-support procedures to some degree hastened the arrival of death. In part, at least, this was permitted because the quality of life during the time remaining in those cases had been terribly diminished. In Elizabeth Bouvia's view, the quality of her life has been diminished to the point of hopelessness, uselessness, unenjoyability and frustration. She, as the patient, lying helplessly in bed, unable to care for herself, may consider her existence meaningless. She cannot be faulted for so concluding. If her right to choose may not be exercised because there remains to her, in the opinion of a court, a physician or some committee, a certain arbitrary number of years, months, or days, her right will have lost its value and meaning.

Who shall say what the minimum amount of available life must be? Does it matter if it be 15 to 20 years, 15 to 20 months, or 15 to 20 days, if such life has been physically destroyed and its quality, dignity and purpose gone? As in all matters lines must be drawn at some point, somewhere, but that decision must ultimately belong to the one whose life is in issue.

Here Elizabeth Bouvia's decision to forego medical treatment or life-support through a mechanical means belongs to her. It is not a medical decision for her physicians to make. Neither is it a legal question whose soundness is to be resolved by lawyers or judges. It is not a conditional right subject to approval by ethics committees or courts of law. It is a moral and philosophical decision that, being a competent adult, is her's alone.

Adapting the language of *Satz v. Perlmutter, supra*, 362 So.2d 160, "It is all very convenient to insist on continuing [Elizabeth Bouvia's] life so that there can be no question of foul play, no resulting civil liability and no possible trespass on medical ethics. However, it is quite another matter to do so at the patient's sole expense and against [her] competent will, thus inflicting never ending physical torture on [her] body until the inevitable, but artificially suspended, moment of death. Such a course of conduct invades the patient's constitutional right of privacy, removes [her] freedom of choice and invades [her] right to self-determination." (*Satz v. Perlmutter, supra*, at pp. 162-163.)

Here, if force fed, petitioner faces 15 to 20 years of a painful existence, endurable only by the constant administrations of morphine. Her condition is irreversible. There is no cure for her palsy or arthritis. Petitioner would have to be fed, cleaned, turned, bedded, toileted by others for 15 to 20 years! Although alert, bright, sensitive, perhaps even brave and feisty, she must lie immobile, unable to exist except through physical acts of others. Her mind and spirit may be free to take great flights but she herself is imprisoned and must lie physically helpless subject to the ignominy, embarrassment, humiliation and dehumanizing aspects created by her helplessness. We do not believe it is the policy of this State that all and every life must be preserved against the will of the sufferer. It is incongruous, if not monstrous, for medical practitioners to assert their right to preserve a life that someone else must live, or, more accurately, endure, for "15 to 20 years." We cannot conceive it to be the policy of this State to inflict such an ordeal upon anyone.

It is, therefore, immaterial that the removal of the nasogastric tube will hasten or cause Bouvia's eventual death. Being competent she has the right to live out the remainder of her natural life in dignity and peace. It is precisely the aim and purpose of the many decisions

upholding the withdrawal of life-support systems to accord and provide as large a measure of dignity, respect and comfort as possible to every patient for the remainder of his days, whatever be their number. This goal is not to hasten death, though its earlier arrival may be an expected and understood likelihood.

Real parties assert that what petitioner really wants is to "commit suicide" by starvation at their facility. The trial court in its statement of decision said:

"It is fairly clear from the evidence and the court cannot close its eyes to the fact that [petitioner] during her stay in defendant hospital, and for some time prior thereto, has formed an intent to die. She has voiced this desire to a member of the staff of defendant hospital. She claims, however, she does not wish to commit suicide. On the evidence, this is but a semantic distinction. The reasonable inference to be drawn from the evidence is that [petitioner] in defendant facility has purposefully engaged in a selective rejection of medical treatment and nutritional intake to accomplish her objective and accept only treatment which gives her some degree of comfort pending her demise. Stated another way, [petitioner's] refusal of medical treatment and nutritional intake is motivated not by a bona fide exercise of her right of privacy but by a desire to terminate her life...."

Here [petitioner] wishes to pursue her objective to die by the use of public facilities with staff standing by to furnish her medical treatment to which she consents and to refrain from that which she refuses."

Overlooking the fact that a desire to terminate one's life is probably the ultimate exercise of one's right to privacy, we find no substantial evidence to support the court's conclusion. Even if petitioner had the specific intent to commit suicide in 1983, while at Riverside, she did not carry out that plan. Then she apparently had the ability without artificial aids, to consume sufficient nutrients to sustain herself, now she does not. That is to say, the trial court here made the following express finding, "Plaintiff, when she chooses, can orally ingest food by masticating 'finger food' *though additional nutritional intake is required intravenously and by nasogastric tube....*" (Emphasis added.) As a consequence of her changed condition, it is clear she has now merely resigned herself to accept an earlier death, if necessary, rather than live by feedings forced upon her by means of a nasogastric tube. Her decision to allow nature to take its course is not equivalent to an election to commit suicide with real parties aiding and abetting therein. (*Bartling v. Superior Court, supra*, 163 Cal.App.3d 186, 209 Cal.Rptr. 220; *Lane v. Candura, supra*, 376 N.E.2d 1232.)

Moreover, the trial court seriously erred by basing its decision on the "motives" behind Elizabeth Bouvia's decision to exercise her rights. If a right exists, it matters not what "motivates" its exercise. We find nothing in the law to suggest the right to refuse medical treatment may be exercised only if the patient's *motives* meet someone else's approval. It certainly is not illegal or immoral to prefer a natural, albeit sooner, death than a drugged life attached to a mechanical device.

It is not necessary to here define or dwell at length upon what constitutes suicide. Our Supreme Court dealt with the matter in the case of *In re Joseph G.* (1983) 34 Cal.3d 429, 194 Cal.Rptr. 163, 667 P.2d 1176, wherein declaring that the State has an interest in preserving and recognizing the sanctity of life, it observed that it is a crime to aid in suicide. But it is significant that the instances and the means there discussed all involved affirmative, assertive, proximate, direct conduct such as furnishing a gun, poison, knife, or other instrumentality or usable means by which another could physically and immediately inflict some death producing injury upon himself. Such situations are far different than the mere presence of a doctor during the exercise of his patient's constitutional rights.

This is the teaching of *Bartling* and *Barber*. No criminal or civil liability attaches to honoring a competent, informed patient's refusal of medical service.

We do not purport to establish what will constitute proper medical practice in all other cases or even other aspects of the care to be provided petitioner. We hold only that her right to refuse medical treatment even of the life-sustaining variety, entitles her to the immediate removal of the nasogastric tube that has been involuntarily inserted into her body. The hospital and medical staff are still free to perform a substantial, if not the greater part of their duty, i.e., that of trying to alleviate Bouvia's pain and suffering.

Petitioner is without means to go to a private hospital and, apparently, real parties' hospital as a public facility was required to accept her. Having done so it may not deny her relief from pain and suffering merely because she has chosen to exercise her fundamental right to protect what little privacy remains to her.

Personal dignity is a part of one's right of privacy. Such a right of bodily privacy led the United States Supreme Court to hold that it shocked its conscience to learn that a state, even temporarily, had put a tube into the stomach of a criminal defendant to recover swallowed narcotics. (*Rochin v. California* (1952) 342 U.S. 165, 72 S.Ct. 205, 96 L.Ed. 183.)

Petitioner asks for no greater consideration.

Bouvia v. Superior Court, 225 Cal.Rptr. 297, 304-307 (Cal.App. 1986).

The appellate court ordered the relief that Bouvia sought.

IT IS ORDERED: Let a peremptory writ of mandate issue commanding the Los Angeles Superior Court immediately upon receipt thereof, to make and enter a new and different order granting Elizabeth Bouvia's request for a preliminary injunction, and the relief prayed for therein; in particular to make an order (1) directing real parties in interest forthwith to remove the nasogastric tube from petitioner, Elizabeth Bouvia's, body, and (2) prohibiting any and all of the real parties in interest from replacing or aiding in replacing said tube or any other or similar device in or on petitioner without her consent. Pursuant to Rule 24(c), California Rules of Court, this Order is final as to this court upon filing.

Bouvia v. Superior Court, 225 Cal.Rptr. 297, 307 (Cal.App. 1986).

The three-judge appellate panel was unanimous in this ruling.

concurring opinion

Judge Compton wrote a concurring opinion in this case. Technically, a concurring opinion is *not* law.

Although I have concurred in the very well-reasoned and superbly-crafted opinion of my colleague Justice Beach, I feel compelled to write separately and reflect on what I consider to be one of the real tragedies of this case which is that Elizabeth Bouvia has had to go to such ends to obtain relief from her suffering.

Fate has dealt this young woman a terrible hand. Can anyone blame her if she wants to fold her cards and say "I am out"? Yet medical personnel who have had charge of her case have attempted to force Elizabeth to continue in the game. In their efforts they have been abetted by two different trial courts.

This is not to say that those members of the medical profession and those courts were not well motivated. In each instance the persons involved have expressed a concern for the sanctity of life and a desire to avoid any conduct that could be characterized as aiding in a suicide. Undoubtedly, those persons were, in no small way, influenced by the presence in our law of Penal Code section 401 which imposes penal sanctions on persons who aid and abet in a suicide.

In my opinion, as I shall point out, the application of that statute to circumstances such as are present here is archaic and inhumane.

I have no doubt that Elizabeth Bouvia wants to die; and if she had the full use of even one hand, could probably find a way to end her life — in a word — commit suicide. In order to seek the assistance which she needs in ending her life by the only means she sees available — starvation — she has had to stultify her position before this court by disavowing her desire to end her life in such a fashion and proclaiming that she will eat all that she can physically tolerate. Even the majority opinion here must necessarily "dance" around the issue.

Elizabeth apparently has made a conscious and informed choice that she prefers death to continued existence in her helpless and, to her, intolerable condition. I believe she has an absolute right to effectuate that decision. This state and the medical profession instead of frustrating her desire, should be attempting to relieve her suffering by permitting and in fact assisting her to die with ease and dignity. The fact that she is forced to suffer the ordeal of self-starvation to achieve her objective is in itself inhumane.

The right to die is an integral part of our right to control our own destinies so long as the rights of others are not affected. That right should, in my opinion, include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible.

That ability should not be hampered by the state's threat to impose penal sanctions on those who might be disposed to lend assistance.

The medical profession, freed of the threat of governmental or legal reprisal, would, I am sure, have no difficulty in accommodating an individual in Elizabeth's situation.

The Hippocratic Oath reads in pertinent part:

"... I will follow that method of treatment which, according to my ability and judgment, I consider for the benefit of my patients.... I will give no deadly medicine to anyone if asked...."

Surely, adherence to that oath would yet admit of a reasonable balancing between the doctor's obligation to alleviate suffering and his obligation to preserve life, remembering that the term "life" has itself recently undergone substantial redefinition.

It is also worth noting that the original oath also contained the phrase "... I will not give to a woman an instrument to produce abortion...." Obviously, the profession has already accommodated a deviation from that part of the oath.

Whatever choice Elizabeth Bouvia may ultimately make, I can only hope that her courage, persistence and example will cause our society to deal realistically with the plight of those unfortunate individuals to whom death beckons as a welcome respite from suffering.

If there is ever a time when we ought to be able to get the "government off our backs" it is when we face death — either by choice or otherwise.

Bouvia v. Superior Court, 225 Cal.Rptr. 297, 307-308 (Cal.App. 1986).

further history

There is no other reported case on the merits involving Elizabeth Bouvia. However, following her victory discussed above, her attorney petitioned the trial court for an award of attorney's fees. The trial court denied the request. The attorney appealed and was granted fees under the state "private attorney general" statute. In passing, the appellate court tersely mentioned some of the subsequent history of Bouvia's medical case.

Immediately after the filing of our decision in the writ proceedings, Bouvia was informed by Dr. Glenchur that the use of morphine in treatment of her chronic pain was no longer

"medically indicated" and that the catheter and pump would be removed. Although plaintiff vehemently objected, the staff gradually began reducing the dosage of the drug and substituting other medications to ease the withdrawal process. With the aid of counsel, Bouvia again filed a damage action accompanied by a request for injunctive relief in hopes of prohibiting the hospital from further decreasing her morphine intake. Following the issuance of a temporary restraining order to preserve the status quo, the trial court appointed two independent physicians as special masters to assist in evaluating plaintiff's medical needs. Their report essentially recommended that Bouvia be transferred to another facility where, after expert examination, she could be involved in a comprehensive treatment regimen designed to lessen her psychological and physiological dependence on morphine. After hearing argument, the court issued a temporary injunction directing in part that plaintiff be returned forthwith to the Medical Center. Conspicuously absent from the order, however, was any reference to future treatment or care.

Bouvia v. County of Los Angeles, 241 Cal.Rptr. 239, 241-242 (Cal.App. 1987).

Apparently, Bouvia decided not to use her legal right to end her life, as she was still alive in 1992.²⁵ My search of the Internet, the PubMed database, and the archives of the *Los Angeles Times* on 10 April 2005 found no mention of Bouvia's death. It is not appropriate to comment on Bouvia's apparent abandoning of her intent to commit suicide: the decision is hers alone.

similar cases

There are other reported cases in the USA, similar to Bouvia, involving quadriplegics who were allowed to die, according to their wish.

- *State v. McAfee*, 385 S.E.2d 651, 652 (Ga. Nov 21, 1989) (Court granted adult quadriplegic's petition to have his ventilator disconnected and also ordered that a sedative be administered to him, to alleviate the pain.).
- *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990) (31 y old mentally competent quadriplegic in Nevada successfully petitioned a court to have his ventilator disconnected, so he could die.).
- *Thor v. Superior Court*, 855 P.2d 375 (Cal. 1993) (Howard Andrews, a quadriplegic inmate of a state prison, decided to commit suicide by refusing to eat, and California state courts refused a physician's request to insert a feeding tube in Andrews.).
- *Tennessee v. Ruane*, 912 S.W.2d 766, 771 (Tenn.Crim.App. 1995) (Defendant shot victim in spine, rendering him a quadriplegic dependent on a ventilator. "The victim's condition was such that he could not live without artificial life-support and he soon expressed a strong desire to discontinue use of the ventilator. The life support was terminated by court order on May 13, 1992. The victim died 10 to 15 minutes later." Defendant found guilty of second-degree murder.).

²⁵ Beverly Beyette, "The Reluctant Survivor," *Los Angeles Times*, p. 1 (13 Sep 1992) (Her lawyer committed suicide, Elizabeth Bouvia still alive.).

- *Illinois v. Caldwell*, 692 N.E.2d 448, 451-452, 454-455 (Ill.App. 4 Dist. 1998) (Defendant hit a 97 y old victim in neck with skillet, rendering her a quadriplegic dependent on a ventilator. Victim asked to be disconnected from ventilator, because “she did not want to live with complete paralysis.”).

Another case related to Bouvia, involved Beverly Requena, a 55 y old woman who was dying of amyotrophic lateral sclerosis (ALS) and was already paralyzed from the neck down. Requena refused to have a feeding tube inserted, which meant that she would soon die of dehydration, instead of dying later from ALS. The hospital, which was operated by the Catholic Church, wanted to either insert the feeding tube or transfer her to another hospital. Courts in New Jersey ordered the hospital to let her die of dehydration there, in a familiar environment. *Matter of Requena*, 517 A.2d 886 (N.J.Super.Ch. 1986), *aff'd* 517 A.2d 869 (N.J.Super.A.D. 1986), cited with approval in *Matter of Jobes*, 529 A.2d 434, 450 (N.J. 1987).

Cruzan

- ***Cruzan v. Harmon* 760 S.W.2d 408 (Mo. 16 Nov 1988), *aff'd*, 497 U.S. 261 (25 June 1990).**

This case involved a young woman, Nancy Cruzan, who was in a persistent vegetative state. Her parents requested an end to the artificial hydration and nutrition via feeding tube. The state hospital, where she was a patient, refused. The parents then filed litigation in court, seeking to order the hospital to withdraw hydration and nutrition. The parents won in the trial court. The pro-life attorney general of Missouri, William L. Webster, then appealed to the state supreme court, in an attempt to get a judicial decision that could help overturn *Roe v. Wade*.²⁶ The Missouri Supreme Court, in a 4 to 3 vote, reversed the decision of the trial court. The parents then appealed to the U.S. Supreme Court, which, in a 5 to 4 vote, affirmed the Missouri Supreme Court. On remand, the trial court held that there was clear and convincing evidence, and again ordered the withdrawal of artificial hydration and nutrition.

I discuss this case here *only* because it is the first (and currently only) case considered by the U.S. Supreme Court involving disconnecting life support of an unconscious patient. As I discuss below, the opinions of the Missouri Supreme Court and U.S. Supreme Court include a significant amount of extraneous and poorly reasoned material, probably because the justices in the majority had an underlying desire to make abortion illegal.

²⁶ *Cruzan*, 760 S.W.2d at 441 (Welliver, J., dissenting) (“This case is not before us to establish groundwork for future right-to-life litigation. It is here to examine and determine Nancy Cruzan's right to die under the federal and state constitutions, ...”); also see the insightful analysis by George J. Annas, “The Long Dying of Nancy Cruzan,” 19 Law, Medicine & Health Care 52 (1991).

In the title of this case, *Cruzan v. Harmon*, Robert G. Harmon was sued in his official capacity as the Director of the Missouri Department of Health, which supervised the state hospital where Nancy Cruzan was a patient.

medical facts

The facts of this case were tersely summarized by the Missouri Supreme Court in November 1988.

At 12:54 a.m., January 11, 1983, the Missouri Highway Patrol dispatched Trooper Dale Penn to the scene of a single car accident in Jasper County, Missouri. Penn arrived six minutes later to find Nancy Beth Cruzan lying face down in a ditch, approximately thirty-five feet from her overturned vehicle. The trooper examined Nancy and found her without detectable respiratory or cardiac function.

At 1:09 a.m., Paramedics Robert Williams and Rick Maynard arrived at the accident scene; they immediately initiated efforts to revive Nancy. By 1:12 a.m., cardiac function and spontaneous respiration had recommenced. The ambulance crew transported Nancy to the Freeman Hospital where exploratory surgery revealed a laceration of the liver. A CAT scan showed no significant abnormalities of her brain. The attending physician diagnosed a probable cerebral contusion compounded by significant anoxia (deprivation of oxygen) of unknown duration. The trial judge found that a deprivation of oxygen to the brain approaching six minutes would result in permanent brain damage; the best estimate of the period of Nancy's anoxia was twelve to fourteen minutes.

Nancy remained in a coma for approximately three weeks following the accident. Thereafter, she seemed to improve somewhat and was able to take nutrition orally. Rehabilitative efforts began. In order to assist her recovery and to ease the feeding process, a gastrostomy feeding tube was surgically implanted on February 7, 1983, with the consent of her (then) husband.

Over a substantial period of time, valiant efforts to rehabilitate Nancy took place, without success. She now lies in the Mount Vernon State Hospital. [FN2] She receives the totality of her nutrition and hydration through the gastrostomy tube.

FN2. The court determined that the State is bearing the entire economic cost of Nancy's care.

Cruzan v. Harmon, 760 S.W.2d 408, 410-411 (Mo. 1988).

The trial court gave more detail about her condition in its opinion of July 1988:

Continuous observations by primary care givers, her family and attending physicians and a recent neurological examination by Dr. George Wong report that Nancy remains unconscious, is unresponsive to her environment with atrophy and contractures of her four extremities. Her fingernails now sometimes cut into her wrists. She is a spastic quadriplegic. Her vital signs, BP 130/80, pulse 78 and regular, and respiration spontaneous at 16 to 18 per minute, all essentially normal for a 30 year old female. At no time has her electroencephalogram registered isoelectric or flat. Her condition is considered permanent. A recent CAT scan of her head reveals abnormalities suggesting severe irreversible upper hemispheric brain damage with massive enlargement of ventricles from filling with cerebrospinal fluid because the brain is degenerating. The degeneration is called cerebral

cortical atrophy which is progressive from her initial condition reflected on CAT scan. The fluid is replacing the area where there is no more brain tissue. This permanent and irreversible condition is the apparent result of time duration of anoxia which was initially feared by the examining and consulting neurosurgeon. Her normal weight of 115 pounds has now risen to about 140 pounds.

....

After examination and treatment by a number of physicians, including three neurologists, a neurosurgeon, and a specialist in rehabilitative medicine and considering the observations of the primary nursing care providers, her family and co-guardians, the Court by clear and convincing evidence finds the current medical condition of our ward to be as follows:

1. That her respiration and circulation are not artificially maintained and within essentially normal limits for a 30 year old female with vital signs recently reported as BP 130/80; pulse 78 and regular; 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 cerebrospinal 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 ordinarily painful stimuli, indicating the experience of pain and her apparent response to sound.
5. That she is 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 to satisfy her needs.

Cruzan , 760 S.W.2d at 431-432 (Higgins, J., dissenting) (quoting Judge Charles E. Teel, Jr., of the trial court).

trial court

The trial court opinion was technically unpublished, but was quoted by Justice Higgins of the Missouri Supreme Court in his dissenting opinion at 760 S.W.2d at 430-434. The trial court said the following about Nancy's wishes:

About a year prior to her accident in discussions with her then housemate, friend and co-worker, she expressed the feeling that she would not wish to continue living if she couldn't be at least halfway normal. Her lifestyle and other statements to family and friends suggest that she would not wish to continue her present existence without hope as it is.

Cruzan , 760 S.W.2d at 432 (Higgins, J., dissenting) (quoting Judge Charles E. Teel, Jr., of the trial court).

The concluding paragraphs of the trial court opinion are:

Her expressed thoughts at age twenty-five in somewhat serious conversation with a housemate friend that if sick or injured she would not wish to continue her life unless she could live at least halfway normally suggests that given her present condition she would not wish to continue on with her nutrition and hydration.

The Law of this State [citation to statutes omitted] and legislatively enunciated public policy prohibits withholding or withdrawal of nutrition or hydration as a death-prolonging procedure and euthanasia or mercy killing by act or omission. Death-prolonging procedures may only be withheld if no innocent third parties require the protection of the state, no homicide or suicide occurs and good ethical standards in the medical profession are maintained. Our law does recognize an individual's primary right to refuse medical treatment and to direct physicians attending to withhold or withdraw further treatment.

In this case there are no innocent third parties requiring state protection, neither homicide nor suicide will be committed and the consensus of the medical witnesses indicated concerns personal to themselves or the legal consequences of such actions rather than any objections that good ethical standards of the professions would be breached if the nutrition and hydration were withdrawn the same as any other artificial death prolonging procedures the statute specifically authorizes. Euthanasia is not statutorily defined and there are differing definitions in both lay and professional terms.

There is a fundamental natural right expressed in our Constitution as the 'right to liberty' [FN3], which permits an individual to refuse or direct the withholding or withdrawal of artificial death prolonging procedures when the person has no more cognitive brain function than our Ward and all the physicians agree there is no hope of further recovery while the deterioration of the brain continues with further overall worsening physical contractures. To the extent that the statute or public policy prohibits withholding or withdrawal of nutrition and hydration or euthanasia or mercy killing, if such be the definition, under all circumstances, arbitrarily and with no exceptions, it is in violation of our ward's constitutional rights by depriving her of liberty without due process of law. To decide otherwise that medical treatment once undertaken must be continued irrespective of its lack of success or benefit to the patient in effect gives one's body to medical science without their consent. We could then sing, less fervently of the land of the free, but as medical science advances to new horizons, much more fervently of the land of the brave. If we are the victim we might not be cognizant of our bravery.

FN3. Article I, Section 2; Article I, Section 10; Constitution of Missouri; Article XIV Amendments to the United States Constitution.

To deny the Co-guardians the authority to act in this instance is to deprive the Ward of the equal protection of the law which is constitutionally guaranteed. [FN4]

FN4. Section 2, Article I Constitution of Missouri; Article XIV, Section 1. Amendments to the United States Constitution.

In this case the Court acts only to authorize the Co-guardians to exercise our Ward's constitutionally guaranteed liberty to request the Respondents to withhold nutrition and hydration.

The Co-guardians are required only to exercise their legal authority to act in the best interests of their Ward as they discharge their duty and are free to act or not with this authority as they may determine.

The Respondents, employees of the State of Missouri, are directed to cause the request of the Co-guardians to withdraw nutrition or hydration to be carried out. Such a request having Court approval, shall be taken the same as a request for discontinuance of any other form of artificial life support systems. Under those circumstances, further feeding could raise the spectre of civil liability and recovery of damages from the provider. The care and compassion the Respondents and their associates have already shown our Ward and her guardians, incomparable by any standards, are in keeping with the overwhelming tragedy that has been visited upon us all.

IT IS SO ORDERED, ADJUDGED AND DECREED this 27th day of July, 1988. *Cruzan*, 760 S.W.2d at 433-434 (Higgins, J., dissenting) (quoting Judge Charles E. Teel, Jr., of the trial court).

The state of Missouri, via Attorney General William L. Webster, appealed to the Missouri Supreme Court. The trial court had appointed an attorney to be guardian ad litem for Nancy Cruzan. This guardian ad litem agreed with the result of the trial court (“we informed the [trial] court that we felt it was in Nancy Cruzan's best interests to have the tube feeding discontinued.”), but nevertheless appealed to the Missouri Supreme Court as a matter of duty.²⁷

Missouri Supreme Court

The Missouri Supreme Court summarized the findings of the trial court and concluded:

In sum, Nancy is diagnosed as in a persistent vegetative state. She is not dead. [footnote on definition of death in Missouri statute omitted] She is not terminally ill. Medical experts testified that she could live another thirty years.

