

**Legal Frontiers of Death and Dying**, NORMAN L. CANTOR, Indiana University Press, Bloomington, Indiana 1987, pp. 182.

In the short story "The Facts in the Case of M. Valdemar,"<sup>1</sup> Edgar Allan Poe captured the horror of a person suspended indefinitely between life and death. Medical technology is now analogous to the function that hypnosis served in Poe's story: maintaining in someone the appearance of life even after the body and the mind have ceased functioning. Technology has created the strange situation in which medicine can keep patients alive—in some sense of that term—longer than they themselves would have wanted to be kept alive, and perhaps longer than would be "humane."<sup>2</sup> It is estimated that at least 10,000 Americans are in irreversible comas.<sup>3</sup> Advances in technology, in turn, have spawned a series of difficult legal problems, given the general name "the right to die." Legal recognition of a patient's right to refuse or to discontinue life-preserving medical treatment is quite recent. The modern development of the doctrine began with the case of Karen Ann Quinlan.<sup>4</sup> A mere dozen years

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<sup>1</sup> GREAT SHORT WORKS OF EDGAR ALLAN POE 479 (G.R. Thompson ed. 1970). In "Valdemar" the narrator hypnotized a patient at the moment of death to determine "to what extent, or for how long a period, the encroachments of Death might be arrested by the process." *Id.* at 480. The narrator "succeeds" in arresting the moment of death for seven months and even gets the patient to "speak"; however, events do not unfold quite as the narrator had expected. *Id.* at 485-89.

<sup>2</sup> *In re Conservatorship of Torres*, 357 N.W.2d 332, 340 (Minn. 1984) ("The ultimate horror [is not] death but the possibility of being maintained in limbo, in a sterile room, by machines controlled by stranger.") (citation omitted). See also *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 437, 497 N.E.2d 626, 637 (1986) (referring to patient maintained in a chronic vegetative state for 37 years).

It may be short-sighted to attribute this problem primarily to advances in technology. A discussion of the long-term causes of this problem should also include the growing likelihood that in our society an elderly person will have to face death alone in a hospital or nursing home, rather than at home surrounded by family.

<sup>3</sup> N.Y. Times, Nov. 17, 1987, at 22, col. 5 (nat'l ed.).

<sup>4</sup> Ms. Quinlan was in an irreversible coma. Her father, as guardian, requested judicial authorization to remove her respirator, an act that medical experts had predicted would result in death shortly thereafter. The Supreme Court of New Jersey granted the request. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), cert. denied 429 U.S. 922 (1976).

The significance of the court's decision can be seen when the decision is considered in its legal context. The New Jersey Supreme Court was acting contrary to its own precedent. Furthermore, the court acted without legislative support, and without any guiding precedent from other courts. See *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971).

In retrospect, the *Quinlan* opinion often seems awkward or unsophisticated. The court instructed the guardian and family of Ms. Quinlan "to render their best judgment" as to whether she would choose to discontinue treatment. *Quinlan*, 70 N.J. at 41, 355 A.2d at 664. Yet the court was unwilling to consider Ms. Quinlan's

later, there are approximately 100 major state court opinions (and a handful of federal district court opinions) concerning the refusal or discontinuation of life-sustaining medical treatment.<sup>5</sup> A growing majority of courts has recognized broad patients' rights in this area.<sup>6</sup>

The right to die cases have captured extensive media attention. The emotional power of these cases may come from our ability to identify in turn with the patient—either as the person who wanted the suffering to end or as the isolated person, vulnerable to an uncaring institution; with the patient's family—who

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own past comments as evidence of what choice she would have made. *Id.* At the same time, the court was sure what her answer would have been: "We have no doubt, in these unhappy circumstances, that if Karen were herself miraculously lucid for an interval . . . and perceptive of her irreversible condition, she would effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death." *Id.* at 39, 355 A.2d at 663. The court was also sure that this choice would "be accepted by a society the overwhelming majority of whose members would, we think, in similar circumstances, exercise such a choice in the same way for themselves or for those closest to them." *Id.* at 41-42, 355 A.2d at 664.

<sup>5</sup> There has been a change in the doctrinal underpinning of the courts' decisions. At first, the courts based the right to discontinue treatment on the federal constitutional right of privacy. *See, e.g., Superintendent of Belchertown v. Saikewicz*, 373 Mass. 728, 739-40, 370 N.E.2d 417, 424 (1977); *In re Quinlan*, 70 N.J. 10, 38-42, 355 A.2d 647, 662-64, *cert. denied* 429 U.S. 922 (1976). Recently, more courts have been basing their decisions wholly or in part on common law principles. *See, e.g., In re Farrell*, 108 N.J. 335, 347, 529 A.2d 404, 410 (1987); *In re Storar*, 52 N.Y.2d 363, 376-77, 420 N.E.2d 64, 70-71, 438 N.Y.S.2d 266, 272-73 (1981), *cert. denied*, 454 U.S. 858 (1981). The first important decision discussing the common law right to refuse even helpful medical treatment was *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914).

