Coming to Terms with Death:  
The *Cruzan* Case†

by

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This is my hand. I can move it, feel the blood pulsing through it.  
The sun is still high in the sky and I, Antonius Block, am playing chess with Death.¹

Death appears as a player in Ingmar Bergman's richly symbolic movie, *The Seventh Seal*. Antonius Block, a knight returning from the crusades, encounters death and engages it in a game of chess as a way of delaying his own death while he searches for meaning in life. Block never doubts the inevitable fate that he, and all of us, must face. So he bargains with death to "live as long as I can hold out against you."²

Few ever encounter death face to face as Block did; many spend their lives fleeing it. Though not dramatically clad in a black cloak and hood, as in Bergman's movie, death haunts most of us at various times in our lives. We might seek to deny death, or like the knight, to forestall it. Like moves in a game of chess with death, we diet or stop smoking or increase our exercise. Perceived but unseen, death lurks behind so many of our dreams and fears, our ambitions and neuroses.³ Though we know that ultimately we cannot play death to a draw, we employ what moves we can devise to hold it at bay.

Medical science today has vastly enriched our repertoire of delaying moves. Doctors can peer inside us to diagnose our condition with incredible precision; they can prescribe ever more accurately defined medications; they can stitch in new bodily organs when ours fail; they have devised machines that can move for our immobile limbs, breathe when our lungs no longer function, or nourish us when we cannot eat.

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This Article is dedicated to the family of Nancy Cruzan, who sacrificed their privacy to protect Nancy's.

1. Spoken by the knight in Ingmar Bergman's movie *The Seventh Seal* (Janus Films 1956).
2. *Id*.
Ultimately, these evasive moves become too much for some to bear. Worn down by the cost of continuing the match, they decide to withdraw. When a terminally ill person remains fully competent and conscious, philosophers and courts generally agree that she should be able to stop medical treatment in order to die in peace and dignity.\(^4\) When the sick person, perhaps with her family, has come to terms with death, she should not be forced to continue the futile moves.

For others, whose lives might be maintained medically for long periods, conscious choice has become impossible. They cannot decide for themselves whether to continue, perhaps for years, to hold off death's inevitable checkmate. For those who have irretrievably lost consciousness or competence, some other party must make life and death choices. This Article focuses on this group and the profound ethical and legal dilemmas involved in making the final moves for them. But choices must be made—to continue to play the game is as much a decision as to withdraw.

In light of the United States Supreme Court's decision in *Cruzan v. Director, Missouri Department of Health*,\(^5\) we address one question: For a permanently unconscious person, who should decide whether to continue or to end the death delaying moves? We conclude that family members, when they remain close and caring, should be presumed to be the ones to come to terms with death for their permanently unconscious loved one. The state's role should remain secondary.

### I. The *Cruzan* Decisions

After an automobile accident in January 1983, Nancy Cruzan was found by a rescue squad face down in a ditch, lifeless and not breathing. Squad members managed to restart her heartbeat and breathing, but she was deprived of oxygen for a significant period of time and suffered brain damage.\(^6\) At first Nancy's family hoped that she would recover. Because she could not swallow on her own, surgeons, with the consent of her husband, implanted a gastrostomy tube directly into her stomach through which she received nutrition and hydration. Soon, however, it became apparent that her brain damage was so severe that

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4. E. Kübler-Ross, *On Death and Dying* passim (1969); see also infra notes 67-70 and accompanying text.
5. 110 S. Ct. 2841 (1990) (plurality opinion).
6. Estimates of the time range from 12 to 14 minutes. "The Missouri trial court . . . found that permanent brain damage generally results after 6 minutes in an anoxic state . . . ." *Id.* at 2845.
her condition would not improve. Her coma developed into a persistent vegetative state.\(^7\) Seven years later, when the Supreme Court decided her case, Nancy, age thirty-two, remained unconscious in a fetal position in a Missouri state hospital. With continued artificial feeding, Nancy could have lived for thirty years or more, completely dependent on others for total care and devoid of pain or pleasure.\(^8\)

In the summer of 1987, Nancy’s parents,\(^9\) who continued through the years to visit and provide what care they could for Nancy, came to terms with this tragic reality and concluded that Nancy would not want to continue tube feeding in her permanent state of unconsciousness. They knew that she could continue to live for many years in this condition if fed through the tube. They knew she would die within a matter of days or a few weeks if the feeding tube were no longer used. After long thought and prayer, they requested that hospital authorities discontinue artificial nutrition and hydration.\(^10\)

When the hospital administration denied their request, Nancy’s parents applied to the local probate court for a guardianship.\(^11\) At trial on their request to terminate use of the feeding tube, testimony was presented concerning the medical reality of Nancy’s condition and evidence was heard from family and friends concerning her prior state-

\(^7\) Patients in a persistent vegetative state (PVS) can breathe, digest food, and eliminate waste. They can open or close their eyes suggesting periods of sleep and waking. They can move their eyes and manifest other reflex responses to external stimuli, such as coughing, gagging, or moving their limbs. But these patients, though occasionally appearing to give conscious responses, do not feel pain or sense their surroundings. They have irretrievably lost consciousness. \textit{Id.} at 2845 n.1; see also \textit{In re Jobes}, 108 N.J. 394, 403, 529 A.2d 434, 438 (1987); \textit{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 \textit{Deciding to Forego}].

\(^8\) Nancy died December 26, 1990, 12 days after her artificial nutrition and hydration were discontinued. Following the Supreme Court’s decision in July 1990, her parents asked the probate court to consider new evidence from three of Nancy’s co-workers. The Missouri Attorney General withdrew from the case in September, claiming the state had no further role in the case once Missouri’s law had been clarified.

At the new hearing in November 1990, Nancy’s physician described her life as a “living hell,” and Nancy’s co-workers testified that she would not want to continue living “like a vegetable.” Probate Judge Charles Teel ruled that the additional testimony met Missouri’s clear and convincing evidence standard and gave permission for the feeding tube to be removed. \textit{Nancy Cruzan Dies, Outlived by a Debate over the Right to Die}, \textit{N.Y. Times}, Dec. 27, 1990, at A1, col. 1.

\(^9\) Nancy’s husband had sought and obtained a divorce after the accident. \textit{Cruzan v. Harmon}, 760 S.W.2d 408, 431 (Mo. 1988) (Higgins, J., dissenting) (quoting trial court judgment).

\(^10\) \textit{Cruzan v. Director}, 110 S. Ct. at 2846.

ments about being kept alive by artificial means. A long-time friend, for example, testified that Nancy had "said that she hoped that [all the] people in her family knew that she wouldn't want to live [as a vegetable] because she knew it was usually up to the family whether you lived that way or not." The trial court concluded that Nancy's lifestyle and other statements to family and friends suggested "that given her present condition she would not wish to continue on with her nutrition and hydration." An unrelated guardian ad litem appointed by the court initially opposed the parents' decision, but changed his mind after hearing the trial testimony. The trial court, with the concurrence of the guardian ad litem, held that Nancy retained the right, under the state and federal Constitutions, to refuse or terminate treatment.

Missouri's Attorney General appealed directly to the Missouri Supreme Court which, in a sharply divided four-to-three decision, reversed the trial court order approving termination of Nancy's artificial feeding. The majority doubted the existence of any privacy rights that Nancy or her family might assert and found that, even if such rights existed, the state's interest "in life, both its preservation and its sanctity" outweighed any personal interest of the individual or family to refuse treatment. The Missouri court held that Nancy's prior conversations concerning her wish to terminate treatment if in a vegetative state failed to satisfy their interpretation of a clear and convincing evidence standard.

The United States Supreme Court, in a fragmented five-to-four decision, affirmed the judgment of the Missouri Supreme Court. All

12. Id. at 2874 n.19 (Brennan, J., dissenting). When Nancy's grandmother died of heart problems, Nancy told her sister "it was better for my grandmother not to be kind of brought back and forth [by] medical [treatment], brought back from a critical near point of death." Id. (quoting Trial Transcript at 541). A close friend testified at trial that Nancy had said "several times' that 'she wouldn't want to live that way because if she was going to live, she wanted to be able to live, not to just lay in a bed and not be able to move because you can't do anything for yourself.'" Id. (quoting Trial Transcript at 390, 396).


14. Id. at 2846, 2874 (Brennan, J., dissenting).

15. Cruzan v. Harmon, 760 S.W. 2d 408.

16. Id. at 424.

17. The Court found that clear and convincing evidence of Nancy's physical condition and its irreversible nature had been established. Id. at 422. With respect to Nancy's wishes however, they held that the trial testimony was "inherently unreliable and thus insufficient to support the co-guardians claim to exercise substituted judgment on Nancy's behalf." Id. at 426.

18. Cruzan v. Director, 110 S. Ct. at 2841. The Cruzan case was decided on the same
members of the Court showed sensitivity to the tragic plight of Nancy Cruzan and her family. Chief Justice Rehnquist prepared the opinion of the Court in which Justices White, O'Connor, Scalia, and Kennedy joined. Justices O'Connor and Scalia submitted separate concurring opinions. Justice Brennan wrote a dissenting opinion in which Justices Marshall and Blackmun joined. Justice Stevens filed a separate dissent. Because of the subtle yet crucial distinctions that separate the members of the Court, their opinions call for a brief summation.

Chief Justice Rehnquist reviewed state court decisions in similar cases and acknowledged that the Cruzan case presented the Court for the first time with an issue involving what is popularly called the “right to die.” Rehnquist briefly conceded the essential thrust of the Missouri Supreme Court decision, the state’s absolute interest in life, and focused primarily on Missouri’s requirement that Nancy’s previously stated wishes be shown by clear and convincing evidence. He assumed that prior decisions implied a constitutional right for a competent person to refuse medical treatment, even treatment essential to life. He insisted, however, that the person’s liberty interest must be balanced against relevant state interests.

This case, Rehnquist concluded, required surrogate decisionmaking, because the patient was no longer able to decide for herself. He accepted Missouri’s interest in the preservation of life as a constitutionally sufficient basis for its requirement that Nancy’s previously expressed wish to die under such circumstances satisfy the clear and convincing evidence test. Because of the finality of the surrogate’s choice of life or death for the incompetent patient, Missouri was not constitutionally prohibited from seeking “to safeguard the personal day as two abortion cases, Hodgson v. Minnesota, 110 S. Ct. 2926 (1990), and Ohio v. Akron Center for Reproductive Health, 110 S. Ct. 2972 (1990). The Court barely acknowledged any relationship between the life and death issues involved in the two different contexts. The philosophical, moral, and constitutional questions in the termination of treatment cases obviously are intertwined and partially overlap with the questions raised in the abortion debate. See, e.g., Minow, The Role of Families in Medical Decisions, 1991 Utah L. Rev. We have chosen in this Article to follow the lead of the Supreme Court and try to shed some light on the issues involved in cases involving health care decisions for incompetent patients without relating them to issues in the abortion debate. In our view, any changes in abortion law should not depend upon nor affect the arguments made here.

19. Cruzan v. Director, 110 S. Ct. at 2846-51. The problem with using the popular term “right to die” is that it broadly encompasses the right to terminate life by active interventions as well as the right to refuse or to terminate treatment. The latter issue is addressed in the Cruzan case. We reject the suggestion that the right to die should embrace the right to kill oneself or to assist someone in killing herself. The distinction between suicide and termination of treatment is discussed below. See infra notes 71-83 and accompanying text.

