The Case of Nancy Cruzan

U.S. Supreme Court Cruzan vs. Director Missouri Department of Health, 1990 407 U.S. 261, 110 S. Ct. 2841, 111 L. Ed. 2d 224

Summary

A thirty-year-old accident victim suffered lack of oxygen to her brain for six to twenty minutes. She was in a persistently comatose and vegetative state, sustained by a gastronomy feeding tube, although her respiration and circulation were normal. She was oblivious to her surroundings except for reflexive grimace-like responses to sound or pain. The patient was in a state of progressive spastic quadriplegia with irreversibly contracted extremities. The opinion of medical professionals was that she could live thirty-years. She now lies in a Missouri state hospital at the state's expense.

Before the injury, Nancy Cruzan had been a "vivacious, active, outgoing, and independent person." She had expressed in a "very serious" conversation with a friend the feeling that she would not wish to continue living if she couldn't be half-way normal, and "do things for yourself." Many other statements to family members suggested that "she would not want to continue her present existence without hope as it is." She remarked upon the stillborn death of a niece as perhaps "part of a greater plan" so as not to have to face a "possible life of mere existence." Commenting on the death of a grandmother after a long illness, she said it was better for. her grandmother "not to be kind of brought back and forth" by treatment.

Her parents, acting as guardians, requested discontinuation of the feeding tube. Officials of the state hospital declined, absent a court order. The parents initiated suit, seeking declamatory judgment sanctioning discontinuation of the feeding tube.

After the hearing, the trial court entered finding that Ms. Cruzan "would not wish to continue with nutrition and hydration." It concluded that no state interest outweighed her "right to liberty," and that denial of her wish constituted unequal protection of the law.

Missouri Supreme Court [760 S.W.2d 408] reversed the trial court (by a 4-3 decision), stating trial court had "erroneously declared the law" [not particularized].

The court concluded that the feeding tube was "not heroically invasive," was not a "painful invasion," and ·was not "oppressively burdensome."

Furthermore, it ruled that "the state's interest in the preservation of life," stated to be "particularly valid" where a ward was not terminally ill, was "unqualified" and outweighed her constitutional right of "privacy" or her common law right to refuse treatment.

The court questioned, without deciding, whether a guardian's authority extends to allow an exercise, derivatively, of the ward's constitutional rights, or may be limited by statutory grant and limited against an election of non-treatment.

Holding by U.S. Supreme Court

Noting that a patient's right to refuse treatment is a "logical corollary" of the common law doctrine of informed consent, stated that "it may be inferred" from prior decisions that a competent person has a "constitutionally protected liberty interest" in refusing treatment (emphasis added).

With respect to the right of an incapacitated patient to have a decision for non-treatment be made by a surrogate, it was noted that the state court had implicitly acknowledged the right and imposed a "procedural safeguard" to assure that the decision "conforms as best it may" to the wishes expressed by the patient. Then the Supreme Court cast the issue for decision as whether the State's imposition of the burden of "clear and convincing evidence;' as asserting "'a societal judgment about how the risk of error should be distributed between the litigants,'" was constitutionally permissible, held it to be permissible, and held that the state Supreme Court finding that the burden had not been satisfied was not constitutionally erroneous.

Rejected an appellant proposition that the "substituted judgment" of "close family members" should control in an instance of absence of clear and convincing evidence of the patient's wishes.

Principal Dissenting Opinion Contentions

Charged that the majority opinion (in finding a lack of clear and convincing evidence as to the patient's treatment choices) "failed to consider" significant hearing testimony of expressed desires of the patient.

Criticized the proposition [of the majority opinion] that the State's interest in guarding against "potential abuses" of unfortunate situations in which family members may act at variance to protection of the patient should allow such state interest to override the patient's interests, arguing that such potential abuses can be avoided in the course of court procedures involving service of a neutral guardian ad litem and "searching inquiry" of a trial judge, as had occurred in the case.

Article: The *Cruzan* Decision

By Richard A. McCormick, S.J.
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The Missouri Supreme Court decision on Nancy Cruzan is, in my judgement, 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 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, I 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 remained 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 judgement.

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 living 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 "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?

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 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 is 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 delegate 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.

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 judgement 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 NG 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 treatment,* 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 non-dying, 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 non-dying 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 muddied 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 is 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 is artificial 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 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-Benefits 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 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 is 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 is reads as follows: "In our judgement, 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 feeing, provides no benefit to those patients."[7]

   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 safe side 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.

Article: The *Cruzan* Decision: A Moral Commentary

By Gilbert Meilaender
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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.

The Missouri Court directs our attention to considerations which are crucial and often confused in discussions of cases like that of Nancy Cruzan. Much of the moral argument surrounding cases like this one imports language that was being used several decades ago to wage a different battle. Twenty years ago, the central struggle was this: to stop useless and/or burdensome treatments to irretrievably dying patients. That is, to let them die. Some opposed such "letting die," thinking it equivalent to killing. They failed, I believe, to distinguish adequately between the aim of an act and its foreseen result. To aim at caring for a dying patient by withdrawing death-prolonging treatments may result in a somewhat earlier death, but the aim is not to kill. The aim is to let die. Others opposed such "letting die" on different ground, arguing that if we were (on humanitarian grounds) prepared to let such patients die, we should be willing to end their suffering still sooner by deliberately aiming to hasten their death. They failed, I think, to distinguish adequately between the aim and the motive of an act – supposing that aiming to kill a fellow human being became permissible if our motives were praiseworthy.