The decisions based on constitutional principles had the disadvantage of foreclosing more flexible, legislative responses to this difficult area. L. TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 15-11, at 937 (1st ed. 1978). Now, with more courts basing their decisions on common law grounds, there have been more frequent legislative responses. However, the courts have consistently held that these statutes supplement, rather than supplant, judicial responses. *See Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983); *Corbett v. D'Alessandro*, 487 So.2d 810 (Fla. App. 1986), *rev. denied*, 492 So.2d 133 (Fla. 1986); *In re Guardianship of Hamlin*, 102 Wash. 810, 689 P.2d 1372 (1984); *In re Welfare of Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983).

For some recent discussions of legislative proposals, see Freamon, *Death With Dignity Laws: A Plea for Uniform Legislation*, 5 SETON HALL LEGIS. J. 105 (1982); Note, *The Right to Die in New Jersey: Another Plea for Legislation*, 18 RUTGERS L.J. 235 (1986).

<sup>6</sup> The United States Supreme Court, however, has been careful not to enter this doctrinal area. The Court has denied *certiorari* in those cases that have been brought before it. *See, e.g., In re President and Directors of Georgetown College*, 331 F.2d 1000 (D.C. Cir. 1964), *cert. denied*, 377 U.S. 978 (1964); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied* 429 U.S. 922 (1976); *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981), *cert. denied*, 454 U.S. 858 (1981).

feel deeply ambivalent about the treatment decision; and with the doctors and nurses—who have devoted their careers to saving lives, but who are now asked to assist in ending life.<sup>7</sup> While the courts' recognition of patients' rights in this area has remained controversial, the decisions seem to have gained general popular support.<sup>8</sup>

In *Legal Frontiers of Death and Dying*,<sup>9</sup> Professor Norman Cantor<sup>10</sup> summarizes and discusses the right to die decisions. He clarifies the concepts underlying the rights that courts have recognized. Professor Cantor offers unifying principles for justifying past decisions, and uses these principles to urge a further expansion of patients' rights.<sup>11</sup> He positions himself just slightly ahead of developing case law. He would allow competent patients to discontinue<sup>12</sup> life-preserving treatment even if the patient could have been kept alive for long periods of time or even restored to full health.<sup>13</sup> Professor Cantor rejects the rea-

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<sup>7</sup> See Minow, *Beyond State Intervention in the Family: For Baby Jane Doe*, 18 U. MICH. J.L. REF. 933, 994-95 (1985).

<sup>8</sup> See 90% in Poll Back Patients' Right to Die, N.Y. Times, Dec. 2, 1986, at 10, col. 3.

<sup>9</sup> N. CANTOR, *LEGAL FRONTIERS OF DEATH AND DYING* (1987). Other recent overviews of the right to die area include: L. TRIBE, *AMERICAN CONSTITUTION LAW* § 15-11 (2d ed. 1988); PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT* (1983) [hereinafter, PRESIDENT'S COMMISSION]; Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* (1987); MOONEY, *Deciding Not to Resuscitate Hospital Patients: Medical and Legal Perspectives*, 1986 U. ILL. L. REV. 1025.

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<sup>11</sup> This book can be seen as a modification and elaboration of the ideas Professor Cantor advanced in earlier discussions of the right to die problem. See Cantor, *Conroy, Best Interests, and the Handling of Dying Patients*, 37 RUTGERS L. REV. 543 (1985); Cantor, *Quinlan, Privacy, and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 243 (1977); Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228 (1973).

<sup>12</sup> In this article, I will not distinguish between decisions to refuse treatment and decisions to discontinue treatment. Though the distinction between refusing and discontinuing treatment was considered significant in some early writings in this area, it has been rejected by nearly every court and commentator that have recently considered the question. See, e.g., HASTINGS CENTER, *supra* note 9, at 130.

<sup>13</sup> N. CANTOR, *supra* note 9, at 16-30. Professor Cantor's analysis thus includes, and agrees with, the court's conclusion in *Bouvia v. Superior Court*, where the patient was a paraplegic, not terminally ill, who wanted her feeding tube removed. 179 Cal. App.3d 1127, 225 Cal. Rptr. 297 (1986). The court authorized the removal, even though there was evidence that the patient's intention was to commit suicide.

Cantor draws the line at cases involving prisoners who are hunger-striking and who want to resist force-feeding. He distinguishes these cases because the prison-

soning in some of the earlier cases that would limit a competent patient's right to refuse treatment to patients whose death was imminent.<sup>14</sup>

He bases his conclusions on the concepts of "self-determination or autonomy," which are "essential part[s] of the human dignity cherished by American society."<sup>15</sup> Professor Cantor argues that these objectives lead to the conclusion that one's desire to resist medical treatment and to shape one's dying process should be respected.<sup>16</sup>

Early writings about the right to refuse treatment suggested that courts respond to these requests by characterizing the type of treatment or the treatment decision based on the following distinctions: distinctions between ordinary and extraordinary treatment, between actively hastening death and passively allowing a person to die, between withholding and withdrawing treatment, and between withholding nutrition and withholding other forms of treatment. These distinctions were the tools the courts and most commentators<sup>17</sup> used to differentiate the common law right to refuse treatment and the common law wrong of suicide. More recent court decisions have rejected these distinctions,<sup>18</sup> and Professor Cantor agrees. "Commentators struggle to find bases on which to differentiate humane termination of treatment of medical care from unlawful killing. . . . Judges [how-

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ers were using their refusal of both food and medical treatment not as a considered choice to die but as a method of extorting concessions from the prison officials. See *In re Caulk*, 125 N.H. 226, 480 A.2d 93 (1984); *State ex rel. White v. Narick*, 292 S.E.2d 54 (W. Va. 1982) (both rejecting prisoner's claim). But see *Zant v. Prevatte*, 248 Ga. 832, 286 S.E.2d 715 (1982) (recognizing the prisoner's claim).

