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DEATH AND LIFE DECISIONS: WHO IS IN CONTROL?

Stephen C. Kenney*

I. INTRODUCTION

What has been described as the greatest publishing event of the century took place recently in the latest edition of the Oxford English Dictionary.1 Nestled among dictionary definitions of North American slang is the “right to die,” a term with origins in both law and medicine. Although not specifically preserved as a constitutional right in federal or state constitutions, the Oxford English Dictionary defines the “right to die” as “the alleged right of a brain-damaged or otherwise incurably ill person to the termination of life-sustaining treatment.”2 Although this dictionary definition is simply stated, the legal, medical and moral applications of this so-called “right” has caused a plethora of vexing problems.

In April 1989, 86-year-old Carrie Coons lay in a New York hospital.3 Doctors diagnosed her condition as a “persistent vegetative state.”4

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1. 13 OXFORD ENGLISH DICTIONARY 923 (2d ed. 1989).

2. Id.


4. For the purposes of this Article, a “persistent vegetative state” is defined as a form of unconsciousness arising from severe disruption of the coordinated functions of the brain.
Shortly after her sister obtained a court order authorizing removal of Coons' life-sustaining feeding tube, Coons regained consciousness and began to talk and eat small amounts of food. She became alert enough for her doctor to advise her of her right to die option, as well as the court order obtained by her sister. When asked by her doctor what she wished to do, Ms. Coons replied, "these are difficult decisions," then lapsed back into a coma.

The causes and places of death have changed dramatically in recent years. Most deaths today are caused by illnesses such as heart disease, cancer or cerebrovascular disease, that frequently progress for years before death occurs. Almost ninety percent of the American population succumbs to chronic degenerative conditions, as opposed to dying a sudden death. Additionally, over the years, death and dying have moved out of the home and into the institutional setting. As a result, death today frequently occurs in institutions equipped with life-sustaining technology that can keep the terminally ill alive for indefinite periods of time.

Scientific advances have made it possible to live longer than ever before, often without regard for the irrevocable loss of physical and mental capacity that many patients suffer. In response, patients and

caused by a physical or chemically-induced injury. See Ingvar, Brun, Johansson & Samuelson, Survival after Severe Cerebral An-cia with Destruction of the Cerebral Cortex: The Apallic Syndrome, 315 ANNALS N.Y. ACAD. SCI. 184, 202 (1978) ("Patients in a persistent vegetative state may appear wakeful and their brain stems maintain subsistence activities and reflexes, however, they suffer a complete loss of the higher functions of speech, voluntary muscular activity, directed emotions, and signs of memory.").

6. Id.
7. Id.
8. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 16 (1983) [hereinafter PRESIDENT'S COMMISSION REPORT].
9. Id. at 15-16.
10. This Article adopts the definition of "terminally ill" as used in Beatty, Artificial Nutrition and the Terminally Ill: How Should Washington Decide?, 61 WASH. L. REV. 419, 419 n.2 (1986) ("[T]erminal illness means an incurable condition caused by injury, disease, or illness from which there is no reasonable chance of recovery or cure, and which will, within reasonable medical judgment, produce death in the foreseeable future, in the absence of life-sustaining treatment."). See also Cohen, Interdisciplinary Consultation on the Care of the Critically Ill and Dying: The Role of One Hospital Ethics Committee, 10 CRITICAL CARE MED. 776, 781 (1982). This Article includes among the terminally ill those persons in a persistent vegetative state.
12. See In re Drabick, 200 Cal. App. 3d 185, 196, 245 Cal. Rptr. 840, 846, cert. denied,
their families have increasingly asserted the "right to die" a natural death, a death without undue dependence on medical technology or unnecessarily protracted agony—in short, the "right to die" with dignity. One court has noted that "'[o]nce someone realizes that the time and manner of death are substantially under the control of medical science, he or she wants to be protected against decisions that make death too easy and quick as well as from those that make it too agonizing and prolonged.'"13

Absent legislation, the courts have been compelled to formulate new standards and procedures for measuring the conduct of persons involved in caring for the terminally ill or irreversibly brain-damaged.14 Courts

109 S. Ct. 399 (1988). The Drabick court noted that current literature recognizes that "'doctors now choose from a vast array of interventions that, when combined with effective therapies for underlying conditions, often greatly prolong survival. Unfortunately, the quality of the additional life so skillfully sought can range from marginally tolerable to positively miserable.'" Id., (quoting Ruark, Raffin & Stanford University Medical Center Committee on Ethics, Special Article: Initiating and Withdrawing Life Support, 318 NEW ENG. J. MED. 25, 25 (1988)).


14. See, e.g., Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987) (where incompetent patient has never expressed her medical desires, decisions concerning patient's medical treatment are to be guided by standard which calls for evaluation of what is in patient's best interest); Drabick, 200 Cal. App. 3d at 189, 245 Cal. Rptr. at 841 (conservator of incompetent person in vegetative state with no hope of recovery is authorized to decide, considering medical advice and conservatee's best interests, that artificial life support should be withdrawn); Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986) (although patient may elect to refuse medical treatment hospital staff is still free to perform part of their duties, such as trying to alleviate patient's pain and suffering); Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984) (parties should act according to patient's instruction); Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (court-appointed or other surrogate should make decisions first based on knowledge of patient's own desires and feelings; in absence of legislation, there is no legal requirement for prior judicial approval); Dority v. Superior Court, 145 Cal. App. 3d 273, 193 Cal. Rptr. 288 (1983) (once infant has been determined to be brain dead, no criminal or civil liability may result from disconnecting life support devices); Lovato v. District Court, 198 Colo. 419, 601 P.2d 1072 (1979) (physician may declare individual dead in accordance with accepted medical standards); Foody v. Manchester Memorial Hosp., 40 Conn. Supp. 127, 482 A.2d 713 (Conn. Super. Ct. 1984) (family of semicomatose patient could act as patient's substitute decision maker and decide to discontinue use of all artificial devices intended to continue respiration and pulse); *In re* Severns, 425 A.2d 156 (Del. Ch. 1980) (guardian may carry out previously expressed intent of patient); John F. Kennedy Memorial Hosp., Inc. v. Bludworth, 452 So. 2d 921 (Fla. 1984) (court approval not necessary for court-appointed guardian to authorize termination of life-support systems for comatose and terminally individual who executed "living" or "mercy" will); Wons v. Public Health Trust, 500 So. 2d 679 (Fla. Dist. Ct. App. 1987) (woman with two minor children could refuse blood transfusion needed to save her life based on religious beliefs, where she had made such a refusal while competent); Corbett v. D'Alessandro, 487 So. 2d 368 (Fla. Dist. Ct. App. 1986) (patient in persistent vegetative state receiving nutritional sustenance solely through nasogastric tube would have constitutionally protected right to have tube removed, subject to safe-
have recognized that the use of medical devices or other artificial life-

guards); \textit{In re} Barry, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984) (under doctrine of substituted judgment, parents could assert right to privacy on behalf of ten-month old son in permanent vegetative state and order termination of life support); \textit{Satz v. Perlmutter}, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978) (competent, terminally ill 73-year-old man, whose affliction was self-induced and who had expressed desire to live on his own power, had right to discontinue use of life-sustaining respirator); \textit{In re L.H.R.}, 253 Ga. 439, 321 S.E.2d 716 (1984) (parents could exercise right to refuse treatment on behalf of their terminally ill infant daughter who existed in permanent vegetative state and who had no hope of developing cognitive function); \textit{Morgan v. Olds}, 417 N.W.2d 232 (Iowa Ct. App. 1987) (although physician has duty to consult with incompetent patient's surrogate decisionmaker before treatment, physician has no such duty to incompetent's family, and patient's family may not recover for any breach of physician's duty); \textit{In re F.V.W.}, 424 So. 2d 1015 (La. 1982) (child in comatose state with no medically reasonable chance of recovery has right to refuse life-sustaining treatment, and child's parents may assert this right on behalf of child in judicial proceeding); \textit{In re Gardner}, 534 A.2d 947 (Me. 1987) (patient in persistent vegetative state has right to have life-sustaining procedures discontinued when he has declared this desire prior to injury and before losing competency); \textit{Brophy v. New England Sinai Hosp., Inc.}, 398 Mass. 417, 497 N.E.2d 626 (1986) (hospital may act in accordance with patient's substituted judgment); \textit{In re Minor}, 385 Mass. 697, 434 N.E.2d 601 (1982) (imposes doctrine of substituted judgment which ensures that personal decisions concerning individual remain with individual); \textit{In re Spring}, 380 Mass. 629, 405 N.E.2d 115 (1980) (private medical decisions by hospital staff must be made responsibly, subject to judicial scrutiny if good faith or due care is brought into question in subsequent litigation); \textit{Superintendent of Belchertown State School v. Saikewicz}, 373 Mass. 728, 370 N.E.2d 417 (1977) (incompetent may exercise right to life by substituted judgment of one acting on his or her behalf); \textit{In re Hier}, 18 Mass. App. Ct. 200, 464 N.E.2d 959 (1984) (in determining guardian's authority to decide treatment for ward, court may consider facts that proposed treatment was intrusive and burdensome, that patient had repeatedly and clearly indicated opposition to procedures necessary to introduce tube feeding, that benefits of procedure were diminished by evidence of patient's medical history), review denied, 392 Mass. 1102, 465 N.E.2d 261 (1984); \textit{In re Dinnerstein}, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978) (judicial approval of guardian's decision not to prolong life is necessary only where life-saving or life-prolonging treatment alternatives exist); \textit{In re Torres}, 357 N.W.2d 332 (Minn. 1986) (conservator must act in best interests of conservatee); \textit{In re Jobes}, 108 N.J. 394, 529 A.2d 434 (1987) (role of guardian ad litem is not to be "life advocate" because case law does not require continuation of life support systems under all circumstances); \textit{In re Peter}, 108 N.J. 365, 529 A.2d 419 (1987) (if guardian and family of patient conclude that patient would not have wanted life support, and attending physician agrees that life support should be discontinued, and both attending physician and hospital prognosis committee verify patient's medical condition, guardian may refuse treatment on patient's behalf); \textit{In re Farrell}, 108 N.J. 355, 529 A.2d 404 (1987) (competent patients living at home may choose to discontinue life support if first determined by two non-attending physicians that patient is competent, properly informed of prognosis, alternative treatments and risks, and patient made choice voluntarily); \textit{In re Conroy}, 98 N.J. 321, 486 A.2d 1209 (1985) (substitute decision maker must balance patient's right to live and to die by determining what decision patient would have made if competent; standard of decision is subjective); \textit{In re Quinlan}, 70 N.J. 10, 355 A.2d 647 (if guardian and patient's family conclude that patient would not have wanted life support, and attending physician agrees that life support should be discontinued, and both attending physician and hospital prognosis committee verify patient's medical condition, then guardian may refuse treatment on patient's behalf), cert. denied sub nom. \textit{Garger v. New Jersey}, 429 U.S. 922 (1976); \textit{In re Requena}, 213 N.J. Super. 475, 517 A.2d 886 (1986) (patient's decision to refuse life support must be honored by hospital and patient may not be removed from hospital without patient's consent); \textit{In re Clark}, 210 N.J.
sustaining measures make it possible to hold people on the “threshold”
of death for indeterminate periods of time. This "threshold" has been described as "the penumbra where death begins but life in some form, continues . . . [where] medical miracles . . . compel us to distinguish between 'death' as we have known it, and death in which the body lives in some fashion but the brain (or a significant part of it) does not."