Paul Ramsey characterized these two viewpoints as "opposite extremes" that turned out to be strangely alike. The one never found reason to acknowledge inevitable death and permit it to come. The other never found reason to permit death to come without taking the next step and hastening its arrival. Neither could just "let die" the irretrievably dying patient.[1]

In that context the language of "letting die" was very important and powerfully applicable. We were arguing about patients who really were dying patients – about whether we should let them die, should fight against that death as long as we were able, or should hasten the coming of that inevitable death. In that context to argue for "letting die" staked out an important position in the dispute; one which sought to continue to care for dying patients while giving up futile attempts to

cure, but one which refused ever to abandon care for still-living human beings. Chapter three of Ramsey's *Patient as Person* remains the classic expression of such a viewpoint and will continue to repay careful study. I return to it below.

The context has now changed, and it is to the great credit of the Missouri Court to have recognized this. We are no longer arguing about irretrievably dying patients, yet the language of the argument often sounds as if we were. The Court is very clear and to the point: "This is not a case in which we are asked to let someone die. Nancy is not dead. Nor is she terminally ill." She isn't dying and, hence, no treatment can be said to be prolonging her dying. If there were such a death-prolonging treatment, we could simply withdraw it and let death take her. But no such treatment is ready at hand for us to withdraw. We cannot simply let her die, because she is not a dying patient. If we want her to go away, we will have to aim at her death (not just let it come as the result of an action aimed at caring for her). This too the Court sees and says. We can add the next sentence to those quoted above. "This is not a case in which we are asked to let someone die. Nancy is not dead. Nor is she terminally ill. This is a case in which we are asked to allow the medical profession to make Nancy die by starvation and dehydration."

What reason could there be to make this our aim? The answer is fairly obvious. Although Nancy Cruzan is neither dead nor dying, her life is the sort no one would choose if given the normal possibilities. Although not dying, she is severely disabled. To see this, however, is to see the true nature of a choice to withdraw nutrition. In doing so we aim at no death-prolonging treatment; rather, we aim at a life though to be of little or no worth. We judge that life not from the perspective of the one actually living it (a perspective about which we must confess radical ignorance), nor, certainly, from od's perspective, but from our own. We compare it to the sort of life we live (and Nancy Cruzan once lived) and judge it by that standard as a *lebensunwerten Leben*, a life not worth living. Understandably. But it should be clear that in so doing we are not simply rejecting a treatment as useless or inadequate – but a life as unworthy. That judgement of comparative worth the Court clearly discerns and rejects. We can add one more sentence to those quoted above. "This is not a case in which we are asked to let someone die. Nancy is not dead. Nor is she terminally ill. This is a case in which we are asked to allow the medical profession to make Nancy die by starvation and dehydration. The debate here is thus not between life and death; it is between quality of life and death." In these sentences the Court recognizes how drastically the terms of debate have shifted within our country in the last two decades and how inadequate is the language of "letting die" for a case like that of Nancy Cruzan. On these matters crucial for moral analysis this opinion is more clear-headed than many of the decisions from "courts of some…sister states" which the Missouri Court recognizes but does not follow.

The Court makes one further distinction of importance at this point in the argument. Having stated that a decision to withdraw nutrition from Ms. Cruzan cannot be described as "letting die" but must be described as intentional killing, the Court makes clear that is peaks here the language of aim, not of motive. "To be sure, no one carries a malevolent motive to this litigation. Only the coldest heart could fail to feel the anguish of these parents who have suffered terribly these many years." The moral life would be far more straightforward than it is if well-motivated people never did what was wrong and those with evil motives never did right. But such is not the case. And the Court quite rightly distinguishes between the motives that left the Cruzans to court and a proper description of the deed they sought permission to enact.

If I am correct in suggesting that the terms of debate have shifted greatly and that the language of "letting die" no longer really fits the circumstances of the patient like Nancy Cruzan, why is this language still used? On this point also the Court's opinion is clarifying and helpful. It notes a "change of focus" – away from language that focuses on "the patient's medical prognosis and the individual patient's assessment of the quality of her life in the face of that prognosis." The ordinary/extraordinary language, though often confusing to some people, at least directed our attention to certain objective reasons for refusing treatment. An "extraordinary" treatment was either useless or excessively burdensome and could therefore rightly be refused. In refusing treatment on such grounds, a patient might, in effect, be choosing a shorter life, but still choosing life. From among the available life-choices that patient would be choosing a certain life – shorter, but free of certain burdensome or useless treatments.

But the "change of focus" discerned by the Court directs our attention away from such relatively objective grounds for choice. Instead, courts begin to focus simply on the right of individual choice. From that perspective, any treatment, even one that is clearly lifesaving and is not experienced as burdensome, may be refused. Once treatment refusal is grounded simply in autonomous patient choice, there is little ground left for denying patients the right to choose, not just among alternative life-choices, but death itself. Thus, the Court says: "Once prognosis becomes irrelevant, and the patient's choice always more important than the state's interest [in preserving life], this standard leads to the judicial approval of suicide." If the only thing that counts is autonomous choice, patients may do more than choose one sort of life by choosing against certain treatments. They may turn against more than a particular treatment: they may turn against life.

In the case of competent patients this may, of course, be difficult to determine legally. There is a clear conceptual distinction between choosing not to live and choosing to live in a certain way (free of the burdens of particular treatments). But even were we to agree that it is morally wrong to choose against life, it would be very difficult for any court of law to determine that in my choices I was rejecting not just the burdens of continued treatment but continued life. (And it would certainly be difficult had I been well instructed by a good lawyer sensitive to the distinction.) Thus, in the case of competent patients, courts will very often need simply to permit competent patients to choose. (This does not mean, naturally, that legislatures could not determine that some choices were not open to competent patients – as some "living will" legislation specifies that nutrition and hydration are not forms of treatment that can be discontinued at patient discretion.)