Cruzan v. Harmon, 760 S.W.2d 408, 411 (Mo. 1988).

The Missouri Supreme Court characterized the issue in this case and then commented on the euphemisms common in these cases.

As we said, this case presents a single issue for resolution: May a guardian order that food and water be withheld from an incompetent ward who is in a persistent vegetative state but who is otherwise alive within the meaning of Section 194.005, RSMo 1986, and not terminally ill? As the parties carefully pointed out in their thoughtful briefs, this issue is a broad one, invoking consideration of the authority of guardians of incompetent wards, the public policy of Missouri with regard to the termination of life-sustaining treatment and the amorphous mass of constitutional rights generally described as the "right to liberty", "the right to privacy", equal protection and due process.

This is also a case in which euphemisms readily find their way to the fore, perhaps to soften the reality of what is really at stake. But this is not a case in which we are asked to let someone die. Nancy is not dead. Nor is she terminally ill. This is a case in which we are asked to allow the medical profession to make Nancy die by starvation and dehydration. The debate here is thus not between life and death; it is between quality of life and death. We are

²⁷ *Cruzan*, 760 S.W.2d. at 410, n. 1; *Cruzan*, 760 S.W.2d at 435 (Higgins, J., dissenting); *Cruzan*, 497 U.S. at 281, n. 9; *Cruzan*, 497 U.S. at 318-319 (Brennan, J., dissenting) (“Where, as here, the family members, friends, doctors, and guardian ad litem agree, it is not because the process has failed, as the majority suggests. [citation omitted] It is because there is no genuine dispute as to Nancy's preference.”).

asked to hold that the cost of maintaining Nancy's present life is too great when weighed against the benefit that life conveys both to Nancy and her loved ones and that she must die. *Cruzan v. Harmon*, 760 S.W.2d 408, 411-412 (Mo. 1988).

The majority opinion of the Missouri Supreme Court noted the existence of substantial case law in other jurisdictions, with a massive footnote that cited 54 cases:

While this is a case of first impression in Missouri, the courts of some of our sister states have grappled with similar issues. [FN4] Nearly unanimously, those courts have found a way to allow persons wishing to die, or those who seek the death of a ward, to meet the end sought. [FN5]

FN4. The following is a list of state court cases since 1976 addressing the initiation or removal of life-sustaining treatment: ARIZONA: *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987); CALIFORNIA: *Barber v. Super. Ct. of State of Cal.*, 147 Cal.App.3d 1006, 195 Cal.Rptr. 484 (1983), *Dority v. Super. Ct. of San Bernardino County*, 145 Cal.App.3d 273, 193 Cal.Rptr. 288 (1983), *Bartling v. Glendale Adventist Medical Center*, 184 Cal.App.3d 961, 229 Cal.Rptr. 360 (1986), *Bouvia v. Super Ct. of Los Angeles*, 179 Cal.App.3d 1127, 225 Cal.Rptr. 297 (1986), *In re Drabick III*, 200 Cal.App.3d 185, 245 Cal.Rptr. 840 (1988); COLORADO: *Trujillo v. Dist. Ct. in & for Tenth Judicial Dist.*, 198 Colo. 419, 601 P.2d 1072 (1979); CONNECTICUT: *Foody v. Manchester Memorial Hospital*, 40 Conn.Supp. 127, 482 A.2d 713 (1984); DELAWARE: *Severns v. Wilmington Medical Center*, 425 A.2d 156 (Del.Ch. 1980); FLORIDA: *Satz v. Perlmutter*, 362 So.2d 160 (Fla.Dist.Ct.App. 1978); *In re Guardianship of Barry*, 445 So.2d 365 (Fla.Dist.Ct.App. 1984); *John F. Kennedy Memorial Hospital v. Bludworth*, 452 So.2d 921 (Fla. 1984), *Corbett v. D'Alessandro*, 487 So.2d 368 (Fla.Dist.Ct.App. 1986), *Wons v. Public Health Trust of Dade County*, 500 So.2d 679 (Fla.Dist.Ct.App. 1987); GEORGIA: *In re L.H.R.*, 253 Ga. 439, 321 S.E.2d 716 (1984); IOWA: *Morgan v. Olds*, 417 N.W.2d 232 (Iowa App. 1987); LOUISIANA: *In re PVW*, 424 So.2d 1015 (La. 1982); MAINE: *In re Joseph v. Gardner*, 534 A.2d 947 (Me. 1987); MASSACHUSETTS: *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977), *In re Dinnerstein*, 6 Mass.App.Ct. 466, 380 N.E.2d 134 (1978), *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980), *Custody of a Minor*, 385 Mass. 697, 434 N.E.2d 601 (1982), *In the matter of Hier*, 18 Mass.App.Ct. 200, 464 N.E.2d 959 (1984), *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 497 N.E.2d 626 (1986); MINNESOTA: *In the matter of Torres*, 357 N.W.2d 332 (Minn. 1986); NEW JERSEY: *In the matter of Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), *In the Matter of Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985), *Iafelice v. Luchs*, 206 N.J.Super. 103, 501 A.2d 1040 (1985), *In the Matter of Clark*, 210 N.J.Super. 548, 510 A.2d 136 (Ch.Div. 1986), *In the Matter of Requena*, 213 N.J.Super. 475, 517 A.2d 886 (Ch.Div. 1986), *In the Matter of Visbeck*, 210 N.J.Super. 527, 510 A.2d 125 (Ch.Div. 1986), *In the Matter of Farrell*, 108 N.J. 335, 529 A.2d 404 (1987), *In the Matter of Jobs*, 108 N.J. 394, 529 A.2d 434 (1987), *In the Matter of Peter*, 108 N.J. 365, 529 A.2d 419 (1987); NEW YORK: *In the Matter of Eichner*, 102 Misc.2d 184, 423 N.Y.S.2d 580 (N.Y.Sup.Ct. 1979), *In the Matter of Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981), *In the Matter of Lydia E. Hall Hospital v. Cinque*, 116 Misc.2d 477, 455 N.Y.S.2d 706 (N.Y.Sup.Ct. 1982), *A.B. v. C.*, 124 Misc.2d 672, 477 N.Y.S.2d 281 (N.Y.Sup.Ct. 1984), *Crouse Irving Memorial Hospital v. Paddock*, 127 Misc.2d 101, 485 N.Y.S.2d 443 (N.Y.Sup.Ct. 1985), *In the Matter of Saunders*, 129 Misc.2d 45, 492 N.Y.S.2d 510 (N.Y.Sup.Ct. 1985), *In the Matter of Delio*, 134 Misc.2d 206, 510 N.Y.S.2d 415 (N.Y.Sup.Ct. 1986), *In re Harvey "U"*, 116 A.D.2d 351, 501 N.Y.S.2d 920 (N.Y.App.Div. 1986), *In the Matter of O'Brien*, 135 Misc.2d 1076, 517 N.Y.S.2d 346 (N.Y.Sup.Ct. 1986), *Vogel v. Forman*, 134 Misc.2d 395, 512 N.Y.S.2d 622 (N.Y.Sup.Ct. 1986), *In the Matter of Fink*, 135 Misc.2d 270, 514 N.Y.S.2d 893 (N.Y.Sup.Ct. 1987), *In the Matter of Weinstein*, 136 Misc.2d 931, 519 N.Y.S.2d 511 (N.Y.Sup.Ct. 1987); OHIO: *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980), *In re Milton*, 29 Ohio St.3d 20, 505 N.E.2d 255 (1987); PENNSYLVANIA: *In re Estate of Dorone*, 349 Pa.Super. 59, 502 A.2d 1271 (1985); WASHINGTON: *In the Matter of Colyer*, 99 Wash.2d 114, 660 P.2d 738 (1983), *Dinino v. State of Washington*, 102 Wash.2d 327, 684 P.2d 1297 (1984), *In the Matter of Hamlin*, 102 Wash.2d 810, 689 P.2d 1372 (1984), *In the Matter of Ingram*, 102 Wash.2d 827, 689 P.2d 1363 (1984), *In re Guardianship of Grant*, 109 Wash.2d 545, 747 P.2d 445 (1987).

FN5. The dissenters adopt a "me too" posture without burdening themselves with any analysis of the legal reasoning upon which *Quinlan* and cases following it rely. The dissenters work backwards, choosing a result then creating reasons to "support" it. It is our duty in a case of first impression in this state not only to consider precedents from other states, but also to determine their strength. We have found them wanting and refuse to eat "on the insane root which takes the reason prisoner." *Shakespeare, MacBeth*, I, iii.

Cruzan v. Harmon, 760 S.W.2d 408, 412-413 (Mo. 1988).

However, the alleged determination of the "strength" of these cases by the majority was actually a quick review of *Quinlan*, *Eichner* (Brother Fox), *Conroy*, and *Brophy*, and a terse statement about *Bouvia* and *Jobes*. The Missouri Supreme Court also discussed *Saikewicz* and the case of John Storar, both of whom were severely mentally retarded and who were *never* competent to express their personal wishes about medical treatment, which distinguishes those two patients from Nancy Cruzan. The Missouri Supreme Court essentially ignored the consensus view of most of the 54 cases from other states.

The Missouri Supreme Court then began applying the law to the case of Nancy Cruzan.

On the dispositive point, the State argues that the trial court erred in "holding that a refusal to allow withdrawal of nutrition and hydration under the facts of this case would deny Nancy Cruzan's 'right to liberty' and that to deny the coguardians the authority to act on her behalf would deprive her of equal protection of the laws." Respondents support the trial court's order by urging that Nancy has both a common law and constitutional right to be free from "invasive, unwanted and nonbeneficial" medical treatment, and that her right to refuse such treatment survives incompetency and may be exercised by her guardians as substituted decisionmakers.

A. The Right to Refuse Treatment

The common law recognizes the right of individual autonomy over decisions relating to one's health and welfare. [FN11] From this root of autonomy, the common law developed the principle that a battery occurs when a physician performs a medical procedure without valid consent. *Hershley v. Brown*, 655 S.W.2d 671, 676 (Mo.App. 1983). The doctrine of informed consent arose in recognition of the value society places on a person's autonomy and as the primary vehicle by which a person can protect the integrity of his body. If one can consent to treatment, one can also refuse it. Thus, as a necessary corollary to informed consent, the right to refuse treatment arose. "The patient's ability to control his bodily integrity ... is significant only when one recognizes that this right also encompasses a right to informed refusal." *Conroy*, 486 A.2d at 1222.

FN11. "The right of self-determination and individual autonomy has its roots deep in our history." *Brophy*, 497 N.E.2d at 633. At this point, courts regularly turn to J.S. Mill for inspiration. "[T]he only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or to forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right." Mill, *On Liberty*, in 43 Great Books of the Western World 271 (R. Hutchins ed. 1952). Aside from citing Mill for the proposition announced, courts seldom indulge the temptation to determine whether one person's autonomy and self-determination can be exercised

by another, though the very terms seem to indicate that these rights are not alienable, unless so determined by the person for whom they are exercised.²⁸

A decision as to medical treatment must be informed.

There are three basic prerequisites for informed consent: the patient must have the capacity to reason and make judgments, the decision must be made voluntarily and without coercion, and the patient must have a clear understanding of the risks and benefits of the proposed treatment alternatives or nontreatment, along with a full understanding of the nature of the disease and the prognosis.

Wanzer, Adelstein, Cranford, Federman, Hook, Moertel, Safar, Stone, Taussig & Van Eys, "The Physician's Responsibility Toward Hopelessly Ill Patients," 310 *New Eng. J. Med.*, 955, 957 (1984). In the absence of these three elements, neither consent nor refusal can be informed. Thus, it is definitionally impossible for a person to make an informed decision—either to consent or to refuse—under hypothetical circumstances; under such circumstances, neither the benefits nor the risks of treatment can be properly weighed or fully appreciated.

Cruzan v. Harmon, 760 S.W.2d 408, 416-417 (Mo. 1988).

The Missouri Supreme Court then considered Nancy Cruzan's right of privacy.

B. The Right to Privacy

Quinlan, and cases which follow it, announce that a patient's right to refuse medical treatment also arises from a constitutional right of privacy. Although some courts find that right embedded in their state constitutions [FN12], the privacy argument is most often founded on decisions of the United States Supreme Court, primarily *Roe v. Wade*, 410 U.S. 113, 93 S.Ct. 705, 35 L.Ed.2d 147 (1973). Unfortunately, the bare statement that the right of privacy extends to treatment decisions is seldom accompanied by any reasoned analysis as to the scope of that right or its application to the refusal of life-sustaining treatment.

FN12. At least five state courts which authorized the refusal of life-sustaining treatment found a right of privacy expressly provided in their state constitutions. See, e.g., *Bouvia v. Superior Court*, 179 Cal.App.3d 1127, 225 Cal.Rptr. 297 (1986); *In re Guardianship of Barry*, 445 So.2d 365 (Fla.Dist.Ct.App. 1984) (noting state constitution was amended after *Satz v. Perlmutter*, 362 So.2d 160 (Fla.Dist.Ct.App. 1978) to recognize a right to privacy in medical treatment decisions); *Matter of Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976); *Matter of Welfare of Colyer*, 99 Wash.2d 114, 660 P.2d 738 (1983); *Rasmussen by Mitchell v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987).

Neither the federal nor the Missouri constitutions expressly provide a right of privacy. In *State v. Walsh*, 713 S.W.2d 508, 513 (Mo. banc 1986), this Court was asked to recognize an unfettered right of privacy. We declined to do so. [FN13] This is consistent with our view that Missouri's constitution must be interpreted according to its plain language and in a manner consistent with the understanding of the people who adopted it. *State ex rel. Danforth v. Cason*, 507 S.W.2d 405, 408-09 (Mo. banc 1973). We thus find no unfettered right of privacy under our constitution that would support the right of a person to refuse medical treatment in every circumstance.

²⁸ Note that the last sentence in footnote 11 implies that Nancy's parents have no standing in court to assert Nancy's legal rights, despite the fact that dozens of courts in the USA had allowed a spouse or parents to refuse medical care on behalf of an unconscious patient. See page 111, below.

FN13. In *Barber v. Time, Inc.*, 348 Mo. 1199, 1205-06, 159 S.W.2d 291, 294 (1942), this Court stated that a right of privacy may grow out of a constitutional right. The *Barber* decision provides protection against the publication of private facts and springs from the well-known tort of invasion of privacy. We find its discussion inapplicable in cases involving decisions of personal autonomy.

If Nancy possesses such a right, it must be found to derive from the federal constitutional right to privacy announced by the United States Supreme Court. That Court "has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the [United States] Constitution." *Roe v. Wade*, 410 U.S. at 152, 93 S.Ct. at 726. The Supreme Court has not, however, extended the right of privacy to permit a patient or her guardian to direct the withdrawal of food and water. We are left to determine for ourselves whether the penumbral right of privacy encompasses a right to refuse life-sustaining medical treatment.

Quinlan is the first case to apply a right of privacy to decisions regarding the termination of life-sustaining treatment. In deciding the applicability of the right to such determinations, *Quinlan* first cites *Griswold v. Connecticut*, 381 U.S. 479, 85 S.Ct. 1678, 14 L.Ed.2d 510 (1965), for the proposition that the right of privacy exists and, without further analysis states: "Presumably this right is broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate a pregnancy under certain conditions." 355 A.2d at 663, citing *Roe v. Wade*. The presumption invoked by the New Jersey Supreme Court provides the precedent for the extension of this right of privacy by other courts whose decisions permitting the termination of life sustaining treatment is founded on privacy.

Yet *Roe* itself counsels against such a broad reading.

The privacy right involved, therefore, cannot be said to be absolute. In fact, it is not clear to us that the claim asserted by some amici that one has an unlimited right to do with one's body as one pleases bears a close relationship to the right of privacy previously articulated in the Court's decisions. The Court has refused to recognize an unlimited right of this kind in the past.

Roe, 410 U.S. at 154, 93 S.Ct. at 727.

The language in *Roe* is not an aberration. The Supreme Court's most recent privacy decision resisted expansion of the privacy right. In *Bowers v. Hardwick*, 478 U.S. 186, 106 S.Ct. 2841, 92 L.Ed.2d 140 (1986), the Supreme Court considered whether the right to privacy extended to the conduct of homosexuals. Noting that the prior right to privacy cases focused on a common theme of procreation and relationships within the bonds of marriage, the court refused to extend the right of privacy beyond those bounds, arguing that such an extension amounted to the discovery of a new right.

Nor are we inclined to take a more expansive view of our authority to discover new fundamental rights imbedded in the Due Process Clause. The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution.... There should be, therefore, great resistance to expand the substantive reach of those clauses, *particularly if it requires redefining the category of rights deemed to be fundamental*. Otherwise, the Judiciary necessarily takes to itself further authority to govern the country without express constitutional authority.

Bowers, 478 U.S. at 194-95, 106 S.Ct. at 2846 (emphasis added).

Based on our analysis of the right to privacy decisions of the Supreme Court, we carry grave doubts as to the applicability of privacy rights to decisions to terminate the provision of food and water to an incompetent patient. [FN14] As will be seen, however, even if we

recognize such a broadly sweeping right of privacy, a decision by Nancy's co-guardians to withdraw food and water under these circumstances cannot be sustained.

FN14. This is not a matter of forfeiture of a constitutional right because that term implies some state action which deliberately removes or limits a constitutional right.

Cruzan v. Harmon, 760 S.W.2d 408, 417-418 (Mo. 1988).

Note that the Missouri Supreme Court considered only *Quinlan* and ignored the other 53 cases cited above, except for the citations in footnote 12. Then the Court briefly quoted *Roe v. Wade* and *Bowers v. Hardwick*. Although the Missouri Supreme Court could not have known this when they wrote this opinion in 1988, the U.S. Supreme Court later overruled *Bowers v. Hardwick* in *Lawrence v. Texas*, 539 U.S. 558 (2003).

Finally, the Missouri Supreme Court considered the classic four state interests (see page 68 above) and focused on the state's interest in preserving life.

C. The State's Interests

Neither the right to refuse treatment nor the right to privacy are absolute; each must be balanced against the State's interests to the contrary. Four state interests have been identified: preservation of life, prevention of homicide and suicide, the protection of interests of innocent third parties and the maintenance of the ethical integrity of the medical profession. See Section 459.055(1), RSMo 1986; *Brophy*, 497 N.E.2d at 634. In this case, only the state's interest in the preservation of life is implicated.

The state's interest in life embraces two separate concerns: an interest in the prolongation of the life of the individual patient and an interest in the sanctity of life itself. As to the former,

The concern for preservation of the life of the patient normally involves an *interest in the prolongation of life*. Thus, the State's interest in preserving life is very high when "human life [can] be saved where the affliction is curable." *Saikewicz*, ... 370 N.E.2d at 425-426. That interest wanes when the underlying affliction is incurable and "would soon cause death regardless of any medical treatment." *Commissioner of Corrections v. Myers*, [379 Mass. 255,] 399 N.E.2d 452, 456 (Mass. 1979). *Saikewicz*, *supra*. The calculus shifts when the issue is not "whether, but when, for how long, and at what cost to the individual that life may be *briefly* extended." *Id.* [370 N.E.2d] at 426.

Brophy, 497 N.E.2d at 635 (emphasis added).

The state's interest in prolonging life is particularly valid in Nancy's case. Nancy is not terminally ill. Her death is imminent only if she is denied food and water. Medical evidence shows Nancy will continue a life of relatively normal duration if allowed basic sustenance.

The state's concern with the sanctity of life rests on the principle that life is precious and worthy of preservation without regard to its quality. This latter concern is especially important when considering a person who has lost the ability to direct her medical treatment. In such a circumstance, we must tread carefully, with due regard for those incompetent persons whose wishes are unknowable but who would, if able, choose to continue life-sustaining treatment. Any substantive principle of law which we adopt must also provide shelter for those who would choose to live — if able to choose — despite the inconvenience that choice might cause others.

At the beginning of life, Missouri adopts a strong predisposition in favor of preserving life. Section 188.010, RSMo 1986, announces the "intention of the General Assembly of

Missouri to grant the right to life to all humans, born and unborn...." Section 188.015(7), RSMo 1986, determines that a fetus is viable "when the life of the unborn child may be continued indefinitely outside the womb by natural or *artificial life-support systems*" (emphasis added). Section 188.130, RSMo 1986, denies a cause of action for wrongful life and wrongful birth.

At the end of life, this State maintains its policy strongly favoring life. In response to the dilemmas which attend the increasing ability of medical science to maintain life where death would have come quickly in former days, legislatures across the country adopted so-called "Living Will" statutes. These permit a competent person to decree in a formal document that she would refuse death prolonging medical treatment in the event of terminal illness and an accompanying inability to refuse such treatment as a result of incompetency.

Cruzan v. Harmon, 760 S.W.2d 408, 419 (Mo. 1988).

In general, living-will statutes protect an individual's right to refuse medical treatment. However, Missouri's living-will statute specifically denies the right to refuse "any procedure to provide nutrition or hydration." This living-will statute was called

... a fraud on the people of Missouri from the beginning and which statute, if directly attacked, must, in my opinion, be held to be unconstitutional."

Cruzan v. Harmon, 760 S.W.2d 408, 441 (Mo. 1988) (Welliver, J., dissenting).

After discussing living-will statutes, the majority opinion of the Missouri Supreme Court concludes:

None of the parties argue that Missouri's Living Will statute applies in this case. First, the law did not take effect until after Nancy's accident. Second, even if the law had been effective, Nancy had not executed a living will. The statute's import here is as an expression of the policy of this State with regard to the sanctity of life. We intend no judgment here as to whether the common law right to refuse medical treatment is broader than the Living Will statute. Beyond the broad policy statement it makes, that statute is not at issue in this case. The trial court erred in finding its provisions unconstitutional.

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

Cruzan v. Harmon, 760 S.W.2d 408, 420 (Mo. 1988).

Instead of joining the other states that held a patient has an absolute right (except for the four state interests discussed above) to refuse medical treatment, even if that refusal would cause the patient to die, the Missouri Supreme Court goes off on a right-to-life tangent that seems to rob individuals of their right to self-determination.

In casting the balance between the patient's common law right to refuse treatment/constitutional right to privacy and the state's interest in life, we acknowledge that the great majority of courts allow the termination of life-sustaining treatment. In doing so, these courts invariably find that the patient's right to refuse treatment outweighs the state's interest in preserving life. In some cases, that result is the product of a hopeless medical prognosis; in others, the court allows concerns with quality of life to discount the state's interest in life. *Quinlan*, of course, is the source in each instance. Although *Quinlan* dealt with a terminally-

ill person,²⁹ it did so in language sufficiently broad that courts cite it for much different purposes.

On the one hand, *Quinlan* based its decision on Karen Quinlan's constitutional right to privacy. While recognizing that privacy rights must be balanced against the state's interest in life, the court found that Karen's treatment was so extraordinary and so invasive that the state's interest paled in comparison. Though unstated, one can properly assume from *Quinlan* that the state's interest might prevail were the patient undergoing ordinary medical treatment. This focus on the extraordinary/ordinary dichotomy provided a ready standard by which the patient's interest could be assessed in a constitutional sense against the state's interest in life.

Since *Quinlan*, the medical profession moved to abandon any distinction between extraordinary and ordinary treatment in considering the propriety of withdrawing life-sustaining treatment. [FN16] *Conroy*, decided by the same court six years later, found distinctions focusing on the type of treatment unpersuasive. "[W]hile the analysis may be useful in weighing the implications of the specific treatment for the patient, essentially it merely restates the question: whether the burdens of treatment so clearly outweigh its benefit to the patient that continued treatment would be inhumane."³⁰ 486 A.2d at 1235.

FN16. The testimony in this case tends to confirm this trend. Dr. Ronald Cranford indicated that hydration and nutrition, however administered is medical treatment; for Cranford, the controlling factors are the patient's desires and those of her family. In cases like Nancy's "if you decided in terms of what the patient wanted or in terms of what the family wanted or the relationship between the two, to discontinue artificial feeding through the gastrostomy tube and then attempt to feed her through a syringe or spoon feeding would make no sense whatsoever in terms of the overall moral standard of decision making."

This change of focus by the medical community led courts away from constitutional foundations for decisions in this area. "The erosion of distinctions based on treatment complicated constitutional analysis since there was no other readily apparent standard which courts could use to calibrate the burden of an individual's privacy right inflicted by particular kinds of treatment." Tribe, *American Constitutional Law*, 1365 (2d ed. 1988).

Perhaps realizing the difficulty of applying a constitutional standard which relied too heavily on medical technology, several courts, led by *Eichner*, abandoned right to privacy reasoning, focusing instead on the common law right to refuse treatment.

The common law right to refuse treatment is not absolute. It too must be balanced against the state's interest in life. From its early application in *Quinlan* and *Eichner*, both of which involved terminally-ill patients,³¹ courts have read the right in an everbroadening manner. *Brophy* led the way. There the court found that an incompetent patient's imputed desire to terminate treatment outweighed the state's interest despite the fact that the patient had a fairly long life expectancy if feeding continued. *Bouvia* and *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987), took the next step; they found that the state's interest in preserving life is not compelling when a competent patient wishes to have life-sustaining treatment withdrawn.