This Article sets out the legal basis for an individual's right to die, along with the countervailing state interests. In addition, the Article provides an overview of the legal doctrine developed following the seminal case of In re Quinlan. Further, the Article identifies who may make the decision to refuse life-sustaining treatment on behalf of an incompetent patient. Finally, the Article proposes measures to ensure that a person's wishes regarding medical treatment are followed after the person becomes incompetent from disease, trauma, or chemical changes.

II. THE RIGHT TO REFUSE MEDICAL TREATMENT

Courts have recognized that competent adult patients can give a binding refusal to permit the use of life-sustaining medical care and treatment. Most judicial decisions also recognize that there are circumstances where the burden of maintaining a person's corporeal existence outweighs the benefit of prolonged life and "degrades the very humanity such maintenance was meant to serve." The California Court of Appeal's decision in Bartling v. Superior Court is a prime example of judicial recognition of this dilemma. William Bartling was seventy years old
and fully competent when he asked a California superior court for an order compelling his physicians and the hospital to disconnect the ventilator which sustained his respiration.\textsuperscript{21} At the time, Bartling was suffering from emphysema, chronic respiratory failure, arteriosclerosis, an abdominal aneurysm and a malignant tumor of the lung.\textsuperscript{22} The trial court denied Bartling's request, a decision which he appealed.\textsuperscript{23} Unfortunately, Bartling died on the afternoon prior to the hearing of his appeal petition.\textsuperscript{24} He died with the ventilator still attached.\textsuperscript{25} His wishes had been totally disregarded by his medical providers who feared civil and criminal liability.\textsuperscript{26} At the urging of the parties, the appellate court addressed the merits of Bartling's petition, so that it could formulate guidelines to prevent a reoccurrence of the tragedy that befell Bartling. In holding that Bartling had a right to have his wishes respected, the court of appeal relied on the rationale of another right-to-die decision:\textsuperscript{27}

It is all very convenient to insist on continuing [the patient'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 his competent will, thus inflicting never ending physical torture on his body until the inevitable, but artificially suspended, moment of death. Such a course of conduct invades the patient's constitutional right of privacy, removes his freedom of choice and invades his right to self-determination.\textsuperscript{28}

Courts confronted with the "right-to-die" dilemma have found both a constitutional and a common-law basis for the right to choose or refuse life-sustaining medical treatment;\textsuperscript{29} however, at least one commentator has observed a trend toward placing more emphasis on common-law grounds:

There appears to be a judicial trend to rely more on common law prerogative and less on constitutional bases in discussions of a 'right' to resist life-preserving treatment . . . . The reason

\begin{itemize}
\item \textsuperscript{21} Id. at 189, 193, 209 Cal. Rptr. at 221, 223.
\item \textsuperscript{22} Id. at 189, 209 Cal. Rptr. at 221.
\item \textsuperscript{23} Id.
\item \textsuperscript{24} Id.
\item \textsuperscript{25} Id.
\item \textsuperscript{26} Id. at 192, 209 Cal. Rptr. at 223.
\item \textsuperscript{27} Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. App. 1980).
\item \textsuperscript{28} Bartling, 163 Cal. App. 3d at 195-96, 209 Cal. Rptr. at 225 (quoting Satz v. Perlmutter, 362 So. 2d 160, 164 (Fla. Dist. Ct. App. 1980)).
\item \textsuperscript{29} See infra notes 31-47 and accompanying text.
\end{itemize}
for this recent trend is probably that the Supreme Court has shown some signs of narrowing its concept of fundamental privacy, confining it primarily to personal choices surrounding reproduction, marriage, and family life. By establishing common law informed consent as an alternative rationale for honoring a patient's prerogative to resist life-preserving treatment, the courts assure the upholding of the patient's prerogative regardless of the vicissitudes of constitutional interpretation. The prerogative is secure as long as Legislatures are willing to accept the judicially evolved doctrine.

A. Constitutional Right to Privacy

The United States Supreme Court has recognized a right to privacy emanating from the specific guarantees of the Bill of Rights and from the language of the first, fourth, fifth, ninth and fourteenth amendments. The freedom to care for one's health and person falls within the purview of the right to privacy. Most courts have interpreted the federal constitutional privacy right as broad enough to encompass a person's decision to refuse medical treatment under certain circumstances. More re-

33. Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1137, 1144, 225 Cal. Rptr. 297, 301, 305 (1986) (insistence on continuing life against patient's will and at patient's sole expense violates patient's constitutional right of privacy); Foody v. Manchester Memorial Hosp., 40 Conn. Supp. 127, 134-35, 482 A.2d 713, 719 (Conn. Super. Ct. 1984) (state's interest outweighed by patient's right to refuse life-sustaining treatment where patient has no hope for recovery); In re Severns, 425 A.2d 156, 158-59 (Del. Ch. 1980) (guardian may direct that patient in vegetative state not be kept on life-support system where patient had previously expressed such wish); Satz v. Perlmutter, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978) (patient's right to refuse treatment based upon constitutional right to privacy as long as patient is competent adult); Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 438-39, 497 N.E.2d 626, 638 (1986) (patient's right to refuse treatment overcomes state interest in preserving life—"[D]eciding 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."); In re Spring, 380 Mass. 629, 634, 405 N.E.2d 115, 119 (1980) (person may assert constitutional right of privacy "to prevent unwanted infringements of bodily integrity"); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 742, 370 N.E.2d 417, 426 (1977) ("[C]onstitutional right to privacy . . . 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."); In re Torres, 357 N.W.2d 332, 339 (Minn. 1984) (guardian may assert incompetent patient's constitutional right to privacy by ordering life-support system to be disconnected); In re Jobes, 108
cently, some states have recognized a right to privacy in their state constitutions and have used state privacy statutes as a basis for finding a right to die.\textsuperscript{34}

The idea of a “right to die” under the United States Constitution was first recognized in \textit{In re Quinlan}.\textsuperscript{35} In that case, Karen Quinlan lay in a persistent vegetative state,\textsuperscript{36} attached to a respirator.\textsuperscript{37} The New Jersey Supreme Court found that the right to privacy was broad enough to encompass the right to decline treatment.\textsuperscript{38} The court also held that Quinlan’s right to privacy survived her incapacity.\textsuperscript{39} To enable the exer-

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\textsuperscript{34} For instance, the California Constitution provides that: “All people are by nature free and independent and have inalienable rights. Among these are enjoying and defending life and liberty, acquiring, possessing, and protecting property, and pursuing and obtaining safety, happiness, and privacy.” \textit{Cal. Const.} art. I, § 1 (emphasis added). \textit{See Bouvia}, 179 Cal. App. 3d at 1137, 225 Cal. Rptr. at 301. \textit{See also Rasmussen v. Fleming}, 154 Ariz. 207, 215, 741 P.2d 674, 682 (1987); \textit{In re Barry}, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984); \textit{Quinlan}, 70 N.J. at 40, 355 A.2d at 663; \textit{Colyer}, 99 Wash. 2d at 120, 660 P.2d at 742.


\textsuperscript{36} \textit{Id.} at 40, 355 A.2d at 663.

\textsuperscript{37} \textit{Id.} at 41, 355 A.2d at 664.
cise of this right, the court allowed Quinlan's guardian and family to use their best judgment to determine whether Quinlan would have exercised her right to privacy and refused further life-sustaining treatment.  