It may, however, be quite appropriate to treat some incompetent patients differently. Other courts have tended to assume that, since competent patients have a right to refuse treatment, we must find someone to assert that right on behalf of incompetent patients. The Missouri Court wisely sees how problematic is that move. Feeding Nancy Cruzan does not seem to be useless, since it sustains her life (and does not just prolong a dying process). Feeding Nancy Cruzan does not seem to be burdensome, since, as far as we know, she cannot experience this treatment as burdensome. Therefore, a decision to withdraw nutrition and hydration is difficult to construe as a choice against either useless or burdensome treatment. It seems like a choice aimed not at her treatment but at her life. It is the only way to get her to die. Should not the Missouri Supreme Court think that at this point the state's interest in prevention of homicide becomes substantial? It should, and it did.

The Court suggests that, at least for incompetent patients, we keep the language of medical prognosis central, that we ground treatment refusals for them in more than a choice asserted on their behalf. This leads us, finally, to consider the possible grounds for such a refusal. Is the provision of nutrition and hydration to Nancy Cruzan either useless or excessively burdensome? I suspect that most of our unexamined assumptions lie here, and that this is the most perplexing element in arguments about cases like this one. We can begin by considering the usefulness of feeding her. She is not a terminally ill patient and will not necessarily die soon if given nourishment and proper care. It is hard, therefore, to avoid saying that if we stop feeding her it is because we think her life is a useless one to live – not because the treatment is itself useless. The treatment seems useless because the life seems not worth sustaining. Is that not essentially what we tend to think?

This much is certainly true: Given alternatives, none of us would choose for ourselves the life of Nancy Cruzan now lives. Judging from our perspective as competent adults, her life may seem comparatively worthless. But if we adopt that perspective in making such judgements, there are many lives that seem comparatively worthless. Our nursing homes are quite literally full of people whose lives we would not choose for ourselves. It is, therefore, not empty or irrelevant rhetoric when the Court writes: "The state's concern with the sanctity of life rests on the principle that life is previous and worthy of preservation without regard to its quality. This latter concern is especially important when considering a person who has lost the ability to direct her medical treatment." Nancy Cruzan is still living, still one of us. As such, she has a claim upon our continued care. She is, to be sure, severely disabled and – so far as we can tell – unlikely ever to recover from her disability. But this means only that we can probably never cure her. It does not release us from the obligation to provide her what care we can. The Court is quite right to worry about an argument which "seems to say that treatment which does not cure can be withdrawn" on that ground alone.

The argument that does need serious consideration here is one Paul Ramsey put forward in *The Patient as Person* – and later recanted. The argument does not perfectly fit the Cruzan case, since Ramsey meant to be talking only about dying patients, but it fits well enough. Ramsey argued that our actions toward the sick and dying ought to be governed by a categorical imperative, the first of which is especially relevant here. That first qualification was: "Never abandon care… except when [the patient is] irretrievably inaccessible to human care."[2] If there should be a patient who was really beyond our care, who could no longer receive that care, then, Ramsey wondered, could we really be obligated to give what could not be received? He wrote:

"The proposed justifiable exception depends on the patient's physiological condition which may have placed him utterly beyond reach. If he feels no suffering, he would feel no hunger if nourishment is withheld. He may be alone, but he can feel no presence… The sort of situation that may be covered and resolved by the present proposal in ethical analysis, if it is valid, are the cases of patients in deep and irreversible coma who can be and are maintained alive for many, many years… Acts of charity or moving with grace among the dying that now communicate no presence or comfort to them are no longer required. If it is the case that a wife is tragically mistaken when she takes twitches of the eyes to be a sort of language from her husband irreversibly comatose for seven years, or when she takes such reflex actions as the response of the lips to a feeding cup to be evidence of reciprocation and some minimal personal relatedness, then her care is now worthless. Indeed, it is no longer care for him. It is no contradiction to withhold what is not capable of being given and received?"

If there is to be moral justification for withdrawing the feeding tube from a patient like Nancy Cruzan, this would be far better than the sorts of arguments the Missouri Court rightly rejects. For this argument is not grounded in a judgement that such a life is not worth living. It is grounded only in the judgement that there can be no obligation to give what cannot be received. And Ramsey quite clearly realized that under such circumstances, if such a justification were found acceptable, there would be little reason so bring about death only by withdrawing nutrition. In such cases "it is entirely indifferent to the patient whether his dying is accomplished by an intravenous bubble of air or by the withdrawal of useless ordinary natural remedies such as nourishment."[3] In either case we would not just be allowing the patient to die. We would be aiming at that death – and the justification, if there could be one, would be the sort sketched here.

This possible qualification of the duty never to abandon care Ramsey largely withdrew in his later work, *Ethics at the Edges of Life*. His reason was, simply, doubt whether we should ever say with confidence that a still living human being had passed beyond the reach of our care. "The serious objection to searching for such exceptions is that – even within the stringent limits of indications of a patient's impenetrable solitude silencing any need on our parts to feel an obligation to continue to extend care – one still might do the deadly deed to someone still in a penultimate stage, to someone who while beyond showing response to us may still be within reach of violation at our hands, and so not altogether in God's keeping."[4]

If it is hard to make the case that feeding Nancy Cruzan is useless (without judging her life – and not just her treatment – to be useless), we might yet consider the possibility that such treatment should be rejected on grounds not of uselessness but of excessive burden. At first blush this will seem a rather difficult argument to make. As the Court notes: "if the testimony at trial that Nancy would experience no pain if she were allowed to die by starvation and dehydration is to be believed, it is difficult to argue with any conviction that feeding by a tube already in places constitutes a painful invasion for her." If she is said no to possess our ordinary capacity for experience, she cannot be held to experience feeding as a burden.

