To this point, we have discussed the forces of policy restraint, the forces of top-down activism associated with a profound transformation in the medical profession, and the forces of bottom-up activism associated with important social changes. With that framework in place, it is time to consider the forces of mediation that do not set the policy agenda so much as they shape policy outcomes in the areas where activism succeeds in overwhelming restraint. Activism and restraint set the stage for policymaking by mediators—the individuals and institutions that then go on to forge policy results.

Policy mediation takes place in a number of different venues. The courts make policy all the time in the form of case law. Courts interpret statutory law in light of the state and federal constitutions, taking case-law precedents from past decisions across the nation into account. Statutory law is the work of the legislatures. Legislators introduce bills, hold hearings, and pass legislation that is sent to the executive, who either signs the bill into law or rejects it. The executive branch of government can make policy as well, in the form of executive orders issued by the executive or regulations formulated and promulgated by executive-branch agencies. Sometimes, policy mediation is relegated to private entities. In that case, policy takes the form of institutionally based guidelines that affect the way the public is treated in areas that are associated, in theory, with some measure of public-sector responsibility.

With regard to the right to die, the governors have stayed out of the policy mediation business for the most part, although various state departments of health have had some passing interest in certain aspects of this issue; for example, the New York State Department of Health became involved in the case of Timothy Quill, and the Missouri Department of Health argued cases against the Busalacchi
and Cruzan families in state court. Private entities have been more involved, particularly in terms of formulating policies on the execution of DNR orders. These exceptions aside, however, the real epicenters of right-to-die policy mediation have been the state courts and, to a lesser degree, the state legislatures. Chapter 7 provides a survey of the state courts’ role in this mediation, and Chapter 8 discusses the role played by the state legislatures.

We find that the state courts and legislatures have been engaged for some years in a game of legal tennis. For the most part, the courts have been serving all along. The legislatures have occasionally returned serve with weak shots, but more often, they have been aced. In short, state-court judges are the political actors who have taken the lead in applying policy alternatives to the right-to-die problems on the agenda, and the legislatures, when pressured to act, have dragged their collective feet if they have done anything at all.

Legal Foundations for a Right to Die

In the decade and a half since 1976, the year the New Jersey Supreme Court decided the landmark case of Karen Ann Quinlan, the state courts have played the central role in legitimizing the right of dying patients to refuse medical treatments. Though the establishment of right-to-die precedents has proceeded incrementally across the States, several common premises have emerged in the case law.

First, the state courts have leaned almost exclusively on two legal pillars in building a case for the right-to-die premise: (1) a common-law recognition of human autonomy and self-determination, as manifest in the informed-consent doctrine, and (2) constitutionally grounded rights to both liberty and privacy. Second, the courts have struggled to establish enduring criteria for surrogate decisionmaking when the principal is incompetent in right-to-die cases, although judges have exhibited a general tendency to be lenient in recommending that decisions be placed in the hands of others (typically, those of the families and health-care professionals) whenever possible. Third, the courts have come to accept the notion that artificial nutrition and hydration is a medical procedure that a patient—or the surrogate making decisions for an incompetent patient—may choose to forgo in exercising the established right to die. And fourth, the right to die applies to both those who are terminally ill and those who are in a persistent vegetative state.

Common-Law Grounds

There is a long-standing common-law tradition in American jurisprudence that recognizes and protects human autonomy and self-determination, based on eigh-
teenth-century English common law. This principle, the basis for what is commonly referred to as informed consent, is regularly applied in cases where petitioners are requesting that medical procedures be withheld.

Case law that draws on this principle of informed consent traces back at least 100 years to the seminal U.S. Supreme Court ruling of 1891, in which the court held that a plaintiff could not be ordered to submit to a surgical exam against his or her will (Union Pacific Railroad v. Botsford). In addressing the issue of bodily control, the court stated: "No right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference by others, unless by clear and unquestionable authority of law."

Justice Benjamin Cardozo reaffirmed this premise twenty-three years later when writing an opinion in Schloendorff v. Society of N.Y. Hospital (1914). In a much-quoted statement from that decision, Cardozo writes that "every human being of adult years and sound mind has the right to determine what shall be done with his body." In effect, Cardozo used this case to expand the liberty concept that preserved the individual's right to resist invasive therapies against his or her will by incorporating a positive obligation on the part of medical personnel to inform patients of their alternatives. Thereafter, the tort doctrine of informed consent would be thought to oblige health-care professionals to explain, in good faith, proposed medical procedures and associated risks to prospective patients, then obtain consent, if possible, before proceeding. Moreover, in Cardozo's words, "a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."

Although Cardozo may not have been thinking along right-to-die lines when he charted this informed-consent doctrine, no one today questions the applicability of his doctrine in right-to-die cases. The motivations of patients exercising informed consent may vary: A patient in George Washington's predicament, where the ministrations of health professionals only serve to hasten death, may refuse treatment just as right-to-die patients may refuse treatments out of fear that medical interventions will keep them alive. Regardless of the motivation, however, common law is thought to protect both kinds of patients equally.

Constitutional Grounds

As we have noted, the doctrine of informed consent is well established in American tort law as a common-law basis for decisionmaking. But common law falls short of offering the sort of enduring protection that typically accompanies rights grounded in the U.S. Constitution. For this reason, although most all courts begin their inquiries into right-to-die cases by calling on informed consent, many look to the Constitution for further guidance. Some courts argue that they have found this guidance in two places: in the penumbral privacy-rights protections
embedded in the Bill of Rights and in the liberty protections of the Fourteenth Amendment.