²⁹ This statement is *wrong*. Karen Quinlan lived for nine years after her ventilator was disconnected, a fact that the Missouri Supreme Court noted in footnote 6 of this opinion.

³⁰ This is a misreading of *Conroy*. Note that Claire Conroy was *not* in a persistent vegetative state. See page 75, above.

³¹ This statement is *wrong*. Karen Quinlan lived for nine years after her ventilator was disconnected, a fact that the Missouri Supreme Court noted in footnote 6 of this opinion.

No longer relying on the nature of the treatment to provide a standard, courts began to focus on the patient's medical prognosis and the individual patient's assessment of the quality of her life in the face of that prognosis. And in the face of a prognosis which promised no reasonable hope of recovery and which the patient found undesirable, the patient's choice prevailed over the state's interest.

Commentators do not find this analysis persuasive. Taken to its logical end, this standard ultimately makes prognosis irrelevant. "This situation is conducive to a rhetorical justification of the cases — authorizing the patient's choice is merely allowing an inexorable dying process to continue. While this distinction is rhetorically convenient, it is not easily justifiable by principle: where the patient's right to refuse medical treatment is constant, the patient's condition and prognosis would no longer seem to be relevant." Tribe, *American Constitutional Law* at 1366. Once prognosis becomes irrelevant, and the patient's choice always more important than the state's interest, this standard leads to the judicial approval of suicide. Tribe, *supra* at 1367.

This result can be obtained only if the state's interest in the preservation of life is substantially discounted. Yet courts manage to find the states' interests wanting and allow surrogates to choose the death of patients by invoking a nearly unbridled right to refuse treatment. For an explanation, we revert to *Quinlan*.

Prior to *Quinlan*, the common law preferred to err on the side of life. Choices for incompetents were made to preserve life, not hasten death. [FN17] *Quinlan* changed the calculus. Moving from the common law's prejudice in favor of life, *Quinlan* subtly recast the state's interest in life as an interest in the quality of life (cognitive and sapient), struck a balance between quality of life and Karen Quinlan's right to privacy and permitted the termination of a life sustaining procedure. By the rhetorical device of replacing a concern for life with quality of life, the court managed "to avoid affronting previously accepted norms" in reaching its decision. Alexander, "Death by Directive", 28 Santa Clara L.Rev 67, 82 (1988).

FN17. Missouri courts have ordered blood transfusions for infants and children over the religious objection of parents in order to preserve the child's life and health. *Morrison v. State*, 252 S.W.2d 97 (Mo.App. 1952). See also *Jehovah's Witnesses v. King County Hosp.*, 278 F.Supp. 488 (W.D.Wash. 1967), *aff'd*, 390 U.S. 598, 88 S.Ct. 1260, 20 L.Ed.2d 158 (1968); *In re Ivey*, 319 So.2d 53 (Fla.App. 1975); *People v. Labrenz*, 411 Ill. 618, 104 N.E.2d 769 (1952); *State v. Perricone*, 37 N.J. 463, 181 A.2d 751, *cert. denied*, 371 U.S. 890, 83 S.Ct. 189, 9 L.Ed.2d 124 (1962); *In re Clark*, 21 Ohio Op.2d 86, 185 N.E.2d 128 (Ohio Comm.Pleas 1962); *Mitchell v. Davis*, 205 S.W.2d 812 (Tex.Civ.App. 1947).

As we previously stated, however, the state's interest is not in quality of life. The state's interest is an unqualified interest in life. In striking the balance between a patient's right to refuse treatment or her right to privacy and the state's interest in life, we may not arbitrarily discount either side of the equation to reach a result which we find desirable.

Cruzan v. Harmon, 760 S.W.2d 408, 420-422 (Mo. 1988).

The Missouri Supreme Court then applied this law to the facts involving Nancy Cruzan.

Nancy's guardians invoke her common law right to refuse treatment and her constitutional right of privacy as bases for their decision to stop feeding Nancy. They claim that her prognosis is hopeless, that her treatment is invasive and that were she able, she would refuse the continuation of tubal feeding. We will consider each of these separately.

First, [emphasis added] the evidence is clear and convincing that Nancy will never interact meaningfully with her environment again. She will remain in a persistent vegetative state until her death. She is totally dependent on others for her care. Respondents contend

that the patient's interest must prevail when medical treatment "serves only to prolong a life inflicted with an incurable condition." *In re Colyer*, 99 Wash.2d 114, 660 P.2d 738, 743 (1983).

As we have said, a focus on prognosis as a basis for permitting the right-to-refuse treatment choice is problematic. Where the patient is not terminally ill, as here, the profoundly diminished capacity of the patient and the near certainty that that condition will not change leads inevitably to quality of life considerations. The argument made here, that Nancy will not recover, is but a thinly veiled statement that her life in its present form is not worth living. Yet a diminished quality of life does not support a decision to cause death.

Second, [emphasis added] Nancy's counsel argues that her treatment is invasive. The invasion took place when the gastrostomy tube was inserted with consent at a time when hope remained for recovery. Presently, the tube merely provides a conduit for the introduction of food and water. The *continuation* of feeding through the tube is not heroically invasive.

This second argument requires us to assume that artificial hydration and nutrition are medical treatments. There is substantial disagreement on this point among physicians and ethicists. [FN18] Dr. Cranford so testified at trial. Arguments on each side are compelling. [FN19] The temptation here is to allow medical terminology to dictate legal principle. "Using medical explanations ... has utility for the courts. It removes the responsibility for decisions that seem harsh when explained in plainer language." Alexander, "Death by Directive", 28 Santa Clara L.Rev 67, 83 (1988). If the testimony at trial that Nancy would experience no pain even if she were allowed to die by starvation and dehydration is to be believed, it is difficult to argue with any conviction that feeding by a tube already in place constitutes a painful invasion for her. And common sense tells us that food and water do not treat an illness, they maintain a life.

FN18. AMA guidelines would permit withdrawal. Opinion 2.18 of the Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association adopted in 1986 reads in pertinent part:

Even if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life-prolonging medical treatment.

Life-prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or irreversible comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained. In its amicus brief, the American Medical Association states that it is not unethical in certain circumstances for a physician to comply with the request of a patient or surrogate to withdraw life-prolonging medical treatment.

FN19. The other amicus curiae briefs filed in this case illustrate the split in thinking.

The American Academy of Neurology in its amicus brief states that Nancy is a "prisoner of medical technology" and that she and her family should be set free.

Concern for Dying urges that "decisions to apply, withhold or withdraw medical care and technology are a matter of personal, not medical, judgment, and that such decisions should be made in accordance with a patient's wishes, values and beliefs."

The Society for the Right to Die, Inc., avers that there is a "fundamental right to refuse life-sustaining treatment" and that "that right can be exercised on behalf of a permanently unconscious individual."

The Brief of the SSM Health Care System and the Center for Health Care Ethics, St. Louis University Medical Center states that "[w]ithin the Christian foundation, the withholding and withdrawing of medical treatment, including artificial nutrition and hydration, is acceptable."

The brief of the Association for Retarded Citizens of the United States and the Ethics and Advocacy Task Force of the Nursing Home Action Group, however, assert that a course such as that

set out by the trial court would "threaten the affirmation and fundamental right to and interest in life of people with disabilities. It would subject them to radical and insidious discrimination based on their disabilities."

The brief of the Missouri Citizens for Life argues that neither the state nor federal constitution allows a competent person to starve or die of thirst and certainly no guardian can make that decision for an incompetent.

The medical argument, if carried to its natural conclusion, takes us into a dangerous realm; it seems to say that treatment which does not cure can be withdrawn. But "[w]hen we permit ourselves to think that care is useless if it preserves the life of the embodied human being without restoring cognitive capacity, we fall victim to the old delusion that we have failed if we cannot *cure* and that there is, then, little point to continue *care*." Green, "Setting Boundaries for Artificial Feeding", *The Hastings Center Report*, December, 1984, 12, 13 (emphasis in original).

The issue is not whether the continued feeding and hydration of Nancy is medical treatment; it is whether feeding and providing liquid to Nancy is a burden *to her*. *Conroy*. We refuse to succumb to the semantic dilemma created by medical determinations of what is treatment; those distinctions often prove legally irrelevant. For the reasons stated, we do not believe the care provided by artificial hydration and nutrition is oppressively burdensome *to Nancy* in this case.

Third, [emphasis added] the co-guardians argue that "Nancy's statements alone are enough to stop this artificial treatment." These statements are best summarized in the testimony of Nancy's roommate that she "would not want to continue her present existence without hope as it is." But "informally expressed reactions to other people's medical condition and treatment do not constitute clear proof of a patient's intent." *Jobes*, 529 A.2d at 443, *citing Conroy*, 486 A.2d at 1209.³²

Our earlier discussion about informed consent noted the requirements for consent or refusal to be truly informed. A decision to refuse treatment, when that decision will bring about death, should be as informed as a decision to accept treatment. If offered to show informed refusal, the evidence offered here "would be woefully inadequate. It is all the more inadequate to support a refusal that will result in certain death." *In re Gardner*, 534 A.2d 947, 957 (Clifford, J., dissenting.) As the court said in *Jobes*, "All of the statements about life-support that were attributed to Mrs. Jobes were remote, general, spontaneous, and made in casual circumstances. Indeed they closely track the examples of evidence that we have explicitly characterized as unreliable." *Jobes*, 529 A.2d at 443. Likewise, statements attributable to Nancy in this case are similarly unreliable for the purpose of determining her intent.³³

³² *Jobes*, 529 A.2d at 443 (NJ 1987) ("Thus, we conclude that although there is some 'trustworthy' evidence that Mrs. Jobes, if competent, would want the j-tube withdrawn [footnote omitted], it is not sufficiently 'clear and convincing' to satisfy the subjective test. Therefore, we must determine the guidelines and procedures under which life-sustaining medical treatment may be withdrawn from a patient like Mrs. Jobes when there is no clear and convincing proof of her attitude toward such treatment."); *Conroy*, 486 A.2d at 1232 (NJ 1985) ("Evidence that, taken as a whole, would be too vague, casual, or remote to constitute the clear proof of the patient's subjective intent that is necessary to satisfy the subjective test — for example, informally expressed reactions to other people's medical conditions and treatment — might be sufficient to satisfy this prong of the limited-objective test.").

³³ This terse statement seems to indicate that the trial court erred because the evidence of Nancy's wishes did not meet a "clear and convincing" level of proof.

Cruzan v. Harmon, 760 S.W.2d 408, 422-424 (Mo. 1988).

The Missouri Supreme Court then concludes this part of the discussion:

The state's relevant interest is in life, both its preservation and its sanctity. Nancy is not dead. Her life expectancy is thirty years.

Nancy's care requirements, while total, are not burdensome to Nancy. The evidence at trial showed that the care provided did not cause Nancy pain. Nor is that care particularly burdensome for her, given that she does not respond to it.

Finally, there is no evidence that Nancy is terminally ill. The quality of her life is severely diminished to be sure. Yet if food and water are supplied, she will not die.

Given the fact that Nancy is alive and that the burdens of her treatment are not excessive for her, we do not believe her right to refuse treatment, whether that right proceeds from a constitutional right of privacy or a common law right to refuse treatment, outweighs the immense, clear fact of life in which the state maintains a vital interest.

Cruzan v. Harmon, 760 S.W.2d 408, 424 (Mo. 1988).

The above section is simply astounding to me. The trial court found that Nancy had expressed the wish, prior to her injury, not to be kept alive artificially "if she couldn't be at least halfway normal."³⁴ The Missouri Supreme Court recognized that Nancy Cruzan "will never interact meaningfully with her environment again. She will remain in a persistent vegetative state until her death. She is totally dependent on others for her care."³⁵ Despite Nancy's meaningless existence in defiance of her wishes, the Missouri Supreme Court insisted that she be kept alive. This case is *not* a quantitative evaluation of the quality of Nancy's life: the quality of her life in a persistent (i.e., permanent) vegetative state is *zero*.

In a lofty discussion of constitutional rights of an individual against the state, it seems venial to mention cost of medical care. However, there is a significant burden to society in that the taxpayers of Missouri must pay for totally *futile* care of Nancy. One of the dissenting justices on the Missouri Supreme Court said:

The absolutist provision is also infirm because the state does not stand prepared to finance the preservation of life, without regard to the cost, in very many cases. [footnote omitted] In this particular case the state has Nancy in its possession, and is litigating its right to keep her. Yet, several years ago, a respected judge needed extraordinary treatment which the hospital in which he was a patient was not willing to furnish without a huge advance deposit, and the state apparently had no desire to help out. Many people die because of the unavailability of heroic medical treatment. It simply cannot be said that the state's interest in preserving and prolonging life is absolute.

Cruzan, 760 S.W.2d at 429 (Blackmar, J., dissenting).

Six years later a review article on persistent vegetative state in a leading medical journal estimated the cost of long-term care in a skilled nursing facility of *one* adult patient at between \$ 126,000/year and \$ 180,000/year. That article then says:

³⁴ *Cruzan*, 760 S.W.2d at 432 (quoting trial court).

³⁵ *Cruzan*, 760 S.W.2d at 422.

A rough approximation for the total annual costs in the United States for the care of adults and children in a persistent vegetative state is \$1 billion and \$7 billion. The Multi-Society Task Force on PVS, "Medical Aspects of the Persistent Vegetative State," 330 *New England Journal of Medicine* 1572, 1576 (2 June 1994).

The Missouri Supreme Court then addressed whether Nancy's parents can assert Nancy's legal rights on behalf of Nancy.

Nancy is incompetent; she cannot make informed choices concerning her medical treatment. We therefore do not decide any issue in this case relating to the authority of competent persons to suspend life-sustaining treatment in the face of terminal illness or otherwise. Our focus here is expressly limited to those instances in which the person receiving the life-sustaining treatment is unable to render a decision by reason of incompetency.

....

As we said, these rights have been explained as rooted in personal autonomy and self-determination. Autonomy means self law — the ability to decide an issue without reference to or responsibility to any other. It is logically inconsistent³⁶ to claim that rights which are found lurking in the shadow of the Bill of Rights and which spring from concerns for personal autonomy can be exercised by another absent the most rigid of formalities.

....

Assuming, *arguendo*, that the right of privacy may be exercised by a third party in the absence of strict formalities assigning that right, the risk of arbitrary decisionmaking and grave consequences attaches all the more when the third party seeks to cause the death of an incompetent. Just as the State may not delegate to any person the right to veto another's right to privacy choices, no person can assume that choice for an incompetent in the absence of the formalities required under Missouri's Living Will statutes or the clear and convincing, inherently reliable evidence absent here.³⁷

Nor do we believe that the common law right to refuse treatment — founded in personal autonomy — is exercisable by a third party absent formalities. A guardian's power to exercise third party choice arises from the state's authority, not the constitutional rights of the ward. The guardian is the delegatee of the state's *parens patriae* power. *In re Link*, 713 S.W.2d 487, 493 (Mo. banc 1986).

Cases which relied on the doctrine of substituted judgment to permit guardians to choose termination of life support simply failed to consider the source of the guardian's authority to decide. Instead those decisions assumed, without benefit of legal precedent, that the guardian's power to decide is derivative of the incompetent's right to decide, if competent. *See Quinlan*, 355 A.2d at 664. That the doctrine has an historical antecedent, *Saikewicz*,

³⁶ The concern of the Missouri Supreme Court here can be alleviated by simply requiring the surrogate decision maker to use the values of the *patient*, a requirement that is widely adopted by courts of other states.

³⁷ This terse statement seems to indicate that the trial court erred because the evidence of Nancy's wishes did not meet a "clear and convincing" level of proof.

370 N.E.2d at 431, does not change its *raison d'etre* or the scope of its reach. To fail to appreciate the legal foundation is to risk permitting the application of the doctrine in an unprincipled manner.

As applied in right-to-terminate-treatment decisions, the doctrine of substituted judgment is applied in abrogation of the state's *parens patriae* power, not in furtherance of it. In cases like this one, the doctrine authorizes a guardian to cause the death of a ward unilaterally, without interference by the state, and contrary to the state's vital interests in preserving life and in assuring the safekeeping of those who cannot care for themselves.

Cruzan v. Harmon, 760 S.W.2d 408, 424-426 (Mo. 1988).

The Missouri Supreme Court could have used the power of the state to appoint a guardian who makes a decision for a patient in a persistent vegetative state. If the guardian could not determine what Nancy Cruzan herself would have wanted to a “clear and convincing” level of proof, then the guardian could have considered informal expressions of her values or wishes, or — failing to find any evidence of her wishes — the guardian could have done what a hypothetical reasonable person would have wanted.

Incidentally, “it appears that Nancy was married at the time she was injured but that her husband was allowed to obtain a dissolution.” *Cruzan*, 760 S.W.2d at 427, n. 1 (Blackmar, J., dissenting). So Missouri courts were able to adjudicate her property rights, and her legal right to alimony, without her presence in court and without any evidence of her wishes.

Finally, the Missouri Supreme Court opinion concluded its majority opinion:

In sum, we hold that the co-guardians do not have authority to order the withdrawal of hydration and nutrition to Nancy. We further hold that the evidence offered at trial as to Nancy's wishes is inherently unreliable and thus insufficient to support the co-guardians claim to exercise substituted judgment on Nancy's behalf.³⁸ The burden of continuing the provision of food and water, while emotionally substantial for Nancy's loved ones, is not substantial for Nancy. The State's interest is in the preservation of life, not only Nancy's life, but also the lives of persons similarly situated yet without the support of a loving family. This interest outweighs any rights invoked on Nancy's behalf to terminate treatment in the face of the uncertainty of Nancy's wishes and her own right to life.

This State has expressed a strong policy favoring life. We believe that policy dictates that we err on the side of preserving life. If there is to be a change in that policy, it must come from the people through their elected representatives. Broad policy questions bearing on life and death issues are more properly addressed by representative assemblies. These have vast fact and opinion gathering and synthesizing powers unavailable to courts; the exercise of these powers is particularly appropriate where issues invoke the concerns of medicine, ethics, morality, philosophy, theology and law. Assuming change is appropriate, this issue demands a comprehensive resolution which courts cannot provide.

The efforts of courts to establish guidelines have been less than satisfactory. In *Quinlan*, the New Jersey Supreme Court attempted to establish guidelines for decisions concerning the termination of life support apparatus. More than ten years later, that same court wrote, “We recognize, ... that given the fundamental societal questions that must be resolved, the

³⁸ This holding was subsequently reviewed by the U.S. Supreme Court.

Legislature is the proper branch of government to set guidelines in this area...." *In re Farrell*, 529 A.2d at 407. *Quinlan* had failed to provide sufficient guidelines to meet the broad diversity of cases presenting termination of life-support issues.

To the extent that courts continue to invent guidelines on an *ad hoc*, piecemeal basis, legislatures, which have the ability to address the issue comprehensively, will feel no compulsion to act and will avoid making the potentially unpopular choices which issues of this magnitude present.

There is another compelling reason to leave changes in policy in this area to the legislature. Representative bodies generally move much more deliberately than do courts; they are a bit slow and ponderous. Courts, on the other hand, are facile and eager to find and impose a solution. But

[t]he medico-legal challenge in this debate is not, as is so often said, to overcome the failure of the law to keep pace with medical technology. The challenge is to prevent the dilemmas of medical decision-making from forcing upon us undesirable changes in the law.

Koop and Grant, "The 'Small Beginnings' of Euthanasia: Examining the Erosion in Legal Prohibitions Against Mercy-Killing," 2 *Journal of Law, Ethics & Public Policy* 585, 616 (1986). When facing issues of life and death, society is best served when decisions are surefooted, not swift and ultimately uncertain.

We find no principled legal basis which permits the coguardians in this case to choose the death of their ward. In the absence of such a legal basis for that decision and in the face of this State's strongly stated policy in favor of life, we choose to err on the side of life, respecting the rights of incompetent persons who may wish to live despite a severely diminished quality of life.

The judgment of the circuit court is reversed.

Cruzan v. Harmon, 760 S.W.2d 408, 426-427 (Mo. 1988).

In contrast to cases on similar issues in courts of 16 other states that were decided unanimously or by a large majority, the decision of the Missouri Supreme Court was by a slender 4 to 3 vote.

The essential holding of the opinion in the Missouri Supreme Court is that the surrogate decision maker, here Nancy Cruzan's parents, must prove by "clear and convincing" evidence that an incompetent person would want withdrawal of life-sustaining treatment.³⁹ However, this holding is mentioned tersely in three different sentences, which I have marked above with footnotes.

Justice Blackmar of the Missouri Supreme Court wrote an eloquent dissent, which was characterized by Justice Stevens of the U.S. Supreme Court as "persuasive".

The [majority] opinion frankly concedes that other courts, "Nearly unanimously ... have found a way to allow persons wishing to die, or those who seek the death of a ward, to meet the end sought." We of course are not bound by the decisions of other courts of coordinate authority, and may adopt unique rules, differing from all others, but we should certainly pause before departing from the overwhelming course of authority. Many other judges have struggled with problems similar to the ones before us. Their opinions demonstrate this struggle. It is often difficult to find the proper words to express a conclusion, and it is easy to

³⁹ *Cruzan*, 497 U.S. 261, 265, 268-269 (1990).

criticize the struggles of others. Our task, however, is to decide cases rather than to philosophize. The conclusion of the judges who have wrestled with the issues is entitled to great weight, and is significant in spite of difficulties of expression.

I believe that decisions about Nancy's future should be made by those near and dear to her, and that no state policy requires the state to intervene in these decisions. The principal opinion fails to convince me that the other judges who have dealt with this problem are wrong.

My disagreement with the principal opinion lies fundamentally in its emphasis on the interest of and the role of the state, represented by the Attorney General. Decisions about prolongation of life are of recent origin. For most of the world's history, and presently in most parts of the world, such decisions would never arise because the technology would not be available. Decisions about medical treatment have customarily been made by the patient, or by those closest to the patient if the patient, because of youth or infirmity, is unable to make the decisions. This is nothing new in substituted decisionmaking. The state is seldom called upon to be the decisionmaker.

I would not accept the assumption, inherent in the principal opinion, that, with our advanced technology, the state must necessarily become involved in a decision about using extraordinary measures to prolong life. Decisions of this kind are made daily by the patient or relatives, on the basis of medical advice and their conclusion as to what is best. Very few cases reach court, and I doubt whether this case would be before us but for the fact that Nancy lies in a state hospital. I do not place primary emphasis on the patient's expressions, except possibly in the very unusual case, of which I find no example in the books, in which the patient expresses a view that all available life supports should be made use of. Those closest to the patient are best positioned to make judgments about the patient's best interest.

In footnote 17 the principal opinion cites several cases in which courts have ordered procedures such as blood transfusions, over the religious objections of the parents. The state's goal there is to provide the medical procedures necessary to give the child a meaningful life. A decision to deny such treatment in the face of medical advice may be considered irrational and abusive. Or it may be said that the state balances the child's interest against the parents' religious views, which are considered outside the mainstream. I am sure that courts which have ordered transfusions or other procedures all have relied or acted on the basis of very strong medical opinion. The Cruzans' decision is of a very different nature, and I cannot conclude that it is irrational or abusive.

Nor would I accept the thought that decisions of relatives as guardians about life sustaining measures necessarily require judicial confirmation. I agree with those courts which hold that relatives may ordinarily make important decisions of this kind without going to court, unless there is a challenge. [FN3] Formal appointment as guardian may be requested, but should not always be necessary. When a person is without close relatives, it may be desirable to appoint a guardian of the person to consider decisions about medical treatment.

FN3. See, e.g., *In re Guardianship of Grant*, 109 Wash.2d 545, 747 P.2d 445, 456 (banc 1987); *In re Drabick*, 200 Cal.App.3d 185, 245 Cal.Rptr. 840 (1988).

I do not find the arguments about the state's interest in "preserving life," and the citation of various statutory provisions in support, particularly helpful. The very existence of capital punishment demonstrates a relativity of values by establishing the proposition that some lives are not worth preserving. Furthermore, the "Living Will" statute, which the majority finds to be "an expression of the policy of this state with regard to sanctity of life," in fact allows and encourages the pre-planned termination of life.

....

It is unrealistic to say that the preservation of life is an absolute, without regard to the quality of life. I make this statement only in the context of a case in which the trial judge has found that there is no chance for amelioration of Nancy's condition. The principal opinion accepts this conclusion. It is appropriate to consider the quality of life in making decisions about the extraordinary medical treatment. Those who have made decisions about such matters without resort to the courts certainly consider the quality of life, and balance this against the unpleasant consequences to the patient. There is evidence that Nancy may react to pain stimuli. If she has any awareness of her surroundings, her life must be a living hell. She is unable to express herself or to do anything at all to alter her situation. Her parents, who are her closest relatives, are best able to feel for her and to decide what is best for her. The state should not substitute its decisions for theirs. Nor am I impressed with the crypto-philosophers cited in the principal opinion, who declaim about the sanctity of any life without regard to its quality. They dwell in ivory towers.

Likewise unimpressive is the suggestion that the conclusions of the trial court, and of the overwhelming majority of courts which have considered the problem, open the door to wholesale euthanasia of persons considered to be defective, but not in a condition approaching Nancy's. A holding is precedent only for the facts of the particular case. The courts are open to protect incompetents against abuse.

