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## Constituting Family and Death Through the Struggle with State Power: *Cruzan v. Director, Missouri Department of Health*

T.A. Tucker Ronzetti

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# COMMENT

## Constituting Family and Death Through the Struggle with State Power: *Cruzan v. Director, Missouri Department of Health*

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### I. INTRODUCTION

The concept of liberty typically presupposes limitations on the nature of the power that the state exercises over individuals.<sup>1</sup> Starting with the notion of a “zone of privacy”<sup>2</sup> into which the state may not

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1. Perhaps the most renowned work to develop this thesis is JOHN S. MILL, *ON LIBERTY* (Marshall Cohen ed., 1961). Mill noted that the “struggle between Liberty and Authority” remained even after the rise of popular government, because of the possibility of the tyranny of the majority. *Id.* at 187. Liberty could only be preserved by respecting the principle that “the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others.” *Id.* at 197.

Mill's fears were not new. James Madison had similar concerns during the debates over ratifying the United States Constitution: “It is of great importance in a republic not only to guard the society against the oppression of its rulers, but to guard one part of the society against the injustice of the other part.” *THE FEDERALIST* No. 51, at 227 (James Madison) (Charles A. Beard ed., 1948). Originally the Constitution addressed the problem of tyranny by outlining governmental power, dispersing that power through checks and balances, and noting a few basic rights, ostensibly leaving the remainder to individual liberty. *See THE FEDERALIST* No. 47 (James Madison), No. 84 (Alexander Hamilton).

2. The “zone of privacy” is a legal metaphor that arises from several sources. Warren and Brandeis considered “the right ‘to be let alone’ ” an “inevitable” development of the law. Samuel D. Warren & Louis D. Brandeis, *The Right to Privacy*, 4 *HARV. L. REV.* 193, 195 (1890) (quoting THOMAS M. COOLEY, *COOLEY ON TORTS* 29 (2d. ed. 1888)) (outlining tort law right to privacy). In *Boyd v. United States*, 116 U.S. 616 (1885), the Supreme Court

intrude without special justification, liberty traditionally assumes that the state acts by permitting or forbidding certain individual behavior.<sup>3</sup> As Michel Foucault and other theorists have argued, however, such a conception of state power fails in two respects to capture the true nature of the state's role in policing its citizens.<sup>4</sup>

First, the state does not simply permit or prohibit certain individual behavior. Rather, it exercises such pervasive and detailed power over people that, in a sense, it constitutes who they are.<sup>5</sup> Second,

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announced a similar principle in its construction of the Fourth and Fifth Amendments: "It is not the breaking of his doors, and the rummaging of his drawers, that constitutes the essence of the offence; but it is the invasion of his *indefeasible right of personal security, personal liberty, and private property* . . ." *Id.* at 630 (emphasis added). Justice Brandeis apparently considered the values described in *The Right to Privacy* to be of constitutional dimension. See *Olmstead v. United States*, 277 U.S. 438, 474-75 (1927) (Brandeis, J., dissenting) (quoting *Boyd*). Presently the doctrine of substantive due process manifests the constitutional right of privacy. See, e.g., *Griswold v. Connecticut*, 381 U.S. 479, 484 (1965) ("Various guarantees [among the Bill of Rights] create zones of privacy."); *Roe v. Wade*, 410 U.S. 113, 152 (1973) (tracing "a right of personal privacy" back to *Union Pacific R. Co. v. Botsford*, 141 U.S. 250, 251 (1891)).

3. The concept of privacy arises from the broader notion of negative liberty, or "the freedom of the individual to be let alone to do whatever she chooses as long as others are not harmed." See Margaret Jane Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849, 1898 n.186 (1987); cf. Jed Rubenfeld, *The Right of Privacy*, 102 HARV. L. REV. 737 (1989) (critiquing privacy, personhood, and Mill's concept of self-regarding acts).

4. By now, we well know the weaknesses in the privacy model. See, e.g., LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 15-2, at 1305 (2d. ed. 1988) ("[M]eaningful freedom cannot be protected simply by placing identified realms of thought or spheres of action beyond the reach of government . . ."). In light of the insufficiency of the privacy model, what is the nature of the individual's relationship to the state?

The French philosopher Michel Foucault envisions a power relation between the state and the individual which constitutes individuality itself. See generally MICHEL FOUCAULT, *THE HISTORY OF SEXUALITY: AN INTRODUCTION* 212 (1980) [hereinafter FOUCAULT, *HISTORY OF SEXUALITY*]; MICHEL FOUCAULT, *Interview—Truth and Power, in POWER/KNOWLEDGE: SELECTED INTERVIEWS AND OTHER WRITINGS 1972-1977*, at 109 (Colin Gordon ed. & Colin Gordon et al. trans., 1980); Michel Foucault, *Afterword—The Subject and Power* to HUBERT L. DREYFUS & PAUL RABINOW, *MICHEL FOUCAULT: BEYOND STRUCTURALISM AND HERMENEUTICS* 208 (2d ed. 1983) [hereinafter Foucault, *Afterword*]. For applications of Foucault in critiques of privacy, see Rubenfeld, *supra* note 3, at 775-82 (evaluating the concept of personhood); and Stephen J. Schnably, *Beyond Griswold: Foucauldian and Republican Approaches to Privacy*, 23 CONN L. REV. 861 (1991); see also Cass R. Sunstein, *Legal Interference with Private Preferences*, 53 U. CHI. L. REV. 1129, 1153-58 (1986) (describing power as the cause of limitations on the potential of autonomous preferences).

5. The pervasive nature of state power stems from the social construction of knowledge. There is no perceivable objective, determinate meaning of reality; the world as we perceive it has its meaning constructed from our relationship with others. Gary Peller, *The Metaphysics of American Law*, 73 CAL. L. REV. 1152, 1167-68 (1985). When persons ignore the socially created character of reality, it becomes "reified," or presumed as true. *Id.* at 1157. Reification defines the bounds of consciousness, so that "[w]hat gets called 'knowledge' is the produced effect of social power institutionalized in social representational conventions." *Id.* at 1170.

The state's power relation with the individual is an exercise of reification that "applies itself to immediate everyday life which categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must

power emanates from a whole range of institutions and discourses that go beyond the state more narrowly conceived, thereby constraining the individual's ability to maintain autonomy.<sup>6</sup>

The case of Nancy Beth Cruzan and her family portrays both points about the relationship between the state and the individual. For years after an automobile accident that left her brain severely damaged,<sup>7</sup> Nancy<sup>8</sup> and her family became entangled in a web of state

recognize and which others have to recognize in him." Foucault, *Afterword*, *supra* note 4, at 212. Power governs by defining an intrinsic course of behavior among an open realm of possibilities, structuring the way in which individuals behave by limiting their consciousness of other possible actions. *Id.* at 221-22. Thus the power relation constitutes, rather than suppresses, the individual. FOUCAULT, *HISTORY OF SEXUALITY*, *supra* note 4, at 81-83 (defining power as constitutive rather than repressive).

6. Foucault conceives of power as "the multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organization." FOUCAULT, *HISTORY OF SEXUALITY*, *supra* note 4, at 92; *see also* Foucault, *Afterword*, *supra* note 4, at 224, 222-24 ("Power relations are rooted in the system of social networks."). For example, the use of sexuality as a means of categorization and control arose from medical, educational, and religious establishments, as well as the family. FOUCAULT, *HISTORY OF SEXUALITY*, *supra*, at 110-11. Under this broad conception of power, Foucault effectively discounts the legitimacy of the state action distinction in order to "escape from the system of Law-and-Sovereign which has captivated political thought for such a long time." *Id.* at 97.

Foucault's theory of power has troubling implications for the concept of autonomy: if the individual is socially constituted, what is left of the authentic individual? Some interpret Foucault to reject autonomy, at least in the conventional sense of self-definition, because the concept is another form of discourse used to dominate the unwary. *See* Nancy Fraser, *Michel Foucault: A "Young Conservative"?*, 96 *ETHICS* 165, 177-82 (1985) (considering a possible reading of Foucault as rejecting autonomy itself as a form of subjection); *cf.* Rubinfeld, *supra* note 3, at 770-82 (finding that "personhood" can be a form of subjection). Foucault himself implies that autonomy exists socially in some sense, by considering individual resistance and freedom essential to the power relation: "Power is exercised only over free subjects, and only insofar as they are free." Foucault, *Afterword*, *supra* note 4, at 221. Perhaps the rejection of the *discourse* of autonomy as self-definition does not preclude autonomy itself. As Professor Sunstein argues, if we are indeed shaped by society, autonomy must be a matter of degree rather than absolute and essential, or we are each utterly manipulable by the state. *See* Sunstein, *supra* note 4, at 1170.

7. The trooper who first discovered Nancy was dispatched at 12:54 a.m. Believing she was dead, he did not attempt to revive her. Brief for Petitioners at 2, *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990) (No. 88-1503). The paramedics, who found Nancy without detectable respiratory or cardiac functions, began resuscitation efforts at 1:09 a.m., and her heartbeat and breathing resumed by 1:12 a.m. 760 S.W.2d at 411. Thus, although no one could know exact time at which Cruzan's heart stopped delivering oxygen-rich blood to her brain, estimates are as high as 20 minutes. *See* Brief of the American Medical Association, American Academy of Family Physicians, American Association of Neurological Surgeons, American College of Surgeons, American Medical Women's Association, American Society for Parenteral & Enteral Nutrition, Missouri State Medical Association, and Missouri State Neurosurgical Society as *Amicus Curiae* in Support of Petitioners at 7, *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990) (No. 88-1503) [hereinafter Brief of the A.M.A.]. The trial court found that permanent brain damage normally occurs six minutes after the sustained deprivation of oxygen begins, and the best estimates of Nancy's deprivation ranged from 12 to 14 minutes. *Cruzan v. Harmon*, 760 S.W.2d 408, 410 (Mo. 1988). The neurosurgeon who treated Nancy feared anoxia from the outset. Brief for Petitioners at 6.

and medical bureaucracy that transformed their lives. Initial attempts to treat Nancy failed to restore her to consciousness, and eventually she lapsed into a persistently vegetative state, kept alive only by a feeding tube implanted in her stomach.<sup>9</sup> Both the hospital and the State of Missouri refused to remove the tube, over the objections of her family.

To say, however, that the hospital simply "refused" to permit exercise of the right to die, or that the State "prohibited" the hospital and the Cruzan family from removing life-sustaining support, is to misunderstand the affirmative effects that those exercises of power had upon the individuals involved. Nancy herself disintegrated into an unconscious shell of her former self, physically degenerating and dominated by hospital tubes and treatment. Medical reports indicated Nancy's "incontinence, her alternative constipation and diarrhea, her stomach troubles, her eye problems and rashes, her bleeding gums and obesity, her contorted limbs and her seizures and vomiting."<sup>10</sup> In a clear and immediate way, the hospital controlled Nancy's life.<sup>11</sup>

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Along with the cerebral contusions which probably resulted from the accident itself, her brain was permanently damaged from anoxia, the sustained deprivation of oxygen. 110 S. Ct. at 2845.

8. This Comment will refer to Nancy Beth Cruzan as "Nancy." The question of using first rather than last names implicates, in our society, issues of respect and denigration. On the one hand, public use of the first name is often seen as degrading to the person to whom such reference is made; in particular, feminists often see such usage as sexist. See Anna Quindlen, *From Name-Calling to First-Name-Calling (Ask Women)*, MIAMI HERALD, Nov. 27, 1991, at 15A. On the other hand, feminists have also objected to the "hierarchy, rigidity, and depersonalization" implicit in the exclusive use of last names in a public context. See Katharine T. Bartlett, *Feminist Legal Methods*, 103 HARV. L. REV. 829, 829 n.\* (1990) ("First names have been one dignified way in which women could distinguish themselves from their fathers and their husbands."). This Comment will refer to Nancy Beth Cruzan by her first name in the spirit of the latter critique, and also to drive home the very direct and personal impact that the exercise of state power had on her.

9. A persistently vegetative patient is entirely and irrecoverably unconscious of her surroundings, despite some involuntary movements. *Cruzan*, 110 S. Ct. at 2845. Patients in a persistently vegetative state manifest reflex actions, and their eyes move, though not in any purposeful manner. Brief of the A.M.A., *supra* note 7, at 8.

10. Andrew H. Malcolm, *Missouri Family Renews Battle Over Right to Die*, N.Y. TIMES, Nov. 2, 1990, at A4 (describing medical reports used by the court-appointed guardian at Cruzan's rehearing following the Supreme Court's ruling).

11. Professor Jed Rubenfeld aptly described the hospital's utter control of the vegetative patient's existence:

For right-to-die patients, being forced to live is in fact to be forced into a particular, all-consuming, totally dependent, and indeed rigidly standardized life: the life of one confined to a hospital bed, attached to medical machinery, and tended to by medical professionals. It is a life almost totally occupied. The person's body is, moreover, so far expropriated from his own will, supposing that he seeks to die, that the most elemental acts of his existence—such as breathing, digesting, and circulating blood—are forced upon him by an external agency.

Similarly, the lives of Nancy's loved ones were transformed, virtually into a continual wake. The Cruzan family had to travel forty-five miles to the hospital daily to care for Nancy.<sup>12</sup> They fed her and laced up her shoes to prevent limb contraction.<sup>13</sup> They prayed for her, begged her to blink, talked to her about her favorite nieces, brushed her hair, touched her, bought her dolls and presents, set up a Christmas tree in the hospital in 1983, and brought her home for three days over Christmas in 1984.<sup>14</sup> But in the end, all of the family's struggling with Nancy's new life could not bring her back again. As one of Nancy's sisters said: "After all this time seeing her so contorted, it's hard to remember Nancy laughing. . . . It's so hard to have all the good memories overshadowed by the image of her now. I'll be glad when we can concentrate on those memories and not her physical existence."<sup>15</sup>

The experience of the Cruzan family teaches us that the power of the state does not merely direct or prohibit, but has the capacity virtually to commandeer people's lives. Equally important, that constitutive power does not emanate solely from the state government, but encompasses a wide range of state and private institutions. In the Cruzans' case, Nancy's family confronted a medical bureaucracy with resources and knowledge so superior to their own that they were powerless to voice their own wishes even when the hospital ostensibly consulted them.<sup>16</sup> The hospital's power became even more apparent

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Rubinfeld, *supra* note 3, at 795; see also *infra* text accompanying notes 73-81 (further describing Nancy Cruzan's medically dominated existence).

12. Brief for Petitioners at 8, *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990) (No. 88-1503). Notably, Nancy had been married for about a year prior to the accident. *Cruzan v. Harmon*, 760 S.W.2d 408, 432 (Mo. 1988) (Higgins, J., dissenting). A few months after her accident, Nancy's husband left her at his grandmother's home, where she had professional nursing care. *Id.* at 431. Nancy's parents became her court-appointed guardians and conservators a little over a year after the accident. *Id.* Her husband failed to attend the guardianship proceedings, and the court decreed a dissolution of marriage. *Id.*

13. Brief for Petitioners at 7-8, *Cruzan* (No. 88-1503).

14. *Id.* at 8.

15. Andrew H. Malcolm, *Case Testing Right to Die 'Aged Us All'*, N.Y. TIMES, Nov. 4, 1990, at L24. The possibility that Nancy somehow knew what was happening to her also disturbed the Cruzans. Although a persistently vegetative person is incapable of consciousness, the person's involuntary muscle activity can give a contrary impression. Brief of the A.M.A., *supra* note 7, at 8. The nursing staff believed that Nancy was more responsive to some persons than to others, would react to conversation, and cried after a Valentine's Day card was read to her and after her family visited. Brief for Respondents Harmon and Lamkins at 3, *Cruzan v. Director, Missouri Dep't of Health*, 110 S. Ct. 2841 (1990) (No. 88-1503). The family believed that, if indeed she were conscious of her treatment, "Nancy would be horrified." Brief for Petitioners at 8, *Cruzan* (No. 88-1503).

16. At the time the doctors sought and received the Cruzan family's permission to implant the tube, they said that Nancy's prognosis was uncertain, and they still hoped that she would recover. Brief for Petitioners at 7, *Cruzan* (No. 88-1503).

when it refused to terminate the feeding at the family's request.<sup>17</sup> From that point on, the Cruzans grappled with the state, which asserted an independent interest in maintaining Nancy's life, apart from her own wishes or those of the family. Their struggle, though necessitated by the potentially transformative nature of power, nevertheless testifies to the fact that such power is not irresistible.<sup>18</sup>

It was this intrusive, nearly pervasive form of power that the Supreme Court failed to understand when it confronted the case. Instead of taking the family's role in the litigation into account, the Court required "clear and convincing" proof that Nancy would want to end such treatment.<sup>19</sup> Thus, in a state like Missouri a family could not exercise the right to terminate treatment on behalf of an incompetent patient by showing that the patient would want the treatment to end, or that the patient expressed such a desire while competent.<sup>20</sup> Even more disturbing was the Court's approval of the Missouri "sanctity of life" policy, which identified a state interest in the patient's life, independent of the patient's own interests and quality of life.<sup>21</sup> Such an interest virtually endorsed the kind of intrusive, transformative

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17. Concerned with potential legal liability, the hospital told the Cruzans it could not honor their request to terminate treatment without a court order. *Id.* at 8. The trial judge described the medical institution's chief concern as "the legal consequences of such actions rather than any objections that good ethical standards of the profession would be breached." *Cruzan v. Harmon*, 760 S.W.2d 408, 433 (Mo. 1988).

18. The Cruzan family's struggle reflects their resistance to the state's power. *See supra* note 6 (discussing the importance of resistance for autonomy).

19. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2853, 2855-56 (1990).

20. The quantum and quality of evidence that satisfies the "clear and convincing" standard is unknown. Practically, the ruling implied that a state may condition the right to die upon the preparation of a "living will," the patient's directions for treatment written in advance of incompetency. *See id.* at 2857 (O'Connor, J., concurring) (noting that the Constitution may require the state to effectuate a patient's advance directives); *see also* H. REP. NO. 101-881, 101st Cong., 2d Sess. 88 (1990) (describing *Cruzan* as "a case in which the Court recognized a patient's right to die and endorsed the withdrawal of life support and withholding of medical treatment in cases where a patient's wishes were known"), *reprinted in* 1990 U.S.C.C.A.N. 2017, 2100. A living will statute allows "a competent person to decree in a formal document that she would refuse death prolonging medical treatment in the event of terminal illness and an accompanying inability to refuse such treatment as a result of incompetency." *Cruzan v. Harmon*, 760 S.W.2d 408, 419 (Mo. 1988).

Unfortunately, living wills, like conventional wills, do not guarantee that the patient's wishes will be complied with in all circumstances. Inevitably some patients will neglect to prepare the necessary documents, and the terms of many living will statutes exclude pregnant women. Linda C. Fentimann, *Privacy and Personhood Revisited: A New Framework for Substitute Decisionmaking for the Incompetent, Incurably Ill Adult*, 57 GEO. WASH. L. REV. 801, 818-22 (1989) (surveying living will statutes). Recently, however, Congress has promoted awareness of advance directives by requiring medicare providers and federally funded state medical programs to provide patients with written notice of their rights to refuse treatment. *See Omnibus Budget Reconciliation Act of 1990*, Pub. L. No. 101-508, §§ 4206, 4751, 104 Stat. 1388-115 to -117, 1388-204 to -206.