The liberty interest found in the Fourteenth Amendment's due process clause is actually something of a constitutional rationale for the common-law informed-consent doctrine. That is, the Fourteenth Amendment's guarantee of "life, liberty, and property" is considered in this context to codify the common-law right of informed consent, which prohibits others from invading one's body—for purposes of surgery or otherwise—against one's will. The privacy interest is much less explicit in the Constitution. For this, one must look to court cases, beginning with the 1965 *Griswold v. Connecticut* decision in which the Supreme Court struck down state legislation that prohibited the use of contraceptives and the dispensing of birth control information among married couples (Kelly and Harbison, 1976).

Writing for the majority in *Griswold*, Justice William Douglas advanced the idea that "specific guarantees in the Bill of Rights have penumbras formed by emanations from these guarantees that give [those guarantees] life and substance" and provide "zones of privacy" for the individual. Douglas found that these penumbras were cast by the guarantees of the First, Fourth, and Fifth Amendments as "protection against all governmental invasions of the sanctity of a man's home" (cited in Kelly and Harbison, 1976, p. 963).

The right to privacy established in *Griswold* was further extended in the 1973 landmark abortion case, *Roe v. Wade*, which struck down a Texas law that made abortion a criminal offense. In reaching its decision in this case, the court relied on a series of privacy-rights cases that constitutionally protected decisions concerning procreation, marriage, and family life. For state courts considering right-to-die cases, it was a small and inevitable step to include death, the next logical (and chronologically the ultimate) zone of private life, under the privacy-rights blanket (Borst, 1985, p. 906). This, in essence, is how the New Jersey Supreme Court approached the case of Karen Ann Quinlan.

**The Supreme Court View**

Fourteen years after *Quinlan* was decided in New Jersey, the U.S. Supreme Court heard its first case ever dealing explicitly with the right to die: *Cruzan v. Director, Missouri Department of Health* (1990). Although the Cruzan family technically lost that case, the Supreme Court did affirm that there was, indeed, a long-standing common-law tradition of informed consent that could be appropriately applied in right-to-die cases. More importantly, the Court agreed that there were constitutionally protected rights at stake—specifically, the liberty interest supported by the Fourteenth Amendment.

At the same time, while the majority decision is clear and forceful in its elaboration of liberty interests, there is a conspicuous absence of discussion regarding privacy rights. This is the case, we suspect, because privacy rights are what the
Roe v. Wade abortion decision rests on. Conservative justices have chafed at the penumbral, evanescent nature of privacy rights, thinking the whole concept to be an ideological fabrication of liberal justices. Thus, William Rehnquist and the conservative wing of the court were not about to find privacy rights in the Constitution that would support the right to die for this would only lend legitimacy to the rationale that undergirds the Roe decision—a decision that conservative justices would just as soon overturn, given the opportunity.

Despite the fact that many state courts have alluded to the privacy-rights argument in defense of the right to die, Chief Justice William Rehnquist—author of the majority opinion—buried his only reference to the privacy question in a footnote, pointing out that “although many state courts have held that a right to refuse treatment is encompassed by a generalized right of privacy, we have never so held. We believe this issue is more properly analyzed in terms of the Fourteenth Amendment liberty interest.”

Even then, the court hedged its bets by arguing that although there was a constitutional basis for the right to die, this right was not absolute. In explaining the majority’s opinion on this score, Chief Justice Rehnquist contended that it was reasonable for states to counterbalance constitutional liberty interests against relevant state interests in preserving life, preventing suicide, protecting innocent third parties, and maintaining the integrity of the medical profession. Accordingly, “determining that a person has a ‘liberty interest’ under the Due Process Clause [of the 14th Amendment] does not end the inquiry; ‘whether respondent’s constitutional rights have been violated must be determined by balancing his liberty interests against relevant state interests’” (Youngberg v. Romero, 1982).

Given this restrictive reading of the Constitution, it is conceivable that the constitutionally protected right to die could be turned on its head. That is, in cases where the principal is incompetent, the Fourteenth Amendment’s due process clause could be relied on to protect the state’s interest in preserving life as much as it might be relied on to protect an individual’s right to decide, on behalf of another, to forgo life-sustaining treatment. In other words, not only must an individual’s Fourteenth Amendment rights be balanced by the state’s interest in preserving life, the state itself may find some protection of its prerogatives in the Constitution’s due process provisions.

For example, Missouri’s Cruzan decision required that guardians of an incompetent patient produce clear and convincing evidence (in accordance with due process) of a patient’s wish to have life-sustaining procedures withdrawn. According to Rehnquist’s opinion, this was a perfectly acceptable qualification to the right to die, given that this evidentiary standard had been found appropriate in other kinds of Fourteenth Amendment cases where the state had an interest in protecting the rights of an individual (e.g., cases involving deportation, denaturalization, civil commitments, contracts, and wills). If clear and convincing evidence of intent was required in other, more pedestrian civil cases, Rehnquist ar-
gued, the same evidentiary standard surely would be appropriate in cases of greater moment, such as those involving life and death. There may be no denying an individual’s right to refuse life-sustaining treatment under the due process clause of the Fourteenth Amendment, including (according to the Supreme Court) the right to withdraw food and fluids. However, when the principal is incompetent to make the decision, questions arise as to what evidence of a patient’s wishes will qualify as valid. Under the liberty-rights rationale grounded in the due process clause, the Supreme Court argued that plaintiffs might reasonably be required to produce clear and convincing evidence sufficient to overwhelm the state’s interest in preserving life. Otherwise, the state’s interests would be allowed to prevail.