20. Cruzan v. Director, 110 S. Ct. at 2852.

21. Id.

22. Id. at 2854.
element of this choice through the imposition of heightened evidentiary requirements."23

In closing, Rehnquist rejected the family's argument that the Constitution required Missouri to recognize decisions made by the family on behalf of an incompetent family member. If the state were required by the Court to recognize a surrogate decisionmaker, "the Cruzans would surely qualify,"24 Rehnquist conceded, but since "there is no automatic assurance that the view of close family members will necessarily be the same as the patient's,"25 the Constitution, he insisted, does not require the state to repose this right of substituted decisionmaking with anyone.26 Only Nancy's own decision to terminate treatment counted, and in Missouri, that must be shown by clear and convincing evidence. Rehnquist concluded "that Missouri may permissibly place an increased risk of an erroneous decision on those seeking to terminate an incompetent individual's life-sustaining treatment."26

Justice O'Connor, who provided the necessary fifth vote to constitute a majority, wrote separately to emphasize that individual states should be allowed to craft "appropriate procedures for safeguarding incompetents' liberty interests."27 The liberty interest of the fourteenth amendment, Justice O'Connor insisted, protects the right of individuals to refuse unwanted medical treatment. On this point, O'Connor agreed with the Rehnquist opinion, as well as with the four dissenters. Justice O'Connor explicitly included in this constitutional right the refusal of nutrition and hydration, which she considered indistinguishable from other life-sustaining medical treatments.28 Noting that the Court had never decided the issue, Justice O'Connor argued that the Constitution might compel the states to give effect to the health care "decisions of a patient's duly appointed surrogate."29

23. Id. at 2853.
24. Id. at 2855.
25. Id. at 2856.
26. Id. at 2854.
27. Id. at 2859 (O'Connor, J., concurring).
28. See id. at 2857.
29. Id. at 2858. The majority opinion also recognized that this issue had not yet been addressed. Id. at 2856 n.12.

Justice O'Connor spoke of a variety of ways that surrogates may be designated. Id. at 2857-58. She identified three categories of current state statutes that assist in the task of surrogate appointment: durable power of attorney statutes, health care decisionmaking statutes, and living will laws.

Durable power of attorney statutes exist in all jurisdictions. For citations to relevant state provisions, see id. at 2858 n.3. They were enacted to correct a defect in common-law powers of attorney, which terminate automatically when the principal becomes incapacitated, thus
Justice Scalia, reiterating his previously expressed views, simply denied that the Constitution was relevant to the issues of this case. He effectively reduced the case to a simple syllogism: States traditionally have punished suicide; termination of medical treatment is suicide; therefore, Missouri had the constitutional power to prohibit the termination of nutrition and hydration to Nancy Cruzan because it would have amounted to assisting suicide. Even if Nancy had been competent, or if she expressed clearly and convincingly her desire to have medical treatment ended if she were ever in a persistent vegetative state, the State of Missouri, according to Scalia, had the power to decide whether or not to honor that wish.

Justice Brennan, in a lengthy dissent, first pointed out that eight members of the Court agreed that a competent person has a constitutional right to refuse or terminate medical treatment. He insisted that this liberty interest amounted to a fundamental right and could be overridden by the state only if the state had a compelling interest. Brennan agreed with O’Connor that artificial nutrition and hydration could not be distinguished from any other form of medical treatment. He also agreed with all members of the Court, perhaps including even Scalia, that an incompetent patient like Nancy Cruzan retains constitutional rights.

After concluding that Nancy Cruzan had a constitutionally protected fundamental right to be free from unwanted medical treatment, Justice Brennan analyzed Missouri’s interest in refusing to allow becoming ineffective in situations like Cruzan’s. “‘[D]urable’ . . . means that an agent’s authority to act continues after his or her principal is incapacitated.” To clarify decisionmaking power in health care matters, 13 states have enacted health care decisionmaking statutes that expressly authorize the appointment of surrogates or proxies for making health care decisions. 31. Cruzan v. Director, 110 S. Ct. at 2857 n.2. An additional 12 states provide for the appointment of health care proxies in their living will statutes. Id. at 2858 n.4.

Of course, probate courts generally have jurisdiction to appoint guardians or guardians ad litem as surrogate decisionmakers. A Meisel, The Right to Die 220 (1989).


31. Cruzan v. Director, 110 S.Ct. at 2860-63 (Scalia, J., concurring).

32. See id. at 2859.

33. See id. at 2865 (Brennan, J., dissenting).

34. Id. at 2869. But in the same breath he stated that “no State interest could outweigh the rights of an individual in Nancy Cruzan’s position.” Id.
termination of the treatment. The state’s only asserted interest was abstract: the preservation of life in general. Justice Brennan found that this did not outweigh Nancy’s choice to end treatment under these circumstances. Missouri did have a legitimate interest, Brennan conceded, in assuring the accuracy of the decision to terminate nutrition. But Missouri could not use its rigorous rule of clear and convincing evidence to achieve the state’s substantive goal: preservation of all life.

Justice Stevens expressed his dissent in a separate opinion. Commenting on the position of the court-appointed guardian ad litem who agreed with the trial court that artificial feeding should be terminated, Stevens questioned whether the state had any interest at all in requiring continued medical treatment.

Justice Stevens reflected sensitively on death and dying in modern society. He commented on modern medical technology and its power through “highly invasive treatment [to] perpetuate human existence . . . that some must reasonably regard as an insult to life.” As a result he concluded that dying remained an area of privacy protected by the Constitution from governmental intrusion. He argued that Missouri’s assertion of an interest in the protection of life failed even to meet the standard of minimum scrutiny, because it was really an effort to define life rather than to protect it. Commenting that “[t]he more precise constitutional significance of death is difficult to describe,” he hinted that an establishment clause issue might be implicated:

[N]ot much may be said with confidence about death unless it is said from faith, and that alone is reason enough to protect the freedom to conform choices about death to individual conscience. . . . It is not within the province of secular government to circumscribe the liberties of the people by regulations designed wholly for the purpose of establishing a sectarian definition of life.

Justice Stevens agreed with Justice Brennan that the Constitution limits a state’s choice of surrogate decisionmaker to “those who will care enough about the patient to investigate her interests with particularity and caution.” He also rejected the majority’s arguments

38. Id. at 2870.
39. Id. at 2871.
40. Id. at 2880-81 (Stevens, J., dissenting).
41. Id. at 2883.
42. Id. at 2883-86.
43. Id. at 2886.
44. Id. at 2885, 2888.
45. Id. at 2891. Justice Brennan concluded that “a State generally must either repose the
for accepting the state's policy favoring life. If the state constitutionally can define life and establish an absolute policy preserving life in any form, Justice Stevens insisted, a state also could insist on the quality of life and "favor a policy designed to ensure quick and comfortable deaths by denying treatment to categories of marginally hopeless cases."

The tenuous balance on the Court presages further cases in which the Court will refine or reconsider the close distinctions that presently mark the boundaries separating its members. The error in the majority's opinion can be stated simply, but an adequate grasp of this error will call for full elaboration of earlier state court decisions and the Supreme Court's own analysis in *Cruzan*. The majority erred in tolerating too broad a role for the State of Missouri in making the substantive moral decision whether to terminate Nancy Cruzan's artificial feeding. In this case, Nancy's family, not the State, should have made the substantive determination and the value judgment leading to that decision. To illustrate the majority's error, we analyze in Part II earlier state court decisions and their underlying philosophical approaches and then sketch in Part III a model for conservative constitutional analysis that should have informed the Supreme Court's decision in *Cruzan*.

II. State Court Analysis

Since relevant federal precedents were lacking, the Supreme Court in *Cruzan* reviewed with care the thoughtful decisions of the state judiciary, beginning with *In re Quinlan*. These state cases also embody a rich and sensitive moral consensus that has developed over the past two decades. The *Cruzan* majority acknowledged this consensus but refused to follow the state courts' lead.

When state courts have addressed the requests of those who wish to die, they have refused to simplify the mystery that attends life and death. Recognizing the wide variety of factors that inform such a de-

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46. *Id.* at 2890 (Stevens, J., dissenting).
47. *Id.* at 2891.
49. 70 N.J. 10, 355 A.2d 647 (1976), *cert denied*, 429 U.S. 922 (1976). There are now over 50 state court decisions dealing with issues of refusal or termination of treatment. See, e.g., *Cruzan v. Harmon*, 760 S.W.2d 408, 412 n.4 (Mo. 1988) (en banc) (collecting cases). For a list of cases since the Missouri Supreme Court's *Cruzan* decision, see *In re Longeway*, 133 Ill. 2d 33, 37-38, 549 N.E.2d 292, 294 (1989).
cision and aware of the complex and sensitive issues involved, state courts have circumscribed termination of treatment decisions with both procedural and substantive safeguards. By procedural determination of the facts, courts have required careful study primarily of the patient’s current medical condition, the medical facts, and if she remains unconscious or incompetent, her relationship with family decision-makers. In making substantive determinations of moral values, courts have explored the patient’s past life, often unveiling a complex tapestry woven from the fabric of life experience, relationships, and deeply held beliefs. Ever aware of the need to avoid simplistic formulas, courts have favored flexible approaches that encourage a search for as complete a revelation of the blend of life history and current physical and emotional needs as possible.

This flexibility has allowed most state courts to remain open to changes in medical technology that continue to present new dilemmas in decisionmaking. Though criticized for using time-consuming and expensive procedures, courts have offered those with controversies unpredictable a generation ago the possibility of a creative resolution to seemingly inscrutable conflicts.

Careful study of these decisions reveals that nearly all state courts aim toward a similar goal: they seek assurance that the patient or her surrogate has the correct medical data upon which to base a decision, and that the selected option is consistent with the expressed desire or

50. In order to retain flexibility, courts have rejected a number of traditional, categorical distinctions proffered to explain or justify a result. Thus, courts have held that it is irrelevant whether the action at issue is the withholding, withdrawal, refusal, or termination of treatment. See, e.g., Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), aff’d, 379 So. 2d 359 (Fla. 1980); In re Dinnerstein, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978); Lane v. Candura, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978); Quinlan, 70 N.J. 10, 355 A.2d 647. Similarly, whether the treatment is “ordinary” or “extraordinary” has been rejected in favor of a more general analysis of benefits and burdens. See, e.g., Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484, 491 (1983); Brophy v. New England Sinai Hosp., 398 Mass. 471, 397 N.E.2d 626, 637 (1986); In re Conroy, 98 N.J. 321, 370-72, 486 A.2d 1209, 1234-35 (1985).

The distinction between active and passive conduct also has been successfully challenged. See, e.g., Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1144, 225 Cal. Rptr. 306 (1986); Bartling v. Superior Court, 163 Cal. App. 3d 222, 225 Cal. Rptr. 220, 225 (1984); Brophy, 398 Mass. at 439, 497 N.E.2d at 638.

the best interests of the patient. In short, state courts seek to discover medical fact and moral reality before a decision to withdraw life-sustaining treatment becomes final. Once medical facts are fully explored using appropriate procedures, with few exceptions courts defer to the patient’s or appointed surrogate’s decision concerning the substantive moral values that inform medical decisionmaking.

A. Procedural State Interests

The state surely has a substantial interest in surrounding life and death decisions with adequate procedural safeguards. The fact-finding process, whether it takes place at the bedside, in hospital ethics committees, or through the judicial system, must protect these decisions by assuring that they are based on accurate, reliable medical fact and projected reality. Both an assessment of the patient’s current status (diagnosis) and a projection of the possibility of change (prognosis) are central to any person’s ability to choose between medical alternatives.

Typically, right-to-refuse-treatment cases are litigated in a life or death scenario. The patient’s current diagnosis is either terminal, painful, or insentient. Prognosis in these cases is for a short remaining life span, continued suffering, or a totally irreversible unconscious state.