<sup>14</sup> N. CANTOR, *supra* note 9, at 11-16, 180-81. *Accord* *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 192-93, 209 Cal. Rptr. 220, 223 (1984); *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 433-38, 497 N.E.2d 626, 635-38 (1986); *In re Conroy*, 98 N.J. 321, 355, 486 A.2d 1209, 1226 (1985).

<sup>15</sup> N. CANTOR, *supra* note 9, at 19.

<sup>16</sup> *Id.* at 19-26, 180-82.

<sup>17</sup> Such commentators include the Vatican. See *Declaration on Euthanasia, the Sacred Congregation for the Doctrine of the Faith*, Vatican City (May 5, 1980), reprinted in *PRESIDENT'S COMMISSION*, *supra* note 9, at 300.

<sup>18</sup> See, e.g., *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 438-39, 497 N.E.2d 626, 637-38; *In re Conroy*, 98 N.J. 321, 369-74, 486 A.2d 1209, 1233-37. See *PRESIDENT'S COMMISSION*, *supra* note 9, at 60-90. Occasionally a lower court decision will maintain some of these distinctions, despite contrary precedent. See *Workmen's Circle Home v. Fink*, 135 Misc. 270, 273-74, 514 N.Y.S.2d 893, 895-96 (Sup. Ct. 1987) (passively allowing to die or actively hastening death); *In re Delio v. Westchester County Medical Center*, 134 Misc. 2d 206, 213-15, 510 N.Y.S.2d 415, 418-20 (Sup. Ct. 1986) (withdrawing nutrition or withdrawing a respirator), *rev'd*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (1987).

ever] have been able to endorse humane medical practices, especially those respecting decisions of competent patients, without reliance on the arcane lines originally suggested."<sup>19</sup>

In the area of treatment decisions made in the name of incompetent patients, Professor Cantor argues that courts have misapplied the formulated standards and that they have been too restrictive as to when treatment may be discontinued.<sup>20</sup> There are basically two approaches to decisionmaking for the incompetent patient: self-determination and best interests.<sup>21</sup> Under the self-determination (or "subjective") standard, courts try to deter-

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<sup>19</sup> N. CANTOR, *supra* note 9, at 31-32. See also Handler, *Social Dilemmas, Judicial (Ir)resolutions*, 40 RUTGERS L. REV. 1, 12-13 & n.31 (1987) (footnote omitted). Justice Handler commented:

These [judicial attempts to distinguish suicide from discontinuation of treatment] are not entirely persuasive, . . . but they reflect our convictions that differentiations can be made; a terminal patient's refusal of extraordinary medical care seems to us an action different in kind from someone shooting herself in the head.

*Id.* at 13.

<sup>20</sup> N. CANTOR, *supra* note 9, at 58-62.

<sup>21</sup> The most recent state court cases have continued to apply the analytical structure suggested in one of the earliest cases, *Superintendent v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977), despite the fact that this analytical structure seems inconsistent with the reasoning and holdings of the more recent cases. *Saikewicz* listed four possible countervailing state interests: 1) the preservation of life; 2) the protection of innocent third parties; 3) the prevention of suicide; and 4) the ethical integrity of the medical profession. *Saikewicz*, 373 Mass. at 741, 370 N.E.2d at 425.

In the few recent cases in which authorization for discontinuation of treatment was refused, none of these specific factors were given as justification. Rather the holding was explained in terms of whether the "subjective" or "objective" standards have been met. See text accompanying notes 21-26.

"Medical ethics" was only seriously considered as a countervailing interest in *Quinlan*. See *In re Quinlan*, 70 N.J. 10, 42-51, 355 A.2d 647, 664-69 (1976), *cert. denied*, 429 U.S. 922 (1976). Even though authorizing the discontinuation of treatment appeared to be contrary to established medical procedures, by the time the New Jersey right to die cases were argued in 1986, standards promulgated by the major state and national medical groups were cited in favor of a broad right to refuse or discontinue treatment. See *In re Farrell*, 108 N.J. 335, 349-52, 529 A.2d 404, 411-12 (1987). The interest in preventing suicide has been dismissed as irrelevant in the few cases in which it has been seriously raised. See *Bouvia v. Superior Court*, 179 Cal. App.3d 1127, 1142-45, 225 Cal. Rptr. 297, 304-06 (1986); *cf.* Comment, *Suicide Competence and the Patient's Right to Refuse Lifesaving Treatment*, 75 CALIF. L. REV. 707 (1987).

