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Donald L. Beschle

The John Marshall Law School, dbeschle@uic.edu

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Autonomous Decisionmaking and Social Choice: Examining the "Right to Die"

BY DONALD L. BESCHLE*

INTRODUCTION

One of the strangest terms to gain acceptance in the legal field is "the right to die." This phrase has been used to gather into a single category a number of more specific claims of right, including a right to commit suicide, a right to refuse life-sustaining medical treatment, and a right to authorize another to engage in euthanasia, either by acting or refusing to act, with respect to the holder of the right.¹

The term "right" has been defined in a number of ways. Much of western legal philosophy has focused on defining the concept and locating its source.² Despite their differences, all mainstream definitions agree in one respect: an actual or alleged right becomes manifest as a result of a claim. Unless someone

* Associate Professor of Law, The John Marshall Law School. B.A. 1973, Fordham University, J.D. 1976, New York University School of Law, LL.M. 1983, Temple University School of Law.

¹ See, e.g., G. GRISEZ & J. BOYLE, *LIFE AND DEATH WITH LIBERTY AND JUSTICE: A CONTRIBUTION TO THE EUTHANASIA DEBATE* (1979) (The authors, after an introductory discussion of the "right to die" movement, address in separate chapters the refusal of medical treatment, suicide, voluntary active euthanasia, nonvoluntary euthanasia, and care of the noncompetent.); see also Symposium Panel, *Is There a Right to Die?*, 12 COLUM. J.L. & SOC. PROBS. 489, 490-91 (1976) [hereinafter Symposium Panel] (remarks of Prof. Frank P. Grad).

Some commentators use the term more specifically, usually excluding nonvoluntary euthanasia, often excluding active euthanasia, either voluntary or involuntary, and often excluding or failing to address the question of suicide. See, e.g., Schimke, *The Natural Death Act: Protection for the Right to Die*, 47 MONT. L. REV. 379 (1986); Note, *The Living Will: The Right to Death With Dignity*, 26 CASE W. RES. 485 (1976).

² See generally HUMAN RIGHTS (NOMOS XXIII) (J. Pennock and J. Chapman, eds., 1981).

desires and seeks something, we have no cause even to discuss whether that something is a right. A right is something valued positively; it is a good. It is also something that someone else seeks to deny to the claimant—something that could be withheld. In the absence of these fundamental starting points, no debate about rights can begin.

The strange nature of the term, if not the concept, "right to die," is immediately apparent. Unlike liberty, equality, justice, a minimum standard of living, and just about any recognized or arguable right,³ death is and almost always has been viewed not as a good, but as perhaps the ultimate evil.⁴ Death may be necessary, and may be accepted, but it is hardly something to be sought, at least not for its own sake.⁵ And while rulers have denied millions the experience of liberty, equality, and other rights, even the most homespun philosophy recognizes that death is the one thing that we all will certainly share. Rights are sought as goods, and must be sought because they may be withheld. Death is not a good, and it is inevitable. It is

³ Constitutional law in the United States sees fundamental rights as generally limited to negative rights, that is, to the right to be free of government compulsion. Positive entitlements are recognized as rights in other constitutional or quasi-constitutional documents, such as the United Nation's *Universal Declaration of Human Rights*, G.A. Res. 217, U.N. Doc. A/810, at 71 (1948), and some state constitutions. See Langdon & Kass, *Homelessness in America: Looking for the Right to Shelter*, 19 COLUM. J.L. & SOC. PROBS. 305, 323-25 (1985). Positive entitlements also attain the status of right through legislation, of course. But however created or defined, rights are good; duties, their correlatives, are burdensome. See Hohfeld, *Some Fundamental Legal Conceptions as Applied in Judicial Reasoning*, 23 YALE L.J. 16 (1913).

⁴ To be sure, philosophers dating back to the Stoics have argued that death should not be feared. Such philosophies have been endorsed by Christian confidence in a happy afterlife and a merciful God. However, these arguments are themselves necessary only because of the overwhelming sense that death is an evil, a defeat. As Robert Olson points out, St. Augustine's theology required him to condemn as sinful his own very human grief at the death of his mother. And "as Christian existentialists never weary of reminding us . . . Christ's death upon the cross was preceded by a lapse of faith and a tortured cry of despair: 'My God, my God why hast thou forsaken me,'" R. OLSON, AN INTRODUCTION TO EXISTENTIALISM 193 (1962).

⁵ Even the most idealized accounts of death draw the distinction between acceptance and happiness. Death is to be faced calmly and courageously, but with the realization of the tragic nature of what is happening. In the *Chanson de Roland*, Roland, dying the death of a hero "weeps and sighs, he cannot help himself." Another hero, "Achilles did not fear death either, but in the underworld, his shade complained, 'I would rather be a stable boy and work for a poor farmer than reign over the dead,'" P. ARIES, THE HOUR OF OUR DEATH 15 (1981).

little wonder that the term "right to die" strikes a dissonant, if not bizarre, note.

Of course, when we analyze the concept behind the term, its dissimilarity to other rights is greatly reduced. A proponent of the right to die, when asked what such a term could possibly mean, will respond by choosing one or more of the specific, death-related things mentioned above. In general, the right will be defined as a claim to control the time and manner of death, not merely to have it be a part of one's existence. Control over the time and manner of one's death can more easily be viewed as a positive goal, and such control can be denied to the individual. To some extent this has always been so. The debate over the legal status of suicide has a long history.⁶ But modern medical technology has made time and manner of death more a matter of choice than ever before. Technology has also forced the issues gathered under the label "right to die" into public consciousness.⁷ Behind the suggestion of death as entitlement, contained in the phrase "right to die," then, is actually the more comfortable concept of freedom from interference in individual decisions about time and manner of death. The right to die, it might be said, is therefore no more strange, either as a term or a concept, than "liberty." Liberty, when understood as a positive entitlement, comes perilously close to designating the loneliness of Robinson Crusoe as the ideal life. But when understood as merely a shorthand term to describe a measure of freedom from interference by certain others in certain aspects of life, "liberty" becomes attractive as a concept and useful as a term.⁸

⁶ The history of the ethical and legal debate is told, from a strong "pro-choice" position, by Joseph Fletcher, who summarizes: "In classical times suicide was a tragic option, for human dignity's sake. Then for centuries it was a sin. Then it became a crime. Then a sickness. Soon it will become a choice again," Fletcher, *In Defense of Suicide* in S. WALLACE & A. ESER, *SUICIDE AND EUTHANASIA: THE RIGHTS OF PERSONHOOD* 38, 50 (1982) [hereinafter *SUICIDE AND EUTHANASIA*]. American jurisdictions have been divided for many years over the criminality of suicide, attempted suicide, aiding or inciting to commit suicide, see generally 83 C.J.S. *Suicide* §§ 1-6 (1953).

⁷ It has done so on a number of medical-legal issues. See Cowen, "In the Rear and Limping a Little" *Some Reflections on Medicine, Biotechnology and the Law: The Roscoe Pound Lectures*, 64 *NEB. L. REV.* 548 (1985).

⁸ Contrast the attitudes toward, and definitions of, liberty, articulated in R. DWORKIN, *TAKING RIGHTS SERIOUSLY* 259-78 (1977) and F. HAYEK, *THE CONSTITUTION OF LIBERTY* 11-21 (1960).

Still, a sense of uneasiness about the "right to die" persists. If specific terms such as suicide and euthanasia are sufficiently descriptive to sustain discussion of their substance (and the fact that they have been for many years indicates that is true), why has a less precise term emerged? Is it simply a matter of semantic economy? If so, why this particular term? Or does the choice of the term "right to die" have potentially serious, and possibly negative, implications for the development of the concept itself?

This Article contends that the use of the term "right to die" is significant and that its use masks some extremely important considerations involved in the current legal debate on the issue of sustaining life. The term allows and encourages us to believe that when society makes significant and painfully difficult decisions about life and death, we are making no decision at all, but merely deferring to individual autonomy. In short, it allows us to mask decisions as non-decisions.

That is not to say that at least some of the ultimate conclusions of the advocates of a "right to die" concerning when law should and should not insist on prolonging life are incorrect. But the question of whether that is so can best be made by abandoning the illusion that we, as a society, are doing nothing more than maintaining neutrality and deferring to individual choice.

Part I of this Article will trace the evolution of the "right to die" to its current place in American law. Part II will discuss and evaluate the generally favorable reception that the concept has received from commentators. Part III will elaborate on the central argument of this Article, that intelligent legal debate on the role of law in continuing or terminating medical treatment requires that we abandon the term "right to die," and that we limit, far more strictly than is now the case, the extent to which we conceive of these questions as involving autonomous, rather than social, decisions. Part IV suggests some alternative ways to conceive of and articulate legal responses to questions of terminating treatment.

I. THE "RIGHT TO DIE": EVOLUTION OF THE CONCEPT

Philosophers have addressed questions concerning the morality of suicide and euthanasia, and the proper relationship

between the physician and the patient confronting death, for centuries. But only in recent decades has Anglo-American law been a significant part of the debate. The traditional attitude of the law was consistent: suicide was a crime at common law,⁹ assisting suicide was uniformly treated as a serious crime,¹⁰ and any type of "mercy killing" was condemned by homicide statutes.¹¹ Although juries might be reluctant to punish defendants who were acting out of sympathy for their victims, the state of the law itself was clear.¹² And there is little reason to believe that this legal attitude toward death was not generally approved.

During the 1930s, societies to promote the concept of euthanasia were established in both Britain and the United States.¹³ These organizations sought to legalize "mercy killings" in particular circumstances. Although bills to that effect were introduced in Britain and some American states,¹⁴ none were enacted.

⁹ See *Tate v. Canonica*, 5 Cal.Rptr. 28 (Dist. Ct. App. 1960), quoting Blackstone: Self-Murder, the pretended heroism, but real cowardice, of the Stoic philosophers, who destroyed themselves to avoid those ills which they had not the fortitude to endure . . . was punished by the Athenian law with cutting off the hand And also the law of England wisely and religiously considers that no man hath a power to destroy life . . . and, as the suicide is guilty of a double offense; one spiritual . . . the other temporal, against the king who hath an interest in the preservation of all his subjects; the law has therefore ranked this among the highest crimes

. . . .

Id. at 31-32 (quoting 4 BLACKSTONE'S COMMENTARIES ch. 14, p. 189 (1778)).

¹⁰ This was true at common law. See *McMahon v. State*, 53 So. 89, 90-91 (Ala. 1910). It continues to be so under statutes. See *Chanslor v. State*, 697 S.W.2d 393 (Tex. Crim. App. 1985).

¹¹ See *State v. Ehlers*, 119 A. 15, 17 (N.J. 1922). *Rex v. Simpson*, L.J.K.B. (1915). The line between active murder and "merely" assisting suicide can be a narrow one. See *People v. Roberts*, 178 N.W. 690 (Mich. 1920) (defendant convicted of murder for mixing poison and placing it within the reach of his suicidal wife).

¹² See Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969, 970-71, 1019-24 (1958).