51. Hospital ethics committees first were used in Seattle to select patients for dialysis. The Quinlan court assumed they existed to assist in sorting out medical facts. Quinlan, 70 N.J. at 49-50, 355 A.2d at 668-69 (citing Teel, The Physician’s Dilemma: A Doctor’s View: What the Law Should Be, 27 BAYLOR L. REV. 6, 8-9 (1975)); see DECIDING TO FOREGO, supra note 7, at 155-56 n.106. The President’s Commission recommended that ethics committees be used as consultative groups “particularly for decisions that have life-or-death consequences for incompetent patients.” Id. at 5. During the past decade, most hospitals formed some sort of committee composed of physicians, clergy, nurses, social workers, and community members that seek to assist in the decisionmaking process. Rosner, Hospital Medical Ethics Committees: A Review of Their Development, 253 J. A.M.A. 2693 (1985).


52. See, e.g., Satz, 379 So. 2d 359.

53. See, e.g., Conroy, 98 N.J. 321, 486 A.2d 1209.

54. This is typical of the PVS cases. See, e.g., Cruzan v. Director, Mo. Dep’t of Health, 110 S. Ct. 2841, 2841 (1990); Quinlan, 70 N.J. 10, 355 A.2d 647.


56. See Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1989);
State courts demand procedural protection for discovery of medical fact for one primary reason: accurate diagnosis and prognosis empower a decisionmaker with the necessary prerequisites for an informed choice. The *Quinlan* court, recognizing the centrality of this need, prescribed a prognosis committee consultation to ensure accurate medical facts. The New Jersey Supreme Court realized that an inaccurate diagnosis could lead a patient or proxy decisionmaker to assume the worst or best when neither was true.\(^5\)

Generally, medical facts provide the essential prerequisite for decisionmaking. For example, for patients in a persistent vegetative state, as Nancy Cruzan was, all state courts until *Cruzan* followed *Quinlan* and deferred to family decisionmakers.\(^9\) Similarly, competent patients


\(^{58}\) Even when diagnosis is correct, as it was in *Quinlan*, inaccurate prognosis may skew the decisionmaking process. Karen Quinlan lived another decade even though her physicians thought she would not be able to breathe on her own without the respirator. Wikler, *Not Dead, Not Dying? Ethical Categories and Persistent Vegetative State*, HASTINGS CENTER REPORT, Feb.-March 1988, at 41.

In a few cases, courts view information concerning diagnosis or prognosis as decisive facts that preempt the treatment decision. For these courts, identification of the patient’s condition or future prognosis does not merely guide the decisionmaker, but instead (improperly we believe) determines the medical outcome. For example, in *Storar*, 52 N.Y.2d at 381, 420 N.E.2d at 73, 438 N.Y.S.2d at 275, no one questioned either the diagnosis of irreversible bladder cancer in a 52-year-old, profoundly retarded man, or the prognosis that he had only a few months to live. The issue, whether to continue blood transfusions that could potentially extend life by a few weeks or months, was decided not by Storar’s mother—who objected to the transfusions because she sensed that he did—but by expert testimony that said the treatment was necessary to prevent the patient from bleeding to death. *Id.* The New York court used procedure, designed to clarify medical fact, to wrest the final decision away from the patient’s close relative who knew him best.


In some cases a patient exhibits all of the same physical incapacity of a patient in a persistent vegetative state but retains some extremely limited communicative skill. This occurred in *In re Westchester County Medical Center*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988), decided only a month before *Cruzan* v. *Harmon*. Unlike Nancy Cruzan, Mrs. O’Connor, the
making decisions for themselves have not been burdened with sub-
stantive restrictions.\textsuperscript{60}

Beyond this interest in assuring accurate procedures for collecting
medical facts, state courts also have an important interest in providing
procedures for fact finding in other areas. For cases involving per-
manently unconscious or incompetent patients, the state's procedural
protections should determine the proper decisionmaker, usually one
or more family members.\textsuperscript{61} The procedures also should ensure that the
designated decisionmakers are the persons closest to the patient and
that there are no conflicts of interest that might sway their judgment.\textsuperscript{62}

B. Substantive State Interests

The Supreme Court majority in \textit{Cruzan} recognized the "principle
that a competent person has a constitutionally protected liberty interest
in refusing unwanted medical treatment."\textsuperscript{63} In other words, the ex-

patient, "was conscious and capable of responding to simple questions and requests and the
medical testimony suggested she might improve to some extent." \textit{Cruzan v. Director, Mo.
Dep't of Health}, 110 S. Ct. 2841, 2875 n.22 (1990) (Brennan, J., dissenting). Further, "both
of her daughters testified that they did not know whether their mother would want to decline
artificial nutrition and hydration under her present circumstances." \textit{Id}.

In other medical circumstances courts ordinarily defer to family or close friends as deci-
sionmakers, trusting those persons to best understand the patient's needs and desires. \textit{See,
e.g., In re Browning}, 568 So. 2d 4, 20 (Fla. 1990); \textit{Leach v. Akron Gen. Medical Center}, 68

In some of these situations, however, as in \textit{Cruzan}, the surrogate decisionmaker may be
faced with an impossible burden of proof concerning moral reality. This occurred in \textit{In re
Conroy}, 98 N.J. 321, 486 A.2d 1209 (1985), in which the court restrained the discretion of
the nephew of an 84-year-old woman suffering from severe and irreversible physical and mental
disability.

State legislatures also have attempted to limit decisionmaking capacity in a number of ways.
Most living will laws require determination of either a terminal diagnosis or persistent vegetative
state before giving effect to written declaration. \textit{See generally DECIDING TO FOREGO, supra
note 7, at 141-45.}

\textsuperscript{60} Occasionally a competent patient who possesses adequate medical information is
incapable of making a life or death medical decision. \textit{See In re O'Brien}, 135 Misc. 2d 1076,
517 N.Y.S.2d 346 (1986). This is more likely to occur early in the decisionmaking process,
when the patient may be coping with grim reality by denying its existence. \textit{See E. Kübler-
Ross, supra note 4, at 34-43. In time, medical facts seep through most patients' denial
mechanisms and they are able to decide. Some patients, however, whether because of lack of
time or heightened fear of loss, never leave the denial mode. Courts confronted with the
inability of a competent person to make a particular decision typically buy as much time as
possible for the patient, allowing a decision based on medical recommendations should the
patient remain unable to decide. \textit{See, e.g., Department of Human Servs. v. Northern}, 563

\textsuperscript{61} See \textit{infra} note 97 and accompanying text.

\textsuperscript{62} \textit{See, e.g., Longeway}, 133 Ill. 2d 33, 549 N.E.2d 292.

\textsuperscript{63} Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2851 (1990). The majority
tremely important and intimately personal moral judgments that go into a decision whether to refuse or to terminate treatment must come from the patient, not from the state. Eight members of the *Cruzan* Court agreed in general with this level of constitutional protection. The Court divided when it confronted the more difficult issue of surrogate decisionmaking. When the patient no longer is able to decide for herself, what happens to this right to refuse or terminate treatment? A further study of state court decisions can shed some light on this issue.

(1) **Rights of Competent Patients**

Before addressing the retained rights of incompetent patients, some qualifications must be made in the assertion of the right of competent patients to make medical decisions. Once the medical facts are clear, the right of competent patients to accept or reject medical intervention has been overruled by state authorities only because of significant state interests. Two sufficiently important state interests may justify state imposition of moral values on medical decisions by competent pa-

emphasized that liberty, not privacy was at issue. *Id.* (citing Washington v. Harper, 110 S. Ct. 1028, 1036 (1990)); *Vitek v. Jones*, 445 U.S. 480, 494 (1980); *Parham v. J.R.*, 442 U.S. 584, 600 (1979)). Fourteenth amendment cases were cited, as well as fourth amendment cases analyzing search and seizure of the body. *Id.* (citing Jacobson v. Massachusetts, 197 U.S. 11, 24-30 (1905)). Justice O'Connor found the notion of liberty and the idea of physical freedom "inextricably entwined." *Id.* at 2856 (O'Connor, J., concurring) (adding Winston v. Lee, 470 U.S. 753, 759 (1985); Schmerber v. California, 342 U.S. 165, 172 (1952); and *Union Pac. R.R. v. Botsford*, 141 U.S. 250, 251 (1891), to the cases cited by the majority).


The majority recognized that this liberty interest also is protected by the common law of battery and informed consent. *Id.* at 2846-47. Justice Brennan was more explicit about the relationship between tort law and the Constitution. He pointed out that the right to decline medical treatment is "securely grounded in the earliest common law" and reflects the Anglo-American premise of "thorough-going self determination." *Id.* at 2865 (Brennan, J., dissenting). "The right to be free from medical attention without consent . . . is deeply rooted in this Nation's traditions, as the majority recognizes." *Id.* Thus, it is "unquestionably among those principles 'so rooted in the traditions and conscience of our people as to be ranked as fundamental.'" *Id.*

The earliest reported informed consent case appears to be *Slater v. Baker & Stapleton*, 95 Eng. Rep. 860 (K.B. 1767), in which the plaintiff prevailed on a negligence theory because the defendant physician failed to adhere to the customary practice of surgeons of obtaining consent before administering treatment.

tients: the protection of third party interests and the protection of life.\textsuperscript{64}

The Supreme Court in \textit{Cruzan} cited Jacobson \textit{v. Massachusetts}\textsuperscript{65} for the proposition that competent patients have the right to refuse medical interventions, limited only by the interests of third parties.\textsuperscript{66} \textit{Jacobson} upheld a state mandated smallpox vaccination scheme against an individual's right to refuse the vaccination because of the danger of spreading contagious disease to others. Absent such a risk of third party injury, the right of a competent person to refuse medical treatment is subject only to a determination whether the person has the requisite facts and ability to decide and has communicated an unequivocal decision. Thus, state courts uniformly have upheld patient choice when a competent patient's rejection of treatment would end her life, even though continued medical treatment could have prolonged it.\textsuperscript{67}

The obvious exception involves patients who express a genuine suicidal wish to die based on a current assessment of their medical condition that seems hopeless but in fact may be treatable.\textsuperscript{68} For example, after careful treatment, a patient experiencing the hopelessness of depression might reverse a previously expressed wish to die.\textsuperscript{69} But when the patient's decision results from accurate knowledge of relevant medical facts, even a seemingly irrational belief in a faith healer, for example, will not justify state intrusion in the autonomous right to refuse treatment.\textsuperscript{70}

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\textsuperscript{64.} State courts also list the ethics of medical practice as a justification for intervention. With respect to this interest, the courts uniformly agree:

\begin{quote}
Prevailing medical ethical practice does not, without exception, demand that all efforts toward life prolongation be made in all circumstances. Rather, as indicated in \textit{Quinlan}, the prevailing ethical practice seems to be to recognize that the dying are more often in need of comfort than treatment. Recognition of the right to refuse necessary treatment in appropriate circumstances is consistent with existing medical mores; such a doctrine does not threaten either the integrity of the medical profession, the proper role of hospitals in caring for such patients or the State's interest in protecting the same. It is not necessary to deny a right of self-determination to a patient in order to recognize the interests of doctors, hospitals, and medical personnel in attendance on the patient.
\end{quote}


\textsuperscript{65.} 197 U.S. 11 (1905).

\textsuperscript{66.} \textit{Cruzan v. Director}, 110 S. Ct. at 2851 (citing \textit{Jacobson}, 197 U.S. at 24-30 (1905)).

