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James Bopp Jr.
Daniel Avila

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Perspectives on Cruzan:

The Sirens' Lure of Invented Consent: A Critique of Autonomy-Based Surrogate Decisionmaking for Legally-Incapacitated Older Persons

by

JAMES BOPP, JR.*

and

DANIEL AVILA**

Then with heavy heart I spoke to my comrades thus: "Friends, it is not right that only one man, or only two, should know the divine decrees that Lady Circe has uttered to me. I will tell you of them, so that in full knowledge we may die or in full knowledge escape, it may be, from death and doom. Her first command was to shun the Sirens—their enchanting notes, their flowery meadow. I alone was to hear their song, she said. You for your part must bind me with galling ropes as I stand upright against the mast-stay, with the rope-ends tied to the mast itself; then I shall stay there immovably. And if I beg and beseech you to set me free, you must bind me hard with more ropes again."

The Sirens: evidently they really sang, but in a way that was not satisfying, that only implied in which direction lay the true sources of the song, the true happiness of the song. Nevertheless, through their imperfect songs, songs which were only a song still to come, they guided the sailor towards that space where singing would really begin. They were therefore not deceiving him; they were really leading him to his goal. But what happened when he reached that place? What was that place? It was a place where the only thing left was to disappear . . . .2

Myths bump the consciousness at odd times, quickening the mind with brief music, then melting in silence. An idea starts, bears new

* Partner, Brames, McCormick, Bopp & Abel, Terre Haute, Indiana; President, National Legal Center for the Medically Dependent and Disabled, Inc.; General Counsel, National Right to Life Committee, Inc.; Former Member, President's Committee on Mental Retardation; Editor, ISSUES IN LAW & MEDICINE; B.A. 1970, Indiana University; J.D. 1973, University of Florida.

** Staff Counsel, National Legal Center for the Medically Dependent and Disabled, Inc.; A.B., St. Francis College (Indiana), 1980; J.D., Valparaiso University, 1983.

The authors appreciate the research assistance of John Altomare and Katherine Jensen.


ideas, undergoes permutation perhaps, and then dies. Thus spins a cycle of reasoning which at its end may barely know why it is there, but still it turns to the once-heard rhythms of the original thought. Yet the meaning may change and the context is altered. Thus, for example, the grand idea of autonomy—to live and let live—may be converted to "die and let die." So it is with the Sirens' lure of invented consent.

By "invented consent," we mean that process of medical decisionmaking whereby one orders care or discontinuance of care for another on a "ghost writer" basis. The order, perhaps to disconnect a feeding tube from an unconscious patient, issues from the patient's surrogate as if it were the command of the soon-to-be deceased. The order is, in reality, not authored by the patient, but ghost-scripted by the surrogate.

Born of a myth and employing a myth, invented consent is the practice of choice in many jurisdictions. The myth is this: a person incapable of choosing is capable of choosing.

American common law upholds autonomy, some argue, as the basis of our legal existence. From this premise comes the lure. Respect for autonomy, the "right to choose," should extend to legally incapacitated persons, and if they cannot choose then someone must choose for them, preserving their "autonomy" (and thus their legal existence) by attributing the surrogate's choice to the incapable person. When applied to choices between life and death, the myth that volitional autonomy survives incapacity is the myth of the Sirens' song. "Nearly unanimously, [the] courts have found a way to allow persons wishing to die, or those who seek the death of a ward, to meet the end sought." Thus it is that those singing autonomy for nonautonomous others will consign those others to the place "where the only thing left [is] to disappear."

4. See In re Browning, 568 So. 2d 4 (Fla. 1990); In re Torres, 357 N.W.2d 332 (Minn. 1984); In re Jobes, 108 N.J. 394, 529 A.2d 434 (1987).
5. "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891); see Welch, Walking in Their Shoes: Paying Respect to Incompetent Patients, 42 VAND. L. REV. 1617, 1623 (1989).
6. Cruzan v. Harmon, 760 S.W.2d 408, 413 (Mo. 1988) (en banc), aff'd, 110 S. Ct. 2841 (1990); see also A. MEISEL, THE RIGHT TO DIE 46-47 (1989 & Cum. Supp. 1991) (courts in right-to-die cases have reached "substantial agreement" that competent and noncompetent patients have the right to refuse treatment and "the interests of the state in opposition to this right are virtually nonexistent in the case of competent patients and very weak in the case of incompetent patients whose prognosis for recovery is dim").
The mythic aspect of invented consent pertains not only to who is consenting, but to what act constitutes consent. Respect for autonomy, it is argued, demands that a patient’s choice be found even when none exists. That is, a patient’s failure to refuse treatment in an overt way before losing consciousness should not prevent a surrogate from discovering a prior refusal somewhere in the mists of the patient’s previous lifestyle, values, preferences, or tastes. Yet again, this form of consentmaking is geared toward accomplishing the patient’s death. Would not the athlete rather die than vegetate? The couch potato, well, she never had a zest for life anyway, right? For the now-permanently unconscious person, a surrogate must honor the “choice” deemed implicit in the patient’s predisabled lifestyle, and that choice invariably is characterized as a decision to die rather than exist impaired. Here the surrogate claims she is simply the editor, not the author, paring the extraneous to highlight the evident, not inventing but only reporting the patient’s “choice” to die.

The prime “beneficiaries” of invented consentmaking are those persons medically dependent and disabled. This includes older persons, particularly those rendered unconscious, perhaps permanently, by illness, injury, dementia, or aging.

This Article critiques the practice of basing surrogate refusals of life-sustaining care for older persons on an idea of “autonomy” far different from the original understanding of autonomy. Invented consent, or “substituted judgment,” is promoted as the best means of respecting an incapacitated patient’s autonomy even though neither the patient nor the purported exercise of choice would satisfy accepted definitions of an autonomous actor or autonomous action. Invented consentmaking radically alters the tradition and practice of informed consent, abolishing in the process those protective legal restraints typically applied to medical decisionmaking for unconscious persons. It is a Siren’s call that must be resisted. This Article concludes, to paraphrase Homer’s Ulysses, that when a surrogate begs and beseeches us to set an unconscious patient free by removing life-sustaining care to bring on the patient’s death, we must bind the surrogate’s powers with more ropes again, to preserve from harm the patient’s life, and consequently, the patient’s autonomy.

I. The Paradigm Case: *Cruzan v. Director, Missouri Department of Health*

The practice of invented consent is better understood in a real-life context. The analysis, therefore, begins with the case of Nancy Cruzan.

The Missouri Supreme Court, in a decision upheld by the United States Supreme Court, blocked Nancy Cruzan's parents, appointed as Nancy's co-guardians, from acting pursuant to the claim that Nancy already had consented, or would consent if she were able, to the withdrawing of nutrition and hydration provided by a gastrostomy tube. Nancy Cruzan was permanently unconscious.

The *Cruzan* case is an appropriate paradigm for invented consent making for two reasons. First, the record is extensive, created at three different judicial levels; it provides the most complete legal description of invented consent in a real-life context available anywhere. Second, the United States Supreme Court apparently did not preclude other states from experimenting in this area, thus leaving open the possibility that other states will recognize invented consent claims similar to that raised by the Cruzans.

The *Cruzan* case, the first "right to die" petition to reach the United States Supreme Court, naturally will be the focal point of analysis in this area for years to come. Accordingly, the American Geriatrics Society has noted:

Although Nancy Cruzan [was] only 32 years old, the ultimate disposition of the issue in this case [has] serious implications for the care of the elderly. How the Court addresses this issue will determine

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10. Nancy's parents were appointed her co-guardians and from this they derived their authority over her; thus, this term is used to identify them throughout this Article.
11. *Cruzan v. Harmon*, 760 S.W.2d 408, 427 (Mo. 1988), aff'd, 110 S. Ct. 2841 (1990). After the U.S. Supreme Court ruled in *Cruzan*, the co-guardians returned to the trial court that had heard the initial petition to present new evidence bearing on Nancy's intent. The new evidence involved the testimony of former co-workers who spoke to Nancy prior to her accident and who claimed Nancy would have refused food and fluids. Transcript at 10, *Cruzan v. Harmon II*, No. CV384-9P (Mo. Cir Ct. Dec. 14, 1990). This evidence was found by the trial court to be "clear and convincing" proof of Nancy's intent to refuse her present care. *Cruzan v. Harmon II*, slip op. at 1. The court therefore authorized the removal of food and fluids from Nancy, id. at 2, feeding was withheld, and Nancy died twelve days later on December 26, 1990. Malcolm, *Burial is End to Long Goodbye for Nancy Cruzan*, N.Y. Times, Dec. 29, 1990, at 1, col. 2.
substantially the choices available to the elderly to plan the ways they will live, and particularly the ways they will die.\textsuperscript{13}

In the fall of 1987, Lester and Joyce Cruzan sought judicial permission to withhold gastrostomy-provided nourishment from their seriously impaired daughter Nancy Beth Cruzan.\textsuperscript{14} Nancy was injured five years earlier in a car accident and never regained consciousness.\textsuperscript{15} Doctors expected that while Nancy could live with nourishment for up to thirty more years,\textsuperscript{16} her mental incapacity would persist.\textsuperscript{17} As Nancy's court-appointed co-guardians, her parents believed that Nancy would refuse further treatment and asserted that her right to refuse nourishment was "paramount to any and all other rights in this case."\textsuperscript{18}