Least of all can I accept the proposition that a judgment as the Cruzans seek is precluded by some amorphous legislative policy "favoring life," so that the courts may only deny this kind of relief until the legislature decrees otherwise. Under Mo. Const. Art. 1, Sec. 14, the courts are open to those who seek relief in proper cases involving actual controversies. The courts have the duty of deciding cases on the basis of what they consider right and just. We cannot shift our burden to the legislature. Nor would I depreciate the capacity of our courts. The common law would be poor indeed if such jurists as Sir Edward Coke and Lord Mansfield had been unwilling to reach their own conclusions about novel issues.

Cruzan, 760 S.W.2d at 427-429 (Blackmar, J., dissenting), three paragraphs quoted with approval in *Cruzan*, 497 U.S. at 336-337 (Stevens, J., dissenting).

Justice Blackmar of the Missouri Supreme Court concluded his dissent:

I am not persuaded that the state is a better decisionmaker than Nancy's parents. We should respect their decision even though, if similarly situated, we might elect to continue the feeding of a loved one. There should be great deference to the trial judge. The appellants have the normal burden of demonstrating error, which these defendants have not done.

The Cruzan family appropriately came before the court seeking relief. The circuit judge properly found the facts and applied the law. His factual findings are supported by the record and his legal conclusions by overwhelming weight of authority. The principal opinion attempts to establish absolutes, but does so at the expense of human factors. In so doing it unnecessarily subjects Nancy and those close to her to continuous torture which no family should be forced to endure. I am grasping for words which elude me, and so will not say more.

Cruzan, 760 S.W.2d at 429-430 (Blackmar, J., dissenting), last paragraph quoted with approval in *Cruzan*, 497 U.S. at 338 (Stevens, J., dissenting).

One commentator noted:

Because the [Missouri Supreme] court set *Cruzan* up as a “right-to-die” case rather than a “right to refuse treatment” case, it frequently dealt with irrelevant and misleading issues. For example, it focused on death and terminal illness without an apparent appreciation of the implications of either term. It used the phrase “Nancy is not dead” almost like a mantra in the opinion. Although the court seems to view this as a major discovery, no one was arguing that the law could or should require guardians to provide artificial feeding to corpses.

George J. Annas, “The Long Dying of Nancy Cruzan,” 19 *LAW, MEDICINE & HEALTH CARE* 52, 53 (1991). My search of the reported opinion in Westlaw shows that the majority opinion used the phrase “not dead” in connection with Nancy Cruzan a total of three times, each of which was quoted above.

U.S. Supreme Court

The U.S. Supreme Court decided only one narrow issue: could a state require evidence of a patient’s desire to terminate medical treatment at a “clear and convincing” level?

The majority opinion considered the common-law right to refuse medical treatment.

At common law, even the touching of one person by another without consent and without legal justification was a battery. See W. Keeton, D. Dobbs, R. Keeton, & D. Owen, *Prosser and Keeton on Law of Torts* 9, pp. 39-42 (5th ed. 1984). Before the turn of the century, this Court observed that “[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.” *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251, 11 S.Ct. 1000, 1001, 35 L.Ed. 734 (1891). This notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment. Justice Cardozo, while on the Court of Appeals of New York, aptly described this doctrine: “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.” *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129-130, 105 N.E. 92, 93 (1914). The informed consent doctrine has become firmly entrenched in American tort law. See Keeton, Dobbs, Keeton, & Owen, *supra*, 32, pp. 189-192; F. Rozovsky, *Consent to Treatment, A Practical Guide* 1-98 (2d ed. 1990).

The logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment. Until about 15 years ago and the seminal decision in *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, cert. denied *sub nom. Garger v. New Jersey*, 429 U.S. 922, 97 S.Ct. 319, 50 L.Ed.2d 289 (1976), the number of right-to-refuse-treatment decisions was relatively few. [FN2] Most of the earlier cases involved patients who refused medical treatment forbidden by their religious beliefs, thus implicating First Amendment rights as well as common-law rights of self-determination. [FN3] More recently, however, with the advance of medical technology capable of sustaining life well past the point where natural forces would have brought certain death in earlier times, cases involving the right to refuse life-sustaining treatment have burgeoned. See 760 S.W.2d, at 412, n. 4 (collecting 54 reported decisions from 1976 through 1988).

FN2. See generally Karnezis, Patient's Right to Refuse Treatment Allegedly Necessary to Sustain Life, 93 A.L.R.3d 67 (1979) (collecting cases); Cantor, A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life, 26 Rutgers L.Rev. 228, 229, and n. 5 (1973) (noting paucity of cases).

FN3. See Chapman, The Uniform Rights of the Terminally Ill Act: Too Little, Too Late?, 42 Ark.L.Rev. 319, 324, n. 15 (1989); see also F. Rozovsky, Consent to Treatment, A Practical Guide 415-423 (1984).

Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261, 269-270 (1990).

The majority opinion then reviews a number of cases, beginning with *Quinlan*, and concludes:

As these cases demonstrate, the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment. Beyond that, these cases demonstrate both similarity and diversity in their approaches to decision of what all agree is a perplexing question with unusually strong moral and ethical overtones. State courts have available to them for decision a number of sources — state constitutions, statutes, and common law — which are not available to us. In this Court, the question is simply and starkly whether the United States Constitution prohibits Missouri from choosing the rule of decision which it did. This is the first case in which we have been squarely presented with the issue whether the United States Constitution grants what is in common parlance referred to as a "right to die." We follow the judicious counsel of our decision in *Twin City Bank v. Nebeker*, 167 U.S. 196, 202, 17 S.Ct. 766, 769, 42 L.Ed. 134 (1897), where we said that in deciding "a question of such magnitude and importance ... it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject."

The Fourteenth Amendment provides that no State shall "deprive any person of life, liberty, or property, without due process of law." The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.⁴⁰ In *Jacobson v. Massachusetts*, 197 U.S. 11, 24-30, 25 S.Ct. 358, 360-361, 49 L.Ed. 643 (1905), for instance, the Court balanced an individual's liberty interest in declining an unwanted smallpox vaccine against the State's interest in preventing disease. Decisions prior to the incorporation of the Fourth Amendment into the Fourteenth Amendment analyzed searches and seizures involving the body under the Due Process Clause and were thought to implicate substantial liberty interests. See, e.g., *Breithaupt v. Abram*, 352 U.S. 432, 439, 77 S.Ct. 408, 412, 1 L.Ed.2d 448 (1957) ("As against the right of an individual that his person be held inviolable ... must be set the interests of society ...").

Just this Term, in the course of holding that a State's procedures for administering antipsychotic medication to prisoners were sufficient to satisfy due process concerns, we recognized that prisoners possess "a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment." *Washington v. Harper*, 494 U.S. 210, 221-222, 110 S.Ct. 1028, 1036, 108 L.Ed.2d 178 (1990); see also *id.*, at 229, 110 S.Ct., at 1041 ("The forcible injection of

⁴⁰ The U.S. Court of Appeals for the Ninth Circuit quoted this sentence and argued that "the Court found a liberty interest and assumed a liberty right." *Compassion in Dying v. State of Washington*, 79 F.3d 790, 814, n. 67 (9th Cir. 1996) (en banc), *rev'd on other grounds sub nom. Washington v. Glucksberg*, 521 U.S. 702, 723-725 (1997). See also *Quill v. Vacco*, 80 F.3d 716, 728 (2d Cir. 1996), *rev'd on other grounds*, 521 U.S. 793 (1997).

medication into a nonconsenting person's body represents a substantial interference with that person's liberty"). Still other cases support the recognition of a general liberty interest in refusing medical treatment. *Vitek v. Jones*, 445 U.S. 480, 494, 100 S.Ct. 1254, 1264, 63 L.Ed.2d 552 (1980) (transfer to mental hospital coupled with mandatory behavior modification treatment implicated liberty interests); *Parham v. J.R.*, 442 U.S. 584, 600, 99 S.Ct. 2493, 2503, 61 L.Ed.2d 101 (1979) ("[A] child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment").

But determining that a person has a "liberty interest" under the Due Process Clause does not end the inquiry; [FN7] "whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests." *Youngberg v. Romeo*, 457 U.S. 307, 321, 102 S.Ct. 2452, 2461, 73 L.Ed.2d 28 (1982). See also *Mills v. Rogers*, 457 U.S. 291, 299, 102 S.Ct. 2442, 2448, 73 L.Ed.2d 16 (1982).

FN7. Although many state courts have held that a right to refuse treatment is encompassed by a generalized constitutional right of privacy, we have never so held. We believe this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest. See *Bowers v. Hardwick*, 478 U.S. 186, 194-195, 106 S.Ct. 2841, 2846, 92 L.Ed.2d 140 (1986).

Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261, 277-279 (1990).

The U.S. Supreme Court then avoid deciding whether the right to refuse medical care is a new constitutional right, by *assuming*, for purposes of argument, that the right exists.

Petitioners [i.e., the parents of Nancy Cruzan] insist that under the general holdings of our cases, the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life, would implicate a competent person's liberty interest. Although we think the logic of the cases discussed above would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we *assume* [emphasis added] that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.

Petitioners go on to assert that an incompetent person should possess the same right in this respect as is possessed by a competent person. They rely primarily on our decisions in *Parham v. J.R.*, *supra*, and *Youngberg v. Romeo*, *supra*, 102 S.Ct. 2452, 73 L.Ed.2d 28 (1982). In *Parham*, we held that a mentally disturbed minor child had a liberty interest in "not being confined unnecessarily for medical treatment," 442 U.S., at 600, 99 S.Ct., at 2503, but we certainly did not intimate that such a minor child, after commitment, would have a liberty interest in refusing treatment. In *Youngberg*, we held that a seriously retarded adult had a liberty interest in safety and freedom from bodily restraint, 457 U.S., at 320, 102 S.Ct., at 2460. *Youngberg*, however, did not deal with decisions to administer or withhold medical treatment.

The difficulty with petitioners' claim is that in a sense it begs the question: An incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right. Such a "right" must be exercised for her, if at all, by some sort of surrogate. Here, Missouri has in effect recognized that under certain circumstances a surrogate may act for the patient in electing to have hydration and nutrition withdrawn in such a way as to cause death, but it has established a procedural safeguard to assure that the action of the surrogate conforms as best it may to the wishes expressed by the patient while competent. Missouri requires that evidence of the incompetent's wishes as to the withdrawal of treatment be proved by clear and convincing

evidence. The question, then, is whether the United States Constitution forbids the establishment of this procedural requirement by the State. We hold that it does not. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 279-280 (1990).

The U.S. Supreme Court then presented its reasoning for its holding about evidence at a “clear and convincing” level of proof.:

Whether or not Missouri's clear and convincing evidence requirement comports with the United States Constitution depends in part on what interests the State may properly seek to protect in this situation. Missouri relies on its interest in the protection and preservation of human life, and there can be no gainsaying this interest. As a general matter, the States — indeed, all civilized nations — demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide. [FN8] We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death.

FN8. See Smith, *All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?*, 22 U.C.D.L.Rev. 275, 290-291, and n. 106 (1989) (compiling statutes).

But in the context presented here, a State has more particular interests at stake. The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements. It cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment.⁴¹ Not all incompetent patients will have loved ones available to serve as surrogate decisionmakers. And even where family members are present, “[t]here will, of course, be some unfortunate situations in which family members will not act to protect a patient.” *In re Jobes*, 108 N.J. 394, 419, 529 A.2d 434, 447 (1987). A State is entitled to guard against potential abuses in such situations. Similarly, a State is entitled to consider that a judicial proceeding to make a determination regarding an incompetent's wishes may very well not be an adversarial one, with the added guarantee of accurate factfinding that the adversary process brings with it. [FN9] See *Ohio v. Akron Center for Reproductive Health*, 497 U.S. 502, 515-516, 110 S.Ct. 2972, 2981-2982, 111 L.Ed.2d 405 (1990). Finally, we think a State may properly decline to make judgments about the “quality” of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.

FN9. Since *Cruzan* was a patient at a state hospital when this litigation commenced, the State has been involved as an adversary from the beginning. However, it can be expected that many disputes of this type will arise in private institutions, where a guardian *ad litem* or similar party will have

⁴¹ The U.S. Court of Appeals for the Ninth Circuit quoted this sentence, among others, and concluded: “These passages make it clear that *Cruzan* stands for the proposition that there is a due process liberty interest in rejecting unwanted medical treatment, including the provision of food and water by artificial means.” *Compassion in Dying v. State of Washington*, 79 F.3d 790, 815 (9thCir. 1996) (en banc), *rev'd on other grounds sub nom. Washington v. Glucksberg*, 521 U.S. 702 (1997). See also *Quill v. Vacco*, 80 F.3d 716, 736 (2dCir. 1996) (Calabresi, J., concurring), *rev'd on other grounds*, 521 U.S. 793 (1997).

been appointed as the sole representative of the incompetent individual in the litigation. In such cases, a guardian may act in entire good faith, and yet not maintain a position truly adversarial to that of the family. Indeed, as noted by the court below, "[t]he guardian *ad litem* [in this case] finds himself in the predicament of believing that it is in Nancy's 'best interest to have the tube feeding discontinued,' but 'feeling that an appeal should be made because our responsibility to her as attorneys and guardians *ad litem* was to pursue this matter to the highest court in the state in view of the fact that this is a case of first impression in the State of Missouri.'" 760 S.W.2d, at 410, n. 1. Cruzan's guardian *ad litem* has also filed a brief in this Court urging reversal of the Missouri Supreme Court's decision. None of this is intended to suggest that the guardian acted the least bit improperly in this proceeding. It is only meant to illustrate the limits which may obtain on the adversarial nature of this type of litigation.

In our view, Missouri has permissibly sought to advance these interests through the adoption of a "clear and convincing" standard of proof to govern such proceedings. "The function of a standard of proof, as that concept is embodied in the Due Process Clause and in the realm of factfinding, is to 'instruct the factfinder concerning the degree of confidence our society thinks he should have in the correctness of factual conclusions for a particular type of adjudication.'" *Addington v. Texas*, 441 U.S. 418, 423, 99 S.Ct. 1804, 1808, 60 L.Ed.2d 323 (1979) (quoting *In re Winship*, 397 U.S. 358, 370, 90 S.Ct. 1068, 1076, 25 L.Ed.2d 368 (1970) (Harlan, J., concurring)). "This Court has mandated an intermediate standard of proof — 'clear and convincing evidence' — when the individual interests at stake in a state proceeding are both 'particularly important' and 'more substantial than mere loss of money.'" *Santosky v. Kramer*, 455 U.S. 745, 756, 102 S.Ct. 1388, 1397, 71 L.Ed.2d 599 (1982) (quoting *Addington, supra*, at 424, 99 S.Ct., at 1808). Thus, such a standard has been required in deportation proceedings, *Woodby v. INS*, 385 U.S. 276, 87 S.Ct. 483, 17 L.Ed.2d 362 (1966), in denaturalization proceedings, *Schneiderman v. United States*, 320 U.S. 118, 63 S.Ct. 1333, 87 L.Ed. 1796 (1943), in civil commitment proceedings, *Addington, supra*, and in proceedings for the termination of parental rights, *Santosky, supra*. [FN10] Further, this level of proof, "or an even higher one, has traditionally been imposed in cases involving allegations of civil fraud, and in a variety of other kinds of civil cases involving such issues as ... lost wills, oral contracts to make bequests, and the like." *Woodby, supra*, 385 U.S., at 285, n. 18, 87 S.Ct., at 488, n. 18.

FN10. We recognize that these cases involved instances where the government sought to take action against an individual. See *Price Waterhouse v. Hopkins*, 490 U.S. 228, 253, 109 S.Ct. 1775, 1792, 104 L.Ed.2d 268 (1989) (plurality opinion). Here, by contrast, the government seeks to protect the interests of an individual, as well as its own institutional interests, in life. We do not see any reason why important individual interests should be afforded less protection simply because the government finds itself in the position of defending them. "[W]e find it significant that ... the defendant rather than the plaintiff" seeks the clear and convincing standard of proof — "suggesting that this standard ordinarily serves as a shield rather than ... a sword." *Id.*, at 253, 109 S.Ct., at 1792. That it is the government that has picked up the shield should be of no moment.

We think it self-evident that the interests at stake in the instant proceedings are more substantial, both on an individual and societal level, than those involved in a run-of-the-mine civil dispute. But not only does the standard of proof reflect the importance of a particular adjudication, it also serves as "a societal judgment about how the risk of error should be distributed between the litigants." *Santosky, supra*, 455 U.S. at 755, 102 S.Ct., at 1395; *Addington, supra*, 441 U.S., at 423, 99 S.Ct., at 1807- 1808. The more stringent the burden of proof a party must bear, the more that party bears the risk of an erroneous decision. We believe that Missouri may permissibly place an increased risk of an erroneous decision on those seeking to terminate an incompetent individual's life-sustaining treatment. An erroneous decision not to terminate results in a maintenance of the status quo; the possibility

of subsequent developments such as advancements in medical science, the discovery of new evidence regarding the patient's intent, changes in the law, or simply the unexpected death of the patient despite the administration of life-sustaining treatment at least create the potential that a wrong decision will eventually be corrected or its impact mitigated. An erroneous decision to withdraw life-sustaining treatment, however, is not susceptible of correction. In *Santosky*, one of the factors which led the Court to require proof by clear and convincing evidence in a proceeding to terminate parental rights was that a decision in such a case was final and irrevocable. *Santosky, supra*, 445 U.S., at 759, 102 S.Ct., at 1397-1398. The same must surely be said of the decision to discontinue hydration and nutrition of a patient such as Nancy Cruzan, which all agree will result in her death.

It is also worth noting that most, if not all, States simply forbid oral testimony entirely in determining the wishes of parties in transactions which, while important, simply do not have the consequences that a decision to terminate a person's life does. At common law and by statute in most States, the parol evidence rule prevents the variations of the terms of a written contract by oral testimony. The statute of frauds makes unenforceable oral contracts to leave property by will, and statutes regulating the making of wills universally require that those instruments be in writing. See 2 A. Corbin, *Contracts* 398, pp. 360-361 (1950); 2 W. Page, *Law of Wills* 19.3- 19.5, pp. 61-71 (1960). There is no doubt that statutes requiring wills to be in writing, and statutes of frauds which require that a contract to make a will be in writing, on occasion frustrate the effectuation of the intent of a particular decedent, just as Missouri's requirement of proof in this case may have frustrated the effectuation of the not-fully-expressed desires of Nancy Cruzan. But the Constitution does not require general rules to work faultlessly; no general rule can.

In sum, we conclude that a State may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration of a person diagnosed to be in a persistent vegetative state. We note that many courts which have adopted some sort of substituted judgment procedure in situations like this, whether they limit consideration of evidence to the prior expressed wishes of the incompetent individual, or whether they allow more general proof of what the individual's decision would have been, require a clear and convincing standard of proof for such evidence. See, e.g., *Longeway*, 133 Ill.2d, at 50-51, 139 Ill.Dec., at 787, 549 N.E.2d, at 300; *McConnell*, 209 Conn., at 707-710, 553 A.2d, at 604-605; *O'Connor*, 72 N.Y.2d, at 529-530, 531 N.E.2d, at 613; *In re Gardner*, 534 A.2d 947, 952-953 (Me. 1987); *In re Jobes*, 108 N.J., at 412- 413, 529 A.2d, at 443; *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 11, 426 N.E.2d 809, 815 (1980).

The Supreme Court of Missouri held that in this case the testimony adduced at trial did not amount to clear and convincing proof of the patient's desire to have hydration and nutrition withdrawn. In so doing, it reversed a decision of the Missouri trial court which had found that the evidence "suggest [ed]" Nancy Cruzan would not have desired to continue such measures, App. to Pet. for Cert. A98, but which had not adopted the standard of "clear and convincing evidence" enunciated by the Supreme Court. The testimony adduced at trial consisted primarily of Nancy Cruzan's statements made to a housemate about a year before her accident that she would not want to live should she face life as a "vegetable," and other observations to the same effect. The observations did not deal in terms with withdrawal of medical treatment or of hydration and nutrition. We cannot say that the Supreme Court of Missouri committed constitutional error in reaching the conclusion that it did.

[footnote omitted]

Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261, 280-285 (1990).

An addition issue, which the U.S. Supreme Court did not decide,⁴² was whether a spouse or parents could substitute their values for the values of an incompetent patient. The Court wrote two paragraphs on that topic.

Petitioners alternatively contend that Missouri must accept the "substituted judgment" of close family members even in the absence of substantial proof that their views reflect the views of the patient. They rely primarily upon our decisions in *Michael H. v. Gerald D.*, 491 U.S. 110, 109 S.Ct. 2333, 105 L.Ed.2d 91 (1989), and *Parham v. J.R.*, 442 U.S. 584, 99 S.Ct. 2493, 61 L.Ed.2d 101 (1979). But we do not think these cases support their claim. In *Michael H.*, we upheld the constitutionality of California's favored treatment of traditional family relationships; such a holding may not be turned around into a constitutional requirement that a State *must* recognize the primacy of those relationships in a situation like this. And in *Parham*, where the patient was a minor, we also upheld the constitutionality of a state scheme in which parents made certain decisions for mentally ill minors. Here again petitioners would seek to turn a decision which allowed a State to rely on family decisionmaking into a constitutional requirement that the State recognize such decisionmaking. But constitutional law does not work that way.

No doubt is engendered by anything in this record but that Nancy Cruzan's mother and father are loving and caring parents. If the State were required by the United States Constitution to repose a right of "substituted judgment" with anyone, the Cruzans would surely qualify. But we do not think the Due Process Clause requires the State to repose judgment on these matters with anyone but the patient herself. Close family members may have a strong feeling — a feeling not at all ignoble or unworthy, but not entirely disinterested, either — that they do not wish to witness the continuation of the life of a loved one which they regard as hopeless, meaningless, and even degrading. But there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had she been confronted with the prospect of her situation while competent. All of the reasons previously discussed for allowing Missouri to require clear and convincing evidence of the patient's wishes lead us to conclude that the State may choose to defer only to those wishes, rather than confide the decision to close family members *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 285-287 (1990).

What is the effect of the U.S. Supreme Court decision in *Cruzan*? Missouri can continue its law of insisting that surrogate decision makers use only the values of the patient. New Jersey is free to use its enlightened law. The U.S. Supreme Court sets only minimum standards of freedom under the U.S. Constitution. States are free to provide more freedom than the federal minimum. Prof. Annas, a well-known attorney who specializes in health policy, described the U.S. Supreme Court's decision in *Cruzan* in the following way:

The U.S. Supreme Court did not set standards of medical practice for the country in deciding this case. It simply decided that Missouri could constitutionally adopt a particular evidentiary standard. It is thus correct to say, as does the bioethicists' statement elsewhere in this issue, [footnote to p. 686] that this very narrow decision "does not alter the laws, ethical

⁴² *Cruzan*, 497 U.S. at 289 (O'Connor, J., concurring) ("I also write separately to emphasize that the Court does not today decide the issue whether a State must also give effect to the decisions of a surrogate decisionmaker. [citation to majority opinion omitted] In my view, such a duty may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment.").

standards, or clinical practices permitting the forgoing of life-sustaining treatment that have evolved in the United States since the *Quinlan* case in 1976.”

....

The truth is, if the state of Missouri can inflict its will on [Nancy] Cruzan and her family, none of us are safe from states that wish to control our health care decisions and our deaths.

....

The reality is that the *Cruzan* opinion does not change the law in any state or in any way alter what physicians could or could not do before the opinion. It simply says that existing law in Missouri requiring clear and convincing evidence of a previously competent patient’s wishes is constitutional and need not be changed. It also means that other states are free to adopt a similar evidentiary standard, but no state is required to do so.

George J. Annas, “Sounding Board: Nancy Cruzan and the Right to Die,” 323 NEW ENGLAND JOURNAL OF MEDICINE 670, 671-672 (6 Sep 1990).

Commentators⁴³ have noted that a majority of justices (the four dissenters plus Justice O’Connor in her concurring opinion)⁴⁴ at the U.S. Supreme Court agreed that the U.S. Constitution protects the right of a patient to refuse medical treatment. However, this recognition of a new constitutional right is *not* law, because it involves a dissenting opinion. Unlike the various state courts that had found a privacy right, the majority opinion of the U.S. Supreme Court suggested the right to refuse medical treatment — if the constitutional right exists — comes from the due process clause of the Fourteenth Amendment.

Justice Brennan’s dissent

Justice Brennan wrote an eloquent dissenting opinion, which was joined by Justices Marshall and Blackmun.

Medical technology has effectively created a twilight zone of suspended animation where death commences while life, in some form, continues. Some patients, however, want no part of a life sustained only by medical technology. Instead, they prefer a plan of medical treatment that allows nature to take its course and permits them to die with dignity.

Rasmussen v. Fleming, 154 Ariz. 207, 211, 741 P.2d 674, 678 (1987) (en banc).

Nancy Cruzan has dwelt in that twilight zone for six years. She is oblivious to her surroundings and will remain so. *Cruzan v. Harmon*, 760 S.W.2d 408, 411 (Mo. 1988). Her body twitches only reflexively, without consciousness. *Ibid.* The areas of her brain that

⁴³ See, e.g., George J. Annas, “The Long Dying of Nancy Cruzan,” 19 Law, Medicine & Health Care 52, 55 (1991).

