

The Cruzan Decision

by Richard A. McCormick, S.J.

The Missouri Supreme Court decision on Nancy Cruzan is, in my judgment, so bad that it may prove to be pedagogically useful. It is muddled, confused and/or downright wrong on virtually every key issue.

Imagine the following scenario. There are four one-thousand-bed long term care facilities strategically placed near population centers in Missouri. Each bed contains a patient in a persistent vegetative state (PVS). Each is sustained by a gastrostomy feeding tube at state expense for an average of 20–25 years, many of them outliving their families and dear friends.

Is this an impossibly fanciful caricature? Not at all, if the pivotal tenets of *Cruzan* (760 S.W.2d 408) are valid and allowed to stand. Yet our sense of the “fitting,” indeed our common sense, is powerfully assaulted by this scenario. I mentioned “pivotal tenets.” Note the following: (1) The Court explicitly adverted to the fact that it was deciding the case “not only for Nancy, but for many, many others.” It was establishing precedent for Missouri. (2) It disallowed **any** quality of life considerations in adjudicating such cases. “The state’s interest is not in quality of life” (422), but in life itself. “Life is precious and worthy of preservation without regard to its quality.” (419) (3) This interest “is an unqualified interest in life.” (420, 422) (4) Even merely vegetative life (PVS) is a benefit to the patient and must be preserved by artificial nutrition-hydration. (5) The Court **seems** to believe that withdrawal of Nancy’s gastrostomy tube would be tantamount to killing her. It refers to a “decision to cause death.” (422) This matter, however, remains unclear in the **dicta** of the decision.

In the remainder of this commentary, I want to raise six substantive issues and conclude by pointing out what I believe to be the philosophical root of the Court’s misguided judgment.

Substantive Issues

1. **The State’s Interest.** As noted, the *Cruzan* Court sees the state’s interest in life itself, not its quality, and this interest is “unqualified.” The Court nowhere defines quality of life. It should have looked at the literature. It would

have discovered two senses of that term and tempered its rationale accordingly. The first refers to the value of a life to society in terms of functional contributions, social usefulness, etc.—and, therefore, to the valuation of that life by a society using such a criterion. That quality of life in this sense—an arbitrarily defined level of functioning—has no legitimate place in cases like that of *Cruzan* is obvious.

But there is another sense to the term, one that apparently escaped the Court’s notice. It refers to the biological condition of the individual and its relationship to the pursuit of life’s goods and goals. Quality of life in this second sense is critical to good decision making. This was acknowledged by the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research when it defined the patient’s best interest broadly to “take into account such factors as the relief of suffering, the preservation or restoration of functioning and the quality as well as the extent of the life sustained.” The *Baby Doe* rules imply a quality-of-life dimension when they exempt from aggressive life-sustaining treatment babies who will be permanently unconscious. Both the *Herbert* and the *Conroy* courts did the same. For instance, the *Conroy* court (New Jersey Supreme Court) acknowledged that “although we are condoning a restricted evaluation of the nature of a patient’s life in terms of pain, suffering and possible enjoyment under the limited-objective and pure objective tests, we expressly decline to authorize decision making based on assessments of the personal worth or social utility of another’s life, or the value of that life to others.”

The *Cruzan* Court rejects **any**—even restricted—quality of life ingredient as pertaining to the state’s interest. In doing so it achieves two remarkable results. First, it puts itself at odds with most persons whose best interests it proposes to protect. Human persons have an enormous stake in the quality of their lives—how they live, how they die, and how they live while dying. That is the assumption that undergirds liv-

ing wills and durable power of attorney arrangements for medical decisions. For instance, I myself, along with countless others I am sure, have specified in my living will that, if I am in a PVS, I do not want artificially administered nutrition and hydration. I judge this to pertain to my personal well-being. Yet the logic of the *Cruzan* Court would sweep this directive aside. Its interest is in life, not its quality, and this interest is “unqualified.” I take that to mean that personal preferences—and the moral and religious soil that nourishes them—are not in any way a state interest. If “unqualified” does not mean this, what does it mean?

