Cruzan v. Director, Missouri Department of Health, 110 S. Ct. 2841 (1990)

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Constitutional Law—IGNORING AN INCOMPETENT PERSON’S CONSTITUTIONAL RIGHT TO FORGO LIFE-SUSTAINING TREATMENT—
Cruzan v. Director, Missouri Department of Health, 110 S. Ct. 2841 (1990)

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IN Cruzan v. Director, Missouri Department of Health,1 the United States Supreme Court recognized for the first time that a competent person has a constitutionally protected right to refuse unwanted medical treatment.2 When the Court decided Cruzan, however, Nancy Cruzan was incompetent and in a persistent vegetative state.3 If Nancy’s right to refuse unwanted medical treatment was to be exercised at all, it had to be done by a proxy. After it became apparent that Nancy would always be in a vegetative state, her parents sought a court order directing the removal of their daughter’s feeding and hydration tube.4

The Missouri Supreme Court refused to honor the wishes of Nancy’s parents on the grounds that her parents had failed to present clear and convincing evidence that Nancy would have chosen to withdraw her life-sustaining treatment.5 In Cruzan, the United States Supreme Court held that the United States Constitution did not forbid Missouri from requiring clear and convincing evidence of an incompetent person’s wishes before life-sustaining treatment could be withdrawn.6 The

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1. 110 S. Ct. 2841 (1990). Cruzan was a 5-4 decision. Justices White, O’Connor, Scalia, and Kennedy joined the majority opinion, which was written by Chief Justice Rehnquist. Justice O’Connor filed a concurring opinion. Id. at 2856 (O’Connor, J., concurring); Justice Scalia also filed a concurring opinion. Id. at 2859 (Scalia, J., concurring). Justices Marshall and Blackmun joined the dissenting opinion, which was written by Justice Brennan. Id. at 2863 (Brennan, J., dissenting); Justice Stevens dissented separately. Id. at 2878 (Stevens, J., dissenting).

2. Id. at 2851-52.

3. Dr. Fred Plum, professor and chairman of the Department of Neurology at Cornell, who coined the term “persistent vegetative state,” describes the vegetative state as follows:
Vegetative state describes a body which is functioning entirely in terms of its internal controls. It maintains temperature. It maintains heart beat and pulmonary ventilation. It maintains digestive activity. It maintains reflex activity of muscles and nerves for low level conditioned responses. But there is no behavioral evidence of either self-awareness or awareness of the surroundings in a learned manner.


Court's decision also allowed Missouri to assert an unqualified interest in preserving life without considering the quality of Nancy Cruzan's life. 7

Quality of life is the value that the continuation of life has for a person. No one should be allowed to decide that another person's life should be discontinued because the quality of that life is inadequate. If quality of life was a legitimate issue, persons with all manner of handicaps might find the state seeking to terminate their lives. Therefore, refusing to judge the quality of another's life is necessary to protect individuals with diminished mental capacities.

However, a persistent vegetative state can be distinguished from any medical condition that involves a diminished mental capacity. Those in persistent vegetative states have no cognitive functions and are completely unaware of their surroundings. 8 They are little more than collections of bodily organs. For these people, quality of life must be considered in order to reach a decision that is in their best interests.

In determining whether to forgo life-sustaining treatment for an incompetent person, the due process clause of the fourteenth amendment 9 requires that a state must act in a way that respects the person's best interests. 10 By ignoring the quality of Nancy Cruzan's life the state of Missouri acted against Nancy's best interests and ignored her constitutional right to forgo life-sustaining treatment. Cruzan is the only case in which a court has decided to continue life-sustaining treatment for a person in a persistent vegetative state. However, the Missouri Supreme Court is not the only court that can be accused of ignoring an incompetent person's constitutional right. 11

Other courts have struggled with the medical, legal, and ethical issues involved in determining what procedural safeguards are appropriate to preserve an incompetent person's constitutional right to refuse

7. Id. at 2853.
11. Many courts permit the family of an incompetent person to decide whether to forgo life-sustaining treatment provided that the family can reach the same decision that the incompetent person would have if he had been able to do so. See infra notes 103-115 and accompanying text. This is clearly impossible when the incapacitated person always has been incompetent or is an infant. In those cases there is absolutely no evidence of what the incompetent person would choose. However, courts have permitted the family of an incompetent to decide whether to forgo life-sustaining treatment when there is absolutely no evidence of what the incompetent person would have done. See infra notes 112-114, 193-194 and accompanying text.
life-sustaining treatment. This Note criticizes these courts for failing to distinguish the withdrawal of life-sustaining treatment for people in persistent vegetative states from all other right to die cases. This Note recommends two procedures that will safeguard the right to refuse or continue life-sustaining treatment for all persons who are incompetent. One procedure applies only to persons in persistent vegetative states. The other procedure applies to any other medical condition that might present itself in a right to die case. This Note also hopes to dispel the common misconceptions concerning the nature of the persistent vegetative state and to justify logically why courts must distinguish cases regarding the withdrawal of life-sustaining treatment for persons in persistent vegetative states.

I. THE FACTS

On January 11, 1983, Nancy Beth Cruzan suffered serious injuries when she lost control of her automobile. Trooper Dale Penn of the Missouri Highway Patrol discovered Nancy lying face down in a ditch, approximately thirty-five feet from her automobile. Nancy did not have any detectable respiratory or cardiac functions. Shortly thereafter, paramedics arrived at the accident scene and successfully revived those functions. By that time, however, Nancy's brain had been deprived of oxygen for approximately twelve to fourteen minutes. Permanent brain damage occurs when the brain is deprived of oxygen for approximately six minutes or more.

Following the accident, Nancy remained in a coma for three weeks and then progressed to an unconscious state. Although Nancy remained unconscious, her respiration and circulation no longer required artificial maintenance. Nancy also was able to take nutrition orally; however, a feeding and hydration tube was surgically implanted to ease the feeding process.

Seven years after her accident, when the United States Supreme Court decided Cruzan, Nancy remained unconscious and completely

12. Cruzan, 110 S. Ct. at 2888 n.21 (Stevens, J., dissenting).
14. Id.
15. Id. at 411.
16. Id.
17. Id.
18. Id.
19. Id.
20. Id.
21. Id.
oblivious to her environment except for primitive reflexes.\textsuperscript{22} She was completely and permanently disabled.\textsuperscript{23} "All four of her limbs are severely contracted; her fingernails cut into her wrists. She is incontinent of bowel and bladder. The most intimate aspects of her existence are exposed to and controlled by strangers."\textsuperscript{24} Nancy Cruzan's parents described their daughter as "an unconscious shell in a room full of strangers."\textsuperscript{25}

While Nancy would never recover, she was not terminally ill.\textsuperscript{26} Medical experts testified that she could have survived another thirty years.\textsuperscript{27} Nancy Cruzan existed in a persistent vegetative state.\textsuperscript{28}

II. THE PERSISTENT VEGETATIVE STATE

A. The Medical Reality of the Persistent Vegetative State

Before undertaking any legal analysis, it is essential to have a complete understanding of the persistent vegetative state, including the similarities and differences between it and other syndromes. The persistent vegetative state is a distinct neurological impairment of the brain and is distinguishable from a coma or brain death.\textsuperscript{29}

The brain controls a person's cognitive functions, such as thoughts, understanding, and awareness, as well as vegetative functions, such as respiration and primitive reflexes.\textsuperscript{30} The cognitive functions occur in the outer layers of the brain or, more specifically, in the cerebral cortex.\textsuperscript{31} The vegetative functions are controlled in the lower center of the brain or, more specifically, in the brain stem.\textsuperscript{32}

Brain death or whole brain death occurs when both the brain's cognitive and vegetative functions cease to exist.\textsuperscript{33} Brain death is a mod-

\textsuperscript{22.} Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2845 (1990).
\textsuperscript{23.} \textit{Id.} at 2869 n.10 (Brennan, J., dissenting).
\textsuperscript{24.} \textit{Id.} (citing to App. to Petition for Cert. A93 and Brief for Respondent Guardian Ad Litem 2).
\textsuperscript{25.} Tallahassee Democrat, June 26, 1990, at 1A, col. 1.
\textsuperscript{26.} Cruzan v. Harmon, 760 S.W.2d 408, 411 (Mo. 1988) (en banc), aff'd sub nom. Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841 (1990).
\textsuperscript{27.} \textit{Id.}
\textsuperscript{28.} \textit{Id.}
\textsuperscript{29.} Cranford, \textit{supra} note 8, at 27-28.
\textsuperscript{30.} \textit{Id.}
\textsuperscript{31.} \textit{Id.}
\textsuperscript{32.} \textit{Id.}
\textsuperscript{33.} The criteria used to determine brain death resulted from recommendations by the Ad Hoc Committee of Harvard Medical School. Harvard Medical School Ad Hoc Committee, \textit{A Definition of Irreversible Coma}, 205 J. A.M.A. 337 (1968).
ern medical and legal definition of death.\textsuperscript{34} When a patient is in a persistent vegetative state, the brain’s cognitive functions have ceased, but the vegetative functions remain.\textsuperscript{35} With a coma, the brain’s cognitive functions have ceased and the vegetative functions are impaired.\textsuperscript{36} Therefore, a person in a coma or persistent vegetative state is not legally dead.\textsuperscript{37}