But perhaps this does not quite get at what one might have in mind in describing such feeding as a burden to her. Thus, for example, the brief submitted by the plaintiffs-respondents, considering (and rejecting) some medical testimony which had suggested that Ms. Cruzan might have "some limited perception of her environment," had argued: "But even if the testimony was believable, it would not detract from Nancy's right to be free from unwanted, invasive, medical treatment. Indeed, it would make her dilemma all the more horrible and compel withdrawal of this treatment if she somehow had some limited perception of her condition…" Judge Blackmar, in his dissent, put what I take to be the same opinion slightly more graphically: "If she has any awareness of her surroundings, her life must be a living hell."

We should be clear that the Court quite rightly rejected the argument presented by the plaintiffs-respondents; for they had argued both that Ms. Cruzan was incapable of experiencing anything and that her treatment was burdensome to her. But if one supposes that we should never sat with certainty that such a patient is beyond experiencing the care we give, we must take seriously the objection that this care would be experienced as terribly burdensome. I am not certain I am prepared to believe this. Judge Blackmar wrote that, on such a supposition, her life must be a living hell. But "hellish" is the one thing it would not be. For what is terrible about hell is the ultimate isolation to which it sentences one. To be in hell is to be utterly enclosed within the self – caring for no one and being cared for by no one. If Ms. Cruzan is not incapable of

experiencing our care, it would be hellish to know that others were discussing how to get her to die. It would not, however, be hellish to know that others were – despite their frustration, anxiety, and sense of hopelessness – struggling to care for her as best they could.

Article: The *Cruzan* Decision – 9.5 Theses for Discussion

Midwest Medical Ethics, Fall 1990
By Gilbert Meilaender

In its long-awaited decision in the case of Nancy Cruzan, the United States Supreme Court upheld the decision of the Missouri Supreme Court. Although that is the decision for which I had hoped and which I think correct, I am not greatly encouraged by the rationale provided in the opinion issued by the Court's majority and am even less encouraged by Justice O'Connor's concurring opinion and the dissenting opinions authored by Justices Brennan and Stevens. The theses below seek to explore some of the reason for this judgement.

(1) If we concentrate on moral rather than legal issues, it is hard to find important differences between the majority opinion authored by Chief Justice Rehnquist and the dissenting opinion authored by Justice Brennan. The majority opinion assumes "for purposes of this case" what Justice Brennan certainly asserts: that a competent person has "a constitutionally protected right to refuse lifesaving hydration and nutrition." In the case of an incompetent person, the Court majority holds that any of the states is entitled to require rigorous proof that this person, when still competent, authorized removal of a feeding tube in the event of his or her future incompetence. The majority does not demand that the states require as rigorous a demonstration of clear and convincing evidence as Missouri had; it simply views such a requirement as constitutionally permitted.

Justice Brennan's dissent, although it regards the "right to be free of unwanted medical intervention" as a fundamental constitutional right, does not describe that right as absolute. Justice Brennan grants that this right may be limited by countervailing state interests but holds that the kind of evidence Missouri required is so strict that it will result in failure to honor what were genuinely the desires of many now incompetent persons.

Justice Brenan is less inclined than the Court majority to defer to Missouri's judgement about the kind of evidence needed to establish a person's desire to refuse treatment. He is more inclined than the Court majority to find that Missouri's rigorous evidentiary requirement would not achieve its supposed purpose: assuring that the wishes of the now incompetent person are accurately determined and enacted. This relative willingness or unwillingness to defer to the judgement of a state legislature is no doubt important in a variety of ways, but it does not point to any very important difference in understanding the moral issues at stake in Cruzan.

(2) Between the majority opinion and the Brennan dissent there may, however, be the following difference, which would be important for moral reflection and judgement. Although the facts of the Cruzan case lead all of us to concentrate on patients who were once competent but are no longer, there are also patients who have never been competent (e.g., infants, the profoundly retarded). Only Justice Scalia in his concurring opinion seems to realize this. But the majority opinion, without precisely noting the significance of this fact, seems to make room for its possible implications. The majority opinion, considering the claim that incompetent persons

have the same right to refuse treatment as the competent, notes the difficulty with such a claim: "[A]n incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right. Such a 'right' must be exercised for her, if at all, by some sort of surrogate." In the circumstances of the Cruzan case, the Court majority then simply notes that the state of Missouri is entitled that a surrogate decision maker is really choosing what Ms. Cruzan herself, when competent, desired.

If, however, we think of cases unlike Cruzan – involving persons who have never been competent – it is clear that no surrogate can know what that person would have desired. The concept has no application in such cases. In such instances some have turned to "substituted judgement," but the Court majority seems (rightly, I think) to doubt the coherence of such a move. The Court may therefore be suggesting that we can quite properly have stricter rules governing treatment refusals for incompetent than competent patients. The issue of artificial feeding is a good one to consider here, since (as I will argue again below) withdrawal of a feeding tube often can only be construed as aiming at the patient's death. The majority opinion may be pointing us towards a compromise in public policy that would go something like this: Even if we permit competent patients the liberty to make choices that seem to aim at their death (and, hence, are suicidal), we might well surround the lives of incompetent persons with greater protection against choices that, in effect, aim to end their lives – against, that is, injustice. Even while holding that it is never morally right to choose to die or to aim at another's death, we could grant competent adults the liberty to make such a morally wrong choice while protecting the incompetent against the infliction of such injustice. Such a vision may be buried within the majority opinion. But in my view only Justice Scalia really discerns the possibility of such a compromise, and he is quite right to ask why such a possible public policy should be a matter for constitutional adjudication rather than public argument and debate.