¹³ See O. RUSSELL, *FREEDOM TO DIE: MORAL AND LEGAL ASPECTS OF EUTHANASIA* 64-86 (1977). Britain's Voluntary Euthanasia Legalization Society was supported by such notables as Julian Huxley, H.G. Wells, George Bernard Shaw, and A.A. Milne. The Euthanasia Society of America, founded by Rev. Charles Francis Potter, included on its advisory council Dr. Harry Emerson Fosdick, Margaret Sanger, and Sherwood Anderson. *Id.*

¹⁴ Lord Ponsonby introduced the Voluntary Euthanasia (Legalization) Bill in the House of Lords on November 4, 1936. *Id.* at 68. As its name implies, it was limited to voluntary choices made by the dying person. A similar bill was introduced in the Nebraska state legislature in February 1937. *Id.* at 68-72.

World War II put a temporary end to such discussions, not only by turning legislators' minds to more pressing matters, but also, and more significantly, by focusing attention on the systematic extermination of millions seen by the Nazis as unfit to live.¹⁵

The debate over euthanasia was revived in the 1950s, largely by the publication of Glanville Williams' book, *The Sanctity of Life and the Criminal Law*.¹⁶ Williams strongly advocated legalization of mercy killing when it was requested by an adult suffering from an incurable illness that would cause severe pain or make the patient incapable of leading a rational existence.¹⁷ The book did not receive universal praise. Professor Yale Kamisar was its most prominent academic critic.¹⁸ States did not alter their laws in response to Williams' arguments.

Before the mid-1970s, reported cases of patients' refusal of lifesaving medical treatment usually focused on the patient's religious beliefs. Where such beliefs precluded acceptance of treatment, the free exercise clause of the first amendment was often found to override any state interest in preserving life.¹⁹ Occasionally, however, a court would weigh the facts differ-

¹⁵ *Id.* at 87-94. In a widely quoted article, Dr. Leo Alexander, American medical consultant at the Nuremberg trials, wrote that Nazi crimes "started with the acceptance of an attitude, basic to the euthanasia movement, that there is such a thing as life not worthy to be lived, and then spread to all 'useless eaters' and politically and socially unwanted persons." *Id.* at 93. In 1950, the World Medical Association, at the same meeting in which the German Medical profession was readmitted to that body, approved a resolution that "condemn[ed] the practice of euthanasia under any circumstances." *Id.* at 94.

¹⁶ G. WILLIAMS, *THE SANCTITY OF LIFE AND THE CRIMINAL LAW* (1972). The book expanded on Williams' 1956 James Carpentier lectures at Columbia University and the Association of the Bar of the City of New York.

¹⁷ Indeed, that may be putting it too mildly. Williams stated that "euthanasia . . . is morally permissible and indeed mandatory where it is performed upon a dying patient with his consent and is the only way of relieving his suffering. . . . [A] man is entitled to demand the release of death from hopeless and helpless pain." *Id.* at 311 (emphasis added). The book also argued for decriminalization of contraception, voluntary sterilization, abortion, suicide and, most strikingly, infanticide, which Williams saw as essentially a psychiatric problem.

¹⁸ Kamisar, *supra* note 12. Of course, the book was also received enthusiastically by some. See Russell, Book Review, 10 STAN. L. REV. 382 (1958).

¹⁹ See, e.g., *Holmes v. Silver Cross Hosp.*, 340 F. Supp. 125 (N.D. Ill. 1972); *Montgomery v. Board of Retirement of Kern County*, 109 Cal.Rptr. 181 (Ct. App. 1973); *In Re Estate of Brooks*, 205 N.E.2d 435 (Ill. 1965).

ently, and the free exercise claim would fail.²⁰ Although the factors discussed were quite similar to those that would be used later, when the constitutional claim had shifted from freedom of religion to a "right to die" as part of the right of privacy, the cases generally employed the type of analysis used in any other free exercise inquiry.²¹

The emergence of the constitutional right to privacy during the 1960s and the recognition in *Roe v. Wade*²² that such a right could extend to fundamental questions of life or death established the foundation of the current debate over the "right to die." No longer is it necessary, or even particularly helpful, to focus on questions of religious belief. Constitutional law is now accustomed to the claim of control of an individual's body without government interference as a freestanding claim of right.

The widely noted case of *In re Quinlan*²³ brought the issue of euthanasia to public prominence and set the tone for the steady acceptance of the concept of the "right to die" since its decision in 1975. The father of Karen Quinlan petitioned a New Jersey court for permission to authorize, as her guardian, discontinuance of "all extraordinary medical procedures" sustaining her life. Ms. Quinlan was a 22-year-old woman who had fallen into an irreversible coma.²⁴ All involved in the litigation

²⁰ See, e.g., *Application of President of Georgetown College*, 331 F.2d 1010 (D.C. Cir. 1964) (ordering emergency transfusion where uncertainty existed over patient's true desires); *United States v. George*, 239 F. Supp. 752 (D. Conn. 1965) (same).

²¹ The modern test for determining whether a government practice violates the first amendment guarantee of free exercise of religion was set forth in *Sherbert v. Verner*, 374 U.S. 398 (1963) and *Wisconsin v. Yoder*, 406 U.S. 205 (1972). Initially, the court must determine whether a government practice substantially burdens the practice of the challenger's religion. If the answer is yes, the court "must next consider whether some compelling state interest" justifies that burden. *Sherbert*, 374 U.S. at 406. On its surface, this is, of course, the difficult-to-satisfy "strict scrutiny" test applied in several constitutional contexts. Several cases, however, indicate that it is often, in practice, a more flexible balancing approach than the normal strict scrutiny inquiry. See *O'Lone v. Estate of Shabazz*, 107 S. Ct. 2400 (1987) (upholding prison regulations that had the effect of preventing Islamic prisoners from attending Friday midday services); *Goldman v. Weinberger*, 475 U.S. 503 (1986) (holding that the Air Force need not permit an Orthodox Jew to wear a yarmulke in violation of uniform dress requirements).

²² 410 U.S. 113 (1973) (invalidating statutes prohibiting abortion).

²³ 355 A.2d 647 (N.J. 1976), cert. denied, 429 U.S. 922 (1976).

²⁴ "[S]he had a temperature of 100 degrees, her pupils were unreactive and she

believed that Ms. Quinlan was being kept alive only by the artificial respirator to which she had been attached since she unexpectedly, for reasons never discovered, lost consciousness.²⁵ Ms. Quinlan was not dead, either by common law standards defining death as the total cessation of "all vital functions,"²⁶ or by more modern statutory standards defining death as the total cessation of brain activity.²⁷ She was, however, in a "chronic and persistent 'vegetative' state," unresponsive, apparently unaware of outside activity, making only "stereotyped cries and sounds and . . . chewing motions."²⁸ Her family, after months of reflection, decided to seek to withdraw the respirator that appeared to be sustaining her life. They did not, however, seek to withdraw artificial feeding tubes also in use.

was unresponsive even to deep pain. . . . [she was] comatose with evidence of decortication, a condition relating to the derangement of the cortex of the brain She required a respirator to assist her breathing." *Id.* at 654.

²⁵ "The experts believe that Karen cannot now survive without the assistance of the respirator; . . . that the strong likelihood is that death would follow soon after its removal" *Id.* at 655. *But see* the comments of Daniel Coburn, her court-appointed guardian, shortly after the decision:

[F]rom my discussions with the doctors it was indicated that when the respirator is disconnected, Karen Quinlan is not going to die. No one knows how long she will survive. She may survive for weeks. When I say she is not going to die I mean that she is not going to die specifically because of the removal of the respirator. She will undoubtedly die because of infection or some other complication.

Symposium Panel, *supra* note 1, at 519. In fact, she survived not merely for weeks, but for several years. *See* Schmeck, *A Medical Turning Point: Quinlan Case Symbolized Ethical Problems Caused by Use of Life-Support Equipment*, N.Y. Times, June 13, 1985, at B2, col. 1.

²⁶ Death is traditionally defined for legal purposes as "[t]he cessation of life." BLACK'S LAW DICTIONARY 360 (5th ed. 1979).

²⁷ *See, e.g.,* KAN. STAT. ANN. § 77-205 (1984 & Supp. 1987); MD. HEALTH-GEN. CODE ANN. §§ 5-201-203 (1982 & Supp. 1987). *See also* Capron & Kass, *A Statutory Definition of the Standards for Determining Human Death*, 121 U. PA. L. REV. 87 (1972-73).

²⁸ *Quinlan*, 355 A.2d at 655. Daniel Coburn described the situation even more strikingly:

We went to St. Clare's Hospital and really expected that we would walk in and just see a girl in a regular hospital bed . . . maybe a tube in her nose or intravenous tubes—nothing more than that. But we saw a ghastly sight. It was absolutely incredible. . . . We just couldn't believe that there was this thing lying in bed. I looked at her, and it seemed like forever. . . .

I looked at her and turned around and said, "Don, can you believe this?"

Symposium Panel, *supra* note 1, at 509.

The Supreme Court of New Jersey held in favor of Joseph Quinlan. Although it might have based its decision on free exercise grounds, in light of Mr. Quinlan's reliance on Catholic teachings to support his decision to remove the respirator, the court specifically declined to do so. It relied instead on the right to privacy. Of crucial significance to the development of the law on this issue was the court's holding that what was at stake was not Joseph Quinlan's right of privacy, but Karen's. Of course, Ms. Quinlan could not make her own decision. Therefore, the court held that "[t]he only practical way to prevent destruction of the right is to permit the guardian and family . . . to render their best judgment . . . as to whether she would exercise it" ²⁹ The court would provide some checks on the decision making power of the family or guardian, but without mandatory recourse to the court system in all cases. The concurrence of the attending physician and the hospital "ethics committee" that "there is no reasonable possibility of [the patient] ever emerging from her present comatose condition to a cognitive, sapient state" ³⁰ was essential. And the court went on to state, in a counterfactual statement that has received some criticism, ³¹ that it had "no doubt . . . that if Karen were herself miraculously lucid for an interval . . . and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus" ³² In short, the guardian's decision to terminate treatment must be reasonable to informed medical observers. At least, the decision must not be clearly inconsistent with what we "know" the patient would choose.

The court's approach in *Quinlan* has, in its broad outlines, set the tone for the analysis of similar cases by most courts in recent years. The starting point has been that withdrawal of

²⁹ *Quinlan*, 355 A.2d at 664.

³⁰ *Id.* at 671.

³¹ See, e.g., Note, *The Tragic Choice: Termination of Care for Patients in a Permanent Vegetative State*, 51 N.Y.U. L. REV. 285, 294-95.

³² *Quinlan*, 355 A.2d at 663. The court seems to base this on its perceptions of what most people would do, rather than on particular characteristics of Karen Quinlan. *Id.* at 664. But is this really, then, her decision, or is it society's? A lucid Karen is, quite simply, someone who is not Karen at all. See Gelfand, *Euthanasia and the Terminally Ill Patient*, 63 NEB. L. REV. 741, 774-75 (1984).

medical treatment is a question that will be left to the decision of the patient. While the patient's discretion will not be unlimited, the scope of any restrictions that exist remains unclear. And, in an analytical leap of great significance, where the patient is in no condition to make a decision, some system will be created, not to make a decision for or about the patient, but to attempt to approximate the patient's own decision. Thus, the decision is seen as one involving the exercise of the patient's individual right. It is most emphatically not characterized as a decision by others (and most certainly not by the state or the community at large) that the patient's life should be terminated. Courts and legislatures strive to maintain this basic orientation in addressing cases involving several different types of problems concerning those near death.