\textsuperscript{67.} \textit{Id.}

\textsuperscript{68.} \textit{See} Jackson \& Youngner, \textit{Patient Autonomy and "Death with Dignity"}, 301 N. Eng. J. MED. 404, 405 (1979). For example, a cancer patient might withdraw prior refusal of chemotherapy if side effects can be abated.

\textsuperscript{69.} \textit{Id.} at 407.

\textsuperscript{70.} \textit{In re} Milton, 29 Ohio St. 3d 20, 505 N.E.2d 255 (1987).
As with the prevention of injury to third parties, the state has an interest in protecting human life strong enough to override decisions to kill oneself or another. The criminal law does give expression to an intuitive principle that human life is basic, worthy of respect and not to be compromised. Although the history is by no means simple and transparent, Justice Scalia’s concurring opinion in *Cruzan* is certainly correct that English common law prohibited the taking of one’s own life and made it a crime to assist another in such an endeavor.

Scalia, because of his basic opposition to the creation of privacy interests, however, insists that no distinction can be made between suicide and the termination of medical treatment essential to life. In his view, no fourteenth amendment right can be found “unless the claimant demonstrates that the State has deprived him of a right historically and traditionally protected against State interference.”72 By identifying termination of medical treatment with suicide, Scalia is able to find tradition in American law adverse to the right asserted in the *Cruzan* case. He concludes that because there is no support for the claim that a right to suicide is rooted in our history or tradition, there can be no support for a right to terminate treatment.

But Justice Scalia distorts history, legal precedent, and clinical experience in his effort to identify the Cruzan family’s decision to terminate Nancy’s medical treatment as the equivalent of assisting suicide. One of the historical sources on which he primarily relied74 repeatedly insists on the traditional distinction “between the withholding of life-prolonging medical treatment, nutrition, or hydration, and the taking of direct action to kill.”75 Indeed, state emphasis on the sanctity

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71. *Cruzan v. Director*, 110 S. Ct. 2841, 2860 (Scalia, J., concurring) (citing 4 W. Blackstone, *Commentaries* *189*). Perhaps because opinion began to change in the eighteenth century, both England and France actually prosecuted only a small fraction of suicides. D. Humphrey & A. Wickett, *The Right to Die* 9-10 (1986). By the nineteenth century, most states had abolished the crime of suicide. Smith, *All’s Well that Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?*, 22 U.C. Davis L. Rev. 275, 290 (1989). Assisting suicide, however, has remained illegal in most states. In fact, as Scalia points out, neither the states that ratified the Constitution nor the 37 states that ratified the fourteenth amendment agreed unanimously about the law of suicide. *Cruzan v. Director*, 110 S. Ct. at 2860.


73. *Cruzan v. Director*, 110 S. Ct. at 2859-60.


75. *Id.* at 9. These authors reiterate the point that “almost all of these decisions have
of life in the context of terminating life-sustaining medical treatment is seen by the courts as a protection of the unique expression of that individual's personality in life. Because we view individual decisions to forego life-sustaining medical treatment as private, most of us do not view them as wrong. They are intensely personal decisions that express our fears, beliefs, and hopes, part of that precious, private domain where the state is not free to roam. The notion that each person's death is as individual as her life is supported by the observations of those who are dying or have died and been resuscitated. From an
drawn an explicit distinction between the sanctioned withholding of care and suicide." Id. at 10. For a third time these authors conclude, "Sound jurisprudential reasons, therefore, support the distinction that now exists in the law between the foregoing of medical treatment, which the law condones, and the commission of suicide, which it presently discourages." Id. at 13. This Article, therefore, flatly contradicts the central point of Scalia's dissent. See McKay v. Bergstedt, 801 P.2d 617, 626 (Nebr. 1991) (collecting cases).

Other historical sources of American law in the nineteenth century, cited by Scalia, likewise provide no basis at all for his position. See, e.g., 1 J. BISHOP, COMMENTARIES ON THE CRIMINAL LAW §§ 295, 511, 615, 652, 968 (5th ed. 1872); 2 J. BISHOP, supra, §§ 686, 1187; J. HAWLEY & M. McGUIRE, THE CRIMINAL LAW 35, 144 (3d ed. 1899); F. WHARTON, A TREATISE ON THE LAW OF HOMICIDE 98-100 (1855); F. WHARTON, A TREATISE ON THE CRIMINAL LAW § 122 (4th ed. 1857). In fact, Justice Scalia is unable to find a single source even suggesting that refusal or withdrawal of medical treatment ever was regarded at law as suicide or assisting suicide. He cited Blackburn v. State of Ohio, 23 Ohio St. 146, 163 (1873), for the proposition that the criminal law protects all, even "[t]he life of those to whom life has become a burden." Cruzan v. Director, 110 S. Ct. at 2860. The Ohio Supreme Court reversed the defendant's conviction for second degree murder in Blackburn, however, because the trial court had rejected "testimony offered to prove the predisposition of the [decedent] to suicide." Blackburn, 23 Ohio St. at 165. Scalia cited Commonwealth v. Bowen, 13 Mass. 356, 360 (1816), for a similar proposition. Cruzan v. Director, 110 S. Ct. at 2860. However, the jury in Bowen found the defendant not guilty for the same reason that the court in Blackburn reversed the conviction. Bowen, 13 Mass. at 360. In People v. Roberts, 211 Mich. 187, 178 N.W. 690 (1920), the defendant husband of a hopelessly ill wife was convicted of second degree murder for placing a poison within the reach of his wife, who knowingly drank it and died. Roberts has been criticized by the commentator whom Scalia cites, however, because it upheld a conviction of an accessory when the principal was not guilty of any crime. Comment, The Crime of Aiding Suicide, 30 YALE L.J. 408, 411 (1921). In any case, Roberts does not involve the withholding of treatment, but rather a direct intervention—poison—to kill. For a recent criticism of Justice Scalia's position on suicide, see McKay v. Bergstedt, 801 P.2d at 626-27 (1991). 76. See E. KEYESLING, SANCTITY OF LIFE OR QUALITY OF LIFE 48 (1979) (quoting A. SOLZHENITSYN). A recent case clarifies this point by articulating an additional state interest "in encouraging the charitable and humane care of afflicted persons." McKay, 801 P.2d at 628.

77. As Justice Brennan stated: "Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence." Cruzan v. Director, 110 S. Ct. at 2868 (Brennan, J., dissenting); see also DECIDING TO FOREGO, supra note 7, at 21-23. Justice Stevens also made this point. See supra notes 41-42 and accompanying text.

78. Elisabeth Kübler-Ross describes five stages of psychological adjustments that she commonly observed in dying patients. They are: denial, anger, bargaining, depression, and acceptance. Although the occurrence of these stages is common, few patients experienced them
individual perspective, then, addressing the tragic choice that faced the Cruzan family required the courage to face the inevitability of death while cherishing the remainder of life.79

The personal experience of dying today confronts medical technologies that "can reclaim those who would have been irretrievably lost a few decades ago."80 Indeed, the very understanding of when death occurs has been changed by machines.81 Medical technology has altered the time, place, and manner of death. Even when not curative, a machine may sustain a vital function while disease, disability, and suffering continue. The expected time of death may be extended by hours, days, months, or years.82 Further, prior to World War II, most Americans died at home, free to express themselves in a familiar and private environment. Dying today, however, normally occurs in an institution dedicated to healing, where a dying patient is often a threat to an institutional mission.83 Attended by persons who handle technology, patients may feel reduced to objects at the very time they most need to express intimate feelings.

The manner of death has also been changed by technology. Death can now occur because of the side effects of aggressive treatment such as chemotherapy that may not prolong life but can add to the dependency and suffering of the patient's final days or weeks. Thus, in the same order and many experienced some but not all. A patient allowed to grieve, who can avoid artificially prolonging her life, is most able to die with peace and to accept death as the "final stage of growth." E. Kübler-Ross, supra note 4; E. Kübler-Ross, Death: The Final Stage of Growth (1975) (collection of essays describing different viewpoints on death). Accounts of the peacefulness of passing into death also are given by patients who have "died" but soon been resuscitated. P. Sheehy, On Dying With Dignity (1981); see also R. Moody, Life After Life (1975).

79. See generally E. Kübler-Ross, supra note 4, at 38 (describing the denial many individuals experience when faced with impending death).
80. Cruzan v. Director, 110 S. Ct. at 2878 (Brennan, J., dissenting).
both clinical experience and caselaw recognize that a competent patient’s refusal or termination of medical treatment, even if it threatens her life, is a constitutionally protected right. Eight members of the Court assume this is true. Only Justice Scalia identifies the refusal of treatment as suicide, and even his own sources contradict his eccentric position.

(2) Rights of Incompetent Patients

For incompetent patients, the focus of the state’s interest in protecting life generally shifts from suicide to the law of homicide because a surrogate necessarily is making decisions for the patient. The words in a typical homicide statute prohibit “the unlawful killing of a human being.” Unlawful’ is the crucial word for the courts. Direct killing or providing the means of death is unlawful and therefore constitutes homicide. Withholding or withdrawing life-sustaining medical treatment, however, has not been viewed as direct killing and therefore is not homicide.

The state cases that discuss homicide conclude that neither physician nor surrogate is criminally liable for implementing a patient’s choice or deciding on behalf of the patient to terminate life sustaining


Justice Brennan recognized the existence of this state interest in cases of incompetent patients, but worried about the effect of the majority’s opinion in *Cruzan*:

Were such interests at stake, however, I would find that the Due Process Clause places limits on what invasive medical procedures could be forced on an unwilling comatose patient in pursuit of the interest of a third party. . . . [W]hy could the State not perform medical experiments on [Nancy’s] body, experiments that might save countless lives, and would cause her no greater burden than she already bears by being fed through the gastrostomy tube? This would be too brave a new world for me and, I submit, for our Constitution.

*Cruzan* v. *Director*, 110 S. Ct. at 2869 n.13 (Brennan, J., dissenting).


86. Nancy Cruzan’s father showed his family’s sensitivity to this difficult moral distinction between withdrawing life sustaining medical treatment and direct killing. While his daughter’s case was pending before the Supreme Court, he said:

There have been times that, you know, I’ve thought, “How can you murder your own child?” Our decision was based on what we felt like that Nancy would want and that’s all we have to justify. If the decision’s wrong, if we’re playing God, then I’ll have to live with that. And I’m willing to.

First, they reason that carrying out the patient's decision to refuse medication or medical technology is simply not unlawful. A physician who acts according to the consent of a patient or surrogate acts consistently with her duty to do no more than is consented to; the patient dies by controlling the cause of her own death.88

Criminal law focuses not only on unlawfulness but also on causation. Cases turning on the causation issue typically involve patients with a serious terminal illness whose death is forestalled only by the continuation of medical technology. Once this medical treatment is removed with adequate consent, courts attribute the cause of the death to the underlying illness, not any intervening act of a physician.89

Even when the patient's condition is not terminal, removing a medical intervention that sustains life is not viewed as causing death, as long as the underlying illness or injury is responsible for compromising an essential bodily function such as breathing or swallowing.90

All of these cases assume that a patient or surrogate may request to


88. A physician's act that terminates or fails to initiate treatment contrary to the expressed wishes of a patient or surrogate, on the other hand, has been regarded as a breach of duty for which criminal penalties are appropriate. A physician who usurps control of a patient's decision has breached a duty to respect patient decisionmaking, and if that unlawful act causes death, a homicide action may follow. Justice Scalia cites People v. Phillips, 64 Cal. 2d 574, 414 P.2d 353, 51 Cal. Rptr. 225 (1966), for the proposition that a physician can be held criminally liable. Cruzan v. Director, 110 S. Ct. at 2861 (Scalia, J., dissenting). The California Supreme Court in that case, however, reversed the second degree murder conviction of a physician who assured a cancer patient's parents that she did not need surgery. Phillips, 64 Cal. 2d at 576, 414 P.2d at 356, 51 Cal. Rptr. at 228. The court held that a "bare showing that Linda's death proximately resulted" from the defendant's conduct was not enough. Id. at 584, 414 P.2d at 361, 51 Cal. Rptr. at 233. A murder conviction must rest on a jury finding of malice or intent as well, an intent that consciously disregarded a duty owed to the defendant. Id. at 587, 414 P.2d at 363, 51 Cal. Rptr at 235. The jury did find such an intent in Barrow v. State, 17 Okla. Crim. 340, 188 P. 351 (1920), convicting the defendant of second degree manslaughter. However, the defendant, notwithstanding his own assertions, was not a physician, although Scalia believed otherwise. See Cruzan v. Director, 110 S. Ct. at 2861.