**B. Common-Law Right**

The right to refuse medical treatment also has common-law origins.  

Most states recognize that adults have the right to exercise control over their own bodies when determining whether or not to submit to medical treatment. Accordingly, courts generally protect a person's right to decide to accept or reject medical treatment, regardless of whether the decision is wise or unwise.

At the heart of the common-law right to be free from non-consen-

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40. Id. at 41, 355 A.2d at 664. A privacy right founded on the United States Constitution and applied to the states through the fourteenth amendment only extends to situations involving state action. United States v. Stanley, 109 U.S. 3, 11-12 (1883); Rasmussen, 154 Ariz. at 215 n.9, 741 P.2d at 682 n.9; In re Storar, 52 N.Y.2d 363, 378, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273, cert. denied, 454 U.S. 858 (1981); Colyer, 99 Wash. 2d at 120, 660 P.2d at 742; Long v. Chiropractic Soc'y, 93 Wash. 2d 757, 760-62, 613 P.2d 124, 127 (1980) (en banc). Applying this rationale, courts have recognized a sufficient nexus between the state and the challenged action so as to imply state presence in the form of a state's capability to impose criminal sanctions, a state's licensing of physicians, state's judicial involvement in guardianship appointments, and a state's *parens patriae* responsibility to supervise the affairs of incompetents. Rasmussen, 154 Ariz. at 215 n.9, 741 P.2d at 682 n.9 (state licensing of physicians); Storar, 52 N.Y.2d at 378, 420 N.E.2d at 71, 438 N.Y.S.2d at 273 (state-appointed guardian); Beth Israel Medical Center, 136 Misc. 2d at 934, 519 N.Y.S.2d at 513 (state *parens patriae* power); Colyer, 99 Wash. 2d at 121, 660 P.2d at 742 (state imposition of criminal sanctions).

41. Union Pac. Ry. Co. v. Botsford, 141 U.S. 250 (1891). In *Union Pacific*, the Court recognized 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." *Id.* at 251.


suual bodily invasion is the doctrine of informed consent. Courts have recognized three basic prerequisites for informed consent. First, the patient must have the capacity to reason and make judgments. Second, the decision must be made voluntarily and without coercion. Third, the patient must have a clear understanding of the risks and benefits associated with the proposed treatment or non-treatment, along with a full understanding of the disease and prognosis.

C. State Interests

Neither the constitutional nor common-law right to refuse life-sustaining treatment is absolute. Courts dealing with this complex issue have uniformly balanced the individual’s right to refuse life support against the countervailing state interest in the preservation of life, prevention of suicide and homicide, protection of interests of innocent third parties, and the maintenance of the medical profession’s ethical integrity. Each of these state interests has received separate judicial consideration.

The judiciary has recognized that the state’s interest in preserving life is the most significant of the four state interests. The state’s interest in preserving life embraces two separate but related concerns: (1) preserving the life of the particular patient; and (2) preserving the sanctity of

44. Rasmussen, 154 Ariz. at 216, 741 P.2d at 683.
45. Id. See also Conroy, 98 N.J. at 347, 486 A.2d at 1222.
46. Rasmussen, 154 Ariz. at 216, 741 P.2d at 683. See also Conroy, 98 N.J. at 347, 486 A.2d at 1222.
all life. The state's interest in preserving life is very high in cases where life can be saved and the affliction is curable. The interest wanes when the underlying affliction is incurable and would soon bring about death despite further medical treatment.

States also have an interest in the prevention of suicide. However, the courts have held that an individual's determination to cease medical treatment pursuant to his or her right of privacy does not constitute suicide. Courts have found a distinction between an individual who intentionally ends an otherwise healthy life and an individual who simply wants to die naturally. In other words, the refusal of medical treatment so that nature can take its course does not necessarily indicate that the patient has a specific intent to die.

The state's interest in prevention of homicide is also implicated by "right to die" cases. The only reported case involving criminal homicide proceedings against medical practitioners for acceding to the wishes of an incompetent patient's family by withdrawing life-support systems is Barber v. Superior Court. In that case, the patient became comatose following surgery when he sustained a cardiac arrest in the recovery room. The patient was not brain dead; rather, he was diagnosed as being in a persistent vegetative state. Based upon the physicians' prognosis that the patient had an extremely poor chance of recovering, the family directed the physicians to remove all life-support equipment, in-

51. Brophy, 398 Mass. at 433, 497 N.E.2d at 635.
52. Id.
54. Rasmussen, 154 Ariz. at 218, 741 P.2d at 685; Foody, 40 Conn. Supp. at 137, 482 A.2d at 720; Saikewicz, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11; Quinlan, 70 N.J. at 51-52, 355 A.2d at 669-70; Colyer, 99 Wash. 2d at 123, 660 P.2d at 743.
55. Saikewicz, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11; Conroy, 98 N.J. at 350-51, 486 A.2d at 1224; Colyer, 99 Wash. 2d at 123, 660 P.2d at 743.
56. Even if that intent were present, the resulting death would arguably be from natural causes. Most importantly, the deceased patient who simply wanted to be allowed to die naturally took no affirmative action intended to cause death. See Rasmussen, 154 Ariz. at 218, 741 P.2d at 685; Foody, 40 Conn. Supp. at 137, 482 A.2d at 720; Saikewicz, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11; Conroy, 98 N.J. at 351, 486 A.2d at 1224; Colyer, 99 Wash. 2d at 123, 660 P.2d at 743.
58. Id. at 1010, 195 Cal. Rptr. at 486.
59. Id. See supra note 4 for a definition of "persistent vegetative state."
cluding a respirator and intravenous feeding tubes. Between the removal of the life-sustaining apparatus and the time of the patient's death, the patient "received nursing care which preserved his dignity and provided a clean and hygienic environment.""

Following the patient's death, the physicians were charged with murder and conspiracy to commit murder. The complaint was initially dismissed by a magistrate, but reinstated by the superior court. The court of appeal in Barber reversed, thereby ending the criminal prosecution. The court of appeal held that there was no duty to continue treatment once the treatment proved to be ineffective. Accordingly, the court found there was no unlawful failure to perform a legal duty. Virtually all jurisdictions have held that health care providers will not be criminally liable for homicide when life-sustaining equipment is removed at the direction of a competent patient, as long as procedures and safeguards outlined by the court have been followed. In addition, courts have indicated that the removal of life-sustaining apparatus from incompetent patients will not involve the risk of criminal liability if such removal is based on substituted decision-making as approved by the court.

The state has an interest in safeguarding the integrity of the medical profession. Even so, courts have noted that prevailing medical ethics recognize that the dying are frequently in need of comfort rather than

60. Barber, 147 Cal. App. 3d at 1011, 195 Cal. Rptr. at 486.
61. Id.
62. Id. at 1010, 195 Cal. Rptr. at 486.
63. Id.
64. Id. at 1022, 195 Cal. Rptr. at 493-94.
65. Id. at 1021, 195 Cal. Rptr. at 493.
66. Id. at 1017-18, 195 Cal. Rptr. at 491. The court held that:
A physician has no duty to continue treatment, once it has proved to be ineffective. Although there may be a duty to provide life-sustaining machinery in the immediate aftermath of a cardio-respiratory arrest, there is no duty to continue its use once it has become futile in the opinion of qualified medical personnel.

67. Cf. A. Meisel, THE RIGHT TO DIE 56-57 (1989) ("Despite the virtual absence of attempts to impose criminal liability for the foregoing of life-sustaining treatment and the refusal of some district attorneys even to participate in civil litigation at the invitation of parties or courts, many right-to-die cases have been litigated in whole or in part as a result of the fear of criminal or civil liability.").
68. Severns v. Wilmington Medical Center, 421 A.2d 1334, 1347 (Del. Ch. 1980); Spring, 380 Mass. at 637, 405 N.E.2d at 121 (citing Collester, Death, Dying and the Law: A Prosecutorial View of the Quinlan Case, 30 Rutgers L. Rev. 304, 310-11 (1977)).
In addition, the medical profession no longer requires the administration of medical treatment under all circumstances. As the law currently stands, if the patient rejects the doctor's advice, the onus of that decision rests on the patient, not the doctor.

Finally, the state's interest in preserving life increases when innocent third parties are affected by an individual's decision to die. In fact, the state's interest may well be superior to an adult's right of self-determination when the exercise of that right deprives dependents of a source of support and care. For example, the courts have historically compelled certain individuals to have medical treatment when the interests of small children are at stake.

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70. Saikewicz, 373 Mass. at 743-44, 370 N.E.2d at 426-27; Colyer, 99 Wash. 2d at 123, 660 P.2d at 743-44.

71. Rasmussen, 154 Ariz. at 217, 741 P.2d at 684. Quoting the American Medical Association, the court noted that the Association does not require medical treatment in all circumstances:

The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his family or legal representative if the patient is incompetent to act in his own behalf, should prevail. In the absence of the patient's choice or an authorized proxy, the physician must act in the best interest of the patient.

For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient whose death is imminent to die. However, he should not intentionally cause death. In deciding whether the administration of potentially life-prolonging medical treatment is in the best interest of the patient who is incompetent to act in his own behalf, the physician should determine what the possibility is for extending life under humane and comfortable conditions and what are the prior expressed wishes of the patient and attitudes of the family or those who have responsibility for the custody of the patient.