The interest in protecting third parties, was once the basis for refusing authorization. See *In re President and Directors of Georgetown College*, 331 F.2d 1000, 1008 (D.C. Cir. 1964), *cert. denied*, 377 U.S. 978 (1964); *Holmes v. Silver Cross Hosp.*, 340 F. Supp. 125, 130 (N.D. Ill. 1972). This interest, however, has also been rejected in all recent cases in which it has been considered. See, e.g., *Wons v. Public Health Trust*, 500 So.2d 679, 688 (Fla. Dist. Ct. App. 1987); *St. Mary's Hosp. v. Ramsey*, 465 So.2d 666, 668-69 (Fla. Dist. Ct. App. 1985); *Mercy Hosp. v. Jackson*, 62 Md. App. 409, 417-18, 489 A.2d 1130, 1134 (1985), *vacated as moot*, 306

mine what choice the patient would have made. This determination, optimally, will be based on explicit instructions left by the patient when still competent. If such instructions are not available, the determination can be based on past comments the patient made about similar subjects<sup>22</sup> or based on a close friend's or close relative's best surmise of how the patient would have reacted. In contrast, the best interests or "objective" standard reflects the traditional standard for guardians of the legally incompetent. A guardian must always act in the best interests of the incompetent.<sup>23</sup> There is a hierarchy within these standards; courts usually attempt to apply a subjective standard, and resort to an objective standard only when subjective standards are completely inapplicable.<sup>24</sup> Professor Cantor argues that when possible, guardians and the courts should seek to effectuate the incompetent patient's right to self-determination.<sup>25</sup> Cantor warns, however, that courts may be too quick to label their determinations as "subjective" in situations where there is no available basis for determining what the patient would have wanted.<sup>26</sup>

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Md. 556, 510 A.2d 562 (1986); *In re Farrell*, 108 N.J. 335, 352-53, 529 A.2d at 404, 412-13.

*Cf. In re A.C.*, 533 A.2d 611 (D.C. App. 1987). In *A.C.*, a hospital was granted judicial authorization to render medical treatment to a terminally ill pregnant woman despite her refusal to consent. The treatment, a caesarean section, however, was not sought for the woman's benefit. It was conceded that the procedure would actually worsen her condition. The procedure's purpose was to give the fetus a chance, albeit a slim one, of surviving. (In fact, both mother and child died soon after the operation was performed.) The court concluded that "the trial judge did not err in subordinating A.C.'s right against bodily intrusion to the interests of the unborn child and the state." *Id.* at 617.

<sup>22</sup> An interesting "feed back" seems to be occurring within the right to die cases. The publicity given the *Quinlan* case has made determinations of patients' wishes in later cases easier. In many recent cases, patients' friends and family have been able to analogize the patients' reactions to *In re Quinlan*. Patients have stated that they would not want to be kept alive if they were in the same situation as Ms. Quinlan. See, e.g., *In re Jobes*, 108 N.J. 394, 410, 529 A.2d 434, 442 (1987); *In re Delio v. Westchester County Medical Center*, 129 A.D.2d 1, 6-7, 516 N.Y.S.2d 677, 681-82 (1987).

<sup>23</sup> For a discussion of the weaknesses and strengths of both approaches to decisionmaking, see *In re Jobes*, 108 N.J. 432-37, 529 A.2d 434, 453-56 (1987) (Handler, J., concurring); see also Minow, *supra* note 7, at 971-74; PRESIDENT'S COMMISSION, *supra* note 9, at 132-36.

<sup>24</sup> See, e.g., *In re Conroy*, 98 N.J. 321, 358-68, 486 A.2d 1209, 1228-33 (1985).

<sup>25</sup> N. CANTOR, *supra* note 9, at 64-67, 79.

<sup>26</sup> *Id.* at 60, 91-96. The most egregious mislabeling may have occurred in the case of *Superintendent v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 413 (1977) where the court put forward the following standard: "the decision in cases such as this should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of

Professor Cantor, unlike most of the courts which have considered the issue, seems fully to appreciate the conceptual complexities even in the most straightforward "subjective" decision. The extent to which the court could go in a case like *Farrell* to show that a treatment decision for a competent patient conforms to her right of self-determination, indicates how unsure we should be that treatment decisions for incompetent patients vindicate their right of self-determination. Experts interviewed Mrs. Farrell to determine that she was competent, her decision was unwavering and not the product of undue influence, and, she understood her condition, her prognosis, and the consequences of discontinuing treatment.<sup>27</sup> Incompetent patients are unable to be questioned and a recent statement of preference cannot be considered equivalent to a decision made when fully facing the terminal consequences.<sup>28</sup>

Professor Cantor is uncomfortable with the criteria courts have established for applying the "best interests" standard. Under such standards, a court is often required to determine a patient's level of pain.<sup>29</sup> "A major problem . . . in administering a best interests standard geared to the temporal physical and mental pain of an incompetent patient is that such suffering (and countervailing positive feelings) may be largely indeterminable."<sup>30</sup>

For anyone offering a theory about how the courts should decide right to die cases, the most revealing question is how the theory would resolve two extreme (though far from unrealistic) fact situations. First, the patient is legally incompetent and there is no basis for determining what she would have decided: there is

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the individual as one of the factors which would necessarily enter into the decision-making process of the competent person." *Id.* at 752-53, 370 N.E.2d at 431. The "subjective" determination under this standard would be complicated even more, for in *Saikewicz*, as in many other cases, the patient not only was incompetent at the time of the treatment decision, but he had never been competent. *Id.* at 419, 370 N.E.2d at 729.