(3) Between Justice O'Connor's concurring opinion and Justice Brennan's dissent there is relatively little to choose. Her view differs from Brennan's only in her somewhat greater willingness to defer to a state legislature when it attempts to establish procedures to ensure that the wishes of incompetent persons are truly ascertained and honored. She goes out of her way, however, to emphasize the right of competent adults to refuse any care provided by medical personnel, including feeding. Moreover, she adds the conjecture – not really required by this case – that *if* a now incompetent patient previously executed an advance directive refusing treatment of any sort (including feeding), the Constitution might well *require* the states to implement and enforce the wishes expressed in that directive. And in her eagerness to endorse various forms of surrogate decision making she is likely to blur the distinctions needed for the sort of compromise position outlined in (2) above.

(4) If the majority opinion, the O'Connor concurring opinion, and the Brennan dissent shape the contours of future thinking, we may safely predict the following: The trend toward an absolutist understanding of patient autonomy, which so dominated medical ethics from the mid-1970s to the mid-80s, will win the day legally. From all sides we will be encouraged and enjoined to execute advance directives; that is, to attempt to outline our treatment desires and extend our autonomy even into any period of our future incompetence. Whether this view is grounded constitutionally in a supposed right to privacy or in a liberty interest to refuse unwanted treatment will not be terribly important. Commentators of all stripes discussing a wide variety of social ills will continue to be disturbed by the fragmentation of our society, but – in our characteristic schizophrenic way – we will continue to bemoan that fragmentation while enshrining it in our understanding of the principles that should govern treatment refusals.

(5) We seem destined to continue to describe the facts of the Cruzan case in ways that are mistaken and misleading. The majority opinion is not without fault on this score. (Its sins are, however, not even in the same league with those of Justice Stevens, to which I will turn later.) Discussing the request by Nancy Cruzan's parents to stop nutrition and hydration, the majority opinion states: "All agree that such a removal would cause her death." Later, however, a decision to withdraw Ms. Cruzan's feeding tube is characterized as a decision which "all agree will result in her death." Granting the difficulties in law of articulating and applying a concept of proximate cause, an act that *causes* death and an that *results* in death are – for all of us who still think there is some point to the distinction between killing and allowing to die – quite different morally. Confusion increases when only a few sentences later the majority opinion describes withdrawal of the feeding tube as "a decision to terminate a person's life." Justice Brennan is guilty of the same confusion when he characterizes a decision to withdraw Ms. Cruzan's feeding tube both as a "right to avoid unwanted medical care" and as a right "to choose to die with dignity."

(6) How we describe a decision to stop feeding someone like Nancy Cruzan is crucial. Her case is persistently described as one dealing with removal of a feeding tube; that is, removing intrusive, unwanted medical care. That description is inaccurate. Ms. Cruzan's parents did not seek removal of the tube, they wanted it in place for administering medications and fluids that would reduce seizures while she died. What they wanted stopped was not the intrusion of the tube, but its use to nourish and sustain her life. What they wished to decline was not medical intrusion but nourishment. To see this is to begin to appreciate the force of a sentence from Justice Scalia's concurring opinion: "Suppose that Nancy Cruzan were in precisely the condition she is in today, except that she could be fed and digest food and water *without* artificial assistance." Indeed! We would then distinguish very quickly between those whose aim was to reject burdensome and invasive treatment and those whose aim was to stop nourishing a person without cognitive capacity in order to bring about that person's death.

(7) This suggests a difficulty with the possible public policy compromise outlined in (2) above. Those desiring to refuse nourishment in order to die, or those for whom such a desire, convincingly documented, is asserted by a duly appointed surrogate, do not wish to die without assistance. They want a considerable amount of help from medical personnel, although this help is no longer characterized as intrusive. What they want may properly be described as assistance with suicide. That may pose, and we should hope it poses, grave difficulties for many caregivers. And it may also permeate our caregiving institutions with a kind of profound symbolic dissonance. If Justice O'Connor's view – that wishes expressed in clear advance directives have a constitutional right to be enforced – wins the day, we will have developed a constitutional right to assisted suicide. The sense that all of us are aggrieved when one of our fellow citizens takes his life (a sense enshrined in the common law tradition which Justice Scalia admirably unpacks) will finally give way to the belief that we are isolated, autonomous individuals. The majority opinion seems to recognize that such questions may be involved, though it does not coherently address them. Noting that "the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide," the Court majority writes: "We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death." But that claim, potentially so far-reaching in its implications for artificial feeding cases, is never precisely related to the Cruzan case in the majority opinion. Once, however, we see that assisted suicide is under debate here we might well think Justice Scalia correct when he says that such an issue ought to be a matter of public debate rather than constitutional determination.

(8) In the face of the terminological confusions that abound in the majority opinion and in Justice Brennan's dissent, it needs to be said again that withdrawing a feeding tube – at least in cases like that of Nancy Cruzan – is properly construed as an act that aims at her death. The care she is receiving, even if we call it medical treatment, is not experienced by her as burdensome; hence, withdrawing the feeding tube is not simply rejecting the burdens of treatment. Nor is the care useless, since it preserves her life. Of course, the life she lives is not one that be the first choice of any of us. But our responsibility is to benefit the life she has, not to determine whether her life has any benefit or worth. Moreover, as I noted in (6) above, when we stop feeding, we do not necessarily cease all medically intrusive intervention. We stop feeding not to free her from a burden but to see to it that she dies. Up to the present time we have been unable to face this truth – hence, the terminological confusions. Perhaps a frank acknowledgement that we were indeed recommending assisted suicide would be more honest.