Brain damage occurs when the brain is denied oxygen for a short period of time.\textsuperscript{38} The cerebral cortex has a high metabolic rate, so it is the part of the brain that is most sensitive to a lack of oxygen.\textsuperscript{39} The brain stem, while not completely immune to a lack of oxygen, is more resilient than the cerebral cortex.\textsuperscript{40} After four to six minutes of complete loss of oxygen to the brain, the cerebral cortex may suffer extensive destruction, but the brain stem will be relatively unharmed.\textsuperscript{41}

After the brain is deprived of oxygen, a person often will become comatose.\textsuperscript{42} The coma could be transient and persist for only a few weeks, or it could be chronic and irreversible.\textsuperscript{43}

A coma is a state of sleep-like unarousability resulting from extensive damage to the brain stem.\textsuperscript{44} A person in this condition has impaired cough, gag, and swallow reflexes.\textsuperscript{45} These impairments account

\begin{itemize}
\item \textsuperscript{34} The common law definition of death was equated with the cessation of respiration and the circulation of blood. D. Meyers, Medico-Legal Implications of Death and Dying § 3:1 (1981). However, the definition of death has changed as medical advances have created the ability to maintain lung and heart functions artificially in patients whose brains were irreversibly damaged. \textit{Id.} at §§ 4:1, 4:7.
\item \textsuperscript{35} Cranford, supra note 8, at 27.
\item \textsuperscript{36} \textit{Id.} at 28.
\item \textsuperscript{37} D. Meyers, supra note 34, at § 4:10 (brain death should not be equated with a coma or a persistent vegetative state).
\item \textsuperscript{38} Cranford, supra note 8, at 28.
\item \textsuperscript{39} \textit{Id.}
\item \textsuperscript{40} The brain stem has survived without oxygen for as long as fifteen minutes. D. Meyers, supra note 34, at § 4:2.
\item \textsuperscript{41} Cranford, supra note 8, at 28. The Missouri trial court determined that permanent brain damage generally results after the brain is deprived of oxygen for six minutes. Cruzan v. Director, Missouri Dep’t of Health, 110 S. Ct. 2841, 2845 (1990). Nancy Cruzan was deprived of oxygen for twelve to fourteen minutes. \textit{Id.}
\item \textsuperscript{42} Cranford, supra note 8, at 28.
\item \textsuperscript{43} \textit{Id.} A study of 215 comatose patients revealed that 60% of comas are transient comas. Levati, Farina, Vecchi, Rossanda & Marrubini, Prognosis of Severe Head Injuries, 57 J. Neurosurgery 779 (1982) [hereinafter Levati]. The majority of the patients in a transient coma recovered fully or progressed to a mentally disabled state. \textit{Id.} The remaining 40% of the comatose patients died. \textit{Id.} This author is defining a chronic and irreversible coma as a condition in which a comatose person remains in a coma until his death. However, some doctors assert that the phrase “chronic and irreversible coma” is misleading, Cranford, supra note 8, at 28, because the lifespan of a truly comatose patient is typically limited to weeks or months, which is not long enough to be appropriately characterized as “chronic.” \textit{Id.}
\item \textsuperscript{44} Cranford, supra note 8, at 28.
\item \textsuperscript{45} \textit{Id.}
\end{itemize}
for the frequent and often fatal respiratory infections that develop in persons who are comatose.\textsuperscript{46} A person who is comatose can be described as terminally ill with a life expectancy of six months to a year.\textsuperscript{47}

After a transient coma, a person's condition can evolve to one of eyes-open unconsciousness; that is, the vegetative state.\textsuperscript{48} The transient coma results from a temporary dysfunction of the brain stem.\textsuperscript{49} A person in a fully developed, persistent vegetative state has a variety of normal brain stem functions, including the protective gag reflexes and the ability to breathe without a respirator.\textsuperscript{50} Because people in vegetative states have a gag reflex, it is theoretically possible, but extremely impractical, to feed these patients by hand.\textsuperscript{51} Most patients in vegetative states are fed nutritional fluids by medical means such as nasogastric tubing or gastrostomy.\textsuperscript{52} It is not uncommon for persons in vegetative states to survive for a number of years.\textsuperscript{53}

People in persistent vegetative states experience a total loss of cognitive functions. They are completely unconscious and unaware of themselves or their environment. The capacities for genuine human thinking and emotions, and for experiencing pain and suffering at a conscious level depend on the cerebral cortex function.\textsuperscript{54} While a person may appear to exhibit signs of conscious human suffering, these are merely brain stem actions of a primitive, reflexive nature.\textsuperscript{55} Those in persistent vegetative states cannot experience pain and suffering because they lack the cognitive ability to do so.\textsuperscript{56}

\textsuperscript{46} Id.
\textsuperscript{47} Id.
\textsuperscript{48} Less than 2\% of all patients who survive a coma will remain in a persistent vegetative state. Levati, supra note 43, at 779. A separate study concluded that up to 12\% of patients who survive a coma will remain in a persistent vegetative state. Feinberg & Ferry, \textit{A Fate Worse Than Death, The Persistent Vegetative State in Childhood}, 138 AM. J. DISEASES CHILDREN 128 (1984).
\textsuperscript{49} Cranford, supra note 8, at 28.
\textsuperscript{50} Id.
\textsuperscript{51} Id. at 31.
\textsuperscript{52} Id.
\textsuperscript{53} The longest documented survival period of a patient in a persistent vegetative state is 37 years and 111 days. Id.
\textsuperscript{54} Position of the American Academy of Neurology on Certain Aspects of the Care and Management of the Persistent Vegetative State Patient, 39 NEUROLOGY 125 (1989).
\textsuperscript{55} Cranford, supra note 8, at 31.
\textsuperscript{56} The American Academy of Neurology has filed amicus curiae briefs in several recent right to die cases, including the \textit{Cruzan} case, which state unequivocally that patients in a persistent vegetative state cannot experience pain and suffering. Munsat, Stuart & Cranford, \textit{Guidelines on the Vegetative State: Commentary on the American Academy of Neurology Statement}, 39 NEUROLOGY 123, 123-24 (1989).
A physician skilled in neurological impairments can diagnose the persistent vegetative state with a reasonably high degree of accuracy within months of the original injury. However, the diagnosis is not foolproof, and a few documented cases exist where a patient has recovered cognitive functions after being diagnosed as being in a persistent vegetative state. Part of the difficulty of obtaining a correct diagnosis is the lack of broadly accepted, specific medical criteria. The primary basis for the diagnosis of a persistent vegetative state is careful clinical observation of the patient. There is a promising test for confirming the diagnosis of the persistent vegetative state on the horizon. The positron emission tomography (PET) scan quantitatively measures the metabolic rate of the cerebral cortex. This is important because consciousness cannot exist below certain metabolic rates. But presently the accuracy of the PET scan is unverified, and only a few centers in the country have the necessary equipment.