A hearing was held in probate court.\textsuperscript{19} The parties included the Cruzans, the State of Missouri (responsible for providing medical care and financing for Nancy), and two guardians ad litem.\textsuperscript{20} Missouri opposed the Cruzans' petition. At the end of the hearing, the guardian ad litem recommended to the court that the petition be granted, because "[u]nder all the evidence there has been a self-determination by Nancy to refuse further treatment."\textsuperscript{21}

The trial court ruled in favor of the guardians.\textsuperscript{22} It found:

About a year prior to her accident in discussions with her then housemate, friend and co-worker, [Nancy] expressed the feeling that she would not wish to continue living if she couldn't be at least halfway normal. Her lifestyle and other statements to family and friends suggest that she would not wish to continue her present existence without hope as it is.\textsuperscript{23}

Holding that Nancy had a "fundamental natural right"\textsuperscript{24} to refuse care in her circumstances, the trial court authorized the co-guardians "to..."
exercise [Nancy's] constitutionally guaranteed liberty to request [the State of Missouri] to withhold nutrition and hydration.\textsuperscript{25}

Thus, the co-guardians and guardians ad litem, along with the trial court, believed that Nancy had consented or would consent to nontreatment, and argued that her feeding should be discontinued. Three Missouri Supreme Court justices,\textsuperscript{26} four United States Supreme Court justices,\textsuperscript{27} and numerous \textit{amici} also eventually supported this claim. Could it be that Nancy alone was silent?

Several important questions, each touching on Nancy's autonomy interests, can be raised here. Did Nancy consent to nontreatment? If she did consent, when was her consent given? If she did not actually consent, does she still have an enforceable claim to effectuate nontreatment? The proponents of Nancy's "right to die" in this case provided answers to these questions that are quite instructive.

A. Did Nancy Consent?

Curiously, the trial court made no finding on whether Nancy legally consented to the withdrawing of her sustenance, except to say that her "lifestyle" and various oral statements she made to family and friends "suggest" that she would not "wish" treatment.\textsuperscript{28} The trial court characterized its final order as one authorizing the co-guardians to exercise Nancy's liberty to consent for her.\textsuperscript{29} The guardians ad litem, asserting on appeal that Nancy had "self-determined" to refuse treatment prior to her incapacity,\textsuperscript{30} urged the United States Supreme Court to find that the Missouri Supreme Court "erred in holding that there was not sufficient evidence of Nancy Cruzan's refusal of life-prolonging medical treatment."\textsuperscript{31} Yet, the guardians ad litem conceded that Nancy had never executed a formal declaration of her consent to nontreatment,\textsuperscript{32} and they considered her prior statements significant more because they evidenced that Nancy \textit{would} refuse treatment, not that she did.\textsuperscript{33}

\textsuperscript{25.} Id.
\textsuperscript{26.} Cruzan v. Harmon, 760 S.W.2d 408, 427 (Mo. 1988) (Blackmar, J., dissenting); \textit{id.} at 430 (Higgins, J., dissenting); \textit{id.} at 441 (Welliver, J., dissenting).
\textsuperscript{27.} Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2863 (1990) (Brennan, J., dissenting, joined by Marshall and Blackmun, JJ.); \textit{id.} at 2878 (Stevens, J., dissenting).
\textsuperscript{29.} \textit{id.} at 7.
\textsuperscript{30.} Respondent Guardian Ad Litem's Brief at 3, \textit{Cruzan v. Director} (No. 88-1503).
\textsuperscript{31.} \textit{id.} at 14.
\textsuperscript{32.} \textit{id.} at 14-15.
\textsuperscript{33.} \textit{id.} at 15-16.
The co-guardians were more direct. In their brief filed with the Missouri Supreme Court, they admitted that Nancy never consented to nontreatment:

[The State of Missouri] argues at one point that these statements, made in advance of [Nancy’s] accident and not directed to specific treatment for her, do not constitute informed consent to removal of artificial nutrition and hydration . . . . 

Respondents [the co-guardians] do not dispute this point. Initially Joe Cruzan consented to the insertion of the gastrostomy tube, believing it might aid in Nancy’s recovery . . . . He is willing to provide similar consent for removal of the artificial treatment now that her prognosis is hopeless.34 The co-guardians thus argued that the presence or absence of Nancy’s informed consent was irrelevant to the case.35 If Nancy never consented to tube-feeding initially, they questioned why her consent was necessary for nourishment to be withdrawn.36

The co-guardians’ argument is precisely the paradigm argument for invented consent that enjoys legal and ethical support today.37 An automatic transfer of decisionmaking authority from the patient to the surrogate, whereby informed consent is sought from the surrogate, has important implications regarding patient autonomy as understood by practitioners of invented consent. Even if the patient’s consent is not required, the surrogate still must act consistently with the patient’s proven or presumed wishes to somehow preserve patient “autonomy.” That is, the standard autonomy claim in “right to die” cases appears not to be that Nancy must consent to nontreatment to gain our respect for her autonomy, but that Nancy likely would refuse treatment, thus obligating us to respect her autonomy by respecting and effectuating that “probable” choice.

B. When Did Nancy Consent?

It is evident that the co-guardians, guardians ad litem, and trial court all would re-phrase the question of Nancy’s consent; they all were satisfied that treatment could be withheld pursuant to actions by Nancy considerably less deliberative than a formal expression of con-
They might state the question this way: "When did Nancy refuse, self-determine, or no longer want treatment?" Or they might ask: "When were Nancy’s caregivers required to withhold care as if Nancy had issued her consent to nontreatment?" Again, the answers provided are instructive.

The trial court located the moment of purported refusal for medical treatment at the point "when the person has no more cognitive brain function than our Ward and all the physicians agree there is no hope of further recovery[,]" and the co-guardians "exercise our Ward’s constitutionally guaranteed liberty to request" nontreatment. Thus, "[t]o deny the Co-guardians the authority to act" at this point "is to deprive the Ward of the equal protection of the law." Once the co-guardians made their decision, the State of Missouri was bound to carry out the co-guardian’s request as if it came from Nancy herself.

The co-guardians and the guardians ad litem focused instead on the period before Nancy’s accident, when she was conscious. Nancy’s father and co-guardian Lester Cruzan testified in probate court:

Nancy was an independent, vivacious person. She enjoyed being out of doors, tending her plants and her pets, and in general, living life to its fullest. Knowing her as only parents can, and based on statements made by her to her sister at the time of their grandmother’s death regarding the prolonging of life when there was no purpose left to the life, it is our belief that she would not want the life support continued in her present condition. Nancy has two sisters, both of whom are in complete agreement with our request and our feeling that this would be Nancy’s request.

Thus, "Nancy’s statements alone are enough to stop this artificial treatment," the co-guardians argued, and "[w]hen coupled with evidence of her personality and what her family and friends believe Nancy would want, there is no other outcome possible." The guardians ad litem concurred, opining that various statements made by Nancy before her accident, "together with her personality, character, and lifestyle," supported the conclusion that "were [Nancy] able to forecast her present condition, she would demand that the feeding tubes be removed."

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38. For a discussion of what actions would constitute sufficiently deliberative and clear expressions of consent, see infra Sections III.B. and IV.A.(3).
40. Id. (emphasis added).
41. Id.
42. Trial Record at 437-38, Cruzan v. Harmon (No. CV384-9P).
43. Plaintiffs-Respondents’ Brief at 25, Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988) (No. 70813).
44. Id.
So when did Nancy refuse treatment? When she was unconscious and therefore unaware of her present circumstances, as concluded by the trial court? Or when she was still conscious, but yet unaware of her future predicament? Did Nancy ever refuse treatment at all? Or can the co-guardians justify their nontreatment request merely by surmising that Nancy would refuse treatment? A simple inquiry about Nancy's consent is more complex than appears at first glance.

C. If Nancy Never Consented To Nontreatment, Does She Still Have the Right To Have Treatment Withheld?

The proponents of forgoing Nancy's care all agreed: Yes, Nancy should be allowed to die, even if her consent to nontreatment cannot be proven, because she retains a "right to be let alone."  

The co-guardians grounded Nancy's right to refuse care in "traditional notions of autonomy" protecting persons from "[u]nwarranted physical invasions of the body," and preserving "an individual's right to self-determination." The co-guardians asserted that Nancy's permanent inability to decide for herself whether to accept or refuse medical intervention, and her apparent failure to consent formally to nontreatment in advance of her incapacity, did not alter the obligation to respect her autonomy. They argued that Nancy's claim "[was] not in literally voicing choices; it [was] in ensuring that [she] receives treatment that reflects [her] interests and desires." If Nancy's prior-expressed "beliefs and values," and even her "lifestyle," suggest that she would want to die in her present circumstances, then her life-support should be terminated.

In effect, to preserve Nancy's "autonomy," her co-guardians sought to invent her consent to die when none existed. How could this conform with "traditional notions of autonomy"? Is the practice of invented consent, as attempted in Cruzan and certain to be employed in future cases, the best means of respecting an incapacitated person's autonomy interests?

It is not. The theory of autonomy used to justify invented consentmaking substantially differs from the classic understanding of autonomy. To understand how, the theoretical premises of invented consent must be examined.