Incompetent Patients and Surrogate Decisionmakers

No court, including the U.S. Supreme Court, has left much doubt about the firm common-law and constitutional basis of the right to die. This makes the right straightforward for those who are competent enough to make their wishes known. And doctors (some more than others) have become increasingly receptive to this notion that patients might refuse treatment at the end of their lives, consistent with the principle of informed consent.

The rub comes when individuals get into right-to-die situations but are unable by reason of incompetency to make those critical life-or-death decisions for themselves. What meaning can informed consent have when patients can no longer communicate their wishes or even understand information about their condition? Can third parties give informed consent in the name of an incompetent principal? That is, can third parties exercise a principal’s liberty interest? These, it turns out, are the questions that have tried judges’ souls.

Decision Criteria

The fact is that the overwhelming majority of the 100 or so right-to-die cases that have ended up in state courts since Quinlan have involved the disposition of incompetent patients—individuals who left no clear instructions as to their wishes before they became incapable of making informed decisions for themselves. Indeed, nearly 85 percent of all right-to-die cases heard in the state courts from 1976 through 1992 involved surrogates who were trying to make decisions for patients whose ability to decide was somehow—and in most cases, severely—impaired. The federal courts have heard six right-to-die cases in that same time frame, five of which involved incompetent patients and surrogate decisionmakers (National Center for State Courts, 1992, pp. 155–172). Court consensus was relatively easy to
achieve on the basic issue of the right to die; the only controversy that remains regarding that basic right concerns what parts of the Constitution apply in such cases. But the issue of incompetency has proved to be a much harder nut to crack.

The “Substituted-Judgment” Standard. The New Jersey Supreme Court took a relatively liberal position on the question of incompetency. With *In re Quinlan* (1976), it was argued that the constitutionally protected right to die could be exercised by a family on behalf of an incompetent patient as long as the family could establish that its decision was consistent with the decision the incompetent principal would make if able to do so. This knowledge might include understandings about the principal’s religious beliefs, general attitudes regarding medical care, and other substantial (albeit indirect) evidence of that person’s frame of mind with regard to right-to-die issues.

As the *Quinlan* court put it: “We have no doubt in these unhappy circumstances, that if Karen were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death.” This reasoning would become known as the “substituted-judgment” standard, which holds that a third party’s best guess about the wishes of the incompetent patient could be substituted for that which was impossible to obtain: the expressed wishes of the patient.

The term *substituted judgment* actually originates with the Massachusetts case *In re Spring* (1980). In this case, the court decided that a seventy-eight-year-old incompetent individual with end-stage kidney disease could forgo hemodialysis, based on what was known about the individual’s general preferences in such matters. No written or specific oral instructions would be required as long as the principal’s predisposition toward the withdrawal of life support could be reasonably demonstrated by a third party.

The “Best-Interests” Standard. In another important Massachusetts case, *Superintendent of Belchertown State School v. Saikewicz* (1977), the court seemed to expand coverage of the constitutionally protected right to die beyond those who were currently incompetent to those who had never been legally competent. Joseph Saikewicz, the principal in this case, had been mentally retarded since birth. But the Massachusetts court hearing the case presumed that those who knew him could reasonably determine what his wishes might be, even though he himself had never been legally competent to make such decisions on his own behalf.

Extending the *Quinlan* rationale to *Saikewicz* was something of a stretch for the substituted-judgment standard, however, leading the *Saikewicz* court to introduce the notion that other factors might be considered, including age (Saikewicz was sixty-seven), the pain associated with continued therapy, the chances for therapeutic success, the suffering associated with the continuation of life, and the
inability to cooperate with therapy when in a degraded mental state. This move to the consideration of other factors broadened the realm of possibilities for those seeking to establish the right to die, and in the process, it laid the groundwork for what would become a second kind of test: the “best-interests” standard, a term that was actually not coined until the New Jersey court heard the case of Claire Conroy five years later.

Claire Conroy was an eighty-four-year-old nursing-home patient who had lapsed into a condition similar to that of Karen Ann Quinlan without leaving any clear instructions regarding further medical treatment (Humphry and Wickett, 1986, p. 257). The Conroy (1985) court, when petitioned by a nephew interested in removing life support from the patient in question, argued that even though there was not enough evidence for a substituted judgment to be made, a patient’s right to die might be secured using a second standard. This alternative standard, based on the best interests of the incompetent patient as balanced against the interests of the state in preserving life, codified what the Saikewicz court had only alluded to.

The Conroy solution involved weighing the net benefits derived from treatment as compared with the burdens imposed by treatment (e.g., the degree of the treatment’s invasiveness, the degree of humiliation, and the extent of uncontrollable discomfort or pain). Also to be considered, according to the court, were the net benefits to the sustained individual of continued existence with treatment, as balanced against the burdens that treatment would impose on the individual (e.g., the degree of dependency and, again, the extent of the uncontrollable discomfort or pain).