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Weigh carefully these words of the Court: “Given the fact that Nancy is alive and that the burdens of her treatment are not excessive for her, we do not believe her right to refuse treatment, whether that right proceeds from a constitutional right of privacy or a common law right to refuse treatment, outweighs the immense, clear fact of life in which the state maintains a vital interest.” (424) Those words are absolute. They state quite astonishingly: given life (even PVS life) and the absence of burden in maintaining it, the state’s “vital interest” overwhelms and negates any other consideration or putative right. One has to wonder why the Court even bothered to discuss the adequacy or inadequacy of information about Nancy’s preferences and intent.

The second result of the Court’s blanket refusal to consider **any** quality of life ingredient in these cases is that it

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reduces overall personal well-being and best interests to its biological component. That is vitalism, a point I shall return to below. The Court states (427) that it chooses "to err on the side of life." Actually it is erring on the side not of life, but of biologism. When we conflate the complex notion of personal "best interests" into sheer medical effectiveness, we equate the **personally** beneficial with the **medically** effective and thereby give powerful analytic support to the noxious idea that whatever **can** be done **ought** to be done.

2. The Guardian's Authority. When an individual is presently incompetent (and has not reliably expressed her preferences previously) or has always been incompetent, decisions about that person's care must fall to others. The analytic basis for this proxy responsibility has varied from court to court depending on the circumstances (e.g., right of privacy in *Quinlan*, common law right of self-determination in *Fox*, best interests in *Storar*, etc.). In other words, if no third party could make decisions about termination of treatment, either the patient's right of privacy, or right of self-determination or best interests would be frustrated.

The *Cruzan* Court rejects the right of privacy as a basis for withdrawing Nancy's gastrostomy tube. Such a right cannot be exercised by third parties. It also denies that the "common law right to refuse treatment—founded in personal autonomy—is exercisable by a third party absent formalities." Why? Because "a guardian's power to exercise third party choice arises from the state's authority, not the constitutional rights of the ward. The guardian is the delegatee of the state's *parens patriae* power." (425) And, of course, the state has this "unqualified" interest in life, even PVS life.

It is the source of the guardian's power that interests me here. The *Cruzan* Court says it is delegated by the state. That confuses **origin** with **recognition**—at least for previously competent patients—a confusion traceable to the Court's utterly legalistic approach to these matters. The logical upshot of this confusion: it becomes impossible to get patients off useless or even burdensome treatment (for if this state's interest in life is "unqualified," what matters the burden?). What the Court has done is to place **all** third party decision making responsibilities under the notion of guardianship.

I want to argue that the common law

notion of self-determination, which is valid for the competent patient, must lead spontaneously to a notion of **family** self-determination for the incompetent one, if best interests and ultimately human dignity are to be served. In other words, the state does not exactly **originate** third party power as it does in some instances of guardianship; it merely **recognizes** (or notarizes) it, at least for cases like the *Cruzan* case.

There are two good reasons for arguing this: First, the family is normally in the best position to judge the real interests of the incompetent patient. The family knows those treatments that might be particularly disturbing and those that the patient may have accepted without distress in the past.

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Second, and more importantly, our society places great value on the family. The family is a basic moral community affirmed to have not only rights, but also responsibilities in determining how best to serve the interests of its incompetent members. For this reason the principle of self-determination can best be understood to extend beyond the individual to encompass the notion of familial self-determination. This familial autonomy or self-determination is a value highly treasured. While it perhaps should not take precedence over individual autonomy in cases where patients are or were competent, it certainly justifies a prominent role for family members in helping to assess what is in the best interests of the incompetent one. Family members are given enormous responsibility for moral nurture, theological and secular education, and decisions about the best interests of their incompetent members throughout the lifetime of the family unit. It should be no different in the case when the incompetent family member is seriously or terminally ill. Occasionally this may lead a family to decide that the incompetent

one's interests can best be served by declining a medical intervention.

To me this means that "familyness" and the kinship bonds we call family are the basic source or foundation of a proxy's power, not the state's grant. Of course, the principle of familial self-determination cannot ride unchecked. Society's responsibility to assure that the interests of its incompetent members are served will place some limits on familial self-determination. However, the state should intervene only when the familial judgment so exceeds the limits of reason that the compromise with what is objectively in the incompetent one's best interest cannot be tolerated.