46. Brief for Petitioners at 18, Cruzan v. Director (No. 88-1503) (quoting Olmstead v. United States, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting)).
47. Id.
48. Id.
49. Petition for Writ of Certiorari to the Missouri Supreme Court at 19-20, Cruzan v. Director (No. 88-1503).
50. Brief for Petitioners at 22, Cruzan v. Director (No. 88-1503).
51. Id. at 33-34.
II. Theory and Justification for Invented Consent

If, at its core, invented consent is a legal fiction, its proponents assert it is a necessary fiction.\textsuperscript{52} When a person falls ill, and thereby loses her capacity to choose her own fate, she no longer can defend her interests by asking for help. Are her claims on our attention and respect for her needs thereby relinquished? Are others free to disregard her and her needs only because nature has stilled her voice? Of course, the answer is no. Advocates of invented consent maintain that it is the best means of acknowledging and responding to both the needs and the interests of persons incapable of caring for themselves.

Why resort to fiction? Why not enforce a duty to care for all persons that obligates others to provide assistance regardless of whether a person can consent or not? Then no one would need to pretend that the assistance was requested or consented to, because a request or consent would not be required.

Fictitious consent, its proponents maintain, is necessary not just because nature robs an incapacitated person of her ability to request help, but because the proponents’ system of ethics requires that all acts of assistance be preceded by the consent of the person assisted. Before we lend help, the “correct” course would be to determine whether help was desired. Thus, for example, Justice Brennan asserted in his 	extit{Cruzan} dissent that the State would have an interest in preserving Nancy’s life only after it “determined that she would want to continue treatment.”\textsuperscript{53} This, in so many words, is the assertion that autonomy is more important than beneficence. In effect, a person’s needs, as perceived by another, alone do not justify the assister’s intervention. Rather, the assister should ask the person needing help, or otherwise determine whether assistance is what the person desired.

Why? Two reasons may be offered. First, we all should be free to define our own needs. Second, we all should be free to reject another’s proffered assistance if we determine we do not need or want that assistance.

Pretending that an incapacitated person consented to being or not being helped preserves something more than her right to receive help when she is incapable of requesting assistance; its proponents contend that invented consentmaking also preserves the patient’s freedom to request or refuse others’ help. In short, they argue that invented consent preserves personal autonomy even though a person’s physical well-
being, as defined by others, may be harmed by honoring a "refusal" of help.

"Autonomy," therefore, is the goal of invented consentmaking. What does this mean? According to proponents of invented consent, decisions governing a patient's medical care must, above all else, be "patient-centered." Respect for autonomy demands "that it is the patient, not the physician, who ultimately decides if treatment—any treatment—is to be given at all." Proponents of invented consent assert that "[t]he patient's perspective is . . . essential in determining how [the patient's] well-being is to be understood."

Thus, the co-guardians of Nancy Cruzan argued that surrogate decisions regarding Nancy's care should be based on "Nancy's own interest in her life," and not on the interests of the state or the medical profession. Yet, those seeking to withhold Nancy's care, while espousing the "patient-centered" principle of respect for autonomy, often disparaged Nancy herself.

Her co-guardians depicted Nancy as "an unconscious 'vegetable,'" and a "biological shell [that] is mechanically preserved." According to the American College of Physicians (ACP), apparently Nancy was no longer a human person: "Patients in a persistent vegetative state do not possess, nor do they have any potential ever again to possess, any of those qualities of distinctively human life . . . ." Her life, the ACP concluded, "[did] not even rise to the level of 'mere animal existence.'" To the National Academy of Elder Law Attorneys, Nancy's life was simply "organic life." The General Board of Church and Society of the United Methodist Church argued that Nancy was not alive at all, because "when the capacity for human relationships is irretrievably lost, death has occurred regardless of what bio-

54. "In applying the value of autonomy to decisions to forgo life-sustaining treatment, we place the patient at the center of the decisionmaking process." Hastings Center, Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying 7 (1987).


57. Brief for Petitioners at 17, Cruzan v. Director (No. 88-1503).

58. Plaintiffs-Respondents' Brief at 12, Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988) (No. 70813).

59. Brief for Petitioners at 15, 38, Cruzan v. Director (No. 88-1503).

60. Brief of the American College of Physicians as Amicus Curiae in Support of Petitioners at 27, Cruzan v. Director (No. 88-1503).

61. Id. at 28 (quoting Munn v. Illinois, 94 U.S. 113, 142 (1877) (Field, J., dissenting)).

logical function can be sustained." Even Justice William Brennan characterized Nancy as being only "metabolically alive."

What sort of respect for autonomy is this, that reduces a permanently incapacitated person to a non-entity, yet demands that we obey the "consent" of this person who never consented to nontreatment and never will? The answer, if any, must be found in the definitions for autonomous persons and autonomous acts implicit in the writings of those espousing invented consent.

A. Autonomous Persons: The Hologram Model

In the film *Star Wars*, Luke Skywalker discovers a hologram message from Princess Leia. After plugging a cartridge into the robot R2-D2, Luke watches and listens as a three-dimensional representation of the Princess gestures and speaks. The figure moves life-like before Luke, but a swoop of an arm through the hologram beam reveals instantly that the figure is just a picture, albeit a sophisticated one. If the flesh-and-blood Princess were to stand next to her hologram, and both were to offer a handshake, we would surely grasp the living hand, not the electronic one. The real from the representational could be readily distinguished.

Imagine now that Princess Leia is seriously injured by Darth Vader, and lies permanently unconscious in a hospital bed. A hologram of her life is playing in his room. Who is the real Princess Leia, the silent dignitary in the bed or the active one in the hologram? Proponents of invented consent, we daresay, would choose the hologram.

63. Brief of the General Board of Church and Society of the United Methodist Church as Amicus Curiae in Support of Petitioners at 9, *Cruzan v. Director* (No. 88-1503) (quoting LIFE ABUNDANT: VALUES, CHOICES AND HEALTH CARE, THE RESPONSIBILITY OF THE PRESBYTERIAN CHURCH (U.S.A.) ¶ 37.744 (Report of the Advisory Council on Church and Society to the 200th General Assembly, 1988)). Justice Stevens in his dissent intimated the same sentiment when he cited with approval the New York Supreme Court, Appellate Division: "A patient in a persistent vegetative state 'has no health, and, in the true sense, no life, for the State to protect.'" *Cruzan v. Director*, 110 S. Ct. at 2886 n.18 (Stevens, J., dissenting) (quoting In re Eichner, 73 A.D.2d 431, 465, 426 N.Y.S.2d 517, 543 (1980)).

64. *Cruzan v. Director*, 110 S. Ct. at 2868 (Brennan, J., dissenting).


66. It is crucial that the hologram records a portion of Princess Leia's *life*, as if the camera followed her continuously throughout. If at some point, the Princess turned to the camera and issued an advance directive, then this may constitute sufficient informed consent. However, the premise of the hologram analogy is that Princess Leia never does indicate clearly her treatment wishes. Rather, the hologram simply shows the Princess living her life; to the proponents of invented consent, her vigorous image in and of itself becomes the "expression" of her intent, as well as the "essence" of her existence.
They stress, for example, that "[h]uman beings are transcendent creatures. Real life comes from beyond bodily function." More precisely, a person or life is to be viewed as more than "mere corporeal existence." The essence of personhood is not flesh and blood, the philosophers in this school assert, it is cognition and a collection of cognitive activities that constitute one's lifestyle. For example, Justice John Paul Stevens argued in his dissenting opinion in *Cruzan*:

Nancy Cruzan is obviously "alive" in a physiological sense. But for patients like Nancy Cruzan, who have no consciousness and no chance of recovery, there is a serious question as to whether the mere persistence of their bodies is "life" as that word is commonly understood, or as it is used in both the Constitution and the Declaration of Independence . . . . When people speak of life, they often mean to describe the experiences that comprise a person's history, as when it is said that somebody "led a good life." They may also mean to refer to the practical manifestation of the human spirit, a meaning captured by the familiar observation that somebody "added life" to an assembly. If there is a shared thread among the various opinions on this subject, it may be that life is an activity which is at once the matrix for and an integration of a person's interests.

From this perspective, the unconscious but breathing Princess Leia or Nancy Cruzan might be less "alive" and thus less a person than her life history, the remaining collection of practical manifestations of her thoughts and feelings as stored in the memories of those who knew her.

One justice of the Illinois Supreme Court has noted that the hologram approach to surrogate decisionmaking requires "[a] surrogate and the court [to] piece together any available testimony from [an unconscious patient's] relatives and other sources to construct a persona. They say that that image, if you will, then represents and decides for the incompetent person. The entire effort is . . . an exercise in fictional characterization . . . ."

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69. "Most of what makes someone a distinctive individual is lost when the person is unconscious, especially if he or she will always remain so. Personality, memory, purposive action, social interaction, sentience, thought, and even emotional states are gone." PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT* 174-75 (1983) [hereinafter PRESIDENT'S COMMISSION].

70. *Cruzan v. Director*, 110 S. Ct. at 2886-87 (Stevens, J., dissenting) (footnotes omitted).