I am aware, of course, that my characterization of withdrawing a feeding tube as aiming at her death will continue to be disputed. For example, Richard McCormick, S.J., has suggested that we consider the following 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 prop from Nancy, was it not the original anoxic trauma that *causes* her death, that killed her?" The short answer to this is no doubt rhetorical question is "no." Moreover, as the language of assisted suicide comes increasingly to the fore, it will become apparent to all that the answer is "no." McCormick's claim that we are simply "letting die" those in Ms. Cruzan's circumstances when we stop nourishment will prove to have been a stopgap measure – language needed to tide us over while we worked up the gumption to face a more adequate description of the act. A human being who does not or cannot achieve "full budding form," who puts forth only "a few anemic leaves," but who can continue indefinitely to live this less-than-fully-flourishing life with some assistance (propping) from us, is not a dying human being. She may be ill or seriously disabled, but she is not dying. And, therefore, she cannot be "allowed to die," though she can be killed.

As infants, all of us were in need of a good deal of propping – including, significantly, feeding. Some of us have flourished and, we like to imagine, now get along with propping. Others of us are more anemic and still need a great deal of propping. If we need it, others should try to give it. The fact that one of us is very anemic and in need of endless propping means simply that others must benefit that weak life as best they can and refrain from judging it as a life of no benefit to the one who lives it.

(9) The viewpoint outlined in (8) above may be grounded in religious belief, but it needs no such ground. Its warrant may be simply a firm commitment to treat human beings equally, making no comparative judgments about the worth of others' lives. Justice Stevens in particular seems to worry that "faith," "some theological abstraction," "theology" or "speculative philosophy" may without any constitutional warrant be inserted into their deliberations. He need not fear. In fact, something almost the opposite is true.

The position held by the dissenters in the Cruzan case would be safe only in a community with certain widely shared religious beliefs. We can see how this may be if we recall an argument made by Albert Camus about capital punishment. He suggested that the justice or injustice of the death penalty depends on the ultimate frame of reference within which it is used and

understood. Capital punishment could be justified only where there was a socially shared religious belief that the final verdict on any person's life was not given in this world. In such a religious society, to condemn a fellow human being to death would not involve divine pretension. Those who issued and executed the verdict would know that, however necessary it seemed to be, it could still be overturned by the only perfectly competent judge, God himself. But what of a society lacked such shared beliefs? In it, Camus thought, execution must mean elimination from the only community that indisputably existed; and, hence, execution would be a godlike activity. Only in a society that believed in the Eternal could it be right to exercise an ultimate mastery over this finite life.

Similarly, it would be one thing to judge Nancy Cruzan's life no longer worth our care, to aim at her death, if we shared the belief that in so doing, we were handing her over to One who might discern in her worth beyond our ability to discover. It is quite another when our decision eliminates her from the only community we are agreed in valuing. The worth of her life, however disabled she may be, lies simply in the fact that she shares with us the human community. As far as we as a publicly constituted people are concerned, she is either valued and treated equally within this community or she is deemed less equal than our equal.

(9.5) About all these matters Justice Stevens is very confused. I offer here only a half a thesis for reasons of charity. He argues against equating Nancy Cruzan's life with the "biological persistence of her bodily functions." Is she no longer a living human being? Well, not exactly. "Nancy Cruzan is obviously 'alive' in a physiological sense. But for patients like Nancy Cruzan, who have no consciousness and no chance of recovery, there is a serious question as to whether the mere persistence of their bodies is 'life' as that word is commonly understood, or as it is used in both the Constitution and the Declaration of Independence." Yet, Justice Stevens does not recommend burying her while her heart still beats. It is clear that in wanting to let her die he is, in fact, turning against not her treatment but that physiological life (biological persistence) she still has.

Justice Stevens is concerned that Ms. Cruzan's rights to life and liberty are in conflict. By holding that he "life expired when her biological existence ceased serving any of her own interests," he no longer needs to worry about her right to life – since she is dead. Yet, of course, he must presuppose some kind of ongoing existence if he is to be concerned for her interest in liberty, in freedom from unwanted medical treatment. He goes so far as to suggest different definitions of life and death for different people. Some of us might argue that our life ends when our continued biological existence no longer serves any of our other interests; others of us might define life "to encompass every form of biological persistence by a human being." Evidently, we get to choose whether we are still alive, still a member of a community and entitled to its care, and we get to make different choices and "die" at different points along some spectrum of possibilities. Here is a recipe for chaos. More important, such confused and confusing views will make it only more difficult than it has already become to believe that we share a common life and have a stake in the lives of each other.

Article: Clear and Convincing Evidence – The Case of Nancy Cruzan

By Richard McCormick
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My initial reaction to the Supreme Court decision in the case of Nancy Cruzan was quite critical. Why? Four reasons especially. First, I judged that one of its primary repercussions would be to remove families from participating in decisions concerned with the best interests of their dear ones. I view such distancing as highly undesirable. There should be in morality and public policy a presumption that family members are best positioned to determine what an incompetent family member would choose or what is the incompetent's best interest. A presumption yields, of course, to contrary evidence. But to disallow Lester and Joyce Cruzan's testimony to qualify as a source of clear and convincing evidence struck me a presumption in the opposite direction, and therefore divisive of families.

My second reason for a critical response was that the Supreme Court, very much as Missouri had done, left totally unprotected those who have been incompetent from birth and babies. Missouri's Supreme Court had asserted that its interest in the preservation of life was "strong enough to foreclose any decision to refuse treatment for an incompetent person unless that person had previously evidenced, in clear and convincing terms, such a decision for herself." (Justice Stevens in his dissent.) Absent that previous evidence, the interest in preservation of life prevails. This means that the always incompetent (e.g., Joseph Saikewicz, John Storar) must be kept alive no matter what. When the Supreme Court says that such an evidentiary requirement (clear and convincing, from the patient herself) is not unconstitutional, it means that it does not violate the liberty interest of the incompetent contained in the due process provisions of the 14th Amendment. But that seems to imply that the always incompetent have no such liberty interest. Strictly speaking, I suppose, they do not. That is, those who were never really free hardly have liberty interests. But at the root of the liberty interest is the dignity interest. And they certainly have that.