21. *See infra* notes 82-83 and accompanying text.

power of the state that tormented the Cruzans for years.<sup>22</sup>

The four dissenting justices displayed a somewhat greater sensitivity to the human tragedy surrounding the case. Yet in advocating a model of simple deference to a private sphere, they too failed to address the affirmative and pervasive effects of power. Justice Brennan urged substituted decisionmaking by the family to be exercised on behalf of the incompetent patient and according to her preferences.<sup>23</sup> Justice Stevens advocated a "best interests" approach, giving the court the primary power to decide what would be best for the patient, while still taking into account the values of the family and patient.<sup>24</sup> Assuming that in both cases the justices' goal is to honor the patient's preferences, both approaches have inherent weaknesses.<sup>25</sup> Substituted judgment risks displacing the patient's desires with those of the surrogate decisionmaker, because no surrogate can make such a decision without somehow incorporating her own values.<sup>26</sup> Best interests deci-

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22. The Cruzan family began its court battle when it sued for declaratory relief in the fall of 1987. Brief for Petitioners at 9, *Cruzan* (No. 88-1503). After the Supreme Court handed down its decision on June 25, 1990, the Cruzans returned to court for a new trial to argue that they had clear and convincing evidence of Nancy's wishes. Malcolm, *supra* note 10. The family produced three friends who remembered specific conversations in which Nancy said she would not want to live like a vegetable. Malcolm, *supra* note 15. The Attorney General of the State of Missouri dropped the case, because its purpose in pursuing the matter was merely to clarify Missouri's law about the removal of life support, and not to challenge the particular removal of Nancy's tube. Lisa Belkin, *Missouri Seeks to Quit Case of Comatose Patient*, N.Y. TIMES, Oct. 12, 1990, at A15. Now essentially unchallenged, the family's suit was successful. On December 26, 1990, twelve days after the hospital removed her feeding tube, Nancy Cruzan died. Tamar Lewin, *Nancy Cruzan Dies, Outlived by a Debate Over the Right to Die*, N.Y. TIMES, Dec. 27, 1990, at A1.

23. See *infra* notes 127-31 and accompanying text.

24. See *infra* notes 114-26 and accompanying text. Designating Justice Stevens' approach as "best interests" and Justice Brennan's as "substituted judgment" may mask the complexity of the different decisionmaking methods. As the majority opinion in *Cruzan* indicates, the state courts have generated diverse decisionmaking methods. See *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2847-50 (1990) (surveying state court analytical methods and their legal foundations); see also Steven M. Richards, Note, *Someone Make Up My Mind: The Troubling Right to Die Issues Presented by Incompetent Patients with No Prior Expression of a Treatment Preference*, 64 NOTRE DAME L. REV. 394 (1989) (surveying treatment decisionmaking methods). Although they may differ in their practical application, their methodological differences stem from the range of objectivity that the court will use. Substituted judgment, which asks what the patient would choose if she could, tends to be subjective; best interests, which asks if a reasonable person would consider the treatment to be inhumane, tends to be objective. See, e.g., *In re Conroy*, 486 A.2d 1209, 1229-33 (N.J. 1988) (outlining "subjective," "limited-objective," and "pure-objective" standards to be used, depending on the amount of evidence available about the patient's wishes); see also Nancy K. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375, 375-78 (1988) (critiquing the subjective and objective standards). Although the methods espoused by Justice Stevens and Justice Brennan may differ from the finer points of the states' various methods, they fairly reflect the "objective" and "subjective" paradigms.

25. See TRIBE, *supra* note 4, § 15-11, at 1369-70.

26. *Id.* at 1369-71 (referring to the exercise of substituted judgment as reaching "almost



sionmaking risks being paternalistic and denying the patient's values entirely.<sup>27</sup>

The majority and dissent also failed to understand that, given the inevitably pervasive, constitutive nature of power, a case like *Cruzan* is bound to result in a struggle for control. The state, the hospital, and the patient's loved ones inevitably find themselves in a battle over the fate of the incompetent patient. When the court defers to the family, it necessarily empowers a select group of individuals, typically those related to the patient by kinship or marriage.<sup>28</sup> Others are excluded, even though they may be more emotionally connected to the patient than the members of the patient's family. There is no reason, however, for kinship or marriage to empower a class of decisionmakers, beyond the intuitive probability that those related by kinship or marriage are in fact emotionally attached to the patient. Nor is there any reason for the court to define death, as the majority in *Cruzan* does, as a purely biological event. By adopting such a view, the majority subordinates the patient's loved ones to the hospital. A more humane approach would be to require the medical establishment to defer to the patient or the patient's loved ones, and allow them to be the ones to define death.

This Comment examines treatment decisionmaking for persistently vegetative patients like Nancy Cruzan, who are, and will be, unconscious until death. Such a form of existence is arguably "life," but only in the technical, medical sense.<sup>29</sup> Consequently, the interest of the patient's family in allowing the patient to "die with dignity"<sup>30</sup> should be accorded at least as much weight as the interests of the state or medical establishment in preserving the patient's life. Under this

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Alice in Wonderland proportions"); see also James Bopp & Daniel Avila, *The Siren's Lure of Invented Consent: A Critique of Autonomy-Based Surrogate Decisionmaking for Legally-Incapacitated Older Persons*, 42 HASTINGS L.J. 779, 780 (1991) (asserting that substituted judgment unjustifiably invents the consent of the incapacitated patient); Louise Harmon, *Falling Off the Vine: Legal Fictions and the Doctrine of Substituted Judgment*, 100 YALE L.J. 1 (1990) (outlining the history of substituted judgment and criticizing its unexamined use); Martha Minow, *Beyond State Intervention in the Family: For Baby Jane Doe*, 18 U. MICH. J.L. REF. 933 (1985) (criticizing use of substituted judgment rationale for decisions about infants). A recent survey indicated that there is a substantial probability that family members will incorrectly predict the life-and-death decisions of their loved ones, and physicians' predictions are no better than chance. Alison B. Seckler et al., *Substituted Judgment: How Accurate Are Proxy Predictions?*, 115 ANNALS INTERNAL MED. 92, 95 (1991).

27. See TRIBE, *supra* note 4, § 15-11, at 1369-71; see also *infra* notes 119-23 and accompanying text (discussing Justice Stevens's approach).

28. See *infra* Part III.A.

29. See *infra* notes 73-88 and accompanying text.

30. See *In re Conroy*, 486 A.2d 1209, 1220 (N.J. 1985) ("[P]atients and their families are increasingly asserting a right to die a natural death without undue dependence on medical technology or unnecessarily protracted agony—in short, a right to 'die with dignity.'").

analysis, the question of who the patient's "family" should be for purposes of making treatment decisions—and what their role should be in the patient's death—resolves the issue of whether the patient's life is worth living.

Part II uses a critique of *Cruzan* to introduce the power relation governing the death of persistently vegetative patients. The majority's holding fails to protect the patient; instead, it supersedes the patient's values in order to support Missouri's sanctity-of-life ideology. The dissenting opinions, while more protective of the patient's liberty and the family's emotions, misjudge the interrelatedness of the family and the state and thereby miss the importance of examining where and how the Court distributes authority. Part III examines state empowerment of the patient's relatives and proposes an alternative, normative method of distributing control based upon mutual emotional attachment, similar to the method used by the New York Court of Appeals in *Braschi v. Stahl Associates*.<sup>31</sup> Part IV examines the effect of the medical establishment's control of the patient, which deepens the family's sense of grief and helplessness. This Comment concludes that, to the extent possible, we should reconceive death itself in order to return control to the patient and her loved ones.

## II. ANALYSIS OF *CRUZAN*

### A. *Historical and Doctrinal Background*

In the fall of 1987, after the hospital administration refused to act without judicial authorization, the Cruzan family sought and obtained a declaratory judgment from a state trial court to authorize the removal of Nancy's gastrointestinal tube.<sup>32</sup> By a four-to-three

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31. 543 N.E.2d 49 (N.Y. 1989).

32. Brief for Petitioners at 9, *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841 (1990) (No. 88-1503). During the time that Nancy was incapacitated, no family member ever witnessed a response from her. *Id.* at 8. By the time the Cruzans filed their petition for declaratory judgment, the statistical possibility of Nancy recovering consciousness was essentially nil. Of an estimated 100,000 patients suffering from her condition, only three recoveries have been reported, and the latest recovery occurred 22 months after the illness began. Brief of the A.M.A., *supra* note 7, at 11-12. Based upon Nancy's remarks to a housemate and her sister, as well as their own intuition, Nancy's mother, father and sisters believed that she would not want to endure in a vegetative condition. While discussing the death of a housemate's relative, Nancy Cruzan told the housemate that she would not want to live as a "vegetable." Brief for Petitioners at 5, *Cruzan* (No. 88-1503). Nancy twice discussed her beliefs with one of her sisters, a year and a half before the accident, following the death of their grandmother and the stillborn birth of their younger sister's baby. *Id.* at 6. The family's convictions were supported by a holistic understanding of Nancy based upon the closeness of their relationship. For instance, Nancy's mother "as her mother" knew that "Nancy would not want to be like she is now." *Id.* at 8.

vote, however, the Missouri Supreme Court reversed.<sup>33</sup> The court held that the state's interest in life prohibits the withdrawal of life-sustaining treatment from an incompetent patient in a persistently vegetative state unless clear and convincing evidence shows that the patient would have wanted the withdrawal.<sup>34</sup> Missouri's "living will" statute<sup>35</sup> expressed the state's "sanctity of life" position—a state interest in life independent of the patient's interests and the quality of her life.<sup>36</sup> The court considered Nancy's informal statements to her family and friends to be "woefully inadequate" as evidence of her refusal of treatment.<sup>37</sup> Balancing such "inherently unreliable" expressions of Nancy's beliefs against the state's interests in preserving human life and furthering the sanctity of life policy, the court held that Nancy's parents did not have authority to withdraw her hydration and nutrition.<sup>38</sup>

On certiorari, the United States Supreme Court sustained Mis-

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33. *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (Blackmar, Higgins, and Welliver, JJ., dissenting).

34. *Id.* at 424, 426.

35. MO. REV. STAT. §§ 459.010-055 (1986). The Missouri living will statute is based upon the Uniform Rights of the Terminally Ill Act, but with "substantial modifications." *Cruzan v. Harmon*, 760 S.W.2d 408, 419 (Mo. 1988). The modifications deny refusal of "the administration of medication or the performance of medical procedure deemed necessary to provide comfort care or to alleviate pain" or "the performance of any procedure to provide nutrition or hydration." MO. REV. STAT. § 459.010(3) (1986). The modifications are so extensive one dissenting justice stated that the statute is "a fraud on Missourians who believe we have been given a right to execute a living will, and to die naturally, respectably, and in peace." *Cruzan v. Harmon*, 760 S.W.2d at 442 (Welliver, J., dissenting). The Missouri living will statute was held not to apply to the case, since the law took effect after Nancy Cruzan's accident, and she had never executed a living will. *Id.* at 420.

36. *Cruzan*, 760 S.W.2d at 420.

37. *Id.* at 424 (quoting *In re Gardner*, 534 A.2d 947, 957 (Me. 1987) (Clifford, J., dissenting)). The court questioned an individual's ability to make an informed decision about medical treatment while not actually faced with suffering a debilitating injury or disease. *Id.* at 416-17. The question whether a person can ever adequately foresee what her values will be following a radical change in the manner of her existence has sweeping implications for the efficacy of both living wills and substituted judgment. *See infra* notes 276-89 and accompanying text.

38. *Cruzan*, 760 S.W.2d at 426-27. The Missouri Supreme Court noted four state interests in refusal of life-sustaining treatment: "preservation of life, prevention of homicide and suicide, the protection of interests of innocent third parties and the maintenance of the ethical integrity of the medical profession." *Id.* at 419 (citing MO. REV. STAT. § 497.055(1) (1986) and *Brophy v. New England Sinai Hospital, Inc.*, 497 N.E.2d 626, 634 (Mass. 1986)). The Missouri Court added the interest in prevention of homicide; the other interests, derived from cases of a patient's refusal of non-vital treatment, were first announced in *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 425 (Mass. 1977). In similar cases, courts routinely state the four state interests, though normally no more than one or two apply. *See, e.g., In re Estate of Longeway*, 549 N.E.2d 292, 299 (Ill. 1989) (quoting *Saikewicz*). The Missouri Supreme Court found that only the preservation of life was at issue in *Cruzan*. *Cruzan*, 760 S.W.2d at 419.

souri's approach, holding that a state may impose a clear-and-convincing burden of proof in proceedings where a guardian seeks to discontinue life-supporting treatment of a persistently vegetative person.<sup>39</sup> Writing for the majority, Chief Justice Rehnquist reasoned that the state has an independent, unqualified interest in human life, as well as an interest in protecting a patient from potential abuses by her family and other risks of an erroneous decision to withdraw life support.<sup>40</sup> Justice O'Connor's separate concurrence stressed that the patient's liberty interests encompassed the right to delegate the choice to a decisionmaker, if adequate procedural safeguards are met.<sup>41</sup> Also concurring, Justice Scalia asserted that there is no constitutional right to the withdrawal of life-sustaining medical treatment.<sup>42</sup>

Four justices dissented. Justice Brennan, joined by Justices Marshall and Blackmun, argued that freedom from unwanted medical treatment—even life-sustaining treatment—is a fundamental right that outweighs a state's general interest in life.<sup>43</sup> Where the patient is incompetent, Brennan proposed that the family exercise substituted judgment on behalf of the patient, subject to oversight by the court to prevent abuses.<sup>44</sup> Justice Stevens' dissent asserted that, by imposing its definition of life on Cruzan without regard to her beliefs, the state had failed "to care for Nancy Cruzan's life in a way that gives appropriate respect to her own best interests."<sup>45</sup> Although a state could use a clear and convincing standard of proof, it should only employ that standard to discern the patient's best interests, not to assert a policy respecting the sanctity of life without regard to its quality.<sup>46</sup>

### B. Critique of the Majority

The Court's analysis of the constitutional issues involved is defi-

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39. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2856 (1990).

40. *Id.* at 2852-53. The Court rejected the Cruzans' argument that close family members should be able to decide for an incompetent patient even if they could not clearly prove that their views reflected those of the patient. *Id.* at 2855. The Cruzans relied on *Michael H. v. Gerald D.*, 109 S. Ct. 2333 (1989), which upheld the statutory protection of traditional family relationships, and *Parham v. J.R.*, 442 U.S. 584 (1979), which upheld parental decisionmaking for mentally ill minors. *Cruzan*, 110 S. Ct. at 2855; see also *infra* notes 173-80 and accompanying text (discussing *Michael H. v. Gerald D.*). The Court distinguished the cases, reasoning that in *Michael H.* and *Parham* the Court upheld the states' power to prescribe individual rights, rather than individual rights themselves. *Cruzan*, 110 S. Ct. at 2855.

41. *Cruzan*, 110 S. Ct. at 2856-59 (O'Connor, J., concurring).

42. *Id.* at 2859-63 (Scalia, J., concurring) ("I assert only that the Constitution has nothing to say about the subject.")

43. *Id.* at 2870.

44. *Id.* at 2877.

45. *Id.* at 2879, 2885-89 (Stevens, J., dissenting).

46. *Id.* at 2889-90.

cient in two respects. First, it ignored the substantive effects of Missouri's rule on the burden of proof. The heightened evidentiary burden required by the clear and convincing standard protects personal choice only if one assumes that the patient would want to remain on life support. But that assumption begs the question whether in fact the patient would want life support continued even when she is persistently vegetative.<sup>47</sup> The appointment of a guardian ad litem could better address the Court's fear that the family might act selfishly.

The second defect in the majority's analysis is its approval of Missouri's unqualified, independent state interest in the preservation of life, an interest that has ominous implications for both individual patients and health care providers. By refusing to consider personal choices about the quality of life, the assertion of an unqualified state interest in the sanctity of life position jeopardizes individual autonomy. The state's unqualified interest promotes the support of life without regard to the beliefs that the patient may hold about the quality of life and the risk of death.

#### 1. RESPECTING THE PATIENT'S WISHES

The Supreme Court approved the clear and convincing standard based on the state's interest in respecting the patient's wishes concerning life support. When the patient is in a vegetative state, the right to refuse life support "must be exercised for her, if at all, by some sort of surrogate."<sup>48</sup> The task of the trial court is "to assure that the action of the surrogate conforms as best it may to the wishes expressed by the patient while competent."<sup>49</sup> The best way to accomplish this, according to the Missouri Supreme Court, was to require the surrogate to back up a claim that the patient would want life support to be withdrawn by clear and convincing evidence.

The Supreme Court's analysis failed to consider Missouri's particularly stringent interpretation of informed consent. The common law doctrine of informed consent requires a voluntary decision by a competent patient with a clear understanding of the risks and benefits of the proposed treatment.<sup>50</sup> As interpreted by the Missouri Supreme Court, however, "informed consent" is virtually impossible to prove in a case like *Cruzan's*, because any remarks a person might make

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47. See, e.g., *In re Conroy*, 486 A.2d 1209, 1220 (N.J. 1985) ("To err either way—to keep a person alive under circumstances under which he would rather have been allowed to die, or to allow the person to die when he would have chosen life—would be deeply unfortunate.").

48. *Cruzan*, 110 S. Ct. at 2852.

49. *Id.*

50. *Cruzan*, 760 S.W.2d at 417.

about treatment she would desire once she lapsed into a persistently vegetative state would be hypothetical. In holding that "it is definitionally impossible for a person to make an informed decision—either to consent or to refuse—under hypothetical circumstances,"<sup>51</sup> the Missouri court places the patient in an impossible situation. Even if the patient clearly expressed her desires while competent, her wishes would reflect no understanding of her existence as an incompetent person.

The Missouri court's analysis does have the merit of recognizing the complexity of a seemingly obvious question: "What would the patient want?" Personhood is dynamic, changing through time to such an extent that an individual might be seen as becoming a different person when she faces the life-support decision.<sup>52</sup> One might wonder, for example, whether the remarks of a twenty year-old person about life-sustaining treatment could accurately capture her feelings about life and death fifty years later. In fact, the extraordinary experience of becoming incompetent could itself effectively generate a "new person" with radically different preferences.<sup>53</sup> Yet, carried to its logical conclusion, this analysis undercuts the very idea of respecting the incompetent's wishes. Instead of honoring the hypothetical—and unreliable—expressions of the formerly competent individual's wishes, the court would have to examine the patient's desires as those of a new person, transformed in ways that the individual might have foreseen but could not have understood.<sup>54</sup> The court would have to ask what the patient would want now, in her new incarnation as an incompetent, rather than ask what she imagined she would want while she was competent. It is unclear what could guide the court. As a new person, her old values would give inadequate guidance, yet as an incompetent, she could not communicate her new values.<sup>55</sup>

The Missouri court's approach helps little if understood to rest upon individual assertions of personhood. On the other hand, the Supreme Court understood the clear and convincing evidence standard as a mechanism for respecting the desires the patient expressed

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51. *Id.*

52. See Rebecca Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373, 379 (1986).

53. *Id.* at 381.

54. *Id.* at 390.