B. Should the Legal Definition of Death Include the Persistent Vegetative State?

The entire controversy concerning what conditions justify the withdrawal of life-sustaining treatment from a person in a persistent vegetative state would disappear if the legal definition of death was altered to include the persistent vegetative state. It is always permissible to

57. Cranford, supra note 8, at 29.
58. Id. at 29-30. See also Brophy v. New England Sinai Hosp., 398 Mass. 417, 425, 497 N.E.2d 626, 630 (1986) (likelihood of a patient in a persistent vegetative state regaining cognitive functioning is substantially less than one percent).
59. Cranford, supra note 8, at 29-30. Physicians can disagree about whether a patient is in a persistent vegetative state. In re Jobes, 108 N.J. 394, 403-07, 529 A.2d 434, 438-41 (1987). A nursing home produced two medical experts who contended that Nancy Jobes was severely brain damaged, although one said she fell "slightly outside of [his] operational definition of the persistent vegetative state." Id. at 404-07, 529 A.2d at 439-40. On the other hand, Doctors Plum and Levy, who have devoted their careers to the diagnosis and treatment of the persistent vegetative state, insisted that Nancy Jobes was in such a state. Id. at 408-09, 529 A.2d at 441. Despite the conflicting evidence, the trial court held that there was clear and convincing evidence that Nancy Jobes was in a persistent vegetative state. Id. at 409, 529 A.2d at 441.
60. In re Guardianship of Browning, 543 So. 2d 258, 263 n.3 (Fla. 2d DCA 1989) (stating the position of the American Academy of Neurology), approved, 568 So. 2d 4 (Fla. 1990).
61. The Supreme Court of New Jersey used the results of a PET scan as evidence that Nancy Jobes was in a persistent vegetative state. In re Jobes, 108 N.J. at 404, 529 A.2d at 439.
63. Id.
64. Id.
65. [The Cruzan] case could have been the perfect occasion for the United States Supreme Court finally to define "death." Instead, time and money were wasted, and the agony of the Cruzan family lengthened, while judges discussed Nancy Cruzan's "right
discontinue treatment when a person is legally dead. In fact, life-support machines that maintain a body's respiratory and cardiac functions are routinely discontinued when a person is declared brain dead. Why shouldn't the legal definition of death be expanded to include a person who is permanently unconscious?

Currently, there are two problems with altering the legal definition of death to include the persistent vegetative state. The first problem is one of education and awareness. The common law definition of death was the cessation of circulatory and respiratory functions. Recent advances in medical science have forced the legal definition of death to include whole brain death. However, the public and even the majority of physicians remain unaware of the correct legal definition of death. In fact, nineteen percent of physicians and nurses likely to be involved in organ procurement for transplantation had a concept of "death" that included a person in a persistent vegetative state. Until health care employees and the public are properly educated and all of the myths about the persistent vegetative state are dispelled, revising the legal definition of death is not advisable. Imposing a definition of death that the majority of the population cannot understand or believe would cause an unacceptable amount of strife.

A second problem with altering the legal definition of death is the current uncertain accuracy of diagnosing the persistent vegetative state. In one right to die case, four physicians were unable to agree on whether the patient was in a persistent vegetative state. Furthermore, there have been documented cases of people recovering after they were diagnosed as being in persistent vegetative states. While such
cases are extremely rare, the method of diagnosis must be literally foolproof and uniformly accepted before the persistent vegetative state can be included in the legal definition of death. The PET scan eventually may solve the present difficulties in diagnosing the persistent vegetative state, but its accuracy is presently unconfirmed and the necessary equipment to perform the test is generally not available. Therefore, it is not now appropriate to alter the legal definition of death. Yet even if a person in a persistent vegetative state is technically alive, it is an existence with only the lowest life functions.

C. The Economic Reality of the Persistent Vegetative State

This section is not meant to suggest that decisions regarding the removal of life-sustaining procedures should be based on anything but ethical and moral grounds. However, the growing number of people in persistent vegetative states, combined with rapidly increasing health care costs, will eventually provide a strong economic motivation for state legislatures to alter the legal definition of death. Two decades ago patients who could not swallow and digest food died because intravenous feeding tubes could not provide enough calories to maintain a patient for more than a short time. Today high-caloric feeding tubes can keep a person alive for years. As many as 10,000 patients presently are being maintained in persistent vegetative states in the United States, and the number is expected to increase significantly. The cost of maintaining these patients is an ever-growing burden on the national health care system. The increasing economic strain has prompted a number of commentators to suggest that the limitation of medical life support may become a necessary cost-containment measure.

when someone in a persistent vegetative state for more than one month later regained cognitive awareness. He testified that neither person recovered completely: "They were left in a state that some people, including myself . . . would [view] as worse than the vegetative state.")


73. Cranford, supra note 8, at 31.

74. The cost of health care to maintain a woman who was in a persistent vegetative state for 17 years was estimated at $6,104,590. Feinberg & Ferry, supra note 48, at 130. The annual national health bill for patients in persistent vegetative states has been estimated as ranging from $120 million to $1.2 billion. Cranford, supra note 8, at 32. Nancy Cruzan's medical expenses were approximately $112,000 per year. N.Y. Times, Dec. 27, 1990, at A1, col. 1.

75. The increasing strain on the nation's medical resources has prompted a number of commentators to suggest a reduction of care for those patients whose care is marginally useful. Alexander, Death By Directive, 28 SANTA CLARA L. REV. 67, 73 (1988). "There are thousands of PVS patients occupying beds in health care institutions and consuming financial resources. In a search for items to cut from the budget, years of support for the permanently unconscious may seem to some a tempting place to start." Wolf, The Persistent Problem of PVS, 18 HASTINGS CENTER REP. 26 (1988).
This author is calling the reader’s attention to this potential economic crisis to emphasize that state legislatures should address the problem of redefining death before such a crisis occurs. This is because sponsors of bills to redefine death to include people in persistent vegetative states will meet opposition based on a perception that they are attempting to rescue a bankrupt health care system at the expense of the unfortunate. This opposition will cloud the true purposes of such bills, which is that the best interest of persons in persistent vegetative states is to terminate life-sustaining treatment. In other words, the proponents of bills to redefine death will be unable to seize the moral high ground unless they act before the inevitable economic crisis.

III. BACKGROUND

For nearly a century, courts have recognized an individual's right to be free from bodily invasion. This notion of bodily integrity is embodied in the requirement that informed consent from a competent patient generally is required for all medical treatment. The logical corollary of the informed-consent doctrine is that a competent person has the right to refuse medical treatment. Many state courts have based a competent person’s right to refuse medical treatment on the common law right of informed consent. Other courts have held that a competent person’s right to refuse unwanted medical treatment is both a constitutional and a common law right.

While it is clear that an incompetent person also has a right to refuse medical treatment, problems arise when one tries to determine

80. Rasmussen v. Fleming, 154 Ariz. 207, 219 n.18, 741 P.2d 674, 686 n.18. (1987). However, the United States Supreme Court has implied that an incompetent person does not have the same constitutional right to refuse medical treatment as a competent person. See infra notes 131-34 and accompanying text.

The Court said: "An incompetent person is not able to make an informed and voluntary
how an incompetent can exercise this right. An incompetent person is unable to make an informed and voluntary decision. Therefore, if an incompetent person's right to refuse life-sustaining treatment is to be exercised at all, it must be done by some form of proxy. Both the courts and the legislatures have struggled with the medical, legal, and ethical issues involved in determining who should be the substitute decision-maker and what conditions justify the termination of life-sustaining procedures for an incompetent person.

A. Methods for Avoiding the Situation of an Incompetent Who Has No Expressed Treatment Preference

Most states have attempted to avoid the situation of an incompetent person who has no expressed treatment preference by enacting legislation that allows an individual to execute a living will. Living wills choice to exercise a hypothetical right to refuse treatment or any other right. Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2852 (1990). Although this statement is unclear, it probably does not stand for the principle that an incompetent person does not have a constitutional right to refuse medical treatment. People do not forfeit their constitutional rights merely because they are incompetent. The true issue is what procedural safeguards must be adopted in order to preserve the incompetent's constitutional right to refuse medical treatment. Therefore, the best interpretation of the Court's statement is that it merely emphasizes the need for procedural safeguards.

81. Cruzan, 110 S. Ct. at 2852.
82. Id.

allow competent people to execute declarations that they would refuse life-prolonging medical treatment in the event of a terminal illness and an accompanying inability to refuse such treatment as a result of incompetence.84

Some states also have enacted statutes that specifically authorize individuals to appoint surrogates to make medical treatment decisions in the event that individuals are rendered incompetent.85 Furthermore, at least one state court has held that a general power of attorney implicitly grants the authority to make medical treatment decisions.86

1. The Living Will87

There are two reasons living wills have not eliminated the problems that arise when people become incompetent and have never expressed...
their intent about life-sustaining procedures. First, only a small percentage of the population has executed a living will.\textsuperscript{88} Second, even if people have executed living wills, their declarations may not apply to their present situations. Living-will statutes vary widely from state to state,\textsuperscript{89} and many states do not recognize a living will that was executed in another state.\textsuperscript{90} Furthermore, some living-will statutes do not authorize a person to direct the removal of a feeding or hydration tube.\textsuperscript{91} Most, if not all, of the states do not provide for a person to direct the withholding of life-sustaining treatment for a nonterminal condition.\textsuperscript{92} A persistent vegetative state is considered a nonterminal condition.\textsuperscript{93} Therefore, a living will could prove inapplicable in many different situations.