This cost-benefit formulation was intended to serve as a guide to what, if any, actions would serve the best interests of the patient. The Conroy court argued that, by taking such evidence into account, the decisionmaker could choose to withdraw treatment if clearly satisfied “that the burdens of the patient’s continued life with the treatment outweigh the benefits of that life for him”—for example, if “the pain and suffering of continued life markedly outweigh any physical pleasure, emotional enjoyment, or intellectual satisfaction that the patient may still be able to derive from [that] life.”

The state courts that have made decisions following Saikewicz and Conroy have generally agreed with the expansion of rights using the best-interests standard. But there has been a notable exception to this trend, first enunciated by the New York court with its Eichner and Storar decisions in the early 1980s and echoed by the Missouri court with its important Cruzan decision later in the decade.

The “Subjective-Decision” Standard. In re Eichner (1980) was a New York case, decided in 1981, involving the disposition of Brother Fox, a man who had suffered a cardiac arrest while undergoing hernia surgery. Fox was left in a persistent vegetative state as a result.
Father Philip Eichner brought the case to court, seeking appointment as Brother Fox’s guardian for purposes of withdrawing life support. The court found in favor of Eichner, but it rejected an open-ended reading of the *Saikewicz* court in the area of incompetence by suggesting that an incompetent could exercise a right to die *only* as long as there was “clear and convincing” evidence of the patient’s earlier wishes. As it turns out, Brother Fox had expressed his desire—while competent, in previous discussions on the matter—that he not be kept alive by extraordinary measures. Satisfied with that evidence, the court granted Father Eichner’s petition to have life support withdrawn from Brother Fox.

In the other right-to-die case heard by the New York court that year, however, the “clear and convincing” test proved to be more detrimental to the petitioner’s case. *In re Storar* (1981) involved the case of John Storar, a man who (like *Saikewicz* in Massachusetts) had been profoundly retarded since birth. Storar had become terminally ill with bladder cancer, and his mother was asking that necessary blood transfusions be stopped. The court denied the mother’s request, arguing that since the patient was—and always had been—mentally retarded (i.e., incompetent in the eyes of the court), he could not possibly have made competent indications as to his desires should a right-to-die scenario ever develop. In the court’s words, it was “unrealistic to attempt to determine whether [a lifelong incompetent] person would want to continue life-prolonging treatment if that person were competent.” By holding that the *Storar* case failed the substituted-judgment standard sketched in *Quinlan* and by rejecting the move toward the best-interests standard advanced in *Saikewicz*, New York’s *Eichner* and *Storar* decisions really introduced a third kind of decision-making criteria: the “subjective-decision” standard.

The New York court argued that life support must be provided unless clear and convincing evidence was produced, demonstrating that a patient, while competent, had made a “subjective decision” regarding his or her wishes should he or she become seriously ill and incompetent at some future time. Ultimately, the decisions of the New York court and, later, the Missouri court (with *Cruzan* following roughly in the footsteps of *Eichner* and *Storar*) stand as important exceptions to the stream of state-court decisions to come—decisions that would more closely follow the evolutionary path charted by court cases using the substituted-judgment standard (e.g., *Quinlan* and *Spring*) or the best-interests standard (e.g., *Saikewicz* and *Conroy*).

**Emergence of a Loose Consensus.** New York’s subjective-decision test remains an important, precedent-setting exception to the rule. Other state courts have generally seemed willing to find that individual interests, however derived and expressed through family members or advocates, more than outweigh the interests of the state in preserving life (even when lacking clear and convincing evidence of the patient’s wishes). This liberal course in decisionmaking is what Thomas Mayo describes as the more mainstream current of jurisprudence. He writes: “State
courts that have considered the question have been, on the whole, quite yielding. They generally recognize a qualified right to refuse life-sustaining medical treatment that may be exercised by competent patients and by guardians or others on behalf of incompetent patients” (Mayo, 1990, pp. 103–155). New Jersey’s second landmark case in this area, In re Conroy, did much to solidify this emerging consensus.

At the same time, however, it would be incorrect to assume that much has been settled in the area of surrogate decisionmaking. First, controversy continues over which standard or standards do the best job of resolving disputes in right-to-die cases involving incompetent patients: substituted-judgment, best-interests, or both (or even neither, as with New York and Missouri’s adherence to the subjective-decision standard). And even when a standard is agreed upon, the inquiry has only begun. For example, if operating under the substituted-judgment standard, what should be done when close family members disagree about what the incompetent patient would want if that person were somehow able to make the choice? Under the best-interests standard, who is to weigh the degree of pain and discomfort, the value of continued life, the degree of humiliation felt by an incompetent patient, as compared with the state’s interest in preserving life? And if both standards are to apply, how will decisions be made when different conclusions are drawn by using the different approaches?

The courts may have agreed in principle to defer to surrogate decisionmakers, but the matter of surrogate decisionmaking is hardly settled. Moreover, controversy over who should do the deciding persists. Indeed, deciding exactly who the decisionmaker(s) should be continues to be one of the larger sticking points in the entire right-to-die debate.

Who Should Decide?