55. *Id.* at 390-91 (advocating behavioral and physiological studies to understand the nature of an incompetent patient's existence). Such an approach risks interpreting the patient's expressions, in whatever form they are made, through our own understanding of what existence is and should be. Just as the patient herself could not realize the nature of incompetence, we ourselves cannot.

while competent, to "safeguard the personal element of . . . choice."<sup>56</sup> However, the evidentiary standard is a poor mechanism to effectuate that aim. It interferes with respect for individual choice and imposes the state's choice by default. The ostensible purpose of the heightened evidentiary burden is to shift the risk of an incorrect decision to parties who bring disfavored claims.<sup>57</sup> Yet "maintenance of the status quo"<sup>58</sup> is as harmful to a patient who would like to refuse medical treatment as terminating life-support is to a patient who wishes to persist.<sup>59</sup> If the Court allows the withdrawal of life-sustaining treatment only when clear and convincing evidence reveals what the patient would want, then inevitably there will be cases where an incompetent patient would want treatment withdrawn but continues to receive treatment because the evidentiary standard was not met. Such a result forces the patient to remain in a persistently vegetative state and distorts her image in the eyes of her loved ones.<sup>60</sup> More important, the Court's analysis presumes that, absent a clear prior directive, the incompetent patient would want to remain vegetative until her organs failed.<sup>61</sup> As this presumption is relaxed, the standard's potential for reaching the incorrect outcome—supporting the patient against the patient's wishes—increases proportionately. Thus, the Court mistakenly analyzes the risk of error in decisionmaking; "maintenance of the status quo" often means continuing the injury to the very liberty interest that the Court has recognized.<sup>62</sup>

Finally, the clear and convincing standard cannot be justified as necessary to "guard against potential abuses."<sup>63</sup> The Court feared that the patient's family would not always act in the patient's best interests.<sup>64</sup> As is typical, the Court reviewed the case as though the

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56. *Cruzan*, 110 S. Ct. at 2853.

57. *Id.* at 2871 (Brennan, J., dissenting).

58. *Id.* at 2854.

59. *See id.* at 2873 (Brennan, J., dissenting) ("An erroneous decision to terminate artificial nutrition and hydration, to be sure, will lead to failure of that last remnant of physiological life, the brain stem, and result in complete brain death. An erroneous decision not to terminate life-support, however, robs the patient of the very qualities protected by the right to avoid unwanted medical treatment.").

60. *See id.* at 2873, 2873-74 (Brennan, J. Dissenting) (arguing that improved medical techniques will factor into the analysis when they arise).

61. *See id.* at 2890 (Stevens, J., dissenting) (stating that the majority "assumes either that the State's policy is consistent with Nancy Cruzan's own interests, or that no damage is done by ignoring her interests.").

62. *See id.* at 2854.

63. *Id.* at 2853.

64. *Id.* at 2853 ("And even where family members are present, '[t]here will, of course, be some unfortunate situations in which family members will not act to protect a patient.'") (citing *In re Jobes*, 529 A.2d 434, 477 (N.J. 1987)).

family might be ill-intentioned,<sup>65</sup> although the facts indicated otherwise. If indeed such abuse really occurred, the court-appointed guardians ad litem would assist in addressing it.<sup>66</sup> The Supreme Court found that the guardians ad litem did not act "the least bit improperly" by believing that Nancy's interests coincided with the judgment of the family.<sup>67</sup> Nevertheless, the Court believed that, even with a good-faith guardian, the adversarial process might fail in such cases.<sup>68</sup> The adversarial process may be an awkward method of uncovering the patient's desires, but a heightened evidentiary burden is a faulty means of adjusting it. Such a burden only increases the difficulty of uncovering the patient's desires, not adversity between the participants.

## 2. THE STATE'S UNQUALIFIED, INDEPENDENT INTEREST IN LIFE

The Supreme Court held that Missouri could maintain an interest in prolonging an individual patient's life, less regard of its quality: "[W]e think a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert *an unqualified interest in the preservation of human life* to be weighed against the constitutionally protected interests of the individual."<sup>69</sup> That interest, the Court ruled, allows a state to deny termination of life-sustaining treatment absent clear and convincing evidence of the patient's desire.

This interest in the "sanctity of life"<sup>70</sup> addresses the danger that the state will define a person "by what the individual can *do* or *feel*, rather than by reference to their nature: that is, what they *are*."<sup>71</sup> Sanctity of life advocates claim that by redefining a person's rights

65. The Court notes that "[n]o doubt is engendered by anything in this record but that Nancy Cruzan's mother and father are loving and caring parents." *Id.* at 2855. Several other courts have expressed similar fears, though their fears also did not arise from the facts themselves. *See, e.g., In re Jobes*, 529 A.2d 434, 447 (N.J. 1987) (anticipating "unfortunate circumstances in which family members will not act to protect a patient" will be exceptional).

66. *See Cruzan*, 110 S. Ct. at 2872 (Brennan, J., dissenting) (discussing the efficacy of a guardian ad litem).

67. *Id.* at 2853 n.9. The guardians ad litem appealed the case to the Missouri Supreme Court, despite feeling that Cruzan's desires matched those of the family. *Id.*

68. *Id.*

69. *Id.* at 2853 (emphasis added).

70. The term "sanctity of life" was used in the Missouri Supreme Court. *See Cruzan v. Harmon*, 760 S.W. 408, 419 (Mo. 1988). For an earlier review of the sanctity-of-life principle in light of modern bioethical issues, see Daniel Callahan, *The Sanctity of Life*, in *UPDATING LIFE AND DEATH* 181 (Donald R. Cutler ed., 1968).

71. Robert A. Destro, *Quality-of-Life Ethics and Constitutional Jurisprudence: The Demise of Natural Rights and Equal Protection for the Disabled and Incompetent*, 2 J. CONTEMP. HEALTH L. PUB. POL. 72, 97 (1986).



according to a judgment of what an individual's quality of life should be, the law might well cease to protect a class of the "manifestly unfit."<sup>72</sup> In this view, any willingness to consider a vegetative patient's quality of life is the first step toward the complete abrogation of individual rights.<sup>73</sup>

Although the concern for the sanctity of life is legitimate, when taken to an extreme, as it was in *Cruzan*, it leads to dangerous results. Two considerations conflict with the declaration that all life is sacred without regard to the quality of that life. First, such a policy ignores the individual values that give meaning to each person's existence. Indeed, for the state to tell a person that she must live despite her inability to see, hear, taste, smell, feel, or think may desecrate her conception of life as well as her family's. Second, an attempt to implement a policy that favors preserving life without qualification would impose absurd burdens on medical resources. Ultimately, the limitation of those resources itself imposes qualifications on the preservation of life.

The sanctity of life approach fails to recognize the values people place on the full range of human experience. Life for most of us means thinking, feeling, touching, and communicating.<sup>74</sup> "Life" for the persistently vegetative patient is profoundly different. The term vegetative state denotes "unconsciousness with persistent brain-stem functions that maintain subsistence functions and often wakefulness."<sup>75</sup> Although organs operate, "[p]ersonality, memory, purposive action, social interaction, sentience, thought, and even emotional states are gone."<sup>76</sup> "Life" for Nancy Beth Cruzan meant atrophying muscles, contracting arms and legs, and fingernails cutting into her wrists.<sup>77</sup> "Eating" meant having a gastronomy tube surgically

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72. Destro traces the evolution of quality of life decisionmaking from *Dred Scott v. Sanford*, 60 U.S. 393 (1857), through *Buck v. Bell*, 274 U.S. 200, 203 (1927) (Holmes, J.) (permitting sterilization of a retarded woman and noting that "[i]t is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind"), and ultimately *Roe v. Wade*, 410 U.S. 113 (1973). Destro, *supra* note 70, at 99-115.

73. See *In re Estate of Longeway*, 549 N.E.2d 292, 313 (Ill. 1989) (Clark, J., dissenting) (discussing attitudes toward nonrehabilitative persons leading to World War II atrocities); see also Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969, 1030-41 (1958) (criticizing euthanasia as the first step towards the "parade of horrors").

74. See *Cruzan*, 110 S. Ct. at 2886 (Stevens, J., dissenting) ("Life, particularly human life, is not commonly thought of as a mere physiological condition or function.").

75. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT* 174 n.9 (1983) [hereinafter *DECIDING TO FOREGO TREATMENT*].

76. *Id.* at 174-75.

77. Brief of the A.M.A., *supra* note 7, at 5.

implanted into her stomach so that nutritional formula could be pumped directly into her gastrointestinal tract.<sup>78</sup> "Medical care" meant blood testing and regular monitoring of her weight and fluids to prevent the problems that gastrointestinal tubes can create—the obstruction of the intestinal tract, erosion and piercing of the stomach wall, leakage into the abdominal cavity, and other gastrointestinal problems.<sup>79</sup> "Daily routine" for Nancy Beth Cruzan meant frequent turning and padding to prevent skin sores,<sup>80</sup> and the application of wet-to-dry dressings or sharp dissection to clear cellular debris, prevent infection, and control any lesions that arose.<sup>81</sup> Nancy Beth Cruzan, herself completely unconscious of her state, potentially could have persisted this way for thirty years.<sup>82</sup>

In short, the Court's disdain for evaluating the quality of life ignores the reality that life *is* a range of qualities.<sup>83</sup> Modern medicine has shown that life encompasses a spectrum of existence, from the vivacious to the comatose,<sup>84</sup> vegetative,<sup>85</sup> brain dead,<sup>86</sup> and circulation dead.<sup>87</sup> The definition of life must be updated to include those forms of life created by medical technology.<sup>88</sup> By keeping the definition constant while medical technology redefines the quality of life, courts deny protection to the newly created class of those who are technically alive but are incapable of higher consciousness or social interaction.<sup>89</sup>

The moral and theological status of the persistently vegetative person ultimately turns upon one's personal philosophy or theology.

78. *Id.*

79. Other potential problems were vomiting, diarrhea, and pneumonia from reflux of the stomach's contents into the lung. *Id.* at 14-15.

80. DECIDING TO FOREGO TREATMENT, *supra* note 75, at 291.

81. *Id.*

82. Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2845 n.1 (1990).

83. See Robert S. Morison, *Death: Process or Event?*, in DEATH INSIDE OUT 63, 66 (Peter Steinfelds & Robert M. Veatch eds., 1975) (describing death as "part of a continuous process that is coextensive (almost) with living").

84. The term "coma" is used imprecisely, but generally refers to a state of impaired consciousness. DECIDING TO FOREGO TREATMENT, *supra* note 75, at 174 n.9.

85. See *supra* note 9.

86. "Brain death" refers to the permanent loss of all brain functions. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DEFINING DEATH 22-24 (1981) [hereinafter DEFINING DEATH].

87. "Circulation death" refers to the cessation of the flow of bodily fluids. *Id.* at 41.

88. See Cruzan v. Director, Mo. Dep't of Health, 110 S. Ct. 2841, 2883-87 (1990) (Stevens, J., dissenting) (discussing definition of life and death in the wake of advanced medical technology).

89. See PHILIPPE ARIES, THE HOUR OF OUR DEATH 583-88 (1981) (discussing "medicalization" of death arising from technological advancements that allow the medical establishment control over the duration of death though it is unable to restore health).

By some persons' conceptions of life and death, Nancy Cruzan was dead, despite the medical community's definition of life.<sup>90</sup> Yet the state successfully asserted a right to keep Nancy's organs functioning, even if it meant disrespecting her wishes. This outcome is especially ironic in light of Missouri's purported "interest in the sanctity of life itself."<sup>91</sup> The term "sanctity" suggests that the value of life lies precisely in the moral and spiritual values that Missouri overrode, and not in the mere fact of physical functioning.<sup>92</sup> Yet the Court's decision essentially ignores Nancy's beliefs and imposes those of the state.<sup>93</sup>

Moreover, the implications of an unqualified state interest in the preservation of life are enormous. Read broadly, the majority opinion allows the state to defy even a competent patient's decision to refuse life-sustaining treatment.<sup>94</sup> The state could impose life-saving treatment against the patient's own wishes, if it was in her presumed "best interests."<sup>95</sup> Considering the unqualified, independent state interest in

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90. See, e.g., Brief of the General Board of Church and Society of the United Methodist Church as Amicus Curiae in Support of Petitioners at 5, *Cruzan v. Director, Missouri Dep't of Health*, 110 S. Ct. 2841 (1990) (No. 88-1503) ("First, life should not be assessed in purely medical terms. Life and health, as *amicus* understands them, are an integration of the spiritual, emotional, and physical aspects of being."); see also Jeff McMahan, *Death and the Value of Life*, 99 ETHICS 32, 54-56 (1988) (life's value stems from experience and psychological connectedness to an identity).

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

92. See *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2886-87 (1990) (Stevens, J., dissenting) ("Life, particularly human life, is not commonly thought of as merely a physiological condition or function. Its sanctity is thought to derive from the impossibility of any such reduction.").

93. Despite the centrality of afterlife to religious devotion, claims of freedom of religion in this context have been ignored since they were rejected in *In re Quinlan*, 355 A.2d 647, 661-662 (N.J.) (noting that in free exercise of religion analysis "[t]he public interest is . . . considered paramount without essential dissolution of respect for religious beliefs"), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976). However, the courts often consider religious beliefs when evaluating the patient's presumed desires in the right to die analysis. See, e.g., *In re Conroy*, 486 A.2d 1209, 1230 (N.J. 1985) (citing *Storar* and noting expression of intent could be derived from religious views); *In re Storar*, 420 N.E.2d 64, 72 (N.Y. 1981) (finding Brother Fox's expressed desire not to have medical treatment "is supported by his religious beliefs and is not inconsistent with his life of unselfish religious devotion"); see also *Cruzan*, 110 S. Ct. at 2885 n.15 (Stevens, J., dissenting) (discussing afterlife).

94. The majority opinion noted a Fourteenth Amendment liberty interest in the refusal of medical treatment generally, but questioned its application in the refusal of life-sustaining treatment. *Cruzan*, 110 S. Ct. at 2851-52.

95. Prior caselaw indicates that a state can force medical treatment upon a patient when the decision to refuse treatment seems non-autonomous. See *TRIBE*, *supra* note 4, § 15-11, at 1363 (noting cases in which parents refuse treatment to children for religious reasons, or the patient was mentally ill). But a competent patient's contemplated decision to refuse treatment is another matter; in such a situation, the courts seem more willing to allow refusal of treatment, despite the resulting death of the patient. *Id.*; see also, e.g., *Bartling v. Superior*

life, the state could conceivably intervene to support life even against the patient's expressed wishes; or the state could forbid a patient from undergoing dangerous surgery that would not lengthen life and might result in death, but, if successful, would vastly increase the individual's quality of life.<sup>96</sup>

An unqualified interest in the preservation of life would also call into question the practice of refraining from resuscitating certain patients. Hospitals began formulating policies not to resuscitate certain patients following "the recognition by professional organizations that non-resuscitation was appropriate when well-being would not be served by an attempt to reverse cardiac arrest."<sup>97</sup> Doctors implement "No Code" or "Do Not Resuscitate" ("DNR") orders after consulting competent patients or the families of incompetent patients.<sup>98</sup> The courts have supported such policies.<sup>99</sup> The primary consideration in deciding not to resuscitate is the patient's medical condition, evaluated by the likelihood of the "restoration of *health* or *satisfactory function*"—an evaluation that apparently examines the patient's quality of life.<sup>100</sup> In states that declare an unqualified interest in life, a doctor could be negligently or indeed intentionally homicidal in ordering non-resuscitation.<sup>101</sup> By its very terms, an unqualified inter-

Court, 209 Cal. Rptr. 220 (Cal. Ct. App. 1984) (allowing non-terminally ill, competent person to refuse life-sustaining treatment); *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990) (same).

96. See DECIDING TO FOREGO TREATMENT, *supra* note 75, at 73. Consider a persistently vegetative patient who will die soon without some additional treatment. One hypothetical procedure will potentially increase the patient's lifespan for thirty years, with a ten percent chance of immediate death during the operation. Presumably the state would permit such a procedure, which by quantitative analysis essentially adds twenty-seven years of life. However, using the state's concept of life itself as an absolute good, the same outcome is reached where the procedure is ninety-nine percent likely to fail, and life will only be prolonged for a month, or even a day—the unqualified interest in life implies an unqualified desire to preserve it. See 110 S. Ct. at 2870 (Brennan, J., dissenting) (discussing adverse consequences of policy of using "heroic measures if there is a scintilla of a chance that the patient will recover").

97. DECIDING TO FOREGO TREATMENT, *supra* note 75, at 236.

98. *Id.* at 494-500 (outlining resuscitation policies of the Bar Association of San Francisco Medical Society, Medical Society of the State of New York, Medical Association of the State of Alabama, and the Minnesota Medical Association).

99. The *Quinlan* court implied that the use of a DNR order would be protected as a "medical decision." *In re Quinlan*, 355 A.2d 647, 657 (N.J.), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976). The Arizona Supreme Court, faced with the issue directly, permitted the use of the order. *Rasmussen v. Fleming*, 741 P.2d 674 (Ariz. 1987) (supporting DNR order for persistently vegetative nursing home patient). See also *In re Dinnerstein*, 380 N.E. 134 (Mass. App. 1978). But see *In re Storar*, 420 N.E.2d 64 (N.Y. 1981) (refusing to decide whether prior judicial approval is required for such termination of treatment).

100. DECIDING TO FOREGO TREATMENT, *supra* note 75, at 495 (statement by the No Code Subcommittee, Medical-Legal Interprofessional Committee, Bar Association of San Francisco Medical Society) (emphasis added).

101. See Bernard L. Siegel, *Perspectives of a Criminal Prosecutor*, in BY NO

ent in life does not differentiate between an act of commission, such as the removal of life support, and an act of omission, such as the failure to resuscitate.<sup>102</sup>

Indeed, the state could require doctors to take affirmative steps to preserve the "life" of those in a persistently vegetative state. Artificial organ surrogates, such as mechanical hearts and lung machines, could be used to maintain the bodily functions of persistently vegetative patients, even though such a practice would divert those resources from other patients. The persistently vegetative could receive organ transplants. If two patients required an organ, but only one were available, the quality of life of the vegetative patient could be ignored in the decision. Indeed, if the state's interest were carried to its natural conclusion, the state could redistribute society's resources to maximize the quantum of life. It could maintain brain-dead bodies to harvest needed organs.<sup>103</sup> The state's interest might justify the removal of a persistently vegetative patient's organs or tissues to save another life as long as the vegetative donor would persist.<sup>104</sup>

To be sure, the Missouri Supreme Court attempted to avoid such absurd possibilities by limiting its analysis to patients who are not terminally ill. Asserting an interest in the prolongation of the life of the individual patient, the court borrowed a formula from *Brophy v. New England Sinai Hospital*:<sup>105</sup>

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EXTRAORDINARY MEANS: THE CHOICE TO FORGO LIFE-SUSTAINING FOOD AND WATER 155, 156 (Joanne Lynn ed., 1986) ("[I]f a medical practitioner engages in conduct which is intentional and planned and which necessarily, deliberately, and intentionally causes someone to die, then that practitioner can be prosecuted for homicide, regardless of the good faith with which that conduct is undertaken."). An act of omission rather than commission may not entail intent that the patient would die, though the removal of life-supporting treatment certainly would. However, given the high probability, if not certainty, that death would result, an act of omission entails reckless disregard for the patient's life at the very least. Ultimately there would be only a question of the degree of criminality that society would assign to the act. Nevertheless, courts reject the prosecution of doctors in right to die cases. See, e.g., *Barber v. Superior Court*, 195 Cal. Rptr. 484 (Cal. Ct. App. 1983); *In re Quinlan*, 355 A.2d 647 (N.J.), cert. denied sub nom. *Garger v. New Jersey*, 429 U.S. 922 (1976).

102. See DECIDING TO FOREGO TREATMENT, *supra* note 75, at 73-77 (discussing the lack of an ethical distinction between acts of commission and omission). In a similar vein, Justice Scalia noted the "irrelevance of the action-inaction distinction," though in the context of suicide: "It would not make much sense to say that one may not kill oneself by walking into the sea, but may sit on the beach until submerged by the incoming tide . . ." *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2861 (1990) (Scalia, J., concurring).

103. See *Strachan v. John F. Kennedy Memorial Hosp.*, 538 A.2d 346 (N.J. 1988) (hospital supported brain-dead body while trying to convince family to donate organs following their refusal).