This imaginary construct of "person" more readily encompasses the concept of autonomous persons as understood by invented consentmakers. The "real" Nancy is the Nancy who talked, felt, and made her own decisions. Throughout the *Cruzan* litigation, her co-guardians carefully contrasted Nancy's prior independent existence with her status as a total dependent. Somehow, preserving her impaired "physiological life" would do grave harm to the memories of Nancy in her more autonomous days. According to Justice Stevens:

Nancy Cruzan's interest in life, no less than that of any other person, includes an interest in how she will be thought of after her death by those whose opinions mattered to her . . . . How she dies will affect how that life is remembered . . . . [Her family] would likely have not only a normal interest in minimizing the burden that her own illness imposes on others, but also an interest in having their memories of her filled predominately with thoughts about her past vitality rather than her current condition.

This view would direct the surrogate decisionmaker to disregard the unconscious Nancy in favor of the memory of Nancy.

Thus, proponents of invented consent consider a decision to withhold food and fluids from an unconscious person to be patient-centered even though the patient would cease to exist as a result. The principle of autonomy could be invoked because even though the unconscious person would be incapable of autonomous choices, the memory of that person living autonomously could be incorporated somehow into the surrogate's decisionmaking process. Under this theory, decisions respecting the memories of persons acting autonomously would then be patient-centered decisions, and therefore would be decisions properly respectful of personal autonomy.

**B. Autonomous Decisions: Dispositional Consent**

Once directed to the "hologram" of a previously thinking person, what should the surrogate look for? According to the Illinois Supreme Court, "the surrogate first [must try] to determine if the patient had expressed explicit intent regarding [the] type of medical treatment [at issue] prior to becoming incompetent." In other words, did the patient while competent decide one way or another on the treatment question now facing the surrogate? Did the patient previously consent to the action the surrogate now seeks permission to accomplish?


74. *Longeway*, 133 Ill. 2d at 49, 549 N.E.2d at 299.
Most would agree that an explicit intent of the patient to accept or refuse treatment should be honored if manifested by the patient through some overt, clear decision. Hence, most would approve of effectuating specific and informed decisions by a patient.

Proponents of invented consent, however, would go a step further. The Illinois Supreme Court, for example decided: "Where no [evidence of] clear intent exists, the patient's personal value system must guide the surrogate." The surrogate therefore is free to seek proof of something other than actual consent by the patient. That something has been called "dispositional consent," a phrase coined by Joel Feinberg and discussed in his treatise, *Harm to Self*. According to Feinberg, dispositional consent is "unvoiced authorization," a hypothetical act of consent that the surrogate presumes the patient would be "disposed" to grant, if able. Feinberg admits that "[d]ispositional consent . . . is not actual consent, and can only be presumed, not known." Yet he argues that this "plausible substitute" for actual consent under certain conditions would have the same significance as actual consent. According to Feinberg, these relevant conditions exist when:

1) there is very strong evidence (and even indirect statistical evidence may be very strong) of the other's disposition to consent in circumstances of that kind; 2) there is no opportunity in the available time to solicit consent directly; 3) the intervention reasonably appears necessary to prevent substantial loss or harm to the other party.

Feinberg distinguishes dispositional consent from what he calls "inferred psychological states," which include "the silent desires, wishes, approvals, or tastes of a person, as inferred from his own past behavior or from actuarial tables." Feinberg acknowledges that by themselves, "mere psychological willingness or passive acquiescence [are] not authorization," and hence cannot be considered actual or dispositional consent. Yet he argues that inferred psychological states "can be a relevant part of the evidential base for inferring dispositional consent, and morally significant for that reason." Indeed, "in emergency circumstances, they may be the best guide we have to the

75. *Id.*
77. *Id.* at 173.
78. *Id.*
79. *Id.*
80. *Id.* at 180.
81. *Id.* at 187.
82. *Id.* at 181.
83. *Id.* at 173.
84. *Id.* at 187.
actual consent [an incompetent person] would express if he could."\(^{85}\)

In addition, some courts endorsing invented consentmaking have incorporated the concept of "patient values," extolling the virtues of plumbing an evidentiary mist somewhat akin to Feinberg's "mere psychological states" and "dispositional consent."\(^{86}\) As the Illinois Supreme Court asserted, the surrogate decisionmaker must divine the values held by the patient when competent and reach a decision consistent with those values.\(^{87}\) The relevant values, according to the New Jersey Supreme Court, must include "[a patient's] philosophical, religious and moral views, life goals, values about the purpose of life and the way it should be lived, and attitudes towards sickness, medical procedures, suffering and death."\(^{88}\)

This focus on values, as amorphous as the subject may be, is an essential component of "patient-centered" decisionmaking. Persons are to be treated as ends, not means, and as subjects, not objects.\(^{89}\) What makes us "ends" or "subjects" is that which constitutes our uniqueness. Thus, to respect persons is to appreciate those personal characteristics that make each individual unique. Of moral significance here is not the color of one's eyes or hair, but the substance of one's life plans. A "life plan" consists of those choices made according to goals that a person has adopted.\(^{90}\) These goals are selected pursuant to what the individual believes is good. What one believes is "good" is that which one values. "Values," therefore, are "synonymous with [freely chosen] personal beliefs, especially personal beliefs about the 'good,' the 'just,' and the 'beautiful,' personal beliefs that propel us to action, to a particular kind of behavior and life."\(^{91}\) Thus, whatever values a person may hold will determine the life plan of choices she pursues.

Because "it is often the case that desired goals are in direct competition with each other," one proponent of invented consent has asserted, "A universal ranking of goals is highly unlikely, as individuals

\(^{85}\) Id. at 181.

\(^{86}\) See, e.g, In re A.C., 573 A.2d 1235, 1250 (D.C. 1990) ("The court ... should pay special attention to the known values and goals of the incapacitated patient, and should strive, if possible, to extrapolate from those values and goals what the patient's decision would be ... "); In re Longeway, 133 Ill. 2d 33, 49-50, 549 N.E.2d 292, 299-300 (1989); In re Jobes, 108 N.J. 394, 415-16, 529 A.2d 434, 445 (1987).

\(^{87}\) Longeway, 133 Ill. 2d at 49-50, 549 N.E.2d at 299-300.

\(^{88}\) Jobes, 108 N.J. at 415-16, 529 A.2d at 445 (quoting Newman, Treatment Refusals for the Critically and Terminally Ill: Proposed Rules for the Family, the Physician and the State, III N.Y.L. SCH. HUM. RTS. ANN. 45-46 (1985)).


\(^{90}\) Glover, supra note 56, at 10.

\(^{91}\) See H. Lewis, A Question of Values 7 (1990).
will balance personal goals and values differently."92 As a result, each person will have a unique individual life plan that must be respected. Thus, "[w]hen we respect choices, we are allowing persons to function as ends in themselves, as autonomous or self-determining."93

This "patient-centered" approach is problematic in the context of decisionmaking for persons no longer able to make their own decisions. If respecting autonomy or autonomous choices is the goal, how can one justify making a choice, any choice, on behalf of another?

Proponents of invented consent dance to curious music when this question is raised. One proponent admits, "[I]t is literally impossible for someone to make an autonomous choice on behalf of someone else. The choice is then no longer self-determined, but rather, other-determined."94 Yet, "respecting choices is part of a much richer concept of respecting persons and their own unique identities. We struggle to respect people and the integrity of their lives, not merely their expressed preferences."95 Under this view, respecting autonomy does not consist of just following another's decisions, but in making decisions for another consistent with that person's values.

But is a particular decision ever obvious from a given set of personal values? Without a specific directive from a patient herself, the surrogate decisionmaker can only guess and extrapolate, since there are no clearly delineated routes by which one can find another's unexpressed "intent." How might the "consistency" of a surrogate's decision be judged when the standard is as amorphous as personal "values"?

A second problem facing the patient-centered approach is its reliance on conflicting assumptions. This approach assumes that, out of deference to the patient's individual life plan and its unique significance, a universal definition of "good" or "well being" cannot and should not be applied in treatment refusal cases. This conflicts with another common assumption. Inventing another's consent to die often is justified by the assertion that physiological life without the capacity for making choices or exercising one's liberty interest is a universal disvalue, and sustaining such life is considered conceptually inconsistent with any "reasonable" definition of well-being.96

93. Id.
94. Id. at 11.
95. Id.
96. This view recently was displayed in the case of Helga Wanglie, a patient in a permanent unconscious condition at Hennepin County Medical Center in Minnesota. See Belkin, As
As noted by the Missouri Supreme Court in *Cruzan*, "Nearly unanimously, those courts [upholding invented consent] have found a way to allow persons wishing to die, or those who seek the death of a ward, to meet the end sought." For example, the New Jersey Supreme Court in *In re Quinlan* designed a theoretical template for disvaluing a person's life according to the severity of her cognitive impairments. The *Quinlan* court found that the state's interest in preserving the life of Karen Quinlan, a woman in a permanent unconscious condition, was "weakened," and that because Karen's prognosis was "extremely poor—she will never resume cognitive life," her right to die prevailed. This template has been applied in almost every right-to-die ruling since.

The *Quinlan* approach involves an assessment of the relative values of living with permanent unconsciousness or death, by which death almost invariably is preferred. When applied in circumstances in which a surrogate has only the patient's "values" as a guide, the *Quinlan* analysis encourages the surrogate to focus on those values purportedly held by the patient that are consistent with the belief that life without liberty is of no value at all.