Even if laws are revised so living wills could provide directives for all medical situations, \textquote{\textquote{w}ritten decisions made ahead of time are not the best way to make choices about health care which is changing all the time.\textquote{94}} An innovative medical procedure arising after a person executed a living will could cast doubt on the past written directive. Medical treatment decisions should be exercised only when all risks and alternatives are completely known. Therefore, a superior alternative to exercising a living will is appointing a proxy or surrogate to make medical treatment decisions on a person's behalf.

2. Statutes Authorizing a Surrogate to Make Treatment Decisions

People can ensure that optimal treatment decisions are made on their behalf by delegating, while competent, the authority to make health care decisions to a family member or trusted friend. Allowing people to designate proxies to carry out their intent may prove a valuable safeguard of patients' interests in directing their medical care.

\textsuperscript{88} See Emanuel & Emanuel, The Medical Directive: A New Comprehensive Advance Care Document, 261 J. A.M.A. 3288 (1989) (only nine percent of the population has executed a living will); but see Nat'l L. J., Dec. 3, 1990, at 7, col. 2 (the Society for the Right to Die has reported that the Cruzan case has spurred a tremendous interest in living wills).

\textsuperscript{89} P. Williams, supra note 84, at 11-12.

\textsuperscript{90} Id. at 10 (only three states will recognize a living will which was executed in another state).

\textsuperscript{91} Id. at 11.

\textsuperscript{92} See, e.g., Rasmussen v. Fleming, 154 Ariz. 207, 214, 741 P.2d 674, 681 (1987) (the Arizona living-will statutes do not provide a right to refuse medical treatment when the person is in a nonterminal condition).

\textsuperscript{93} A terminal illness has been defined as one in which death is imminent. See In re Guardianship of Browning, 543 So. 2d 258, 265 (Fla. 2d DCA 1989), approved, 568 So. 2d 4 (Fla. 1990). The court did not define the length of "imminent." Id.

\textsuperscript{94} Wall St. J., June 26, 1990, at A8, col. 1 (quoting Nancy Dickey, an American Medical Association trustee).
Unfortunately, less than half of the states have expressly authorized the appointment of proxies for medical treatment decisions.\textsuperscript{95} Even if all fifty states authorized the appointment of proxies to make these decisions, nothing will be accomplished if the majority of the public fails to take advantage of this appointment power. Few individuals provide any directives regarding their intent to refuse life-sustaining treatment. People are ""just as careful to bury thoughts of death as they are to bury the dead.'"\textsuperscript{96}

Even if attitudes change and every competent person enacts a living will or appoints a proxy to make medical decisions, legislatures never will be able to avoid completely the problem of people who are incompetent and have never expressed their preferences. Legislation cannot cure situations involving minors or those who have been incompetent their entire lives. Such people have no opportunity to legally formulate their wishes. Therefore, the problem of deciding how to exercise an incompetent person's right to refuse life-sustaining treatment may be minimized but never totally eliminated.

3. Patient Self-Determination Act\textsuperscript{97}

Federal legislation that takes effect in November 1991 will require federally funded health care facilities to provide entering patients with written information regarding their rights under state law to refuse medical treatment and their rights to execute a living will or durable power of attorney.\textsuperscript{98} Each health care facility must document in each patient's medical record whether the patient executed an advance medical directive.\textsuperscript{99} Furthermore, facilities must conduct educational programs for staff and the general public on issues concerning advance medical directives.\textsuperscript{100}

The legislation is designed to eliminate ignorance of the law concerning advance medical directives for both patients and physicians.\textsuperscript{101}

\textsuperscript{95} See supra note 85.

\textsuperscript{96} Fehren, \textit{Lord of Mercy and Compassion}, U.S. Catholic 39, 39 (August 1990) (quoting the writings of Jacques-Benigne Bossuet). "[A]t bottom no one believes in his own death, or to put the same thing in another way, in the unconscious every one of us is convinced of his own immortality." S. Freud, \textit{Our Attitude Towards Death}, in \textit{4 COLLECTED PAPERS} 304, 305 (1915).


\textsuperscript{99} Id.

\textsuperscript{100} Id.

\textsuperscript{101} 136 CONG. REC. E943-01 (daily ed. Apr. 3, 1990) (statement of Rep. Levin). "A survey in Colorado found that 23 percent of doctors are not familiar with living wills, and 74 percent are not familiar with durable powers of attorney." Id.
However, it is important to emphasize that this legislation does not create any new rights.\textsuperscript{102}

\textbf{B. Safeguarding an Incompetent Person's Right to Refuse Life-Sustaining Treatment: Solutions Adopted by the Courts}

Courts have adopted various methods to safeguard an incompetent person's right to refuse life-sustaining treatment. The two methods most often used in right to die cases are the substituted-judgment standard and the best-interests standard.

\textbf{1. The Substituted-Judgment Standard}

The substituted-judgment standard is most often chosen by the courts to safeguard an incompetent person's right to refuse unwanted medical treatment.\textsuperscript{103} The objective of this standard is for decision makers to reach the same decision that incapacitated people would make if they could choose.\textsuperscript{104} The courts have applied the substituted-judgment standard in two distinct ways.

Under a subjective version of the substituted-judgment standard, courts require the inquiry to be narrowed to the person's expressed intent.\textsuperscript{105} The probative value of any general statement the patient made in the past must be considered in the light of its remoteness, consistency, thoughtfulness, and specificity.\textsuperscript{106} Clearly, the best evidence of a person's intent would be a living will that specifically explains preferences about life-sustaining procedures.\textsuperscript{107} However, even a living will is not foolproof and may be challenged as insufficient evidence of a person's intent.\textsuperscript{108} The subjective substituted-judgment standard maximizes principles of self-determination and individuality because it requires decision makers to abandon their own competing ethical standards and focus on individuals.

\textsuperscript{102} Id.


\textsuperscript{104} PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BEHAVIORAL RESEARCH, \textit{DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT} I, 132 (1983) [hereinafter COMMISSION REPORT].

\textsuperscript{105} In re Westchester County Medical Center, 72 N.Y.2d 517, 530-31, 531 N.E.2d 607, 613, 534 N.Y.S.2d 886, 892 (1988).

\textsuperscript{106} In re Colyer, 99 Wash. 2d 114, 131-32, 660 P.2d 738, 748 (1983).


Under an objective version of the substituted-judgment standard, courts have held that actual, specific, express intent of an individual's treatment preference is not necessary.109 Clear and convincing evidence of a person's intent can be derived from the context of an individual's entire life. The person's religious beliefs, philosophical views, life goals, and attitudes toward death are appropriate factors to be considered.110 "The theory of [the objective] substituted judgment [standard] is that if we know someone well enough—her ideals, values, attitudes, philosophy of life—we can figure out how she would have reacted to a new situation."111

When there is absolutely no reliable evidence of a person's intent, neither substituted-judgment standard provides any guidance. In Superintendent of Belchertown State School v. Saikewicz,112 the Supreme Judicial Court of Massachusetts erroneously applied a substituted-judgment standard to a patient who had been profoundly mentally retarded since birth.113 Such patients cannot leave evidence of their intentions because they cannot formulate legally effective wishes.114 Under such circumstances, both substituted-judgment standards are pure fiction and should be abandoned in favor of a best-interests standard.115

2. The Best-Interests Standard

Only a few courts have used the best-interests standard,116 which involves the decision maker using a set of objective criteria to assess what would be in the patient's best interests.117 Life-sustaining treatment can only be removed if the burdens of a continued existence clearly outweigh the benefits.118

110. Id. at 49-50, 549 N.E.2d at 299-300; see also In re Conroy, 98 N.J. 321, 361-362, 486 A.2d 1209, 1229-1230 (1985).
113. Id. at 752-53, 370 N.E.2d at 431-32.
118. In re Conroy, 98 N.J. at 365, 486 A.2d at 1232.
Generally, all courts agree that the amount of pain a person must endure, the possibility of restored functionality, and life expectancy are appropriate objective criteria to be included in the best-interests standard. What is debated is whether quality of life is also an acceptable objective criterion. Some courts exclude quality of life from the best-interests standard because of the fundamental notion that no person should be able to decide what is an acceptable quality of life for another person. Other courts say that an accurate assessment of a person's best interests must include quality of life.

3. Balancing an Incompetent's Right Against State Interests

Regardless of the standard used to exercise an incompetent person's right to refuse unwanted medical treatment, the right is not absolute and must be balanced against relevant state interests. Generally, the four state interests involved are preventing suicide, preserving the ethical integrity of the medical profession, protecting the interests of innocent third parties, and preserving life. The state's interest in the preservation of life is generally characterized as the most significant of the asserted interests.

The state's interest in preserving life weakens, and the individual's right to refuse treatment grows, when bodily invasion increases and the prognosis dims. Considering the circumstances of a person in a persistent vegetative state, no state interest is strong enough to outweigh the person's right to discontinue life-sustaining treatment.