⁴⁴ *Cruzan*, 497 U.S. at 287 (O’Connor, J., concurring), 497 U.S. at 303-314 (Brennan, J., dissenting, joined by Justices Marshall and Blackmun), 497 U.S. at 338-339 (Stevens, J., dissenting).

once thought, felt, and experienced sensations have degenerated badly and are continuing to do so. The cavities remaining are filling with cerebro-spinal fluid. The "cerebral cortical atrophy is irreversible, permanent, progressive and ongoing." *Ibid.* "Nancy will never interact meaningfully with her environment again. She will remain in a persistent vegetative state until her death." *Id.*, at 422. [FN2] Because she cannot swallow, her nutrition and hydration are delivered through a tube surgically implanted in her stomach.

FN2. Vegetative state patients may *react reflexively* to sounds, movements, and normally painful stimuli, but they do not *feel* any pain or *sense* anybody or anything. Vegetative state patients may appear awake but are completely unaware. See Cranford, *The Persistent Vegetative State: The Medical Reality*, 18 *Hastings Ctr.Rep.* 27, 28, 31 (1988).

A grown woman at the time of the accident, Nancy had previously expressed her wish to forgo continuing medical care under circumstances such as these. Her family and her friends are convinced that this is what she would want. See n. 20, *infra*. A guardian ad litem appointed by the trial court is also convinced that this is what Nancy would want. See 760 S.W.2d, at 444 (Higgins, J., dissenting from denial of rehearing). Yet the Missouri Supreme Court, alone among state courts deciding such a question, has determined that an irreversibly vegetative patient will remain a passive prisoner of medical technology — for Nancy, perhaps for the next 30 years. See *id.*, at 424, 427.

Today the Court, while tentatively accepting that there is some degree of constitutionally protected liberty interest in avoiding unwanted medical treatment, including life-sustaining medical treatment such as artificial nutrition and hydration, affirms the decision of the Missouri Supreme Court. The majority opinion, as I read it, would affirm that decision on the ground that a State may require "clear and convincing" evidence of Nancy Cruzan's prior decision to forgo life-sustaining treatment under circumstances such as hers in order to ensure that her actual wishes are honored. See *ante*, at 2853-2854, 2855-2856. Because I believe that Nancy Cruzan has a fundamental right to be free of unwanted artificial nutrition and hydration, which right is not outweighed by any interests of the State, and because I find that the improperly biased procedural obstacles imposed by the Missouri Supreme Court impermissibly burden that right, I respectfully dissent. Nancy Cruzan is entitled to choose to die with dignity.

"[T]he timing of death — once a matter of fate — is now a matter of human choice." Office of Technology Assessment Task Force, *Life Sustaining Technologies and the Elderly* 41 (1988). Of the approximately 2 million people who die each year, 80% die in hospitals and long-term care institutions, [FN3] and perhaps 70% of those after a decision to forgo life-sustaining treatment has been made. [FN4] Nearly every death involves a decision whether to undertake some medical procedure that could prolong the process of dying. Such decisions are difficult and personal. They must be made on the basis of individual values, informed by medical realities, yet within a framework governed by law. The role of the courts is confined to defining that framework, delineating the ways in which government may and may not participate in such decisions.

FN3. See President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life Sustaining Treatment* 15, n. 1, and 17-18 (1983) (hereafter *President's Commission*).

FN4. See Lipton, *Do-Not-Resuscitate Decisions in a Community Hospital: Incidence, Implications and Outcomes*, 256 *JAMA* 1164, 1168 (1986).

The question before this Court is a relatively narrow one: whether the Due Process Clause allows Missouri to require a now-incompetent patient in an irreversible persistent vegetative state to remain on life support absent rigorously clear and convincing evidence that avoiding the treatment represents the patient's prior, express choice. See *ante*, at 2851. If a fundamental right is at issue, Missouri's rule of decision must be scrutinized under the standards this Court has always applied in such circumstances. As we said in *Zablocki v. Redhail*, 434 U.S. 374, 388, 98 S.Ct. 673, 682, 54 L.Ed.2d 618 (1978), if a requirement imposed by a State "significantly interferes with the exercise of a fundamental right, it cannot be upheld unless it is supported by sufficiently important state interests and is closely tailored to effectuate only those interests." The Constitution imposes on this Court the obligation to "examine carefully ... the extent to which [the legitimate government interests advanced] are served by the challenged regulation." *Moore v. East Cleveland*, 431 U.S. 494, 499, 97 S.Ct. 1932, 1936, 52 L.Ed.2d 531 (1977). See also *Carey v. Population Services International*, 431 U.S. 678, 690, 97 S.Ct. 2010, 2018-2019, 52 L.Ed.2d 675 (1977) (invalidating a requirement that bore "no relation to the State's interest"). An evidentiary rule, just as a substantive prohibition, must meet these standards if it significantly burdens a fundamental liberty interest. Fundamental rights "are protected not only against heavy-handed frontal attack, but also from being stifled by more subtle governmental interference." *Bates v. Little Rock*, 361 U.S. 516, 523, 80 S.Ct. 412, 416, 4 L.Ed.2d 480 (1960).

The starting point for our legal analysis must be whether a competent person has a constitutional right to avoid unwanted medical care. Earlier this Term, this Court held that the Due Process Clause of the Fourteenth Amendment confers a significant liberty interest in avoiding unwanted medical treatment. *Washington v. Harper*, 494 U.S. 210, 221-222, 110 S.Ct. 1028, 1036-1037, 108 L.Ed.2d 178 (1990). Today, the Court concedes that our prior decisions "support the recognition of a general liberty interest in refusing medical treatment." See *ante*, at 2851. The Court, however, avoids discussing either the measure of that liberty interest or its application by assuming, for purposes of this case only, that a competent person has a constitutionally protected liberty interest in being free of unwanted artificial nutrition and hydration. See *ante*, at 2851-2852. Justice O'CONNOR's opinion is less parsimonious. She openly affirms that "the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause," that there is a liberty interest in avoiding unwanted medical treatment, and that it encompasses the right to be free of "artificially delivered food and water." See *ante*, at 2856.

But if a competent person has a liberty interest to be free of unwanted medical treatment, as both the majority and Justice O'CONNOR concede, it must be fundamental. "We are dealing here with [a decision] which involves one of the basic civil rights of man." *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 541, 62 S.Ct. 1110, 1113, 86 L.Ed. 1655 (1942) (invalidating a statute authorizing sterilization of certain felons). Whatever other liberties protected by the Due Process Clause are fundamental, "those liberties that are 'deeply rooted in this Nation's history and tradition' " are among them. *Bowers v. Hardwick*, 478 U.S. 186, 192, 106 S.Ct. 2841, 2844, 92 L.Ed.2d 140 (1986) (quoting *Moore v. East Cleveland*, *supra*, 431 U.S., at 503, 97 S.Ct., at 1938 (plurality opinion)). "Such a tradition commands respect in part because the Constitution carries the gloss of history." *Richmond Newspapers, Inc. v. Virginia*, 448 U.S. 555, 589, 100 S.Ct. 2814, 2834, 65 L.Ed.2d 973 (1980) (BRENNAN, J., concurring in judgment).

The right to be free from medical attention without consent, to determine what shall be done with one's own body, *is* deeply rooted in this Nation's traditions, as the majority acknowledges. See *ante*, at 2847. This right has long been "firmly entrenched in American tort law" and is securely grounded in the earliest common law. *Ibid*. See also *Mills v. Rogers*, 457 U.S. 291, 294, n. 4, 102 S.Ct. 2442, 2446, n. 4, 73 L.Ed.2d 16 (1982) ("[T]he

right to refuse any medical treatment emerged from the doctrines of trespass and battery, which were applied to unauthorized touchings by a physician"). "Anglo-American law starts with the premise of thorough-going self determination. It follows that each man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of lifesaving surgery, or other medical treatment." *Natanson v. Kline*, 186 Kan. 393, 406-407, 350 P.2d 1093, 1104 (1960). "The inviolability of the person" has been held as "sacred" and "carefully guarded" as any common-law right. *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251-252, 11 S.Ct. 1000, 1001, 35 L.Ed. 734 (1891). Thus, freedom from unwanted medical attention is unquestionably among those principles "so rooted in the traditions and conscience of our people as to be ranked as fundamental." *Snyder v. Massachusetts*, 291 U.S. 97, 105, 54 S.Ct. 330, 332, 78 L.Ed. 674 (1934). [FN5]

FN5. See, e.g., *Canterbury v. Spence*, 150 U.S.App.D.C. 263, 271, 464 F.2d 772, 780, cert. denied, 409 U.S. 1064 (1972) ("The root premise" of informed consent "is the concept, fundamental in American jurisprudence, that '[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body' ") (quoting *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129-130, 105 N.E. 92, 93 (1914) (Cardozo, J.)). See generally *Washington v. Harper*, 494 U.S. 210, 241, 110 S.Ct. 1028, 1047, 108 L.Ed.2d 178 (1990) (STEVENS, J., dissenting) ("There is no doubt ... that a competent individual's right to refuse [psychotropic] medication is a fundamental liberty interest deserving the highest order of protection").

That there may be serious consequences involved in refusal of the medical treatment at issue here does not vitiate the right under our common-law tradition of medical self-determination. It is "a well-established rule of general law ... that it is the patient, not the physician, who ultimately decides if treatment — any treatment — is to be given at all.... The rule has never been qualified in its application by either the nature or purpose of the treatment, or the gravity of the consequences of acceding to or foregoing it." *Tune v. Walter Reed Army Medical Hospital*, 602 F.Supp. 1452, 1455 (DC 1985). See also *Downer v. Veilleux*, 322 A.2d 82, 91 (Me. 1974) ("The rationale of this rule lies in the fact that every competent adult has the right to forego treatment, or even cure, if it entails what for him are intolerable consequences or risks, however unwise his sense of values may be to others"). [FN6]

FN6. Under traditional tort law, exceptions have been found only to protect dependent children. See *Cruzan v. Harmon*, 760 S.W.2d 408, 422, n. 17 (Mo. 1988) (citing cases where Missouri courts have ordered blood transfusions for children over the religious objection of parents); see also *Winthrop University Hospital v. Hess*, 128 Misc.2d 804, 490 N.Y.S.2d 996 (Sup.Ct. Nassau Cty. 1985) (court ordered blood transfusion for religious objector because she was the mother of an infant and had explained that her objection was to the signing of the consent, not the transfusion itself); *Application of President & Directors of Georgetown College, Inc.*, 118 U.S.App.D.C. 80, 88, 331 F.2d 1000, 1008 (blood transfusion ordered for mother of infant); cert. denied, 377 U.S. 978, 84 S.Ct. 1883, 12 L.Ed.2d 746 (1964). Cf. *In re Estate of Brooks*, 32 Ill.2d 361, 373, 205 N.E.2d 435, 441-442 (1965) (finding that lower court erred in ordering a blood transfusion for a woman--whose children were grown--and concluding: "Even though we may consider appellant's beliefs unwise, foolish or ridiculous, in the absence of an overriding danger to society we may not permit interference therewith in the form of a conservatorship established in the waning hours of her life for the sole purpose of compelling her to accept medical treatment forbidden by her religious principles, and previously refused by her with full knowledge of the probable consequences"). *Cruzan*, 497 U.S. at 301-306 (Brennan, J., dissenting).

After recognizing the right to refuse medical treatment, Justice Brennan explained why that right also included the right to refuse hydration and nutrition via a feeding tube.

No material distinction can be drawn between the treatment to which Nancy Cruzan continues to be subject — artificial nutrition and hydration — and any other medical treatment. See *ante*, at 2857 (O'CONNOR, J., concurring). The artificial delivery of nutrition and hydration is undoubtedly medical treatment. The technique to which Nancy Cruzan is subject — artificial feeding through a gastrostomy tube — involves a tube implanted surgically into her stomach through incisions in her abdominal wall. It may obstruct the intestinal tract, erode and pierce the stomach wall, or cause leakage of the stomach's contents into the abdominal cavity. See Page, Andrassy, & Sandler, Techniques in Delivery of Liquid Diets, in *Nutrition in Clinical Surgery* 66-67 (M. Deitel 2d ed. 1985). The tube can cause pneumonia from reflux of the stomach's contents into the lung. See Bernard & Forlaw, Complications and Their Prevention, in *Enteral and Tube Feeding* 553 (J. Rombeau & M. Caldwell eds. 1984). Typically, and in this case (see Tr. 377), commercially prepared formulas are used, rather than fresh food. See Matarese, Enteral Alimentation, in *Surgical Nutrition* 726 (J. Fischer ed. 1983). The type of formula and method of administration must be experimented with to avoid gastrointestinal problems. *Id.*, at 748. The patient must be monitored daily by medical personnel as to weight, fluid intake, and fluid output; blood tests must be done weekly. *Id.*, at 749, 751.

Artificial delivery of food and water is regarded as medical treatment by the medical profession and the Federal Government. [FN7] According to the American Academy of Neurology: "The artificial provision of nutrition and hydration is a form of medical treatment ... analogous to other forms of life-sustaining treatment, such as the use of the respirator. When a patient is unconscious, both a respirator and an artificial feeding device serve to support or replace normal bodily functions that are compromised as a result of the patient's illness." Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient, 39 *Neurology* 125 (Jan.1989). See also Council on Ethical and Judicial Affairs of the American Medical Association, Current Opinions, Opinion 2.20 (1989) ("Life-prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration"); President's Commission 88 (life-sustaining treatment includes respirators, kidney dialysis machines, and special feeding procedures). The Federal Government permits the cost of the medical devices and formulas used in enteral feeding to be reimbursed under Medicare. See Pub.L. 99-509, 9340, note following 42 U.S.C. § 1395u, p. 592 (1982 ed., Supp. V). The formulas are regulated by the federal Food and Drug Administration as "medical foods," see 21 U.S.C. § 360ee, and the feeding tubes are regulated as medical devices, 21 CFR § 876.5980 (1989).

FN7. The Missouri court appears to be alone among state courts to suggest otherwise, 760 S.W.2d, at 419 and 423, although the court did not rely on a distinction between artificial feeding and other forms of medical treatment. *Id.*, at 423. See, e.g., *Delio v. Westchester County Medical Center*, 129 App.Div.2d 1, 19, 516 N.Y.S.2d 677, 689 (1987) ("[R]eview of the decisions in other jurisdictions ... failed to uncover a single case in which a court confronted with an application to discontinue feeding by artificial means has evaluated medical procedures to provide nutrition and hydration differently from other types of life-sustaining procedures").

Nor does the fact that Nancy Cruzan is now incompetent deprive her of her fundamental rights. See *Youngberg v. Romeo*, 457 U.S. 307, 315-316, 319, 102 S.Ct. 2452, 2459-2460, 73 L.Ed.2d 28 (1982) (holding that severely retarded man's liberty interests in safety, freedom

from bodily restraint, and reasonable training survive involuntary commitment); *Parham v. J.R.*, 442 U.S. 584, 600, 99 S.Ct. 2493, 2503, 61 L.Ed.2d 101 (1979) (recognizing a child's substantial liberty interest in not being confined unnecessarily for medical treatment); *Jackson v. Indiana*, 406 U.S. 715, 730, 738, 92 S.Ct. 1845, 1858, 32 L.Ed.2d 435 (1972) (holding that Indiana could not violate the due process and equal protection rights of a mentally retarded deaf mute by committing him for an indefinite amount of time simply because he was incompetent to stand trial on the criminal charges filed against him). As the majority recognizes, *ante*, at 2852, the question is not whether an incompetent has constitutional rights, but how such rights may be exercised. As we explained in *Thompson v. Oklahoma*, 487 U.S. 815, 108 S.Ct. 2687, 101 L.Ed.2d 702 (1988): "[T]he law must often adjust the manner in which it affords rights to those whose status renders them unable to exercise choice freely and rationally. Children, the insane, and *those who are irreversibly ill with loss of brain function, for instance, all retain 'rights,'* to be sure, but often such rights are only meaningful as they are exercised by agents acting with the best interests of their principals in mind." *Id.*, at 825, n. 23, 108 S.Ct., at 2693, n. 23 (emphasis added). "To deny [its] exercise because the patient is unconscious or incompetent would be to deny the right." *Foody v. Manchester Memorial Hospital*, 40 Conn.Supp. 127, 133, 482 A.2d 713, 718 (1984).

The right to be free from unwanted medical attention is a right to evaluate the potential benefit of treatment and its possible consequences according to one's own values and to make a personal decision whether to subject oneself to the intrusion. For a patient like Nancy Cruzan, the sole benefit of medical treatment is being kept metabolically alive. Neither artificial nutrition nor any other form of medical treatment available today can cure or in any way ameliorate her condition. [FN8] Irreversibly vegetative patients are devoid of thought, emotion, and sensation; they are permanently and completely unconscious. See n. 2, *supra*. [FN9] As the President's Commission concluded in approving the withdrawal of life support equipment from irreversibly vegetative patients:

FN8. While brain stem cells can survive 15 to 20 minutes without oxygen, cells in the cerebral hemispheres are destroyed if they are deprived of oxygen for as few as 4 to 6 minutes. See Cranford & Smith, *Some Critical Distinctions Between Brain Death and the Persistent Vegetative State*, 6 *Ethics Sci. & Med.* 199, 203 (1979). It is estimated that Nancy's brain was deprived of oxygen from 12 to 14 minutes. See *ante*, at 2845. Out of the 100,000 patients who, like Nancy, have fallen into persistent vegetative states in the past 20 years due to loss of oxygen to the brain, there have been only three even partial recoveries documented in the medical literature. Brief for American Medical Association et al. as *Amici Curiae* 11-12. The longest any person has ever been in a persistent vegetative state and recovered was 22 months. See Snyder, Cranford, Rubens, Bundlie, & Rockswold, *Delayed Recovery from Postanoxic Persistent Vegetative State*, 14 *Annals Neurol.* 156 (1983). Nancy has been in this state for seven years.

FN9. The American Academy of Neurology offers three independent bases on which the medical profession rests these neurological conclusions:

"First, direct clinical experience with these patients demonstrates that there is no behavioral indication of any awareness of pain or suffering.

"Second, in all persistent vegetative state patients studied to date, post-mortem examination reveals overwhelming bilateral damage to the cerebral hemispheres to a degree incompatible with consciousness....

"Third, recent data utilizing positron emission tomography indicates that the metabolic rate for glucose in the cerebral cortex is greatly reduced in persistent vegetative state patients, to a degree incompatible with consciousness."

Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient, 39 *Neurology* 125 (Jan.1989).

"[T]reatment ordinarily aims to benefit a patient through preserving life, relieving pain and suffering, protecting against disability, and returning maximally effective functioning. If a prognosis of permanent unconsciousness is correct, however, continued treatment cannot confer such benefits. Pain and suffering are absent, as are joy, satisfaction, and pleasure. Disability is total and no return to an even minimal level of social or human functioning is possible."

President's Commission 181-182.

There are also affirmative reasons why someone like Nancy might choose to forgo artificial nutrition and hydration under these circumstances. Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence. "In certain, thankfully rare, circumstances the burden of maintaining the corporeal existence degrades the very humanity it was meant to serve." *Brophy v. New England Sinai Hospital, Inc.*, 398 Mass. 417, 434, 497 N.E.2d 626, 635-636 (1986) (finding the subject of the proceeding "in a condition which [he] has indicated he would consider to be degrading and without human dignity" and holding that "[t]he duty of the State to preserve life must encompass a recognition of an individual's right to avoid circumstances in which the individual himself would feel that efforts to sustain life demean or degrade his humanity"). Another court, hearing a similar case, noted:

"It is apparent from the testimony that what was on [the patient's] mind was not only the invasiveness of life-sustaining systems, such as the [nasogastric] tube, upon the integrity of his body. It was also the utter helplessness of the permanently comatose person, the wasting of a once strong body, and the submission of the most private bodily functions to the attention of others."

In re Gardner, 534 A.2d 947, 953 (Me. 1987).

Such conditions are, for many, humiliating to contemplate, [FN10] as is visiting a prolonged and anguished vigil on one's parents, spouse, and children. A long, drawn-out death can have a debilitating effect on family members. See Carnwath & Johnson, *Psychiatric Morbidity Among Spouses of Patients With Stroke*, 294 *Brit.Med.J.* 409 (1987); Livingston, *Families Who Care*, 291 *Brit.Med.J.* 919 (1985). For some, the idea of being remembered in their persistent vegetative states rather than as they were before their illness or accident may be very disturbing. [FN11]

FN10. Nancy Cruzan, for instance, is totally and permanently disabled. All four of her limbs are severely contracted; her fingernails cut into her wrists. App. to Pet. for Cert. A93. She is incontinent of bowel and bladder. The most intimate aspects of her existence are exposed to and controlled by strangers. Brief for Respondent Guardian Ad Litem 2. Her family is convinced that Nancy would find this state degrading. See n. 20, *infra*.

FN11. What general information exists about what most people would choose or would prefer to have chosen for them under these circumstances also indicates the importance of ensuring a means for now-incompetent patients to exercise their right to avoid unwanted medical treatment. A 1988 poll conducted by the American Medical Association found that 80% of those surveyed favored withdrawal of life-support systems from hopelessly ill or irreversibly comatose patients if they or their families requested it. *New York Times*, June 5, 1988, p. 14, col. 4 (citing *American Medical News*, June 3, 1988, p. 9, col. 1). Another 1988 poll conducted by the Colorado University Graduate School of Public Affairs showed that 85% of those questioned would not want to have their own lives maintained with artificial nutrition and hydration if they became permanently unconscious. *The Coloradoan*, Sept. 29, 1988, p. 1.

Such attitudes have been translated into considerable political action. Since 1976, 40 States and the District of Columbia have enacted natural death Acts, expressly providing for self-determination under some or all of these situations. See Brief for Society for the Right to Die, Inc.,

as *Amicus Curiae* 8; Weiner, Privacy, Family, and Medical Decision Making for Persistent Vegetative Patients, 11 Cardozo L.Rev. 713, 720 (1990). Thirteen States and the District of Columbia have enacted statutes authorizing the appointment of proxies for making health care decisions. See *ante*, at 2857-2858, n. 2 (O'CONNOR, J., concurring).

Cruzan, 497 U.S.at 307- 312 (Brennan, J., dissenting).

Justice Brennan presents a parade of horrors in his footnote 13 to show that the power of the state government must be limited.

Although the right to be free of unwanted medical intervention, like other constitutionally protected interests, may not be absolute, [FN12] no state interest could outweigh the rights of an individual in Nancy Cruzan's position. Whatever a State's possible interests in mandating life-support treatment under other circumstances, there is no good to be obtained here by Missouri's insistence that Nancy Cruzan remain on life-support systems if it is indeed her wish not to do so. Missouri does not claim, nor could it, that society as a whole will be benefited by Nancy's receiving medical treatment. No third party's situation will be improved and no harm to others will be averted. Cf. nn. 6 and 8, *supra*. [FN13]

FN12. See *Jacobson v. Massachusetts*, 197 U.S. 11, 26-27, 25 S.Ct. 358, 361-362, 49 L.Ed. 643 (1905) (upholding a Massachusetts law imposing fines or imprisonment on those refusing to be vaccinated as "of paramount necessity" to that State's fight against a smallpox epidemic).

FN13. Were such interests at stake, however, I would find that the Due Process Clause places limits on what invasive medical procedures could be forced on an unwilling comatose patient in pursuit of the interests of a third party. If Missouri were correct that its interests outweigh Nancy's interest in avoiding medical procedures as long as she is free of pain and physical discomfort, see 760 S.W.2d, at 424, it is not apparent why a State could not choose to remove one of her kidneys without consent on the ground that society would be better off if the recipient of that kidney were saved from renal poisoning. Nancy cannot feel surgical pain. See n. 2, *supra*. Nor would removal of one kidney be expected to shorten her life expectancy. See The American Medical Association Family Medical Guide 506 (J. Kunz ed. 1982). Patches of her skin could also be removed to provide grafts for burn victims, and scrapings of bone marrow to provide grafts for someone with leukemia. Perhaps the State could lawfully remove more vital organs for transplanting into others who would then be cured of their ailments, provided the State placed Nancy on some other life-support equipment to replace the lost function. Indeed, why could the State not perform medical experiments on her body, experiments that might save countless lives, and would cause her no greater burden than she already bears by being fed through the gastrostomy tube? This would be too brave a new world for me and, I submit, for our Constitution.

Cruzan, 497 U.S.at 312-313 (Brennan, J., dissenting).

Later, Justice Brennan correctly points out that avoiding one kind of error makes another kind of error more likely.

Missouri's heightened evidentiary standard attempts to achieve balance by discounting evidence; the guardian ad litem technique achieves balance by probing for additional evidence. Where, as here, the family members, friends, doctors, and guardian ad litem agree, it is not because the process has failed, as the majority suggests. See *ante*, at 2853, n. 9. It is because there is no genuine dispute as to Nancy's preference.