<sup>27</sup> *In re Farrell*, 212 N.J. Super. 294, 294-300, 514 A.2d 1342, 1342-44 (1986), *aff'd*, 108 N.J. 335, 529 A.2d 404 (1987).

<sup>28</sup> See *In re Gardner*, 534 A.2d 947, 956-59 (Me. 1987) (Clifford, J., dissenting); *In re Jobes*, 108 N.J. 394, 432-33, 438 n.9, 529 A.2d at 434, 453-54, 456 n.9 (Handler, J., concurring).

<sup>29</sup> See, e.g., *In re Conroy*, 98 N.J. 321, 364-67, 486 A.2d 1209, 1231-33 (1985), *cf.* HASTINGS CENTER, *supra* note 9, at 28-29.

<sup>30</sup> N. CANTOR, *supra* note 9, at 75. Some medical authorities seem to believe that "[i]f medicine's capacity for relieving pain and suffering were fully tapped," there would be no justification for discontinuation of treatment on the basis of the patient's level of pain. See HASTINGS CENTER, *supra* note 9, at 129.

no evidence of prior comments on the subject, and no close friends or relatives. Second, the patient seeks to refuse treatment when the refusal would probably result in death, but with treatment the patient would be restored to full physical and mental functioning.

As to the first extreme case, Professor Cantor offers a subtle but provocative position. He argues that a broad set of standards can be established for incompetent patients for whom the subjective standard is inappropriate, without relying exclusively on determinations of the patient's level of pain. Professor Cantor postulates that a consensus can be created through case law and accompanying public opinion regarding circumstances under which persons would want treatment discontinued. "[I]t may be possible to gradually discern acceptable societal norms of humane handling of moribund patients. . . . [S]hared notions of human dignity will ultimately govern decision-making on behalf of incompetent moribund patients."<sup>31</sup>

Professor Cantor suggests some "tentative answers" to the question of what form this consensus may eventually take: patients should be granted relief from painful dying processes;<sup>32</sup> when there is a total absence of mentation (patients who are comatose or in a permanent vegetative state) "termination of life support is consistent with respect for human dignity"<sup>33</sup> and termination of treatment may be humane for patients who were "formerly active, independent, and articulate," whose condition has deteriorated to "total immobility, along with virtually total incomprehension" or who need to use elaborate physical restraints.<sup>34</sup> If Professor Cantor's view can be criticized, it would be for being premature in his prediction of a developing consensus and perhaps a little too optimistic about the ability of judges to find the best answers.

The unstated conceptual assumption of Professor Cantor's approach to the right to die cases is that the fear of abuse cuts both ways. In the event of doubt, treatment should not always continue.<sup>35</sup> The argument is that there are situations so contrary

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<sup>31</sup> N. CANTOR, *supra* note 9, at 76-77.

<sup>32</sup> *Id.* at 79.

<sup>33</sup> *Id.* at 79-81.

<sup>34</sup> *Id.* at 81-82.

<sup>35</sup> See *Satz v. Perlmuter*, 362 So.2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So.2d 359 (Fla. 1980). The Florida District Court of Appeals stated:

It is all very convenient to insist on continuing Mr. Perlmuter's life so that there can be no question of foul play, no resulting civil liability and



to human dignity that (if there is no evidence of the patient's desires to the contrary) treatment should be discontinued, and it would be an abuse not to do so. The question of dignity is obviously separate from any claim based on autonomy. A claim based on dignity is more amorphous, harder to ground in traditional legal analyses, and perhaps more controversial once translated into specific criteria.

As to the second extreme case, Professor Cantor seems willing to recognize a right to refuse life-saving treatment regardless of the prognosis.<sup>36</sup> The following quotation is illustrative of Professor Cantor's approach to the right to die issues.

The thesis is that patient self-determination or autonomy is an essential part of the human dignity cherished by American society. That dignity is impinged when a competent person's voluntary choice is overridden, even where the patient's determination is distasteful to the medical and judicial personnel confronting the situation. Perhaps the offense to human dignity and autonomy exists in its most objectionable form where treatment is forced on a dying patient who is intent on maintaining dignity in the face of an irremediable dying process. But an offense exists as well when the will of a salvageable patient is overridden.<sup>37</sup>

It is difficult to test one's position against actual fact situations of the second type of extreme case, because, unlike the first type of extreme case, these cases do not seem to reach the courts without factors that present alternative bases for decision.<sup>38</sup>

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no possible trespass on medical ethics. However it is quite another matter to do so at the patient's sole expense and against his competent will, thus inflicting never ending physical torture on his body until the inevitable, but artificially suspended, moment of death.

Satz, 362 So.2d at 164. See also *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985). The New Jersey Supreme Court advanced: "To err either way—to keep a person alive under circumstances under which he would rather have been allowed to die, or to allow that person to die when he would have chosen to cling to life—would be deeply unfortunate." *Id.* at 343, 486 A.2d at 1220.

<sup>36</sup> N. CANTOR, *supra* note 9, at 16-26, 180-81.

<sup>37</sup> *Id.* at 19-20.