At this point, the only thing we can say about the “who” question is that the courts have charted a meandering course that has taken some interesting twists. “In short,” according to Norman Cantor (1987, p. 106), “the development of a definitive and comprehensive legal approach to decision-making authority on behalf of terminally ill incompetent patients has not yet occurred.” The courts have understandably beseeched their respective state legislatures—both in written decisions and in public pronouncements—to take the lead in codifying surrogate decision-making rules. The response from the legislatures has been slow in coming, however (when it has come at all), leaving the courts to struggle with the implementation side of the policy equation.

Still, there is a general trend in court decisions toward devolution of responsibility away from the bench and toward those with a personal and professional in-
terest. For example, the *Quinlan* court introduced the notion that hospital ethics committees, made up of physicians, social workers, ethicists, attorneys, and theologians, be formed to review and approve all right-to-die decisions.

The *Saikewicz* court in Massachusetts stepped in at this point to issue a notable exception to the *Quinlan* philosophy of letting private parties make decisions. Indeed, *Saikewicz* moved in exactly the opposite direction in arguing for a stronger judicial role, stating that “we take a dim view of any attempt to shift the ultimate decision-making responsibility away from the duly established courts of proper jurisdiction to any committee, panel, or group, ad hoc or permanent.” This judicially centered approach held that, no matter who was involved in the decision-making process at the lower levels, all parties should repair to the courts for the final decision.

The Washington court returned to the path blazed by the New Jersey court with its *In re Welfare of Colyer* decision of 1983, while at the same time adding its own peculiar twist. This court took a more medically oriented approach than its New Jersey counterpart by suggesting that a prognosis board, two physicians specializing in the patient’s condition along with the attending physician, be used to guide the decision-making process.

The following year, this same court explicitly rejected the *Saikewicz* approach in its *Hamlin* decision, a case involving Joseph Hamlin, a man who was blind, severely retarded since birth (reminiscent of *Saikewicz* and *Storar*), and without any immediate family members. Hamlin’s case ended up in court after he was diagnosed as being in a persistent vegetative state. The court argued that a suitable guardian, chosen on behalf of an incompetent patient, should be allowed to proceed with decisionmaking without any further intervention on the part of the judiciary (*In re Guardianship of Hamlin*, 1984). On this score, the Washington state judges were quite explicit, arguing that the court “need not always be involved in the actual substantive decision [to terminate treatment], even for lifetime incompetents” (cited in Robertson, 1985, p. 868).

Ultimately, with the weight of these two Washington cases added to the precedent established in *Quinlan*, the judicial trend advocated in the courts would be one where the judiciary’s role would diminish and the part played by family, guardians, and health-care professionals would expand. Instead of taking the path outlined by the Massachusetts court in *Saikewicz* (that courts should play a central decision-making role) or following in the footsteps of the New York court’s *Storar* and *Eichner* decisions (that lifetime incompetents cannot have the right to die exercised on their behalf because they could not possibly satisfy the “clear and convincing” test), the courts have generally preferred to entrust the decisionmaking to private parties, acting as referee only in cases where consensus among such parties fails to emerge.
Policy Mediation in the State Courts

The Decision-making Maze

Ironically, what the courts have done with their surrogate decisions is simply to ratify the private-professional decision-making cooperative that has existed ad hoc for years, even before Quinlan. It is more and more common for physicians and family members to make decisions for incompetent patients, quietly and privately in waiting rooms and at bedsides in American hospitals. The courts really only added a sense of legitimacy to these arrangements by discussing them openly and in a favorable light, while setting a few guidelines along the way.

At the same time, it should be noted that the issue of what criteria these interested parties should apply—the criteria the courts would presumably apply when a guardian’s decision is challenged legally—has proved to be much more difficult to resolve for judges across the States. Perhaps it is not surprising that the state legislatures have had even less success in this realm.

Artificially Provided Food and Fluids

Although the state courts may have labored with the surrogate decision-making issue, most seem to have become relatively comfortable with what for many is still a very contentious issue: the right to withdraw artificially provided food and fluids. The central role that food plays in our culture makes the nutrition and hydration issue especially controversial outside the courtroom (Callahan, 1990). For the most part, however, the state courts are clearly moving toward sanctioning the withholding or withdrawal of ANH for patients who otherwise qualify under the emerging set of right-to-die rules.

The ground-breaking case in this area was Barber v. Superior Court (1983). In that case, the family of the plaintiff, Clarence Herbert, had asked that tube feeding be discontinued, and the attending physicians consented. Herbert died six days later. Shortly thereafter, his two attending physicians were charged by the Los Angeles district attorney with murder. Sustaining the lower courts, the California Court of Appeals ruled that the administration of ANH could be categorized as medical treatment exactly as the use of mechanical supports was since ANH was “more similar to other medical procedures than to typical human ways of providing nutrition and hydration.”

To expand on the explanation, the court went on to argue that the distinction between ANH and other medical procedures “seems to be based more on an emotional symbolism of providing food and water to those incapable of providing for themselves rather than on any rational difference.” Furthermore, “medical nutrition and hydration may not always provide net benefits to patients.”