Lawyers and philosophers have used several distinctions to categorize different types of euthanasia. The two most widely used are the distinction between "voluntary" and "involuntary" euthanasia and the distinction between "active" and "passive" methods of euthanizing patients.³³ While each of these distinctions can be criticized as being imprecise,³⁴ they continue to be influential and helpful to courts and commentators. Voluntary euthanasia is, of course, chosen by the patient, while involuntary euthanasia is performed pursuant to the wishes of another.³⁵ Active methods of euthanasia include those things done to hasten the natural process of death. Passive methods go no further than refusal to engage in life-prolonging medical activity.³⁶ As might be expected, voluntary euthanasia is generally

³³ See, e.g., G. GRISEZ & J. BOYLE, *supra* note 1, at 86-97 and 139-42; Vodiga, *Euthanasia and the Right to Die - Moral, Ethical and Legal Perspectives*, 51 CHI. [-]KENT L. REV. 1, 2-5 (1974).

³⁴ See Kamisar, *supra* note 12, at 1014-30 (on the voluntary-involuntary distinction) and Gelfand, *supra* note 32, at 753-56 (on the active-passive distinction).

³⁵ "[A]ctive euthanasia is *voluntary* only if Patient is legally competent and gives informed consent to being killed by Agent." G. GRISEZ & J. BOYLE, *supra* note 1, at 139.

³⁶ [E]uthanasia is mercy killing; it involves an activity: someone's doing something in order to bring about death. In recent discussion "euthanasia" in this sense is often called "active euthanasia." . . .

Distinguished from active euthanasia in much recent discussion is the withholding or termination of medical treatment . . . required to preserve or prolong life in someone suffering from a painful or prolonged mortal

seen as far more acceptable than involuntary euthanasia, and passive methods are more readily accepted than active measures.

In recent cases involving choices by competent adults choosing passive means of euthanasia, courts have generally had little difficulty deferring to the patient's wishes. In *Lane v. Candura*,³⁷ for example, a Massachusetts court found the patient to be competent and held that her decision not to submit to amputation of a limb would be respected, even if that decision was not the medically "rational" thing to do.³⁸ A New York court, upholding a competent patient's wish to be removed from dialysis, stated: "It is well settled in this state that 'every human being of adult years and sound mind has a right, at common law, to determine what shall be done with his own body and cannot be subjected to medical treatment without his consent.'" ³⁹ Like all rights, this is not said to be absolute but is subject to being overridden by a compelling state interest.⁴⁰ It has been rare, however, for courts to find the generalized state interest in preserving life sufficient to override the patient's choice. Occasionally a court has invoked the patient's duties toward dependent children to override a choice to refuse treatment,⁴¹ but aside from these exceptions, courts have responded

illness or injury . . . Such withholding or termination of lifesaving medical treatment has been called "passive euthanasia."

Id. at 86.

³⁷ 376 N.E.2d 1232 (Mass. App. Ct. 1978).

³⁸ "[T]he irrationality of her decision does not justify a conclusion that Mrs. Candura is incompetent in the legal sense." *Id.* at 1235-36. The court rejected the argument that the irrationality of the decision along with "some indications of a degree of senility and confusion" were sufficient to prove incompetence. *Id.* at 1234.

³⁹ *In re Application of Lydia E. Hall Hosp.*, 455 N.Y.S.2d 706, 711 (Sup. Ct. 1982) (quoting *Schloendorff v. New York Hosp.*, 105 N.E. 92 (1914)). By the time of the decision, October 22, 1982, the patient had fallen into a coma. However, since he had stated his desire to end treatment only a few days before he lost consciousness on October 17, the court treated this as a case involving the choice of a competent patient. *Id.*

⁴⁰ "Such interests include the prevention of suicide and/or protection of minor children or other dependents." *Id.*

⁴¹ See, e.g., *George*, 239 F. Supp. 752 (patient was the father of a minor child and the court had doubts about the firmness of his resolve). The importance of the presence of children most often is noted not as *ratio decidendi*, but as dicta. See, e.g., *Holmes*, 340 F. Supp. at 130. The most compelling type of case involving the welfare of a child is that involving a pregnant patient, whose refusal of treatment would imperil the unborn child. See *Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson*, 201 A.2d 537 (N.J. 1964), *cert. denied*, 377 U.S. 985 (1964).

favorably to the voluntary choices of competent patients to accept death as the consequence of rejecting medical treatment.

The legal and ethical distinction between voluntary and involuntary euthanasia has remained firm. Courts and legislatures still refuse to authorize withdrawal of treatment against the express wishes of the patient, and there is little reason to anticipate that this will change in the foreseeable future.⁴² The prohibition on involuntary euthanasia makes no distinction between active and passive methods. The distinction between active and passive methods continues to be relevant to the analysis of voluntary euthanasia. While some have criticized the distinction as artificial,⁴³ and some have advised against a blanket prohibition against active euthanasia,⁴⁴ the law remains wary of active

⁴² The recent furor over the publication by the *Journal of the American Medical Association* of an essay describing a mercy killing by a physician under circumstances at least calling into question whether it was voluntary is clear evidence that the public strongly opposes involuntary euthanasia. Johnson, *A Piece of the AMA's Mind*, Chicago Tribune Mar. 9, 1988, at 19 col. 1.

⁴³ The active-passive distinction seems clear only against a background that has already decided, to a large extent, what duties run from one person to another. Is there a duty to provide medical care? If so, the failure to do so is an act for purposes of the criminal law. A parent who fails to call a doctor for a sick child may be guilty of homicide, where a stranger engaging in the same conduct has done no criminal act. See W. LAFAYE & A. SCOTT, CRIMINAL LAW 184 (1972). Other legal systems, by defining the scope of duty more broadly, have altered the concept of what it means to act so that it becomes less a matter of observable movement and more of choosing one course of conduct over another. See Larguier, *French Penal Law and the Duty to Aid Persons in Danger*, 38 TUL. L. REV. 81 (1963-64). But the active-passive distinction has its defenders, see, e.g., Louisell, *Euthanasia and Biathanasia: On Dying and Killing*, 22 CATH. U.L. REV. 723, 739 (1973).

⁴⁴ "[T]he rightness or wrongness of euthanasia . . . whether direct or indirect, depends on the situation. Neither form is intrinsically or invariably good or evil. Sometimes mercy killing is right; sometimes 'letting the patient go' is wrong. It depends." Fletcher, *The "Right" to Live and the "Right" to Die* in BENEFICENT EUTHANASIA 44, 50 (M. Kohl ed. 1975). Marvin Kohl goes even further than to grant mere permission to active euthanasia in cases involving

the inducement of a relatively painless and quick death, the intention and actual consequences of which are the *kindest possible treatment* of an unfortunate individual in the actual circumstances My claim is that in situations where there are no overriding rights or similar considerations voluntary active beneficent euthanasia . . . is a moral obligation.

Kohl, *Voluntary Beneficent Euthanasia* in BENEFICENT EUTHANASIA, *supra* at 130, 134-35. By no means do all commentators agree. See Sullivan, *The Immorality of Euthanasia* in BENEFICENT EUTHANASIA, *supra*, at 12 nn.9-18 and accompanying text. ◊

methods, even in voluntary cases. The state, it is recognized, still may prohibit facilitation of suicide.⁴⁵

Thus, voluntary passive euthanasia is the type that has most readily gained legal acceptance, and it is clear that the voluntary nature of the decision is of greater importance than the passive nature of the methods. The law still sharply rejects involuntary euthanasia, yet the seminal case in the acceptance of voluntary withdrawal of treatment, *Quinlan*, did not involve a decision by the patient herself. It is this leap from the decision of a competent patient near death to the decision of some surrogate that has led to the most extensive discussion of the "right to die." Under what circumstances may withdrawal of life-sustaining treatment pursuant to the decision of someone other than the patient validly be classified as voluntary euthanasia?

When permitting the withdrawal of care, courts have generally characterized the decision by the surrogate as the best possible approximation of the patient's wishes. The leading example, already discussed, is *Quinlan*. The hopelessness of the situation, the relationship of the patient to the surrogate decision maker, and the absence of any indication that the patient would clearly prefer continued artificial respiration combined to create circumstances in which the court felt justified in finding her father's decision to be the patient's own.⁴⁶

Some courts have made genuine assessments of the patient's own feelings on extraordinary medical treatment and have reached different results depending on the outcome of this inquiry. In *In re Storar*,⁴⁷ for example, the New York Court of Appeals decided consolidated cases involving applications by guardians for permission to terminate medical treatment. In the first case, the patient was an 83-year-old member of a religious order who had fallen into a coma following a hernia operation. He was being kept alive by means of an artificial respirator.⁴⁸ Evidence was produced demonstrating that over a period of

⁴⁵ See *supra* notes 9-11 and accompanying text.

⁴⁶ The interplay of the "several variables" present in a case such as *Quinlan* is discussed by Cantor in *Quinlan, Privacy, and the Handling of Incompetent Dying Patients*, 30 *RUTGERS L. REV.* 243, 256-61 (1977).

⁴⁷ 420 N.E.2d 64 (N.Y. 1981), *cert. denied*, 454 U.S. 858 (1981).

⁴⁸ *Id.* at 67.

years and as recently as "a couple of months before his final hospitalization," he had stated during formal discussion of biomedical ethical issues that he would not wish his life prolonged by such means.⁴⁹ Largely on the basis of this evidence, the court authorized discontinuance of treatment.⁵⁰

In the companion case, however, the court refused to authorize termination of treatment. The mother of a 52-year-old profoundly retarded patient sought to discontinue a series of blood transfusions necessary to prolong her son's life. The patient had been diagnosed as having terminal cancer. In this case, the Court of Appeals acknowledged that to speculate about the patient's own choice "if he were competent" would be a completely artificial exercise.⁵¹ In denying the request to terminate treatment, the court noted that the treatment "did not involve excessive pain,"⁵² but it is unclear whether the decision is the result of some sort of balancing test, or of a rule requiring treatment in the absence of convincing evidence of an incompetent adult's prior wishes, expressed while competent.⁵³

Not all courts have frankly acknowledged their own role in choosing for those who cannot make their own choice. In the

⁴⁹ *Id.* at 68. "[T]he Pope had stated that Catholic principles permitted the termination of extraordinary life support systems when there is no reasonable hope for the patient's recovery and . . . that use of [a] respirator . . . constituted an extraordinary measure under the circumstances." *Id.*

⁵⁰ *Id.* at 72-74.

⁵¹ "As one of the experts testified at the hearing, that would be similar to asking whether 'if it snowed all summer would it then be winter?' Mentally John Storar was an infant and that is the only realistic way to assess his rights . . ." *Id.* at 72-73.