104. See *Cruzan*, 110 S. Ct. at 2869 n.13 (Brennan, J., dissenting) (arguing independent state interests would justify taking tissues from and performing experiments on vegetative patients).

105. 497 N.E.2d 626 (Mass. 1986).

The concern for the preservation of the life of the patient normally involves an interest in the prolongation of life. Thus, the state's interest in preserving life is very high when "human life [can] be saved where the affliction is curable." That interest wanes when the underlying affliction is incurable and "would soon cause death regardless of any medical treatment." The calculus shifts when the issue is not "whether, but when, for how long, and at what cost to the individual that life may be briefly extended."<sup>106</sup>

Thus, the court concluded that "[t]he state's interest in prolonging life is particularly valid in Nancy's case" because she "is not terminally ill."<sup>107</sup> But, given that the state has an unqualified interest in life, the prognosis of the patient should have been irrelevant.<sup>108</sup>

In *Cruzan* and cases like it, a tension exists between the policies of prolonging life and ignoring its quality. There can be no "calculus shifting" or interest that is "particularly valid" without examining the quality of the individual patient's life, at least in terms of her probability of persisting.<sup>109</sup> The Missouri Supreme Court avoided this tension by noting that Nancy Cruzan was not terminally ill, and thus both the prolongation of Cruzan's life and the state's unqualified interest in life coincided.<sup>110</sup> But the moment the court moved from exclusive reliance on its sanctity of life position, qualitative criteria infected the court's analysis. Eventually the court will have to address the tension squarely, while faced with the demands of a patient who *is* terminally ill and who, through her family, wishes to reject life-sustaining treatment. In such a case the court will likely retreat from its sanctity of life position by allowing the patient's quality of life, implicitly or explicitly, to justify terminating treatment.<sup>111</sup> In short, the strict sanctity of life position, relied upon by the Missouri Supreme Court and upheld by the U.S. Supreme Court, is untenable.

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106. *Id.* at 635 (quoting Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 425-26 (Mass. 1977) and Commissioner of Corrections v. Meyers, 399 N.E.2d 452, 456 (Mass. 1979)), quoted in *Cruzan*, 760 S.W.2d at 419.

107. *Cruzan*, 760 S.W.2d at 419.

108. Apparently the Missouri Supreme Court felt this tension as well. Ironically, after adopting the *Brophy* calculus, later in its opinion the same majority criticized that decision for discounting the state's interest. *Id.* at 421-22.

109. See *TRIBE*, *supra* note 4, § 15-11, at 1366-68, 1368 n.24 (noting the tension between preservation of life and ignorance of the quality of life in *Brophy*); see also *Cruzan*, 760 S.W.2d at 421-22 (citing *TRIBE* with approval).

110. *Cruzan*, 760 S.W.2d at 424.

111. See, e.g., Superintendent of Belchertown v. Saikewicz, 370 N.E.2d 417 (Mass. 1977) (refusing to consider quality of life while evaluating probability of remission, age, and painfulness of treatment).

### C. Critique of the Dissents

The two dissenting opinions in *Cruzan* each deliver the same message: the state should attempt to defer right to die decisionmaking to the private sphere. Justice Brennan's dissent advocates a substituted judgment method, relying almost exclusively upon the family while the court simply examines the family's decisionmaking for abuse.<sup>112</sup> In contrast, Justice Stevens proposes a best interests approach, in which the court would decide whether or not treatment would continue in light of the patient's condition and values.<sup>113</sup> Although under Justice Stevens' approach the court seems to govern decisionmaking exclusively, a deeper examination reveals that the court determines best interests by evaluating the patient's interests in privacy and personhood, which in turn are determined by the family's description of the patient's preferences. Thus, although the means differ, the aim of each method is to protect a private sphere of autonomy. This aim is unworkable.

Justice Stevens stated that "the Constitution requires the State to care for Nancy Cruzan's life in a way that gives appropriate respect to her own best interests."<sup>114</sup> This statement, of course, begs the questions of what Nancy's best interests are, and how they are discovered. Though Stevens' opinion does not explicitly answer these questions, his analysis underscores the conclusions of the trial judge, who found that Nancy had no cognitive ability or possibility of recovery,<sup>115</sup> and the guardians ad litem, who considered termination of treatment to be in Nancy's best interests.<sup>116</sup> Thus, a patient's prognosis and quality of life, decided by independent parties, are material in deciding her best interests. Stevens also accepted the clear and convincing standard,<sup>117</sup> but not the state's interest in life independent of Nancy's own interest.<sup>118</sup> The best interests method thus requires a court to make substantive choices about treatment, given the limitations of the patient's present state, but informed by the individual's values.

Because the court ultimately controls which of the patient's values will be considered and how they will be weighed, the best interests method risks being paternalistic. While the court may claim that it

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112. See *infra* notes 116-28 and accompanying text.

113. See *infra* notes 129-33 and accompanying text.

114. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2879 (1990).

115. *Id.* at 2879 n.2, 2879-80 (Stevens, J., dissenting) (outlining the trial court's findings about Nancy's physical condition).

116. *Id.* at 2880 & n.6 (Stevens, J., dissenting) (describing the guardian ad litem's finding that removal of Nancy's gastrointestinal tube was in her best interests).

117. *Id.* at 2889.

118. *Id.* at 2890.

seeks to determine what would be best for the patient in terms of the patient's own values, the trial judge's values may in fact enter into the court's decision.<sup>119</sup> More careful scrutiny indicates that an element of paternalism may be justified—indeed, required—for the sake of liberty.<sup>120</sup> To be sure, if the court entirely ignores the individual's values, it denies the very liberty interest that it intends to protect.<sup>121</sup> The ideal of pure respect for another person's wishes ignores the fact that individual preferences are often shaped by circumstances, constraints of information, and other factors.<sup>122</sup> To that extent, preferences are nonautonomous, and there is no a priori reason to accord them absolute respect. It is doubtful, for example, that a competent person can *fully* fathom the experience and meaning of being in a persistently vegetative state, at least not without far more sustained reflection than many people are likely to give the matter.<sup>123</sup> For that reason, the court may properly discount the patient's own wishes in some cases, even if in so doing the judge's own values may enter into the best-interests calculus. In that sense, the decision to terminate or continue life support will always be paternalistic. By rejecting an independent state interest in life, Stevens rejects the wholesale substitution of the state's values, but by accepting the heightened evidentiary burden, Stevens promotes the procedural "paternalism" that examines the basis of proposed desires of the patient to be sure they are a product of individual autonomy to the extent possible.

The best interests analysis depends upon the interests defined by the patient herself. Stevens' sharpest criticisms of the Missouri

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119. Indeed, to the extent that judges attempt to consider the patient's values through the lens of a "reasonable person" under the best interests standard, they increase the probability of displacing the patient's own needs and values. See Dresser, *supra* note 52, at 383 (noting that, by trying to objectify the patient's interests, "judicial opinions have at times incorrectly attributed to the incompetent patient the concerns of others, raising questions about whose interests the court decisions actually serve"); Rhoden, *supra* note 23, at 398-403 (criticizing the objective analysis of best interests for examining only the patient's present, physical condition).

120. Paternalism is justified where, for example, the patient's desires arise from a distorted view of reality. See Sunstein, *supra* note 4, at 1171; see also *infra* notes 280-90 and accompanying text (describing the potential for erroneous death decisions once the right-to-die becomes firmly entrenched).

121. This has been the chief criticism of the best interests approach. See *TRIBE*, *supra* note 4, § 15-11, at 1367-68. The criticism breaks down in cases where the patient was born incompetent. Compare *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626, 633 (Mass. 1986) with *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977).

122. See Sunstein, *supra* note 4, at 1138-39 (cataloguing distorted preferences that may justify government intervention).

123. See *supra* notes 278-80 and accompanying text (discussing the inability of a competent person to fathom the state of being incompetent).



Supreme Court's decision—its denial of Nancy's own conceptions of life and death<sup>124</sup> and its adoption of an unqualified interest in life for symbolic effect<sup>125</sup>—arise because those actions are truly paternalistic. To define best interests without invoking the patient's own values tacitly substitutes the state's values for those of the patient. Stevens chastises the Missouri Supreme Court for creating an "opposition of life and liberty" by neither defining Nancy's life "by reference to her own interests," nor questioning whether "Nancy Cruzan herself defined life to encompass every form of biological persistence by a human being."<sup>126</sup> Such references to the patient's values indicate that the "best interests" analysis is a court-appraised judgment of Nancy's own wishes.

Justice Brennan's dissent is less complex, outlining two roles for the state, both of which safeguard the patient's autonomy through procedural mechanisms. First, where the patient has expressed intentions regarding treatment, the state as *parens patriae*<sup>127</sup> should determine those intentions as accurately as possible and, if need be, effectuate them.<sup>128</sup> Second, where it is not possible to ascertain the patient's treatment decision, the state should ensure that at least the surrogate decisionmaker would be the patient's choice, excluding any person with improper motives.<sup>129</sup> The state itself should resolve treatment decisions only in the exceptional case where the patient had no relative or other suitable proxy.<sup>130</sup> The decision is thus made by the patient through her family or another designated person, either as an instrumentality of the patient's intentions or as a proxy for the patient. In Brennan's view, the family's dominant role is justified in the first instance because the testimony of family members best indicates the patient's desire, and in the second, because the family members' bonds with the patient place them in a better position than the

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124. See *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2885-86 (1990) (Stevens, J., dissenting).

125. *Id.* at 2889.

126. *Id.* In this passage, Stevens emphasized that life could be defined by "any of her own interests," or the persistently vegetative state would define her life if there were "any evidence" that was her wish. *Id.* The use of such a minimal basis for best-interests decisionmaking could, of course, lead to paternalism. Justice Stevens may have merely been emphasizing the Missouri Court's ignorance of Cruzan's own values.

127. *Parens Patriae*, "literally 'parent of the country,' refers to role of state as sovereign and guardian of persons under legal disability." BLACK'S LAW DICTIONARY 1003 (5th ed. 1979). In its role as *parens patriae*, the court decides what is in the "best interests" of an incompetent patient. See, e.g., *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 425 (Mass. 1977).

128. *Cruzan*, 110 S. Ct. at 2871 (Brennan, J., dissenting).

129. *Id.* at 2877.

130. *Id.*

state to decide for the patient.<sup>131</sup>

In practice, the best interests and substituted judgment tests will often resemble each other. In applying the "best interests" test, the trial court found that Nancy was irrecoverably, persistently vegetative, that she did not want to be medically supported (at least as well as anyone could tell), and that no other significant interests beyond those of the family and the hospital was involved.<sup>132</sup> Upon these determinations of fact, the judge empowered Nancy's parents, as her guardians, to terminate treatment.<sup>133</sup> Thus in practice, at least in *Cruzan*, the trial court's role in its "best interest" determination closely tracks the role espoused by Brennan, in which the court seeks to perform the patient's wishes and prevent abuses. The practical resemblance ends, however, where the patient is incompetent and terminally ill, but conscious. Under the best interests test, the patient's state of consciousness would evince a greater realm of possibilities—a higher "quality of life" that the court must consider, even if the family's values dictate otherwise. In that event, Stevens's best interests construct might not empower the family, whereas Brennan's method would.<sup>134</sup> Despite these differences, however, both the dissents' schemes seek to defer to the individual, to the individual through the family, or to the family itself.

Although the dissenting opinions empower those persons closest to the patient, they ignore the more difficult issue of who in fact is, or who should be, closest. Inevitably, the court empowers someone. By the very nature of its role, the court distributes decisionmaking authority, even in those instances where it ostensibly does not empower anyone.<sup>135</sup> To take the extreme examples, compare Justice Scalia's treatment of the *Cruzan* case with that of Justice Brennan. In response to the family's challenge, derivatively in the name of the patient, Justice Scalia would dismiss the case, and thereby reaffirm the alignment of power in the status quo—that is, in favor of the medical establishment, which refused to terminate the treatment, or the State

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131. *Id.*

132. See *Cruzan v. Harmon*, 760 S.W.2d 408, 432-34 (Mo. 1988).

133. See *id.* at 434 ("In this case the Court acts only to authorize the Co-guardians to exercise our Ward's constitutionally guaranteed liberty to request the Respondents to withhold nutrition and hydration. The Co-guardians are required only to exercise their legal authority to act in the best interests of their Ward as they discharge their duty and are free to act or not with this authority as they may determine.").

134. Compare 110 S. Ct. at 2889 n.22 (Stevens, J., dissenting) (state's interests increase as patient's level of consciousness rises) with 110 S. Ct. at 2877 (Brennan, J., dissenting) (empowering the proxy in every event).

135. MARTHA MINOW, MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION, AND AMERICAN LAW 328 (1990).

of Missouri, which imposed its independent ideological interest in life.<sup>136</sup> On the other hand, Justice Brennan would defer to private decisionmaking by merely authorizing the proxy whom the patient would have chosen. But even this deference empowers select individuals to perform as surrogates to the exclusion of others who may wish to make the decision, thereby profoundly affecting those who claim affinity with the patient. Thus, the notion of the state's refraining from intervention is illusory.<sup>137</sup> The state and the family are intimately and inextricably interrelated.

### III. DEFINING THE PATIENT'S FAMILY

The courts intuitively turn to the family when choosing an incompetent patient's surrogate decisionmakers.<sup>138</sup> Family members seem to be the best authorities, even if the court cannot know that their views would match those of the patient, because there is no "reason to suppose that a State is *more* likely to make the choice that the patient would have made than someone who knew the patient intimately."<sup>139</sup> The persons with whom the patient had formed mutual emotional bonds "treat the patient as a person, rather than a symbol of a cause."<sup>140</sup>

Not every family, however, consists of such loving and caring persons.<sup>141</sup> Indeed, the family can be—and often is—the locus of violence and sexual abuse, hidden from view all the more effectively

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136. In his concurrence, Justice Scalia stated that "the federal courts have no business in this field"; that is, the Due Process Clause does not govern a state's regulation of the life and death of its citizens. *Cruzan*, 110 S. Ct. at 2859. Regulatory abuses are prevented by "the Equal Protection Clause, which requires the democratic majority to accept for themselves and their loved ones what they impose on you and me." *Id.* at 2863.

137. See generally Frances E. Olsen, *The Myth of State Intervention in the Family*, 18 U. MICH. J.L. REF. 835 (1985) (arguing that the state's treatment of the family is too incoherent to justify the notion of a private sphere of family life).

138. Legislatures instinctively turn to the family as well. See, e.g., IND. CODE ANN. § 16-8-12-4(a)(2) (Burns 1990) (authorizing "a spouse, parent, adult child, or adult sibling unless disqualified" where an incompetent patient has not appointed a health care representative and there is no judicially appointed guardian); *In re Lawrance*, 579 N.E.2d 32 (Ind. 1991) (interpreting the Indiana Code as allowing the family to terminate medical treatment without court intervention).

139. *Cruzan*, 110 S. Ct. at 2877 (Brennan, J., dissenting).

140. *Id.* (quoting *In re Jobes*, 529 A.2d 434, 445 (N.J. 1987)).

141. To some extent, both the majority and the dissenting opinions in *Cruzan* recognized this. *Cruzan*, 110 S. Ct. at 2855; *id.* at 2877 (Brennan, J., dissenting); *id.* at 2890 (Stevens, J., dissenting) (agreeing with the Court that "in some cases there may be a conflict between the interests of an incompetent patient and the interests of members of her family"). Indeed, in asserting that "a State generally must either repose the choice with whom the person would most likely have chosen as proxy or leave the decision to the patient's family," Justice Brennan implies that the family should have authority, but only if there is no preferable surrogate. *Id.* at 2877 (Brennan, J., dissenting).

because it is deemed private.<sup>142</sup> Doubtless, the parents who abuse their infant to the point of brain death should not have the same state support for their relationships as loving parents.<sup>143</sup> Chronic illness itself is an event that precipitates changes in attachment and detachment in the conventional family.<sup>144</sup> Consequently, the courts must use norms more penetrating than kinship in analyzing the relationship between the incompetent patient and those who claim control over the patient's destiny.

By authorizing persons to make life and death decisions solely on the basis of their marriage or kinship relation to the patient, courts risk the possibility that family members will disregard the patient's own treatment preferences or best interests. One example is the case of Christine Busalacchi, a woman on the same ward at the Missouri Rehabilitation Center ("MRC") as Nancy Cruzan.<sup>145</sup> Although Christine obviously was severely impaired, the extent of her brain damage was unknown.<sup>146</sup> The MRC refused to perform an extensive neurological diagnosis on her, claiming it was not essential to her treatment.<sup>147</sup> The Center intended to discharge Christine, but her father could not secure placement for her at a nursing home in Missouri.<sup>148</sup> Christine's father sought to remove her for treatment in Minnesota, which allows greater discretion in ending treatment.<sup>149</sup> The local probate judge approved the decision made between the family and the physician despite a lack of clear evidence of the patient's wishes. Impressed by the dialogue between the family and the physician, the judge commented, "[The doctor] didn't say one word about

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142. Studies of domestic violence reveal abuse of spouses, children, and parents. See, e.g., MILDRED D. PAGELOW, *FAMILY VIOLENCE* (1984) (general study of family abuse); ELIZABETH PLECK, *DOMESTIC TYRANNY* (1987) (tracing history of society's treatment of family violence in the United States); see also John C. Koski, Comment, *Idaho v. Wright: The Defenestration of Corroborating Evidence*, 46 U. MIAMI L. REV. 205, 206-07 (1991) (describing sexual abuse in *Wright*).

143. Compare *Alvarado v. New York City Health & Hosps. Corp.*, 547 N.Y.S.2d 191 (Sup. Ct. 1989) (court permitted removal of life support where Jehovah's Witness parents disputed hospital's determination of infant's death), *order vacated*, *Alvarado v. City of New York*, 550 N.Y.S.2d 353 (App. Div. 1990) with *Dority v. Superior Court*, 1193 Cal. Rptr. 288 (Dist. Ct. App. 1983) (life support for brain-dead child over the objection of parents charged with child abuse).

144. See Amy H. Gervasio, *Family Relationships and Compliance*, in *COMPLIANCE: THE DILEMMA OF THE CHRONICALLY ILL* 98 (Kenneth E. Gerber & Alexis M. Nehemis eds., 1986) (discussing the effects of chronic illness on relationships among family members).

145. *Father Wins a Ruling on Right to Die*, N.Y. TIMES, Dec. 18, 1991, at A15.

146. In 1987, Christine was diagnosed as being in a persistently vegetative state, but the State altered its position when it challenged her removal. *In re Busalacchi*, No. 59582, slip. op. at 11 (Mo. Ct. App. March 5, 1991).

147. *Id.* at 3.

148. *Id.*

149. *Id.* at 3-4.

the courts. . . . I think that's the way it should be and the way it has been since time immemorial."<sup>150</sup>

In a split decision, the Missouri Court of Appeals reversed and remanded, holding that the state may forbid a guardian to remove his ward from Missouri, absent evidence that removal is in the ward's best interests.<sup>151</sup> The appellate court was troubled that Christine's father may not have been acting in her best interests, despite the trial judge's finding that the guardian's primary purpose was not to remove the feeding tube.<sup>152</sup> The court expressly challenged the motives of Christine's father: "[W]e will not permit [the] guardian to forum shop in an effort to control whether Christine lives or dies."<sup>153</sup>

The *Busalacchi* case illustrates the potential difficulties that arise in an unexamined delegation of control to the family. The trial judge's comment revealed his feelings about how such decisions should be made: where the doctor and the family agree, the court should not intrude. But this approach is unworkable for two reasons. First, courts cannot take for granted who "the family" is. Second, courts cannot ignore the possibility that whoever the family may be, its motivations may be questionable. To be sure, the court's concern should not automatically be that those who have an emotional bond will act to relieve their own grief. If the patient and loved one shared a bond of mutual care, relieving the loved one's grief would be in the interests of the patient as well.<sup>154</sup> The more compelling concern arises from the possibility that the family member is acting not out of an emotional tie with the incompetent patient, but with more selfish motives, or even if in good faith, under the pressures created by society that makes health care a major personal financial burden.