My third reason for an initial negative response was the lack of a sustained and enlightening analysis of the state's interest in the preservation of life. Justice Stevens adverted to this in his dissent. Indeed, by failing to make this analysis, the Supreme Court seemed to equate the preservation of life with the preservation of biological persistence of Nancy's bodily functions.

Finally, if evidence must be clear and convincing from the patient herself, it struck me that the *Cruzan* decision would foster a general reluctance to start life-preserving interventions if it is to be so difficult to stop them when they are no longer beneficial to the patient.

My second reaction was much less critical. Once again, for several reasons. First, it is clear that the decision was crafted along the most narrow grounds. It stated only that Missouri's heightened evidentiary requirement was not unconstitutional. It did not say it was necessary or wise or the only available approach. In other words, the Constitution permits, but does not require, a heavy burden of proof. I believe it was to the expected that the Court's ruling would be strictly constructionist. That did no help the Cruzans very much; but it leaves a lot of room for future development, what Justice O'Connor refers to as "the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests."

Second, the Court explicitly acknowledged for competent persons the existence of a constitutionally protected (14th Amendment) liberty interest in refusing unwanted medical treatment. Indeed, it agrees that such a liberty interest perdures into incompetency when it, along with Missouri, supports a surrogate's decision to reject treatment as long as there is clear and convincing evidence of the patient's wishes.

Third, there are indications in the dicta that the Court would find lesser evidentiary demands and other arrangements constitutionally acceptable. For instance, writing about surrogate decision makers and the duty of a state to accept such decisions, Justice O'Connor states: "In my view, such a duty may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment."

Finally, I am relieved that the Court did not anchor the right to refuse treatment in the right of privacy. Indeed, it explicitly rejects such a basis when it notes (footnote 7) that "we believe this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest."

At this juncture it is appropriate to make two points. First, I am not a constitutional lawyer or historian. Therefore, I read the constitutional aspects of this decision as an amateur. Second, however, it is remarkable how indistinguishable is so-called constitutional reasoning from straight-out moral reasoning. Because of this considerable overlap I am emboldened to continue the discussion and raise some philosophical issues that seem to me to be incomplete.

The Supreme Court has clearly acknowledged a liberty interest in refusing unwanted medical treatment. It has also acknowledged relevant state interests. It describes the constitutional problem as follows (citing *Youngberg v. Romeo*): "Whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interest." This is the structure not only of the constitutional issue, but also the structure of the moral issue. Central to both the constitutional and moral issue is a balancing of interests, specifically those of Nancy and those of the state. Before a balancing of interests can be successfully accomplished, an accurate statement of those interests must be made. It is here that I find the Court's analysis quite vulnerable.

Let me begin with the state's interest. As the Court notes, "Missouri relies on its interest in the protection and preservation of human life, and there can be no gainsaying this interest."

Realizing that this is a very general statement, the Court tries to particularize it by noting that the state's interest is really in safeguarding "the personal element of this choice [between life and death] by heightened evidentiary requirements." These "heightened evidentiary requirements" refer, of course, to the patients' own earlier statements made while competent. One can bicker all day whether clear and convincing personal statements are the best way to protect the "personal element." Obviously, Justice O'Connor thinks other ways would be constitutionally acceptable. She notes that the *Cruzan* decision does not "prevent States from developing other approaches for protecting an incompetent individual's liberty interest in refusing medical treatment."

But this is not my concern. It is rather, "the personal element of this choice" as the state's interest to be protected. What does this phrase mean? The Court notes that "the choice between life and death is a deeply personal decision of obvious and overwhelming finality" and

it wants to protect this personal dimension. True enough, but perhaps not enough of the truth. Decisions that can lead to life or death are indeed *ordinarily* "of obvious and overwhelming finality." The Court includes the removal of Nancy's gastrostomy tube in this category. But Nancy's situation is not ordinary. She is in a persistent vegetative state. Relapse from this state is hardly a matter of "overwhelming finality." What is or was of overwhelming finality, I would agree, was the original cerebral insult that left Nancy in this condition. Let me put this in another way. The Court professes an interest in "the personal element of this choice." It was precisely this "element" that led it to support the constitutionality of Missouri's heightened evidentiary requirements. At this point, however, I want to question the significance of this "personal element" *in these circumstances*. Once a person is in a persistent vegetative state, there would seem to be no "personal element of this choice" remaining to protect. What I am suggesting is that the analytic soft spot in the Court's approach is the equation of a decision about the persistently vegetative Nancy Cruzan with an "ordinary" decision between life and death.

The point I am making can be urged from several different perspectives. For instance, in allowing Missouri's heightened evidentiary requirements, the Court asserts that "we think a State may properly decline to make judgements about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." In short, no "quality-of-life" judgements. Paradoxically, in refusing to allow *any* quality-of-life dimension, the Supreme Court (with Missouri) is actually making precisely such a judgement. It is saying that preserving a life even *in that condition* represents a value to the person and a state interest.

But does it really? I believe Justice Brennan is much closer to the truth when he argues that "no state interest could outweigh the rights of an individual in Nancy Cruzan's position." Brennan immediately continues: "The only state interest asserted here is a general interest in the preservation of life. But the state has no legitimate general interest in someone's life, completely abstracted from the interest of the person living that life, that could outweigh the person's choice to avoid medical treatment." Justice Stevens is getting at the same idea when he asserts that Missouri's policy "is an effort to define life, rather than to protect it." He continues: "Missouri insists, without regard to Nancy Cruzan's own interests, upon equating her life with the biological persistence of her bodily functions." He sees this as aberrant. So do I. And it is at the very heart of every key notion in this discussion (state's interest, patient benefit).