⁵² The court expressly reserved the question of whether the presence or absence of excessive pain would be determinative. *Id.* at 73. See Kohl's formulation of the "kindest possible treatment," *supra* note 44. The question of pain, either from the treatment or from the patient's condition, also profoundly affects assessment of a decision by a competent patient. See Twycross, *Voluntary Euthanasia*, in *SUICIDE AND EUTHANASIA*, *supra* note 6, at 88-98.

⁵³ After discussing Storar's condition and the positive and negative effects of treatment the court concluded

that the application for permission to continue the transfusions should have been granted. Although we understand and respect his mother's despair, . . . a court should not in the circumstances of this case allow an incompetent patient to bleed to death because someone, even someone as close as a parent or sibling, feels that this is best for one with an incurable disease.

Storar, 420 N.E.2d at 73.

widely discussed case of *Superintendent v. Saikewicz*,⁵⁴ the guardian ad litem of a mentally retarded 67-year-old petitioned for permission to discontinue chemotherapy for the patient's leukemia. The Supreme Judicial Court of Massachusetts held that "a general right in all persons to refuse medical treatment in appropriate circumstances"⁵⁵ exists, and "that right must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both."⁵⁶

Although the court recognized the difficulty of ascertaining the wishes of an incompetent,⁵⁷ it nevertheless held that

the decision in cases such as this should be that which would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person.⁵⁸

The language of the Massachusetts court, and its view of what it was doing, differ sharply from that of the New York court.⁵⁹ Yet the two approaches may, in substance, be largely the same. Both call for the court, a competent decision maker, to act upon an assessment of the choice an incompetent would make, were he competent. The Massachusetts court sees this as carrying out the wishes of the incompetent. The New York court recognizes that a hypothetically competent incompetent is a different person than the actual incompetent.⁶⁰ Thus, a decision concerning treatment will inevitably be that, not of the incompetent, but of another, albeit another acting in light of the incompetent's best interests.

Courts that have faced these questions have often avoided the *Storar* court's conclusion that, at least in some cases, it is

⁵⁴ 370 N.E.2d 417 (Mass. 1977).

⁵⁵ *Id.* at 427.

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ *Id.* at 431. The court strains, with limited success, to explain the difference between this "subjective" standard and an "objective" standard governed by the views of the majority of the community or the choices of the "reasonable person." *Id.* at 430-31.

⁵⁹ See *supra* notes 47-53 and accompanying text.

⁶⁰ See *supra* note 51 and accompanying text.

simply impossible to speak of the patient's own choice. Rather, they have followed the basic orientation of *Quinlan* and *Sai-kewicz*, that is, that the key to resolving questions involving the termination of life-sustaining medical treatment is to ascertain the wishes of the patient, even if the patient is unable to express them.⁶¹ While courts note that the patient's choice may sometimes be outweighed by the interests of specific third parties,⁶² or the generalized interest of the state in preserving life,⁶³ these instances seem to be rare exceptions, at least in recent reported cases.⁶⁴ The decision of the autonomous individual has become, if not decisive, by far the most important factor to be considered.⁶⁵ Attention has largely turned to other issues, such as whether the same analysis should be extended to discontinuance of artificial feeding techniques,⁶⁶ or whether the patient should be allowed to enlist medical personnel in clearly active methods of euthanasia, such as the injection of lethal drugs.⁶⁷ In short,

⁶¹ *E.g.*, *In re L.H.R.*, 321 S.E.2d 716 (Ga. 1984) (recognizing parent's duty to substitute judgment of infant); *In re Torres*, 357 N.W.2d 332 (Minn. 1984) (court's determination of conservatee's best interest includes consideration of conservator's actual wishes); *In re Colyer*, 660 P.2d 738 (Wash. 1983) (en banc) (recognizing guardian's duty to determine the wishes of formerly competent patient). Several other courts have continued to speak of substituted judgment but have explicitly realized that in the case of someone who was never competent, that must become somewhat of an objective, "reasonable person" test. *E.g.*, *Barber v. Superior Court*, 195 Cal. Rptr. 484 (Ct. App. 1983) (where patient's choice is unascertainable, decision should be based upon objective assessment of best interests); *Foody v. Manchester Memorial Hosp.*, 482 A.2d 713, 721 (Conn. Super. Ct. 1984) (necessity of "reference to objective societally shared criteria").

⁶² See *supra* note 41 and accompanying text.

⁶³ This interest alone, while recognized as legitimate, rarely outweighs the patient's privacy interests. See *In re Severns*, 425 A.2d 156 (Del. Ch. 1980); *In re Conroy*, 486 A.2d 1209 (N.J. 1985).

⁶⁴ See, *e.g.*, *Foody v. Manchester Memorial Hospital*, 482 A.2d 713 (Conn. Super. Ct. 1984) (right to die held to override state interest in preserving life); *In re Guardianship of Barry*, 445 So. 2d 365 (Fla. App. 1984) (same).

⁶⁵ See generally Note, *The Conflict Continues: Who Decides Treatment Questions For the Terminally-Ill Incompetent Patient*, 18 SUFFOLK U.L. REV. 641 (1984).

⁶⁶ See, *e.g.*, Connery, *The Ethical Standards for Withholding/Withdrawing Nutrition and Hydration*, 2 ISSUES L. & MED. 87 (1986); *Ethical Symposium*, 2 ISSUES L. & MED. 99 (1986); see also *Gray v. Romeo*, 87-05873B (D.R.I. Oct. 17, 1988) (patients have the right to refuse medical treatment, including feeding tubes, when they fall into persistent, vegetative states).

⁶⁷ See *supra* notes 43-44; see also O'Brien, *Facilitating Euthanatic, Rational Suicide: Help Me Go Gentle into That Good Night*, 31 ST. LOUIS U.L.J. 655 (1986-87); Note, *Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, 69 CORNELL L. REV. 363 (1983-84).

it seems to have become generally accepted that the discontinuance of "extraordinary" medical treatment is, and should be, a personal decision, the exercise of a "right to die."

If the patient's choice is considered crucial, the fact that the patient will often be incompetent at the point at which the decision to continue or to terminate treatment must be made is, of course, troublesome. In an attempt to deal with this problem, and also, presumably, to reduce the need for extensive judicial intervention, a number of states have, by legislation, authorized "living wills." A "living will" is a written declaration indicating the declarant's wishes concerning future medical treatment, specifically stating when such treatment should be withheld. Since the initial effort of California in 1976,⁶⁸ more than thirty states have chosen this route in an attempt to bring more certainty to this area of the law.⁶⁹

The statutes are largely alike in their fundamental outline. They establish some procedure by which a person may execute a directive that treatment be withheld when that person is terminally ill.⁷⁰ Health professionals who act in accord with a properly executed directive of this sort are held immune from any civil or criminal liability for doing so.⁷¹ Still, there are important differences among the statutes. To some extent, they differ in their definition of a "terminal illness" that gives effect to a directive.⁷² Some, but not all, suspend the effect of the

⁶⁸ Natural Death Act, ch. 1439, 1976 Cal. Legis. Serv. 6478 (West) (codified at CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1988)).

⁶⁹ Note, *To Die or Not To Die: The New York Legislature Ponders a Natural Death Act*, 13 FORDHAM URB. L.J. 639, 654 n.114 (1985).

⁷⁰ *Id.* at 654-55.

⁷¹ *Id.* at 655.

⁷² The most commonly used definition of terminal illness, with minor modifications, is found in the California statute: "an incurable condition caused by injury, disease or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life-sustaining procedures serve only to postpone the moment of death . . ." CAL. HEALTH & SAFETY CODE § 7187(f) (West Supp. 1988); see, e.g., OR. REV. STAT. § 97.050(6) (1988); TEX. REV. CIV. STAT. ANN. art. 4590h § 2(7) (Vernon Supp. 1988). Other states use different formulations. See, e.g., N.M. STAT. ANN. § 24-7-2(F) (1978). Still others do not define the term at all. See, e.g., N.C. GEN. STAT. § 90-321(b)(1) (1985).

directive during a patient's pregnancy.⁷³ The formalities required for the execution of the document vary widely.⁷⁴

The most significant differences among the statutes are found, however, with respect to three questions: (1) who may make a decision to terminate treatment; (2) when that decision may be made; and (3) which medical procedures, if any, cannot be terminated despite the existence of a directive to stop treatment. Some statutes permit a decision to be made only by the patient,⁷⁵ others permit some type of proxy decisions. The latter can be further divided into two types of substitute decision-making: a decision to terminate treatment made by a person appointed in advance by the patient to make such decisions,⁷⁶ or a decision made by a proxy appointed by statute, usually a close relative, whether or not an advance declaration to that effect has been made by the patient.⁷⁷ With regard to the "when" question, some states permit an effective declaration to be made only after a diagnosis of terminal illness,⁷⁸ others have no such requirement.⁷⁹ Some,⁸⁰ but not all,⁸¹ statutes provide a limited

⁷³ Compare TEX. REV. CIV. STAT. ANN. art. 4590h § 3(d) (Vernon Supp. 1988) (directive shall have no force or effect during pregnancy) with VA. CODE ANN. § 54-325.8:4 (Supp. 1987) (no such provision).

⁷⁴ See generally Note, *supra* note 69, at 654-63. See also SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS 1981-84 (1984) [hereinafter HANDBOOK], especially the "Checklist Chart" at 31-34.

⁷⁵ See, e.g., CAL. HEALTH & SAFETY CODE §§ 7185-7195; GA. CODE ANN. §§ 31-32-1 - 12 (1985 & Supp. 1988); KAN. STAT. ANN. §§ 65-28, 101 - 109 (1985).

⁷⁶ E.g., VA. CODE ANN. § 54-325.8:4 (declaration may include "designation of another person to make the treatment decision for the declarant should he be" unable to do so); FLA. STAT. ANN. § 765.05 (West 1986) (same).

⁷⁷ See, e.g., N.C. GEN. STAT. § 90-322 ("Procedures for natural death in the absence of a declaration"); VA. CODE ANN. § 54-325.8:6 ("Procedures in absence of declaration").

⁷⁸ See CAL. HEALTH & SAFETY CODE §§ 7185-7195 (although directive may be executed by any adult, it is binding only if the adult was a "qualified patient," i.e. under a diagnosis of terminal illness. Otherwise, the directive "may" be given weight in the physician's decision); TEX. REV. CIV. STAT. ANN. art. 4590h, § 4 (same); see also IDAHO CODE §§ 39-4504 (Supp. 1988) (directive must include statement that patient has been diagnosed with terminal illness; apparently ineffective otherwise).

⁷⁹ Apparently, only the three statutes cited in *supra* note 78 limit the declaration to already diagnosed terminal patients. See Note, *supra* note 69, at 659-60.

⁸⁰ CAL. HEALTH & SAFETY CODE § 7189.5 (five years).