119. Id. at 353-64, 486 A.2d at 1231; Rasmussen, 154 Ariz. at 222, 741 P.2d at 689; In re Conservatorship of Torres, 357 N.W.2d at 338-39.
120. In re Conroy, 98 N.J. 321, 367, 486 A.2d 1209, 1232-33 (1981) (allowing a person to judge the quality of another person's life would create an intolerable risk for socially isolated people suffering from physical or mental handicaps).
121. Rasmussen v. Fleming, 154 Ariz. 207, 222, 741 P.2d 674, 689 (1981). It is important to note that "quality of life" refers to the value that the continuation of life has for the patient and not the value that others might find in the continuation of the patient's life. Id. at 222 n.23, 741 P.2d at 689 n.23.
126. In re Sevems, 425 A.2d 156, 158-59 (Del. Ch. 1980); In re Peter, 108 N.J. 365, 380, 529 A.2d 419, 427 (1987) ("We find it difficult to conceive of a case in which the state could have an interest strong enough to subordinate a patient's right to choose not to be artificially sustained in a persistent vegetative state.")
IV. THE UNITED STATES SUPREME COURT’S DECISION IN CRUZAN

Although many state courts have held that a right to refuse unwanted medical treatment is encompassed by the federal right to privacy under the Bill of Rights, the United States Supreme Court found that the right to refuse unwanted medical treatment is more properly analyzed under the fourteenth amendment of the United States Constitution. In Cruzan the Court recognized for the first time that a person has a constitutionally protected liberty interest under the due process clause to refuse unwanted medical treatment. However, a state may properly decline to make judgments about the “quality” of a person’s life and assert an unqualified interest in life that is to be balanced against the constitutionally protected interests of that individual.

While a competent person has a constitutional right to refuse unwanted medical treatment, the Court did not recognize that same right for an incompetent person. An incompetent person is incapable of making an informed and voluntary decision; therefore, the Court held, a state may establish procedural safeguards to ensure that a proxy’s actions conform to the wishes the incompetent person expressed when the person was still competent. In Cruzan, the Court held that the Constitution does not forbid the state of Missouri from requiring clear and convincing evidence of an incompetent person’s wishes before life-sustaining treatment is withdrawn.

Ordinarily, the standard of proof in a civil proceeding is a preponderance of the evidence. However, the Supreme Court has previously mandated that a clear and convincing standard is required when the individual interests at stake are particularly important and more substantial than a mere loss of money. The clear and convincing evidence standard has been described as “proof sufficient to persuade

128. See supra note 9.
129. Cruzan, 110 S. Ct. at 2851.
130. Id. at 2853.
131. Id. at 2852. Although the Court’s statement is unclear, it probably does not stand for the principal that an incompetent person does not have a constitutional right to refuse medical treatment. The best interpretation of the Court’s statement is that it merely emphasizes the need for procedural safeguards to ensure that an incompetent’s constitutional right to refuse medical treatment is preserved. See also supra note 80.
132. Cruzan, 110 S. Ct. at 2852.
133. Id.
134. Id.
136. Cruzan, 110 S. Ct. at 2853 (citing Santosky v. Kramer, 455 U.S. 745, 756 (1982) (a clear and convincing standard was required in a proceeding for the termination of parental rights)).
the trier of fact that the patient held a firm and settled commitment to the termination of life supports under the circumstances like those presented.\textsuperscript{137} The evidence must be so clear, direct, and weighty that the factfinder can determine, without hesitation, an incompetent's intent.\textsuperscript{138}

The \textit{Cruzan} majority also asserted that placing a more stringent burden of proof on the party seeking to remove life-sustaining treatment is appropriate because an erroneous decision to withdraw treatment cannot be corrected.\textsuperscript{139} An erroneous decision not to withdraw treatment merely preserves the status quo.\textsuperscript{140} The possibility of advancements in medical science, the discovery of new evidence of a patient's intent, changes in the law, or simply the patient's unexpected death create the possibility that an erroneous decision eventually will be corrected.\textsuperscript{141} Therefore, a state may apply a clear and convincing evidence standard in proceedings where a proxy seeks to remove life-sustaining treatment from a person diagnosed as being in a persistent vegetative state.\textsuperscript{142}

The final issue before the Court was whether the Missouri Supreme Court correctly applied the clear and convincing evidence standard in the \textit{Cruzan} case. Nancy Cruzan's mother and sister both testified that they were certain Nancy would want to discontinue her artificial feeding and hydration.\textsuperscript{143} Furthermore, Athena Comer, Nancy's close friend and roommate, testified that Nancy had stated that she would not want to live in a vegetative state.\textsuperscript{144} The conversation between Nancy and Athena took place only a year before Nancy's accident and was described as a serious conversation that lasted thirty minutes.\textsuperscript{145} The Missouri Supreme Court characterized Nancy's statements as "remote, general, spontaneous, and made in casual circumstances,"\textsuperscript{146} and dismissed her statements as unreliable.\textsuperscript{147} The majority of the

\begin{thebibliography}{99}
\bibitem{137} \textit{In re Westchester County Medical Center}, 72 N.Y.2d 517, 531, 531 N.E.2d 607, 613, 534 N.Y.S.2d 886, 892 (1988).
\bibitem{139} \textit{Cruzan v. Director, Missouri Dep't of Health}, 110 S. Ct. 2841, 2852 (1990).
\bibitem{140} \textit{Id}.
\bibitem{141} \textit{Id}. The majority misconceived the relevance of advancements in medical science by treating it as a reason to force a person to receive medical treatment against his will. \textit{Id}. at 2873 (Brennan, J., dissenting). The possibility of a medical advancement is merely an additional factor in determining what the incompetent person would choose if he were able to do so. \textit{Id}. at 2873-74 (Brennan, J., dissenting).
\bibitem{142} \textit{Id}. at 2854.
\bibitem{143} \textit{Id}. at 2874 n.20 (Brennan, J., dissenting).
\bibitem{144} \textit{Id}. at 2874 n.19 (Brennan, J., dissenting).
\bibitem{145} \textit{Id}.
\bibitem{147} \textit{Id}.
\end{thebibliography}
United States Supreme Court simply concluded that the Missouri Supreme Court correctly applied the clear and convincing standard. However, the Court failed to state specifically what evidence it would find clear and convincing.

In summary, the majority of the Court held that the Constitution does not prevent a state from applying a subjective version of the substituted-judgment standard as the appropriate procedure to safeguard an incompetent person's right to refuse life-sustaining treatment. Furthermore, the subjective substituted-judgment standard can be asymmetrically applied in that the Court did not require clear and convincing evidence that Nancy Cruzan wanted to continue treatment.

A. The Concurring Opinions

Justice O'Connor wrote separately to emphasize the limited scope of the Court's decision. Although Cruzan permits each state to craft its own procedure to safeguard an incompetent's right to refuse treatment, Justice O'Connor suggested that each state should take into account the proxy's decision to protect the incompetent patient's liberty interest to refuse treatment. Allowing people to designate proxies to carry out their intent is a valuable safeguard of their interests in directing their medical care, Justice O'Connor wrote.

Justice Scalia was unable to distinguish a right to refuse life-sustaining treatment from a right to commit suicide. He pointed out that states always have had the authority to prevent suicide. Even when there is clear and convincing evidence that a person would wish to withdraw life-sustaining treatment, state legislatures may decide whether that wish will be honored because the United States Constitution does not discuss suicide, he wrote. Although the equal prote-

148. Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2855 (1990). The majority's general discussion suggests that only a living will or equivalently formal directive from the patient when competent would constitute clear and convincing evidence of an incompetent's wishes. Id. at 2874-75 (Brennan, J., dissenting).
149. See supra notes 103-115 and accompanying text.
150. Id. at 2856 (O'Connor, J., concurring).
151. Id. at 2858-59 (O'Connor, J., concurring).
152. Id. at 2857 (O'Connor, J., concurring).
153. Id. at 2858 (O'Connor, J., concurring).
154. Id. at 2859 (Scalia, J., concurring). "Starving oneself to death is no different from putting a gun to one's temple as far as the common-law definition of suicide is concerned . . . ."
155. Id. at 2861 (Scalia, J., concurring).
156. Id. at 2861-62 (Scalia, J., concurring).
157. Id. at 2862-63 (Scalia, J., concurring).
tion clause\textsuperscript{158} places some limitations on what a state may force an individual to endure in order to sustain his or her life, the due process clause\textsuperscript{159} does not prevent a state from prohibiting suicide, Justice Scalia noted.\textsuperscript{160}