The majority next argues that where, as here, important individual rights are at stake, a clear and convincing evidence standard has long been held to be an appropriate means of enhancing accuracy, citing decisions concerning what process an individual is due before he can be deprived of a liberty interest. See *ante*, at 2854. In those cases, however, this Court imposed a clear and convincing standard as a constitutional minimum on the basis of its

evaluation that one side's interests clearly outweighed the second side's interests and therefore the second side should bear the risk of error. See *Santosky v. Kramer*, 455 U.S. 745, 753, 766-767, 102 S.Ct. 1388, 1401-1402, 71 L.Ed.2d 599 (1982) (requiring a clear and convincing evidence standard for termination of parental rights because the parent's interest is fundamental but the State has no legitimate interest in termination unless the parent is unfit, and finding that the State's interest in finding the best home for the child does not arise until the parent has been found unfit); *Addington v. Texas*, 441 U.S. 418, 426-427, 99 S.Ct. 1804, 1809-1810, 60 L.Ed.2d 323 (1979) (requiring clear and convincing evidence in an involuntary commitment hearing because the interest of the individual far outweighs that of a State, which has no legitimate interest in confining individuals who are not mentally ill and do not pose a danger to themselves or others). Moreover, we have always recognized that shifting the risk of error reduces the likelihood of errors in one direction at the cost of increasing the likelihood of errors in the other. See *Addington, supra*, at 423, 99 S.Ct., at 1807-1808 (contrasting heightened standards of proof to a preponderance standard in which the two sides "share the risk of error in roughly equal fashion" because society does not favor one outcome over the other). In the cases cited by the majority, the imbalance imposed by a heightened evidentiary standard was not only acceptable but required because the standard was deployed to protect an individual's exercise of a fundamental right, as the majority admits, *ante*, at 2853-2854, n. 10. In contrast, the Missouri court imposed a clear and convincing evidence standard as an obstacle to the exercise of a fundamental right.

The majority claims that the allocation of the risk of error is justified because it is more important not to terminate life support for someone who would wish it continued than to honor the wishes of someone who would not. An erroneous decision to terminate life support is irrevocable, says the majority, while an erroneous decision not to terminate "results in a maintenance of the status quo." See *ante*, at 2854. [FN17] But, from the point of view of the patient, an erroneous decision in either direction is irrevocable. An erroneous decision to terminate artificial nutrition and hydration, to be sure, will lead to failure of that last remnant of physiological life, the brain stem, and result in complete brain death. An erroneous decision not to terminate life support, however, robs a patient of the very qualities protected by the right to avoid unwanted medical treatment. His own degraded existence is perpetuated; his family's suffering is protracted; the memory he leaves behind becomes more and more distorted.

FN17. The majority's definition of the "status quo," of course, begs the question. Artificial delivery of nutrition and hydration represents the "status quo" only if the State has chosen to permit doctors and hospitals to keep a patient on life-support systems over the protests of his family or guardian. The "status quo" absent that state interference would be the natural result of his accident or illness (and the family's decision). The majority's definition of status quo, however, is "to a large extent a predictable, yet accidental confluence of technology, psyche, and inertia. The general citizenry ... never said that it favored the creation of coma wards where permanently unconscious patients would be tended for years and years. Nor did the populace as a whole authorize the preeminence of doctors over families in making treatment decisions for incompetent patients." Rhoden, *Litigating Life and Death*, 102 Harv.L.Rev. 375, 433-434 (1988).

Cruzan, 497 U.S.at 318-320 (Brennan, J., dissenting).

Justice Brennan recognized that it was impossible for Nancy Cruzan to recover, because of the irreversible deterioration in her brain.

Even a later decision to grant him his wish cannot undo the intervening harm. But a later decision is unlikely in any event. "[T]he discovery of new evidence," to which the majority refers, *ibid.*, is more hypothetical than plausible. The majority also misconceives the

relevance of the possibility of "advancements in medical science," *ibid.*, by treating it as a reason to force someone to continue medical treatment against his will. The possibility of a medical miracle is indeed part of the calculus, but it is a part of the *patient's* calculus. If current research suggests that some hope for cure or even moderate improvement is possible within the life span projected, this is a factor that should be and would be accorded significant weight in assessing what the patient himself would choose. [FN18]

FN18. For Nancy Cruzan, no such cure or improvement is in view. So much of her brain has deteriorated and been replaced by fluid, see App. to Pet. for Cert. A94, that apparently the only medical advance that could restore consciousness to her body would be a brain transplant. Cf. n. 22, *infra*.

Cruzan, 497 U.S.at 320-321 (Brennan, J., dissenting).

Justice Brennan discussed the evidence of Nancy's wishes in greater detail than either the Missouri Supreme Court or the majority opinion of the U.S. Supreme Court. (Incidentally, I have often observed that lawyers and judges simply ignore facts that get in the way of their conclusion, in a kind of intellectual fraud. A scientist who behaved this way would be judged incompetent and dishonest.)

Even more than its heightened evidentiary standard, the Missouri court's categorical exclusion of relevant evidence dispenses with any semblance of accurate factfinding. The court adverted to no evidence supporting its decision, but held that no clear and convincing, inherently reliable evidence had been presented to show that Nancy would want to avoid further treatment. In doing so, the court failed to consider statements Nancy had made to family members and a close friend. [FN19] The court also failed to consider testimony from Nancy's mother and sister that they were certain that Nancy would want to discontinue artificial nutrition and hydration, [FN20] even after the court found that Nancy's family was loving and without malignant motive. See 760 S.W.2d, at 412. The court also failed to consider the conclusions of the guardian ad litem, appointed by the trial court, that there was clear and convincing evidence that Nancy would want to discontinue medical treatment and that this was in her best interests. *Id.*, at 444 (Higgins, J., dissenting from denial of rehearing); Brief for Respondent Guardian Ad Litem 2-3. The court did not specifically define what kind of evidence it would consider clear and convincing, but its general discussion suggests that only a living will or equivalently formal directive from the patient when competent would meet this standard. See 760 S.W.2d, at 424-425.

FN19. The trial court had relied on the testimony of Athena Comer, a long-time friend, co-worker, and housemate for several months, as sufficient to show that Nancy Cruzan would wish to be free of medical treatment under her present circumstances. App. to Pet. for Cert. A94. Ms. Comer described a conversation she and Nancy had while living together, concerning Ms. Comer's sister who had become ill suddenly and died during the night. The Comer family had been told that if she had lived through the night, she would have been in a vegetative state. Nancy had lost a grandmother a few months before. Ms. Comer testified: "Nancy said she would never want to live [in a vegetative state] because if she couldn't be normal or even, you know, like half way, and do things for yourself, because Nancy always did, that she didn't want to live ... and we talked about it a lot." Tr. 388-389. She said "several times" that "she wouldn't want to live that way because if she was going to live, she wanted to be able to live, not to just lay in a bed and not be able to move because you can't do anything for yourself." *Id.*, at 390, 396. "[S]he said that she hoped that [all the] people in her family knew that she wouldn't want to live [in a vegetative state] because she knew it was usually up to the family whether you lived that way or not." *Id.*, at 399.

The conversation took place approximately a year before Nancy's accident and was described by Ms. Comer as a "very serious" conversation that continued for approximately half an hour without interruption. *Id.*, at 390. The Missouri Supreme Court dismissed Nancy's statement as "unreliable" on the ground that it was an informally expressed reaction to other people's medical conditions. 760 S.W.2d, at 424.

The Missouri Supreme Court did not refer to other evidence of Nancy's wishes or explain why it was rejected. Nancy's sister Christy, to whom she was very close, testified that she and Nancy had had two very serious conversations about a year and a half before the accident. A day or two after their niece was stillborn (but would have been badly damaged if she had lived), Nancy had said that maybe it was part of a "greater plan" that the baby had been stillborn and did not have to face "the possible life of mere existence." Tr. 537. A month later, after their grandmother had died after a long battle with heart problems, Nancy said that "it was better for my grandmother not to be kind of brought back and forth [by] medical [treatment], brought back from a critical near point of death...." *Id.*, at 541.

FN20. Nancy's sister Christy, Nancy's mother, and another of Nancy's friends testified that Nancy would want to discontinue the hydration and nutrition. Christy said that "Nancy would be horrified at the state she is in." *Id.*, at 535. She would also "want to take that burden away from [her family]." *Id.*, at 544. Based on "a lifetime of experience [I know Nancy's wishes] are to discontinue the hydration and the nutrition." *Id.*, at 542. Nancy's mother testified: "Nancy would not want to be like she is now. [I]f it were me up there or Christy or any of us, she would be doing for us what we are trying to do for her. I know she would, ... as her mother." *Id.*, at 526.

Cruzan, 497 U.S. at 321-322 (Brennan, J., dissenting).

Justice Brennan noted that most people do not have formal, legal documents specifying directions for medical care if they become incompetent to express their decision. But the lack of a formal, legal advance directive should not rob that person of his/her right to express a choice and have that choice honored by physicians and judges.

Too few people execute living wills or equivalently formal directives for such an evidentiary rule to ensure adequately that the wishes of incompetent persons will be honored. [FN21] While it might be a wise social policy to encourage people to furnish such instructions, no general conclusion about a patient's choice can be drawn from the absence of formalities. The probability of becoming irreversibly vegetative is so low that many people may not feel an urgency to marshal formal evidence of their preferences. Some may not wish to dwell on their own physical deterioration and mortality. Even someone with a resolute determination to avoid life support under circumstances such as Nancy's would still need to know that such things as living wills exist and how to execute one. Often legal help would be necessary, especially given the majority's apparent willingness to permit States to insist that a person's wishes are not truly known unless the particular medical treatment is specified. See *ante*, at 2855.

FN21. Surveys show that the overwhelming majority of Americans have not executed such written instructions. See Emmanuel & Emmanuel, *The Medical Directive: A New Comprehensive Advance Care Document*, 261 JAMA 3288 (1989) (only 9% of Americans execute advance directives about how they would wish treatment decisions to be handled if they became incompetent); American Medical Association *Surveys of Physician and Public Opinion on Health Care Issues* 29-30 (1988) (only 15% of those surveyed had executed living wills); 2 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Making Health Care Decisions* 241-242 (1982) (23% of those surveyed said that they had put treatment instructions in writing).

As a California appellate court observed:

The lack of generalized public awareness of the statutory scheme and the typically human characteristics of procrastination and reluctance to contemplate the need for such arrangements however makes this a tool which will all too often go unused by those who might desire it.

Barber v. Superior Court, 147 Cal.App.3d 1006, 1015, 195 Cal.Rptr. 484, 489 (1983).

When a person tells family or close friends that she does not want her life sustained artificially, she is "express [ing] her wishes in the only terms familiar to her, and ... as clearly as a lay person should be asked to express them. To require more is unrealistic, and for all practical purposes, it precludes the rights of patients to forego life-sustaining treatment." *In re O'Connor*, 72 N.Y.2d 517, 551, 534 N.Y.S.2d 886, 905, 531 N.E.2d 607, 626 (1988) (Simons, J., dissenting). [FN22] When Missouri enacted a living will statute, it specifically provided that the absence of a living will does not warrant a presumption that a patient wishes continued medical treatment. See n. 15, *supra*. Thus, apparently not even Missouri's own legislature believes that a person who does not execute a living will fails to do so because he wishes continuous medical treatment under all circumstances.

FN22. New York is the only State besides Missouri to deny a request to terminate life support on the ground that clear and convincing evidence of prior, expressed intent was absent, although New York did so in the context of very different situations. Mrs. O'Connor, the subject of *In re O'Connor*, had several times expressed her desire not to be placed on life support if she were not going to be able to care for herself. However, both of her daughters testified that they did not know whether their mother would want to decline artificial nutrition and hydration under her present circumstances. Cf. n. 13, *supra*. Moreover, despite damage from several strokes, Mrs. O'Connor was conscious and capable of responding to simple questions and requests and the medical testimony suggested she might improve to some extent. Cf. *supra*, at 2863. The New York Court of Appeals also denied permission to terminate blood transfusions for a severely retarded man with terminal cancer because there was no evidence of a treatment choice made by the man when competent, as he had never been competent. See *In re Storar*, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64, cert. denied, 454 U.S. 858, 102 S.Ct. 309, 70 L.Ed.2d 153 (1981). Again, the court relied on evidence that the man was conscious, functioning in the way he always had, and that the transfusions did not cause him substantial pain (although it was clear he did not like them).

The testimony of close friends and family members, on the other hand, may often be the best evidence available of what the patient's choice would be. It is they with whom the patient most likely will have discussed such questions and they who know the patient best. "Family members have a unique knowledge of the patient which is vital to any decision on his or her behalf." Newman, Treatment Refusals for the Critically and Terminally Ill: Proposed Rules for the Family, the Physician, and the State, 3 N.Y.L.S. Human Rights Annual 35, 46 (1985). The Missouri court's decision to ignore this whole category of testimony is also at odds with the practices of other States. See, e.g., *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987); *Brophy v. New England Sinai Hospital, Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986); *In re Seaverns*, 425 A.2d 156 (Del.Ch. 1980).

The Missouri court's disdain for Nancy's statements in serious conversations not long before her accident, for the opinions of Nancy's family and friends as to her values, beliefs and certain choice, and even for the opinion of an outside objective factfinder appointed by the State evinces a disdain for Nancy Cruzan's own right to choose. The rules by which an incompetent person's wishes are determined must represent every effort to determine those wishes. The rule that the Missouri court adopted and that this Court upholds, however, skews the result away from a determination that as accurately as possible reflects the individual's own preferences and beliefs. It is a rule that transforms human beings into passive subjects of medical technology.

[Justice Brennan then quoted a case from California:]

[These cases recognize that]⁴⁵ medical care decisions must be guided by the individual patient's interests and values. Allowing persons to determine their own medical treatment is an important way in which society respects persons as individuals. Moreover, the respect due to persons as individuals does not diminish simply because they have become incapable of participating in treatment decisions. [While William's⁴⁶ coma precludes his participation,] it is still possible for others to make a decision that reflects his interests more closely than would a purely technological decision to do whatever is possible. Lacking the ability to decide, he has a right to a decision that takes his interests into account.

Conservatorship of Drabick, 200 Cal.App.3d 185, 208, 245 Cal.Rptr. 840, 854-855, cert. denied, 488 U.S. 958, 109 S.Ct. 399, 102 L.Ed.2d 387 (1988).

Cruzan, 497 U.S. at 323-326 (Brennan, J., dissenting).

Justice Brennan concluded his dissenting opinion:

Finally, I cannot agree with the majority that where it is not possible to determine what choice an incompetent patient would make, a State's role as *parens patriae* permits the State automatically to make that choice itself. See *ante*, at 2855 (explaining that the Due Process Clause does not require a State to confide the decision to "anyone but the patient herself"). Under fair rules of evidence, it is improbable that a court could not determine what the patient's choice would be. Under the rule of decision adopted by Missouri and upheld today by this Court, such occasions might be numerous. But in neither case does it follow that it is constitutionally acceptable for the State invariably to assume the role of deciding for the patient. A State's legitimate interest in safeguarding a patient's choice cannot be furthered by simply appropriating it.

The majority justifies its position by arguing that, while close family members may have a strong feeling about the question, "there is no automatic assurance that the view of close family members will necessarily be the same as the patient's would have been had she been confronted with the prospect of her situation while competent." *Ibid.* I cannot quarrel with this observation. But it leads only to another question: Is there any reason to suppose that a State is *more* likely to make the choice that the patient would have made than someone who knew the patient intimately? To ask this is to answer it. As the New Jersey Supreme Court observed: "Family members are best qualified to make substituted judgments for incompetent patients not only because of their peculiar grasp of the patient's approach to life, but also because of their special bonds with him or her.... It is ... they who treat the patient as a person, rather than a symbol of a cause." *In re Jobs*, 108 N.J. 394, 416, 529 A.2d 434, 445 (1987). The State, in contrast, is a stranger to the patient.

A State's inability to discern an incompetent patient's choice still need not mean that a State is rendered powerless to protect that choice. But I would find that the Due Process Clause prohibits a State from doing more than that. A State may ensure that the person who makes the decision on the patient's behalf is the one whom the patient himself would have selected to make that choice for him. And a State may exclude from consideration anyone having improper motives. But a State generally must either repose the choice with the person

⁴⁵ I have restored the words deleted by Justice Brennan from the original.

⁴⁶ William Drabick was in a persistent vegetative state, and fed through a nasogastric tube.

whom the patient himself would most likely have chosen as proxy or leave the decision to the patient's family. [FN23]

FN23. Only in the exceedingly rare case where the State cannot find any family member or friend who can be trusted to endeavor genuinely to make the treatment choice the patient would have made does the State become the legitimate surrogate decisionmaker.

As many as 10,000 patients are being maintained in persistent vegetative states in the United States, and the number is expected to increase significantly in the near future. See Cranford, *supra* n. 2, at 27, 31. Medical technology, developed over the past 20 or so years, is often capable of resuscitating people after they have stopped breathing or their hearts have stopped beating. Some of those people are brought fully back to life. Two decades ago, those who were not and could not swallow and digest food, died. Intravenous solutions could not provide sufficient calories to maintain people for more than a short time. Today, various forms of artificial feeding have been developed that are able to keep people metabolically alive for years, even decades. See Spencer & Palmisano, Specialized Nutritional Support of Patients — A Hospital's Legal Duty?, 11 *Quality Rev. Bull.* 160, 160-161 (1985). In addition, in this century, chronic or degenerative ailments have replaced communicable diseases as the primary causes of death. See R. Weir, Abating Treatment with Critically Ill Patients 12-13 (1989); President's Commission 15-16. The 80% of Americans who die in hospitals are "likely to meet their end ... 'in a sedated or comatose state; betubed nasally, abdominally and intravenously; and far more like manipulated objects than like moral subjects.'" [FN24] A fifth of all adults surviving to age 80 will suffer a progressive dementing disorder prior to death. See Cohen & Eisdorfer, Dementing Disorders, in *The Practice of Geriatrics* 194 (E. Calkins, P. Davis, & A. Ford eds. 1986).

FN24. Fadiman, The Liberation of Lolly and Gronky, *Life Magazine*, Dec. 1986, p. 72 (quoting medical ethicist Joseph Fletcher).

"[L]aw, equity and justice must not themselves quail and be helpless in the face of modern technological marvels presenting questions hitherto unthought of." *In re Quinlan*, 70 N.J. 10, 44, 355 A.2d 647, 665, cert. denied, 429 U.S. 922, 97 S.Ct. 319, 50 L.Ed.2d 289 (1976). The new medical technology can reclaim those who would have been irretrievably lost a few decades ago and restore them to active lives. For Nancy Cruzan, it failed, and for others with wasting incurable disease, it may be doomed to failure. In these unfortunate situations, the bodies and preferences and memories of the victims do not escheat to the State; nor does our Constitution permit the State or any other government to commandeer them. No singularity of feeling exists upon which such a government might confidently rely as *parens patriae*. The President's Commission, after years of research, concluded:

"In few areas of health care are people's evaluations of their experiences so varied and uniquely personal as in their assessments of the nature and value of the processes associated with dying. For some, every moment of life is of inestimable value; for others, life without some desired level of mental or physical ability is worthless or burdensome. A moderate degree of suffering may be an important means of personal growth and religious experience to one person, but only frightening or despicable to another." President's Commission 276.

Yet Missouri and this Court have displaced Nancy's own assessment of the processes associated with dying. They have discarded evidence of her will, ignored her values, and deprived her of the right to a decision as closely approximating her own choice as humanly possible. They have done so disingenuously in her name and openly in Missouri's own. That Missouri and this Court may truly be motivated only by concern for incompetent patients

makes no matter. As one of our most prominent jurists warned us decades ago: "Experience should teach us to be most on our guard to protect liberty when the government's purposes are beneficent.... The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well meaning but without understanding." *Olmstead v. United States*, 277 U.S. 438, 479, 48 S.Ct. 564, 572-573, 72 L.Ed. 944 (1928) (Brandeis, J., dissenting).

I respectfully dissent.

Cruzan, 497 U.S. at 327-330 (Brennan, J., dissenting).

Justice Stevens' dissent

Justice Stevens wrote a long dissent, of which I find the following paragraphs particularly significant.

These considerations cast into stark relief the injustice, and unconstitutionality, of Missouri's treatment of Nancy Beth Cruzan. Nancy Cruzan's death, when it comes, cannot be an historic act of heroism; it will inevitably be the consequence of her tragic accident. But Nancy Cruzan's interest in life, no less than that of any other person, includes an interest in how she will be thought of after her death by those whose opinions mattered to her. There can be no doubt that her life made her dear to her family and to others. How she dies will affect how that life is remembered. The trial court's order authorizing Nancy's parents to cease their daughter's treatment would have permitted the family that cares for Nancy to bring to a close her tragedy and her death. Missouri's objection to that order subordinates Nancy's body, her family, and the lasting significance of her life to the State's own interests. The decision we review thereby interferes with constitutional interests of the highest order.

To be constitutionally permissible, Missouri's intrusion upon these fundamental liberties must, at a minimum, bear a reasonable relationship to a legitimate state end. See, e.g., *Meyer v. Nebraska*, 262 U.S., at 400, 43 S.Ct., at 627; *Doe v. Bolton*, 410 U.S. 179, 194-195, 199, 93 S.Ct. 739, 748-749, 751, 35 L.Ed.2d 201 (1973). Missouri asserts that its policy is related to a state interest in the protection of life. In my view, however, it is an effort to define life, rather than to protect it, that is the heart of Missouri's policy. Missouri insists, without regard to Nancy Cruzan's own interests, upon equating her life with the biological persistence of her bodily functions. Nancy Cruzan, it must be remembered, is not now simply incompetent. She is in a persistent vegetative state and has been so for seven years. The trial court found, and no party contested, that Nancy has no possibility of recovery and no consciousness.

It seems to me that the Court errs insofar as it characterizes this case as involving "judgments about the 'quality' of life that a particular individual may enjoy," *ante*, at 2853. Nancy Cruzan is obviously "alive" in a physiological sense. But for patients like Nancy Cruzan, who have no consciousness and no chance of recovery, there is a serious question as to whether the mere persistence of their bodies is "life" as that word is commonly understood, or as it is used in both the Constitution and the Declaration of Independence. [FN18] The State's unflagging determination to perpetuate Nancy Cruzan's physical existence is comprehensible only as an effort to define life's meaning, not as an attempt to preserve its sanctity.

FN18. The Supreme Judicial Court of Massachusetts observed in this connection: "When we balance the State's interest in prolonging a patient's life against the rights of the patient to reject such prolongation, we must recognize that the State's interest in life encompasses a broader interest than mere corporeal existence. In certain, thankfully rare, circumstances the burden of maintaining the corporeal existence degrades the very humanity it was meant to serve." *Brophy v. New England Sinai Hospital, Inc.*, 398 Mass. 417, 433-434, 497 N.E.2d 626, 635 (1986). The *Brophy* court then stressed that this reflection upon the nature of the State's interest in life was distinguishable from

any considerations related to the quality of a particular patient's life, considerations which the court regarded as irrelevant to its inquiry. See also *In re Eichner*, 73 App.Div.2d 431, 465, 426 N.Y.S.2d 517, 543 (1980) (A patient in a persistent vegetative state "has no health, and, in the true sense, no life, for the State to protect"), modified in *In re Storar*, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64 (1981).

This much should be clear from the oddity of Missouri's definition alone. Life, particularly human life, is not commonly thought of as a merely physiological condition or function. [FN19] Its sanctity is often thought to derive from the impossibility of any such reduction. When people speak of life, they often mean to describe the experiences that comprise a person's history, as when it is said that somebody "led a good life." [footnote omitted] They may also mean to refer to the practical manifestation of the human spirit, a meaning captured by the familiar observation that somebody "added life" to an assembly. If there is a shared thread among the various opinions on this subject, it may be that life is an activity which is at once the matrix for, and an integration of, a person's interests. In any event, absent some theological abstraction, the idea of life is not conceived separately from the idea of a living person. Yet, it is by precisely such a separation that Missouri asserts an interest in Nancy Cruzan's life in opposition to Nancy Cruzan's own interests. The resulting definition is uncommon indeed.

FN19. One learned observer suggests, in the course of discussing persistent vegetative states, that "few of us would accept the preservation of such a reduced level of function as a proper *goal* for medicine, even though we sadly accept it as an unfortunate and unforeseen *result* of treatment that had higher aspirations, and even if we refuse actively to cause such vegetative life to cease." L. Kass, *Toward a More Natural Science* 203 (1985). This assessment may be controversial. Nevertheless, I again tend to agree with Judge Blackmar, who in his dissent from the Missouri Supreme Court's decision contended that it would be unreasonable for the State to assume that most people *did* in fact hold a view contrary to the one described by Dr. Kass.

My view is further buttressed by the comments of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research:

"The primary basis for medical treatment of patients is the prospect that each individual's interests (specifically, the interest in well-being) will be promoted. Thus, treatment ordinarily aims to benefit a patient through preserving life, relieving pain and suffering, protecting against disability, and returning maximally effective functioning. If a prognosis of permanent unconsciousness is correct, however, continued treatment cannot confer such benefits. Pain and suffering are absent, as are joy, satisfaction, and pleasure. Disability is total and no return to an even minimal level of social or human functioning is possible."

Deciding to Forego Life-Sustaining Treatment 181-182 (1983).

Cruzan, 497 U.S. at 344-347 (Stevens, J., dissenting).

