

Editor's Introduction

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The judicial philosophy supporting decisions of the patient or a surrogate to decline life-sustaining treatment has been amply affirmed. Courts have based the prerogative to discontinue treatment on the federal or state constitutional right of privacy, or the common law.

The U.S. Supreme Court, however, has never affirmed the constitutional or common law principle that a person or surrogate has a privacy right to refuse life sustaining treatment. It is particularly worrying that the Court has chosen *Cruzan v. Harmon*¹ for the October 1989 term as its first right-to-die case. The Missouri Supreme Court in *Cruzan*, disregarding over 50 judicial decisions in 25 jurisdictions, refused entirely to recognize the right of a patient to refuse life support. In *Cruzan* the court would not respect the family's request to terminate artificial hydration and nutrition in a 30-year old patient in a persistent vegetative state for more than five years.

The *Cruzan* decision differs from those made by the highest courts in all other jurisdictions to consider the issue in two important respects. First, it specifically rejects a federal constitutional right to privacy for decisions to terminate life support. Second, it holds that a surrogate's power arises from the state's authority *parens patriae*, "not from the constitutional rights of the ward." The Missouri court cited *Bowers v. Hardwick*² in which the U.S. Supreme Court strongly resisted any "expansion of the privacy right." In *Bowers* the court would not find a privacy interest even to avoid criminal prosecution of consenting homosexual relationships between adults. The Supreme Court in *Webster v. Reproductive Health Services, Inc.*,³ another case emanating from Missouri, reconfirmed the Supreme Court's retrenchment of the constitutional right to privacy. The Chief Justice in *Webster* criticized *Roe v. Wade*⁴ because it "sought to deal with areas of medical practice traditionally left to the States." An adverse decision in *Cruzan* would reinforce differences among individual jurisdictions rather than create a uniform national standard for decisions to abate treatment.

Because interpretation of a state constitution and the

common law lies with the state's highest court, a right to refuse treatment based on state law should be unaffected by the decision in *Cruzan*. However, in a state like Missouri where there is no state constitutional right, *Cruzan* could have a critical impact.

Many of the interest groups concerned with the Supreme Court's erosion of women's rights to abortion have focused on the wider implications of narrowing the scope of privacy. The right to decline life-sustaining treatment is a critically important aspect of the right to privacy to be determined by the Supreme Court this term. *Law, Medicine & Health Care* has sought to forecast emerging issues in health law and ethics. Accordingly, this issue provides a series of provocative articles, editorials, and case studies on death and dying, while our next issue will feature an analysis of law, policy, and ethics regarding abortion.

There are some treatment decisions which have come to be less controversial than they once were. Our legal traditions and ethical codes will usually respect a personal decision to abate treatment. This respect for personal autonomy extends beyond a competent person's express decision to refuse treatment. It also includes the right of a surrogate to decide for a patient who is incompetent and cannot articulate her own wishes. There are two circumstances where surrogate decision-making has become well accepted. First, if the patient left a clear advance directive, surrogates can reasonably purport to know what the patient would have chosen. Second, for those patients who cannot experience life, such as those who are permanently comatose, a surrogate's wishes will usually be respected.

The real difficulty is to decide whether to discontinue treatment where the patient's wishes are unknown and where she is capable of some minimal interaction with her environment. Ethical and legal theory flounder when principles of self determination are unclear because the patient's will is unknown.

Quality of life assessments are inevitably highly subjective. Nancy Rhoden would place a large measure of trust in the patient's family who are in the best position

to assess what she might want and what might serve her interests. This is an approach gaining increased acceptance in the courts. Rebecca Dresser and John Robertson take a far more radical position. They question the bedrock principle that even trusted surrogates should always effectuate the patient's wishes as stated in an advance directive. Dresser and Robertson suggest powerfully that a person's wishes expressed in a state of health and well being may be quite different from the interests of the same person who later in life has suffered physical decline to the point of incompetence. The consequences of this observation, of course, are far reaching. How many of those who have written living wills or durable powers of attorney would be comforted by the knowledge that their current wishes could be ignored in the future? After all, isn't it the precise intention of an advance directive to make a binding choice while competent to continue after incompetence?

The Dresser and Robertson proposal is sympathetically intended not to let a life go when we are unsure the incompetent person would want to die. These authors use psychological theory, not moralism, to support a pro-life position. David Price and Paul Armstrong remind us that, just as there was a moral zeal to keep handicapped neonates alive at almost any cost, there is a new zeal to defend life for the elderly. They draw an apt analogy between the Baby Doe debate a decade ago and the "Granny Doe" debate they predict is emerging. Price and Armstrong, members of the New Jersey Bioethics Commission, discuss a controversial policy initiated by the Office of the Ombudsman in their state to examine every non-treatment decision in a New Jersey nursing home as a case of "possible abuse." Since the article was written, the policy has been retracted, but it has left a confusion of unsolved problems in its wake. In their article, Price and Armstrong clarify many of the issues and point toward institutional ethics committees as part of the solution.

In another state-based study, Tracy Miller, Executive Director of the New York State Task Force on Life and the Law, explains and defends her state's recently enacted law regarding do-not-resuscitate orders, a law which was

based largely on Task Force recommendations. "The law sends a clear signal about... the centrality of dialogue between patient and physician..." Miller writes.

Decisions to abate treatment are often regarded as quite different from decisions to actively promote death. Suppose a physician injects a sedative which she knows could possibly, or will probably, result in the patient's death. On which side of the ethical controversy does this quite common medical action lie? Many legal scholars and ethicists might answer this question by relying on the physician's intent. If the primary intent is to ease pain and provide comfort, even if it may halt breathing, then the action is simply allowing death, which is generally considered ethically permissible. If the intention is to facilitate death for the same humane reasons, then the action is active euthanasia and may be ethically impermissible. The physician in *JAMA's* case study, "It's Over Debbie," was widely, and properly, criticized for taking a life. In this issue of *LMHC*, "The Case of Betty Wright," which actually occurred in the professional and personal life of Ronald Cranford MD, ASLM's former President, is presented. We invited nationally respected physicians, lawyers and ethicists to comment. The interdisciplinary exchange among Cranford, Robert Weir, James Childress, Alan Meisel, Bernard Lo, and Christine Cassel makes compelling reading. I suggest that the true difference between "It's Over Debbie" and Betty's case is not in the intent of the physician or between active and passive euthanasia. Rather, the difference is in the care, sensitivity and consensus that surrounded Dr. Cranford's actions.

References

1. *Cruzan v. Harmon*, 760 S.W. 2nd 408, cert. granted, 58 U.S.L.W. 9999 (U.S. July 3, 1989)(No. 88-1503).
2. *Bowers v. Hardwick*, 478 U.S. 186, 106 S. Ct. 2841d, 92 L.Ed. 2nd 140, reh'g denied, 478 U.S. 1039, 107 S.Ct. 29, 92 L.Ed. 2nd 779 (1986).
3. *Webster v. Reproductive Health Services*, 1989 WL 70950 (U.S. July 3, 1989)(No. 88-605).
4. *Roe v. Wade*, 410 U.S. 113, 93 S. Ct. 705, 35 L. Ed. 2nd 147 (1973).