\textbf{B. The Dissenting Opinions}

After emphasizing the grim details of Nancy Cruzan's condition, Justice Brennan's dissenting opinion\textsuperscript{161} said that no state interest could outweigh the rights of someone in her position.\textsuperscript{162} A state's generalized interest in life must yield to a person's particularized and intense interest in refusing unwanted medical treatment, Justice Brennan wrote.\textsuperscript{163} Therefore, a state may only impose procedural requirements that enhance the accuracy of determining an incompetent person's wishes.\textsuperscript{164} The procedural "safeguards" adopted by the Supreme Court of Missouri do not provide this enhancement.\textsuperscript{165}

Missouri's requirement of a heightened evidentiary standard attempts to safeguard an incompetent patient's wishes, but it discounts relevant evidence.\textsuperscript{166} An incompetent person's wishes are better protected by appointing a guardian ad litem whose task is to uncover any conflicts of interest and to ensure that other members of the family, friends, doctors, and clergy are consulted, Justice Brennan wrote.\textsuperscript{167} The guardian ad litem safeguards an incompetent person's wishes by probing for more evidence, rather than discounting relevant evidence, he wrote.\textsuperscript{168}

While courts always have used a heightened evidentiary standard to place the greater risk of erroneous decisions on a person bringing a disfavored claim, Missouri cannot disfavor Nancy Cruzan's choice to refuse unwanted medical treatment, Justice Brennan wrote.\textsuperscript{169} The ma-

\textsuperscript{158} "No State shall . . . deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV, § 1.

\textsuperscript{159} See supra note 9.

\textsuperscript{160} Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2863 (1990) (Scalia, J., concurring).

\textsuperscript{161} Justice Brennan's dissenting opinion was joined by Justices Marshall and Blackmun. Id. at 2863 (Brennan, J., dissenting).

\textsuperscript{162} Id. at 2864 (Brennan, J., dissenting).

\textsuperscript{163} Id. at 2870 (Brennan, J., dissenting).

\textsuperscript{164} Id. at 2871 (Brennan, J., dissenting).

\textsuperscript{165} Id.

\textsuperscript{166} Id. at 2872 (Brennan, J., dissenting). For example, relevant evidence that would be discounted includes Athena Comer's testimony that Nancy Cruzan had said she would not want to live in a vegetative state. Id. at 2874 n.19 (Brennan, J., dissenting).

\textsuperscript{167} Id. at 2872 (Brennan, J., dissenting).

\textsuperscript{168} Id.

\textsuperscript{169} Id. at 2871-72 (Brennan, J., dissenting).
Majority claimed that an erroneous decision to withdraw life-sustaining treatment is irrevocable; however, from the point of view of the patient, an erroneous decision in either direction is irrevocable, he pointed out.\(^{170}\)

An erroneous decision to continue life-sustaining treatment robs incompetent people of their right to refuse unwanted medical treatment.\(^{171}\) Their degraded existences are perpetuated, the suffering of their families is prolonged, and the memory they leave behind becomes more and more distorted, Justice Brennan wrote.\(^{172}\) This harm cannot be undone by a later decision to withdraw life-sustaining treatment, he wrote.\(^{173}\) Furthermore, the event of such a later decision is more hypothetical than plausible.\(^{174}\)

Justice Brennan also wrote that if an incompetent’s wishes cannot be determined, a state cannot automatically make the decision for the incompetent.\(^{175}\) The majority found that there is no guarantee that the views of close family members will coincide with those of the patient.\(^{176}\) However, there is no reason to believe that the state, rather than a close family member, would be more likely to make the same choice as the patient, Justice Brennan pointed out.\(^{177}\) “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...”\(^{178}\) The due process clause prohibits a state from doing more than protecting an incompetent’s wishes.\(^{180}\) In summary, Justice Brennan appears to support an objective version of the substituted-judgment standard as the appropriate procedure to safeguard an incompetent’s right to refuse life-sustaining treatment. He would not require actual, specific, and express intent of an individual’s treatment preference and would allow family members to derive intent from the mere context of his life.

Justice Stevens, in a separate dissent, criticized Missouri’s effort to define life as the biological persistence of bodily functions without re-

\(^{170}\) Id. at 2873 (Brennan, J., dissenting).
\(^{171}\) Id.
\(^{172}\) Id.
\(^{173}\) Id.
\(^{174}\) Id.
\(^{175}\) Id. at 2877 (Brennan, J., dissenting).
\(^{176}\) Id.
\(^{177}\) Id.
\(^{178}\) Id. (quoting In re Jobes, 108 N.J. 394, 416, 529 A.2d 434, 445 (1987)).
\(^{179}\) See supra note 9.
\(^{180}\) Cruzan v. Director, Missouri Dep’t of Health, 110 S. Ct. 2841, 2877 (1990) (Brennan, J., dissenting).
garded to Nancy Cruzan's individual interests. He suggested that the definition of "life," as it is commonly understood and used in the Constitution, fails to encompass a person in a persistent vegetative state. "Lives do not exist in abstraction from persons, and to pretend otherwise is not to honor but to desecrate the State's responsibility for protecting life." Justice Stevens would hold that the due process clause requires the state to act in Nancy Cruzan's best interests.

A court should not place an incompetent person's best interests to one side and focus the inquiry solely on the person's prior expressions of intent, Justice Stevens wrote. The constitutional right to be free from unwanted medical treatment is not categorically limited to those who had the foresight to execute formal statements of their wishes while they were competent, he wrote. In situations where an incompetent person's treatment decision cannot be determined, Justice Stevens would require a best-interests standard as the appropriate procedure to safeguard a person's right to refuse life-sustaining treatment.

V. ANALYSIS

Every member of the Court except Justice Scalia would agree that a person has a constitutionally protected liberty interest under the due process clause to refuse unwanted medical treatment. However, members of the Court could not agree on the appropriate procedure to safeguard an incompetent person's right to refuse life-sustaining treatment. This section will analyze the various procedures used in previous right to die cases and will attempt to identify the procedure most able to protect the constitutional right to refuse unwanted medical treatment.

The initial question is whether a court should apply a best-interests standard or one of the versions of the substituted-judgment standard. In answering this question, it is important to remember that the constitutional right to refuse unwanted medical treatment is an individual right.

181. Id. at 2886 (Stevens, J., dissenting).
182. Id.
183. Id. at 2892 (Stevens, J., dissenting).
184. See supra note 9.
186. Id. at 2882 (Stevens, J., dissenting).
187. Id. at 2882-83 (Stevens, J., dissenting).
188. Id. at 2855 (the due process clause does not require the state to confer the right to refuse medical treatment to anyone but the patient himself).
Both versions of the substituted-judgment standard are subjective standards, while the best-interests standard is an objective standard. Under a subjective standard an individual could choose a course of action that objectively may not be in his or her best interests. Therefore, both versions of the substituted-judgment standard attempt to maximize principles of self-determination and individuality. A substituted-judgment standard should always be pursued before applying a best-interests standard. The more difficult question is which version of the substituted-judgment standard is most appropriate to safeguard an incompetent person’s constitutional right.

A. Should Courts Apply a Subjective or Objective Version of the Substituted-Judgment Standard?

As explained previously, the objective substituted-judgment standard allows clear and convincing evidence of a person’s intent to be derived from the context of his or her life. However, this standard is premised upon a legal fiction. Some courts have even used an objective substituted-judgment standard to determine whether to discontinue life-sustaining treatment for an infant. Under such circumstances, it is clearly impossible for a proxy to ascertain what the incompetent individual would decide. In reality, the objective substituted-judgment standard is merely a best-interests standard with no specified objective criteria for the proxy to follow.

It is this author’s opinion that the objective substituted-judgment standard merely allows the courts to avoid the difficult question of whether “quality of life” is an appropriate criterion in a best-interests standard. When a court allows a proxy to derive an incompetent

189. See supra text accompanying notes 103-15. The goal of both the subjective and objective substituted-judgment standards is to reach the decision the incapacitated person would reach if he or she were able to do so. Therefore, in theory, both versions are subjective. However, the objective substituted-judgment standard is subjective only in a fictitious sense. See infra text accompanying notes 192-95.

190. See supra text accompanying notes 116-21.

191. The substituted-judgment standard promotes the underlying values of self-determination and well-being better than the best-interests standard. COMMISSION REPORT, supra note 104, at 136.

192. “[I]n 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 sustained decision-making.” In re Conroy, 98 N.J. 321, 364, 486 A.2d 1209, 1231 (1981).