### A. *The Form and Substance of the Family*

The problems that *Busalacchi* illustrates stem from the state's

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150. *Father Wins a Ruling on Right to Die*, *supra* note 145.

151. *In re Busalacchi*, No. 59582, slip. op. at 16-17 (Mo. Ct. App. March 5, 1991). Interestingly, the court distinguished *Cruzan*, in an effort to isolate the patient's Fourteenth Amendment rights from the guardian's privileged position as a delegatee of the State's *patris patriae* authority. *Id.*

152. *Id.* at 5-6.

153. *Id.* at 17. The possibility of forum shopping reveals a complication with leaving solutions to the protection of the patient's liberty interest to "the 'laboratory' of the States." *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. at 2859 (O'Connor, J., concurring) (citation omitted). *Busalacchi* reveals a tension between the heightened requirements for the right to die and the more easily enjoyed constitutional right to interstate travel. See *Busalacchi*, slip. op. at 28-29 (citing U.S. CONST. amend. XIV and *Bigelow v. Virginia*, 421 U.S. 809 (1975)).

154. See *Cruzan*, 110 S. Ct. at 2892 (Stevens, J., dissenting).

treatment of the family as a timeless association of nurturing parents and children. The Supreme Court views the family relationship as so well-founded by tradition that it repeatedly supports the family's role in substantive due process cases, implying family rights from beyond the text of the Constitution.<sup>155</sup> For example, in *Pierce v. Society of Sisters*<sup>156</sup> the Supreme Court refused to allow

any general power of the State to standardize its children by forcing them to accept instruction from public teachers only. The child is not the mere creature of the State; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for additional obligations.<sup>157</sup>

The traditional, nuclear family consists of a household of parents and their children.<sup>158</sup> The role of the family as educator and nurturer of the child, however, is a particularly modern phenomenon. For example, during the middle ages, children did not go to school.<sup>159</sup> Rather, they learned a trade by apprenticeship with a virtual stranger.<sup>160</sup> The communal nature of the village in medieval times facilitated this relationship.<sup>161</sup> When the medieval period ended and schooling substituted for apprenticeship in social initiation, the modern concept of the family's role in the child's direction took hold.<sup>162</sup> Thus, the school's and the family's duty as educator arose coincidentally, around the seventeenth century.<sup>163</sup> Finally, in the eighteenth century, the modern family surfaced as an enclave apart from society.<sup>164</sup>

The contrast between the structure of the family now and in the medieval age reveals that the family is a social organization of a form

155. See, e.g., *Griswold v. Connecticut*, 381 U.S. 479, 486 (1965).

156. 268 U.S. 510 (1925).

157. *Id.* at 535.

158. Dictionary meanings reflect our common perceptions of "family." Family "[m]ost commonly refers to group of persons consisting of parents and children; father, mother, and their children; immediate kindred, constituting fundamental social unit in a civilized society." BLACK'S LAW DICTIONARY 543 (5th ed. 1979). Similarly, Webster's defines family as the "household," but alternatively "a social unit consisting of parents and the children that they rear." WEBSTER'S NEW WORLD DICTIONARY 505 (2d ed. 1980). More precisely, however, this is the conventional "nuclear" family; the extended family consists of those related by kinship.

159. PHILLIPE ARIES, CENTURIES OF CHILDHOOD 367 (1962) (noting that schooling was reserved for the clergy).

160. *Id.* at 366.

161. *Id.* at 366-69.

162. *Id.* at 369-70.

163. *Id.* at 370, 403 ("[T]he modern family originated at the same time as the school, or at least as the general habit of educating children at school.").

164. *Id.* at 406. Novel health objectives of the eighteenth century also buttressed the formation of the family's role as child-rearer. See MICHEL FOUCAULT, *The Politics of Health in the Eighteenth Century*, in POWER/KNOWLEDGE 166, 173 (Colin Gordon ed. & Colin Gordon et al. trans., 1980).

varying through history and among cultures.<sup>165</sup> Though this social unit seems "natural," in part because it appears to arise from biological reproduction, "nature" is a poor justification for the family.<sup>166</sup> Ultimately, the nuclear family can legitimate itself only by serving the needs of its members for mutual, emotional security, and society's need to train its children.<sup>167</sup> When the nuclear family fails to meet these needs, new social forms must replace it.<sup>168</sup>

Because the family itself is indeterminate, courts can never simply defer to the family. Indeed, through family-rights discourse, the courts themselves constitute the family by defining its legitimate roles.<sup>169</sup> The instrumentality of the family effectively defines a person by channeling him or her into a prevailing structure of obligations and rights, then attaching associated tasks and rewards to the individual's self-definition.<sup>170</sup> Not only do the courts provide a means of

165. See STEPHANIE COONTZ, *THE SOCIAL ORIGINS OF PRIVATE LIFE* 13, 13-18 (1988) (describing family as "a way of organizing or symbolizing certain kinds of group interactions in terms of personal relations").

166. *Id.*; see also MICHELE BARRETT & MARY MCINTOSH, *THE ANTI-SOCIAL FAMILY* 26-29 (1982); *id.* at 34-40 (noting that biology does not, and indeed should not, dictate social organization and control).

167. BARRETT & MCINTOSH, *supra* note 166, at 21-26.

168. If indeed the form of the nuclear family's replacement will be definite, it is presently unresolved. Considering society's present state of rapid change, the "postmodern family" is almost an oxymoron. See JUDITH STACY, *BRAVE NEW FAMILIES* 16-19 (1990); see also Katharine T. Bartlett, *Rethinking Parenthood as an Exclusive Status: The Need for Legal Alternatives When the Premise of the Nuclear Family has Failed*, 70 VA. L. REV. 879 (1984) (arguing that the modern disintegration of the nuclear family requires a broader concept of parenthood).

169. The substantive due process cases illustrate the Court's individualizing discourse. In *Poe v. Ullman*, 367 U.S. 497, 546 (1961), Justice Harlan provided an evocative discussion:

The laws regarding marriage which provide both when the sexual powers may be used and the legal and social context in which children are born and brought up, as well as laws forbidding adultery, fornication and homosexual practices which express the negative of the proposition, confining sexuality to lawful marriage, form a pattern so deeply pressed into the substance of our social life that any Constitutional doctrine in this area must build upon that basis.

If the laws are a "pattern pressed into the substance of our social life," beneath this pattern are the individualizing forces that such discourse produces: the adulterer, the fornicator, the homosexual, and indeed, the child and the married persons.

Similarly, in *Griswold v. Connecticut*, 381 U.S. 479, 486 (1965), the Court's discourse reinforces an individualizing concept of proper sexual and social interaction:

Marriage is a coming together for better or for worse, hopefully enduring, and intimate to the degree of being sacred. The association promotes a way of life, not causes; a harmony in living, not political faiths; a bilateral loyalty, not commercial or social projects. Yet it is an association for as noble a purpose as any involved in prior decisions.

By announcing a right to privacy arising from "an association for as noble a purpose as any," Justice Douglas unfortunately propagates an ignoble, excluded class along with a presumed "traditional" one.

170. See COONTZ, *supra* note 165, at 13-17; see also FOUCAULT, *HISTORY OF SEXUALITY*,

identifying individuals within the family, thereby relegating them to a particular social position; they also effectively differentiate, exclude, and disempower individuals outside the family.<sup>171</sup> The concept of family defines its members in relation both to each other and to society.<sup>172</sup> To the extent that family-rights discourse alters our self-perception by propagating unreflective acceptance of a social unit as legitimate and unchanging, it increases the likelihood that we will ignore the true values upon which we should base treatment decisions. Family-rights discourse does not harm merely by wrongfully including or excluding certain decisionmakers. It also harms by bidding us to treat as fixed and unchanging what is socially constructed and potentially contested.

The courts have tended to propagate this discourse, viewing the family as a fixed social form without regard to its substantive effects.<sup>173</sup> The Supreme Court invoked this formal approach in *Michael H. v. Gerald D.*,<sup>174</sup> a case that highlights the inadequacy of simple reliance on marriage or blood ties in defining the family. In

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*supra* note 4, at 212 (Power “applies itself to immediate everyday life which categorizes the individual, marks him by his own individuality, attaches him to his own identity, imposes a law of truth on him which he must recognize and which others have to recognize in him.”). For some, the family’s greatest *benefit* to society is its individualization of its members:

When the legal system . . . protects such relationships as kinship and formal marriage, it advances not only the individual interests involved, but society’s interest in social and political structures that sustain long-term individual liberty. . . . [T]he structure of marriage and kinship responds to that social interest by maximizing the interest of children and society in a stable family environment; by ensuring a socialization process and an attitude toward personal obligation that maximizes democracy’s interest in the voluntary “public virtue” of its citizens; by maintaining marriage and kinship as legally recognizable structures that mediate between the individual and the State, thereby limiting governmental power; and by maintaining sources of objective jurisprudence that will ensure stable personal expectations and encourage generality of laws, thereby minimizing the arbitrary power of the State.

Bruce C. Hafen, *The Constitutional Status of Marriage, Kinship, and Sexual Privacy—Balancing the Individual and Social Interests*, 81 MICH. L. REV. 463, 559 (1983).

171. Michel Foucault deems this phenomenon “identification.” FOUCAULT, *THE HISTORY OF SEXUALITY*, *supra* note 4, at 42-43.

172. See COONTZ, *supra* note 165, at 13-17; FOUCAULT, *HISTORY OF SEXUALITY*, *supra* note 4, at 221, 222 (“The exercise of power consists in guiding the possibility of conduct and putting in order the possible outcome.”).

173. The court’s method of applying rights and duties strictly by relation of blood, adoption, or marriage is the “formal approach.” Note, *Looking for a Family Resemblance: The Limits of the Functional Approach to the Legal Definition of Family*, 104 HARV. L. REV. 1640, 1644-45 (1991); see also Olsen, *supra* note 137, at 847-48. The courts conceive of the family as a private sphere, but in fact they do not consistently treat it as an autonomous body. *Id.* at 842-46. See generally Lee E. Teitelbaum, *Family History and Family Law*, 1985 WIS. L. REV. 1135 (reviewing judicial treatment of the family and concluding that the public/private distinction is unhelpful).

174. 109 S. Ct. 2333 (1989)



that case, Michael sued to establish paternity of his alleged natural daughter, Victoria.<sup>175</sup> The child was born while her mother was married to Gerald, and an 1872 California statute established that a child born within a marriage is the product of the marriage. Justice Scalia's plurality opinion rejected Michael's substantive due process claim because the relationship of a natural, extramarital father is not "treated as a protected family unit under the historic practices of our society."<sup>176</sup>

The case might not have been exceptional if Michael were simply an "outsider," disrupting the family and frustrating the best interests of the child. But Michael H. was "almost certainly Victoria D.'s natural father, lived with her as her father, contributed to her support, and from the beginning sought to strengthen and maintain his relationship with her."<sup>177</sup> Moreover, Victoria's father-by-marriage lived apart from her for years, while her mother continued an intermittent relationship with Michael.<sup>178</sup> In dissent, Justice Brennan criticized the plurality for using tradition to mask the more difficult issue of the norms presumed by its ruling and their relation to the facts of the case.<sup>179</sup> The importance of tradition is not to define the interests that society will protect, but rather to indicate those values that society considers important. Rather than the "unitary family," society traditionally protects the parent-child relationship, where it is marked by emotional commitment and responsibility.<sup>180</sup>

Another case, *Alison D. v. Virginia M.*,<sup>181</sup> illustrates a "natural," biological justification of the formal approach. Alison and Virginia were lesbian partners who, after having a relationship for a few years, decided to have a child. The two planned the conception and agreed to share the rights and responsibilities of parenthood. Virginia became pregnant by artificial insemination and ultimately gave birth. For two years and four months the couple raised the child together, but ultimately they ended their relationship. Alison continued to visit

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175. Blood tests established a 98.07% probability that Michael was the father. *Id.* at 2337.

176. *Id.* at 2342.

177. *Id.* at 2352 (Brennan, J., dissenting).

178. *Id.* at 2337.

179. *Id.* at 2349 ("Because reasonable people can disagree about the content of particular traditions, and because they can disagree even about which traditions are relevant to the definition of 'liberty,' the plurality has not found the objective boundary that it seeks.") (Brennan, J., dissenting). The "objective boundary" to which Justice Brennan refers is a form of judicial restraint, attempting to forbid "judges to substitute their own preferences for those of elected officials." *Id.* Formalism gives the illusion of judicial restraint, when in reality it is an unexamined imposition the judge's presupposed norms.

180. *Id.* at 2352.

181. 572 N.E.2d 27 (N.Y. 1991).

the child, who referred to each parent as "Mommy," until Virginia terminated all such interaction. When Alison sued for visitation rights, the New York Court of Appeals affirmed the trial court's dismissal and refused to recognize her as a parent: "[S]he is not the biological mother of the child nor is she a legal parent by virtue of an adoption."<sup>182</sup> Ostensibly deferring to the legislature, the court refused to "read the term parent . . . to include categories of nonparents who have developed a relationship with a child or who have had prior relationships with a child's parents and who wish to continue visitation with the child."<sup>183</sup>

The danger of empowering certain persons as family members is that it may exclude other "loved ones" with whom the patient has a mutual emotional bond. This situation occurs primarily in so-called "non-traditional" relationships, where the loved one was neither married to the patient nor a member of the patient's conventional family. In some cases there is no dispute, because the family and the loved one agree on what the patient would want or what would be in the patient's best interests.<sup>184</sup> But if the family and the loved one disagree, their conflict can erupt into a bitter battle for control of the patient, leaving the loved one disempowered and without legal recourse.

Such a conflict arose over Sharon Kowalski, who was left physically and mentally impaired by an automobile accident.<sup>185</sup> Sharon's

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182. *Id.* at 29.

183. *Id.* The dissent responded that the legislature had never defined "parent" specifically, and the court could easily have interpreted the term to effectuate the legislative purpose of supporting the best interests of the child. *Id.* at 31.

There is a stunning contrast between the New York court's formal approach in this case and its more reasoned, normative approach in *Braschi v. Stahl Assocs.*, 543 N.E.2d 49 (N.Y. 1989). See *infra* notes 201-03 and accompanying text; see also Note, *supra* note 173, at 1648-50 (contrasting *Braschi* with the formalism of the Appellate Division's decision in *Alison D. v. Virginia M.*, 552 N.Y.S.2d 321 (1990), *aff'd*, 572 N.E.2d 27 (N.Y. 1991)). Perhaps the distinction is that *Braschi* dealt with housing and *Alison D.* with child custody, which is obviously more central to the conventional concept of family. Consequently, the New York Court of Appeals may have believed that broadening the definition of family in the child custody setting would be a radical departure from existing social values, reflected in prior statutory interpretations. See *Alison D.*, 572 N.E.2d at 29 ("While one may dispute in an individual case whether it would be beneficial to a child to have continued contact with a nonparent, the Legislature did not . . . give such nonparent the opportunity to compel a fit parent to allow them to do so."). As Associate Judge Judith S. Kaye asked, "How would we not be fundamentally redefining the term 'parent' throughout the statutory law and case law of the State of New York?" Kevin Sack, *Crux of Visitation Case: Definition of Parenthood*, N.Y. TIMES, Mar. 24, 1991, at Y20.

184. See *Conservatorship of Drabick*, 245 Cal. Rptr. 840 (Ct. App. 1988) (four brothers and unmarried partner agreed that patient would want to discontinue life support).

185. *In re Guardianship of Kowalski*, 382 N.W.2d 861 (Minn. Ct. App. 1986). Sharon Kowalski's accident left her confined to a wheelchair, able to communicate only by hand and

four-year partner and lesbian lover, Karen Thompson, petitioned to become her guardian. Sharon Kowalski's father cross-petitioned for the appointment.<sup>186</sup> The court initially found "each to be a suitable and qualified person to discharge the trust," but by agreement of the parties, Sharon Kowalski's father became the guardian, while both had equal access to medical and financial records, the right to consult with medical and financial personnel, and visitation rights.<sup>187</sup> At one point, after the relationship between Karen Thompson and Sharon Kowalski's father deteriorated, Karen Thompson lost her rights on behalf of Sharon, including visitation, because the court found that Thompson's presence was not in Sharon's "best interest."<sup>188</sup>

The father's initial success in *Kowalski* stemmed from medical evidence that Sharon became depressed after Karen Thompson's visits.<sup>189</sup> But the language and rationale of the opinion were extraordinary. The court essentially agreed with the father's assertion that "his confirmation as guardian is proper because he is the ward's father and therefore has unconditional parental love for his daughter."<sup>190</sup> The father's relationship was presumptively legitimate and beneficial to the incompetent patient, whereas the homosexual lover's position needed the support of the ward's choice.<sup>191</sup> Since Sharon Kowalski was incompetent, she could not effectively make a choice, and the

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facial movements, and with the mental capacity of a child between four and six years old. *Id.* at 863.

186. *Id.* at 863.

187. *Id.*

188. *Id.* at 864. Sharon's father, Donald Kowalski, objected to Karen Thompson's role at least in part because of his rejection of homosexuality: "It's just not a normal life style. The Bible will tell you that." Nan D. Hunter, *Sexual Dissent and the Family*, 253 *NATION* 406, 408 (1991). He also described Thompson to reporters as "an animal" who was lying about his daughter's lesbianism. *Id.*

189. *Kowalski*, 382 N.W.2d at 864. The Missouri Court of Appeals noted, however, that "[a] pattern has developed indicating that Thompson's visits may produce significant responses from the ward, but the ward regularly experiences depression and moodiness following Thompson's visits." *Id.* at 866. Stated this way, the end of Thompson's visit could have been the cause of the depression as easily as the visit itself. See David Link, *The Tie that Binds: Recognizing Privacy and the Family Commitments of Same-Sex Couples*, 23 *LOY. L.A.L. REV.* 1055, 1138 (noting support for the possibility that "Sharon missed Thompson when she was gone"). The opinion, however, focuses strictly upon the effect of depression rather than its cause. *Id.*

190. *Kowalski*, 382 N.W.2d at 865. Thompson argued that she was effectively Kowalski's spouse. *Id.* Though the court did not discredit that argument entirely, it considered "the strong confidential relationship which exists between parent and child" to be as or more important. *Id.*

191. *Id.* The language of the opinion revealed the court's homophobia. The court discounted the strength of the relationship by referring to Thompson as Sharon's "friend" and "roommate," and stating that their lesbian relationship was merely "claimed," even though the two exchanged rings and named one another as beneficiaries of life insurance. *Id.* at 863; see also Link, *supra* note 189, at 1136. Compare *In re Guardianship of Friedman*, No. C2-91-

court would not recognize the legitimacy of her partner's position.<sup>192</sup> Thus, initially the court allowed the father, with some supporting medical evidence,<sup>193</sup> to dominate the incompetent patient and, derivatively, her loved one.