By automatically scissoring a prior consent to die out of a flimsy sheet of cardboard "values" or "dispositions," proponents of this approach disregard the very uniqueness they claim they are respecting. It is a contradiction to assert that only the patient's unique choices should be at the center of any surrogate decision and at the same time presume that all patients would be "disposed" to choose death if seriously incapacitated. Yet that is the approach taken in invented consent cases.

Why is it that proponents of invented consent favor a process of surrogate decisionmaking that posits the existence of holographic persons and dispositional consent? This practice may stem from their conviction that liberty is the essence of life, and thus is the primary

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*Family Protests, Hospital Seeks an End to Woman's Life Support,* N.Y. Times, Jan. 10, 1991, at 1, col. 1. Despite prior expressions by Ms. Wanglie indicating her desire that "everything [be] done" should anything happen to her, the hospital announced that it would seek to remove the woman from her ventilator. *Id.* The hospital director told the press: "[W]e don't feel that physicians are obliged to provide inappropriate medical treatment that is not in the patient's medical interest." *Id.* The care was deemed "futile" and of no benefit because it could not restore Ms. Wanglie to consciousness. *Id.*

97. *Cruzan v. Harmon,* 760 S.W.2d 408, 413 (Mo. 1988) (en banc).
99. "[T]he State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims." *Id.* at 41, 355 A.2d at 664.
100. *Id.*
101. *Cruzan v. Harmon,* 760 S.W.2d at 422.
value from which all other values take their measure. Proponents of invented consent view autonomy, not life, as the cardinal good.

They argue that autonomy is an intrinsic good, not an instrumental good.\textsuperscript{102} We respect personal autonomy not because its exercise medically may benefit the patient in these cases, but because of the principle of autonomy. As one commentator argues: "Respecting a patient's autonomy does not necessarily entail concern for consequences and thus can be at odds with a physician's vision of medical benefit. When such a conflict arises, an approach... that begins with patient autonomy places a priority on adherence to that principle over considerations of beneficial results."\textsuperscript{103} Thus, if a patient or a patient's guardian refuses treatment as an attempt to exercise personal choice, that refusal should be honored even if it results in the patient's death. Autonomy should be considered an intrinsic good: a goal to be met regardless of any consequences, even death.

The corollary argument is that life is of only instrumental value. That is, life has value only as long as a person can exercise her capacity for liberty. Justice Brennan argued in his \textit{Cruzan} dissent: "[T]he State has no legitimate general interest in someone's life, completely abstracted from the interest of the person living that life..."\textsuperscript{104} Thus, according to the dissent of Justice Stevens, when a person loses the physical or mental capacity to make choices, her life should be preserved only if the patient had previously directed that her life be maintained.\textsuperscript{105} From this perspective, life is contingent on liberty and is only a vehicle for liberty's exercise; absent liberty, life has no intrinsic value for proponents of invented consent. The consequence of death, should it follow, therefore would have little, if any, negative significance.

Thus, the end sought—vindication of autonomy—is being used to justify a problematic means of achieving this end whatever the consequences. If one must invent the appropriate consent by trolling through a person's value system to capture the one value combination that would approximate a decision to die, then so be it.

The Sirens' call may entice, but where will it lead? In the next Part, the classic understanding of autonomy and its influence on patient care is examined. How invented consentmaking alters the traditional approach to caring for those persons competent and not competent to care for themselves also is discussed.

\textsuperscript{102} Welch, \textit{supra} note 5, at 1622-23.
\textsuperscript{103} Id. at 1622.
\textsuperscript{104} Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2870 (1990) (Brennan, J., dissenting).
\textsuperscript{105} Id. at 2889 (Stevens, J., dissenting).
III. Impact of Invented Consent on Patient Care Tradition: Grafting the Rootless Bough

What is autonomy and how does respect for autonomy within the medical context reveal itself through the procedures and criteria typically used to obtain consent for medical decisionmaking? Proponents of invented consent have formulated their own thesis, but their approach differs considerably from the traditional understanding of autonomy and respect for autonomy, at least regarding patients unable to make their own decisions.

While the proponents of invented consent appeal to the tradition of informed consent and rely on much of the same terminology, invented consent is more a rootless bough than a natural branch, grafted to, rather than generating from, the traditional approach to patient care.

The word "autonomy" comes from two Greek terms meaning "self" (autos) and "rule" or "law" (nomos). It was a political term originally, referring to self-governance within the Greek city-states. "In moral philosophy personal autonomy has come to refer to personal self-governance: personal rule of the self by adequate understanding while remaining free from controlling interferences by others and from personal limitations that prevent choice." The traditional view of autonomy relies on more limited definitions of "autonomous person" and "autonomous action" than found in the theory of invented consent. The following discussion highlights the differences.

A. Autonomous and Non-Autonomous Persons

According to the traditional view, those persons capable of "self-governance" are those "who have the capacity to be independent and in control." If "the exercise of autonomy depends on an individual's ability to make at least minimally reasoned choices . . . [w]hen that capacity is lacking—because of infancy, mental incompetence, or unconsciousness—it would seem that the concept of autonomy should have little significance."

Classically, personal autonomy presupposes conscious and mature persons, but does not foreclose respect for unconscious or immature

107. Id.
108. Id.
109. Id.
110. Applebaum & Klein, Therefore Choose Death?, 81 Commentary 23, 24-25 (1986).
persons. In his treatise *On Liberty*, John Stuart Mill asserted that while "[o]ver himself, over his own body and mind, the individual is sovereign,"\(^{111}\) this principle did not apply in the same way to all persons. He wrote:

It is, perhaps, hardly necessary to say that this doctrine is meant to apply only to human beings in the maturity of their faculties. We are not speaking of children or of young persons below the age which the law may fix as that of manhood or womanhood. Those who are still in a state to require being taken care of by others must be protected against their own actions as well as against external injury.\(^{112}\)

Thus, Mill and other traditionalists would disagree with the premise of invented consent that a person incapable of choosing is still somehow capable of choosing. The traditional position also conflicts with the view that life without liberty is life without value and that incapacity extinguishes the obligation to protect those who cannot protect themselves.

Personal autonomy, or sovereignty over one's own body and mind as Mill described it, has two components: an individual's "right to himself,"\(^{113}\) that is, a right to bodily integrity, as well as a right to "thorough-going self determination,"\(^{114}\) which protects one's mental and volitional integrity. The "person" to be protected thus consists of both a corporeal element and an incorporeal element.

Respect for persons, therefore, involves not only appreciation of a person's mental faculties and the fruits of those faculties (i.e., thoughts, feelings, and choices), but also incorporates due regard for a person's body, which by its integrated function bears a fruit of its own—continued existence.

Thus, a battery can be committed upon a person, even when the person is unaware of the physical intrusion.\(^{115}\) Consciousness and the capacity to make choices are not conditions precedent to a personal interest against bodily invasion.\(^{116}\) Moreover, when there is a duty to provide care for another, failing to act consistent with that duty may be actionable even if the beneficiary of the duty was unaware of the breach because of mental or other incapacity.\(^{117}\)

Under the traditional approach to caring for competent patients, both the patient's body and mind are the natural focii of "patient-

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112. *Id.*
113. Mohr v. Williams, 95 Minn. 261, 268, 104 N.W. 12, 14 (1905).
116. See Mohr v. Williams, 95 Minn. at 268, 104 N.W. at 14-15.
centered” decisionmaking. The doctrine of consent obligates a caregiver to obtain a competent patient’s consent before undertaking any nonemergency treatment. The common law considered it a battery for a surgeon to perform even a therapeutic operation upon a patient without her consent. This protected a patient’s physical person from unwanted touching or intrusion.

The doctrine of informed consent, emerging more recently, seeks to vindicate a competent patient’s interests in self-determination through the exercise of her mental faculties. The caregiver must secure the patient’s “informed” consent, making a reasonable disclosure to the patient of the nature and probable consequences of the proposed treatment. In effect, the traditional approach moved from a paternalism model of decisionmaking to a participatory model in which both patient and caregiver benefit “from a sharing of control over many of the decisions arising out of the relationship.”

It is important to remember that for competent patients the traditional approach presumes that life and continued existence are beneficial to the patient. Physicians are obligated under the duty of due care to “help, or at least do no harm.” As noted by the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, “The primary basis for medical treatment of patients is the prospect that each individual’s interests (specifically, the interest in well-being) will be promoted. Thus, treatment ordinarily aims to benefit a patient through preserving life, relieving pain and suffering, protecting against disability, and returning maximally effective functioning.” Particularly when a physician is providing lifesaving care, the physician will be liable for any injuries to the patient resulting from premature withdrawal of treatment without the patient’s consent. “This value of benefiting the patient has long been treated as a foundational value—and sometimes as the foundational value—in medical ethics.”

The traditional obligation to care for patients continues even when the patient loses the capacity to make choices. The traditional ap-

123. President’s Commission, supra note 69, at 181.
proach presumes that even though a person’s mind may no longer function, the person’s bodily existence must continue to be respected. Respect under this approach takes the form of providing necessary and effective life-prolonging care, since incapacity does not extinguish the traditional duty of care.\textsuperscript{126} This duty continues unless the care is ineffective,\textsuperscript{127} the treatment imposes severe physiological or psychological burdens on the patient (such as pain),\textsuperscript{128} or clear proof of a prior consent to nontreatment by the patient is discovered.\textsuperscript{129}

Thus, unlike the "respect" employed by practitioners of invented consent, the traditional approach requires recognition that a "person" exists whether or not the individual possesses the capacity for volitional autonomy. The "person" is not located in some ephemeral construct consisting solely of memories of the individual acting autonomously; personhood exists in one's flesh and bones. When choices to the contrary have not been made by the patient, respect for persons requires duly-appointed caregivers to do just that—give care even to incapacitated persons.