194. See Kamisar, Karen Ann Quinlan and the “Right-to-Die,” 29 LAW QUADRANGLE NOTES 2-3 (1985) (Quinlan was a poorly disguised “quality of life” case which “badly smudged . . . the distinction between the right to choose one’s own death and the right to choose someone else’s . . .”).
person’s wishes from such vague notions as the context of the person’s life, the proxy is given wide latitude in arriving at his or her decision. Typically in these situations, the proxy nominated by the court is the family of the incompetent patient. The court is implicitly allowing the family to consider the quality of the incompetent person’s life. The court also is implicitly allowing the family to consider the financial burden of continuing life-sustaining treatment, as well as other unknown factors. The objective substituted-judgment standard is merely a convenient avenue for the courts to avoid specifying the appropriate objective criteria to be used in a best-interests standard.

The objective substituted-judgment standard fails to protect all individuals with diminished mental capacities. In most cases an incompetent person’s family will reach a decision that is in the person’s best interests. However, this will not always be true. For instance, a family’s decision to terminate life-sustaining treatment could be motivated by a desire to end expensive hospital bills or to hasten an anticipated inheritance. The only way courts can protect the incompetent person from potential abuse is if the courts abandon the objective substituted-judgment standard.

In Harmon, the Missouri Supreme Court used the subjective version of the substituted-judgment standard. Nancy Cruzan’s close friend and roommate testified that Nancy had stated in a serious and lengthy conversation that she would not want to live in a vegetative state. Nancy’s mother and sister both testified that they were certain that, under the circumstances, Nancy would not want to continue life-sustaining treatment. The Missouri Supreme Court held that this evidence alone did not amount to clear and convincing evidence of Nancy Cruzan’s wishes to terminate life-sustaining treatment. The Cruzan decision suggests that anything short of a formal declaration, such as a living will, will fail to constitute clear and convincing evidence of an incompetent person’s intent. This is the essence of the subjective substituted-judgment standard.

Justice Brennan would prefer that the states use an objective substituted-judgment standard, which allows the family of the incompetent person to reach a treatment decision. However, he is ignoring the fact


196. Cruzan v. Director, Missouri Dep’t of Health, 110 S. Ct. 2841, 2874 n.19 (Brennan, J., dissenting).

197. Id. at 2874 n.20 (Brennan, J., dissenting).


199. Cruzan, 110 S. Ct. at 2874-75 (Brennan, J., dissenting).
that the constitutional right to refuse life-sustaining treatment is an individual right. As explained previously, the substituted-judgment standard dictates that a proxy must attempt to reach the same decision as the incompetent person would make if he or she were able to do so. The patient’s constitutional right to refuse unwanted medical treatment cannot be confused with an opinion poll. A subjective substituted-judgment standard is necessary to ensure that the proxy’s decision would be the same as that of the incompetent.

Relying on a person’s past conversations with friends and relatives falls short of a clear and convincing evidentiary burden. Without a formal declaration of what an incompetent person would choose, the substituted-judgment standard merely amounts to a legal fiction.

The existence of a writing suggests the author’s seriousness of purpose and ensures that the court is not being asked to make a life-or-death decision based upon casual remarks. Further, a person who has troubled to set forth his or her wishes in a writing is more likely than one who has not to make sure that any subsequent changes of heart are adequately expressed, either in a new writing or through clear statements to relatives and friends. In contrast, a person whose expressions of intention were limited to oral statements may not as fully appreciate the need to “rescind” those statements after a change of heart.

Therefore, it was appropriate for the Missouri Supreme Court to hold that the evidence presented did not clearly and convincingly establish that Nancy Cruzan would want to forgo life-sustaining treatment. Courts that have allowed parol evidence to constitute clear and convincing evidence of an incompetent’s wishes are applying an objective substituted-judgment standard. In conclusion, courts should apply a subjective substituted-judgment standard.

B. Should the Subjective Substituted-Judgment Standard Be Applied Symmetrically or Asymmetrically?

The Missouri Supreme Court and the United States Supreme Court erroneously applied the subjective substituted-judgment standard.

200. See supra note 188.
201. In re Guardianship of Browning, 543 So. 2d 258, 273 (Fla. 2d DCA 1989).
202. See Note, In re Gardner: Withdrawing Medical Care from Persistently Vegetative Patients, 41 Me. L. REV. 447, 458-62 (1989) (by holding that Gardner’s casual statements clearly show an actual decision to forgo life-sustaining treatment, the Maine Supreme Judicial Court has established a precedent whereby informal and abstract remarks become life and death decisions).
asymmetrically by not requiring clear and convincing evidence that Nancy Cruzan would want to continue life-sustaining treatment. An asymmetrical substituted-judgment standard affords no protection to children or to persons who have been mentally handicapped since birth. Under these circumstances, there will never be clear and convincing evidence that the person would refuse life-sustaining treatment since he or she never was able to formulate a legally effective wish. Therefore, under an asymmetrical substituted-judgment standard, such persons will always be forced to continue treatment regardless of their individual medical circumstances. By applying the substituted-judgment standard symmetrically, however, such persons are protected since the standard correctly determines that the person’s decision cannot be known, and the substituted-judgment standard yields to a best-interests standard.

The Supreme Court permitted an asymmetrical standard based on an assumption that an erroneous decision to continue an incompetent person’s life-sustaining treatment is a harmless mistake. This assumption ignores the very reasons why people would choose to exercise their rights to refuse life-sustaining treatment. People may exercise these rights to avoid the perpetuation of a degrading existence. As Justice Brennan correctly pointed out in his dissenting opinion, the damage done to people and their families by erroneous decisions to continue treatment is irrevocable. Clear and convincing evidence that an incompetent person would want to continue life-sustaining procedures must be required to safeguard incompetent people’s constitutional rights to refuse life-sustaining treatment.

In Cruzan, no evidence was introduced to demonstrate that Nancy Cruzan would have wanted to continue receiving life-sustaining treatment given her circumstances. Therefore, the result of a symmetrical substituted-judgment standard would be that it was impossible to know Nancy’s wishes by clear and convincing evidence. Whenever the subjective substituted-judgment standard fails to provide any guidance, the best-interests standard must be adopted to preserve an incompetent person’s right to refuse unwanted medical treatment.

C. The Best-Interests Standard and the "Quality of Life" Controversy

As previously explained, the goal of the best-interests standard is to assess what decision would be in a patient’s best interests by examin-
ing a set of objective criteria. By applying each criterion in the patient's case, the proxy must determine if the burdens of a continued existence outweigh the benefits.

Courts have disagreed on specifically which criteria should be used in a best-interests standard. In Rasmussen v. Fleming, the objective criteria considered by the court were the amount of physical pain a person must endure, the possibility of restored functionality, the life expectancy, and the quality of the person's life. Other courts have strongly criticized the inclusion of the quality of life as a factor in a best-interests analysis.

1. Ethical Considerations for Omitting the "Quality of Life" from the Best-Interests Standard

Quality of life is the value that the continuation of life has for the individual person. No one should be allowed to determine that the quality of another person's life is inadequate and should be discontinued. If quality of life was a legitimate criterion, then people with all manner of handicaps might find the state seeking to terminate their lives. For example, does a profoundly mentally retarded adult have an acceptable quality of life? Does a person who is profoundly mentally retarded with multiple physical handicaps have an acceptable quality of life? The answers to these difficult questions probably will depend on who is asked. No one should ever be able to decide this question for someone else. While each person in these hypotheticals has a diminished mental capacity, it should be stressed that, unlike a patient in a persistent vegetative state, each has some mental capacity. Regardless of the level of a person's mental capacity and the extent of any accompanying physical handicaps, quality-of-life judgments never should be included in the best-interests standard.

The objective criteria to be considered in the best-interests standard are the amount of physical pain a person must endure, the possibility of restored functionality, and the person's life expectancy. These criteria are more than adequate to protect individuals with diminished mental capacities from enduring a painful and burdensome existence. However, these criteria fail to protect individuals who are in persistent vegetative states.

208. Id. at 222, 741 P.2d at 689.
209. See supra note 120.
2. Why Courts Must Consider "Quality of Life" for Persons in a Persistent Vegetative State

While a person in a persistent vegetative state never will recover any level of functionality, he or she also is not experiencing any pain, and the life expectancy can be lengthy. Therefore, without considering the quality of life for a person in a persistent vegetative state, it would appear that continuing life-sustaining treatment is in the patient's best interests. However, this result is unacceptable when the persistent vegetative state is fully understood.