What Nancy Cruzan’s family sought permission to do is not and never has been considered suicide or criminal in American law.

Justice Scalia, however, points to cases in which parents have been prosecuted for murder for starving their child to death. These cases, dealing with omissions when there is a duty to act, certainly are not the same as the decision made by Nancy Cruzan’s parents. American courts have long held that a person has a right to refuse medical treatment, even when this means acquiescing in imminent and inevitable death. Eight members of the Supreme Court are surely on solid ground in assuming that Nancy, if competent, would have had a constitutional right to have the artificial feeding tube removed. Scalia’s extreme position thus reflects neither American history nor law and prevents him from confronting the real issue in the Cruzan case: Since Nancy was not competent, who should have decided for her?

C. Selecting the Best Decisionmaker

Respecting the personal choice of a permanently unconscious or incompetent patient calls for greater skill, sensitivity, and tenacity than courts need draw upon when dealing with competent patients.

Typically, state courts recognize and approve of the fact that the vast majority of decisions on behalf of incompetent patients are made privately, "outside the judicial forum" in a clinical setting. In the clinical context, medical decisions are made by surrogate decision-makers identified by the patient’s physician. Diagnosis, prognosis, and what the patient would choose are discussed and implemented privately, sometimes with the aid of an institutional ethics committee. Although it may be possible to identify a time when a specific decision has been made, clinical decisionmaking is dynamic rather than static. Decisions evolve in a process over time, as relatives and friends of a

91. See, e.g., Satz v. Perlmutter, 379 So. 2d 359 (Fla. 1980).
92. Cruzan v. Director, 110 S. Ct. at 2861.
patient respond to periodic updates about the patient’s condition from health care professionals.96

Participants in this private decisionmaking process seek judicial intervention, usually in the form of a guardianship proceeding, only if disagreements persist. State courts respond by using court procedures to select a decisionmaker97 and assure accurate assessment of medical facts.

Most often, as Justice O’Connor pointed out, a patient will not have expressed any specific desire concerning either the medical intervention being considered or the disease being suffered.98 Most of us refuse to come to terms with death. Our instinctive denial prevents us from expressing anything about our own dying process. Young people especially remain blind to the possibility of their own death and seldom express their preferences for life prolonging medical treatment.99

For cases in which little or no information concerning a patient’s wishes is obtainable, most state courts, unlike the Missouri Supreme Court in Cruzan, seek to safeguard the person-centered clinical approach by deferring to a decisionmaker who is most likely to understand the patient’s general approach to life,100 or by instructing a stranger to decide for the patient only after careful consideration of

96. See A. MEISEL, supra note 29, at 152-53, 161-62; DECIDING TO FOREGO, supra note 7, at 153-54, 159.

97. Courts appoint one or more guardians from among those who request such a responsibility. Usually a family member is selected, although friends who know the patient well may be preferred. See A. MEISEL, supra note 29, at 224-34.

98. Cruzan v. Director, Mo. Dept’ of Health, 110 S. Ct. 2841, 2857 (O’Connor, J., concurring). Specific statements the patient made concerning the circumstance that now confronts her are of course relevant and usually determinative. See, e.g., In re Severns, 425 A.2d 156, 158 (Del. Ch. 1980); Browning, 568 So. 2d 4, 27 (Fla. 1990); Delio v. Westchester County Medical Center, 129 A.D.2d 1, 6-9, 516 N.Y.S.2d 677, 681-83 (1987); Eichner v. Dillon, 52 N.Y.2d 363, 371-72, 420 N.E.2d 64, 68, 438 N.Y.S.2d 266, 270 (1981).

Written statements in living wills or durable powers of attorney carry greater weight than conversations and life-styles because of the presumption that they manifest greater reflection and determination. See, e.g., Severns, 425 A.2d at 158.

Even written statements, however, might not contain sufficiently specific instructions to settle subsequent, unanticipated care decisions. See, e.g., Browning, 568 So. 2d at 32-33. See also infra notes 109-110 and accompanying text.

99. For example, it is unrealistic to expect a 16-year old to think about or express her views on life sustaining treatment. This is the dilemma faced by Pete Busalacchi, who currently seeks to move his severely brain damaged daughter, Christine, out of Missouri so that he can have the freedom to make the same decision that faced the Cruzans. See infra note 116.

the views of those who have known and currently care for that person. In these cases, state courts search for general attitudes toward life, death, illness, or dependency as well as religious or philosophical beliefs. Such a search enables the decisionmaker, insofar as is possible, to "don the mental mantle" of the now incompetent patient in an effort to protect that person's subjective concept of deeply held belief.

These courts recognize that a proxy who has known or currently cares for a patient is likely to understand a patient's response in subtle ways that often defy objective description. Even when no relative can be found to fulfill this function, a court can direct the inquiry of those who know or care for the patient to focus on the benefit and burden of treatment to that unique person, rather than to a hypothetical, objective patient under "normal" circumstances.

The inherent difficulties of this judicial approach must be confronted directly. Courts, searching conscientiously to find what medical treatment the now incompetent patient herself would want, ultimately are seeking to unscrew the inscrutable, to speak the ineffable. Commentators have discussed the impossible task courts have set for themselves when they seek to pry into the mystery of the person who never again can express her desires, her preferences, her pains and pleasures, her current beliefs in life and afterlife. They also worry that subjective standards could be used as a charade to cover an unconscious attempt by decisionmakers to impose their own views about the value of the patient's life on that person.

101. See In re Torres, 357 N.W.2d 332 (Minn. 1984); In re Ingram, 102 Wash. 2d 827, 689 P.2d 1363 (1984).
104. The court in Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977), marked the outer limits of applying a subjective standard. In that case the Massachusetts court considered whether to initiate chemotherapy for a 67-year-old, severely retarded man in a state institution. Focusing on the burden and benefit to a patient with a mental age of two years and eight months, the court discounted evidence that most competent patients would choose chemotherapy. Id. at 750, 370 N.E.2d at 431. It found that, for Saikewicz, the discomfort of chemotherapy could not be overcome because of his inability to understand its purpose, and therefore that the burden of the treatment outweighed the 40% chance for a few more months to live. Id., 370 N.E.2d at 432. The court's focus on Saikewicz's individual circumstances avoided depersonalizing his unique needs. The subjective focus of the inquiry would have been more persuasive, however, if the court tested the doctor's testimony about Saikewicz by ordering an initial trial of chemotherapy to assess whether, in fact, he could not tolerate the intervention.
105. See generally Dresser, Relitigating Life and Death, 51 OHIO ST. L.J. 425 (1990) (use of living wills, patient's prior values, and family discretion is morally insufficient to protect
If a court, finding no writing and no clear prior statements, seeks an objective standard, however, it often will rest on an equally unstable footing. The late Professor Rhoden contrasted the subjective and objective approaches:

[T]he subjective test views a barely conscious person as the competent person that she was, a person whose personality continues on in some sense. The objective tests, on the other hand, direct us to focus only upon the benefits and burdens that beset the patient in her current state—as a barely conscious person unable to hold or affirm values requiring cognition.106

The objective approach focuses on a utilitarian, present-oriented analysis of the burdens and benefits to this patient. For some conscious but incompetent patients for whom a careful inquiry into pain and pleasure can be fruitful, this objective standard might make sense.107 But for a permanently unconscious patient like Nancy Cruzan, who no longer was able to experience pain or pleasure, the utilitarian balance becomes meaningless.108 Benefit as well as burden inevitably will amount to zero.

This distinction between a subjective and an objective approach to assessing the wishes of an incompetent patient sheds light on the Cruzan case. The Missouri Supreme Court was not the first to address the inherent difficulty of making health care decisions for a person in a persistent vegetative state. It properly pointed out that no one can achieve certainty about what any particular person facing a current health care crisis would want. Third party recollection of previous statements by the patient may be hazy. Even if clear, those thoughts were shared in a context that makes them hypothetical because they were unconnected to the current disease or treatment options. The few persons who do express clear wishes concerning specific disease conditions and treatments109 may change their opinion as life moves on and perhaps becomes more precious.110

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107. Just as a parent translates the sounds and movement of an infant into expressions of comfort, pain, or pleasure, so too can a person familiar with a patient sense and understand their response to medical care and intervention.


109. Many persons use living wills to accomplish this. These enactments typically are limited
Recognizing that a person may change over time, the Missouri Supreme Court proposed a new judicial approach to decisionmaking for incompetent patients. Driven by its substantive value judgment that life in any form must be preserved, it required that Nancy's wishes be proved by clear and convincing evidence. Next, it labeled testimony regarding Nancy's wishes "inherently unreliable" because they were made under hypothetical circumstances. Finally, it concluded that, once these inherently unreliable statements were disregarded, no clear and convincing evidence remained to justify the trial court's conclusion.

Even if the court's driving motivation is flawed, its candor is refreshing. If the testimony regarding Nancy's wishes was unreliable, then no evidence was presented that could justify the judge's finding that Nancy would have preferred to die. The court, in other words, imposed on the Cruzan family an impossible standard. By imposing this unattainable goal of clear and convincing evidence of what Nancy would have wanted, the Missouri Supreme Court effectively imposed upon Nancy its value judgment absolutely preferring physical existence in all circumstances. In this it erred. Even if it were impossible for Nancy's family to prove that Nancy would have preferred to terminate the artificial feeding, Nancy's family, not the state, should have been allowed to make the moral decision for Nancy.

in scope, however, by factors outside the control of the patient. For example, California's statute requires the physician to inform the patient of the terminal prognosis before the patient's wishes are binding. CAL. HEALTH & SAFETY CODE § 7188 (West 1988). In addition, this statute does not allow the patient to name a proxy. Id.


111. Dresser, supra note 105, at 432.

112. Cruzan v. Harmon, 760 S.W.2d 408, 424 (Mo. 1988) (en banc). A few other courts have also followed this approach. See Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2824, 2855 n.11 (1990).

Miles & August suggest that gender may account for these differences in approach. Miles & August, Courts, Gender and "The Right to Die," 18 L., MED. & HEALTH CARE 85 (1990).

113. Cruzan v. Harmon, 760 S.W.2d at 426.

114. In the time following the initial trial court hearing, three additional witnesses came forward offering testimony regarding Nancy's conversations about terminating medical treatment. Stewart, Right to Die, But . . ., A.B.A. J., Sept. 1990, at 36, 40. The probate court subsequently ruled that this evidence met the clear and convincing evidence standard and gave permission for the feeding tube to be removed. See supra note 8.