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 irreversibly 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.

Id. (quoting Council on Ethical and Judicial Affairs, American Medical Ass'n, Withholding or Withdrawing Life Prolonging Medical Treatment (March 15, 1986) (statement on file at Loyola of Los Angeles Law Review) (emphasis added)).

72. Conroy, 98 N.J. at 352, 486 A.2d at 1225.


75. In re President & Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir. 1964) (mother of seven-month-old infant compelled to submit to blood transfusion, over
Most courts have held that a competent person's right to have life-sustaining treatment withheld or withdrawn extends to persons who become incompetent. Some courts have allowed otherwise incompetent adult patients to exercise the right to refuse medical treatment in situations where the person was deemed competent enough to make health care decisions. In other cases the incompetent patient's right to refuse further life-prolonging care has been successfully raised by third persons where the patient is terminally ill and the care offers no real hope of restoring the patient to relative health. Most cases in this area have
dealt with patients who were irreversibly comatose or suffering from a persistent vegetative state.\textsuperscript{79}

The legal trend is to give first priority to treatment preferences that the incompetent patient expressed when competent.\textsuperscript{80} Most courts have also held that, at least to some extent, incompetent patients have the same rights with regard to medical treatment as competent patients.\textsuperscript{81} The courts have extended these rights to incompetent patients by applying one of three tests: (1) the subjective test; (2) the limited-objective test; or (3) the pure-objective test.

\textit{A. The Subjective Test}

The "subjective test" is predicated on a guardian's substituted judgment\textsuperscript{82} and is applied when there is evidence that the patient would have refused the medical treatment under the circumstances if the patient


\textsuperscript{81} Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 745, 370 N.E.2d 417, 427 (1977) (right to refuse medical treatment based on individual circumstances must be extended to incompetent patient to protect human dignity); Colyer, 99 Wash. 2d at 124, 660 P.2d at 744 (to protect their privacy and dignity, right of incompetent persons to refuse medical treatment should be equal to rights of competent persons).

\textsuperscript{82} Levant, Natural Death: An Alternative in New Jersey, in Hospital Liability 476 n.16 (M. Bertolet 5th ed. 1987). Levant remarks:

The doctrine of substituted judgment is sometimes used by courts in carrying out their \textit{pares patriae} responsibility to protect those under disability in the area of medical decision making. It is the method by which a guardian, in making a decision for his ward, tries to determine what decision the ward would have made under the circumstances, if able.

\textit{Id.} (citation omitted). See also In re Storar, 52 N.Y.2d 363, 369, 420 N.E.2d 64, 66, 438 N.Y.S.2d 266, 268 (court authorized removal of mechanical ventilator from terminally ill patient, finding that termination of treatment was consistent with wishes patient had expressed when competent; intermediary was religious superior who had known patient for lengthy period of time when patient had clearly and convincingly demonstrated patient's choice), \textit{cert. denied}, 454 U.S. 858 (1981); Leach v. Akron Gen. Medical Center, 68 Ohio Misc. 1, 3-4, 426 N.E.2d 809, 811 (1980) (after numerous witnesses testified to patient's medical condition and her previously expressed desire not to be placed on life-sustaining machines, court adopted substituted judgment test, holding that husband could exercise patient's privacy rights by directing discontinuance of life-sustaining measures).
were competent.\textsuperscript{83}

Support for the use of the substituted judgment test first appeared in the landmark case \textit{In re Quinlan}\.\textsuperscript{84} Karen Ann Quinlan ceased breathing for two separate fifteen-minute periods on the night of April 15, 1975\.\textsuperscript{85} As a result, she suffered severe brain damage and was characterized by medical experts as being in a persistent vegetative state\.\textsuperscript{86} Quinlan was not brain dead within any definitional terms\.\textsuperscript{87} In fact, she was "alive" under the controlling legal and medical standards at the time\.\textsuperscript{88} Quinlan's father petitioned the court to order removal of her respirator\.\textsuperscript{89} Agreeing with the medical experts, the Supreme Court of New Jersey concluded that Karen would never be restored to cognitive or sapient life\.\textsuperscript{90} The \textit{Quinlan} court held that Karen's father, as her guardian, could exercise his daughter's constitutional right to privacy and authorize the removal of the respirator, which was thought to sustain her breathing\.\textsuperscript{91} In so doing, the court preserved Karen's personal right of privacy against bodily intrusions by allowing a third person to assert that right on her behalf\.\textsuperscript{92}

In espousing the principle of substituted judgment, the New Jersey Supreme Court noted that "[t]he only practical way to prevent destruction of the right [to privacy in choosing or refusing life-sustaining medical treatment] is to permit the guardian and family of Karen to render their best judgment . . . as to whether she would exercise it in these circumstances."

\begin{itemize}
\item \textsuperscript{83} Levant, \textit{supra} note 82, at 476.
\item \textsuperscript{85} \textit{Id.} at 23, 355 A.2d at 654.
\item \textsuperscript{86} \textit{Id.} at 23-24, 355 A.2d at 654.
\item \textsuperscript{87} \textit{Id.} at 24, 355 A.2d at 654.
\item \textsuperscript{88} \textit{Id.} at 28, 355 A.2d at 656.
\item \textsuperscript{89} \textit{Id.} at 18, 355 A.2d at 652.
\item \textsuperscript{90} \textit{Id.} at 25-29, 355 A.2d at 655-57.
\item \textsuperscript{91} \textit{Id.} at 41, 355 A.2d at 664.
\item \textsuperscript{92} \textit{Id.} at 41-42, 355 A.2d at 664.
\item \textsuperscript{93} \textit{Id.} at 41, 355 A.2d at 664. This holding was subject to some qualifications:
\begin{itemize}
\item 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 . . . .
\end{itemize}
\textit{Id.} at 54, 355 A.2d at 671.
\end{itemize}

The \textit{Quinlan} court's quality-of-life considerations (cognitive and sapient) have subsequently been eschewed by some courts. \textit{See, e.g.}, Brophy v. New England Sinai Hosp., 398
Following Quinlan, the substituted judgment test was next considered by the Supreme Judicial Court of Massachusetts in the case of Superintendent of Belchertown State School v. Saikewicz. In Saikewicz, a mentally retarded adult resident of a state school suffered from acute myeloblastic monocytic leukemia and was incapable of giving the informed consent necessary for chemotherapy treatment. Saikewicz was profoundly mentally retarded and had a mental age of two years, eight months. The court recognized that although most persons with a similar diagnosis would choose to undergo chemotherapy, Saikewicz' inability to cooperate with treatment and to understand the disruption in his routine—in particular, the severe side effects of the chemotherapy—made it likely that Saikewicz would, if he could, decide against undergoing treatment. In applying the substituted judgment test, the Saikewicz court mentioned that

the decision in cases such as this should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person.

Like Quinlan, the Saikewicz decision was premised on the right to privacy founded in the United States Constitution.

In 1981, the New York Court of Appeals held that the common-law right to refuse medical treatment was sufficient to warrant the termination of life-sustaining treatment, in In re Storar. In that case, one Eichner represented the interests of Brother Fox, who was a retired member of the Society of Mary. Brother Fox lived with, and performed limited duties for religious members who operated the Chami-Mass. 417, 434, 497 N.E.2d 626, 635 (1986); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 754-55, 370 N.E.2d 417, 432 (1977); Cruzan v. Harmon, 760 S.W.2d 408, 420-22 (Mo. 1988), cert. granted, 109 S. Ct. 3240 (1989).

95. Id. at 729, 370 N.E.2d at 419.
96. Id. at 731, 370 N.E.2d at 420.
97. Id. at 753-55, 370 N.E.2d at 432.
98. Id. at 752-53, 370 N.E.2d at 431; cf. Storar, 52 N.Y.2d at 379-80, 420 N.E.2d at 72, 438 N.Y.S.2d at 274. The Storar case involved two plaintiffs, one of whom was also profoundly retarded. Id. at 373, 420 N.E.2d at 68, 438 N.Y.S.2d at 270. In that case the court noted that "it [would be] unrealistic to attempt to determine whether [the patient] would want to continue potentially life prolonging treatment if he were competent." Id. at 380, 420 N.E.2d at 72, 438 N.Y.S.2d at 275.
101. Id. at 370-71, 420 N.E.2d at 67, 438 N.Y.S.2d at 269.
nade High School. While undergoing surgery to repair a hernia, he suffered a cardiac arrest. As a result of the loss of oxygen to his brain, Brother Fox suffered substantial brain damage. This in turn caused the loss of Fox’s ability to breathe independently and he was thereafter maintained in a persistent vegetative state by a respirator. Prior to his cardiac arrest, Brother Fox had engaged in formal discussions regarding the Quinlan case; such discussions had been prompted by Chaminade’s mission to teach and promulgate Catholic moral principles. Brother Fox had clearly indicated that he wanted nothing extraordinary done to keep him alive if it became necessary. Noting the solemn and formal circumstances of Brother Fox’s expressed desire to forego extraordinary medical treatment, the court found his common-law right to refuse medical treatment controlling.