⁸¹ The large majority of states with living will statutes do not provide for automatic expiration but rather provide that declarations remain effective until revoked. See HANDBOOK, *supra* note 74, at 32-33.

period of time in which the declaration will be effective. Finally, some states exclude procedures that provide nourishment or relieve pain from the scope of treatment that may be terminated pursuant to such a declaration.⁸²

Generally, then, statutory approaches have not diverged sharply from the approaches of courts that have addressed these questions without clear legislative guidance. The basic goal of courts and legislatures in this field is to recognize and protect the "right to die," that is, the power of the autonomous individual to resolve the question of whether to attempt to preserve that individual's life. While courts and legislators differ on the ways in which that end is best achieved, they seem to concur in their endorsement of the end itself. Commentators have also generally endorsed this basic orientation, and most seem to endorse the less restrictive approaches to defining the scope of that autonomous choice. Criticism has been aimed, for example, at the distinction between "extraordinary" medical procedures, which may be terminated, and such "ordinary" procedures as nutrition, which may not.⁸³ Some have criticized the requirement that an effective declaration of desire to terminate treatment be executed very near the time of its use.⁸⁴ Still others criticize the denial of the extension of proxy decisionmaking authority in the case of incompetent patients.⁸⁵ Despite what appears to be an emerging favorable consensus, some serious questions must be raised not only about the details of "living will" legislation,

⁸² FLA. STAT. ANN. § 765.03(3); GA. CODE ANN. § 31-32-2(5) (Supp. 1988); ILL. ANN. STAT. ch. 110 1/2 § 702(d) (Smith-Hurd Supp. 1984-85); WIS. STAT. ANN. § 154.01(5) (West Supp. 1988); WYO. STAT. § 35-22-101(a)(iii) (1988). See *supra* note 66 and accompanying text.

⁸³ See *Conroy*, 486 A.2d at 1233: "[T]he primary focus should be the patient's desires and experience of pain and enjoyment—not the type of treatment involved." See also *supra* note 66 and accompanying text.

⁸⁴ See, e.g., Martyn & Jacobs, *Legislating Advance Directives for the Terminally Ill: The Living Will and Durable Power of Attorney*, 63 NEB. L. REV. 779, 790 (1984) ("such provisions are unrealistic and unworkable"); Note, *supra* note 69, at 675 (recommending against such restrictions).

⁸⁵ See, e.g., Comment, *Withholding Life-Sustaining Treatment from the Incompetent Patient: The Need for Statutory Guidelines*, 17 LOY. U. CHI. L.J. 427, 444 (1985-86) ("To preserve the traditional doctor-patient-family relationship, legislatures should establish the right of families or guardians of incompetent patients, in conjunction with the attending physician, to make decisions concerning the withdrawal or initiation of the patient's medical treatment.").

but also about some of the fundamental assumptions that underlie the concept of the "right to die."

II. THE "RIGHT TO DIE": CRITICISM OF A FLAWED CONCEPT

Published responses to the recognition and development of the "right to die" have been generally favorable. Negative reaction to statutes and court opinions on the subject often take the position that particular definitions of the scope of the right are too timid and do not go far enough in eliminating legal obstacles to the withdrawal of medical treatment in hopeless cases.⁸⁶ But there seems to be little dissent from several fundamental propositions that underlie the "right to die." First, there is a right to have medical treatment withheld in cases of terminal illness. Second, this right can be best secured through legal recognition of the power of proxy decisions to this effect, both through the use of legally binding "living wills" and through grants of power to relatives to act on behalf of incompetent patients. Finally, the guiding principle in the development of law on this subject is that these decisions properly should be removed from society as a whole, and vested in the autonomous individual.⁸⁷

That the withdrawal of treatment, once labelled as a right, should be analyzed as a situation in which the interests of the autonomous individual are set against those of the state (or, to use a less harsh word, those of society) is hardly surprising. It

⁸⁶ See *supra* notes 83-85 and accompanying text.

⁸⁷ Surely the most florid expression of this sentiment is that of Luis Kutner: The *Living Will* is one of the most pervasive and dominant ideologies of the brands of liberalism in the last half of the 20th Century It is the principle of the sole end for which mankind is privileged the role of self-determination: non-interference with the liberty of action. Liberty and individuality have become the dominant and unassailable values of contemporary liberalism. The insatiable demand for individual liberty of decision knows scarcely any bounds, certainly not those of tradition, moderation, prudence, common sense, decency, civility, or any higher law. The *Living Will* breaks with the tradition of the western world with its complete denigration of authority, which, perforce, must be viewed illegitimate.

Kutner, *The Living Will: Coping With the Historical Event of Death*, 27 BAYLOR L. REV. 39, 41 (1975). Kutner was an early advocate of the right to die and the legitimacy of the advance directive to withdraw treatment.

is quite consistent with the way law has come to regard disputes over a broad range of life choices, including the "life or death" issues present at the start of the life cycle, i.e., the decision to use birth control or the decision to have an abortion.⁸⁸ If all other questions involving control of one's body are seen as questions setting individual choice against societal control, then the decision to die should be seen the same way. Commentators explaining the basis of the "right to die" generally trace its roots through the expansion of the general right of privacy.⁸⁹

If the decision to die is substantially similar to other decisions seen as properly within the zone of privacy, then similar standards should apply. But the law has not taken a position of entirely uncritical acceptance of an individual's stated preferences, even in matters ultimately viewed as private. In assessing a patient's decision to accept, rather than reject, proffered medical treatment, for example, courts have insisted that an autonomous decision worthy of respect by the courts must be that of an informed individual.⁹⁰ Likewise, it would seem that the decision to refuse treatment should be subject to the same test of informed consent. But application of the traditional tests of informed consent to the circumstances surrounding the exercise of the "right to die" raises serious problems. These problems have not gone unnoticed, in fact several were discussed at least as early as 1958 by Professor Yale Kamisar in his widely noted attack on legalized euthanasia.⁹¹

Informed consent assumes at least two things: that the consent is uncoerced and that it is made with a sufficient amount of accurate information about consequences.⁹² To the extent

⁸⁸ See, e.g., *Griswold v. Connecticut*, 381 U.S. 479 (1965) (use of contraceptives); *Roe v. Wade*, 410 U.S. 113 (1973) (abortion). The connection between these cases and the "right to die" cases has been frequently noted, and the abortion and birth control analyses are often used by commentators in thinking through the extent of the "right to die." See, e.g., Note, *Rejection of Extraordinary Medical Care by a Terminal Patient: A Proposed Living Will Statute*, 64 IOWA L. REV. 573, 596-600 (1978-79).

⁸⁹ See, e.g., Cantor, *supra* note 46, at 244-51; Note, *supra* note 88, at 596-611.

⁹⁰ See, e.g., Leflar, *Liberty and Death: Advance Health Care Directives and the Law of Arkansas*, 39 ARK. L. REV. 375, 391-400 (1976-77); Note, *supra* note 88, at 587-91.

⁹¹ Kamisar, *supra* note 12, at 985-93.

⁹² For a collection of modern cases setting forth the scope of this doctrine in

that a choice to die is made under conditions of severe physical pain, can it properly be said to be voluntary?⁹³ And to the extent that medical prognosis is an inexact science and is further hampered by the inability to foresee future advances in the ability to cure, is the choice to die based upon sufficient information?⁹⁴

These objections have a surface appeal, but strong responses to them may be made. The coercion that invalidates individual consent in most areas of the law is typically brought to bear by the state, or other individuals, to gain some sort of advantage.⁹⁵ Incurable, severe pain is not this type of coercion. Rather, it is simply a part of the overall situation in which an individual exists.⁹⁶ In an abstract sense this makes a choice to die involuntary, but not in the sense that will make a choice legally invalid. Tragic choices are not necessarily unworthy of respect.

Similarly, the imperfection of available information is quite similar to the situation that exists throughout the law. As long as a patient is not deprived of the best available information, he is in no different position than anyone else who must make a significant decision based upon imperfect knowledge of the future. Once again, the law typically will act to invalidate individual choices when they are made under conditions that

traditional tort litigation, see Annotation, *Modern Status of Views as to General Measure of Physician's Duty to Inform Patient of Risks of Proposed Treatment*, 88 A.L.R. 3d 1008 (1978).

⁹³ Kamisar, *supra* note 12, at 985-93. Kamisar quotes Dr. I.P. Frohman, who stated that much proposed "mercy killing" legislation proposes that the patient's request to die be valid "only if the victim is both sane and crazed with pain." *Id.* at 986 (quoting Frohman, *Vexing Problems in Forensic Medicine: A Physician's Viewpoint*, 31 N.Y.U. L. REV. 1215, 1222 (1956)).

⁹⁴ Kamisar, *supra* note 12, at 993-1013.

⁹⁵ For example, a criminal defendant may argue that he acted only pursuant to a threat of serious bodily injury made by another. See *United States v. Johnson*, 381 F. Supp. 210, 211-12 (D. Minn. 1974), *aff'd*, 516 F.2d 209 (8th Cir. 1975), *cert. denied*, 423 U.S. 859 (1975). Personal economic necessity, however, such as hunger, will not excuse theft of food. *State v. Moe*, 24 P.2d 638 (Wash. 1933). See *People v. Whipple*, 279 P. 1008 (Cal. Dist. Ct. App. 1929).

⁹⁶ This is assuming, of course, that the pain actually cannot be eased. Robert Twycross cautions that in discussing euthanasia, "much of the supporting 'evidence' derives from instances in which pain or other symptoms have been inadequately controlled and from the use of inappropriate treatments," Twycross, *Voluntary Euthanasia*, in *SUICIDE AND EUTHANASIA*, *supra* note 6, at 97. He calls for increased attention by the medical profession to the art of pain relief. *Id.* at 98.

someone could, and should, have improved. But the fact that choices are made under imperfect conditions does not make them invalid.⁹⁷

There is, however, a more serious problem with the characterization of many of the decisions given controlling effect under living will statutes or "right to die" caselaw as products of informed consent. Much commentary has praised the advance declarations of the living will as the most effective way to assure informed consent. Under such an arrangement, it is said, the individual will make his or her decision about future medical treatment under conditions that best assure a rational choice.⁹⁸ The absence of pain and the ability to reflect are optimal conditions for planning one's life. But these assumptions are troubling. As Professor Kamisar noted thirty years ago:

Is this much different from holding a man to a prior statement of intent that if such and such an employment opportunity would present itself he would accept it, or if such and such a young woman were to come along he would marry her? Need one marshal authority for the proposition that many an "iffy" inclination is disregarded when the actual facts are at hand?⁹⁹

The more important a decision is to one's life, the less reliable abstract speculation about how that decision would be made in the indefinite future becomes. Despite neoclassical microeconomic theory,¹⁰⁰ important life decisions will not turn entirely on the calculus of rational considerations. These decisions will also include assessment of emotions, desires, fears, and other feelings that cannot possibly be made, except in the actual presence of those sentiments. To be "informed" in such circumstances means not merely to have access to data, or

⁹⁷ Thus, mistake will justify rescission of a contract only in limited circumstances; mere imperfect information about present or future conditions of fact will not be sufficient to do so in itself. See J. CALAMARI & J. PERILLO, *CONTRACTS* 378-85 (3rd ed. 1987).