Justice Stevens recognized that the approach of the Missouri Supreme Court was "anomalous":

Nor does Missouri's treatment of Nancy Cruzan find precedent in the various state-law cases surveyed by the majority. Despite the Court's assertion that state courts have demonstrated "both similarity and diversity in their approaches" to the issue before us, *none* of the decisions surveyed by the Court interposed an absolute bar to the termination of treatment for a patient in a persistent vegetative state. For example, *In re Westchester County Medical Center on behalf of O'Connor*, 72 N.Y.2d 517, 534 N.Y.S.2d 886, 531 N.E.2d 607 (1988), pertained to an incompetent patient who "was not in a coma or vegetative state. She was conscious, and capable of responding to simple questions or requests sometimes by squeezing the questioner's hand and sometimes verbally." *Id.*, at 524-525, 534 N.Y.S.2d at 888-889, 531 N.E.2d, at 609-610. Likewise, *In re Storar*, 52 N.Y.2d 363, 438 N.Y.S.2d

266, 420 N.E.2d 64 (1981), involved a conscious patient who was incompetent because "profoundly retarded with a mental age of about 18 months." *Id.*, at 373, 438 N.Y.S.2d, at 270, 420 N.E.2d, at 68. When it decided *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985), the New Jersey Supreme Court noted that "Ms. Conroy was not brain dead, comatose, or in a chronic vegetative state," 98 N.J., at 337, 486 A.2d, at 1217, and then distinguished *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), on the ground that Karen Quinlan had been in a "persistent vegetative or comatose state." 98 N.J., at 358-359, 486 A.2d, at 1228. By contrast, an unbroken stream of cases has authorized procedures for the cessation of treatment of patients in persistent vegetative states. [FN21] Considered against the background of other cases involving patients in persistent vegetative states, instead of against the broader — and inapt — category of cases involving chronically ill incompetent patients, Missouri's decision is anomalous.

Cruzan, 497 U.S.at 347-349 (Stevens, J., dissenting).

Justice Stevens was also not persuaded by the majority opinion's desire to avoid a possible error in decision.

Indeed, to argue that the mere possibility of error in *any* case suffices to allow the State's interests to override the particular interests of incompetent individuals in *every* case, or to argue that the interests of such individuals are unknowable and therefore may be subordinated to the State's concerns, is once again to deny Nancy Cruzan's personhood. The meaning of respect for her personhood, and for that of others who are gravely ill and incapacitated, is, admittedly, not easily defined: Choices about life and death are profound ones, not susceptible of resolution by recourse to medical or legal rules. It may be that the best we can do is to ensure that these choices are made by those who will care enough about the patient to investigate his or her interests with particularity and caution. The Court seems to recognize as much when it cautions against formulating any general or inflexible rule to govern all the cases that might arise in this area of the law. *Ante*, at 2851. The Court's deference to the legislature is, however, itself an inflexible rule, one that the Court is willing to apply in this case even though the Court's principal grounds for deferring to Missouri's Legislature are hypothetical circumstances not relevant to Nancy Cruzan's interests.

On either explanation, then, the Court's deference seems ultimately to derive from the premise that chronically incompetent persons have no constitutionally cognizable interests at all, and so are not persons within the meaning of the Constitution. Deference of this sort is patently unconstitutional. It is also dangerous in ways that may not be immediately apparent. Today the State of Missouri has announced its intent to spend several hundred thousand dollars in preserving the life of Nancy Beth Cruzan in order to vindicate its general policy favoring the preservation of human life. Tomorrow, another State equally eager to champion an interest in the "quality of life" might favor a policy designed to ensure quick and comfortable deaths by denying treatment to categories of marginally hopeless cases. If the State in fact has an interest in defining life, and if the State's policy with respect to the termination of life-sustaining treatment commands deference from the judiciary, it is unclear how any resulting conflict between the best interests of the individual and the general policy of the State would be resolved. [footnote omitted] I believe the Constitution requires that the individual's vital interest in liberty should prevail over the general policy in that case, just as in this.

Cruzan, 497 U.S.at 354-355 (Stevens, J., dissenting).

remand to trial court

Because the decision of the trial court is *unpublished*, the following summary is taken from reports in legal journals.⁴⁷

After the U.S. Supreme Court decision, the case was remanded to the trial court. The state of Missouri withdrew from the case, leaving the parents unopposed in trial court. Because of the publicity of the proceedings in the Missouri Supreme Court and U.S. Supreme Court, three of Nancy's friends came forward to testify that she had said she did not want to live "like a vegetable", while connected to machines. The trial court judge accepted this testimony as clear and convincing evidence of Nancy's desire. On 14 Dec 1990, the trial judge ordered the feeding tube withdrawn. The state did not appeal. Nancy Cruzan died on 26 Dec 1990, approximately eight years after her initial injury.

Theresa Schiavo

This was initially a simple case, in which Theresa Schiavo had been in a persistent vegetative state since February 1990. After six years of waiting for her to recover, her husband petitioned the probate court in Florida to allow her feeding tube to be removed, so she would die. As discussed above, individuals have the right to decide whether they want to be kept alive by artificial feeding and hydration. Schiavo's husband, in testimony accepted by courts, said that Theresa expressed a wish not to be kept alive that way. I do not discuss the opinions in this case, because they are straightforward applications of well-established law.

What is remarkably about the *Schiavo* case is that Theresa's parents (i.e., the Schindler family) fought in court for *nine years*, and also managed to get both the Florida legislature and the U.S. Congress to enact *unconstitutional* statutes, all intended to keep the feeding tube in Theresa. Theresa's husband consistently prevailed on the merits in *all* of almost forty cases. I list the cases in the Westlaw database here, as a monument to futile — and often repetitive and frivolous — litigation paid for by the pro-life movement.

⁴⁷ George J. Annas, "The Long Dying of Nancy Cruzan," 19 *Law, Medicine & Health Care* 52, 56 (1991); Cathaleen A. Roach, "Paradox and Pandora's Box: The Tragedy of Current Right-to-Die Jurisprudence," 25 *University of Michigan Journal of Law Reform* 133, 139 (Fall 1991).

medical facts

The first appellate court opinion in the Westlaw database for this case gave the following facts, as of Jan 2001.

Theresa Marie Schindler was born on December 3, 1963, and lived with or near her parents in Pennsylvania until she married Michael Schiavo on November 10, 1984. Michael and Theresa moved to Florida in 1986. They were happily married and both were employed. They had no children.

On February 25, 1990, their lives changed. Theresa, age 27, suffered a cardiac arrest as a result of a potassium imbalance. Michael called 911, and Theresa was rushed to the hospital. She never regained consciousness.

Since 1990, Theresa has lived in nursing homes with constant care. She is fed and hydrated by tubes. The staff changes her diapers regularly. She has had numerous health problems, but none have been life threatening.

The evidence is overwhelming that Theresa is in a permanent or persistent vegetative state. It is important to understand that a persistent vegetative state is not simply a coma. [FN1] She is not asleep. She has cycles of apparent wakefulness and apparent sleep without any cognition or awareness. As she breathes, she often makes moaning sounds. Theresa has severe contractures of her hands, elbows, knees, and feet.

FN1. For more extensive discussions of persistent vegetative state, see Dorothy J. McNoble, *The Cruzan Decision — A Surgeon's Perspective*, 20 Mem. St. U.L.Rev. 569, 610 n. 3 (1990); John B. Oldershaw, M.D., J.D., et al., *Persistent Vegetative State: Medical, Religious, Economic and Legal Perspectives*, 1 DePaul J. Health Care L. 495-536 (1997).

Over the span of this last decade, Theresa's brain has deteriorated because of the lack of oxygen it suffered at the time of the heart attack. By mid 1996, the CAT scans of her brain showed a severely abnormal structure. At this point, much of her cerebral cortex is simply gone and has been replaced by cerebral spinal fluid. Medicine cannot cure this condition. Unless an act of God, a true miracle, were to recreate her brain, Theresa will always remain in an unconscious, reflexive state, totally dependent upon others to feed her and care for her most private needs. She could remain in this state for many years.

Theresa has been blessed with loving parents and a loving husband. Many patients in this condition would have been abandoned by friends and family within the first year. Michael has continued to care for her and to visit her all these years. He has never divorced her. He has become a professional respiratory therapist and works in a nearby hospital. As a guardian, he has always attempted to provide optimum treatment for his wife. He has been a diligent watch guard of Theresa's care, never hesitating to annoy the nursing staff in order to assure that she receives the proper treatment.

Theresa's parents have continued to love her and visit her often. No one questions the sincerity of their prayers for the divine miracle that now is Theresa's only hope to regain any level of normal existence. No one questions that they have filed this appeal out of love for their daughter.

In re Guardianship of Schiavo, 780 So.2d 176, 177-178 (Fla.App. 2001).

initial group of cases

- *In Re: GUARDIANSHIP OF THERESA SCHIAVO*, 1996 WL 33496839 (Fla.Co.Ct. June 18, 1996) (Theresa's parents get right to discuss Theresa's condition with nursing home personnel, and Theresa's husband agrees to give copies of annual guardianship reports and neurological reports to her parents.)
- *In re Guardianship of Schiavo*, 780 So.2d 176 (Fla.App. 2 Dist. Jan 24, 2001), *rehearing denied* (Feb 22, 2001), *rev. den. sub nom. Schindler v. Schiavo ex rel. Schiavo*, 789 So.2d 348 (Fla. Apr 18, 2001).

The feeding tube was removed on 24 April 2001. Two days later, the Schindler family filed again in court, alleging new evidence, and a court ordered the feeding tube immediately re-inserted.

- *In re Guardianship of Schiavo*, 792 So.2d 551 (Fla.App. 2 Dist. Jul 11, 2001), *appeal after remand*, 800 So.2d 640 (Fla.App. 2 Dist. Oct 17, 2001), *rehearing denied* (Nov 01, 2001), *rehearing denied* (Nov 07, 2001), *review denied*, 816 So.2d 127 (Fla. Mar 14, 2002), *on remand*, 2002 WL 31817960 (Fla.Cir.Ct. Nov 22, 2002), *aff'd*, 851 So.2d 182 (Fla.App. 2 Dist. Jun 06, 2003), *rehearing denied* (Jul 09, 2003), *review denied sub nom. Schindler v. Schiavo*, 855 So.2d 621 (Fla. Aug 22, 2003).
- *Schindler v. Schiavo ex rel. Schiavo*, 829 So.2d 220 (Fla.App. 2 Dist. Oct 04, 2002) (motion denied without opinion).
- *In re Guardianship of Schiavo*, 2002 WL 31876088 (Fla.Cir.Ct. Nov 22, 2002).
- *Theresa Marie Schindler SCHIAVO, an Incompetent Ward, Incapacitated, by her Parents and Next Friends, Robert and Mary Schindler, Plaintiff, v. Michael SCHIAVO, Individually, and in his Capacity as Guardian of the Person of Theresa Marie Schindler Schiavo, Incapacitated, Defendant.*, Not Reported in F.Supp.2d, 2003 WL 22469905 (M.D.Fla. Sep 23, 2003).
- *Schindler v. Schiavo*, 865 So.2d 500 (Fla.App. 2 Dist. Oct 14, 2003) (writ of prohibition denied, without opinion).
- *Advocacy Center for Persons With Disabilities, Inc. v. Schiavo*, Not Reported in F.Supp.2d, 2003 WL 23305833 (M.D.Fla. Oct 21, 2003).

Florida Statute

On 15 October 2003, the feeding tube was removed for a second time. The Schindler family persuaded Gov. Jeb Bush and the Florida legislature to enact a statute on 21 Oct 2003 that permitted the Governor to issue a one-time stay of any court order that withholds hydration or nutrition from a patient in Florida. The Governor acted immediately and the feeding tube was re-inserted six days after it had been removed for the second time. The new Florida statute was later declared unconstitutional by Florida courts, as shown below.

- *Michael SCHIAVO, as Guardian of the Person of Theresa Marie Schiavo, Petitioner, v. Jeb BUSH, Governor of the State of Florida, and Charlie Crist, Attorney General of the State of Florida, Respondents.*, Not Reported in So.2d, 2003 WL 22762709 (Fla.Cir.Ct. Nov 04, 2003) (denied Schindler leave to intervene, invited amicus curiae brief instead).
- *Bush v. Schiavo*, 861 So.2d 506 (Fla.App. 2 Dist. Dec 10, 2003) (Governor lost his motion to disqualify judge in Florida trial court).
- *Michael SCHIAVO, as Guardian of the person of Theresa Marie Schiavo, Petitioner, v. Jeb BUSH, Governor of the State of Florida, and Charlie Crist, Attorney General of the State of Florida, Respondents.*, 2004 WL 628663 (Fla.Cir.Ct. [no day/month] 2004) (Schindlers lost another motion to intervene),
rev'd sub nom. Schindler v. Schiavo, 866 So.2d 140 (Fla.App. 2 Dist. Feb 13, 2004).
- *Bush v. Schiavo*, 866 So.2d 136 (Fla.App. 2 Dist. Feb 13, 2004) (denied Husband's motion for protective order in depositions)
- *Bush v. Schiavo*, 871 So.2d 1012 (Fla.App. 2 Dist. Apr 23, 2004) (denied Governor's motion to dismiss).

Finally, the courts addressed the merits of the Florida statute and found it *unconstitutional*:

- *Schiavo v. Bush*, 2004 WL 980028 (Fla.Cir.Ct. May 05, 2004),
aff'd, 885 So.2d 321 (Fla. Sep 23, 2004), rehearing denied (Oct 21, 2004)
cert. den., 125 S.Ct. 1086 (U.S. Jan 24, 2005).

more litigation in Florida

- *Schindler v. Schiavo*, 2004 WL 2726107 (Fla.App. 2 Dist. Nov 24, 2004) (Schindlers' petition denied without opinion).
- *In re Guardianship of Schiavo*, 2005 WL 459634 (Fla.Cir.Ct. Feb 25, 2005) (Ordered removal of feeding tube from Theresa on 18 March 2005)
aff'd, ___ So2d ___, 2005 WL 600377 (Fla.App. 2 Dist. Mar 16, 2005),
stay denied, 125 S.Ct. 1622 (U.S. Mar 17, 2005).

The frustration of the trial court was apparent when it wrote on 25 Feb 2005:

The Court after hearing excellent argument of counsel, reviewing the pleadings and being otherwise advised in the premises, finds as follows:

Five years have passed since the issuance of the February 2000 Order authorizing the removal of Theresa Schiavo's nutrition and hydration and there appears to be no finality in sight to this process. The Court, therefore, is no longer comfortable in continuing to grant stays pending appeal of Orders denying Respondents' various motions and petitions. The process does not work when the trial court finds a motion to be without merit but then stays the effect of such denial for months pending appellate review. Also, the Court is no longer comfortable granting stays simply upon the filing of new motions and petitions since there will always be "new" issues that can be pled. The Respondents will need to demonstrate before the appellate courts that their requests have merit and accordingly are worthy of a stay.

The parties through counsel have requested this Court to rule on the issue of whether or not the Petitioner needs court permission to act upon the February 11, 2000 Order once the stay expires. Counsel agree that the Court is not required to have another hearing to set such time and date should the Court wish to do so. The Court is persuaded that no further hearing need be required but that a date and time certain should be established so that last rites and other similar matters can be addressed in an orderly manner. Even though the Court will not issue another stay, the scheduling of a date certain for implementation of the February 11, 2000 ruling will give Respondents ample time to appeal this denial, similar in duration to previous short-time stays granted for that purpose. Therefore it is

ORDERED AND ADJUDGED that the Motion for Emergency Stay filed on February 15, 2005, is DENIED. It is further

ORDERED AND ADJUDGED that absent a stay from the appellate courts, the guardian, MICHAEL SCHIAVO, shall cause the removal of nutrition and hydration from the ward, THERESA SCHIAVO, at 1:00 p.m. on Friday, March 18, 2005.

In re Guardianship of Schiavo, 2005 WL 459634 at *1-*2 (Fla.Cir.Ct. Feb 25, 2005)

The feeding tube was finally withdrawn on Friday, 18 March 2005.

A committee of the U.S. House of Representatives considered issuing a subpoena to Theresa Schiavo, to force her to testify in Washington, DC. This subpoena was a gimmick to get the feeding tube re-inserted. The subpoena was plainly a gimmick, since Theresa had been unable to communicate since the year 1990.

- *Committee on Government Reform of U.S. House of Representatives v. Schiavo*, 125 S.Ct. 1622 (U.S. Mar 18, 2005) (request for injunction denied).

U.S. Statute

The U.S. Congress considered a special bill to gave the U.S. District Court jurisdiction to hear a *de novo* review of Theresa's case. During the discussion on the floor of the U.S. Senate, Dr. Bill Frist, the majority leader in the Senate and a former cardiac surgeon, said:

She will be starved to death next Friday. I have had the opportunity to look at the video footage upon which the initial facts of this case were based. And from my standpoint as a physician, I would be very careful before I would come to the floor and say this, that the facts upon which this case were based are inadequate. To be able to make a diagnosis of persistent vegetative state — which is not brain dead; it is not coma; it is a specific diagnosis and typically takes multiple examinations over a period of time because you are looking for responsiveness — I have looked at the video footage. Based on the footage provided to me, which was part of the facts of the case, she does respond.

That being the case, and also recognizing she has not had a complete neurological exam by today's standards — allegedly, she has not had a PET scan or MRI scan; not that those are definitive, but before you let somebody die, before you starve somebody to death, you want a complete exam and a good set of the facts of the case upon which to make that decision.

Frist, 151 CONGRESSIONAL RECORD S2927-2928 (17 Mar 2005).

Later that same day, Dr. Frist said:

Persistent vegetative state, which is what the court has ruled, I say that I question it, and I question it based on a review of the video footage which I spent an hour or so looking at last night in my office here in the Capitol. And that footage, to me, depicted something very different than persistent vegetative state.

Frist, 151 CONGRESSIONAL RECORD S3091 (17 Mar 2005).

Bill Frist was a cardiothoracic surgeon (1978-1994), then a U.S. Senator (1995-2007), and was the majority leader in the U.S. Senate during 2003-2007. It is *unprofessional* for any physician to diagnose a patient who the physician has not personally examined. Beyond that, Dr. Frist, a cardiac surgeon, was challenging the diagnosis of three board-certified neurologists (Drs. Bambakidis Cranford, and Greer — each of whom had personally examined the patient), when the problem was neurological, so Dr. Frist was outside of his specialty. For example, Frist wanted an MRI scan, but the patient had a thalamic stimulator implanted (as an experimental therapy) and an MRI scan would have heated the stimulator, probably causing serious injury to the patient.⁴⁸

Jumping ahead of the story, in mid-June 2005 the autopsy report was issued that showed that Theresa Schiavo's brain was less than half the weight of a normal brain, as a result of "massive cerebral atrophy" and she was blind. When confronted by journalists, Dr. Frist then attempted to

⁴⁸ Autopsy Report of Dr. Stephen J. Nelson, neuropathologist, p. 9 (8 June 2005).

deny that in March he had diagnosed her as *not* in a persistent vegetative state.⁴⁹ Dr. Frist is quoted as saying “I respect the pathologist’s report yesterday. She had devastating brain damage, and with that, the chapter’s closed.”⁵⁰ *The Washington Post* reported that 31 of Frist’s former classmates at Harvard Medical School had “sent him a letter saying he had used his medical degree improperly.”⁵¹ This unpleasant incident should remind physicians *not* to diagnose patients who they have never personally examined, as well as not to make diagnoses outside their specialty. This incident, along with the testimony of physicians hired by the Shindler family,⁵² shows that physicians are *not* immune to false statements. Prof. George Annas, an expert on health law, identified Senator Frist as one of two “primary villains” in this case.⁵³

The U.S. Congress passed the statute⁵⁴ on Sunday, 20 March 2005. I mention that this statute was blatantly *unconstitutional*, for reasons given below, beginning at page 149.

Because such a review by the U.S. District Court of a voluminous record could take months, the first step was for Theresa’s parents to request an injunction that ordered the feeding tube re-inserted in Theresa, to preserve the status quo. Before an injunction is granted, the moving party must show that:

- (1) it has a substantial likelihood of success on the merits;
- (2) irreparable injury will be suffered unless the injunction issues;
- (3) the threatened injury to the movant outweighs whatever damage the proposed injunction may cause the opposing party; and
- (4) if issued, the injunction would not be adverse to the public interest.

Theresa Schiavo v. Michael Schiavo, 357 F.Supp.2d 1378, 1383 (M.D.Fla. Mar 22, 2005).

⁴⁹ Charles Babington, “Frist Defends Remarks on Schiavo Case,” *The Washington Post*, (17 June 2005)
<http://www.washingtonpost.com/wp-dyn/content/article/2005/06/16/AR2005061600501.html>

⁵⁰ *Ibid.*

⁵¹ *Ibid.*

⁵² See, e.g., Ronald Cranford, “Facts, Lies, and Videotapes: The Permanent Vegetative State and the Sad Case of Terri Schiavo,” 33 *JOURNAL OF LAW MEDICINE & ETHICS* 363 (Summer 2005).

⁵³ George J. Annas, “‘I Want to Live’: Medicine Betrayed by Ideology in the Political Debate Over Terri Schiavo,” 35 *STETSON LAW REVIEW* 49, 77 (see also 58-59 and 71-72) (Fall 2005).

⁵⁴ The vote in the U.S. Senate was 2 to 1 with only three senators present (i.e., 97% of the senators were absent during the Easter recess). Senator Tom Harkin of Iowa, the only Democrat present in the U.S. Senate, did not object to the lack of a quorum. In the U.S. House of Representatives, the vote was 203 to 58, with 47 of 100 Democrats voting for the bill. I mention the Democrats, because that party has traditionally been more liberal and more in favor of a right-to-die, as well as in favor of a right to abortion.

The U.S. District Court denied the injunction because Parents failed to show a substantial likelihood of success on the merits in subsequent litigation:

- *Schiavo ex rel. Schindler v. Schiavo*, 357 F.Supp.2d 1378 (M.D.Fla. Mar 22, 2005) (), *aff'd*, 403 F.3d 1223 (11th Cir. Mar 23, 2005) (A three-judge panel of the U.S. Court of Appeals in Atlanta affirmed by a 2 to 1 vote.)
rehearing en banc denied, 403 F.3d 1261 (11th Cir. Mar 23, 2005) (Refused to reconsider the case, by a 10 to 2 vote.)
stay denied, 125 S.Ct. 1692 (U.S. Mar 24, 2005) (The U.S. Supreme Court unanimously declined to hear the case.)

The Schindler family continued to file litigation, but they consistently lost or were denied review by appellate courts.

- *Schiavo ex rel Schindler v. Schiavo*, 358 F.Supp.2d 1161 (M.D.Fla. Mar 25, 2005) (Amongst four new counts, parents alleged Eighth Amendment violation (i.e., “cruel and unusual punishment”), although that Amendment *only* applies to defendants who have been convicted of a crime, unlike Theresa Schiavo.⁵⁵ Parents lost on all counts.)
aff'd, 403 F.3d 1289 (11th Cir. Mar 25, 2005),
rehearing en banc denied, 404 F.3d 1270 (11th Cir. Mar 30, 2005) (by a 9 to 2 vote),
rehearing denied, 404 F.3d 1282 (11th Cir. Mar 30, 2005),
stay denied, 125 S.Ct. 1722 (U.S. Mar 30, 2005).

Two judges at the U.S. Court of Appeals concurred in the decision to deny an en banc hearing and explained that there had already been “clear and convincing” evidence presented in Florida state courts about Theresa’s wish not to be kept alive with a feeding tube. Their entire opinion is quoted here:

We write briefly for the purpose of responding to Judge Tjoflat's opinion dissenting from the denial of rehearing en banc.

The plaintiffs' position concerning Count 8 of the amended complaint⁵⁶ has been fluid throughout these proceedings. Judge Tjoflat's interpretation of their latest contention is that they are arguing there was insufficient evidence before the state courts to support by clear and convincing evidence the findings of those courts. As he understands the plaintiffs' latest arguments, “[t]he relevant question here is whether a rational factfinder could have found by clear and convincing evidence that Mrs. Schiavo would have wanted nutrition and hydration to be withdrawn under these circumstances.” That is not the way we understand the arguments that the plaintiffs have put forward in their current suggestion for rehearing en banc.

⁵⁵ Courts in New Jersey had rejected the “cruel and unusual punishment” argument thirty years earlier. See above at pages 21 and 23.

⁵⁶ “Count Eight is a procedural due process claim asserting that under *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 110 S.Ct. 2841, 111 L.Ed.2d 224 (1990), the Due Process Clause requires that decisions to remove hydration and nutrition from an incapacitated person must be supported by clear and convincing evidence that she would have made the same decision, and that there was not enough evidence in this case to meet that standard.” *Schindler v. Schiavo*, 403 F.3d at 1294 (11th Cir. 2005).

However, even if Judge Tjoflat's understanding of those arguments is correct and the question presented is the one he has articulated, this Court is correct in denying rehearing en banc.

Assuming, as Judge Tjoflat may, that the Due Process Clause requires clear and convincing evidence, there was abundant testimony before the state trial court to prove by that evidentiary standard that Mrs. Schiavo would have wanted nutrition and hydration to be withdrawn under these circumstances. Some of that evidence is set out at some length in the trial court's detailed order of February 11, 2000. While there was some conflict in the evidence, credibility determinations are within the province of the factfinder. *See Anderson v. City of Bessemer City*, 470 U.S. 564, 575, 105 S.Ct. 1504, 1512, 84 L.Ed.2d 518 (1985) (special deference is due where a trial court's findings are based on the credibility of witnesses, "for only the trial judge can be aware of the variations in demeanor and tone of voice that bear so heavily on the listener's understanding of and belief in what is said"); *Inwood Lab., Inc. v. Ives Lab., Inc.*, 456 U.S. 844, 856, 102 S.Ct. 2182, 2189, 72 L.Ed.2d 606 (1982) ("Determining the weight and credibility of the evidence is the special province of the trier of fact."); *United States v. Pineiro*, 389 F.3d 1359, 1366 (11th Cir. 2004) ("Such a credibility finding is within the province of the factfinder."). It is not the role of an appellate court to second-guess credibility determinations.