Importantly, the court rejected the distinction between extraordinary and ordinary treatment enunciated by the Catholic church and often bandied about by
ethicists, physicians, and lawyers, as well as judges. Catholic teachings since the 1957 encyclical of Pope Pius XII had held that food and fluids were ordinary treatments that could not morally be withheld or withdrawn from seriously ill patients, a position that has carried great, albeit diminishing, weight in religious and secular circles alike. But beginning with the Herbert case, courts began to conceive of ordinary treatments as those that offer reasonable hope of benefit to the patient without incurring excessive cost or subjecting the patient to excessive discomfort. Extraordinary treatments, then, would be taken to mean everything of a medical nature that offers little hope of benefit to the patient, while incurring excessive costs or producing excessive discomfort (Meisel, 1989, p. 83).

In other words, though the Catholic church had determined artificially provided food and fluids to be ordinary by definition, the courts now began to depart from that understanding. Instead, the Herbert case marked the beginning of a judicial tendency to take a more flexible approach that would allow for a determination that, in some cases, ANH could be withdrawn. This would be determined, according to California's Barber decision, using a "benefits versus burdens of treatment" test (i.e., the best-interests standard) under which the removal of ANH might be an entirely appropriate course of action if the burdens of treatment were perceived to outweigh the benefits.

A 1984 Massachusetts case, In re Hier, was the next to deal with the ANH issue in an explicit and important way. Mary Hier was a ninety-two-year-old woman who had lived in a psychiatric hospital for fifty-seven years (Humphry and Wickett, 1986, p. 255.) Unable to take food orally, she was fed through a gastroscopy tube, which she continually pulled out. In this case, the Massachusetts court reaffirmed what the California court had established in the Barber decision: that artificially provided nutrition and hydration is a medical procedure that could be withheld or withdrawn like any other, even for incompetents. The court cited a three-part rationale in coming to its decision: (1) the burden and intrusiveness of the proposed surgery (to reimplant the feeding tube), (2) the patient's earlier objections to treatment (even though she was legally incompetent when she made them), and (3) the decreased benefits of treatment because of the patient's lack of cooperation (Collins, 1987, p. 273). New Jersey's In re Conroy (1985) followed close on the heels of the California and Massachusetts precedents. In this case, Claire Conroy's nephew (and legal guardian) had petitioned the superior court to have his aunt's nasogastric tubes removed. The court agreed, but Conroy's court-appointed lawyer objected to the decision and filed an appeal. In their appellate decision, the New Jersey court equated artificial feeding through tubes with artificial breathing through the use of a respirator. Then, in an attempt to remove some of the emotionalism from the issue, the court ruled that "nasogastric tubes, gastrotomies, and intravenous infusions ... are medical procedures with inherent risks and possible side effects, instituted by skilled health care providers to compensate for impaired physical
functioning.” The court went on to explain that “once one enters the realm of complex high-technology medical care it is hard to shed the ‘emotional symbolism’ of food. However, artificial feeding such as nasogastric tubes, gastrostomies and intravenous feedings are significantly different from spoon feeding. They are medical procedures … and can be seen as the equivalent to artificial breathing” (*In re Conroy*, 1985, p. 1236).

Lastly, there is the Florida case of *Corbett v. D’Alessandro* (1986), which is important for its role in explicitly rejecting right-to-die limitations imposed by statutory law. Florida’s natural-death law at the time specifically excluded “sustenance”—the legislature’s term for food and fluids—from the category of procedures that could be withdrawn under right-to-die rules. Though this law gave pause to the lower courts, the Appeals Court ruled that the individual’s prerogative to have a nasogastric tube removed was a constitutional right that could not be infringed upon by legislation.

Interestingly, given the courts’ clear and generally unwavering trend toward allowing the withdrawal of food and fluids, many states passed living-will legislation throughout the 1980s that expressly forbade the withdrawal of ANH. The courts had been asking, both publicly and in their judicial decisions, that the legislatures provide statutory guidance in the right-to-die area. But this invitation to the legislatures was neither an open nor unqualified one. Indeed, as the Florida court’s decision illustrates, judicial mediators would not hesitate to reject those provisions of state law that were found to violate some essential aspect of what the courts considered to be constitutionally protected rights—in this case, a right to withdraw food and fluids from individuals who are either terminally ill or in a persistent vegetative state.

**Who Qualifies to Exercise the Right to Die?**

This all brings us to the last critical issue: Who qualifies to exercise the right to die? There are really four possible classes of individuals to consider. First, there are the terminally ill individuals—those with life-threatening illnesses who have a finite amount of time left (six months or less is one generally accepted standard). Second, there are those in a PVS. These are individuals who, even though their eyes may be open, have no consciousness of their surroundings. People in a PVS are not terminally ill in the traditional sense, however, for theoretically they can exist for years and even decades with the appropriate life-support assistance. The third class consists of individuals who suffer from chronic, irreversible medical afflictions. These afflictions are not terminal either per se. Yet, even though death is not imminent for these individuals, their conditions are painful or debilitating enough to lead some to think life is not worth living. The fourth class involves everyone else. Let us consider the classes in reverse order.
No one makes the case in court (or anywhere else) that suicide should be granted as an individual right in the absence of a serious medical condition. Suicide has been and continues to be taboo in Western civilization, and we see no evidence of that changing. Consequently, the fourth class of individuals is eliminated a priori from qualifying under right-to-die rules.