⁹⁸ See, e.g., Kuttner, *supra* note 87, at 39 ("[A] thinking individual owes [it] to himself to rationally approach death without terror or anxiety anticipating the event when his life processes may be, and are, irreversibly disabled."); Cantor, *supra* note 46, at 261-62.

⁹⁹ Kamisar, *supra* note 12, at 989.

¹⁰⁰ This theory has been most cogently explained and applied to legal topics by Judge Richard Posner. R. POSNER, *THE ECONOMICS OF JUSTICE* (1981).

command of philosophy or other theories of life, but to be aware of one's own reaction to the situation in the concrete—information that cannot be obtained apart from actual confrontation with the situation.

This may be most clearly so with respect to the question of the reaction to one's own mortality. It may be true that the awareness of one's own mortality, more than any other single factor, makes us human. The Book of Genesis sets forth the fundamental story of how men and women fell from the undisturbed joy of Eden to the anxious and often tragic state that is the human condition. The moment of the fall from grace, the moment at which Adam and Eve became recognizable as fully human, is described as the moment at which they acquired knowledge of good and evil.¹⁰¹ Evil connotes imperfection; imperfection connotes limits; the ultimate limit for the individual is death. Adam and Eve became conscious of their nakedness, that is, their vulnerability. And the crucial point in defining their humanity is not when they became vulnerable, but when they became conscious of it. It is this awareness of vulnerability, and ultimately of mortality, not merely the objective existence of the condition, which defines the tragic aspects of humanity.

Much, if not most, of human activity can be seen as reaction to the awareness of mortality. This will range from the most simple and concrete steps necessary to keep the self physically healthy to the most abstract activity of creating philosophies to explain the transcendent meaning of what can seem to be a futile existence.¹⁰² This reaction to mortality, the drive for self-

¹⁰¹ "But, of the tree of the knowledge of good and evil, thou shalt not eat of it; for in the day that thou eatest thereof thou shalt surely die." *Genesis* 2:17.

¹⁰² See Slote, *Existentialism and the Fear of Dying*, in *BIOMEDICAL ETHICS AND THE LAW* (J. Humber and R. Almeder 2d ed. 1979). Slote discusses Kierkegaard's criticism of the tendency of people to live in the "world-historical," that is, to find meaning not in subjective experience, but only in one's minor participation in the outside world.

[W]e may be able to *explain* the tendency to live for the world-historical as resulting from our characteristically human fear of dying Consider the claim that people who live for the world-historical sometimes make that they will *be or become immortal through their works*, or that they will *live on through their works*

Id. at 591-92 (emphasis in original). The artificiality of this claim can, of course, be seen by one with insight, even one engaged in creating works that will survive him.

preservation in all of its forms, can lead to positive, even heroic, activity in creating and preserving the beautiful and valuable aspects of existence. It can also, however, take neurotic and profoundly destructive forms.¹⁰³

One of the basic insights of various nineteenth and twentieth century philosophies and psychologies that might loosely be grouped together under the label of existentialism¹⁰⁴ is the importance of the ways in which people construct elaborate defenses to enable them to avoid feeling the full force of the presence of mortality.¹⁰⁵ While we all agree, if asked, that our eventual death is inevitable, careful observers of the human condition note that, to most of us most of the time, this abstract proposition is so distant from full consciousness as to hardly qualify as a belief at all. Freud noted that most people do not actually believe in their own individual mortality.¹⁰⁶

And this is hardly surprising. To believe in something requires at a minimum the ability to conceive of it. To conceive of death, at least in the absence of an afterlife that resembles earthly existence, requires the ability to imagine one's own non-existence, at least in any form recognizable as worldly existence. And any attempt to imagine one's own non-existence calls forth the problem of Descartes's *cogito ergo sum*.¹⁰⁷ The best you can do is imagine a world without you, but still, there you are,

Woody Allen, when asked in a television interview whether he hoped to live forever in his movies, once responded "no, I hope to live forever in my apartment."

¹⁰³ For an extensive discussion of the negative results, personal and social, of the realization of mortality, see E. BECKER, *THE DENIAL OF DEATH* (1973).

¹⁰⁴ For brief introductions to the major themes and philosophers of this "school," see R. OLSON, *supra* note 4; W. BARRET, *IRRATIONAL MAN: A STUDY IN EXISTENTIAL PHILOSOPHY* (1958). See also, Slote, *supra* note 102.

¹⁰⁵ See E. BECKER, *supra* note 103.

¹⁰⁶ Freud, "Thoughts for the Times on War and Death," in 4 S. FREUD, *COLLECTED PAPERS* (1975). Thus, the most prominent expert on the psychological aspects of the process of dying, Dr. Elisabeth Kubler-Ross, has noted that the typical initial reaction to a diagnosis of terminal illness is fierce denial. See E. KUBLER-ROSS, *ON DEATH AND DYING* 34 (1969). The most extensive social history of attitudes toward death is probably P. ARIES, *supra* note 5.

¹⁰⁷ Descartes, *Discourses on the Method*, in *PHILOSOPHICAL WORKS OF DESCARTES* (E. Haldane and G. Ross eds. 1955). This short piece, indeed this single insight, is generally considered to be the starting point of "modern" philosophy, for good or ill. See generally J. STOUT, *THE FLIGHT FROM AUTHORITY: RELIGION, MORALITY AND THE QUEST FOR AUTONOMY* (1981).

somewhere above and outside the world, as if in a spaceship, doing the imagining. The whole problem is so profoundly disturbing that in order to go through life without being paralyzed by fear and anxiety, we generally succeed in avoiding it until it cannot be avoided. We generally resemble Tolstoy's Ivan Illich:

The syllogism he had learned from Keizwetter's Logic "Caius is a man, men are mortal, therefore Caius is mortal" always seemed to him correct as applied to Caius, but certainly not as applied to himself. That Caius—man in the abstract—was mortal was perfectly correct, but he was not Caius, not an abstract man, but a creature quite, quite separate from all others.¹⁰⁸

Tolstoy understood that the contemplation of the death of others, however sad or even frightening, is simply not comparable to the consideration of one's own death. And by extension, thinking, speaking, and planning for one's own death at a time when it lies in the indefinite future may be closer to facing the death of another than the death of the self. The rational approach that we generally accept as the best way to plan our lives calls on us to put aside emotion, to put aside the sense of our own uniqueness, and to treat "ourselves in the future" not as self, but as another.¹⁰⁹ Even if we sincerely try to overcome this obstacle, we may not be successful. The person actually facing death is not the same person as before; a new set of perceptions and feelings that were previously unknown are now part of his or her consciousness. These new perceptions can cause profound changes in attitudes, as folk wisdom has acknowledged for centuries:

The wretch who "called out every day/for death to come his way" sends it back when it arrives. "Come no further, O death! O death, leave me alone."¹¹⁰

¹⁰⁸ L. TOLSTOY, *THE DEATH OF IVAN ILICH* (1965), quoted and discussed in W. BARRETT, *supra* note 104, at 117-29.

¹⁰⁹ The dangers of this objectification of self, especially of self in the future, is one of the central themes of existentialist philosophy, particularly that of Martin Heidegger. See R. OLSON, *supra* note 4, especially at 197-201. See also Slote, *supra* note 102.

¹¹⁰ P. ARIES, *supra* note 5, at 15. These attitudes are noted by Aries in ages that he finds to be, overall, far more accepting of the reality of death than our own, as well as in contemporary society.

This is not to suggest that stubborn refusal to accept death is the only possible, or even the most likely response to its actual approach. But it surely does suggest that no response can be said to be a genuinely informed one until the full reality of the choice is present to the individual, that is, until death has "come his way." This is also not necessarily to endorse the position that medical treatment should never, or even rarely, be withheld in cases involving patients with terminal illness who are unable to make their own decisions when death is imminent. It is, however, enough to cause serious doubt about the characterization of prior directives made by the patient as clear autonomous choices which, as examples of informed consent made under optimal conditions for decisionmaking, should clearly be followed out of respect for the patient's rights.

Therefore, prior declarations by the patient present serious problems when we too easily regard them as clearly representing the patient's choice at the time of actual decision concerning the termination of care. If this is indeed the case, then how much more serious are the problems caused by the classification as the patient's own present choice of decisions made, not by advance declarations, formal or informal, but rather by a third party designated by the court, by statute, or by an advance proxy appointment made by the patient? Although such decisions may be made with some regard for the patient's unique situation, the decision is much more a choice made by someone other than the patient. Yet there remains a widespread refusal to acknowledge this, and an insistence on describing the choices as mere deference to the exercise of the patient's autonomous decision.¹¹¹ A number of questions must be addressed. Why do we see this insistence on classifying these decisions as autonomous choices to invoke individual rights despite the obvious ways in which such a characterization is strained? How, if not as the exercise of individual rights, should these decisions be characterized? Are there preferable alternative views, or is the autonomous rights model, despite its flaws, the best available? And if there are preferable alternative ways to look at the problem, how should that shift in viewpoint change the current

¹¹¹ See *supra* notes 9-85 and accompanying text.

approach of courts and legislatures to the issues related to the "right to die?"

III. TERMINATING MEDICAL CARE: THE INDIVIDUAL AND THE COMMUNITY

The persistence of courts, legislatures, and commentators in insisting that issues of terminating medical care are essentially matters of discerning the autonomous choices of the patient is not merely the product of a failure to recognize the flaws in the use of such concepts. Kamisar's critique¹¹² has been in print for thirty years, and others have followed.¹¹³ The prevalent view may be another example of an attitude quite common in American law with regard to the exercise of power over people. Americans are both attracted to and afraid of the exercise of power, and the law must somehow deal with this ambivalence in its approaches to issues that directly deal with questions of control over people's lives. Often, this dilemma will be resolved by describing the choice to exercise power as not a choice at all, but merely something the decision maker is compelled to do, either by another decision maker or by circumstances beyond his control. The decision thus becomes more palatable, not only to those directly affected and to a society ambivalent about power, but also to the decision maker. The responsibility of the decision maker for the harm done by the decision is deflected, diffused, or eliminated altogether. Whether this is done as a conscious strategy or a largely unconscious defense against the pain of living with the consequences of one's own actions is an interesting question, but the answer is less important for our purposes than the recognition that this type of denial does occur quite frequently.¹¹⁴

¹¹² Kamisar, *supra* note 12.

¹¹³ See, e.g., Gelfand, *supra* note 32; Hunsaker, *Unnatural Life v. Natural Death: Some Legal and Ethical Considerations*, 7 GEORGE MASON U. L. REV. 1 (1984).