Many other courts have dealt with situations where the incompetent patient did not articulate his or her preferences regarding death and life-sustaining procedures prior to becoming incompetent. Some courts considered the patient’s character, tastes, religious beliefs, and prior behavior patterns to determine what the patient would want. In In re Colyer, the court allowed the patient’s husband to rely on the patient’s independent personality and dislike for physicians to determine that the patient would not want to be maintained in a persistent vegetative state. In In re Torres, a decision to withdraw medical treatment was based in part on testimony that the patient, prior to becoming comatose, had refused a pacemaker to compensate for a serious heart problem. In In re Spring, the court permitted the introduction of evidence regarding a senile seventy-eight-year-old man’s physical condition to support the determination of his wife and son that the patient would want to be removed from kidney dialysis apparatus.

Decisions allowing the removal of a life-sustaining medical apparatus from a patient who did not express a prior preference regarding terminal care have been the subject of criticism by commentators, on the
ground that the patient's approval was not obvious. Some courts have similarly refused to engage in substituted decision making unless clear and convincing evidence of the patient's wishes when the patient was competent is available. For example, in In re Westchester County Medical Center, the Court of Appeals of New York held that the substituted judgment approach "remains unacceptable because it is inconsistent with our fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another." Accordingly, the New York court held that the daughters of seventy-seven-year-old Mary O'Connor, who was brain damaged and hospitalized from multiple strokes, could not refuse artificial feeding by a nasogastric tube without clear and convincing evidence that the patient held a firm and settled commitment to the termination of life supports under the same or similar circumstances.

B. The Limited Objective Test

The "limited objective test" is based on a "best interests" standard. The best interests standard was initially articulated by a New Jersey court in In re Conroy. In that case, Claire Conroy was an elderly nursing home patient who had become increasingly confused, disoriented and physically dependent. She became incapable of swallowing sufficient amounts of food and water, and ultimately a nasogastric tube

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113. See, e.g., N. CANTOR, supra note 30, at 66.
116. Id. at 530, 531 N.E.2d at 613, 534 N.Y.S.2d at 892 (citation omitted).
117. Id. at 530-34, 531 N.E.2d at 613-15, 534 N.Y.S.2d at 892-94. Cf. In re Beth Israel Medical Center, 136 Misc. 2d 931, 919 N.Y.S.2d 511 (N.Y. Sup. Ct. 1987) (patient's right to refuse medical treatment should not be rejected because incompetent patient did not sufficiently manifest her wishes when she was competent).
118. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 746-47, 370 N.E.2d 417, 428 (1977); In re Conroy, 98 N.J. 321, 365, 486 A.2d 1209, 1232 (1985); see also Levant, supra note 82, at 477 n.25. Levant observes: The "best interests" standard is a shorthand phrase that describes the criteria used by the state, through its courts, in exercising its parens patriae power, when making decisions for an incompetent person whose wishes cannot be clearly established. Such decisions are based on a determination of what will serve the incompetent person's interests. If a decision whether to withhold or withdraw life-sustaining treatment must be made for an incompetent, courts will consider whether the pain and suffering experienced by the patient outweigh the benefits that the patient will derive from the treatment.
120. Id. at 336, 486 A.2d at 1216.
was inserted to provide her with nutrition and hydration. Conroy’s nephew, acting as her guardian, brought an action seeking permission to remove the feeding tube.

At the trial, evidence demonstrated that Conroy was confined to bed in a fetal position and that she suffered from arteriosclerotic heart disease, hypertension, and diabetes mellitus. Her left leg was gangrenous to the knee and she had necrotic decubitus ulcers on her left foot, leg, and hip. She had a urinary catheter in her bladder and had bowel incontinence. She was unable to speak or interact meaningfully with her environment. Her intellectual capacity was limited, and the doctors felt that her mental capacity would never improve. However, she was not brain dead, comatose, or in a persistent vegetative state.

The trial court found that Conroy’s intellectual functioning had been reduced to a primitive level and that her life was impossibly burdensome. The court held that it was therefore permissible to remove the feeding tube. The case was appealed but Ms. Conroy died before the appellate court could resolve the matter. In spite of her death, the appellate court decided to resolve the meritorious issues because they were of significant public importance and capable of repetition.

The Conroy court found that Conroy had a common-law right to self-determination that survived her becoming incompetent. The court held that the right was exercisable by a substitute decision-maker who was required to simultaneously respect the patient’s right to live, as well as the right to die of natural causes without medical intervention. However, Conroy had never made her desires regarding life-sustaining treatment known when she was competent. The Conroy court noted that

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121. Id. at 337, 486 A.2d at 1217.
122. Id. at 335, 486 A.2d at 1216.
123. Id. at 337, 486 A.2d at 1217.
124. Id.
125. Id.
126. Id. at 337-38, 486 A.2d at 1217.
127. Id. at 337, 486 A.2d at 1217.
128. Id. at 341, 486 A.2d at 1219.
129. Id. at 340, 486 A.2d at 1218.
130. Id. at 342, 486 A.2d at 1219.
131. Id.
133. Conroy, 98 N.J. at 356, 486 A.2d at 1227. See supra notes 82-117 and accompanying text for a discussion of the substituted judgment test.
134. Conroy, 98 N.J. at 363-64, 486 A.2d at 1231. One commentator has observed:
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. . . . [Rather,] [a]n 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 . . . .

The *Conroy* court went on to formulate the limited objective test. The test recognizes that actual patient preferences will be undiscernible in many instances, and that "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." The test is well taken. Self-determination normally requires an individualized assertion of tastes, preferences, and priorities on the part of a competent being. Usually, this means an exercise of choice contemporaneous with the medical circumstances facing the patient. Free choice may also be meaningful when an individual's prior instructions are implemented after the individual has become incompetent. Where a patient has never articulated personal preferences about death, the dying process, and tolerable burdens in the face of death, it is somewhat presumptuous to purport to be effectuating patient choice.

In acknowledging these factors, *Conroy* averted a basic error, mentioned above, which has plagued predecessor courts. This was the attempt to articulate and apply a "substituted judgment" standard—deciding what the now incompetent patient would want done under the current circumstances—in the absence of clear-cut or meaningful indications of patient feelings about death and dying. . . . [For example, . . . some courts have tried to use an incompetent patient's prior aversion to doctors and hospitals as a basis for a substituted judgment that the patient would resist life-preserving medical treatment. This appears to be a questionable premise, at least where the prior aversion was not in the context of a potentially fatal medical condition.

While the *Conroy* court realized that substituted judgment was largely a pretense in the absence of meaningful prior expressions by a patient, the court wished to promote humane handling for languishing patients who had not clearly expressed their own preferences. That is, the judges did not wish to condemn to an indefinite lingering state a dying patient whose continued existence is torturous, or of no net benefit to the patient, but who had lacked the foresight or opportunity to supply prior instructions. The solution adopted by the *Conroy* court was a "best interests of the patient" standard involving assessment of net benefit or burden to the patient from the preservable existence.

The best interests standard was broken down into two strands—denominated the "limited objective" and "pure objective" tests.


136. Id. at 365, 486 A.2d at 1232.
treatment outweigh the benefits of that life . . . ."137 Under the limited objective test, medical evidence must establish that the burdens of treatment outweigh the benefits of continued life, so as to clearly demonstrate that the treatment would merely prolong the patient's suffering without providing any net benefit.138 Trustworthy evidence that the incompetent patient would have wanted the treatment terminated can be presented in various forms, such as the patient's competently expressed reactions to other people's medical conditions and treatment, or the patient's personal philosophies or religious beliefs.139

C. The Pure Objective Test

The Conroy court articulated a third test, called the "pure objective test," for circumstances where there is either no trustworthy evidence that the incompetent patient would have wanted treatment terminated, or no evidence that the patient would have declined life-sustaining treatment.140 The pure objective test is also based on a best interests standard.141 According to the Conroy court, the pure objective test should be applied when the net burdens of the patient's life with treatment clearly and markedly outweigh the benefits the patient derives from life.142 In addition, the court held that the recurring, unavoidable and severe pain of the patient's life with treatment must be such that it would be inhumane to provide life-sustaining treatment.143 However, the court warned that even in the context of severe pain, the pure objective test should not be used to withdraw life-sustaining treatment from an incompetent patient who has previously stated a wish to be kept alive even in the event of pain or suffering.144

In Conroy, the appellate court ultimately held that the record did not satisfy any of the standards articulated under either the subjective, limited objective or pure objective tests.145 While the evidence of Conroy's wishes was sufficient to meet the limited objective test's lower burden of proof required to show the pre-incompetency desires of the

137. Id. The burdens of continued life with treatment outweigh the benefits of that life in situations where the patient is suffering and will continue to suffer unavoidable pain, so as to markedly outweigh any physical pleasure, emotional enjoyment, or intellectual satisfaction that the patient derives from life. Id.
138. Id. at 365-66, 486 A.2d at 1232.
139. Id. at 366, 486 A.2d at 1232.
141. See supra note 118.
143. Id.
144. Id. at 366-67, 486 A.2d at 1232.
145. Id. at 385-87, 486 A.2d at 1242-43.
patient, the court found that there was insufficient information in the record regarding the benefits and burdens of Conroy's continued life to satisfy the balancing component of either the limited objective or pure objective tests.146