<sup>38</sup> Three types of cases exemplify this extreme situation. The first category are cases where patients refuse to consent to life-saving amputations of a limb knowing that death is likely without the operation. See, e.g., *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (Morris County Ct. 1978). Professor Cantor recognized that these cases can be seen as judicial deference to understandable value judgments: "What is distasteful to these patients is the prospective incapacity and dependency after the amputation. The lesson of the amputation cases ought to be that patient autonomy includes the prerogative to resist life-preserving treatment where the existence to be preserved would represent a subjective hell for the patient." The second category of cases are those in which a patient refuses relatively

The development of case law may "define classes of cases in which decision-making principles are well established, and in which such principles are routinely applied to actual cases without reported abuse. Those decisions can safely be left to the traditional decision-making processes—medical staff and next of kin acting in conjunction with one another."<sup>39</sup> Treatment decisions are scrutinized according to a number of factors: the vulnerability of the patient, whether established procedures and standards are available within the medical care community, and how likely error or improper motive<sup>40</sup> would be in particular situations.<sup>41</sup> Professor Cantor points out that there will always be procedural and institutional checks on these decisions to prevent abuse: decisions can be challenged within institutions by doctors or ethics committees, or they can be challenged in court by concerned friends, relatives or the state's public advocate. Additionally, patients can always leave instructions specifying that they wish to be maintained even if they suffer extreme physical and mental deterioration.<sup>42</sup>

The right to die cases are difficult in part because they present the legal system with novel situations, which were borne of modern technology. Traditional legal doctrines fit only awkwardly when applied to these issues.<sup>43</sup> The difficulty of these cases may also come from our seeking legal answers to problems too deeply rooted in the human situation to be solved by statements about rights and liberties. Our doubts and hesitations regarding these cases come from

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trivial life-sustaining treatment because such treatment is contrary to religious beliefs. See, e.g., *Wons v. Public Health Trust*, 500 So.2d 679 (Fla. Dist. Ct. App. 1987); *In re Brown*, 478 So.2d 1033 (Miss. 1985); *In re Milton*, 29 Ohio St. 3d 20, 505 N.E.2d 255 (1987). In these cases, countervailing state interests must overcome not only the patient's right to refuse treatment, but also her right to religious free expression. The third category of cases are those involving hunger-striking prisoners. See *supra* note 13.

Cf. *Evans v. Bellevue Hosp.*, No. 16536/87 (N.Y. Sup. Ct. July 27, 1987); N.Y.L.J. July 28, 1987, at 11, col. 1. In *Evans*, the patient was unconscious due to the effects of an AIDS-related disease. He had explicitly requested no medical treatment if he could not be restored to a "meaningful quality of life." The judge refused to authorize the discontinuation of treatment because the patient was not terminally ill, and his present infection was considered treatable.

<sup>39</sup> N. CANTOR, *supra* note 9, at 117.

<sup>40</sup> Professor Cantor offers an interesting discussion of "improper factors" in treatment decision-making. See N. CANTOR, *supra* note 9, at 83-91. Cf. Minow, *supra* note 7, at 974-76, 1001-04.

<sup>41</sup> See *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987); *In re Peter* by Johanning, 108 N.J. 365, 529 A.2d 419 (1987); *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987). These cases establish varying substantive and procedural criteria, depending on the factual context, for authorizing the discontinuation of treatment.

<sup>42</sup> N. CANTOR, *supra* note 9, at 82.

<sup>43</sup> See generally Handler, *supra* note 19.

problems of trust and distrust, which cannot be glossed over by the legal system, but might be ameliorated by procedural changes in some of the institutions involved in this litigation.<sup>44</sup> We distrust the motivation of guardians who are too close to the patient; they cannot be objective.<sup>45</sup> But we also distrust decisionmakers who are not close enough to the patient; how can they know what the patient would have wanted? We distrust decisions made by hospitals and nursing homes, because we fear for the vulnerability of elderly patients cut off from family and friends, and we fear that treatment decisions might sometimes be made out of concerns of profit or convenience.<sup>46</sup>

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<sup>44</sup> See Minow, *supra* note 7, at 998-1009. Professor Minow discusses how the search for the optimal distribution of rights and protective procedures may serve only to hide the real underlying problems. She commented:

No new substantive rule, procedural technique, or new position on the state intervention debate will promote trust between people concerning this subject that so invokes personal vulnerabilities. . . . Over time new rules may well secure public confidence through new routines that recede into the background of settled expectations much like the old routines . . . . The debates over state intervention, right to life versus quality of life, and procedural alternatives themselves express dimensions of distrust between people—distrust that runs deeper than the particular medical treatment decisions at issue. Addressing the conditions of distrust themselves may open the way for new routines to gain wide acceptability for dealing with medical treatment decisions . . . . Because sharp disagreements are bound to persist, these routines will chiefly involve ways of channeling disagreement away from simplistic, adversarial alternatives, and toward contextual discussions that address what really could and should happen . . . .

*Id.* at 999.

<sup>45</sup> See *Superintendent v. Saikewicz*, 373 Mass. 728, 758-59, 370 N.E.2d 417, 434-35. The Massachusetts Supreme Court stated:

We take a dim view of any attempt to shift the ultimate decision-making responsibility away from the duly established courts. . . . [S]uch questions of life and death seem to us to require the process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created.