¹¹⁴ The propriety of a legal decision maker choosing to deviate from outside influences that could be said to "compel" a contrary decision is, of course, a central question of legal philosophy. Compare R. DWORKIN, *LAW'S EMPIRE* (1986) with M. KELMAN, *A GUIDE TO CRITICAL LEGAL STUDIES* (1987). But leaving the normative question aside, it is clear that legal decision makers can, if they so choose, resist or at least attempt to resist the most clear compulsion for one decision over another. See,

Perhaps the most famous and possibly the most significant example in American law of exercising power while insisting that its exercise was not a matter of choice is *Marbury v. Madison*.¹¹⁵ John Marshall's defense of the power of judicial review was couched in an elaborate argument that there was simply no other way to resolve the dispute before him. But even scholars who have no doubt that Marshall's decision was correct see his protestations of having no choice in the matter as being disingenuous.¹¹⁶ Marshall could have avoided finding a conflict between the statute before him and the Constitution through interpretation,¹¹⁷ or he could have resolved the conflict by adopting the rule of deference to the legislature.¹¹⁸ While such decisions may have been wrong, they were actual options. The rejection of those alternatives and the assertion of the power of judicial review was a decision, not an inevitable occurrence.¹¹⁹

In these efforts to avoid responsibility for the exercise of power, the concept of a "right" can be of great value. One need not accept the overall world view of the Critical Legal

e.g., *Jaffree v. Bd. of School Comm'rs*, 554 F. Supp. 1104 (S.D. Ala. 1983), *rev'd in part*, 705 F.2d 1516 (11th Cir. 1983), *aff'd sub nom. Wallace v. Jaffree*, 472 U.S. 38 (1984). The existentialist philosopher would see the repression of the actual power to diverge from outside expectations as part of the "anguish of freedom." See R. OLSON, *supra* note 4, at 51-63.

¹¹⁵ 5 U.S. (1 Cranch) 137 (1803).

¹¹⁶ See, e.g., Van Alstyne, *A Critical Guide to Marbury v. Madison*, 1969 DUKE L.J. 1; Currie, *The Constitution in the Supreme Court: The Powers of the Federal Courts, 1801-1835*, 49 U. CHI. L. REV. 646, 651-61 (1982).

¹¹⁷ See Van Alstyne, *supra* note 116, at 14-16; Currie, *supra* note 116, at 653-55. The authors demonstrate that either the relevant portions of the Judiciary Act of 1789 or Article III of the Constitution could, quite rationally, be read in a way that would make them entirely consistent.

¹¹⁸ The Supremacy Clause states that the Constitution is the supreme law of the land, but it does not address the question of who decides whether its provisions conflict with a government practice or statute. See Van Alstyne, *supra* note 116, at 22; see also *Eakin v. Raub*, 12 Serg. & Rawle 330 (Pa. 1825).

¹¹⁹ But it was a correct decision, even in the eyes of some who are skeptical about whether it was faithful to the original understanding of the powers of the judicial branch. See L. HAND, *THE BILL OF RIGHTS* 1-30 (1958). Of course, there is much evidence that judicial review was contemplated by the framers. See *THE FEDERALIST* No. 78 (A. Hamilton). Alexander Bickel thought that the framers' approval of judicial review was "as clear as such matters can be." A. BICKEL, *THE LEAST DANGEROUS BRANCH* 15 (1962).

Studies movement¹²⁰ to recognize the value of its insight that the use of the term "right" may mask an exercise of power over another in the guise of a mere logical conclusion from first principles.¹²¹ This is relatively clear in the many instances where one party asserts the right to control another's behavior, and the other person counters with a claim of right to be free from such control. Since it is clear that we have a clash of interests, there is little danger that we will misread the outcome. The court will affirm the right of the winner and deny the right asserted by the loser. Society, whether it agrees with the outcome or not, will therefore have a good idea of who the winners and losers are.

Somewhat more dangerous is the situation where the person exercising power over another is able to characterize what is happening as the vindication of the right of the person actually being harmed by the decision. Possibly the clearest historical example involved the constitutional challenges to early labor laws. In invalidating such attempts to limit economic exploitation of workers, courts would often speak not of the rights of industry, but rather of the "right" of the worker to contract freely for employment.¹²² Thus the courts, and society if it were so inclined, could rest easy, assured that they were not responsible for the exploitation of labor. They had merely deferred to the rights of the workers to make their own contracts. How they used their rights might be unfortunate, but it was not society's fault.

Similarly, the situation presented by a patient with a terminal illness presents society with the need to make a decision, to exercise power over the individual. That exercise of power

¹²⁰ To the extent that the movement has a single "world view," see generally Kelman, *supra* note 114. See also *Critical Legal Studies Symposium*, 36 STAN. L. REV. 1-674 (1984). While disagreeing among themselves, Critical Legal Studies scholars are generally skeptical about the binding nature of rules, including widely accepted rules affirming the sanctity of individual rights. *Id.*

¹²¹ Indeed, the most prominent recent proponent of the concept that the terminology of constitutional rights can be used to disempower others, that is, the majority, was Robert Bork. See Bork, *Styles in Constitutional Theory*, 26 S. TEX. L.J. 383 (1985).

¹²² See *Lochner v. New York*, 198 U.S. 45 (1905); *Adkins v. Children's Hospital*, 261 U.S. 525, 545 (1923).

will be far less troubling to us if we think of it as not our decision at all, but merely our response to the exercise of the individual patient's rights. Adherents of the "right to die" can recognize this clearly in the approach of courts who refuse to accept the right.¹²³ To keep a patient alive at all cost, despite the existence of great pain, is a difficult decision. It can be softened by the assertion that it is being done only to vindicate the patient's right to live. Still, such a decision is not being made by the individual but by those who have found themselves with power over the patient. Should the decision to terminate treatment, under the same circumstances, also be seen as one made by others rather than simply being a matter of deference to the patient's rights?

Why is there such reluctance to recognize the extent to which the decision to terminate treatment is a decision which others make for the patient, and entails more than mere recognition of the patient's autonomous rights? Beyond the general reluctance to recognize our own exercises of power, the answer lies in the nature of these particular decisions, and their implications on a broad range of issues. As Richard Sherlock has pointed out, the decision of whether, and under what circumstances, to permit euthanasia requires some resolution of the question of when a life is not worth living, and therefore not worth preserving.¹²⁴ To venture any answer at all, Sherlock contends, threatens the most fundamental assumption of American liberal democracy: the proposition that all are equal in the eyes of the law.¹²⁵ To designate some forms of human life as unworthy of protection, or even to tolerate discussion of the question, then, is to threaten that basic principle and all of the valuable principles that flow from it.

The question seems too frightening to face, yet advances in medical technology make facing it inevitable. One way to cut

¹²³ See, e.g., Dr. Eric Cassell's comments on the way in which preserving a patient's life can often lead to ignoring a person's autonomy, thereby interfering with individual rights in order to protect what are essentially the values of the physician, not the patient. Symposium Panel, *supra* note 1, at 501-07.

¹²⁴ Sherlock, *Liberalism, Public Policy and the Life Not Worth Living: Abraham Lincoln on Beneficent Euthanasia*, 26 AM. J. JURIS. 47 (1981).

¹²⁵ *Id.* at 49-50.

through this dilemma is to redefine terms so that a decision seems to be no decision at all. The principle of individual autonomy, and the right to structure one's own life, even foolishly, is honored by almost all groups in the American political community. Although strong disagreement exists over concrete applications of the principle of liberty, in the abstract the concept commands nearly universal respect. Thus, it is relatively easy to convince ourselves that, faced with tragic choices, we have merely to defer to individual decisions to avoid, as a community, the need to face the question of the value of life, or of certain forms of life.¹²⁶

Upon reflection, this model of mere deference to individual wishes simply does not ring true in many "right to die" cases, any more than it did in the early child labor cases.¹²⁷ As we have already seen, the delegation of the decision to withhold medical care to a relative or other proxy clearly makes the final decision one made by someone other than the patient, regardless of the solemn declarations of courts that the proxy decision must be made in accord with the thoroughly speculative standard of what the patient would decide, if competent. The proxy decision maker, not facing his or her own death, but the death of another, will almost surely treat death as an objective, distant thing. Yet the decision maker's task is to decide as if he were the patient, that is, someone to whom death is a real, and very subjective, presence. Even if the proxy decision maker quite faithfully carries out detailed advance instructions executed by the patient prior to the fatal illness, the patient was very much a different person at that time. We simply cannot know, unless the patient can tell us, what the actual approach of death has done to his or her prior choice.¹²⁸

¹²⁶ "[T]here must be an admission that there are some lives that are not worth living anymore." *Id.* at 48.

¹²⁷ See Note, *Child Labor Laws—Time to Grow Up*, 59 MINN. L. REV. 575 (1975); see also Stem, Smith & Doolittle, *How Children Used to Work*, 39 J. OF LAW & CONTEMP. PROBS. no. 3, 93 (1975).

¹²⁸ A prior choice, because of its remoteness, is more like choosing for someone else than for oneself here and now. The difference between speaking of self in an objectified, abstract way and relating honestly to actual experience is discussed by Slote, *supra* note 102, at 591-606.

Of course, even aside from these problems, and even in cases when the model of autonomous decision making seems most compelling (that is, a present request by a competent patient), is society free from responsibility in deciding to ratify that choice? Sherlock writes:

First, consider the case of person A who asks someone else B to aid him in bringing about his death (either passively or actively). A's request must be acted on by B in order to be successful. B must ratify A's decision. Now if B is a seriously concerned moral agent he will not just blindly acquiesce in any such request. He will independently evaluate what he as a moral agent should do. Will not this decision by B necessarily involve an assessment of A's condition, which of course will largely determine the reasonableness of A's request? In essence then are we not back with a judgment that A's life is no longer worth living or, rather, more mildly, are we not forced as independent moral agents to decide that it would be reasonable for a person with A's condition to conclude that life is no longer worth living?¹²⁹

The "B" involved here can be seen to include not only the individual charged with making the decision to terminate or to continue treatment, but also the community which gives that person immunity from the usual legal consequences that flow from terminating the life of another.¹³⁰ Sherlock's own suggestion for resolving the dilemma is to reinvigorate the often criticized distinction between active and passive methods of euthanasia. He contends that a decision "between hastening death and only prolonging dying,"¹³¹ at least when made by the patient when "actually dying in an irreversible process"¹³² can accurately be seen as a decision that does not place a particular value on life itself, but rather selects one of two available types of life. It is, under such circumstances, "the choice to live in one fashion, for one goal, and not another."¹³³

¹²⁹ Sherlock, *supra* note 124, at 61-62.

¹³⁰ Since this entails change in long-standing legal rules, it requires a "public judgment." *Id.* at 49.

¹³¹ *Id.* at 62.

¹³² *Id.*

¹³³ *Id.* at 62-63.

There is much to be said in favor of Sherlock's distinction, but even if we follow his recommended course, we are still engaging in some sort of social choice. The community often prohibits individual choices "to live in one fashion . . . and not another."¹³⁴ Perhaps we should defer to these sort of "lifestyle" choices but such a decision is not inevitable, and it does not entirely avoid the "value of life" question. Surely, the decision to acquiesce says something about our view of the extra time on earth that the patient chooses to surrender. At the very least, we are declaring skepticism over the value of that part of a life.