Subsequent to Conroy, the limited objective and pure objective tests were reviewed by a New York court in In re Beth Israel Medical Center,147 a case involving an incompetent patient named Sadie Weinstein. There was no evidence before the court of Weinstein's desires regarding life-sustaining treatment when she was competent.148 The court stated that, nevertheless, "[c]learly, some objective standards must be employed" so that decisions can be made in the incompetent patient's behalf.149 The Beth Israel court concluded that the following factors should be considered in order to determine whether the burdens to a particular patient in prolonging life markedly outweigh the benefits of continued life: age; life expectancy with, and without, the treatment or procedure; degree of present and future pain or suffering; the extent of the patient's physical and mental disability and the degree of hopelessness; statements (if any) made by the patient which directly or impliedly manifest the patient's views on life-prolonging measures; the quality of the patient's life with, or without, the procedure; the risks to life or adverse side effects created by the contemplated procedure; the patient's religious or ethical beliefs; the views of the patient's family and friends; the views of the physicians; the type of care which will be required if life is prolonged as contrasted with the availability of such care; and, whether the state has any overriding parens patriae interests in sustaining life.150 The Beth Israel court indicated that decisions involving these criteria are best made by the family, in consultation with the patient's physician.151 However, in the absence of family, or where there is a dispute, the court will step in to resolve the issues.152

146. Id.
148. Id. at 941, 519 N.Y.S.2d at 518.
149. Id. at 938, 519 N.Y.S.2d at 516; but cf In re Spring, 380 Mass. 629, 405 N.E.2d 115 (1980) (private medical decisions by hospital staff must be made responsibly, subject to judicial scrutiny if good faith or due care is brought into question in subsequent litigation); In re Torres, 357 N.W.2d 332 (Minn. 1986) (if conservatee's best interests are no longer served by maintenance of life supports, court may empower conservator to order removal of life-sustaining equipment).
150. Beth Israel, 136 Misc. 2d at 940, 519 N.Y.S.2d at 517.
151. Id. at 937, 519 N.Y.S.2d at 515.
152. Id. at 937-38, 519 N.Y.S.2d at 515.
D. Cruzan v. Harmon

Since the landmark decision in *In re Quinlan*, several states have developed bodies of law dealing with the "right to die." As might be expected, state courts confronted with "right to die" cases have not produced uniform decisions, and have left many important issues unresolved. To date, the United States Supreme Court has not resolved the doctrinal issues posed by these conflicting decisions. However, with the United States Supreme Court's recent decision to grant certiorari in the Missouri case, *Cruzan v. Harmon*, that may soon change.

Following an automobile accident where she was found lying at the side of the road, Nancy Cruzan was diagnosed as being in a persistent vegetative state with no hope of recovery. In a narrowly drafted decision, the Missouri Supreme Court held that substituted judgment could not be utilized on Nancy Cruzan's behalf unless there was clear and convincing evidence that, prior to her accident, Nancy held a firm commitment to the termination of life support under the same or similar circumstances. The court concluded that the evidence presented did not meet this quantum of proof. On that basis, the court declined to terminate artificial hydration and nutrition as requested by Cruzan's guardians. The guardians appealed.

The *Cruzan* case affords the United States Supreme Court the opportunity to address a number of unsettled issues, which could include the promulgation of a comprehensive statement of federal constitutional law unifying the legal treatment in right to die cases. The issues could not be more ripe for consideration. With the spread of the AIDS virus and heightened public consciousness of the debilitating and wasting effect of that disease, there is now, more than ever before, a practical necessity for uniform guidelines from the United States Supreme Court on the "right to die" issue. Additionally, the *Cruzan* case gives the United States Supreme Court an opportunity to provide a uniform legal basis for

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154. 760 S.W.2d 408 (Mo. 1988), cert. granted sub nom. Cruzan v. Director, Mo. Dep't of Health, 109 S. Ct. 3240 (1989). Oral argument on the *Cruzan* case was entertained by the United States Supreme Court on December 6, 1989. A decision in that case is pending.
155. *Id.* at 410-11.
156. *Id.* at 424.
157. *Id.* The court stated that "informally expressed reactions to other people's medical condition and treatment do not constitute clear proof of a patient's intent." *Id.* (citation omitted).
158. *Id.* at 427.
the "right to die." The Supreme Court has previously noted that the constitutional privacy right includes the freedom to care for one's health and person.\textsuperscript{160} Whether that freedom includes the right to terminate life-sustaining health care is an unanswered question. Although the United States Supreme Court has shown reluctance to sharply delineate the outer boundaries of specific privacy rights,\textsuperscript{161} it may be more willing to address this question with regard to the "right to die."

The \textit{Cruzan} case also presents the Court with the issue of what the proper quantum of proof should be to determine the decision an incompetent patient would have made, prior to becoming incompetent, in choosing or refusing life-sustaining medical treatment.\textsuperscript{162} In addition, the Court is faced with deciding when a "best interests" analysis is appropriate.\textsuperscript{163}

Several other questions exist with respect to the subjective, limited objective and pure objective tests which the Court may decide in \textit{Cruzan}. One open question is whether, if the subjective test is not satisfied, the law should allow the exercise of substituted judgment or whether the two-tiered approach of the limited objective test should be utilized. If no trustworthy evidence of a patient's desire to choose or refuse life-sustaining medical treatment under the limited objective test exists, should the pure objective test be used to evaluate whether the provision of medical treatment would be inhumane?\textsuperscript{164} Further, if the limited objective or the pure objective tests are to be used, the question arises as to what extent the burdens of treatment must outweigh the benefits of continued life in order to discontinue life support systems. The United States Supreme Court may use \textit{Cruzan} to clarify the usage of and interrelationships among the three existing right to die tests, or it may fashion its own standard. In any event, \textit{Cruzan} presents the opportunity for a definitive judicial statement on the "right to die."

\textsuperscript{161} This reluctance is evidenced by the Court's recent abortion decision in \textit{Webster v. Reproductive Health Servs.}, 109 S. Ct. 3040, 3057-58 (1989).
\textsuperscript{162} For example, in applying the subjective test, state courts have differed on the degree of proof required to show the patient's desires prior to becoming incompetent in order that the substituted judgment of the guardian may be exercised. See \textit{supra} notes 107-117 and accompanying text for a discussion of these cases.
\textsuperscript{163} For instance, under the limited objective analysis, how much evidence of the patient's competent wishes must be shown before the court will weigh the benefits of continued life against the burdens of treatment? Alternatively, under the pure objective analysis, in what instances would the provision of medical treatment be inhumane?
\textsuperscript{164} An example of how the subjective, limited objective and pure objective tests could be utilized is set forth in Figure A, infra, at 828.
IV. WHO MAY EXERCISE THE RIGHT TO REFUSE MEDICAL TREATMENT?

The essence of the concern surrounding the "right to die" is that steps be taken to assure that patients do not fall victim to the twin evils of neglect and abuse. In the words of one court, "[t]o err either way—to keep a person alive under circumstances under which he would rather have been allowed to die, or to allow that person to die when he would have chosen to cling to life—would be deeply unfortunate." Courts have recognized that an approach that confronts both dangers is necessary.

The legal trend is to allow competent patients the right to refuse life-sustaining treatment. Since In re Quinlan, however, there has been great uncertainty regarding the appropriate procedures for making decisions about life-sustaining medical treatment in situations where patients lack the capacity to make treatment decisions.

For example, in 1988, Rudy Linares' infant son swallowed a balloon and stopped breathing. Eight months later, the child remained in an irreversible coma in a persistent vegetative state. Mr. Linares begged doctors to remove life-sustaining machinery from his son.

The child's physician stated that "the doctors agreed that the child was in an irreversible coma and would not recover," and that "[t]here was no medical opposition to removing the ventilator." However, the hospital refused to act out of fear of potential legal liability. While Illinois law permitted hospitals to withdraw life-support mechanisms from patients having no brain activity, there was no precedent in Illinois

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165. A. MIESEL, supra note 67, at 6-7.
170. A. MIESEL, supra note 67, at 6-7.
172. Id.
173. Id.
174. Id.
175. Id.
governing patients who had only minimal brain function, as the Linares boy had.176 The hospital's chief attorney had advised the health care providers not to remove the life-support system because of a possibility that criminal charges would be filed.177

On April 26, 1989, Mr. Linares walked into the pediatric intensive care unit of St. Luke's Hospital and, while keeping hospital personnel away with a .357 magnum, unplugged his son's respirator and cradled his son in his arms until the boy died.178 Though initially charged with first-degree murder, a grand jury refused to indict Mr. Linares.179

In contrast, a recent line of California cases has allowed a guardian to make a good-faith decision to discontinue life-sustaining treatment when such a decision is in the best interests of the patient.180 Today California doctors and hospital staff confronted with a Linares-type situation are required to carry out the decision of the guardian and may do so without fear of criminal prosecution.181 Currently, under California law, physicians or hospital staff who object for moral or ethical reasons to discontinuation of medical treatment are obligated to transfer the patient to another facility that will carry out the guardian's decision.182

Overall, the decision-making procedures for incompetent patients fall within two alternative approaches: a clinical approach and a judicial approach.183 The clinical approach takes place in a clinical, rather than a courtroom, setting. This approach involves an assessment of the pa-