On appeal from the state trial court's decision and findings, Florida's Second District Court of Appeal did carefully review the record and determined that the question the trial court decided:

... was whether Theresa Marie Schindler Schiavo, not after a few weeks in a coma, but after ten years in a persistent vegetative state that has robbed her of most of her cerebrum and all but the most instinctive of neurological functions, with no hope of a medical cure but with sufficient money and strength of body to live indefinitely, would choose to continue the constant nursing care and the supporting tubes in hopes that a miracle would somehow recreate her missing brain tissue, or whether she would wish to permit a natural death process to take its course and for her family members and loved ones to be free to continue their lives.

After due consideration we conclude that the trial judge had clear and convincing evidence to answer this question as he did.

In re Guardianship of Schiavo, 780 So.2d 176, 180 (Fla. 2d DCA 2001).

Even assuming that this type of sufficiency of the evidence issue is a proper one for an en banc determination, there is no substantial question in this case about whether a rational factfinder could have found, as the Florida court did, that there was clear and convincing evidence that Mrs. Schiavo would not have wanted nutrition and hydration continued in these circumstances. Given the credibility determinations that the state trial court was authorized to and did make, the evidence clearly was sufficient to meet the clear and convincing evidence standard, which the Florida courts had imposed and did apply in this case.

Schindler v. Schiavo, 404 F.3d 1270, 1278-79 (11th Cir. 2005) (Carnes and Hull, JJ., concurring).

U.S. Statute *Unconstitutional*

It is basic jurisprudence that judges are *not* to consider the constitutionality of a statute, if the case can be decided on other grounds. The District court avoided considering the constitutionality of the statute by denying the injunction for re-insertion of the feeding tube on grounds that success on the merits was unlikely.

One judge in the U.S. Court of Appeals in Atlanta, in a concurring opinion filed one day before Theresa died, noted that the federal statute was *unconstitutional*:

A popular epithet directed by some members of society, including some members of Congress, toward the judiciary involves the denunciation of "activist judges." Generally, the definition of an "activist judge" is one who decides the outcome of a controversy before him or her according to personal conviction, even one sincerely held, as opposed to the dictates of the law as constrained by legal precedent and, ultimately, our Constitution. In resolving the Schiavo controversy it is my judgment that, despite sincere and altruistic motivation, the legislative and executive branches of our government have acted in a manner demonstrably at odds with our Founding Fathers' blueprint for the governance of a free people — our Constitution. Since I have sworn, as have they, to uphold and defend that Covenant, I must respectfully concur in the denial of the request for rehearing *en banc*. I conclude that Pub.L.109-3 ("the Act") is unconstitutional and, therefore, this court and the district court are without jurisdiction in this case [footnote omitted] under that special Act and should refuse to exercise *any* jurisdiction that we may otherwise have in this case.

Schindler v. Schiavo, 404 F.3d 1270, 1271 (11th Cir. 2005) (Birch, J., specially concurring).

Judge Burch argued that the Act was *unconstitutional*, as a violation of separation of powers in the U.S. Constitution:

Section 2 of the Act provides that the district court: (1) shall engage in "de novo" review of Mrs. Schiavo's constitutional and federal claims; (2) shall not consider whether these claims were previously "raised, considered, or decided in State court proceedings"; (3) shall not engage in "abstention in favor of State court proceedings"; and (4) shall not decide the case on the basis of "whether remedies available in the State courts have been exhausted." Pub.L. 109-3, 2. Because these provisions constitute legislative dictation of how a federal court should exercise its judicial functions (known as a "rule of decision"), the Act invades the province of the judiciary and violates the separation of powers principle.

An act of Congress violates separation of powers if it requires federal courts to exercise their Article III power "in a manner repugnant to the text, structure, and traditions of Article III." *Plaut v. Spendthrift Farm, Inc.*, 514 U.S. 211, 218, 115 S.Ct. 1447, 1452, 131 L.Ed.2d 328 (1995). By setting a particular standard of review in the district court, Section 2 of the Act purports to direct a federal court in an area traditionally left to the federal court to decide. See *Fla. Progress Corp. v. Comm'r*, 348 F.3d 954, 959 (11th Cir. 2003) (noting that the standard of review is for the court to determine). In fact, the establishment of a standard of review often dictates the rule of decision in a case, which is beyond Congress's constitutional power. See *United States v. Klein*, 80 U.S. (13 Wall.) 128, 146, 20 L.Ed. 519 (1871) (noting that Congress may not prescribe a "rule of decision" for a particular case). In addition, "the separation-of-powers doctrine requires that a branch not impair another in the performance of its constitutional duties." *Loving v. United States*, 517 U.S. 748, 757, 116 S.Ct. 1737, 1743, 135 L.Ed.2d 36 (1996). By denying federal courts the ability to exercise abstention or inquire

as to exhaustion or waiver under State law, the Act robs federal courts of judicial doctrines long-established for the conduct of prudential decisionmaking. See *Ungaro-Benages v. Dresdner Bank AG*, 379 F.3d 1227, 1237 n. 13 (11th Cir. 2004) (describing abstention as a "prudential" doctrine); *Duncan v. Walker*, 533 U.S. 167, 178-79, 121 S.Ct. 2120, 2127-28, 150 L.Ed.2d 251 (2001) (discussing the jurisprudential merits of State remedy exhaustion doctrines); *Labat v. Bennett*, 365 F.2d 698, 707 (5th Cir. 1966) (discussing courts' use of the doctrine of waiver). In short, certain provisions of Section 2 of the Act attempt to "direct[] what particular steps shall be taken in the progress of a judicial inquiry," *Plaut*, 514 U.S. at 225, 115 S.Ct. at 1456 (quoting THOMAS COOLEY, CONSTITUTIONAL LIMITATIONS 94-95). Because this is violative of the fundamental principles of separation of powers enshrined in our Constitution, they are unconstitutional. See *Plaut*, 514 U.S. at 240, 115 S.Ct. at 1463 (finding unconstitutional a congressional act which impinged on the independence of the judiciary by requiring federal courts to reopen federal judgments); *Klein*, 80 U.S. at 147 (invalidating legislation because "it passed the limit which separates the legislative from the judicial power" by dictating a rule of decision in a pending case). [FN4] Manifestly, because the Act applies to only this case [FN5] it lacks the generality and prospectivity of legislation that comports with the basic tenets of the separation of powers.

FN4. In his dissenting opinion, Judge Tjoflat questions why I have not cited any cases for the proposition that Congress cannot, in a statute, withdraw our ability to use the doctrines of abstention, exhaustion and waiver. As I have explained, the Act is unprecedented in nature, and therefore a lack of controlling case law is unremarkable. Furthermore, my reading of *Plaut*, 514 U.S. 211, 115 S.Ct. 1447, 131 L.Ed.2d 328 (1995), demonstrates that unprecedented congressional acts can be lacking in constitutional propriety absent prior precedent. Moreover, I do not suggest that the provision of a standard of review is in a general sense a "rule of decision." See *Nichols v. Hopper*, 173 F.3d 820, 823 (11th Cir. 1999)(Birch, J.)(stating that Congress may enact "standards," such as a general standard of review, provided it "has left to the courts the judicial functions of applying those standards" prospectively). Rather, it is the abrogation of such standards in a *single* case, not in a category of cases like *habeas corpus* cases, which is improper. See *Klein*, 80 U.S. at 146 (discussing the impropriety of a legislative act which directs a "rule of decision" in a particular case pending before a court); *Benjamin v. Jackson*, 124 F.3d 162, 173 (2d Cir. 1997)(citing *Klein* for the proposition that separation of powers is violated when a congressional act does not "permit[] courts to exercise their judicial powers independently" in a given case).

FN5. The Act references the parties by name, designates the forum for the dispute, sets a time limit on decision-making, and suspends previous judgments, all so that the federal judiciary is instructed as to how to conduct this specific case.

In sum, while Congress may grant jurisdiction to a federal court consistent with Article III as it did in Section 1 of the Act, [footnote omitted] it may not "assume[] a function that more properly is entrusted to" the judiciary. See *INS*, 462 U.S. at 963, 103 S.Ct. at 2790 (Powell, J., concurring). By arrogating vital judicial functions to itself in the passage of the provisions of Section 2 of the Act, Congress violated core constitutional separation principles, it prescribed a "rule of decision" and acted unconstitutionally.

Schindler v. Schiavo, 404 F.3d 1270, 1273-75 (11th Cir. 2005) (Birch, J., specially concurring). Judge Birch concluded:

The separation of powers implicit in our constitutional design was created "to assure, as nearly as possible, that each branch of government would confine itself to its assigned responsibility." *INS*, 462 U.S. at 951, 103 S.Ct. at 2784. But when the fervor of political passions moves the Executive and the Legislative branches to act in ways inimical to basic constitutional principles, it is the duty of the judiciary to intervene. *If sacrifices to the independence of the judiciary are permitted today, precedent is established for the*

constitutional transgressions of tomorrow. See *New York*, 505 U.S. at 187, 112 S.Ct. at 2434. Accordingly, we must conscientiously guard the independence of our judiciary and safeguard the Constitution, even in the face of the unfathomable human tragedy that has befallen Mrs. Schiavo and her family and the recent events related to her plight which have troubled the consciences of many. Realizing this duty, I conclude that Pub.L. 109-3 is an unconstitutional infringement on core tenets underlying our constitutional system. Had Congress or the Florida legislature, in their *legislative* capacities, been able to constitutionally amend applicable law, we would have been constrained to apply that law. See *Robertson v. Seattle Audubon Soc'y*, 503 U.S. 429, 441, 112 S.Ct. 1407, 1414, 118 L.Ed.2d 73 (1992). By opting to pass Pub.L. 109-3 instead, however, Congress chose to overstep constitutional boundaries into the province of the judiciary. Such an Act cannot be countenanced. Moreover, we are bound by the *Rooker-Feldman* doctrine not to exercise any other jurisdictional bases to override a final state judgment. Should the citizens of Florida determine that its law should be changed, it should be done legislatively. Were the courts to change the law, as the petitioners and Congress invite us to do, an "activist judge" criticism would be valid.

Schindler v. Schiavo, 404 F.3d 1270, 1276 (11th Cir. 2005) (Birch, J., specially concurring).

I believe that this federal statute is also unconstitutional as violative of equal protection of laws, because it gives Theresa Schiavo jurisdiction in federal court that a similarly situated vegetable⁵⁷ does not have. As the U.S. Supreme Court declared in a famous case in 1985:

The Equal Protection Clause of the Fourteenth Amendment commands that no State shall "deny to any person within its jurisdiction the equal protection of the laws," which is essentially a direction that all persons similarly situated should be treated alike. *Plyler v. Doe*, 457 U.S. 202, 216, 102 S.Ct. 2382, 2394, 72 L.Ed.2d 786 (1982).

Cleburne v. Cleburne Living Center, Inc., 473 U.S. 432, 439 (1985).

Plyler quotes a similar holding in *F. S. Royster Guano Co. v. Virginia*, 253 U.S. 412, 415 (1920).

Historically, the federal courts refuse to hear cases involving family law (e.g., divorces, alimony, child custody, guardianships)⁵⁸ or probate law.⁵⁹ The issues in the case of Theresa Schiavo may be outside the subject matter jurisdiction of federal courts.

⁵⁷ By calling her a "vegetable", I mean no disrespect. In my opinion, the *person* had already died — probably sometime years prior to discontinuation of life support — and what remained of her was her body, now an empty shell, without functioning cognitive power and without personality. See the four reasons, especially Nr. 4, for why termination of life support is *not* legally the cause of death, above, at page 7. Indeed, the autopsy identified the cause of death as "complications of anoxic encephalopathy" that occurred in 1990, *not* the dehydration from the removal of her feeding tube in 2005.

⁵⁸ Ronald B. Standler, *Federal Court Jurisdiction in the USA in Family Law Cases*, <http://www.rbs2.com/dfederal.pdf> (May 2004).

⁵⁹ See e.g., *Markham v. Allen*, 326 U.S. 490, 494 (1946); *Lepard v. NBD Bank, a Div. of Bank One*, 384 F.3d 232, 237-238 (6th Cir. 2004). But see *Blouin ex rel. Estate of Pouliot v. Spitzer*, 356 F.3d 348 (2nd Cir. 2004).

Finally, if the U.S. Congress had written the statute differently, so that the statute was a legislative determination of the case, that hypothetical statute would be an *unconstitutional bill of attainder*. About ten years before the U.S. Congress considered Theresa Schiavo, the Congress did pass such an unconstitutional statute in another case. Dr. Elizabeth Morgan was divorced from Dr. Foretich. Morgan alleged that her ex-husband sexually abused their daughter, but the courts did not agree. To prevent further abuse, Morgan refused to allow Foretich to visit their daughter. Morgan served two years in jail for contempt and then fled from the USA with their daughter. Against this background, the U.S. Congress in Sep 1996 passed a federal statute that allowed Morgan to return to the USA without sanctions/penalties and also denied visitation to Foretich. The U.S. Court of Appeals held that the federal statute was “an unconstitutional bill of attainder.” *Foretich v. U.S.*, 351 F.3d 1198, 1216-1217, 1223-1226 (D.C.Cir. 2003).

It is possible to have valid statutes that affect only a single individual. See, e.g., *Nixon v. Administrator of General Services*, 433 U.S. 425 (1977) (Government owns presidential papers.), but such valid statutes must be nonpunitive. In 1965, the U.S. Supreme Court held unconstitutional as a bill of attainder a federal statute prohibiting communists from being an officer or employee of a labor union. *U.S. v. Brown*, 381 U.S. 437 (1965). The Court reviewed the history of bills of attainder at 381 US at 441-449.

autopsy

On 18 March 2005, the feeding tube was removed from Theresa Schiavo for the third and final time. She died of dehydration on 31 March 2005, 13 days after her feeding tube was removed. At autopsy the next day, her brain weighed 615 grams, while there was 678 grams of cerebrospinal fluid inside her skull — approximately half of her cranium was filled with liquid, after her brain had atrophied.⁶⁰ The weight of her brain was “less than half” the normal value for her height, weight, age, and gender.⁶¹ She was blind.⁶² The autopsy identified the cause of death as “complications of anoxic encephalopathy” that occurred in 1990, *not* the dehydration from the removal of her feeding tube in 2005. Making the underlying disease or condition the official cause of death is consistent with the legal rule stated above, beginning at page 7.

⁶⁰ Report of Dr. Stephen J. Nelson, neuropathologist, p. 2 (8 June 2005).

⁶¹ *Ibid.* at p. 5.

⁶² Report of Dr. Jon R. Thogmartin, Chief Medical Examiner for Pinellas County, Florida, p. 8 (13 June 2005).

Prof. George Annas, an expert on health law, summarized Theresa Schiavo's condition:

She was so far beyond "disabled" that the term could not accurately be used to describe her condition. She was permanently unconscious and unable to do anything; her upper brain was not "damaged," but absent altogether.

George J. Annas, " 'I Want to Live': Medicine Betrayed by Ideology in the Political Debate Over Terri Schiavo," 35 STETSON LAW REVIEW 49, 65 (Fall 2005).

excessive litigation

On 29 May 2005, I searched the Westlaw database and listed above all of the judicial decisions in the case of Theresa Schiavo. There are a total of 38 decisions, which is one of the most litigated cases in U.S. history. Most of the decisions of the trial court are *not* included in the Westlaw database, so the total amount of litigation is even greater than what appears above.

Most of this litigation was filed by Theresa's parents, who are retired and not wealthy. How could those parents afford attorneys' fees that surely must have exceeded one million dollars? Some of their attorneys were provided by pro-life organizations, as a way to fighting to get legal victory that could be used in future situations of this kind. Also, the Schindler family set up a fund that solicited donations to pay for the Schindler's personal attorney.

It is a basic strategy in civil procedure to present *all* of the relevant facts and also *all* of the applicable legal theories in the record of the first trial. The Schindlers' attorneys seemed to introduce new facts and new legal arguments *after* losing in a court. This violation of civil procedure may be responsible for the consistent pattern of losses for the Schindler family, and may be responsible from some of the brusque comments in judicial opinions in this case during the year 2005. Furthermore, the large amount of prior litigation in Florida state courts showed that Theresa Schiavo had already received *much more* due process of law than was legally required, making it unlikely that Theresa would be successful on the merits in a *de novo* review by the U.S. District Court in March 2005.

I wonder if Theresa's husband could sue the Schindler family for abuse of process or wrongful prosecution, and seek to recover the attorney's fees that he paid in defending against the large amount of litigation filed on behalf of the Schindlers. Florida has a vexatious litigant statute,⁶³ but it only applies to plaintiffs who proceed *pro se* (i.e., without an attorney). Interestingly, that statute defines a "vexatious litigant" as one who filed and lost at least five civil actions in any five year interval.

⁶³ Florida Statutes § 68.093 (effective 2000).

Furthermore, the Schindler family made numerous public allegations of abuse or misconduct by Theresa's husband that may have been defamatory to the husband, or intentional infliction of emotional distress to the husband.

A CAT scan showed that most of Theresa Schiavo's brain had been replaced with cerebrospinal fluid, which is an *irreversible* change that makes her recovery impossible, and also means that Theresa had no cognitive function. Nonetheless, attorneys for Theresa's parents presented edited videotapes in court that purportedly showed Theresa responding to voices, which — if true — meant that she was *not* in a persistent vegetative state. Actually, Theresa was making random motions and the editing of the videotape selected only scenes in which her motion *appeared* to be her intelligent response. I wonder if the preparation of this edited videotape and the assertion in court that it accurately depicted Theresa, was an attempt to perpetrate a fraud on the court. One can easily understand the delusion of Theresa's parents that Theresa was not in a persistent vegetative state and that she would someday recover. However, the attorneys for Theresa's parents had a legal obligation to *not* mislead the court about the facts of the case.

It is interesting to compare the duration of the Schiavo case with the earlier Quinlan and Fox cases. In *Quinlan*, the parents requested the ventilator be disconnected from Karen just 107 days after her initial injury, and the New Jersey Supreme Court agreed just 349 days after her initial injury. In *Fox*, the trial court ordered the ventilator disconnected just 65 days after Fox initially became unconscious. However, in *Schiavo*, the trial court ordered the feeding tube removed from Theresa for the first time on 24 April 2001, which was approximately 4075 days after she initially became unconscious. Despite the lack of haste in *Schiavo*, her parents wanted to wait even longer, in the *unreasonable* hope that she would recover.

The pro-life rhetoric condemns liberal “activist judges” who allegedly kill patients in a persistent vegetative state. Justice Brennan, who wrote a dissenting opinion in *Cruzan*, was a Catholic who was appointed by President Eisenhower, a Republican. Judge Greer, the trial judge in *Schiavo*, is a Southern Baptist and a conservative Republican.⁶⁴ It seems to me that good conservative values favor the choice of the *individual* (including the legal right to refuse medical treatment) instead of permitting a paternalistic government to impose choices on people. Regardless of whether a judge is conservative or liberal, *all* judges have an obligation to develop the common law. Making new common law is necessary when existing law is not adequate to decide a case.

⁶⁴ See, e.g., William R. Levesque, “Quiet judge persists in Schiavo maelstrom,” *St. Petersburg Times*, http://www.sptimes.com/2005/03/06/Tampabay/Quiet_judge_persists_.shtml (6 March 2005).

Finally, during the last two weeks of Theresa's life, there was a continuous presence of pro-life protesters outside the hospice. The number of protesters varied from between a few dozen to approximately one hundred. A local newspaper reported that the "Hospice paid about \$40,000 for off-duty Pinellas Park police officers to provide security, in addition to officers assigned there by the Police Department."⁶⁵ Another journalist reported that "More than 50 protesters had been arrested since Schiavo's feeding tube was removed, most for trespassing as they tried to symbolically bring her water."⁶⁶ Taking a cup of water to Theresa was only symbolic, because she could *not* swallow, which is why a feeding tube had been inserted in her. The yelling of slogans, beating of drums, singing religious songs, and the frequent press conferences containing hyperbole by spokesmen for the Schindler family, all contributed to a carnival atmosphere that detracted from the dignity of the hospice, which had about fifty patients.

More Information

This section is *not* a bibliography for this essay. The quotations and facts mentioned above have full citations in the text above. There are numerous articles in medical journals and law reviews since the mid-1970s on this topic. A frequently cited treatise on this specific topic is:

- Alan Meisel and Kathy L. Cerminara, *The Right to Die: The Law of End-of-Life Decisionmaking*, New York: Aspen Publishers (Third Edition, Supplemented Annually). I can recommend one law textbook as having many citations to articles on the right to refuse life-sustaining treatment:
 - William J. Curran, Mark A. Hall & David H. Kaye, *Health Care Law: Forensic Science and Public Policy*, Boston: Little, Brown (Fourth Edition, 1990).
- In addition, see the articles in legal and medical literature cited by judges in their opinions quoted above.

My earlier versions of this essay, prepared in April/May 2005, included links to other websites on euthanasia, right-to-die, and physician-assisted suicide. In June 2012, I moved these links to a separate webpage at <http://www.rbs2.com/euthlink.htm> and added more links.

⁶⁵ Stephen Nohlgren, "Routine returns a sense of calm," *St. Petersburg Times*, 2 April 2005.

⁶⁶ Ron Word, "Protesters Linger at Schiavo's Hospice," *Associated Press*, 1 April 2005 at 06:07 EST. This news article was filed 21 hours *after* Theresa Schiavo died.

Conclusion

The current law in the USA permits a patient to be dehydrated/starved to death, but does not permit physician-assisted suicide. I suggest that such law comes from a refusal to logically confront the issues. The end result of removing a feeding tube is death of the patient. Such a death could more humanely (i.e., more quickly) be accomplished by physician-assisted suicide.

A survey article in a medical journal in the year 1994 estimated that there are between 10,000 and 25,000 adults in a persistent vegetative state in the USA.⁶⁷ But these only a few dozen published judicial opinion on persistent vegetative state in the USA since *Quinlan* in 1975. So an obvious question is: “Why are such legal cases so rare?” The answer seems to be that nearly all end-of-life issues are resolved by a consensus of family members and the physician. The major cases on this topic arose when either:

1. there was a strong disagreement inside the family (e.g., Theresa Schiavo’s parents wanted the feeding tube to remain, while Theresa’s husband said Theresa would have wanted her feeding tube removed, and both parties were willing to litigate their dispute.).
2. the hospital or physician(s) were concerned about being prosecuted for homicide or civil liability for malpractice.
3. pro-life politicians (e.g., district attorney, state attorney general, state legislature) became involved, and attempted to impose their pro-life religious beliefs on the patient and the patient’s family.

Issues in right-to-die cases span the disciplines of medicine, philosophy, religion, and law. There is little hope of reaching a consensus between pro-life Christians and those who favor euthanasia. However, one can hope that everyone would respect each individual’s right to make his/her own personal choices, according to his/her religion and philosophy. The U.S. Court of Appeals for the Ninth Circuit remarked in a physician-assisted suicide case:

Given the nature of the judicial process and the complexity of the task of determining the rights and interests comprehended by the Constitution, good faith disagreements within the judiciary should not surprise or disturb anyone who follows the development of the law. For these reasons, we express our hope that whatever debate may accompany the future exploration of the issues we have touched on today will be conducted in an objective, rational, and constructive manner that will increase, not diminish, respect for the Constitution.

There is one final point we must emphasize. Some argue strongly that decisions regarding matters affecting life or death should not be made by the courts. Essentially, we agree with that proposition. In this case, by permitting the *individual* to exercise the right to *choose* we are following the constitutional mandate to take such decisions out of the hands of the government, both state and federal, and to put them where they rightly belong, in the hands of the people. We are allowing individuals to make the decisions that so profoundly affect their very existence — and precluding the state from intruding excessively into that

⁶⁷ Multi-Society Task Force on PVS, “Medical Aspects of the Persistent Vegetative State,” 330 *New England Journal of Medicine* 1499, 1503 (26 May 1994).

critical realm. The Constitution and the courts stand as a bulwark between individual freedom and arbitrary and intrusive governmental power. Under our constitutional system, neither the state nor the majority of the people in a state can impose its will upon the individual in a matter so highly “central to personal dignity and autonomy,” *Casey*, 505 U.S. at 851, 112 S.Ct. at 2807. Those who believe strongly that death must come without physician assistance are free to follow that creed, be they doctors or patients. They are not free, however, to force their views, their religious convictions, or their philosophies on all the other members of a democratic society, and to compel those whose values differ with theirs to die painful, protracted, and agonizing deaths.

Compassion in Dying v. State of Washington, 79 F.3d 790, 838-839 (9th Cir. 1996) (en banc), *rev'd on other grounds sub nom. Washington v. Glucksberg*, 521 U.S. 702 (1997). Italics are in the original document.

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