More than a decade ago the seminal right to die case involved a person in a persistent vegetative state. But despite the prominence of that case, courts and physicians have continued to experience difficulty in completely understanding the persistent vegetative state. The Georgia Supreme Court incorrectly characterized the persistent vegetative state as a terminally ill condition. In Brophy v. New England Sinai Hospital, the trial court incorrectly decided to continue treatment because a person in a persistent vegetative state would experience a painful death if the person's feeding and hydration tubes were removed. "Some in the 'Right to Life' movement have worked long, hard, and successfully to create a false belief, even in many physicians, that to withdraw nutrition and hydration [from a person in a vegetative state] is to 'condemn' a patient to a horrible, painful, grotesque end. Nothing could be farther from the truth."

Even in the Cruzan decision, Justice Stevens noted that the Missouri Supreme Court had said that if Nancy Cruzan has any awareness of her surroundings, her life must be a living hell. This again demonstrates the misunderstandings that surround the persistent vegetative state. People in this state have no cognitive functions; they are

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210. Cranford, supra note 8, at 31; see also Cruzan v. Harmon, 720 S.W.2d 408, 411 (Mo. 1988) (en banc), aff'd sub nom. Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841 (1990) (medical experts testified that Nancy Cruzan could have lived another thirty years in a persistent vegetative state). See also supra notes 26, 27, 53, and accompanying text.


212. In re L.H.R., 253 Ga. 439, 447, 321 S.E.2d 716, 723 (1984) ("In the case of incompetent adults who are terminally ill, in a chronic vegetative state with no reasonable possibility of regaining cognitive function, we find that the family of the adult or the legal guardian may make the decision to terminate life support systems . . . .") (emphasis added).


214. Id. at 426-27 n.20, 497 N.E.2d at 631 n.20.


216. Cruzan v. Director, Missouri Dep't of Health, 110 S. Ct. 2841, 2882 (1990) (Stevens, J., dissenting) (referring to Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988) (Blackmar, J., dissenting)).
completely unaware of their surroundings and cannot experience pain.\textsuperscript{217} People in persistent vegetative states are little more than collections of organs.\textsuperscript{218} While Nancy Cruzan was in a persistent vegetative state, her body was a passive prisoner of advanced medical technology.

Considering the quality of life for a person in a persistent vegetative state does not offend the principle that no person should decide what is an unacceptable quality of life for another. The principle is logical only when an incompetent individual has some level of mental capacity.

Consider the consequences of applying a best-interests standard that does not consider quality of life to a person who is brain dead, but whose body is artificially maintained. While a person who is brain dead will never recover any level of functionality, he or she is also not experiencing any pain.\textsuperscript{219} The results are very similar to those reached for a person in a persistent vegetative state. Without considering quality of life, it is arguable that the best interest of a person who is brain dead is, ironically, to continue life-sustaining treatment. This is an absurd result. The only way to reach a rational result is to apply a best-interests standard that considers the person's quality of life. A person in a persistent vegetative state is easily distinguishable from a person with any other medical condition that might present itself in a right to die case. A person in a persistent vegetative state has no cognitive functions, and the condition is irreversible.\textsuperscript{220} The only possible way to obtain a rational result is to apply a best-interests standard which considers the quality of a person's life. Once the quality of life for a person in a persistent vegetative state is considered, the result is apparent: life-sustaining treatment must be terminated.

3. Courts Must Distinguish Persons in a PVS from All Other Right to Die Cases

No single procedure can be logically applied to every right to die case. Courts must distinguish cases involving the withdrawal of life-sustaining treatment for persons in a persistent vegetative state from all other right to die cases. When a court is applying a best-interests

\textsuperscript{217} See supra text accompanying notes 48-56.


\textsuperscript{219} By definition, brain death is the irreversible loss of all brain function. See D. Meyers, supra note 34, at § 4:3. A person cannot experience pain without the cognitive ability to do so. See supra notes 54-56 and accompanying text.

\textsuperscript{220} A person in a coma can be distinguished from a person in a persistent vegetative state because most comatose patients eventually recover some cognitive ability. See supra note 43.
standard in a right to die case where a person is in a vegetative state and has no mental capacity, the court must consider "quality of life" in order to reach a decision that is in the person's best interests. When a court is applying a best-interests standard in all other right to die cases, the court must not consider "quality of life" in order to protect all persons with diminished mental capacities.

VI. CONCLUSION

State legislatures should attempt to minimize the occurrence of the situation of an incompetent person with no expressed treatment preference. This can be done by promptly adopting Justice O'Connor's suggestion to enact statutes that specifically allow the appointment of proxies for health care decisions. Ultimately states may determine that the best solution for persons in a persistent vegetative state is to redefine death to include the persistent vegetative state. Such legislation could be prompted by Justice Stevens' suggestion that the constitutional and commonly used definition of "life" may not include a person in a persistent vegetative state. The availability of such a solution will depend on medical advances in diagnosing the persistent vegetative state and public acceptance of such a definition. Therefore, the *Cruzan* decision may best be remembered for Justice O'Connor's concurring opinion and Justice Stevens' dissenting opinion.

Regardless of what action the legislatures take, there always will be incompetent individuals who have not expressed treatment preferences. The courts must adopt procedural safeguards which are best suited to preserving an incompetent person's constitutional right to refuse unwanted medical treatment. The decision in *Cruzan* abandoned Nancy Cruzan's constitutional right to refuse life-sustaining treatment simply because she was incompetent.

In deciding whether to forgo life-sustaining treatment for an incompetent person, a court should first apply a subjective substituted-judgment standard. This standard should be applied symmetrically so clear and convincing evidence is required to forgo or to continue life-sustaining treatment. In the absence of a formal declaration of the incompetent person's wishes, the subjective substituted-judgment standard should be abandoned in favor of a best-interests standard.

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222. *See supra* note 182.
224. *Id.* at 2878-92 (Stevens, J., dissenting).
For some people, such as those with a diminished mental capacity and multiple physical handicaps, the objective criteria to be considered in a best-interests standard are the amount of pain that the person must endure, the possibility of restored functionality, and the person's life expectancy. If the incompetent person is in a persistent vegetative state, the quality of life should also be included as an objective criterion in the best-interests standard.

In conclusion, it should be noted that judicial intervention in right to die cases takes too long and could infringe on the very rights the courts should be protecting. A guardian ad litem, the family, and the doctors can follow the aforementioned procedures for safeguarding an incompetent's right without court supervision. The state's role should be limited to ensuring that the procedures to safeguard an incompetent's right are correctly followed by the family, doctors, and guardian ad litem. Courts should only intervene when there is a disagreement between these parties or if there is evidence of improper motives or malpractice. Because disagreements between the interested parties should prove unlikely, judicial intervention will seldom be necessary.

VII. EPILOGUE

Two months after the Supreme Court's decision in Cruzan, Nancy Cruzan's family obtained a hearing in a Missouri trial court on the basis of new evidence. Three of Nancy's former coworkers recalled Nancy stating that she would not want to live "like a vegetable." The state of Missouri withdrew from the case, saying it had no further role to play once the legal issue was decided. Finally, it is apparent that the state of Missouri was not concerned about the individual in-

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225. In re Jobes, 108 N.J. 394, 423, 529 A.2d 434, 449 (1987). An alternate point of view was articulated by the Supreme Judicial Court of Massachusetts. See Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 758-59, 370 N.E.2d 417, 434-35 (1977). Questions of life and death require the "detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created." Id. at 759, 370 N.E.2d at 435. The Saikewicz decision has been strongly criticized. See Relman, The Saikewicz Decision: A Medical Viewpoint, 4 AM. J. L. & MED. 233, 237 (1978) (criticizing the decision as "a new intrusion of the judiciary into an area of medical practice previously considered the private domain of physicians, patients and their families"); Curran, Law-Medicine Notes: The Saikewicz Decision, 298 NEW ENG. J. MED. 499, 500 (1978) (the decision's requirement of a judicial hearing in every case shows a distrust and lack of understanding of medical care procedures).


229. Id.

230. Id.
terests of Nancy Cruzan. In the eyes of the state, Nancy Cruzan was merely a legal pawn. Again, the state’s role in right to die cases should be limited to ensuring that the procedures to safeguard an incompetent’s right are followed correctly by the family, doctors, and guardian ad litem.

After the ex parte hearing, Judge Teel ruled that there was clear and convincing evidence of Nancy Cruzan’s wishes and gave permission for her feeding and hydration tube to be removed. Doctors discontinued Nancy Cruzan’s life-sustaining treatment on December 14, 1990. Twelve days later Nancy died. After her death Nancy’s father commented, “We all feel good that Nancy’s free at last. We stopped a useless medical technology that was serving no use whatsoever.”

While Judge Teel’s decision was certainly crucial for Nancy Cruzan, the decision has virtually no value as a legal precedent. The Missouri Supreme Court’s decision in *Cruzan* remains the controlling case in the state.

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231. *Id.*
232. *Id.*
233. *Id.*