176. Id.
177. Id.
178. Id.
180. In In re Drabick, a California appellate court held that a conservator could authorize the removal of life-sustaining equipment of a patient languishing in a persistently vegetative state. 200 Cal. App. 3d 185, 189, 245 Cal. Rptr. 840, 841, cert. denied, 109 S. Ct. 399 (1988). The court reasoned that each patient has the right to determine the scope of his or her medical treatment, and noted that the right survives incompetence. Id. at 208, 245 Cal. Rptr. at 854. The court also concluded that it is necessary for a conservator to exercise this right for an incompetent in order to prevent its loss. Id. at 209, 245 Cal. Rptr. at 855.
181. In Barber v. Superior Court, the patient was in a persistent vegetative state, though he was not brain dead within the statutory definition. 147 Cal. App. 3d 1006, 1013, 195 Cal. Rptr. 484, 488 (1983). Two doctors were charged with murder, based on their accession to the request of the patient's family to discontinue life-support equipment and intravenous tubes. Id. at 1010-11, 195 Cal. Rptr. at 486. The California Court of Appeal held that "a physician has no duty to continue treatment, once it has proved to be ineffective." Id. at 1017, 195 Cal. Rptr. at 491. California's Health and Safety Code now provides a definition of "brain dead": "An individual who has sustained . . . irreversible cessation of all functions of the entire brain, including the brain stem, is dead." CAL. HEALTH & SAFETY CODE § 7180(a)(2) (West Supp. 1990).
183. A. Meisel, supra note 67, at 148-49.
tient’s capacity to decide whether to continue life-sustaining treatment, the designation of a surrogate to carry out the decision of the patient, and a review of the decision by independent experts, or an ethics or prognosis committee. The judicial approach, on the other hand, requires assessment of capacity, designation of a surrogate, and review of the decisions to be made in court by a judge. The clinical approach is increasingly favored by the courts because the overall result of judicial involvement has tended to be cumbersome and expensive. Recent decisions by courts in California, Florida, Georgia, Minnesota and Wash-

184. Id.
185. Id. at 149. Cf. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 759, 370 N.E.2d 417, 435 (1977). In Saikewicz, the court stated, “questions of life and death . . . require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created. Achieving this ideal is our responsibility and that of the lower court, and is not to be entrusted to any other group purporting to represent the ‘morality and conscience of our society,’ no matter how highly motivated or impressively constituted.” Id.

186. See N. CANTOR, supra note 30, at 114; A. MEISEL, supra note 67, at 149 n.5 (citing In re Jobes, 108 N.J. 394, 428, 529 A.2d 434, 451 (1987)). The New Jersey Supreme Court has commented that no matter how expedited, judicial intervention in this complex and sensitive area may take too long. . . . The mere prospect of a cumbersome, intrusive, and expensive court proceeding during such an emotional and upsetting period in the lives of a patient and his or her loved ones would undoubtedly deter many persons from deciding to discontinue treatment. . . . Too many patients have died before their right to reject treatment was vindicated in court.

In re Farrell, 108 N.J. 335, 357, 529 A.2d 404, 415 (1987). See also In re Storar, 52 N.Y.2d 363, 385, 420 N.E.2d 64, 75, 438 N.Y.S.2d 266, 277 (Jones, J., dissenting in part) (“The lapse of time necessarily consumed in appellate review before there can be a final judicial determination will almost always be unacceptable and makes recourse to judicial proceedings impractical.”), cert. denied, 454 U.S. 858 (1981); In re Grant, 109 Wash. 2d 545, 565-66, 747 P.2d 445, 456 (1987) (court adheres to opinion that judicial process is unresponsive and cumbersome mechanism for decisions of this nature).

187. Barber, 147 Cal. App. 3d at 1006, 1021, 195 Cal. Rptr. at 484, 493 (patient’s immediate family, in consultation with doctors, can make decision that reflects known desires of patient, or, if patient’s desires are unknown, decision can be made that is in patient’s best interests).

188. John F. Kennedy Memorial Hosp., Inc. v. Bludworth, 452 So. 2d 921, 926 (Fla. 1984) (vegetative, irreversibly comatose patient’s right to refuse treatment could be exercised either by close family members or by court-appointed guardian after primary treating doctor certifies that patient is in permanent vegetative state with no reasonable prospect of regaining cognitive function where patient had executed “mercy” will stating his desire to be allowed to die).

189. In re L.H.R., 253 Ga. 439, 446, 321 S.E.2d 716, 723 (1984) (“infant’s right to refuse or terminate medical treatment may be exercised by parents or legal guardian of infant after two physicians concur in diagnosis that infant is terminally ill with no hope of recovery and infant exists in chronic vegetative state with no reasonable possibility of attaining cognitive function”).

190. In re Torres, 357 N.W.2d 332, 341 & n.4 (Minn. 1984) (judicial order was appropriate in that particular case, but, normally, consultation between physician and family, followed by
have indicated that, under certain circumstances, termination decisions may be made by family members and physicians without judicial involvement.192

The consequences of limiting the authority of an interested surrogate to carry out the desires of an incapacitated patient may be tragic. For example, several years ago in Florida, Joy Griffith was injured in an accident that left her in a persistent vegetative state.193 Eight months after the accident, Joy’s father, distraught over his daughter’s condition, shot and killed her as she lay in her hospital bed.194 Griffith was convicted of first-degree murder and sentenced to life imprisonment.195 Although similar in nature to the Linares incident,196 the Griffith case resulted in a vastly different outcome.

The tendency of the few state legislatures which have addressed the question of surrogate decision making, is to avoid judicial involvement in making decisions for incompetent dying patients, permitting, instead, the decisions to be made by physicians and immediate family.197 The courts tend to agree that a judicial approach is required in cases where there is disagreement among the participants to the decision-making process.198

approval of ethics committee, would suffice for decision making on behalf of incompetent, dying patient).


We take a dim view of any attempt to shift the ultimate decision-making responsibility away from the duly established courts of proper jurisdiction to any committee, panel or group, ad hoc or permanent. Thus, we reject the approach adopted by the New Jersey Supreme Court in the Quinlan case of entrusting the decision whether to continue artificial life support to the patient’s guardian, family, attending doctors, and hospital ‘ethics committee.’ . . .

. . .

We do not view the judicial resolution of this most difficult and awesome question—whether potentially life-prolonging treatment should be withheld from a person incapable of making his own decision—as constituting a ‘gratuitous encroachment’ on the domain of medical expertise. Rather, such questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created.

Id. (citations omitted) (footnote omitted).


194. Id.

195. Id. The conviction was, however, overturned because Griffith’s attorney failed to obtain defendant’s “knowing and intelligent” waiver of his right to a twelve-person jury. Id. at 245-46.

196. See supra notes 171-79 and accompanying text.


In California, section 2355 of the California Probate Code permits a conservator to authorize removal of life-sustaining medical treatment if the decision is made in good faith, consistent with the patient's best interests, and is based on medical advice. In California, the role of the courts is limited to assuring compliance with the conservator's duty under section 2355 and resolving disputes between interested parties concerning the best interests of the incompetent patient. California courts do not become involved in weighing the benefits versus the burdens of continued life.

In cases where there is no family member or close friend who can serve as a surrogate decision maker, some states allow courts to appoint a guardian. Courts may look to public or private non-profit agencies to act as guardian of the incompetent patient. In some cases, a court's only option may be to act as the surrogate decision maker itself. In those cases, the court directly approves decisions regarding the withholding or withdrawal of life-sustaining treatment.

V. ENSURING THAT ONE'S WISHES REGARDING MEDICAL TREATMENT ARE FOLLOWED

Due to the problems associated with decision making for incompetent patients, increased attention has been given to “advance directives,” wherein people can plan for a time when they are unable to participate in actual decision making. Many legislatures have responded by enacting...
natural-death and health-care durable power-of-attorney statutes. Natural-death acts allow competent individuals to plan for decisions regarding the termination of life-sustaining treatment. The health-care durable power-of-attorney statutes allow competent adults to designate an agent to make health-care decisions, including a decision to withhold

Id. at 318.

207. A. MEISEL, supra note 67, at 319. Meisel observes that:

"Natural death act directive" is a term sometimes used to apply to an advance directive executed pursuant to a statute enacted for the purpose of permitting, usually under circumscribed conditions, individuals to terminate life-sustaining treatment. The name of these directives is derived from the official name of some of the natural death acts. The terms 'natural death act' and 'natural death act directive' have become more generally used to refer to any directive executed pursuant to such a statute, whether or not the statute is officially named a Natural Death Act.

208. N. CANTOR, supra note 30, at 123 ("The power of attorney is a writing conferring upon a person authority to perform specified actions on behalf of the signer. Durable refers to a vehicle for embodying such a statement, such as a living will, durable power of attorney, or natural death act directive.

life-sustaining treatment. Some experts have indicated that the durable power of attorney may provide for better informed decision making because the drafter of a living will cannot foresee and deal with the multitude of relevant variables and the legal permutations that surround the dying process. By contrast, a durable power of attorney is retained by a person who acts as an advocate for the patient, and as such possesses full information about the patient's condition and is therefore better able to make a decision consistent with the patient's previously expressed desires.

Most of the living-will statutes specifically preserve patients' common-law rights, thereby leaving the door open for further evolution of right-to-die doctrines through the judiciary. Courts that have considered this issue have agreed that natural-death acts were not intended to

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[M]ore recently the Legislature enacted a statute permitting individuals to create "springing powers of attorney," which come into effect when another designated person determines that the maker has become incompetent. This broadens the "durable power of attorney" which simply survives incompetency. Although powers of attorney have traditionally been limited to delegation of financial powers as opposed to personal decisions, this limitation has been eroded by court recognition of the ability of third parties to express the wishes of incompetent patients without written authority.