*Id.* See also *In re Beth Israel Medical Center*, 136 Misc. 931, 519 N.Y.S.2d 511 (Sup. Ct. 1987) (implying that friends and relatives may, out of mercy, make up "recalled" relevant comments by the now-incompetent patient); Merritt, *Equality for the Elderly Incompetent: A Proposal for Dignified Death*, 39 STANFORD L. REV. 689, 724-25 (1987) (A grieving family may falsely project their own suffering onto the incompetent patient.).

<sup>46</sup> See *In re Conroy*, 98 N.J. 321, 374-85, 486 A.2d 1209, 1237-42 (1985). The courts' troublesome problem of trust and distrust can be seen perhaps most clearly in *Quinlan*. The court purports to discuss the patient's right to choose and what choice she would have made. However, most of the opinion is devoted to describing the patient's guardian, her father, as a religious person, a caring person, a person without ulterior motives, and a person who came to the decision to discontinue Ms. Quinlan's treatment only after lengthy deliberation. *In re Quinlan*, 70 N.J. 10, 28-34, 53, 355 A.2d 647, 656-60, 670-71 (1976), *cert. denied*, 429 U.S. 922 (1976).

Consider the courts' confused discussions of whether it is appropriate to consider "quality of life" factors in decisionmaking for incompetent patients.<sup>47</sup> Several things are clear from reading such discussions. First, there is no agreement on what is meant by "quality of life" as a factor in a medical treatment decision.<sup>48</sup> Second, the courts are using "quality of life" as a straw man argument. To my knowledge, no party or amicus curiae to a right to die case has ever argued, as one court implied had occurred, that medical treatment should be terminated because the patient's "value to society seems negligible."<sup>49</sup> The opinions are trying to respond to public distrust of decisions to discontinue medical treatment.<sup>50</sup> The courts are trying to form positions which seem more trustworthy, more reasonable, more benign and more objective<sup>51</sup> by contrasting their standards with irrational or dangerous hypothetical standards.

The courts seek decisionmaking approaches that will both respect the right to refuse medical treatment and assure the public that such decisions are being made for legitimate reasons. In *In re Conroy*, the New Jersey Supreme Court may have tried too hard to gain public trust. The procedures set up by the court<sup>52</sup> were so

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In sharp contrast to more recent right to die opinions, we learn a great deal about the patient's guardian from the opinion, and almost nothing about the patient.

<sup>47</sup> Compare *Brophy v. New England Sinai Hosp.*, 398 Mass. 417, 433-34, 497 N.E.2d 626, 635 (1986) with *In re Conroy*, 98 N.J. 321, 363-67, 486 A.2d 1201, 1232-33 and 98 N.J. at 391-92, 397-99, 486 A.2d at 1246, 1249 (Handler, J., concurring in part and dissenting in part). See generally Handler, *supra* note 19, at 18-20 & n.62.

Professor Cantor's discussion of "quality of life" is far more clear and helpful. N. CANTOR, *supra* note 9, at 53-57, 180-82. Cf. Merritt, *supra* note 45, at 734-35; Minow, *supra* note 7, at 954-56, 961-69.

<sup>48</sup> For example, the *Brophy* opinion rejected "qualify of life" factors, immediately after it affirmed consideration of factors that the *Conroy* majority would have labeled as "quality of life." See *supra* note 47.

<sup>49</sup> See *In re Conroy*, 98 N.J. 321, 367, 486 A.2d 1209, 1233.

<sup>50</sup> Still fresh in many persons' memories are the atrocities that doctors in Nazi Germany committed under the aegis of euthanasia and "quality of life" determinations. See R. LISTON, *THE NAZI DOCTORS* (1986).

<sup>51</sup> The majority opinion in *Conroy* labeled as a "pure-objective test" the standard that allowed the termination of treatment for terminally ill patients suffering from "recurring, unavoidable and severe pain." *Conroy*, 98 N.J. at 366, 486 A.2d at 1232. However, it is not self-evident that every decision made for a patient under this standard would be what the patient would have wanted. Some patients may have desired the continuation of life-sustaining treatment even under extreme circumstances. Some patients might value a view of human dignity higher than the avoidance of pain. There is no "objective" reason for attributing to incompetent patients pain as a factor for treatment decisions. See *id.* at 393-96, 486 A.2d at 1247-48 (Handler, J., concurring in part and dissenting in part); *In re Jobes*, 108 N.J. 365, 441, n.12, 529 A.2d 434, 458 n.12 (Handler, J., concurring).