This is the thrust of much of what Charles B. Blackmar says in his dissent. In his words: "I believe that decisions about Nancy's future should be made by those near and dear to her..." Exactly. This is, as a matter of fact, done all the time, and it is done by people who would be shocked to learn that they may do so because they have been empowered by the state. As Blackmar stated: "Decisions of this kind are made daily by the patient or relatives..." (428) That fact should have alerted the *Cruzan* Court that its understanding of the source of third party responsibility was incomplete.

3. The Notion of a Dying Patient. The Court repeats several times that Nancy is not dying or "terminally ill." I suggest that the notion of a "dying patient" or "terminally ill" one is ambiguous. Who is said to be terminally ill is often a function of available technology. A person with end-stage renal disease is a dying patient—if no dialysis is available. A patient without spontaneous respiration is a terminal patient—if no respirator is at hand. A person who cannot take food and water in normal ways is a dying patient—unless we intervene technologically with an N.G. tube or gastrostomy tube.

"Terminally ill" is, therefore, capable of two readings. First, it can refer to an incurable condition that will lead to death in a short time whether interventions are used or not. I will call this the **narrow** sense. Missouri adopted it in its living will statute when it specified "terminal condition" as "a death will occur within a short time *regardless of the application of medical procedures.*" (emphasis added) The second sense is **broader**. The Uniform Rights of the Terminally Ill Act (URITA) defined "terminal condition" as follows: "an incurable or irreversible condition that, *without the administration of life-sustaining treat-*

ment, will, in the opinion of the attending physician, result in death within a relatively short time." (emphasis added) In the first sense Nancy Cruzan is not terminal. In the second sense she is.

This is a crucial issue for two reasons. First, if Nancy is said to be nondying, that assertion strengthens the state's interest in her fate in the face of a decision that could leave her dead. Second (and this buttresses the first point), if she is nondying but dies as a result of nutrient withdrawal, that makes such withdrawal look positively causative, a killing act. This seems to be the approach of the *Cruzan* Court. For it refers to "a decision to **cause** death" (422) and "seeks to **cause** the death of an incompetent" (425).

That language assumes the answer to a serious philosophical issue—the difference between an **occasion** and a **true cause**. Take an analogy. Suppose hurricane winds bend and break a sapling tree. We prop it up, hoping to revive it, but see that it will never return to full budding form, even though it will stand and possibly produce a few anemic leaves. So we remove the prop and the tree dies. What killed the tree? Was it not the hurricane winds? Analogously, if we remove nutritional props from Nancy, was it not the original anoxic trauma that **caused** her death, that killed her?

This matter is only muddled by the usage "starve." I have heard physicians adamantly assert that the term is an exclusively medical term. I question that. While the term can be parsed in terms of medical effects and phenomena, it is a value term. "To starve another" means to withhold food and water from one **to whom it ought to be given**. That leaves totally untouched the question of "to whom it ought to be given" and the criteria for this determination. To jump ahead a bit, "ought to be given" assumes that the person will derive genuine benefit from feeding. More of this below.

4. The Nature of Artificial Nutrition-Hydration. The *Cruzan* Court, in contrast to virtually every other authoritative source, regards this issue as irrelevant. "The issue is not whether the continued feeding and hydration of Nancy is medical treatment; it is whether feeding and providing liquid to Nancy is a burden *to her*." (423) I believe the Court is straightforwardly wrong here. Regardless of their ultimate conclusion on the matter, all authorities (moral theologians, philosophers, courts, professional medical societies) have seen this as a key issue. For if arti-

ficial nutrition-hydration is not medical care or treatment, but simply identical with the normal provision of food and water, it pertains to those procedures we refer to as "ordinary care." In other words, we do not judge its withholding or withdrawal as we would, for instance, a respirator or other medical treatments.

As I read the literature, most—not all—commentators view artificial nutrition-hydration as medical treatment. This is true of the *Barber, Conroy, Jobes, Brophy* courts. It is true of the President's Commission, the American Medical Association and the American Academy of Neurology. It is true of many philosophers and theologians.

The *Cruzan* Court regards the whole discussion as a "semantic dilemma" and is determined to avoid it. Even here it fails, and in two ways.