Ultimately Karen Thompson received guardianship over Sharon Kowalski, but only after the Minnesota Court of Appeals found the trial court's refusal of Thompson's renewed petition to be clearly erroneous.<sup>194</sup> Sharon Kowalski's father had to remove himself as guardian due to his own medical problems, but the family nevertheless continued to oppose Thompson's appointment by trying to install a "neutral third party" as successor.<sup>195</sup> At first the family was successful: the trial court appointed Karen Tomberlin, a friend of the Kowalskis, to be guardian.<sup>196</sup> In its reversal, the Minnesota Court of Appeals noted that "Thompson and Sharon are a family of affinity, which ought to be accorded respect,"<sup>197</sup> ending seven years of litigation that Karen Thompson described as "a nightmare."<sup>198</sup>

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1047, 1991 WL 263225, at \*1 (Minn. Ct. App. Dec. 17, 1991) (noting early in the opinion that Karen Thompson was Sharon Kowalski's lesbian partner).

192. *Kowalski*, 382 N.W.2d at 865.

193. As Kowalski's guardian, the father had a duty to limit the ward's personal freedom "only to the extent to provide needed care and services." *Id.* at 866 (quoting MINN. STAT. § 525.56(3)(6) (1984)). The court could only grant to the guardian or conservator necessary powers to fulfill demonstrated needs. *Id.* However, prompted by Kowalski's physicians, the court determined that "[q]uietude [was] essential to a patient's recovery or improvement and in the patient's best interests." *Id.* at 866. Moreover, the ward was incompetent; even if Sharon Kowalski could effectively communicate her desire to continue the visits, "the reliability of her responses [was] uncertain." *Id.* at 867. Reactions of excitement or depression from her association with Thompson were equivalently unhealthy. Since Kowalski needed quiet, and quiet was incompatible with free association, the father could exclude visitation rights entirely.

194. *Friedman*, No. C2-91-1047, 1991 WL 263225.

195. *Id.* at \*5.

196. *Id.* at \*5-6. The ruling of the Minnesota Court of Appeals revealed the trial court's bias against Karen Thompson. It noted that Tomberlin, the "neutral" third party, as hardly impartial; she testified that "her first and primary goal as guardian was to relocate Sharon . . . close to her family." *Id.* at \*6. Moreover, the trial court chose Tomberlin without questioning Tomberlin's relationship with or ability to care for Sharon, *id.* at \*5, and without formal petition or sufficient notice to the parties. *Id.* at \*6. The Minnesota Court of Appeals found that "the record is clear that at all times, the focus of the evidentiary hearing was to evaluate Thompson's qualifications to be guardian, not to evaluate the qualification of Tomberlin." *Id.* at \*5.

197. *Id.* at \*7. The court also based its holding on medical evidence that Sharon Kowalski was competent to choose and in fact did choose Karen Thompson, and that Thompson was an able caretaker. *Id.* It approved of Thompson's revelation of the lesbian relationship, but for *medical* reasons: "[I]t is crucial for doctors to understand who their patient was prior to the accident, including that patient's sexuality." *Id.* at \*6.

198. Ruben Rosario, *Lesbian Wins Right to Care for Disabled Lover*, N.Y. TIMES, Dec. 18, 1991, at 9A, col. 3.

### B. *Loved Ones and the Normative Approach to Family*

The immediate danger of the courts' protection of marriage and kinship is the possibility that it will obscure deeper concerns of right to die decisionmaking. The incompetent patient needs substitute decisionmakers with her best interests in mind, who will also consider her values. Relatives by blood or marriage may indeed be the correct persons to make such a determination. However, they are not automatically so. Treating relatives as if they are the presumptively proper decisionmakers increases the probability that the incompetent patient will suffer a wrongfully motivated decision. It also excludes from the decisionmaking process other loved ones whose values may be more harmonious with those of the patient.

In order to avoid the harm of an unexamined delegation of power to the family, courts should examine the norms upon which the family is based. Love, according to one philosopher, is formed by the mutual surrender of the individual personality.<sup>199</sup> The family is an intuitively appealing decisionmaker because we consider it marked by love; it represents the caring, mutually supportive relationships that we value most. Society's preconceptions, however, should not dictate the outcome of family-rights disputes. Rather, the court should preserve the individual's own long-term relationships by identifying the characteristics that society admires in such relationships, such as long-term emotional commitment and interdependence, and use them to analyze the dispute in question.<sup>200</sup> The judiciary must continue to articulate society's values, but apply them in a less formal way.

The New York Court of Appeals' decision in *Braschi v. Stahl Associates*<sup>201</sup> is an excellent example of such an approach. In *Braschi*, the court judged the issue of whether a New York City regulation denying the right of the landlord to dispossess "either the surviving spouse of the deceased tenant or some other member of the deceased tenant's family" would apply to protect a homosexual partner of ten

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199. Georg W.F. Hegel, *Introduction to the Philosophy of History*, in *THE EUROPEAN PHILOSOPHERS FROM DESCARTES TO NIETZSCHE* 537, 574 (Monroe Beardsley ed., 1960). This conception of love is platonic, removed from sexuality to whatever extent is possible. A feminist critique might deem mutual compassion a more apt description. See Ruth Colker, *Feminism, Theology, and Abortion: Toward Love, Compassion, and Wisdom*, 77 *CAL. L. REV.* 1101, 1022-28 (1989) (defining "love" as "the experience of intimate interconnectedness, including but not limited to sexual love," and "compassion" as "a fully empathetic attitude").

200. One analysis describes this as the "functional approach." Note, *supra* note 173, at 1646. However, the method does not examine the relationship to determine whether it fulfills a particular function analogous to one of the traditional nuclear family. Instead it seeks those values that society chooses should be preserved, without regard to their existence in the traditional family. Thus, the "normative approach" is more apt.

201. 543 N.E.2d 49 (N.Y. 1989).

years.<sup>202</sup> Resolving the case in the partner's favor, the court applied a progressive four-part test of "family" which examined "the exclusivity and longevity of the relationship, the level of emotional and financial commitment, the manner in which the parties have conducted their everyday lives and held themselves out to society, and the reliance placed upon one another for daily family services."<sup>203</sup>

Two basic criticisms might be made of such a normative approach. The first, offered by the *Braschi* dissent, focuses on the highly subjective nature of the test.<sup>204</sup> The court offered little guidance for its determination of family status beyond a "totality of the relationship" standard. Such a loose standard allows courts to disregard the wishes of an incompetent patient's loved ones by ruling according to their preconceptions of family. For example, a judge faced with the facts in *Kowalski* could find that Kowalski's father had a longer and more exclusive relationship with his daughter than did her lesbian lover of four years. The conventional family, in that case, would merely assume a new discourse.

This argument, however, assumes that courts will be left with near-unfettered discretion in deciding what a family is. It ignores the fact that, once the courts indicate a willingness to look beyond the confines of a traditional definition, people with nontraditional relationships to the patient are more likely to insist that the courts recognize their claims. The more the new form of family is accepted, the more the previously excluded loved ones will consider themselves entitled to participate in their loved one's treatment decisions. The heightened awareness of non-traditional relationships reshapes individual preferences, and perhaps ultimately, social norms themselves.<sup>205</sup> The courts themselves will not be immune to such reshaping.

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202. *Id.* at 49.

203. *Id.* at 60 (citations omitted).

204. *Id.* at 67 (Simons, J., dissenting). For comprehensive reviews of the *Braschi* decision, see Eileen Kaspar, Comment, *Braschi v. Stahl: Family Redefined*, 8 N.Y.L. SCH. J. HUM. RTS. 289 (1990); Mary F. Gardner, Note, *Braschi v. Stahl Associates Co.: Much Ado About Nothing?*, 35 VILL. L. REV. 361 (1990).

205. Simply put, people tend to want only what they realize they can get. Professor Cass Sunstein calls this phenomenon of "adaptive preferences." Sunstein, *supra* note 4, at 1146-50. Traditional gender and class roles use adaptive preferences as a means of reducing civil unrest, to preserve the status quo. *Id.* at 1154. Sunstein's theories of ideology and adaptive preferences thus resemble Foucault's theories of power and discourse. Compare *supra* note 4 (discussing Foucault's theories). By changing the traditional roles, or at least recognizing other roles, the government allows persons to form their desires more freely. Sunstein, *supra* note 4, at 1154; cf. David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research*, 45 U. MIAMI L. REV. 979 (1991) (advocating the use of the therapeutic aspects of the legal process).

The second criticism of the normative approach is that it requires the court to make rulings beyond its competence—that is, on whether the patient and the potential surrogate were bound by a loving relationship. As a fundamental aspect of our self-definition, love constitutes one's personhood, arguably something that a court is or should be unfit to determine. A court's decision that someone does or does not love the patient is intuitively distasteful. If the court errs, its ruling is now doubly hurtful: the court, as the mouthpiece of society, has told you that you do not love someone you really do.

This criticism fails to recognize that, although they are an aspect of personhood, interpersonal relationships exist in the vortex of society.<sup>206</sup> Persons involved in disputes over an incompetent patient's desires cannot escape public scrutiny. In such disputes, the court inevitably judges the potential surrogate's relationship with the patient. Presently, tacit presumptions about the traditional family dominate that judgment. The real issue is whether finding true loved ones outside of presumptions about the family justifies the additional intrusiveness of evaluating the relationship between the patient and the potential surrogate.

The court is no more unfit to decide such a matter of compassion than it is any other issue. The judiciary faces its recurring epistemological paradox: it must determine who has a subjective and thus unknowable value, like love, through objective, knowable criteria, like shared commitments. As in all the tests of mental states, the court ultimately defines the abstractions, like intent, *mens rea*, or love, using their socially recognized manifestations.<sup>207</sup> Inevitably the decision of an individual case rests upon evaluations of the parties' manifestations of mutual devotion. By requiring love and describing the badges of love, the court promotes such compassion and its incidents.<sup>208</sup> We

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206. Aspects of personhood are never free from conflict unless they are entirely self-regarding. See Rubinfeld, *supra* note 3, at 758. As defined here, love requires mutuality—love *between* the patient and surrogate—and therefore it cannot be exclusively personal. In the context of right-to-die analysis, love is important only to the extent that it is shared between the patient and the surrogate. A person who feels unreciprocated compassion for a patient is presumably incapable of truly understanding the desires of the patient.

207. Indeed, since all mental states are unknowable abstractions, legal effects essentially arise from acts themselves, interpreted through social generalizations. Cf. Peter M. Tiersma, *The Language of Offer and Acceptance: Speech Acts and the Question of Intent*, 74 CAL. L. REV. 189 (1986) (proposing that speech acts govern the issue of intent in contract formation).

208. In the past, the Supreme Court considered voicing the fundamental values of our society as its essential role. The language of the Court in cases such as *Griswold v. Connecticut*, 381 U.S. 479 (1965), which found a married couple's right to contraception among the "penumbras" of the bill of rights, indicates that the justices had this perception of their role. See Schnably, *supra* note 4, at 862-63; see also ALEXANDER BICKEL, *THE LEAST DANGEROUS BRANCH* 109 (1962) (noting that the Court must apply "society's fundamental

should prefer a doctrine centered around love, or another normative "good," to one that depends strictly upon form.

#### IV. DEFINING THE PATIENT'S DEATH

Some consider death, like family, a biological or natural fact. Increasingly, however, death is recognized as something society defines. The recent formulation of "brain death" in response to advances in medical technology is one example. Less often recognized is the definition of death that emerges from the struggle for control of the patient as her loved ones and the medical establishment each seek to employ the power of the state.

*Cruzan* illustrates the medical establishment's potential for control over the patient's loved ones. The loved ones,<sup>209</sup> like the members of Nancy Cruzan's family, are emotionally and psychologically bound to the patient. But the medical establishment effectively controls the patient and, through the loved ones' emotional bond with the patient, the loved ones as well. The hospital not only controls the medical care that the patient needs, it also controls the medical knowledge that defines that need. When the hospital tells Nancy Cruzan's father that she has hope for recovery, and that it needs his consent to treat her, he naturally signs the form.<sup>210</sup> But ultimately Nancy does not recover, and her loved ones conclude that issues are no longer *medical*—that is, beyond their control—but *familial*.<sup>211</sup> The hospital administration refuses to terminate treatment without a court order, and conflict ensues.<sup>212</sup> At this point the parties enter a less structured realm of behavior in which they struggle for control.

Exercising what Foucault has called "bio-power," the state allo-

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principles"). To be sure, there are troubling implications for a democratic government when the ostensibly "least dangerous branch" of unelected officials announces our central values. See generally JOHN H. ELY, *DEMOCRACY AND DISTRUST* chs. 2-3 (1980) (criticizing constitutional interpretivism and the implausibility of realizing "fundamental" values). Even when courts avoid or reject such a role, however, inevitably they shape our values. See *supra* notes 169-72 (noting the normative effects of court decisions about the family). Since laws do order our preferences to some degree, lawmakers—including the courts—should lead in promoting welfare and autonomy. See Sunstein, *supra* note 4, at 1172 (noting the legislatures should pass laws, and courts should invalidate them, in order to promote autonomy).

209. Hereinafter the term "loved ones" will refer to those individuals that have established a substantial and reciprocal emotional bond with the patient. The term is distinguishable from "family," a group related by marriage and kinship. See *supra* notes 139-54 and accompanying text (distinguishing the conventional family and loved ones).

210. See Brief for Petitioners at 7, *Cruzan v. Director, Missouri Dep't of Health*, 110 S. Ct. 2841 (1990) (No. 88-1503). Both Nancy's father and her husband (later divorced) issued authorizations. *Id.*

211. *Id.* at 8.

212. *Id.*



cates control and thereby constitutes the loved ones' relation to the medical establishment, as well as to the rest of society.<sup>213</sup> Faced with the conflict between the medical establishment and the loved ones, the court must ultimately empower one over the other.<sup>214</sup> Either the loved ones will control, and give death their own meaning, or the medical establishment will control, and death will become "medicalized"—controlled by the medical bureaucracy and its technology. By strictly subscribing to the medical definition of brain death, the state initiates the medicalization of the death of the incompetent patient.<sup>215</sup> The patient becomes an object, supported by the gastronomic tube and monitored by the electroencephalograph, while the loved ones look on in submission to medical authority.<sup>216</sup>

In *Cruzan*, Justice Brennan correctly recognized that this "status quo" is the result of the state empowerment of the medical establishment, but nevertheless he concluded that the state can defer to the individual in order to allow a natural result:

Artificial delivery of nutrition and hydration represents the "status quo" only if the State has chosen to permit doctors and hospitals to keep the patient on life-support systems over the protests of his family or guardian. The "status quo" absent that state interference would be the natural result of his accident or illness (and the family's decision).<sup>217</sup>

This assertion illustrates two fallacies similar to those inherent in the courts' treatment of family.<sup>218</sup> First, the notion of "state interference" is defective because the state cannot merely refuse to intervene. Inevitably the courts must resolve disputes over terminating life support. Second, the patient's death is not a "natural" result, or to the extent that it is, the distinction between nature and artifice is morally

213. As Michel Foucault notes, "[f]or a long time, one of the characteristic privileges of sovereign power was the right to decide life and death." FOUCAULT, *HISTORY OF SEXUALITY*, *supra* note 4, at 135. The raw exercise of power reflected by the control over death later developed into its more subtle, modern form—"bio-power"—or the regulation of life through the control of health care. *Id.* at 139-43. From a Foucauldian perspective, recent technology that has brought about new forms of life simply highlights a power relation that has extended throughout history.

214. See MINOW, *supra* note 135, at 328.

215. See Eric J. Cassell, *Dying in a Technological Society*, in *DEATH INSIDE OUT*, *supra* note 83, at 43, 46-47 (describing hospital's depersonalization of dying).

216. *Id.*

217. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2873 n.17 (1990) (Brennan, J., dissenting). Note the statement reveals a misconception of the power relation. The state does not "interfere"; its role is intimately connected to the production of the medical establishment's relation to the family. By permitting hospitals to deny the family's wishes, the state subordinates the family. But by refusing to allow hospitals to deny the family's wishes—what Justice Brennan might consider "nonintervention"—the state empowers the family.

218. See *supra* Part III.

unimportant.<sup>219</sup> We cannot simply ignore the fact that our society has the means to support the ill.<sup>220</sup> Beyond this, however, the passage reveals a presumption that death is a purely biological event, when in fact we only understand death through our society.

#### A. *The Constitution of Death as a Medicalized Event*

Death poses the unique existential dilemma. It is unique, in part, because it is unknowable. Whether it is a transformation into nothingness or immortality, the experience of death has never been related, at least not to most. Indeed, what little we "know" consists of beliefs that, though supported by historical evidence, cannot be confirmed by actual experience.<sup>221</sup> Such induction may inform us of the nature of dying until the moment of death, but beyond that moment, death is so alien to our experience that it can neither be known nor understood.<sup>222</sup>

The unknowable quality of death gives it a character that is at once profoundly personal and utterly social. In one sense, death is private because it cannot be shared or even known in advance. The anxiety we each will suffer alone in the face of our unknowable fate "must give us pause."<sup>223</sup> Yet to cope with the anxiety caused by the unknown, societies have developed rituals that help individuals cope with death.<sup>224</sup> These rituals, which are shared by those with personal

219. See ROBERT M. VEATCH, *DEATH, DYING, AND THE BIOLOGICAL REVOLUTION* 286-89 (1976) (noting that use of description of "natural" death obscures normative issues).

220. Ignoring the ability to preserve the patient reinstates the dubious ethical distinction between neglecting to care for a dying patient and actively removing the patient's care, or indeed, causing the patient to die. See *supra* note 102 and accompanying text.

221. BERTRAND RUSSELL, *THE PROBLEMS OF PHILOSOPHY* 60-69 (1912), reprinted in *AN INTRODUCTION TO PHILOSOPHICAL INQUIRY* 565-69 (Joseph Margolis ed., 2d ed. 1978).

222. Upon the moment of death, an observer may still inductively draw conclusions about non-life; for example, the dead "person" is essentially inanimate. But at this point the living observer can no longer analogize her nature with that of the dead person, at least in any meaningful sense. See BERTRAND RUSSELL, *HUMAN KNOWLEDGE: ITS SCOPE AND LIMITS* 482-86 (1948), reprinted in *AN INTRODUCTION TO PHILOSOPHICAL INQUIRY* 117-21 (Joseph Margolis ed., 2d ed. 1978) (describing personal knowledge through analogy). Perhaps she could conclude, "If I were dead, I would be inanimate." However, this inference misses the existential crux of the issue: what is the state of conscious being upon death?

223. As he grappled with the nature of death, Hamlet said,

To sleep, perchance to dream, ay there's the rub,  
For in that sleep of death what dreams may come  
Must give us pause . . . .

WILLIAM SHAKESPEARE, *HAMLET* act 3, sc. 1, ll. 65-68 (John D. Wilson ed., Cambridge University 1934). Hamlet was concerned with the nature of the afterlife that he presumed existed, rather than the potential lack of such an afterlife. Considering what a hell afterlife may be, even such faith did not offer adequate relief for anxiety about death.

224. See William May, *The Metaphysical Plight of the Family*, in *DEATH INSIDE OUT*, *supra* note 83, at 49 (describing family's reaction to the unknowable quality of death).

ties to the dying individual, are also profoundly influenced by social conceptions of death.<sup>225</sup> A person must be free "to conform choices about death to individual conscience,"<sup>226</sup> yet the person's death has meaning only according to "how she will be thought of after her death by those whose opinions mattered to her."<sup>227</sup> The social ritual of death, and what that ritual means to the individual, inform the individual's freedom to define death.