B. Autonomous Actions and Effective Consent

Just as the discussion about autonomous persons must necessarily focus on the meaning of "person," the meaning of "action" is an essential question in the inquiry about autonomous actions. The definition of autonomous "action" suggested by proponents of invented consent is much broader than that endorsed by traditionalists.

As noted above, the traditional mechanisms of consent and informed consent effectuate the individual autonomy of patients. Thus, a particular action or class of actions that constitute the exercise of individual autonomy structure the patient-caregiver relationship.

What is meant by "action"? Unlike invented consent, the traditional view restricts its definition of "consent" to events of communication, often involving bodily movements cognizable by others.\textsuperscript{130} Unexpressed or otherwise unrecognizable desires, wishes, thoughts, feelings, or emotions would not be characterized as actions and would not qualify as autonomous actions. Thus a mere psychological or emotional disposition could not rise to the level of consent or informed consent under traditional theory.

\textsuperscript{126} 70 C.J.S. Physicians & Surgeons § 67 (1987). \textit{But see supra} note 96.

\textsuperscript{127} Barber v. Superior Court, 147 Cal. App. 3d 1006, 1017-18, 195 Cal. Rptr. 484, 491 (1983).


\textsuperscript{129} John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921, 924-26 (Fla. 1984).

\textsuperscript{130} J. Feinberg, \textit{supra} note 76, at 176.
Traditional theorists would recognize only those actions freely-given, uncoerced, and intentionally directed as effective means of consent or informed consent.131 More important to this discussion, these actions must amount to authorizations.132

That is, "the idea of an informed consent suggests that a patient or subject does more than express agreement with, acquiesce in, yield to, or comply with an arrangement or a proposal."133 The action must grant a privilege to another that otherwise would not exist, or cancel another's obligations towards the actor.134 There must be a transfer both of authority and responsibility between the actor and the other:135 "Thus, the crucial element in an authorization is that the person who authorizes uses whatever right, power, or control he or she possesses in the situation to endow another with the right to act."136

The traditional appreciation of personal autonomy requires that consent provide authorization. Faden and Beauchamp explain:

Authorization is needed because of the kind of proposal tendered to the person. Typically proposed in informed consent contexts is that a professional do something, or refrain from doing something, that directly and personally affects a patient or subject and that the professional cannot rightfully, by reference to the principle of respect for autonomy, do (or not do) on his or her authority alone. Frequently, the proposal cannot with moral sanction be implemented without the patient's or subject's authorization or permission. Thus, mere assent or agreement is insufficient.137

The lack of concern demonstrated by the co-guardians of Nancy Cruzan for whether Nancy ever consented to nontreatment138 is contrary to the traditional position that a patient manifest specific authorization before treatment is withheld. In effect, the co-guardians too readily dismissed a significant protection of Nancy's autonomy interests on the mistaken belief that her interests somehow would be vindicated without proof of her consent.

Finally, the "action" in question, particularly in the context of informed consent, must be an exercise of choice—a decision to choose one option rather than another. Autonomy necessarily presumes a context in which choices are available. "Freedom will exist only where there exists the possibility of choice . . . ."139 Thus, "[f]reedom in its

132. J. FEINBERG, supra note 76, at 173.
133. R. FADEN & T. BEAUCHAMP, supra note 106, at 278.
134. J. FEINBERG, supra note 76, at 178.
136. Id.
137. Id. at 295 n.12.
138. See supra text accompanying notes 34-36.
positive aspect is the activity or process of choosing for oneself and acting on one's own initiative.’’ Since consent and informed consent are types of autonomous actions, proof of their occurrence should consist of evidence that the patient made a decision to choose one course of treatment (or to refuse treatment) over another.

According to Webster's Dictionary, the word "decide" comes from a Latin term meaning "to cut off." Thus, a decision is an action that cuts off one option in favor of another, representing a clear-cut choice for or against a particular alternative. The more specific an expression of consent or refusal, the more likely that others authorized to effectuate the patient's choice indeed will effectuate that choice and not some other choice the patient intended to cut off from consideration. Whether for competent or noncompetent persons, "[a]ccuracy, therefore, must be our touchstone.’’

The traditional approach requires the caregiver to disclose information that will allow the patient an opportunity to evaluate intelligently the medical options and their consequences. An informed decision regarding medical care can be made only after the patient has obtained "a full understanding of the nature of the illness and the prognosis, the information necessary to evaluate the risks and benefits of all the available treatment options, and the competency to make a reasoned and voluntary decision.’’

The disclosure requirement not only enhances the quality of the patient's deliberation and final choice, but also increases the clarity of the patient's instructions to caregivers. Recognizing this, courts following the traditional view have required that a decision to refuse treatment be just as informed as a decision to consent to treatment.

Thus, the traditional approach to patient care would give operative legal significance to only a limited range of action—a range smaller than that accepted by proponents of invented consent. Only statements of decision, not expressions of preference or taste, would be treated as autonomous choices.

The traditional view, while limiting the definition of autonomy and restricting the scope of its application, nevertheless seeks to encourage patient-centered decisions, particularly for the most vulner-

140. Id. at 223.
144. Bopp, supra note 118, at 600.
able patients—those unable because of incapacity to make their own decisions. This is done through two basic mechanisms.

First, only those actions by the patient clearly representing the patient’s exercise of choice are to be honored. This avoids the possibility that a patient mistakenly will receive unwanted care or be denied desired care. Second, the life of the patient, not “autonomy,” must be accorded the highest value. The traditional approach encourages decisions by the caregiver that protect the patient’s interests in life and bodily integrity, unless those decisions clearly thwart the patient’s autonomous choices. This mode of decisionmaking protects the patient from irreversible injury or death that could result from a mistaken interpretation of her “values.”

In effect, the traditional approach holds that the patient’s existence is the core value in patient decisions. A caregiver’s obligation to provide care remains as long as a patient can benefit from such care by continuing to live. This interest in living attaches irrespective of the patient’s capacity for autonomous actions. One’s right to live does not come into existence only when the patient “chooses” to live and does not vanish solely because the patient becomes permanently incapacitated. While life is a prerequisite of autonomy, it is not a species of autonomy that evaporates when autonomy is lost. A “person” worthy of respect exists even when the personal capacity to make choices does not. Decisions still can be “patient-centered” if they respect the patient’s right to exist without conflicting with a clearly exercised autonomous decision by the patient.

Thus, the process of invented consent, which creates a consent to die, should be rejected on the grounds that it not only co-opts the patient’s interest in volitional autonomy (creating a “choice” when none existed), but also because it interferes with the patient’s interest in bodily integrity (allowing death—the ultimate form of bodily disintegration).

What invented consent proponents offer is a new definition of “informed consent.” They seek to distinguish between true autonomy or consent and effective autonomy or consent.147 True autonomy satisfies all the classic elements of autonomous action, while effective autonomy is treated as if it were truly autonomous action.148 “[R]equirements for [effective] informed consent typically do not focus on the autonomy of the act of giving consent [as true consent does], but rather on regulating the behavior of the consent-seeker and

148. Id. at 280.
on establishing *procedures and rules* for the context of consent.\(^{149}\)

The question is whether the ersatz form of consent should replace true consent as an "effective" act of personal autonomy deserving respect. For reasons based on principle and practice, invented consent should be rejected as a dangerous denigration of personal autonomy.

**IV. The Shortcomings and Dangers of Invented Consent in Cases Involving Legally Incapacitated Patients**

Both principle and practice dictate the rejection of invented consent in cases involving patients who are incapable of issuing their own consent or refusal. Lifted from its proper context of medical decisionmaking by competent individuals, volitional autonomy distorts the decisionmaking process and endangers the compelling interests of non-competent individuals.

**A. Objections Based on Principle**

**(1) Violation of Bodily Integrity**

Nancy Cruzan lived in a permanently unconscious condition.\(^{150}\) She required only gastronomical feeding, a form of care initiated soon after she sustained her injuries. But for her inability to assist herself, Nancy's body continued to function physiologically, and therefore she possessed a bodily integrity conducive to life. In seeking to withdraw her artificially-provided nourishment, Nancy's co-guardians attempted to end her physical existence. They did not try to prove, however, that Nancy actually consented to nontreatment and ultimately death. They thereby sought to end her life without her consent.

The co-guardians argued, in effect, that given Nancy's permanent impairment and the resulting quality of her life, their decision—leading to her death if carried out—would be based on Nancy's implied consent. This claim stands the traditional doctrine of implied consent on its head.

Traditionally, consent *to* treatment is implied in an emergency that threatens death or serious bodily harm when the treatment will preserve life or prevent serious injury.\(^{151}\) For the co-guardians' argument to prevail, Nancy's continued life, and not the threat of death,

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149. *Id.*
150. See supra text accompanying note 17.
would have to have been considered an emergency condition to be eliminated, a continuing harm to her interests.