<sup>52</sup> See *Conroy*, 98 N.J. at 379-84, 486 A.2d at 1240-42.

cumbersome that affected persons apparently chose not to exercise their right or to circumvent the procedures.<sup>53</sup>

The courts' reasoning in upholding patients' rights has been broader than what was necessary to decide the questions before them. This has led some commentators to question what limitations there are on patients' rights in this area.<sup>54</sup> Courts circumvented this line-drawing problem by relying (explicitly or implicitly) on an intuitive, but ultimately unprincipled, distinction: the difference between termination of treatment that simply allows an inexorable dying process to continue and situations where that characterization does not seem appropriate.<sup>55</sup> If there is a right to refuse medical treatment, why should that right vary in strength depending on the person's prognosis? If our constitutional right to privacy allows us, rather than our doctors or the government, to control how we are to be treated near death, why should this right wax and wane according to our level of consciousness or our level of pain?<sup>56</sup> The answer given is that the state interest in life diminishes as the patient's

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<sup>53</sup> Well over 100 persons made inquiries with the office of the Ombudsman for the Institutionalized Elderly regarding the procedures to be followed for authorizing the withdrawal of medical treatment for nursing home patients. Yet only one case had been officially brought to the Ombudsman's attention, the first step in the procedures. Sullivan, *Curbs on Ending Life Supports Are Ignored*, N.Y. Times, Nov. 28, 1986, at B15, col. 1.

<sup>54</sup> See, e.g., L. TRIBE, *supra* note 9, at 1366-71.

<sup>55</sup> See, e.g., *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1344 (Del. 1980) ("the penumbra where death begins but life, in some form, continues . . . the medical miracles which now compel us to distinguish between 'death' as we have known it, and death in which the body lives in some fashion but the brain (or a significant part of it) does not."); *In re L.H.R.*, 253 Ga. 439, 445-46, 321 S.E.2d 716, 722, 723 (1984) ("Under these circumstances, we find that the life support system was prolonging her death rather than her life . . . While the state has an interest in the prolongation of life, the state has no interest in the prolongation of dying."); *In re Eichner*, 102 Misc. 2d 184, 204, 423 N.Y.S.2d 580, 593 (Sup. Ct. 1979) ("a treatment which, in these circumstances, serves only more or less briefly to extend the process of dying"), *modified*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980), *modified*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981), *cert. denied*, 454 U.S. 858 (1981); *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 6, 426 N.E.2d 809, 812 (1980) ("She is on the threshold of death, and man has, through a new medical technology, devised a way of holding her on that threshold.").

<sup>56</sup> The shifting balance analysis, with obvious resonance from *Roe v. Wade*, 410 U.S. 113 (1973) was advanced in *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied* 429 U.S. 922 (1976). "We think that the State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the state interest." *Quinlan*, 70 N.J. at 41, 355 A.2d at 664. This analytical structure has been adopted unquestioned by many subsequent decisions. See, e.g., *In re Beth Israel Medical Center*, 136 Misc. 931, 942, 519 N.Y.S.2d 511, 518. Later commentators, however, have shown that this reasoning is inappropriate and illogical within the right to die area. See Capron, *Borrowed Lessons: The*

prognosis dims.<sup>57</sup>

However, that seems wrong as well, for it requires that states "regularly make value judgments about the value of a life," a position that most courts have taken great efforts to avoid.<sup>58</sup> Professor Cantor is correct in arguing for a right that is invariable. The courts' contrary position is a result of distrust or lack of confidence in the decisionmaking process. They fear that the possibility, and the consequences, of abuse might be greater if the scope of the right includes patients not close to death.<sup>59</sup> However, as long as the medical treatment decisions are grounded in the common law right to refuse treatment, the fear that courts will cross the line between discontinuation of treatment and "active euthanasia" is unfounded.<sup>60</sup>

Professor Cantor has given us an important and well-written guide to a doctrinal area in its adolescence. The right to die area is still developing. The courts' analytical tools are only just beginning to fit the breadth of the factual situations before them and the subtle but important differences among those situations. The courts are becoming more comfortable in dealing with the problems of medical treatment cases. In retrospect, the earlier opinions can be seen to reflect a caution and hesitancy that is slowly fading.<sup>61</sup> However, we are still far from the consistency and uniformity of a more developed doctrinal area: regarding, e.g. the criteria for a "best interests" standard and the procedures for authorizing discontinuation of treatment. Professor Cantor helps us to understand this field in transition, and he offers one possible path along which doctrine might develop.<sup>62</sup>

Brian Bix\*

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*Role of Ethical Distinctions in Framing Law on Life-Sustaining Treatment*, 1984 ARIZ. ST. L.J. 647, 656-58; L. TRIBE, *supra* note 9, at 1367-68.

<sup>57</sup> See, e.g., *In re Quinlan*, 70 N.J. 10, 41, 355 A.2d 647, 664.

<sup>58</sup> L. TRIBE, *supra* note 9, at 1366; see *supra* text accompanying notes 47-51.

<sup>59</sup> See *In re Jobes*, 108 N.J. 365, 430-31, 529 A.2d 434, 455-56 (Handler, J., concurring).

<sup>60</sup> See, e.g., HASTINGS CENTER, *supra* note 9, at 128-29.

<sup>61</sup> See *supra* notes 4 & 56.

<sup>62</sup> Professor Cantor devotes a chapter of his book to the related topic of treatment decisions for severely handicapped infants. Though he deals with issues and procedural problems unique to that area, his analysis follows many of the concepts and arguments that he advanced in his discussion of the right to die cases.

On the topic of the appropriate standards and procedures in treatment decisions for severely handicapped infants, I have nothing to add to the fine analysis and discussion offered by Professor Minow in Minow, *Beyond State Intervention in the Family: For Baby Jane Doe*, 18 U. MICH. J.L. REF. 933 (1985).

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