First, it does indeed take a position—the position that artificial nutrition-hydration is not medical treatment. It states: "Common sense tells us that food and water do not treat an illness, they maintain a life." In short, it is not medical treatment because it does not treat a disease. This is similar to the argument of some philosophers that artificial nutrition-hydration is not medical treatment because it merely provides "what all need to live."

This is analytically incomplete, and, I believe, ultimately wrong. It assumes that **how** nutrients are supplied and **why** their artificial provision is necessary is irrelevant to the idea of treatment. Is it not the case that the inability to eat is caused by Nancy's cerebral anoxia and the subsequent ongoing cerebral cortical atrophy? Is not such atrophy and dysfunction a disease? When we use medical technology to bypass the inability to eat normally, in a broad sense we **treat** that disease even though we do not cure it. We should not, I think, equate all treatment with cure; otherwise many medical modalities that we commonly regard as treatment would not merit the name (prostheses, bypass surgery, analgesics for pain, some infertility interventions, etc.).

The second move by the *Cruzan* Court is to assert that the "medical argument" (artificial nutrition-hydration = medical treatment) is dangerous. "It seems to say that treatment which does not cure can be withdrawn." That is a thudding *non sequitur*. It need say or imply nothing of the kind. All it need say is that **any** treatment may be withheld or withdrawn when it is, in human estimate, nonbeneficial to the patient. There are many

treatments that cannot cure but ought to be used and not withdrawn, e.g., analgesics for pain in terminal illness as noted above.

5. The Burdens-Benefit Calculus.

Everyone—from the Congregation for the Doctrine of the Faith (*Declaration on Euthanasia*, 1980) to the President's Commission—agrees that the criterion for treatment decisions is the burdens-benefit calculus. Briefly, if a proposed treatment will offer no benefit, or the benefit will be outweighed by the burdens, the treatment is morally optional.

The *Cruzan* Court focuses only on the burden of the treatment. In doing so it supposes that preservation of life in a PVS is a benefit to the patient. Indeed, it says so explicitly. This point constitutes my most crucial disagreement with the decision. Furthermore, it is the point that sharply divides opinion on this and similar cases.

For instance, Judge David Kopelman (trial court of the *Brophy* case) asserted: "The proper focus should be on the quality of treatment furnished to Brophy, and not on the quality of Brophy's life." He went on to state that Brophy "does derive a benefit in that his life is sustained." He further stated that artificial nutrition-hydration "is useful in that it preserves his life and prevents his death."

Similarly, a group of philosophers and theologians signed a statement on artificial feeding of PVS patients. At one point it reads as follows:

"In our judgment, feeding such patients and providing them with fluids by means of tubes is not useless in the strict sense because it does bring to these patients a great benefit, namely, the preservation of their lives."¹

Robert Barry, O.P., is in this same corner. Of Clarence Herbert he states: "Provision of food and fluids would have been of nutritional value to him because they would have sustained his life."² At another place he states (of Herbert) that food and fluids "could have achieved their fundamental purpose which was to sustain his bodily functions and support its natural defenses against diseases."³ Any quality of life approach is too susceptible to biases and prejudices and "there is no rational way in which the 'quality of life' of individuals could be justly and certainly assessed."

Of a sharply different view is Daniel Callahan. Speaking of the "irreversibly comatose, utterly vegetative," he says that food and water can be stopped. Why? "Neither provides any genuine

benefit; there is no meaningful life of any kind—it is a mere body only, not an embodied person.”⁴

John Paris, S.J., agrees. “Those who argue that quality of life cannot be a consideration in the treatment decisions for such (persistent vegetative) patients are placing the maintenance of mere biological existence above all other considerations.”⁵ Dennis Brodeur is of the same view. Artificial nutrition-hydration that “simply puts off death by maintaining physical existence with no hope of recovery...is useless and therefore not ethically obligatory.”⁶ Similarly the American Academy of Neurology stated: “Once this PVS diagnosis has been clearly established, medical treatment in general, including artificial feeding, provides no benefit to those patients.”⁷

The Catholic tradition never counted mere vegetative life a patient-benefit. The *Cruzan* court does.