These statements, like the prior testimony concerning Nancy's wishes, would most likely be labeled "inherently unreliable" by the Missouri Supreme Court. However, the case never reached the appellate court because the Attorney General gave up the fight, and no one else had standing to raise the issue. Court Firm on Cruzan Ruling, N.Y. Times, Dec. 21, 1990, at A30, col 3; Missouri Seeks to Quit Case of Comatose Patient, N.Y. Times, Oct. 12, 1990, at A15, col 3.
One need only read the Missouri Supreme Court majority opinion to perceive that the evidentiary clear and convincing test was applied in Nancy Cruzan's case because of the state's asserted absolute interest in life. Missouri ruled that the Cruzan family's decision on Nancy's behalf would constitute an unlawful taking of her life. Although the issue arose in a guardianship proceeding rather than a criminal trial, Missouri's interest in "the sanctity of life itself" leads to the same conclusion: the Cruzan family's intended act is immoral, unlawful, and criminal.

Eight members of the United States Supreme Court at least assumed that Nancy, if competent, would have "a constitutionally protected liberty interest in refusing unwanted medical treatment." Not every individual prefers life to death. Nancy's right, if competent, to terminate treatment, did not escheat to the state because she became incompetent. When permanently incompetent, she retained the right to have decisions made on her behalf by those who knew and loved her best.

D. The Slippery Slope

The state's two legitimate substantive interests—preventing injury

115. As the majority wrote, after listing four possible state interests for rejecting the Cruzan family's request to terminate treatment:

In this case, only the state's interest in the preservation of life is implicated.

The state's interest in life embraces two separate concerns: an interest in the prolongation of the life of the individual patient and an interest in the sanctity of life itself. . . . The state's concern with the sanctity of life rests on the principle that life is precious and worthy of preservation without regard to its quality.

Cruzan v. Harmon, 760 S.W.2d at 419.

116. It follows that the family's only remaining option, moving Nancy to another state with intent to effectuate her interest, would have been attempted murder in Missouri. On January 19, 1991, the Missouri Court of Appeals enjoined such an act. A probate court had granted Pete Busalacchi's request to move his daughter, Christine, from the same institution where Nancy Cruzan resided to Minnesota. He hoped that more discretion would be granted him there, enabling him to choose to remove tube feedings that had kept Christine alive for three and a half years following an auto accident that caused her severe brain damage. Father in Right-to-Die Case Loses an Appeal, N.Y. Times, Jan. 19, 1991, at A17, col. 2. William Colby, counsel for the Cruzans, predicted that this option would be possible "in any other state in the union." Stewart, supra note 114, at 40.


118. Justice Brennan recognized several factors that might compel a family to conclude that a comatose loved one would wish to terminate life supports. A patient may not want to be remembered in a degraded existence, nor wish to protract family suffering. Id. at 2868 (Brennan, J., dissenting). In short, any person who defines her own existence in relational terms that exceed mere biological functions may have strong reasons to forego life-sustaining treatment once relationship becomes impossible.
to third parties and protecting life by prohibiting suicide and homicide—have no relevance to the case of Nancy Cruzan. Yet, some immediately conjure up another substantive state interest.\(^{119}\) Although they might have no specific objection to the Cruzan family’s decision to terminate artificial feeding for Nancy, they fear where this decision might lead. Cruel, selfish families might use the example of the Cruzan family to get rid of unwanted, helpless, and incompetent relatives. The example of Nancy Cruzan might lead to voluntary or even involuntary euthanasia.\(^ {120}\) Thus a slippery slope argument looms large in discussions of termination of life-sustaining medical treatment for the incompetent.\(^ {121}\) This reasoning accepts the moral correctness of an act under consideration, but frets over the impossibility of distinguishing the current case from others more morally troubling.\(^ {122}\)

Some people, therefore, share the Missouri Supreme Court’s concern that allowing Nancy’s parents to withdraw her nutrition and hydration would have been impossible to distinguish from other cases in which a family with less pure motives seeks to end the life of a dependent relative.\(^ {123}\) Justice Rehnquist noted that “not all incompetent patients will have loved ones available to serve as surrogate decisionmakers,”\(^ {124}\) and concluded that “[a] state is entitled to guard against potential abuses in such situations.”\(^ {125}\) What already has been said concerning the state’s interest in ensuring adequate procedures to protect fact-finding for medical care of competent or incompetent patients provides the best answer to this facet of the slippery slope argument.\(^ {126}\) The state can and should assure the accuracy of the medical facts, diagnosis, and prognosis of each case and also assure that any surrogate decisionmaker has been a close, caring family member or friend without a conflict of interest.\(^ {127}\) This, of course, was done by

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120. The term voluntary euthanasia refers to the direct intervention to terminate life by request of a competent patient or pursuant to an advance directive of a now incompetent patient. Involuntary euthanasia occurs when the life-sustaining treatment is discontinued against the wishes of the patient. A. Meisel, supra note 29, § 3.9, at 61-64.

121. See Deciding to Forego, supra note 7, at 28-30.


123. See E. Keyserlingk, supra note 76, at 148-51.


125. Id.

126. See supra notes 51-62 and accompanying text.

127. Two basic kinds of conflicts have been identified: financial and emotional. Often, family decisionmakers will be heirs of a patient or may be released from financial obligation if the patient dies. Similarly, a close friend or relative may be “motivated, perhaps uncon-
the trial court in the *Cruzan* case. These procedural protections assure a secure toehold to prevent further decline down the slippery slope.

The slippery slope argument, however, goes further to perceive the possible tragedy of euthanasia lower down the slope. The ultimate worry that a surrogate decisionmaker might end another’s life too soon today carries with it the weight of the "Nazi Albatross":

The slippery slope argument, however, goes further to perceive the possible tragedy of euthanasia lower down the slope. The ultimate worry that a surrogate decisionmaker might end another’s life too soon today carries with it the weight of the "Nazi Albatross":

Some argue that allowing surrogate decisionmaking in the face of any uncertainty is the “small beginning” of a wedge that inevitably will lead to the abuse of dependent people. For them, the fear of the slippery slope seems decisive. Perhaps this is why allowing Missouri to err on the side of life seemed warranted to the *Cruzan* majority. It avoided the chance that the voluntary could become involuntary. But legal and medical tradition provide a clear toehold to assure no slide to such tragic consequences. The line has been tra-


129. R. LIFTON, THE NAZI DOCTORS (1986). The Nazi euthanasia program was never the subject of positive law because Hitler knew that the public would object. A small group of doctors, infected with the eugenic belief of Aryan biological superiority, signed on to the Nazi political agenda that originally used compulsory sterilizations as a means of purifying the body politic. See Koop & Grant, supra note 105, at 589-91. Eventually, the rationale for sterilization became the justification for mass murder of those sent to certain state institutions. Attempts were made to mask the killings by official letters that lied about the cause of death. Hitler hoped that the reality of war would desensitize the population’s concern for human life in general, and that precious resources such as food could be directed elsewhere. Eventually, gas chambers perfected at state institutions were reassembled in concentration camps outside Germany. The euthanasia program within Germany officially ended when individual families and communities began to question the deaths. R. LIFTON, supra, at 89-95.

130. See Koop & Grant, supra note 105, at 589-91.

ditionally drawn, as already indicated, between direct killing and refusal of treatment.\textsuperscript{132}

The line between voluntary and involuntary termination of treatment raises more difficult problems in cases involving permanently incompetent or unconscious patients. Surrogates necessarily must decide. Leaving the topic of surrogate decisionmaking solely to the "laboratory" of the States," as Justice O'Connor suggested,\textsuperscript{133} must be examined in light of the risk of erroneous decisionmaking, which was so important to the Rehnquist opinion.

Chief Justice Rehnquist pointed to the need to shift the burden of persuasion to the family because of the risk of erroneous decisionmaking. But where lies the greatest risk of making the wrong decision? If Nancy Cruzan’s family had made an erroneous decision, one person would suffer—Nancy.\textsuperscript{134} Yet, if the state of Missouri in fact erred in insisting that artificial nutrition be continued for Nancy, there was serious injury not only to Nancy but also to her family.

Furthermore, if the state has the ultimate power to render life and death decisions for the seriously ill, it has the power to err on behalf of large groups of people. Following the Supreme Court’s logic in \textit{Cruzan}, all persons with similar disabilities will be artificially fed regardless of the personal choice of a patient. But this power to decide has an even darker side. The state that can compel artificial feeding to preserve life can also stop treatment and thereby destroy entire categories of the sick and dying. Every slippery slope has a reverse side.\textsuperscript{135} Justice Stevens mentions such a possibility: "Tomorrow, another State equally eager to champion an interest in the ‘quality of life’ might favor a policy designed to ensure quick and comfortable deaths by denying treatment to categories of marginally hopeless cases."\textsuperscript{136}

Chief Justice Rehnquist rightly perceives the risk of erroneous decisionmaking. But he ignores another important fact: the state, unlike families and friends, is totally unable to make personalized decisions. Most families treat the unconscious loved one as a treasured

\textsuperscript{132}. \textit{See supra} notes 19, 86-91 and accompanying text.

\textsuperscript{133}. \textit{Cruzan} v. \textit{Director}, Mo. Dep’t of Health, 110 S. Ct. 2841, 2859 (1990) (O’Connor, J., concurring).

\textsuperscript{134}. \textit{See supra} note 118.

\textsuperscript{135}. \textit{See} Schauer, \textit{supra} note 122, at 381.

\textsuperscript{136}. \textit{Cruzan} v. \textit{Director}, 110 S. Ct. at 2891 (Stevens, J., dissenting).

The recent case of Helga Wanglie raises this issue. Doctors in a county hospital there argue that their desire to stop ventilator support should supersede Mrs. Wanglie's husband's desire to continue life-sustaining treatment for his comatose wife, based on her strong religious convictions. The public hospital has petitioned the probate court to appoint a guardian who will seek to have her life supports removed. \textit{As Family Protests, Hospital Seeks an End to Woman's Life Support}, N.Y. Times, Jan. 10, 1991, at A1, col. 1.
individual because they are aware of that person’s history and unique characteristics. The state, however, is unaware of individual qualities and inevitably must categorize in order to make medical decisions for incompetent patients. Entrusting decisionmaking to the state exacerbates the risk of error because it does not know and will find it impossible to discover the unconscious patient’s wishes. Individuals pigeonholed contrary to their own personal views and values will be treated according to the state’s concept of how those in their group should be treated; they will be compelled to live and suffer contrary to their true belief or doomed to die against their will.

The other option, deferring to family decisionmakers, does not prevent mistake. But, mistakes that occur will be individual, not institutionalized, and will be made in good faith by those who care for that unique person rather than by politicians and bureaucrats who are strangers and act for reasons of group utility. Ultimately, the best safeguard against abuse is curbing state power by placing decisions in the hands of persons best able to focus on subjective values and particular moral facts unique to each patient.

In cases like *Cruzan*, we should look to families to make crucial health care decisions precisely to act as a buffer against the oppressive potential of the state. The Supreme Court majority in *Cruzan*, therefore, did not err in identifying the possibility of mistake in surrogate decisionmaking. It erred in favoring a remote, depersonalized stranger—the state—to make the decision. Deference to state power does not relieve, but only aggravates the virus of mistake. Hitler rightly feared the early end of his euthanasia program if left to the people. Though Missouri’s motives appear beneficent, deferring to the state increases the vulnerability of dependent people. The slope is far more slippery when the state preempts life and death decisions.

State court decisions prior to the United States Supreme Court’s *Cruzan* decision and the underlying philosophical positions on which they were based, established the moral right of Nancy Cruzan to have her family, not the state, decide whether and when to terminate artificial feeding. One question remains, however: does the United States
Constitution impose some minimum standard that would prohibit the state from interfering with the value judgments involved in her family’s decision to allow Nancy to die?