Though the universal, unknowable nature of death has caused fear throughout history, the meaning of death has changed over time and among cultures.<sup>228</sup> It is true, as Justice Stevens noted in *Cruzan*, that recent "[medical] advances, and the reorganization of medical care accompanying the new science and technology, have . . . transformed the political and social conditions of death: people are less likely to die at home, and more likely to die in relatively public places, such as hospitals or nursing homes."<sup>229</sup> Until the beginning of the twentieth century, however, the death of an individual was a ritual shared by "a social group that could be extended to include the entire community."<sup>230</sup> Throughout the medieval and early modern period, the community protested death's invincibility by general, public mourning, but over the nineteenth century such mourning became personal and, ultimately, anti-social.<sup>231</sup> Death became private and shameful as the event of dying transferred from the home to the hospital.<sup>232</sup> Today death has become taboo.<sup>233</sup> Far from naturally a private event, death became so by our society's construction.

The present control modern medicine exerts over death, termed the "medicalization" of death by historian Philippe Aries,<sup>234</sup> arose from the medical monopoly in the health care field.<sup>235</sup> This health

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225. See *id.* See generally ARIES, *supra* note 89 (describing history of death rituals).

226. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2885 (1990) (Stevens, J., dissenting).

227. *Id.* at 2885-86.

228. See generally ARIES, *supra* note 89 (narrating the history of European and American treatment of death from medieval to modern periods). For a compilation of different cultural views on the right to die itself, as well as death, see TO DIE OR NOT TO DIE?: CROSS-DISCIPLINARY, CULTURAL, AND LEGAL PERSPECTIVES ON THE RIGHT TO CHOOSE DEATH (Arthur S. Berger & Joyce Berger eds., 1990).

229. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2883 (1990) (Stevens, J., dissenting).

230. ARIES, *supra* note 89, at 559.

231. See *id.* at 582-83.

232. See *id.* at 570-71, 575, 583.

233. See *id.* at 583.

234. *Id.* at 583-88.

235. Since death and health define one another, the medical establishment's control over health encompasses death as well. See IVAN ILLICH, *The Political Uses of Natural Death, in DEATH INSIDE OUT*, *supra* note 83, at 25.

care monopoly originated in the years following the Civil War, with the support of the state, through licensing requirements, increased selectivity by medical schools, and accreditation requirements for the schools themselves.<sup>236</sup> True power, however, did not arise merely from a constrained supply of trained doctors, but from a monopoly of medical knowledge that is, from the perspective of the laity, impenetrable.<sup>237</sup> We visit the doctor not simply for treatment, but also to learn what sickness we have, or whether we even are sick.<sup>238</sup> This deference to the doctor, learned in childhood through the family,<sup>239</sup> becomes natural and forecloses the consideration of health care alternatives.

The medicalization of death developed with modern advances in medical technology.<sup>240</sup> Prior to the advent of life-support techniques, few patients survived extended periods of deep coma.<sup>241</sup> Heart function, measured initially by stethoscope and later by electrocardiograph, determined death.<sup>242</sup> With advances in technology, brainstem activity became the gauge of human existence, ranging from irreversible loss of function to normal brainstem activity.<sup>243</sup> The irreversibly brain-dead, whose respiration and circulation were supported wholly by artificial means, posed a recurring dilemma.<sup>244</sup> Spurred by the need for viable organs, the costs of maintaining the bodies' support,

236. See PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICA MEDICINE* 102-27 (1982); see also ELLIOT A. KRAUSE, *POWER & ILLNESS* 34-41 (1977) (describing domination through expertise legitimated by licensing); JAMES A. MORONE, *THE DEMOCRATIC WISH* 254-65 (1990) (relating the fruition of the medical monopoly following World War II).

237. STARR, *supra* note 236, at 114; see also FOUCAULT, *supra* note 164, at 176 (describing the development of "medico-administrative" knowledge).

238. See STARR, *supra* note 236, at 14; Alasdair MacIntyre, *Medicine Aimed at the Care of Persons Rather Than What . . . ?*, in *CHANGING VALUES IN MEDICINE* 83, 86 (J. Cassel & Mark Siegler eds., 1979).

239. See FOUCAULT, *supra* note 164, at 174-75 (describing the use of the family-child complex in the medicalization of individuals).

240. ARIES, *supra* note 89, at 583-88.

241. *DEFINING DEATH*, *supra* note 86, at 21 (crediting "intravenous hydration, nasogastric feeding, bladder catheterization and respirators" as life-supporting techniques).

242. *Id.* at 14-15.

243. "Brain death, coma and the vegetative state differ to the extent to which there is function of the brainstem, the part of the brain that controls unconscious activity. In brain death, there is complete and irreversible loss of brainstem function," and organ functions can only be maintained for a few days or weeks. Brief of the A.M.A., *supra* note 7, at 7-8 (footnotes omitted). Patients in a vegetative state, though oblivious to their surroundings, maintain a relatively normal brainstem function allowing them to breathe air, digest food, and produce urine without assistance. *Id.* at 8. Coma is an intermediate position rarely lasting more than two to four weeks, following which the patient either dies, enters a vegetative state or regains some degree of consciousness. *Id.* at 9.

244. A President's Commission study of four acute care centers found that two-to-four cases of irreversible loss of brain functions occurred each month. *DEFINING DEATH*, *supra* note 86, at 22.

and the suffering of the patients' families, the medical community reformed its definition of death to include the complete loss of brain function.<sup>245</sup> Following the medical community's lead, a group of representatives from the American Bar Association, the American Medical Association, and the National Conference of Commissioners on Uniform State Laws created the Uniform Determination of Death Act, which defines death by the irreversible cessation of either circulation and respiration or all functions of the entire brain.<sup>246</sup>

Significantly, the distinction between "brain death" and "heart death" is cast as a matter of medical observation and diagnosis. Such diagnosis allows the medical establishment nearly total control over the patient.<sup>247</sup> Moreover, the very definition of death remains subject to change with further discoveries in the medical field. In the process, the medical establishment aspires to complete control over the measurement of human existence. Intuitions of what constitutes life and death, and the attributes we consider central to humanity, assume a secondary role at best. Ultimately, loved ones must appeal to the standards of medical technology.<sup>248</sup> The result is the phenomenon of

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245. See *id.* at 23-24; see also Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 205 J. A.M.A. 337 (1968) (formalizing the definition of irreversible coma). Medicine's division of the death of the human being into "heart death" and "brain death" is widely criticized, much for the same reason that we question the "life" of Nancy Cruzan: it is possible for a person to have a functioning lower brain, and so not qualify as brain dead, even after the person has lost all possibility of ever regaining consciousness. See *supra* notes 74-82 and accompanying text (describing Nancy Cruzan's "life" in the persistently vegetative state).

246. See UNIF. DETERMINATION OF DEATH ACT, 12 U.L.A. 338-39 (Supp. 1991) (describing the history of the Act); DEFINING DEATH, *supra* note 86, at 73. The court in *Cruzan* found that under such a statute Nancy was living; it cited MO. REV. STAT. § 194.005 (1986), which provides:

For all legal purposes, the occurrence of human death shall be determined in accordance with the usual and customary standards of medical practice, provided that death shall not be determined to have occurred unless the following minimal conditions have been met:

- (1) When respiration and circulation are not artificially maintained, there is an irreversible cessation of spontaneous respiration and circulation; or
- (2) When respiration and circulation are maintained, and there is total and irreversible cessation of all brain function, including the brain stem and that such determination is made by a licensed physician.

*Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2845 n.1 (1990).

247. See Dena S. Davis, *Slim Just Left Town: Decisionmaking on an Intensive Care Unit*, 23 CONN. L. REV. 261, 269 (1991) ("The reason power remains with the physicians is that all of these [medical] approaches are, and in the nature of things must be, dependent on the *medical prognosis*.").

248. The medical measurement of death is important in light of the rising number of persons dying in hospitals and thus susceptible to life-sustaining treatment. See ROBERT VEATCH, *DEATH, DYING, AND THE BIOLOGICAL REVOLUTION* 4 (1976) (deaths occurring in U.S. hospitals rose from 37% in 1937 to 61% in 1958).

death as we know it today, in which the individual, often isolated and helpless, is left to the control of medicine.

The medicalization of death takes over the lives of the patient and her loved ones. A vegetative patient, or any patient forced to accept life-sustaining medical treatment, continues to live against her will where she would not want to persist in such a fashion. The patient's loved ones, in turn, suffer a more subtle injury. Their emotional attachment to the patient demands that they preserve the patient's personhood, a burden that requires appealing to the medical establishment and, if need be, the courts. This burden is so substantial that, to a great extent, the medicalization of the patient's death determines the course of the loved ones' lives.

As *Cruzan* illustrates, the medicalization of death injures the patient and her loved ones by stripping the patient of her personhood. Medicalization depersonalizes the patient by dominating the patient's existence with medical procedures.<sup>249</sup> A dying person is both an individual with a uniquely human personality and a physiology that is functioning inadequately.<sup>250</sup> To investigate the patient's physiology effectively, medicine "depersonalizes" the patient by focusing on the faulty bodily process to the exclusion of the individual's personhood.<sup>251</sup> Such depersonalization also stems from the growing corporate bureaucracy of health care<sup>252</sup> and the tendency of doctors to demand every possible treatment to forestall death.<sup>253</sup>

The patient's loved ones, meanwhile, must suffer by witnessing the degradation of the patient's individuality. As *Cruzan* illustrates, the loved ones suffer both from their own denial of the fundamental

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249. See *supra* notes 74-82 and accompanying text (describing the extent to which medical procedures dominated the existence of Nancy Cruzan).

250. Cassell, *supra* note 215, at 46.

251. *Id.* To the extent that clinical medicine is an "applied" science and not a "pure" one, however, the abstraction of the body into separate mechanisms is by no means complete. Ernan McMullin, *Clinical Medicine as a Science: A Commentary on Eric Cassell*, in CHANGING VALUES IN MEDICINE, *supra* note 238, at 167.

252. To maximize profits, medical care has grown in scope and scale into multihospital corporate bureaucracies. See STARR, *supra* note 236, at 428-36 (describing the evolution of incorporated medicine). Individualized care is lost in such a bureaucracy: the patient is the sum of the entries on her forms and records, seen by different physicians at different times, left to wait, and entirely dependent on the expertise the organization controls. MacIntyre, *supra* note 238, at 83-89. Potential legal liability can figure more prominently into decisionmaking than the personal values of the patient, as the *Cruzan* case itself illustrated. There the trial judge described the medical institution's chief concern as "the legal consequences of such actions rather than any objections that good ethical standards of the profession would be breached." *Cruzan v. Harmon*, 760 S.W.2d 408, 433 (Mo. 1988) (Higgins, J., dissenting).

253. LARRY R. CHURCHILL, RATIONING HEALTH CARE IN AMERICA 9 (1987) (discussing physicians' "maximalist" ethic, a philosophy analogous to the sanctity of life). The maximalist ethic is also promoted by "physician insecurity and patient anxiety." *Id.*

change in the patient's state of being, as well as from their conviction that the patient herself would refuse to remain in such a state.<sup>254</sup> The slow decay of the patient's physical being serves as a continual wake, denying her loved ones the emotional healing that accompanies burial and bereavement.<sup>255</sup>

The loved one's helplessness in the wake of the hospital's control compounds their anguish. One mother whose child was born after only twenty-seven weeks of pregnancy and hemorrhaging into his brain and lungs witnessed "a roomful of doctors around this tiny baby, trying to resuscitate him."<sup>256</sup> When the doctors were finished and the mother questioned their aggressive treatment of the infant, one of them angrily replied: "'You don't make those decisions. We do.'"<sup>257</sup> Hospitals exert such control not only to preserve patients whom they deem alive, but also to terminate patients whom they consider suffering and incapable of recovery.<sup>258</sup>

Despite the family's emotional suffering and subjugation, the Court's right to die discourse considers the family to have no rights independent of the incompetent patient.<sup>259</sup> The lack of an independ-

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254. See *supra* notes 12-15 and accompanying text (describing the emotional trauma experienced by the Cruzan family).

255. Bereavement is a social and psychological process of detachment, transition, and return to society. See William May, *Attitudes Toward the Newly Dead*, in *DEATH INSIDE OUT*, *supra* note 83, at 139, 145; see also Alan Stoudemire & J. Trig Brown, *Delayed and Distorted Grief: Pathological Patterns of Bereavement*, 26 *TRAUMA* 5 (Dec. 1984) (unresolved bereavement can lead to pathological grief). Justice Brennan also noted that "[a] long drawn out death can have a debilitating effect on family members." *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2869 (1990) (Brennan, J., dissenting). As Nancy Cruzan's father said, "Nancy's gone. . . . I've accepted that. But when this is over and she formally dies, then we can get into the formal grieving." Malcolm, *supra* note 15, at 24L.

256. Gina Kolata, *Parents of Tiny Infants Find Care Choices Are Not Theirs*, *N.Y. TIMES*, Sept. 30, 1991, at A1.

257. *Id.*

258. For example, an Atlanta court recently refused permission to remove life support for a 13-year old girl where the hospital considered its own treatment to have become "abusive and inhumane." Ronald Smothers, *Atlanta Court Bars Efforts to End Life Support for Stricken Girl*, 13, *N.Y. TIMES*, Oct. 18, 1991, at A10. Although following the hospital's discussions with her, the girl's mother agreed to cease the support, her father believed that a miracle would come to save his daughter. *Id.* The court ruled in the father's favor, finding that there was no clear evidence of "medical abuse"; thus, "if either parent, in the exercise of his or her rights with regard to the welfare of Jane Doe, makes the decision to continue Jane Doe's life, as the father has in this case, that decision must be respected." *Id.* The girl died eight days after the ruling. Ronald Smothers, *Ailing Girl at Center of Fight Over Life Dies*, *N.Y. TIMES*, Oct. 26, 1991, at A6; see also *Doctors Assert Patient's Right to Die*, *ABA JOURNAL*, Oct. 1991, at 26 (trial court enjoined hospital from removing support where loved ones refused to give up hope for patient diagnosed as persistently vegetative); *Husband Wins Right-to-Live Case*, *MIAMI HERALD*, July 2, 1991, at 6A.

259. The right to die is based upon a person's Fourteenth Amendment liberty interest. The family cannot exercise the right on behalf of their relative in the absence of proof that their

ent right arises in part from liberalism's tendency to view even the incompetent person as an autonomous, self-determinative individual.<sup>260</sup> Under this framework, the Court did not believe that "the Due Process Clause requires the State to repose judgment on these matters with anyone but the patient herself."<sup>261</sup> In fact, the family is suspect as a substitute decisionmaker precisely because of its closeness with the patient. The very closeness that may justify substituted judgment could deny an objective evaluation of the patient's circumstances.<sup>262</sup>

Neither of these aspects of the right to die explains the courts' refusal as a matter of law to consider the emotional and psychological burdens of family members.<sup>263</sup> Courts may consider the emotional costs to the family,<sup>264</sup> or deny termination of treatment without fam-

views reflect those of the relative. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2855 (1990); see also *supra* note 40.

260. Cf. Rosa Eckstein, Comment, *Towards a Communitarian Theory of Responsibility: Bearing the Burden for the Unintended*, 45 U. MIAMI L. REV. 843, 845-48 (1991) (criticizing applications of liberalism in the context of institutions); MICHAEL J. SANDEL, *LIBERALISM AND THE LIMITS OF JUSTICE* 175-83 (1982) (arguing that because society at least partially constitutes character, individual and community interests may coincide). The mission of this Comment's analysis of family is, in a sense, to define the individual's "community." See *id.* at 173 ("[C]ommunity must be constitutive of the shared self-understandings of the participants and embodied in their institutional arrangements, not simply an attribute of certain of the participant's plans of life.").

261. *Cruzan v. Director, Mo. Dep't of Health*, 110 S. Ct. 2841, 2855 (1990).

262. See *id.* at 2855-56 (noting close family members may have "a strong feeling" that is "not at all ignoble or unworthy, but not entirely disinterested either"); see also Minow, *supra* note 26, at 974-76 (contending that closeness of family to the patient may taint objectivity).

263. The court indeed noted that the Cruzans are "loving and caring" but did not recognize, legally or otherwise, the cost of that love in enduring their daughter's fate. See *Cruzan*, 110 S. Ct. at 2855.

264. See, e.g., *In re Estate of Longeway*, 549 N.E.2d 292, 301 (Ill. 1989) ("The slow, deliberate nature of the court system may frustrate the family and loved ones of the patient."). A dissent in the Missouri Supreme Court keenly empathized:

The principal opinion attempts to establish absolutes, but does so at the expense of human factors. In doing so it unnecessarily subjects Nancy and those close to her to continuous torture which no family should endure. I am grasping for words which elude me, and so will not say more.

*Cruzan v. Harmon*, 760 S.W.2d 408, 430 (Mo. 1988) (Blackmar, J., dissenting). The dissents in the United States Supreme Court were sensitive to the issue as well. Justice Brennan noted that "[a] long, drawn-out death can have a debilitating effect on family members." *Cruzan*, 110 S. Ct. at 2869 (Brennan, J., dissenting). Justice Stevens essentially argued that the family's interest should be honored through the patient, as a derivative right:

Each of us has an interest in the kind of memories that will survive after death. To that end, individual decisions are often motivated by their impact on others. A member of the kind of family identified in the trial court's findings of this case would likely have not only a normal interest in minimizing the burden that her own illness imposes on others, but also an interest in having their memories of her filled predominantly with thoughts about her past vitality rather than her current condition.



ily approval,<sup>265</sup> but currently they do not recognize the loved ones' emotional suffering as an independent criterion for the removal of treatment. However, the judicial analysis of state interests does typically include "the protection of the interests of innocent third parties."<sup>266</sup> The courts use this factor to consider emotional and financial damage resulting from the death of a patient, especially with respect to minor children.<sup>267</sup> The calculus could also include the emotional damage to the patient's loved ones by *not* terminating treatment, but courts are currently unwilling to recognize this kind of harm.

The failure to recognize the family's independent interest in the treatment of the patient is significant because, beyond the patient herself, the family has the most at stake in the dispute. The family is, after all, still conscious, and it is typically the impetus for removal of life support. But the true source of a loving family's interest is its emotional bond with the patient. Faced with the loss of the person they knew, family members are denied relief from their sorrow, a relief that the patient herself would have wanted them to have. Instead, the family is helpless, and forced to witness their loved one slowly decay.

Siding with the medical establishment, the state extends the loved ones' trauma by placing them in a subservient role in right to die litigation. State interests weighed against the right to terminate treatment also include the protection of medical ethics.<sup>268</sup> Nothing in the legal nature of the physician-patient relationship justifies weighing the medical profession's interests against the patient's.<sup>269</sup> By supporting the presumption that death is a purely biological event, the state nevertheless places control of the patient in the hands of the medical establishment and constitutes the loved ones' subordinated role. Just as the state uses the family to classify and disempower individuals, it classifies the patient as "living" according to the medical establishment's definition, thereby placing the patient in the hospital's control. If the hospital refuses to abide by treatment directives, the patient's loved ones must petition the court to change the status quo.<sup>270</sup>

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*Id.* at 2892 (Stevens, J., dissenting).

265. See *In re Conroy*, 486 A.2d 1209, 1242 (N.J. 1985) (requiring approval of kin under tests not based entirely on the patient's wishes).

266. *Cruzan*, 110 S. Ct. at 2847-48 (citing Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 426 (Mass. 1977)).

267. *Saikewicz*, 370 N.E.2d at 426.

268. See *Cruzan*, 110 S. Ct. at 2848.

269. See Ben A. Rich, *The Assault on Privacy in Healthcare Decisionmaking*, 68 DENV. U. L. REV. 1, 4-10, 15-17 (1991).

270. See Rhoden, *supra* note 24, at 429-32 (noting that the courts do not question medical intervention and instead burden the family to change the status quo).