211. N. Cantor, supra note 30, at 122.

212. Id. at 122-23. Cantor points out that:

The assumption behind a designated proxy [durable power of attorney] is that the designator will not only choose a particularly dependable person to act as surrogate decision-maker, but that extensive conversations will be held instructing the proxy about the wishes and preferences of the designator. If this assumption is fulfilled, the advantages of the designated proxy are patent. A specific individual then exists at the moment of critical decision-making who is intimately familiar with the now-incompetent patient's wishes. This eases the tasks of medical staff both by providing important information in the fact gathering process regarding the patient's previously expressed wishes, and by avoiding confusion about legal authority such as occurs when close family are not available or are not unanimous in their desires. Moreover, the proxy furnishes someone to act as an advocate of the patient's position and potential enforcer of the patient's wishes, should medical staff be reluctant to follow the patient's previously expressed desires.

Id. at 122.

213. Id. at 106. See also Barber v. Superior Court, 147 Cal. App. 3d 1006, 1015, 195 Cal. Rptr. 484, 489 (1983) ("The lack of generalized public awareness of the statutory scheme and the typically human characteristics of procrastination and reluctance to contemplate the need for such arrangements however makes this [California Natural Death Act] a tool which will all too often go unused by those who might desire it.").
preempt common-law rights. Courts have also held that restrictions imposed by natural-death acts might be avoidable if an incompetent patient had made a common-law advance directive. However, at least one commentator has cautioned that some courts may find the state's natural-death act to be the "exclusive means for issuing an advance directive, [and, therefore] it might be advisable to draft two directives, one [that complies] with the [natural-death] act and one [that does] not."\(^{216}\)

VI. CONCLUSION

The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research has observed, "[d]eath comes to everyone. To a few, it comes suddenly and completely unexpectedly, but to most, it follows an opportunity for leave-taking and for directing to some extent the mode and timing of death."\(^{217}\) In our country, most people eventually succumb to chronic degenerative conditions.\(^{218}\) Irrespective of age, many people have concluded that, where life-sustaining medical treatment is involved, death is preferable.\(^{219}\) In recent years, courts have confirmed that competent patients have the right to choose or refuse life-sustaining medical treatment.\(^{220}\)


\(^{215}\) According to one court:

[A]s commentators have noted, the [Natural Death] Act functions as intended for only a very limited number of patients. If the directive is executed by a person prior to his having been diagnosed as terminally ill, it is not binding on the physician. In addition, the procedural requirements . . . are so cumbersome that it is unlikely that any but a small number of highly educated and motivated patients will be able to effectuate their desires.

Barber, 147 Cal. App. 3d at 1016, 195 Cal. Rptr. at 489 (citation omitted) (emphasis in original); see also A. Meisel, supra note 67, at 325.

There is growing judicial support for advance directives without a statutory basis, that is, for common-law advance directives. Their acceptance validates directives that would not pass muster under a natural death act. Courts have given some approval to written common-law advance directives, which are conventionally thought of as living wills. Somewhat ironically, there is an even greater degree of precedent for enforcing oral advance directives [Subjective Test].

Id.; see supra notes 80-112 and accompanying text.

\(^{216}\) A. Meisel, supra note 67, at 360.

\(^{217}\) President's Commission Report, supra note 8, at 15.

\(^{218}\) Id. at 16.


\(^{220}\) See, e.g., Bartling, 163 Cal. App. 3d at 193-94, 209 Cal. Rptr. at 224.
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courts have held, is based on the constitutional right to privacy or on the common-law doctrine of informed consent. Some states have found a right of privacy in their state constitutions or have enacted legislation that specifically endorses the patient’s privacy right.

 Whatever the basis of the right to refuse medical treatment, the patient’s right of self-determination has been the underlying driving force behind the development of the right to die. Courts have generally found that the right of self-determination survives even after a person becomes incompetent and have allowed incompetent patients to exercise their right to refuse life-sustaining medical treatment through third persons, using the substituted judgment or the best interests doctrines.

 In virtually all jurisdictions, the subjective substituted judgment test is applied. Under this test, if there is sufficient evidence that the now incompetent patient would have refused such medical treatment when competent, then a guardian or close family member can direct future withholding or withdrawal of life-sustaining medical procedures. A few jurisdictions use the limited objective and pure objective tests. These tests are based on a best interests standard. The limited objective test is applied when there is little evidence of what the incompetent patient wants, but there is trustworthy information that the patient when competent would have refused treatment. The pure objective test is applied when there is no evidence or less than trustworthy evidence of the patient’s pre-incompetency wishes. For both the limited objective and the pure objective tests, medical evidence must establish that, to some specified degree, the burdens of continued life with treatment outweigh the benefits of that life. Under the pure objective test, a third person can refuse or direct withdrawal of life-sustaining treatment on behalf of the incompetent patient when it is clear that the provision of such treatment would be inhumane. Although courts have failed to provide a uniform body of right-to-die law, the United States Supreme Court may provide some guidance as to how the various tests could be used uniformly on a national scale when it reviews the Cruzan case.

 In addition to the evolution of judicial common-law doctrine, various state legislatures have enacted laws which allow competent patients to direct the course of medical decision making in the event of incompetency. State legislatures generally enact natural-death acts or a durable power-of-attorney in health-care statutes to provide proxy decision-mak-

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221. See supra notes 18-47 and accompanying text for a discussion of the various sources of the “right to die.”

ers. Due to the restrictions inherent in most natural-death acts, there is a growing recognition that the health-care durable powers-of-attorney may be the best post-competency decision-making tool. Unfortunately, most patients do not take the time to address these issues prior to a crisis that may render them unable to make the decision to refuse life-sustaining treatment. For that reason, the judicial common-law doctrine will continue to evolve and play an important role in decision making.

Under the common-law doctrine of informed consent, medical providers have an obligation to see that patients are allowed to exercise their prerogative in choosing between the available and potentially beneficial medical treatments and procedures. Recently, an article in the New England Journal of Medicine stated that:

"Physicians have a responsibility to consider timely discussions with patients about life-sustaining treatment and terminal cases. Only a minority of physicians now do so consistently. The best time to begin such discussions is during the course of routine nonemergency care, remembering that not all patients are emotionally prepared, by virtue of their stage in life, their psychological makeup, or the stage of their illness. Nevertheless, as a matter of routine, physicians should become acquainted with their patients' personal values and wishes and should document them just as they document information about medical history, family history, and sociocultural background. Such discussions and the resultant documentation should be considered a part of the minimal standard of acceptable care . . . . In general, health care institutions must recognize their obligation to inform patients of their right to participate in decisions about their medical care, including the right to refuse treatment, and should formulate institutional policies about the use of advance directives and the appointment of surrogate decision makers. Hospitals, health maintenance organizations, and nursing homes should ask patients on admission to indicate whether they have prepared a living will or designated a surrogate. It seems especially important that nursing homes require a regular review of patient preferences,"


with each patient's physician taking responsibility for ensuring that such information is obtained and documented.

The writers in the New England Journal of Medicine article\textsuperscript{225} have set forth, at long last, new standards of care that should govern the future actions of the medical profession, and, hopefully, will lead to an increased awareness of those seeking medical care.

Increasing the awareness of patients and their families regarding their role in life and death decisions may increase consideration of other highly charged issues. For example, once the medical providers have done everything possible for a patient who is terminally ill, is it bad medical practice or immoral to assist a patient who rationally desires to commit suicide? If a patient is physically unable to carry out a suicide plan, what role, if any, can physicians and other health care providers play in assisting the patient who wishes to effect his or her right of self-determination? As one judge has written,

[i]he 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.\textsuperscript{226}

The Beverly Hills Bar Association has been considering proposed legislation which would modify California's Natural Death Act.\textsuperscript{227} The proposed legislation would create a procedure whereby a competent, terminally ill patient could receive the active assistance of a physician in dying. It is anticipated that this proposed legislation will be presented to the American Bar Association House of Delegates at the August 1990 Annual Meeting in Chicago.\textsuperscript{228} This issue will surely be raised again. Undoubtedly, the debate will continue, and the center point of that debate will focus on the patient's right of self determination.

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\textsuperscript{225} Id. \\
\textsuperscript{227} CAL. HEALTH \& SAFETY CODE §§ 7185-7195 (West Supp. 1990). \\
\textsuperscript{228} Telephone interview with Louis B. Fox, Executive Director of the Beverly Hills Bar Association (March 2, 1990).
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1. SUBJECTIVE TEST

Clear and convincing evidence of patient's wishes?

- Yes → Patient desires treatment?
  - Yes → Treatment inhumane?
    - Yes → NO TREATMENT
    - No → TREATMENT
  - No → No treatment outweighs benefit?
    - No → TREATMENT
    - Yes → NO TREATMENT

- No → No

2. LIMITED-OBJECTIVE TEST

Trustworthy evidence of patient's wishes?

- Yes → Patient desires treatment?
  - Yes → Treatment inhumane?
    - Yes → NO TREATMENT
    - No → TREATMENT
  - No → No treatment outweighs benefit?
    - No → TREATMENT
    - Yes → NO TREATMENT

- No → No

3. PURE-OBJECTIVE TEST

Burden of treatment outweighs benefit?

- Yes → Treatment inhumane?
  - Yes → NO TREATMENT
  - No → TREATMENT

- No → TREATMENT

FIGURE A: ONE ANALYSIS THAT MIGHT BE USED FOR "RIGHT TO DIE" DECISIONS