I agree with the Callahan-Paris-Brodeur approach. When the American Medical Association adopted a similar position, the then archbishop of New Orleans (Philip Hannan) stated: “The Church strongly condemns this position.”⁸ With all due respect, I believe that is just plain wrong. In my view, those who take such a position have departed from the substance of the Catholic tradition on this matter. That tradition never counted mere vegetative life a patient-benefit. The *Cruzan* Court does.

6. The Major Concern of the *Cruzan* Court. In any number of places the Court leads us to believe that withdrawing artificial nutrition-hydration from Nancy will expose others with a reduced quality of life to similar withdrawals. In other words, allowing any quality of life consideration here would open the door to abuses of the weak.

This is certainly a legitimate concern and I do not wish to minimize it. But the proper response is not the safeside victimization of Nancy Cruzan and her family. It lies rather in hard and fast exception-stoppers. Concretely, third party decisions to withdraw nutrition-hydration should be rigidly controlled by two conditions: irreversible PVS and the dying condition. (It is here that the notion of “the dying patient” becomes urgently relevant—and possibly divisive.)

The Philosophical Roots of the *Cruzan* Court

At the outset I stated that I believe the Court to be “muddled, confused and/or downright wrong on virtually every key issue.” I have tried to list some of these issues. But perhaps more important is the underlying philosophy that has guided the Court’s deliberations.

That philosophy is what I call “legal positivism.” The Court has decided the *Cruzan* case only on the narrow basis of constitutional or legal precedent. Finding analytical soft spots in the *dicta* of previous courts, it has ignored the wisdom and plain common sense struggling for expression in those decisions.

I can put this another way by saying that the *Cruzan* Court gave no weight to moral tradition. It faced profound human problems with only legal tools and categories. Equivalently this means that it was attempting to decide human problems without benefit of the values that inform the human. This is like facing medical dilemmas with only medical tools and expertise, as if medical good is simply identified with personal good. The case of Nancy Cruzan goes far deeper than the reach of constitutional and legal precedent. If we deny that, we freeze the ability of courts

to face new and profoundly human problems. We paralyze their ability to be wise.

¹ William May, et. al., “Feeding and Hydrating the Permanently Unconscious and Other Vulnerable Persons,” *Issues in Law and Medicine* 3 (Winter, 1987), pp. 203–217, at 209.

² Robert Barry, O.P., “The Ethics of Providing Life-Sustaining Nutrition and Fluids to Incompetent Patients,” *Journal of Family and Culture* 1 (n. 2, 1985), pp. 23–37, at 32.

³ *Loc. cit.*, pp. 32–33.

⁴ Daniel Callahan, “Feeding the Dying Elderly,” *Generations* (Winter, 1985), p. 17.

⁵ John J. Paris, S.J., “Critical Life Issues,” *Health Progress* 66 (December, 1985), p. 23.

⁶ Dennis Brodeur, “Feeding Policy Protects Patients’ Rights, Decisions,” *Health Progress* 66 (June, 1985), pp. 38–43.

⁷ Summarized in the *Newsletter of the Society for the Right to Die* (Summer, 1988).

⁸ Cited in *National Catholic Register*, April 6, 1986.

The *Cruzan* Decision: A Moral Commentary

by Gilbert Meilaender

In this commentary I focus on issues important for moral analysis. I attempt no discussion of the merits or demerits of the Missouri Supreme Court’s decision as a piece of legal reasoning, a matter on which I have little competence. It should be clearly said, however, that the *Cruzan* decision is an excellent example of moral analysis. It directs attention to crucial issues, turns away from flaws in decisions of courts in some other jurisdictions, and renders a verdict that should be applauded and (one hopes) imitated.

In arguing for this point of view, I may come under the indictment of Judge Blackmar who, in his dissenting opinion, writes that he is not “impressed with the crypto-philosophers cited in the principal opinion, who

declaim about the sanctity of any life without regard to its quality. They dwell in ivory towers.” It is difficult, however, to take seriously as moral analysis the separate dissenting opinions of Judges Blackmar and Welliver. (The dissenting opinion of Judge Higgins is more carefully crafted.) In any case, to consider how we ought to think about sanctity or quality of life is precisely **not** to dwell in an ivory tower; it is to ponder the difficult problems of how to care for the many different human beings for whom we have some responsibility and with whom we are united in a bond of citizenship.

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