### B. *Death De-Medicalized*

Because death is not a timeless, biological event, but a socially constructed phenomenon, it should not be defined by a single standard, at least in the patient-hospital relationship.<sup>271</sup> Instead, courts should allow the individual to define death within bounds set by the norms of society. Moreover, we should seek to empower individuals and their loved ones against the tendency of the state and the medical establishment to dictate the constitution of death, allowing people the widest potential for self-determination.

Death need not be the medicalized event that it has become. Rather than shrouding death in medical technology and bureaucracy, courts should permit people to retain a sense of dignity by allowing patients a degree of control over the manner in which they die. Courts should empower loved ones to decide the patient's treatment, leaving doctors with an advisory role.<sup>272</sup> Rather than burdening the loved ones with the often impossible task of proving what the patient would have wanted, the presumption would lie in the favor of the loved ones.<sup>273</sup> The physicians' drive to preserve life, coupled with their right to petition the court for the appointment of a guardian, would help prevent potential abuses by the family.<sup>274</sup> But even subject to that check, the shift of power to the loved ones in the first instance would help prevent them from being relegated to a subordinate role.

The exact degree of latitude that loved ones should have in directing the patient's treatment is difficult to quantify. They should have the greatest freedom where a patient, like Nancy Cruzan, has irrecoverably lost all consciousness; arguably, the patient does not fit the general conception of human life. Precisely because the aim is to empower the loved ones, however, they should have similar latitude when religious or moral beliefs compel them to seek to continue life support for a patient whom the hospital considers dead.<sup>275</sup> Despite

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271. This does not mean, however, that a certain biological event should not be used to determine other legal relationships, such as life insurance contracts, wills, etc.

272. See Rhoden, *supra* note 24, at 439-45 (advocating relegating doctors to an advisory role). The medical community's liability should diminish, however, to the extent that its control diminishes and the patient's liberty expands. See Corlett v. Caserta, 562 N.E.2d 257 (Ill. Ct. App. 1990) (holding that patient's estate must share liability for patient's death where the physician causes a life-threatening injury and the patient refuses medical care for religious reasons).

273. Rhoden, *supra* note 24, at 441.

274. *Id.*

275. See Alvarado v. New York City Health & Hosps. Corp., 547 N.Y.S.2d 191 (Sup. Ct. 1989) (Jehovah's Witness parents disputed hospital's determination of infant's death), *order vacated*, Alvarado v. City of New York, 550 N.Y.S.2d 353 (App. Div. 1990).

the medical definition of death, some religions such as Orthodox Judaism consider life to have ended only when the heart stops functioning and thus would not consider a patient to be "dead" if brain functions alone had ceased.<sup>276</sup> The devotion of the patient's loved ones in such instances should outweigh the hospital's desire to terminate treatment, even in a case where medical prognosis is poor.<sup>277</sup>

When the patient stands within the threshold of consciousness, more difficult qualitative choices arise, and the danger of euthanasia emphasized by proponents of the sanctity of life argument becomes real. Opponents of euthanasia reject the termination of life support out of fear that the patient may have chosen to remain alive. But the idea of absolute respect for the wishes of a competent person regarding treatment when she becomes incompetent is untenable because the incompetent patient herself may not have adequately conceived of her fate.<sup>278</sup> Indeed, in this respect, even living wills are flawed. To be sure, they should not be cast away lightly, because the very act of signing a written document may occasion greater reflection than would an off-handed remark to a friend. To question the extent to which we remain the same persons over time is not to assert that the incompetent individual is an entirely different person from her former self.<sup>279</sup> Rather, the person's prior directives reflect the values of the patient—values which should be a compelling, albeit rebuttable, factor in evaluating present desires.<sup>280</sup>

The freedom to die necessarily permits death choices that can be poorly motivated. People who had never considered advance directives will do so upon realizing that they have such liberty.<sup>281</sup> However, their new preferences will continue to reflect limitations upon their ability to choose, typically imposed by ignorance. *McKay v. Bergstedt*,<sup>282</sup> a case decided after *Cruzan*, illustrates this problem.

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276. Charlotte K. Goldberg, *Choosing Life After Death: Respecting Religious Beliefs and Moral Convictions in Near Death Decisions*, 39 SYRACUSE L. REV. 1197, 1214-15 (1988) (brain death definition is rejected by Orthodox Jews and certain Native Americans and Japanese). Others might refuse the brain-death definition to oppose active euthanasia or harvesting of organs. *Id.* at 1216-17.

277. *See supra* note 258.

278. *See supra* notes 119-23 and accompanying text.

279. Rhoden, *supra* note 24, at 415 (criticizing "insisting on viewing a person only in a highly restricted slice of time").

280. *Id.*

281. A person's preferences adapt to choices of which she is conscious. When the evolutions of the law reveal a new form of liberty, such as the freedom to die, the person restructures her preferences around opportunities previously foreclosed from her contemplation. *See supra* note 205 (discussing Professor Sunstein's theory of "adaptive preferences").

282. 801 P.2d 617 (Nev. 1990).

Kenneth Bergstedt, a thirty-one year-old quadriplegic, sought removal of his life-supporting respirator.<sup>283</sup> Bergstedt did not have a terminal illness, and he found distraction in reading, writing poetry, and watching television.<sup>284</sup> However, he relied upon others entirely. Faced with the imminent death of his last surviving parent, "Kenneth was plagued by a sense of foreboding concerning the quality of his life without his father."<sup>285</sup> Despite realizing that "Kenneth's suffering resulted more from his fear of the unknown than any source of physical pain,"<sup>286</sup> the Nevada Supreme Court sanctioned the termination of his life-support. "Given the circumstances under which he labored to survive, we could not substitute our own judgment for Kenneth's when assessing the quality of his life."<sup>287</sup>

Ironically, the court's substitution of its judgment is *most* defensible when a patient's decisionmaking is distorted by such despondency. The dissent noted that the court did not adequately resolve "whether [Bergstedt's] decision to take his own life was completely rational or possibly a product of some kind of clinically identifiable depression."<sup>288</sup> There may have been little attempt to convince Bergstedt that life was worthwhile.<sup>289</sup> Although Bergstedt surely understood the meaning of life as an invalid, he could not conceive of such a life without the loved ones that had supported him.<sup>290</sup> Rather than allowing him to make such an "autonomous" judgment about the quality of his life, the court should have demanded that the judgment be a truly informed one.

The *Bergstedt* case reflects the potential harm of unenlightened life-and-death decisionmaking. Consider the situation of a lone, elderly person contemplating the possibility of becoming incompetent. Prior to the establishment of the right to die, the person may not have even considered a death directive. But now she does, and perhaps more out of fear of becoming a burden than of truly desiring not to be placed on life support, the person elects to die. In this setting the

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283. *Id.* at 620.

284. *Id.* at 624.

285. *Id.*

286. *Id.*

287. *Id.* at 624-25.

288. *Id.* at 637 (Springer, J., dissenting). The dissent, also troubled by the lack of adversity in the case, believed that "there was no real case or controversy before the district court." *Id.* at 632; see also *id.* at 634 n.6 (noting that the only argument favoring life instead of death was presented by an amicus brief rejected by the court because of its late filing).

289. *Id.* at 637 ("Mr. Bergstadt was completely lacking in positive support . . . all input was one-sided, all death and no life.").

290. Interestingly, the only argument in the case in favor of preserving Bergstedt's life was made by general counsel for the National Legal Center for the Medically Dependent and Disabled, a group that perhaps could best conceive of Bergstedt's fate. See *id.* at 634 n.6.

court must evaluate the situation of the decisionmaker, and the context of the decision, to be sure that the choice is an informed, rational one. To the extent that it avoids ill-conceived directions, such an evaluation justifies the somewhat paternalistic, idealized standard of best interests.<sup>291</sup>

When the patient is still capable of consciousness—"alive" in the intuitive sense—quality of life judgments must consider life from the patient's circumstances to whatever extent possible.<sup>292</sup> Although decisionmakers will be able to identify with the patient, no one will be able to view life directly from the patient's perspective or transcend personal values.<sup>293</sup> Such an approach, however, does not automatically assume fantastic "Alice in Wonderland" proportions,<sup>294</sup> but simply attempts to more sensitively judge the situation.<sup>295</sup> In such cases, the doctor's understanding of the patient's perceptions and desires has its greatest importance.<sup>296</sup> Ideally, the incompetent patient's treatment decision will arise from a dialogue between the doctors and the loved ones, marked by shared information and mutual care for the patient.<sup>297</sup> Without such a relationship, the loved ones risk making an erroneous decision, fashioned perhaps not from an improper motivation but out of the inability to empathize with the patient's position. Although the presumption of correctness should still lie with the decision of loved ones, the court should appoint a guardian ad litem in each instance where such dialogue does not occur.

Moreover, in determining the parameters of the freedom to die, society should not conceive of life and death as opposite, exclusive states but rather as poles at the ends of the spectrum of existence. These poles are the forms of existence that nearly all of us understand to be life and death: the healthy, thinking, emotional, social interactive person and the utterly unconscious, circulation-less corpse.<sup>298</sup> In between are gradations of existence, with varying degrees of mental

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291. See Sunstein, *supra* note 4, at 1171 (noting that paternalism may be justified where subjectively perceived interests arise from distortions).

292. See *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 430-32 (Mass. 1977).

293. See MINOW, *supra* note 135, at 335.

294. *TRIBE*, *supra* note 4, § 15-11, at 1369 (criticizing *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977)).

295. See MINOW, *supra* note 135, at 322.

296. See Dresser, *supra* note 52, at 391-93 (advocating new methods of understanding the patient's perspective).

297. See Fentimann, *supra* note 20, at 840-48 (proposing conversation in decisionmaking).

298. The person defined in this manner is more than a mechanism; activities central to personhood such as reasoning and feeling are equally as important. See *DEFINING DEATH*, *supra* note 86, at 38-40 (discussing "higher brain" formulations of death). The common understanding of life consists of more than its physical aspects. *Cruzan v. Director, Mo. Dep't*

and physiological well-being: poor health, incompetence, terminal illness, coma, persistent vegetation, lack of independent circulation, and cessation of all brain activity. At each pole, society demands particular behavior without questioning the deeper meanings of life and death. At some point, however, society permits the affirmative act of modifying the existence from one form to another: often our society permits causing a persistently vegetative person to become brain-dead.

One alternative to today's medical definition of death, further towards the middle of the spectrum, focuses on "neocortical death," or the irreversible loss of consciousness and cognitive activity. Neocortical death consists of the irreversible cessation of activity in specific areas of the brain that govern awareness of the self and the environment, whereas "brain death" requires the cessation of all brain activity.<sup>299</sup> A neocortical definition of death seems preferable to a whole-brain basis of death because the higher function of the brain—human consciousness—seems to be the sine qua non of humanity.<sup>300</sup> The definition is also a single, recognizable phenomenon, and therefore an adequate standard.<sup>301</sup>

Another alternative conception of death, further towards the intuitive standard for life, is the irreversible loss of the capacity for interpersonal relationships.<sup>302</sup> Advances in artificial intelligence indicate that, rather than consciousness, such interpersonal relationships distinguish us as human.<sup>303</sup> Unlike neocortical death, the capacity for

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of Health, 110 S. Ct. at 2886 (Stevens, J, dissenting) ("Life, particularly human life, is not commonly thought of as a mere physiological condition or function.").

299. See Raymond J. Devettere, *Neocortical Death and Human Death*, 18 LAW MED. & HEALTH CARE 96 (1990).

300. A neocortical definition of death centers on the irreversible loss of "the capacity to think, feel, communicate, or experience our environment" that is "the key to human life." David R. Smith, *Legal Recognition of Neocortical Death*, 71 CORNELL L. REV. 850, 860 (1986). Neocortical death can be diagnosed by Positron Emission Tomography ("PET") scanning, which, though expensive, is relatively cheap when compared with costs maintaining a neocortically dead patient. *Id.* at 878-883. Critics of neocortical death argue that public policy demands retaining the "old" definition of death, which itself is misunderstood and morally objectionable to many. See DEFINING DEATH, *supra* note 86, at 58-59; Devettere, *supra* note 299, at 102. In light of the importance of death to self-determination, the socially understood meaning of death as loss of consciousness rather than electrical activity to the brain, and the ability to judicially construct exceptions to the definition of neocortical death much as to the present exceptions to brain death, arguments that the redefinition will create "confusion" or "resistance" by the society are questionable.

301. See DEFINING DEATH, *supra* note 86, at 57-61 (outlining policy objectives for the definition of death).

302. See Kevin P. Quinn, *The Best Interests of Incompetent Patients: The Capacity for Interpersonal Relationships as a Standard for Decisionmaking*, 76 CAL. L. REV. 897 (1988).

303. See Steve Goldberg, *The Changing Face of Death: Computers, Consciousness, and Nancy Cruzan*, 34 STAN. L. REV. 659 (1991).

interpersonal relationships is free from the control of medical technology. But the standard is based upon the presumption that capacity for interpersonal relationships is essential to the incompetent patient's personhood; such a qualitative judgment, made from the perspective of a now-and-always competent person, is problematic.<sup>304</sup> The interpersonal relationship standard also neglects the practical necessity of a definite baseline for evaluating life and death.

Wherever it is fixed, the baseline of death should reflect the values of society as a whole, rather than those of the medical establishment or the government alone. Treating death as a matter of purely medical definition perpetuates the conception that life ends only when electrical impulses in the brain permanently cease. Society holds life sacred, but life's sanctity does not arise from electrical impulses alone. In protecting sacred life through the medical definition of death, courts and legislatures needlessly injure people who do not hold scientific beliefs. People may not know that the persistently vegetative patient has lost consciousness forever, and they may believe the patient's twitches and noises prove she is alive. Until we become aware of what the "life" of the persistently vegetative patient is, and the capability of medical technology to ascertain life and death through different criteria, we can never be free to give life and death meaning according to our own values.<sup>305</sup>

In sum, this model of treatment decisionmaking requires a standard of death that reflects societal values, and a hierarchy of decisionmaking, giving priority to the patient's values, related by her loved ones. The different levels in the hierarchy would be (1) the patient's prior directives made while competent; (2) the loved ones' decision; and (3) the decision of the physicians or guardian ad litem. Lower priority decisionmakers could rebut the higher ones by adequately proving that the decision arises from a mistaken view of reality.

The aim of the analysis is not to ensure absolute respect for the patient's autonomous choices. Much of what constitutes each person's value system is socially constructed.<sup>306</sup> If our values are formed to some extent by the society with which we share our lives, then the

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304. See Dresser, *supra* note 52, at 379-81 (noting that transformation to an incompetent state can radically change a person's interests). *But see* Rhoden, *supra* note 24, at 414-19 (critiquing Dresser and advocating using the incompetent patient's past values for evaluating present interests).

305. See Sunstein, *supra* note 4, at 1147, 1154-55 (discussing distorted preferences arising from relations of power and the possibility of reconstructing preferences).

306. See Rubinfeld, *supra* note 3, at 764-70 (finding self-definition is based upon definition in relation to others); Sunstein, *supra* note 4, at 1170-71 (noting that, because desires are socially constructed, autonomy is a matter of degree).

issue of what we would want becomes, to some extent, the issue of from whom our values are formed. By establishing those persons with whom the patient has bound herself emotionally, the court can establish the patient's values. The issue of familial abuse, though still a possibility, is greatly diminished; those who are emotionally bound to the patient, rather than bound simply economically or in some other fashion, should not be improperly motivated. The proposed hierarchy at least alters the existing means of choice to increase the probability of deciding as the patient would desire, with the least injury to the patient's loved ones.

The courts' role is limited but important. It must resolve disputes where the loved ones challenge the patient's prior directive, or the physician or guardian ad litem challenges the loved ones. The court's role increases where the patient has no surrogate, or the patient is born incompetent and can never choose others with whom to associate and form values. As a preliminary matter, the court must decide whether the condition of the patient is within the range of human quality that will permit the removal of treatment.<sup>307</sup> Finally,

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307. A decision by the Supreme Court of Delaware, *Newmark v. Williams*, 588 A.2d 1108 (Del. 1991), exemplifies this method. Colin Newmark, a three-year-old, was dying of lymphoma. Colin's doctor prescribed a radical form of radiation therapy which had only a 40% chance of success but would be painful and potentially lethal. *Id.* at 1111. After Colin's parents refused the treatment for religious reasons, the Delaware Division of Child Protective Services sued and won custody of the child in the Family Court. *Id.* at 1110. The Delaware Supreme Court reversed, noting two failures in the lower court's opinion: the failure to consider "the special importance and primacy of the familial relationship," and the failure to consider invasiveness and ineffectiveness of the treatment. *Id.* at 1115.

In several respects the *Newmark* decision resembles the method of decisionmaking proposed here. The court noted the patient's quality of life, recognized that quality as within the range of quality that should permit freedom to refuse treatment, and consequently allowed the patient's loved ones to determine treatment as they saw fit. *Id.* at 1120. The court distinguished cases in which parents were not allowed to deny treatment where the side effects were minimal or there was a significantly greater likelihood of success. See *Custody of a Minor*, 379 N.E. 1053 (Mass. 1978) (child suffered no significant side effects from treatment); *In re Willman*, 493 N.E.2d 1380 (Ohio Ct. App. 1986) (amputation would save child's life).

On the other hand, the court glossed over the troubling issue of whether the family's decision arose from its religious values rather than love for the child. The court noted "the unquestioned close bond between Colin and his family." *Newmark*, 588 A.2d at 1120. The court also criticized the family court's failure to formally analyze whether the child was neglected. *Id.* at 1114. Despite this, the court did not remand for a more stringent analysis of the parent/child relationship. The issue became moot because the child died shortly after the court's oral decision. *Id.* at 1121 n.13. Nevertheless, the court's written decision, handed down several months later, is replete with formalistic family-rights discourse. *Id.* at 1115-16 ("the essential element of preserving the integrity of the family is maintaining the autonomy of the parent-child relationship"). Compare *supra* Part III.A. (critiquing formalistic analysis of family rights). The implication of such family-rights discourse is that the values of the parent and child coincide; considering that the child was only three years old, doubtless he had little opportunity to consider his own choices rationally.



and perhaps most important, courts must decide who are the "loved ones."

## V. CONCLUSION

Society determines death and family. The way in which society fashions those concepts dictates the manner and extent of an individual's freedom to define herself in relation to them. For the Cruzan family, death empowered the medical establishment and threatened to render them helpless. In a similar way, family at least initially empowered Sharon Kowalski's father and excluded her loved one, Karen Thompson. These uses of death and family are offensive because their precepts—the physiological basis of death and the kinship basis of family—are often out of synch with more fundamental social values. The concepts are malformed to the extent that a human is not human without consciousness, though the brain sparks and the heart beats, and a family is not family without love, though as kin they share one blood.

Death is personal. Each person has an exceptional liberty interest in the way she dies. Those who are emotionally bound to the one who is dying also have an interest in the manner in which she dies. Present approaches to the termination of life-supporting treatment either ignore or subordinate the emotional harm that occurs to the patient's loved ones, the very class of persons that the patient herself would want to protect. It may not be desirable or even possible for the patient and the patient's loved ones to have nearly absolute freedom to decide how she will die; the order that society demands cannot and would not permit each individual to formulate death in his or her own way.

Our society only permits *ordered* liberty—the freedom to act within a socially defined structure of behavior. All aspects of that structure—even the seemingly necessary ones like family and death—are subject to transformation. Considering not only the patient's autonomy and values as overall guides, but also the effect on the patient's loved ones, we can reconceive death decisionmaking. But by adopting policies based upon an assumed but unexamined cultural meaning, we irreparably harm the relationships we value most in our society.

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