The urgent question is the evaluation of life in a persistent vegetative state. Is such a life a value to the one in such a condition? Is its preservation a benefit to the patient and therefore a state interest? Avoiding this question is obviously the more comfortable path. But it cannot be avoided, it can only be delayed. Missouri gave its answer when it referred to "the immense, clear fact of life in which the state maintains a vital interest." Obviously, then, the "immense clear fact of life" is identified with *any* life regardless of condition.

Some philosophers also take this point of view. Writing about artificial nutrition and hydration for permanently vegetative patients, William May and others stated: "In our judgement, feeding such patients and providing them with fluids by means of tubes is *not* useless in the strict sense because it does not bring to these patients a great benefit, namely, the preservation of their lives." (*Issues in Law and Medicine*, vol. 3, no. 3, 1987.) This "great benefit" and Missouri's "immense, clear fact of life" strike me as examples of biologism or vitalism. By these terms I refer to a positive evaluation of circulation and ventilation regardless of what personal goals it enables for the individual.

We are understandably afraid of allowing a quality-of-life ingredient a role in decision making for the incompetent patient. It is dangerous. But I agree with Bernard D. Davis, professor emeritus at Harvard Medical School, that "irreversible coma is so clearly defined, as a special class, that it could be given special treatment without starting on a slippery legal slope." (*Wall Street Journal*, July 31, 1990) What is that special treatment? A reversal of the presumption currently honored. At present, absent any prior expression of preference, we must presume an interest of the patient, or the state, in continuing life support. Davis proposes that in this extreme case (persistent vegetative state) evidence of a prior request should no longer be required. With appropriate safeguards we should presume a preference for termination of treatment.

What is the basis for this shift of presumptions? Davis refers to a "meaningful estimate…of public attitudes" and suspects that a survey of such attitudes would find a large majority opposed to continuing to life-preservation for persistently vegetative patients. I do not have to suspect this. I am convinced of it. For several years, I have asked audience after audience if they would want artificial nutrition and hydration were they irreversibly unconscious. With virtual unanimity the answer has been no. these people were saying that they did not regard *continuing in that condition* a benefit to them. For if they regarded this as a benefit, especially a "great benefit," they would be inconsistent in rejecting it if the treatment were otherwise not burdensome. If the vast majority of people do not regard existence in a persistent vegetative state as a genuine benefit, why should the state assert such a continuance as an interest? In Justice Steven's words, "life, particularly human life, is not completely thought of as a merely physiological condition or function." For that reason, Stevens concluded "there is no reasonable ground for believing that Nancy Beth Cruzan has any *personal* interest in the perpetuation of what the State has decided is her life."

The Supreme Court has judged that Missouri's heightened evidentiary requirements are not unconstitutional, that they are not an infringement of Nancy's liberty interest. Implied in such a view, I believe, is a further judgement that continuance in a persistent vegetative state is a patient benefit and therefore a state interest. I cannot accept that. So, while the *Cruzan* opinion has in my view analytic soft spots, it does leave the door wide open for further development. In that there is hope.

CRUZAN: Discussion Questions

Questions following the Missouri Supreme Court decision

1. The Missouri Supreme Court felt there were two separate interests in life that were at stake here, viz., the interest in sustaining the life of the individual patient and the interest in the sanctity of life itself. What arguments can be brought to bear to show the priority of one interest over another?

2. Did the court view Nancy's condition terminal or non-terminal? What difference did it make in the outcome of the state court's decision? Is there a moral difference between life-sustaining and death-prolonging treatment? How is "terminal" defined?

3. Dr. Meilander suggests that at issue is the determination of "a life not worth living," rather than the determination of a treatment as useless or inadequate. Can you give the arguments for/against his position? In your opinion which is the stronger argument? Why?

4. What is the role of the surrogate in cases where the patient once had decisional capacity and in cases where the patient never had decisional capacity? Why is there a difference here? How can you argue that Nancy's parents ought/ought not be her surrogates?

5. How would you identify the philosophical foundation for the Missouri Supreme Court's decision? Do you agree with McCormick that it is "legal positivism"? Could it be any other position?

Questions following the U.S. Supreme Court decision

1. What is the most convincing argument you can make that the preservation of human life is not simply the preservation of vegetative life? Where is the weakest point in your argument?

2. Why does the Court state that to base its majority judgment in a "liberty interest" is a stronger argument than to base it in "the right to privacy"?

3. Again, there is a "balancing" of liberty interests against the state's interest in preserving life. Like much ethical argument that attempts to balance one good over another, the U.S. court placed personal liberty over the state's interest. Do you think the argument is strong? Where is its weakest point?

4. Is it ethically significant that Nancy's food and hydration was administered through a gastrostomy tube and that Karen Quinlan's air was administered through a ventilator? What reasons do you have to support your answer?

5. Why is the definition of death ethically significant? All states recognize the heart/lung definition of death (when the heart stops beating and the lungs stop breathing) and most states recognize brain death (a flat EEG signifying no activity of brain or brain stem). Brain death is a product of this century. Why did it come into being? What ethical significance holds here?

6. Efforts are being made to extend "brain death" to include the irreversible loss of higher brain activities (consciousness) as one finds in patients in a permanent vegetative state. Argue this issue pro and con.

Further Readings

Midwest Medical Ethics. 1989. 5:1 and 2 (Winter-Spring). The entire issue is devoted to the Missouri Supreme Court ruling.

See also:

Susan M. Wolf. 1990. "Nancy Beth Cruzan: In No Voice At AIL" Hastings Center Report 20: 38-40 nd

James Bopp, Jr. 1990. "Choosing Death for Nancy Cruzan." Hastings Center Report 20: 42-47. Midwest Medical Ethics. 1990. 6:4 (Pal). The entire issue is devoted to the U.S. Supreme Court Ruling.

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