The third class of individuals, those with chronically painful or seriously debilitating medical conditions, prompt significant controversy. Because some of these individuals will not necessarily die if medical procedures are withheld or withdrawn, they actually need assistance in dying. And that opens up the entire assisted-suicide debate. Generally, the courts have been tolerant. Aside from slapping a restraining order on Jack Kevorkian, which did not seem to be having much effect, the Michigan courts have more or less buckled under on the question of assisted suicide. The same could be said regarding Timothy Quill’s case—lots of handwringing went on, but Quill was left unscathed by the judiciary. There is also the landmark California case involving Elizabeth Bouvia to consider.

Elizabeth Bouvia was twenty-eight in 1986 when she asked that medical personnel withdraw food and fluids from her so that she could die. A quadriplegic with severe cerebral palsy and intense arthritic pain, she was almost entirely dependent on others for her care. Over time, Bouvia came to believe that her condition made life not worth living. When the hospital refused her request to have food and fluids withdrawn, she took her case to the California courts, which ultimately found in her favor. One of the majority opinions put the matter quite bluntly: “The right to die is an integral part of our own destinies so long as the rights of others are not affected. That right should, in my opinion, include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible” (Bouvia v. Super. Ct. of Los Angeles County, 1986).

By and large, however, today’s judiciaries are not engaged in euthanasia cases of this sort. Instead, the courts have been dealing primarily with the first two classes of individuals in this schema: the terminally ill and those in a persistent vegetative state (or irreversible coma). Here, we can report overwhelming consensus: Those who find themselves in either of these conditions has the right to die, period. The courts, as has been noted, run into trouble when the individuals in question are rendered incompetent before having a chance to leave clear instructions on what they would want done. But the central point is that there seems to be little if any dissention. Both those who are terminally ill and those who are in a persistent vegetative state qualify, in theory, to exercise an inherent, constitutionally protected right to die.

Case Law in Perspective

Although the courts continue to grapple with issues and standards of surrogate decisionmaking for incompetent patients, there is a general agreement on the
three other central issues addressed in the right-to-die policy context. First, there is not much question about the right to die in the state courts. That right usually functions as a bottom-line foundation, below which the state courts are unwilling to go. New York’s “clear and convincing” test can and has proved to be an important qualification to the right to die, as in the cases of Storar and, in Missouri, Cruzan. Still, most state case law supports the concept of a right to die. And the only Supreme Court decision on the right to die, Cruzan v. Missouri, suggests that the state courts are on firm ground here.

Second, when it comes to ANH, it seems clear that this is a medical therapy that can be either withheld or withdrawn pursuant to the right to die. And third, all patients who are either terminally ill or in a persistent vegetative state qualify for right-to-die status. Even conservative courts grant that much, as long as clear and convincing evidence can be produced as to the patient’s wishes. The sole exception here seems to be for lifelong incompetents. In subjective-decision states like New York and Missouri, these individuals apparently must forgo any constitutionally protected right to die in favor of the state’s due process interests in preserving life.

All this consensus begs the question: Why is there such widespread agreement? Theories of federalism suggest that the states have the capacity to operate independently of each other and that, absent rulings from the Supreme Court, the state courts are on their own to formulate decisions in cases that come before them. Of course, the courts do not operate in a vacuum: They are guided by constitutions, statutory laws, common laws, political culture, and judicial precedents within their own states. But if this were all there was to state-court decisionmaking, we would have to conclude that consensus was the serendipitous result of the various state courts stumbling, independent of each other, to the same policy conclusions.

Actually, this is not as improbable as it might sound at first blush. Indeed, the fifty states operate within political cultures in which similarities among laws, common-law traditions, and constitutional frameworks are the rule rather than the exception. In addition, there is a good deal of commonality to the cases that end up in the state courts. Incompetence is one common theme. The overwhelming majority of patients were either clearly incompetent (80 out of 108 patients) or marginally incompetent (another 6 patients) at the time their cases were heard. Combining these two categories reveals that in 4 cases out of 5, the patient’s ability to make decisions for himself or herself was impaired to one degree or another. Usually, family members were allowed to serve as decisionmakers in such situations (court-appointed guardians were involved in only 11 of 80 cases involving incompetents).

Artificial nutrition and hydration provides another common thread of contention running through the body of case law: ANH was an issue in 43 percent of the cases (46 out of 108 cases). Old age was also a common characteristic of princi-
Policy Mediation in the State Courts

Policy Diffusion

Policy diffusion is a communications process in which judicial opinions of one court are picked up and used in the formulation of the decisions of another court in a different state. Often, lawyers are the messengers, making judges aware of innovative opinions in other states through their oral arguments and legal briefs. And, of course, court clerks do their own interstate reviews of decisions when helping judges draft decisions of their own. The proliferation of interest groups willing to file amici curiae briefs (these are unsolicited, “friend of the court” advisories, filed by interested third parties) and the proliferation of computerized legal data bases have combined in recent years to facilitate the diffusion process. There may be no sound constitutional reason for state courts to give out-of-state court decisions any weight in their own deliberations, but it is clear that these rulings have an important impact on in-state decisionmaking nonetheless.

The 1976 case of Karen Ann Quinlan is a quintessential example of diffusion at work. The *Quinlan* decision was cited as a legal precedent in no less than 80 percent of all rulings rendered by superior state courts since the New Jersey case was heard. This is not to suggest that all the courts that have cited *Quinlan* agreed with that decision without qualification. Indeed, both the Massachusetts and New York courts made important qualifications to *Quinlan* in their own opinions.