III. Constitutional Analysis

Philosophical positions deeply held by individual justices no doubt influence many of the Supreme Court’s majority, concurring, or dissenting decisions. Nonetheless, the Court’s decisions seldom rely explicitly on these underlying positions. The Court can never forget Justice Holmes’s stinging barb in *Lochner*, “The Fourteenth Amendment does not enact Mr. Herbert Spencer’s Social Statics, . . . General propositions do not decide concrete cases.”

A. Conservative Model

The Court’s own method of analysis, not explicitly philosophical, provides surer footing for applying the Constitution in a novel case such as that involving Nancy Cruzan. Of course, the Constitution speaks not a word about such a case, and no one approach to constitutional analysis of individual implied rights has captured unanimous assent on the Court. Nonetheless, the thoughtful, fully articulated methodology followed by two recent, highly respected conservative Justices will best undergird the arguments for constitutional protection of the right of future Cruzan families to terminate their daughter’s treatment.

“Conservative” obviously is a term of many hues and shades, not uniformly applicable to any Justice in each and every decision. Central to any conservative analysis of a new constitutional issue is a respect for the past. The second Justice Harlan and Justice Powell fit most everyone’s definition of conservative. Their approach, therefore, to fundamental rights or liberty interests not explicitly based on the text of the Constitution will provide a framework for this analysis of the Cruzan case.

Both Harlan, in *Poe v. Ullman*, and Powell, in *Moore v. East Cleveland*, appreciated the hazards, exposed in *Lochner*, of finding

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143. 431 U.S. 494 (1977) (plurality opinion).
substantive protection for rights implied in the bafflingly vague words of the fourteenth amendment: "[N]o State [shall] deprive any person of life, liberty, or property, without due process of law." On the one hand, if the due process clause merely guaranteed fair procedures, Harlan insisted, then a state law, though guaranteeing "the fairest possible procedure," could "nevertheless destroy the enjoyment of all three" (i.e., life, liberty, and property). But once a Justice accepts the due process clause as a substantive limit on state laws, Holmes's gibe returns. "As the history of the Lochner era demonstrates," Powell confessed, "there is reason for concern lest the only limits to such judicial intervention become the predilections of those who happen at the time to be Members of the Court." Harlan and Powell struggled to avoid the appearance of incorporating into the due process clause their own philosophical predilections by searching in history, tradition, and precedent for a more objective meaning of "liberty" and "due process." Harlan, in a passage quoted with approval by Powell, acknowledged that the amorphous concept of "due process" could never be codified. "Due Process," he insisted, "through the course of this Court's decisions . . . has represented the balance which our Nation, built upon postulates of respect for the liberty of the individual, has struck between liberty and the demands of organized society." To furnish content for open-ended terms like "due process" and "liberty," Harlan and Powell looked to "what history teaches are the traditions from which [this country] developed as well as the traditions from which it broke." The liberty protected from state interference by the fourteenth amendment due process clause, Harlan and Powell agreed, means far more than the discrete and "isolated points pricked out in terms of" the federal guarantees in the Bill of Rights. Each clause of the

144. U.S. Const. amend. XIV.
145. Poe, 367 U.S. at 541.
147. Id. at 501.
149. Id.
150. Id.
151. Id. at 543. The Harlan and Powell insight into the broad, undefined scope of "liberty" in the fourteenth amendment is confirmed by recent historical scholarship. See W. Nelson, The Fourteenth Amendment 140-47 (1988).

For Justice Harlan, the fourteenth amendment, not the Bill of Rights, restricted state power to impair the procedural or substantive rights of individuals. As he insisted in his dissent in Duncan v. Louisiana, 391 U.S. 145 (1968), "the First section of the Fourteenth Amendment was meant neither to incorporate, nor to be limited to, the specific guarantees of the first eight Amendments." Id. at 174 (Harlan, J., dissenting).

But for Harlan, the meaning of the crucial restricting words of the fourteenth amendment,
Bill of Rights, of course, helps fill out the meaning of "liberty." But the concept of "liberty" reaches further, Harlan and Powell argued: It is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints... and which also recognizes, what a reasonable and sensitive judgment must, that certain interests require particularly careful scrutiny of state needs asserted to justify their abridgment.\(^{152}\)

Harlan underscored his point by insisting that the Court must look beyond the narrow words of the various clauses of the Bill of Rights. Fourteenth amendment "liberty" embraces the purposes behind each clause of the first eight amendments. Harlan's own words best convey his conviction:

For it is the purposes of those guarantees and not their text, the reasons for their statement by the Framers and not the statement itself... which have led to their present status in the compendious notion of "liberty" embraced in the Fourteenth Amendment.\(^{153}\)

Harlan wrote his dissenting opinion in *Poe\(^{154}\)* to identify a constitutionally-based restriction on the State of Connecticut's power to

"liberty" and "due process," only could be grasped in light of our nation's history and tradition. This history included the enormously significant fact that a Bill of Rights had been added to the Constitution. "[T]he Bill of Rights," he stated, "is evidence... of the content Americans find in the term 'liberty' and of American standards of fundamental fairness." *Id.* at 179.

\(^{152}\) *Poe*, 367 U.S. at 543.

\(^{153}\) *Id.* at 544. Harlan's insistence that the clauses of the Bill of Rights must not be narrowly limited to their text has been fully confirmed by the historical analysis of the ninth amendment: "the enumeration in the Constitution, of certain rights, shall not be construed to deny or disparage others retained by the people." U.S. CONST. amend. IX. Some interpret the ninth amendment to mean that there are rights, unenumerated elsewhere in the Constitution, which are retained by the people and which serve as judicially enforceable constraints on government. Barnett, *Reconceiving the Ninth Amendment*, 74 CORNELL L. REV. 1 (1988); Massey, *Federalism and Fundamental Rights: The Ninth Amendment*, 38 HASTINGS L.J. 305 (1987); Sherry, *The Founders' Unwritten Constitution*, 54 U. CHI. L. REV. 1127, 1161-67 (1987); *Symposium on Interpreting the Ninth Amendment*, 64 CHI.-KENT L. REV. 37 (1988). Others, however, read the ninth amendment as intended primarily to bar an expansive interpretation of the Federal government's enumerated power. This residual rights approach emphasizes that the ninth amendment reserves rights to the people precisely by assuring that the government's powers are narrowly construed. McAfee, *The Original Meaning of the Ninth Amendment*, 90 COLUM. L. REV. 1215 (1990).

For Harlan, who looks to the Bill of Rights as a way of finding historical tools to unlock the meaning of "liberty" in the fourteenth amendment, either reading of the ninth amendment suffices to confirm his point. The ninth amendment, after all, is also part of our history and tradition and provides essential insights into the purposes behind the text of the first eight amendments. The ninth amendment is best viewed as a rule of constitutional interpretation. It instructs the Court today that it may not construe anything in the Constitution, including "liberty" in the fourteenth amendment, to disparage rights retained by the people. L. TRIBE & M. DORF, *ON READING THE CONSTITUTION* 54 (1991). Whatever else the Court might say to explain why Nancy Cruzan did not retain the right to have her parents decide to terminate her treatment, it may not rely solely on the argument that her right does not exist because it is not enumerated in the Constitution.

criminalize the use of contraceptives. He thought the Court should have declared unconstitutional the Connecticut statute, which “allow[ed] the State to enquire into, prove and punish married people for the private use of their marital intimacy.” It exceeded the state’s constitutional power because it “involve[d] what, by common understanding throughout the English-speaking world, must be granted to be a most fundamental aspect of ‘liberty,’ the privacy of the home in its most basic sense, and it is this which requires that the statute be subjected to ‘strict scrutiny.’”

Justice Powell’s plurality opinion in *Moore* employed the same methodology to identify a constitutional right of family members to live together in the face of a city ordinance that restricted that right to a few narrow categories. Looking to precedent as well as to history and tradition, Powell concluded, “Our decisions establish that the Constitution protects the sanctity of the family precisely because the institution of the family is deeply rooted in this Nation’s history and tradition.”

One final element characterizes a conservative model for protecting implied fundamental rights: the principle of federalism. It is likely that this principle was crucial in *Cruzan*. In her concurring opinion, Justice O’Connor ultimately turned to federalism to decide that Missouri’s refusal to allow Nancy’s parents to terminate artificial feeding did not violate the Constitution. She relied on the oft-quoted passage from Justice Brandeis, who insisted that an advantage of the federal system was that individual states can “serve as laborator[ies].” Justices Harlan and Powell both repeatedly looked to this same principle of federalism and cited the same words of Justice Brandeis. As Harlan put it, “one of the great strengths of our federal system is that we have, in the forty-eight states, forty-eight experimental social laboratories.”

nonjusticiable the challenge to Connecticut’s criminal penalties for the use of contraceptive drugs or devices. Harlan’s dissent in *Poe* became a concurring opinion when the Court in *Griswold v. Connecticut*, 381 U.S. 479 (1965), finally held the Connecticut birth control law unconstitutional.

156. *Id.*
158. *Id.* at 503.
But Harlan and Powell recognized the limits to federalism. When a state had intruded upon a fundamental personal liberty interest, Harlan and Powell upheld the liberty interest, even though only implicit in the fourteenth amendment, and held the state law unconstitutional. *Poe* and *Moore* are striking illustrations that the principle of federalism can be trumped by an implied liberty interest.

Despite the principle of federalism, conservative justices can find an implied constitutional basis for declaring invalid "all substantial arbitrary [state] impositions and purposeless restraints." Missouri's intrusion into the Cruzan family's decision to terminate Nancy's artificial feeding fits this description.

**B. Application to *Cruzan***

Nancy Cruzan's case cries out for a sensitive approach similar to Harlan's opinion in *Poe* and Powell's opinion in *Moore*. The rights that Justices Harlan and Powell have discerned in the fourteenth amendment are closely related to the rights asserted on behalf of Nancy. Furthermore, the methodology followed by Justices Harlan and Powell sets forth the most fruitful and the most solidly established conservative approach to finding an implied right for Nancy Cruzan to have her family make the decision whether to order termination of artificial nutrition.

In *Cruzan v. Harmon*,164 the Missouri Supreme Court imposed state norms and state values—the state's purported overriding interest in life—upon the family's attempt to terminate artificial nutrition to Nancy in her persistent vegetative state. The decision to end treatment was taken out of the loving hands of Nancy's family. The issue before the United States Supreme Court should have been: Did Nancy Cruzan have a constitutional right to have the decisions concerning termination of her medical treatment made by her caring parents? Does the Constitution protect patients like Nancy from the unwarranted intrusion of the state into this area of private family decisionmaking?