This would require a philosophical shift in outlook, whereby life without consciousness would be deemed life unworthy of living. If transformed into an objective standard, this outlook would mandate a societal presumption that all "reasonable persons" in Nancy's condition would have consented to nontreatment, thus devaluing the lives of all similarly-situated, vulnerable persons. If incorporated into a subjective process of invented consent or "substituted judgment," this approach would be unsatisfactory 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."¹⁵²

(2) Autonomy Lapses with Incapacity but Other Rights Remain

The fictions of invented consent and "substituted judgment" presuppose that a person's autonomy interests survive incapacity and thus must be respected. This view is correct only to a point. To the extent that autonomy refers to decisions already made and communicated by the patient before losing the capacity to make further choices, then it is true that the patient's interest in having those choices honored must survive incapacity. The incapacity does not affect those prior decisions: it did not prevent those prior choices from being made and communicated and does not, by itself, extinguish the responsibility of others authorized by the patient to act according to those prior decisions.

This view differs, however, from the invented consent proponents' view that the patient's authority to decide for herself automatically shifts upon incapacity to a surrogate, giving the surrogate the freedom to act as if the surrogate were the patient. As noted by the Supreme Court in *Cruzan*, it "begs the question" to presume that a surrogate has the right to effectuate any particular decision on the patient's behalf, without evidence that the decision indeed was the patient's own.¹⁵³

But proponents of invented consent argue that the patient's right to autonomy must be transferred to a surrogate in order to preserve the right. The very transfer of authority, however, erodes the right, if done without the consent or direction of the patient. Because the

patient no longer is capable of exercising this right on her own, and because such a right evaporates once placed in the hands of another, the right of autonomy is a wholly personal liberty that lapses upon incapacity.

Other rights survive, however. As noted above, an incapacitated patient has a right to the effectuation of decisions regarding her property and personal interests made prior to incapacity. In addition, the patient retains those rights arising out of the patient-doctor and other professional caregiver relationships. Those services explicitly and implicitly contracted for prior to incapacity must be provided, unless capacity itself is an express or implied condition of release. Thus, the physician still may be obligated to provide necessary and ordinary life support such as tube-feeding, but need not provide, for example, eyeglasses if the patient loses consciousness. The physician’s authority to act on the patient’s behalf arises from her legal relationship as fiduciary to the patient, not from any notion of patient autonomy.

Finally, the incapacitated patient retains the right to live and to exist free of unwarranted bodily intrusions. These rights arise from state and federal guarantees of due process and equal protection, as well as from common law and statutory sources. These rights are not autonomy-based: their enforcement does not depend on an initial decision by the patient to live and to live free of bodily intrusions. These rights are passive because they attach irrespective of any invocation of a patient’s autonomy. Nonetheless, these rights are important preconditions to a person’s capacity to make choices. A person obviously must be alive and must possess bodily existence before she can ever assert or exercise her right to choose. This right, however, like other rights arising from sources other than the patient’s autonomy, does not disappear upon incapacity.

Thus, a surrogate may be authorized under law, particularly as a court-appointed guardian charged with protecting the patient’s best interests, to make decisions protecting the patient’s rights to live and to maintain bodily integrity. Again, the source of authority is not patient autonomy but rather the state’s parens patriae powers.

It is, then, both possible and necessary to make “patient-centered” decisions for unconscious persons without resorting to the fiction of invented consent. An incompetent patient is not an empty shell, and decisions that take her “passively-attached” rights into account—when there are no autonomy-based rights arising from the patient’s

prior decisions—constitute the fullest respect for that patient.

(3) *Invented Consent Is Not Informed Consent*

The final objection based on principle is that invented consent, because it relies on a surrogate’s interpretation of the patient’s values and lifestyle, lacks any similarity to informed consent. There may be no identifiable act of consent, no opportunity to be informed, and ultimately no patient participation in the process. The practice is wholly other-directed.

By necessity, a surrogate must stand outside and only can peer in at the patient’s system of beliefs. Even family members and spouses may not fully comprehend which goals are significant and which are not.

Because of a patient’s unexpressed goals and desires, a surrogate may be unable to correctly determine the most likely decision a patient would have made. Thus, a surrogate must invent rather than discern a patient’s unvoiced authorizations and follow these “authorizations” as if, not because, the patient decided on her own. This determination is inherently subjective, and “a third party acting on the patient’s behalf often cannot say with confidence that his treatment decision for the patient will further rather than frustrate the patient’s right to control his own body.”

In not requiring tangible evidence of “consent,” relying instead on a surrogate’s interpretation of a patient’s personal predilections, invented consent has no analogue in the law. Transfers of property, agreements for services, and designations of agency all depend on overt actions or other objective evidence of intention to define the rights and duties of the parties.

Under contract theory, “[i]t is a necessary requirement in the nature of things that an agreement in order to be binding must be sufficiently definite to enable a court to give it exact meaning.” Thus, “[a]n expression of desire or hope is not of itself an offer which will become a contract on acceptance by an adversary party.”

Moreover, in a contract in which the occurrence of some condition will extinguish a party’s duty under the contract (a condition subsequent), “the intent to create a condition subsequent must appear expressly or by clear

156. *Whitelaw v. Brady*, 3 Ill. 2d 583, 590, 121 N.E.2d 785, 790 (1954) (quoting 1 S. WILLISTON, WILLISTON ON CONTRACTS § 37, at 98 (rev. ed. 1936)).
implication." Forfeitures of contract rights otherwise due and enforceable are not favored by the law, and therefore evidence of intent is particularly important. Indeed, the New York Court of Appeals has recognized the connection between the issues surrounding consent to treatment or nontreatment and evidentiary requirements in other areas of the law:

There are numerous instances in which the law refuses to recognize the exercise or waiver of an important right unless the intent to do so is clearly manifested . . . [Thus] it cannot be seriously urged that it would be "unrealistic" for the law to accord the same protections to the individual's life and right to survive, as have long been accorded to the individual's land and pocketbook.

Though the current practice of informed consent has its shortcomings, the legal requirements of disclosure and consent have impressed upon the medical profession the importance of the patient's perspective in medical decisionmaking:

Physicians had heretofore considered the physician-patient relationship by beginning from the patient's submission to the physician's professional beneficence. The law [of informed consent] enlarged that perspective by . . . emphasizing instead that patients voluntarily initiate the relationship and have the right to define its boundaries to fit their own ends . . . [thus] demonstrating to medicine the validity of autonomy concerns.

At the very least, informed consent requires the patient's consent; mere suppositions about what the patient will or will not consent to are insufficient. A doctor cannot simply guess what the patient wants done, but must disclose to the patient all necessary information about alternatives and consequences and then obtain the patient's authorization to proceed. In the event of incompetency, the physician must "do no harm" and must maintain the patient's status quo by not subjecting the patient to further injury.

Unlike invented consent, informed consent relies on fact, not fiction. Patients capable of giving informed consent are given the opportunity to clearly refuse or consent to treatment or non-treatment. Patients not capable of giving informed consent nonetheless are protected under the physician's duty of due care. Proof of a condition subsequent extinguishing that duty of care must show that the patient,

159. Id.
162. R. FADEN & T. BEAUCHAMP, supra note 106, at 142-43.
before incapacity, gave her informed consent to nontreatment,\textsuperscript{163} or that effective means of sustaining life or health are no longer available.\textsuperscript{164}

B. Objections Based on Practice

As a matter of practice, invented consent destroys the procedural protection against patient abuse found in the law of informed consent and “best interests” decisionmaking. When a surrogate bases a medical decision on the surrogate’s opinion of the patient’s wishes and values, rather than the patient’s interests in life and health, invented consent eviscerates the objectivity needed to make decisions truly respectful of all the patient’s interests. Decisions resulting in the patient’s death obviously are irreversible. Inventing consent to hasten the patient’s demise, therefore, invites abusive practices with no opportunity for correction.

(1) Proximity Breeds Projection

Invented consent, according to one commentator, requires the substitute decisionmaker to “share the life-world of the [patient] . . . not only comprehend[ing] the biography of the individual, but ideally [becoming] a part of it.”\textsuperscript{165} The surrogate must decide for the incapacitated patient as if she were the patient. Yet, by “don[ning the patient’s] mental mantle,”\textsuperscript{166} the surrogate risks losing the objective distance necessary for rational and compassionate decisionmaking.

The process of “identifying” with the patient’s perspective so completely that the surrogate’s identity meshes with that of the patient involves a risk of projection and overidentification.\textsuperscript{167} The surrogate may not be able to shed completely her own persona with its integration of memories, feelings, desires, and goals. The surrogate may carry into the process her own feelings about the patient, about similarly situated persons, and about similar circumstances she herself is facing. The surrogate, however, is capable of autonomous action and the incapacitated patient is not. The patient cannot defend her own perspective if the surrogate’s perspective slides in to fill in the blanks.

\textsuperscript{163} Cruzan v. Harmon, 760 S.W.2d 408, 424 (Mo. 1988) (en banc).
\textsuperscript{164} D. MEYERS, supra note 124, § 8:14, at 155.
\textsuperscript{165} Glover, supra note 56, at 11.
The surrogate may project her own fears of dependency onto the patient—editing memories of the patient to reflect only certain manifestations of the patient’s fear of dependency. The surrogate may overidentify with the patient, leading to an “I-know-how-you-feel” reaction that encourages the surrogate to act upon her own insecurities. In the end, the surrogate’s capacity to act autonomously allows her wishes, desires, and values to motivate a decision regarding the patient. Because the surrogate is supposed to represent the patient, it is easy for the surrogate to claim that her decision is the patient’s as well.