The New York court decision enjoyed some diffusion of its own: The Missouri court adopted New York’s “clear and convincing” test, as did the court in Maine. Still, we should not let these admittedly important exceptions cloud the larger
picture. State courts around the country, including those in New York and Missouri, have used *Quinlan* almost as if that were a precedent in the body of case law in their own state. And New Jersey's 1985 *In re Conroy* decision, legitimizing the withdrawal of food and fluids from terminally ill and hopelessly vegetative patients, was used the same way—again, just as if it were an in-state precedent upon which to build. Obviously, then, state courts borrow from each other, but we are still left to wonder why this is so.

One of the more durable explanations for borrowing holds that some trendsetting, activist courts are traditionally considered beacons of jurisprudence. As Glick (1992, p. 141) puts it, a "small subset of states with large and diverse populations and complex economies and government structures are much more likely to generate model litigation than simpler, homogeneous states." These trendsetters are looked to, it is argued, with some regularity by courts in other states. The state courts in California, New Jersey, New York, and Massachusetts are among those most often mentioned in this light.

It should come as no surprise to those familiar with the "beacons of jurisprudence" explanation of policy diffusion that twelve of the seventeen important right-to-die cases discussed in some detail in this chapter come from the courts of these four states. Nor would it be a surprise that, within this group, New Jersey's three decisions have stood out as landmarks among landmarks, for the New Jersey court has been a jurisprudential leader in the specific area of individual liberties for two decades (Sullivan, 1990).

"Intrinsically," argues John Sexton, dean of the New York University Law School, New Jersey "is just one of fifty voices among the state courts .... But time and time again other state courts and the Federal Court in constitutional and common law matters tend to follow the reasoning of the New Jersey Supreme Court" (Sullivan, 1990).

Still, two important questions about trendsetting might legitimately be raised. First, how does a state become a trendsetter? Part of the answer to this question may relate to the fact that controversial issues are more likely to arise and get dumped in the laps of justices who preside in states with heterogeneous populations, concentrated in densely packed cities and suburbs. The four beacon states cited here—California, New York, Massachusetts, and New Jersey—would certainly qualify on this score. Political subculture (Elazar, 1984, pp. 134–142) may be in play here, as well. Citizens in states with "individualistic" political subcultures might be predisposed to bringing their rights-based claims to the courts for mediation. According to Elazar, the populations of all four states noted here as trendsetters have dimensions of individualism to their political subcultures, with New Jersey the most individualistic of all. In addition, the judges in these states (who are products of this individualist political subculture themselves) may be more likely to take an activist role in setting precedents.

The second question the theory of trendsetting courts begs has to do with the following: Why do other states follow trendsetters' leads? The answer to this ques-
tion may have something to do with the absence of prominent intrastate precedents. With newly emerging issues like those swirling around the right to die, diffusion may become something of a necessity. The absence of federal-court leadership is important to note here, as well. In such an environment, it becomes "increasingly important," according to Stewart Pollock (1985, p. 992), "for the courts to communicate with each other about significant decisions affecting fundamental rights. Horizontal federalism, a federalism in which states look to each other for guidance, may be the hallmark of the rest of the century."

There is one other possible explanation: It could be that trendsetters and followers alike are actually following a third source of guidance. This may well be the case with right-to-die issues for the dearth of precedents, both legislative and judicial, and the technicality of the subject matter have forced courts to look elsewhere for guidance. Apparently, the President's Commission report is one place the courts have looked with some regularity. That landmark document was cited in approximately 70 percent of all right-to-die court cases decided in the five years following its 1983 release. The position paper released by the American Medical Association in 1982, stating that it would be ethical for physicians to withhold or withdraw life-support systems (including ANH) from hopelessly ill individuals (including those in a PVS), was also heavily cited by courts in the years following its release (Glick, 1992, pp. 139-140).

Whatever the merits of this alternative explanation and regardless of whether the courts continue to adhere to Pollock's advice, it is enough for our purposes to note that state courts for the most part have followed each other's leads on the right to die. Naturally, then, they have also ended up in roughly the same places.

Summary: Case Law Versus Statutory Law

Overall, despite some twists and turns on the incompetency question, the courts have come to a consensus on the major right-to-die issues. But the same degree of general consensus in this area cannot be attributed to the state legislatures. Indeed, it was not until 1985 that a majority of the states even had living-will laws on the books to codify the right to die. And today, even though all but four states have such laws in force (the four holdouts are Massachusetts, Michigan, Nebraska, and New York), not much of a controversial nature has been resolved by that body of statutory law.

State judges, such as members of the New Jersey Supreme Court in its Conroy decision, have all but begged the legislatures to be more responsive in dealing with the right to die. But the legislatures, with a only few notable exceptions, have resisted the call. And even if state-court decisions have stimulated legislatures to address the right to die (Glick, 1992, p. 158), the substance of most laws that have been passed leave many important questions unanswered. Treatment of incompe-
tent patients, artificial nutrition and hydration, and a number of other important matters have been dodged by many states, leaving one to wonder what exactly the legislatures have accomplished to date. We will answer that question in the next chapter, in order to shed some light on where the right-to-die debate is headed. We will also explore other problems that may lie on the horizon for those who wonder whether the right to die, for themselves and for their family, will be protected or even continue to exist under statutory law.