The State of Missouri had a role to play in this decisionmaking process, but its role was purely procedural. The state should provide procedures, within hospital ethics committees in the first instance and in courts if necessary, to assure that the Cruzan family's decision165 was based on reliable medical information and not motivated by self-interest. But the state should be constitutionally barred from im-

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164. 760 S.W.2d 408 (Mo. 1988) (en banc).
165. In Nancy's case her parents, by their continuing attendance, had demonstrated that they should make health-care decisions for her, rather than her husband who had sought and obtained a divorce after the accident.
166. State procedural protection is discussed *supra* notes 51-62 and accompanying text.
posing substantive standards on this life and death decision. The norms and values in this decision should have come from those closest to Nancy, those who knew and loved her and could best and most sensitively do what Nancy would have wanted done.167

Although Nancy had lost all conscious life, she had not lost her constitutional rights. She was a person who could not be deprived of her liberty without due process.168 Because of her permanent vegetative state, however, her right necessarily took on a new meaning, a right to have health care decisions made in her interest by those who best knew her and appreciated her moral sensitivity and value system. As one commentator has written:

[Family members are best qualified to make these decisions, because of their knowledge of the patient’s likely preferences and their special bonds with the patient. Not only are family members most likely to be privy to any relevant statements that patients have made on the topics of treatment or its termination, but they also have longstanding knowledge of the patient’s character traits. Although evidence of character traits may seem inconclusive to third parties, closely related persons may, quite legitimately, “just know” what the patient would want in a way that transcends purely logical evidence. Longstanding knowledge, love, and intimacy make family members the best candidates for implementing the patient’s probable wishes and upholding her values.169

Although no longer competent to make her own health care decisions, it was Nancy’s right to have her caring family make these decisions in her best interest.170 Prior to its decision in Cruzan, the Supreme Court had never addressed this right of an incompetent person to have life and death decisions concerning her medical treatment made by her family. Following the guidance of Justices Harlan and Powell, we can find faint traces of this right in analogous Supreme Court precedents dealing with implied fourteenth amendment rights, as well as in history and tradition.

Justice Harlan in Poe insisted on strict judicial scrutiny of a Connecticut law that had violated “the privacy of the home in its most

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167. As discussed earlier, Nancy Cruzan’s family should not have been compelled merely to implement a decision that Nancy previously had made to terminate treatment. Such decisions or statements, made in good health, are inherently unreliable and difficult to prove. See supra notes 109-114 and accompanying text.


170. Garvey, Freedom and Choice in Constitutional Law, 94 Harv. L. Rev. 1756, 1782 (1981). As Justice Stevens stated in Thompson v. Oklahoma, 487 U.S. 815, 825 n.23 (1988): “Children, the insane, and those who are irreversibly ill with loss of brain function, for instance, all retain ‘rights,’ to be sure, but often such rights are only meaningful as they are exercised by agents acting with the best interests of their principals in mind.”
basic sense.’’ As marital privacy is a matter of family privacy protected from state intrusion, so also are the family decisions respecting the medical care and death of a loved one, decisions that traditionally have been made by the family within the home. As Harlan observed, "if the physical curtilage of the home is protected, it is surely as a result of solicitude to protect the privacies of the life within. . . . The home derives its pre-eminence as the seat of family life.” Heightened scrutiny was essential in Poe, Harlan insisted, precisely because "the State [was] asserting the right to enforce its moral judgment” concerning marital intimacy. In Cruzan, the state of Missouri likewise has forced its moral judgment—that the value of life must transcend all other moral values—upon the closest family circle.

Justice Powell in Moore also insisted that “the Constitution protects the sanctity of the family precisely because the institution of the family is deeply rooted in this Nation’s history and tradition.” He spoke in Moore of the right of family members to share the same home where Mrs. Moore’s two grandsons, who were not brothers, lived with her. But his words apply as well to the right of Nancy Cruzan to have family members decide whether to terminate medical treatment on her behalf. The right Justice Powell found as a bar to state intrusion into the family would apply to Mrs. Moore’s grandsons whether they were minors or adults. Similarly the right asserted by Nancy Cruzan’s family should have been applicable whether Nancy was a child or a permanently unconscious adult. Moreover, the right asserted in Cruzan applies broadly to family health care decisions for incompetent relatives, whether the relative is a child, a parent, or a spouse. Certainly in some cases the closest caring relative might be a grandparent or an aunt or uncle or cousin. As Justice Powell insisted in Moore, “in times of adversity . . . the broader family has tended to come together for mutual sustenance,” such as caring for a dying loved one.

Other decisions by the Supreme Court have upheld the rights of family members to make uniquely important decisions affecting their life or destiny. State laws unjustifiably trampling on these rights have been held unconstitutional, even though the Constitution itself fails explicitly to mention the rights. "There does exist a ‘private realm

172. Id. at 551.
173. Id. at 548.
175. Id. at 505.
176. See Wisconsin v. Yoder, 406 U.S. 205 (1972) (compulsory school attendance law held inapplicable to Amish children on free exercise grounds); Loving v. Virginia, 388 U.S. 1 (1967)
of family life which the state cannot enter' . . . that has been afforded both substantive and procedural protection."

In her *Cruzan* opinion, Justice O'Connor highlighted this point: "[A]s patients are likely to select a family member as a surrogate . . . giving effect to a proxy's decisions may also protect the 'freedom of personal choice in matters of . . . family life." Chief Justice Rehnquist attempted in *Cruzan* to weaken the authority of such cases by contending that they uphold the constitutionality of a state's "favored treatment of traditional family relationships," but cannot be used to argue that a state "must recognize the privacy of those relationships." Rehnquist simply ignored cases like *Meyer*, *Pierce*, *Griswold*, *Loving*, and *Yoder*. In these cases the Constitution clearly was applied as a limitation on the state's power to intrude into areas of family decisionmaking, even though there is no explicit constitutional guarantee of the family right at issue in any of them.

As already discussed, if Nancy had been competent, state courts would have allowed her to refuse treatment or to terminate treatment that had been begun. The Supreme Court also has recognized that a person has a fundamental liberty interest in resisting state ordered invasions of her bodily integrity. "[I]t is obvious," the Court has recently reiterated, "that [a] physical intrusion, penetrating beneath the skin, infringes an expectation of privacy that society is prepared to recognize as reasonable."
Similarly the Supreme Court has repeatedly upheld "[t]he fundamental liberty interest of natural parents in the care, custody, and management of their child."\(^{187}\) Even the extremely sensitive decision of parents voluntarily committing their minor child to a psychiatric hospital has been upheld by the Court.\(^{188}\) No rational distinction can be made between these cases and the right of Nancy Cruzan, as an incompetent adult, to have her parents decide on her behalf to terminate artificial feeding.

This right of Nancy Cruzan rests not only on these analogous precedents of the Supreme Court, but also on a long-standing tradition of the role of family in American society. Again, following in the steps of Justices Harlan and Powell, we can find clear roots of this right in our history and tradition.

Until the Second World War, people generally died at home. Historically in this country, the family "was the usual place of recourse for sick persons and the elderly."\(^{189}\) The society of the founding fathers thought that the home and the family needed protection from governmental intrusion in the form of the quartering of troops or warrantless searches of the home; the drafters of the third and fourth amendments reacted to governmental abuses with which they were familiar. If they had ever dreamed that state officials would overrule health care decisions of the family for a dying relative, they surely likewise would have prohibited such officious intermeddling. Since virtually everyone died at home,\(^{190}\) secure from officially dictated treatment, no explicit protection of the right found its way into the Bill of Rights. The drafters of our Bill of Rights could do no more than to assure the people through the ninth amendment that they retained other unenumerated rights as limits on governmental interference.\(^{191}\)

At the time the fourteenth amendment was written, American criminal law distinguished between withdrawal of medical treatment and assisting suicide.\(^{192}\) No cases can be found at that time in which a family member was prosecuted for deciding, on behalf of an incompetent relative, to discontinue some medical treatment thought necessary to life. At the time of the drafting of the fourteenth amend-

190. See Thomas, Dying as Failure, 447 Annals 1, 2-4 (1980); Mauksch, The Organizational Context of Dying, in E. Kübler-Ross, Death, supra note 78, at 7-24.
191. For commentary on the ninth amendment, see supra note 153.
192. See supra notes 71-75 and accompanying text.
ment's limitation on state deprivations of personal liberty, Americans had a clear and vivid image of death and dying. The widely read novels of the period portrayed dying as entirely a family affair. The loved one died at home surrounded by family and perhaps by close friends and a clergyman. State officials played no role whatever in this intimate setting.

Conservative Justices like Harlan and Powell, however, look beyond history and precedent to the principle of federalism. Indeed, the *Cruzan* plurality and concurring opinions manifest the crucial importance of deference to state decisionmakers. But as illustrated in cases like *Poe* and *Moore*, no deference to state decisions is due when, without a substantial interest, the state has seriously interfered with a fundamental right. After all, according to federalism's basic tenet, decisions should be made by the unit closest to those who will be affected by them, by the unit most sensitive to individual rights and least likely to err, by the states rather than by the federal government. Those who look to the principle of federalism to provide guidance in this type of case proclaim that state governments should check the irresponsible or oppressive potential of the national government.

Viewing federalism in light of its historical meaning, this principle should have heightened the claim of the Cruzan family to decide whether and when to terminate Nancy's treatment. The family was the decisionmaking unit closest to Nancy, most sensitive to her rights, and most strongly motivated to resist oppressive governmental intrusion. As we have already seen, the risk of erroneous life and death decisionmaking by the state far exceeded the risk of erroneous decisionmaking by Nancy's family. If, as Justice O'Connor insisted, the state's role as experimental laboratory should be preserved to safeguard the liberty interests of permanently incompetent patients like Nancy Cruzan, should not the family have had an even stronger claim to agonize over what was best for Nancy? Perhaps Justice

193. This American portrait of death has been well captured in four widely read novels of the mid-nineteenth century: L. ALCOTT, LITTLE WOMEN chs. 17-19 (1868); M. CUMMINS, THE LAMPLIGHTER chs. 15, 25 (1854); H. STOWE, UNCLE TOM'S CABIN chs. 24-26 (1852); E. WETHERELL, THE WIDE, WIDE WORLD chs. 41-42 (1850). That these four novels were best sellers is documented in F. MOTT, GOLDEN MULTITUDES: THE STORY OF BEST SELLERS IN THE UNITED STATES 307-09 (1947).

194. See supra notes 154-175 and accompanying text.


196. See supra notes 134-137 and accompanying text.

O'Connor did not reflect on how frightening it is to allow the state to experiment with life and death decisions.

Certain values lie close to the heart of our constitutional system of limited government. The Supreme Court has surrounded these values with the ramparts of strict judicial scrutiny. Conviction of an innocent person is so abhorrent to our system of government that the Court has insisted a person be presumed innocent. The government must bear the heavy weight of proof of guilt beyond a reasonable doubt. Likewise, when the Supreme Court at last appreciated the horror of apartheid society, it required strictest judicial scrutiny of racially discriminatory classifications. The Court also has protected the entire democratic process from governmental subversion by imposing the highest burden of justification when public officials attempt to suppress a particular message.

The right asserted here merits no less protection by the Court. The Court long ago proclaimed, "The child is not the mere creature of the State." In our constitutional system this aphorism implicitly has been expanded to announce that no person is the mere creature of the state. The outrage that the Court has expressed in response to the Connecticut birth control law, or the East Cleveland restriction on which family members may live together is that these state laws take over the lives of those they touch. The state must not occupy the lives of the people; it must not attempt to coerce uniformity. For this reason, the Court has required strict judicial scrutiny when state laws intrude into this realm of personal privacy. The state of Missouri should not be allowed to standardize one of the most basic and intimate of personal areas—the right of an incompetent to have her family, not the state, decide whether and when to terminate medical treatment.

Coda

No one would expect government officials to interfere with the chess match between Antonius Block and death. Block himself decides when to end the game.

205. Missouri's withdrawal from the case following the Supreme Court's decision, see supra note 8, acknowledges its own victory as pyrrhic and the Cruzan family's as genuine.
In the *Cruzan* case, Nancy Cruzan came to terms with death as much as she ever could. Her earlier statements and her basic life values had communicated to those who knew and loved her best that she would want to end the game. Nancy's family came to terms with her death. They accepted the medical facts and they best understood Nancy's moral world. By what right, by what constitutional power, did the state of Missouri refuse to allow Nancy to die?