The risks of projection and overidentification by health care professionals in their relationships with competent patients are well known. When they occur, these problems hinder the professional’s ability to see the patient as an individual. Physicians and other caregivers therefore are advised to maintain an appropriate distance from their patients “until the uniqueness of the other person emerges.” Invented consent, however, encourages precisely the type of behavior that leads to these problems.

(2) Insulation Invites Abuse

Vesting surrogate decisionmakers with the authority to divine a patient’s values insulates the surrogate’s decision from review. The whole idea of invented consent is that the incompetent patient should be free to have effectuated on her behalf any choice available to her when competent. Even if a particular choice conflicts with society’s view of what is best for the patient, the patient’s autonomy interests protect her right to that choice irrespective of its rationality. The Massachusetts Supreme Judicial Court asserted that “impos[ing] a solution on an incompetent [patient] based on external criteria” would conflict with the patient’s personal rights to autonomy and integrity. Thus, that court rejected the objective “best interest” standard traditionally applied in medical decisionmaking for incapacitated patients. If no “objective” criteria can be applied to measure the legitimacy of surrogate decisions, then what limits are there on the surrogate?

There is little comfort in an assurance that the surrogate must decide as the patient would decide. If the patient indeed has not de-

168. Id. at 162.
169. Id. at 160-62.
170. Id. at 161.
171. Id. at 162.
cided, then any claim that the patient would decide in a particular way is only a prediction based on the surrogate’s own opinion. The only person qualified to critique the surrogate would be the patient, but the patient is unavailable to challenge the surrogate’s decision. Thus, no one can authoritatively determine whether the surrogate’s invented consent would conform to the patient’s unformed decision.

Proponents of invented consent assert that “objective” decision-making has its own risks. One commentator argues, “All treatment decisions . . . are ‘tainted by idiosyncrasy.’” Because “[d]ecisions about medical treatment are inherently subjective and cannot be separated from the values and preferences of the decisionmaker,” even “best interest” determinations may be based on subjective, personal opinions. “The language of ‘medical necessity’ is sometimes used to mask the value judgments being made.” The Supreme Court of Illinois thus rejected the “best interest” approach in favor of substituted judgment: “The problem with the best-interests test is that it lets another make a determination of a patient’s quality of life, thereby undermining the foundation of self-determination and inviolability of the person . . . .” In essence, the argument is that “if treatment decisions are going to be based on someone’s value influenced opinion, should it not be the patient’s opinion? This is what substituted judgment is all about.”

It is true that certain variations of the “best interest” test apply “objective” criteria that actually incorporate subjective evaluations of a patient’s interests based on estimations of the patient’s quality of life. The Arizona Supreme Court, for example, formulated the following “best interest” criteria: “[R]elief from suffering, preservation or restoration of functioning, and quality and extent of sustained life.” Another commonly used approach, the Quinlan “template,” which asserts that a state’s interest in preserving life diminishes when cognitive function wanes, is vulnerable to the same criticism. These variations of the “best interest” approach encourage the decision-maker to subjectively discount the value of life for permanently or severely impaired persons.

173. Welch, supra note 5, at 1634-38.
174. Id. at 1637 (quoting Clayton, From Rogers to Rivers: The Rights of the Mentally Ill to Refuse Medication, 13 Am. J.L. & MED. 7, 19 (1987)).
175. Id.
176. Id.
177. Id. at 1636.
179. Welch, supra note 5, at 1637.
181. See supra notes 98-100 and accompanying text.
Not all "best interest" approaches, however, are the same. The Missouri Supreme Court in *Cruzan* employed an analysis that placed "an express, affirmative duty on guardians to assure that the ward receives medical care [and other services that are needed]."¹⁸² Under the *Cruzan* analysis, the duty to provide care could not be qualified by the ward's "diminished" quality of life¹⁸³ and would continue as long as medical care effectively sustained life and placed no "excessive" burden on the patient.¹⁸⁴ The interest in preserving life outweighs a person's interests in dying if that person did not specifically choose to die.¹⁸⁵ This approach avoids the subjective quality of life factors found elsewhere, and thus offers a satisfactory approach that properly respects personal interests.

(3) The "Fox-Rules-the-Coop" Dilemma

Because of their incapacity, patients unable to make their own decisions must depend on others, including surrogate decisionmakers, for the protection of their rights and interests. These patients, particularly the elderly, are especially vulnerable to abuse and neglect, sometimes from the very persons responsible for meeting their needs and making decisions on their behalf.¹⁸⁶ Thus, the "assumption is questionable" that "the proxy who is deciding on [the vulnerable person's] behalf should naturally occupy the role of advocate."¹⁸⁷

Proponents of invented consent argue that relatives of an incapacitated person are the most appropriate decisionmakers and therefore should be given broad discretion to make decisions on the person's behalf. The "most obvious decision-makers are those who love us and/or are obligated to care for and about us," writes one proponent: "Family and friends most closely fit these requirements."¹⁸⁸

According to a recent congressional report,¹⁸⁹ however, family members are most likely to be the perpetrators of elder abuse.¹⁹⁰ Based

¹⁸². Cruzan v. Harmon, 760 S.W.2d 408, 424 (Mo. 1988) (en banc).
¹⁸³. *Id.* at 420.
¹⁸⁴. *Id.* at 421.
¹⁸⁵. *Id.* at 420-22.
¹⁸⁶. See Kayser-Jones & Kapp, *Advocacy for the Mentally Impaired Elderly: A Case Study Analysis*, 14 Am. J.L. & Med. 353, 356-62 (1989) (An elderly mentally impaired nursing home patient died of apparently treatable infection when her son, who had not visited his mother in two or three years, told the attending physician that there was "nothing to save" and that the family didn't want anything "elaborate" done.).
¹⁸⁷. *Id.* at 362.
¹⁹⁰. *Id.*, Executive Summary at XIV.
on data from adult protective services agencies from forty-three states, the report concluded that approximately 1.5 million older adults may be victims of abuse each year:

The majority of elder abusers are relatives of the victims, often a son or daughter with whom the elderly individual resides. The States indicated that, on average, only 25 percent of abusers are caretakers unrelated to the elderly victims. Thus, nationally, up to 3 of 4 elder abusers are family members. 191

Thus, in many cases family members may want to act contrary to the express decisions of older relatives and against their best interests. 192 If given broad authority to decide on behalf of these vulnerable persons, the family members who choose to ignore the patient's interests are left "effectively unaccountable." 193

Even when family members do not seek to harm their incapacitated relatives intentionally, the process of invented consent is still subject to great risk of error. "[R]esearch suggests that older patients rarely offer even informal advance direction about treatment preferences in the form of discussions with their younger relatives, unless they have already developed a serious chronic illness." 194 Even then, these conversations are typically "casual," "general," or "indirect." 195 Family members who are "physician-selected" to make decisions on behalf of incompetent relatives may lack sufficient knowledge about their relatives' prior treatment decisions. 196 Not surprisingly, one study found that recommendations by family members differed from the patients' actual decisions from twenty-four to fifty percent of the time. 197

The same difficulties confront physicians, 198 nurses, 199 and court-appointed guardians. 200 Professionals are no more adept than family members at divining the patient's desires in these cases.

In sum, invented consent invites "incompetent patients' genuine interests to be quietly and conveniently subordinated to the interests of others." 201 At the very least, invented consent enables "those who

191. Id.
193. Id.
195. Id. at 616.
196. Id.
197. Id. at 618.
199. Id.
201. Dresser, Life, Death and Incompetent Patients: Conceptual Infirmities and Hidden
seek the death of the ward, to meet the end sought" with little re-
sistance or oversight.\footnote{202}

For these reasons, the doctrine of invented consent diminishes
rather than enhances the interests of persons with long-term inca-
pacities in autonomy and bodily integrity. This practice subjects these
patients to the threat of a wrongful or erroneous waiver of their right
to live and receive necessary medical care. By increasing the chance
that the patient will be denied life-sustaining medical treatment against
her will and contrary to her best interests, invented consent can hardly
be called "patient-centered."

\section*{Conclusion}

The goal of "patient-centered" decisionmaking can be served best
by allowing duly-appointed surrogates to make decisions regarding
medical treatment and care for incapacitated patients only when the
particular decision is consistent either with a prior authorization of
the patient or with the patient's best interests in life and bodily in-
tegrity. If before her incapacity, the patient decided to refuse treat-
ment and communicated that decision clearly, then her autonomy
interest is vindicated by effectuating that decision, subject to appro-
priate review.

Absent a prior decision by the patient, the patient's remaining
interests in life and bodily integrity should be respected by requiring
the surrogate decisionmaker to act in conformance with the preser-
vation of those interests. A decision to maintain ordinary and effective
life-prolonging care does not contravene an incapacitated patient's au-
tonomy interest when the patient has failed to exercise her right to
refuse such care before incapacity. This policy would encourage per-
sons concerned about the preservation of their autonomy to make de-
cisions before incapacity in a manner that ensures the respect of others.

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  \item Values in the Law, 28 ARIZ. L. REV. 373, 390 (1986).
  \item Cruzan v. Harmon, 760 S.W.2d 408, 413 (Mo. 1988) (en banc).
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