Whether characterized as a choice between life and death or as a choice of ways to live, even those choices that most clearly resemble other autonomous choices are not made by an individual who holds and has formed his views in a vacuum, but rather by one who has been instructed by society as to the "proper" way to face death. Phillippe Aries has described the evolution of social attitudes toward death over the centuries.¹³⁵ Although views of death have changed, at any given time there seems to be some socially approved version of the proper way to face death, which is communicated in one way or another to the individual. The most obvious examples of this phenomenon were the *artes moriendi* of the late Middle Ages, illustrated instructional books teaching the art of dying well.¹³⁶ While other generations and cultures may not have been as direct as medieval Europe, each culture teaches its version of a fitting death through its art, symbols, and literature.¹³⁷

Not only does society teach the individual in advance, it often supplies an audience when the time comes for the individual to apply those lessons. Before the twentieth century, the

¹³⁴ *Id.*

¹³⁵ P. ARIES, *supra* note 5.

¹³⁶ *Id.* at 107-10. These were profusely illustrated so that even the illiterate could learn from them.

¹³⁷ The *artes moriendi* underwent subtle changes through the years. See *id.* at 129-30 and 303-05. The United States developed its own literature of the "beautiful death" during the eighteenth and nineteenth centuries. See *id.* at 446-60. Aries agrees with Lewis Saum that "during the first half of the nineteenth century the American sensibility was dominated by death," *id.* at 446-47, as evidenced in private correspondence, and in popular literature with titles such as *Agnes and the Keys to Her Little Coffin*, *Stepping Heaven-ward*, and *Our Children in Heaven*, see *id.* at 450.

ideal scene of death was one surrounded by people. Family, friends, even strangers were there. Death was by no means an event experienced only by its isolated victim: it was quite social. At different times, the dying person might be seen as the primary actor in the drama, with others as his audience,¹³⁸ or as an observer to a scene played out around him by others.¹³⁹ Always, though, to the end, the dying person was relating to others. Until the end, or at least until the loss of consciousness, the dying person was aware of the social role he or she was playing. The presence of others and what they all had learned about death would influence death's victim to follow the script, to follow the assigned role in the socially approved pageant of death.¹⁴⁰

Present day artists continue to put forward visions of a proper death. These need not, and do not, necessarily resemble the peaceful death of earlier times. Dylan Thomas's urgings to "rage against the dying of the light"¹⁴¹ are a far different type of advice. Aries has described the typical death of the twentieth century, a time which has seen an attempt to deny death, to make it invisible: "[a] new image of death is forming: the ugly

¹³⁸ The earliest accounts of the proper way to die stress the acts of ceremony performed by the dying person. See *id.* at 14-15 (account of the death of Roland). This is also the attitude of much nineteenth century American death literature: "[T]he dying man was expected to die well Death was still a spectacle of which the dying man was the director." *Id.* at 447-50. Also, letters speak of how well or poorly dying relatives played their roles in the drama. *Id.*

¹³⁹ "In his analysis of the iconography of the [fifteenth century] *artes moriendi*, Alberto Teneti suggests that the dying man attends his own drama as a witness rather than as an actor." *Id.* at 109. The drama rages around the dying man in his bedroom, as Satan and the angels battled for his soul.

¹⁴⁰ "According to custom, the bedroom is full of people, for one always dies in public." *Id.* at 108.

To die surrounded by friends and relatives was a satisfaction. But to be one of those surrounding his death . . . was also a "privilege" It was the duty of one of these privileged persons to be the indispensable herald of death . . . to warn the dying person in plain language. If the dying man understood the warning and accepted it, he was "sensible" but if not, he was "very stupid."

Id. at 448.

¹⁴¹ Thomas, *Do Not Go Gentle into That Good Night*, in D. THOMAS, *DEATHS AND ENTRANCES* (1946).

and hidden death, hidden because it is ugly and dirty.”¹⁴² But even the “hidden” death, the death quite consciously removed from the gaze of society, has social implications. The privatization of death reinforces the image of it as a matter for the autonomous individual to deal with, something in which the community has no role, even as observer.

In recent years, as the negative consequences of the denial of death have become more clear, a new *ars moriendi* has emerged. This new way of confronting death has been both individual and social. Dr. Elisabeth Kubler-Ross has been extremely influential in charting the typical history of a fatal illness and the response of the terminal patient. From observation of dying patients, Dr. Kubler-Ross has asserted that such patients progress through a series of psychological stages.¹⁴³ Beginning with denial, the patient works through several intermediate stages to the ultimate point of acceptance.¹⁴⁴ While her work, at least initially, was primarily descriptive rather than prescriptive, it does seem clear that Dr. Kubler-Ross and her disciples feel that this progression toward acceptance of death is what should happen, as well as what does happen. And not only should the patient journey toward acceptance, but society should also be supportive of this psychological journey. While her writings and her clinical work are based upon observation and are clearly sensitive to the individuality of the patient, it is quite clear that Dr. Kubler-Ross has set forth a modern *ars moriendi*, something which is at least seen as somewhat of an instruction manual on the way a terminal patient should face death.¹⁴⁵ As with the ancient *artes*, the individual is expected to learn the “proper” response to the approach of death well

¹⁴² P. ARIES, *supra* note 5, at 569. This twentieth-century attitude toward the “dirty death,” to conceal it, deny it, and privatize it, is seen by Aries as a sharp break with all that has gone before.

¹⁴³ E. KUBLER-ROSS, *supra* note 106.

¹⁴⁴ Kubler-Ross has concluded that the terminally ill typically move from denial to anger, to “bargaining” (with God or fate), to depression, to acceptance. Clearly Dr. Kubler-Ross sees this as the proper stage at which to face the moment of death, and she outlines ways for family and health care professionals to assist the patient through these stages. *Id.* Once again, the patient and those closest to the patient fulfill their roles in the drama of death.

¹⁴⁵ See D. HUMPHREY, *LET ME DIE BEFORE I WAKE* (1982) (more explicit modern *artes moriendi* specifically addressed to the issue of voluntary euthanasia).

ahead of time, so that he or she will play the part correctly when the time comes. Once again, death will be a community event; the patient will have an audience.

On a more explicitly social level, debate about the allocation of scarce medical resources has led many to the conclusion that society cannot continue to urge and support the choice of the individual to "rage" against death regardless of the cost. Former Colorado Governor Richard Lamm caused an uproar when he suggested that the elderly might have a duty to forego expensive medical treatment intended to prolong their lives by some brief span, in light of society's needs that may be neglected if heavy resource commitments must be made to such treatment.¹⁴⁶ While there is a vast and significant difference between compulsion and influence, clearly the advocates of such a position are attempting to educate, to influence, and to condition individuals so that when death approaches they will make the "right" autonomous choice.

One way or the other, then, society will label certain types of decisions about death as "right" and others as "wrong," some as courageous and noble, others as at least disappointing, possibly cowardly, or even disgraceful. These social labels cannot fail to influence subsequent individual choices. In addition, such attitudes can cause decision makers to interpret the statements and actions of the individual patient in ways that are at least problematic. Possibly the most striking example of the phenomenon is contained in the opinion of the California Court of Appeal in *Bartling v. Superior Court*.¹⁴⁷

Bartling petitioned the Superior Court for permission to compel the withdrawal of life support equipment. Although he died prior to the appeal of the lower court's denial of his petition, the appellate court nevertheless reversed, in order "to set forth a framework in which both the medical and legal

¹⁴⁶ See generally, Battin, *Age Rationing and the Just Distribution of Health Care: Is There a Duty to Die?*, 97 *ETHICS* 317 (1987). Battin notes that this is hardly an unprecedented suggestion. Societies and philosophers have suggested, with varying degrees of directness and sensitivity, that at some point the aged infirm person has no claim on society's resources.

¹⁴⁷ 209 Cal.Rptr. 220 (Ct. App. 1984).

professions can deal with similar situations.”¹⁴⁸ Although Bartling’s legal competency was undisputed, the hospital opposed the petition, stating concern about the sincerity and finality of Bartling’s decision. Not only had Bartling made some statements to the effect that he wanted to live and did not want his respirator disconnected, but nurses also testified that on more than one occasion “the ventilator tube [keeping him alive] accidentally detached and Mr. Bartling signalled frantically for them to reconnect it.”¹⁴⁹ The court held that the hospital should have deferred to Bartling’s desire to have his respirator disconnected.¹⁵⁰

In a rather remarkable sentence, the court dismissed as insignificant “[t]he fact that Mr. Bartling periodically wavered from his posture *because of severe depression or for any other reason*.”¹⁵¹ The court would persevere, even where Bartling has wavered, and follow his true intent. But why should one of two conflicting wishes be labelled true and the other a distortion caused by depression or some other impediment to the ability to choose well? If anything, isn’t the wish to die more likely to be a consequence of depression than the wish to live? And even if the wish to live is influenced by emotion rather than pure reason, why is emotion irrelevant, or worse, a distortion? The answers to these questions seem painfully clear. When Bartling chose to die, his decision was seen as proper, courageous, and admirable. When he chose to live, his decision was seen as unfortunate, almost cowardly. He had wavered from the socially approved “script” for his death scene; he had forgotten the current *ars moriendi*. The court would endorse his decision to

¹⁴⁸ *Id.* at 221 (quoting *Dority v. Superior Court*, 193 Cal.Rptr. 288 (Ct. App. 1983)).

¹⁴⁹ *Id.* at 223.

¹⁵⁰ *Id.*

¹⁵¹ *Id.* The court focuses on his wavering in his resolve to determine that Bartling was not legally incompetent. It seems to ignore entirely the significance of the wavering in determining just what Bartling’s fixed choice (if indeed he had made one) was. Robert Twycross stresses the fact that requests for euthanasia are quite often actually cries to be relieved of some other pain, physical or psychological. To see the request for euthanasia as automatically the “true” request and the contrary evidence as the result of pathology not only stands this finding on its head but relieves the physician of his primary duty, to deal directly with the pain through some sort of therapy. See Twycross, *Voluntary Euthanasia*, in *SUICIDE AND EUTHANASIA*, *supra* note 6, at 96-97.

die, despite the moot nature of the case, and do so in the usual judicial language of mere deference to Bartling's autonomous decision. While the decision would not serve to end Bartling's life, it would serve to continue the subtle process of promoting the "proper" type of individual choice in the future.

Thus, even in those cases where the model of autonomous decision making seems most compelling, that is, those involving decisions by competent patients actually facing death, decisions to withdraw treatment in cases of terminal illness are not made apart from social attitudes on the subject. To continue to address those issues as if they are, should be, or even could be resolved merely by elaboration of and deference to an individual "right to die" would be to continue to apply a flawed paradigm. Decisions to withdraw treatment are not purely autonomous. At the very least, they are decisions in which individual choice is accompanied by social choice, a social choice which, as Sherlock has pointed out, requires confronting in some way the momentous decision of when, if ever, a life has no value.¹⁵²

The fact that courts, legislatures, and commentators have mischaracterized the issues before them does not necessarily mean that their ultimate conclusions about whether care should be terminated or continued are wrong. It does, however, compel us to reexamine the validity of these conclusions with a new awareness of the involvement of others in the "autonomous" decisions being respected. While this may not require many changes in rules of law, it will certainly require some changes in the vocabulary that we use in analyzing and resolving these issues.

How does current law with respect to the "right to die" fare when seen as not responding to a set of decisions made by isolated autonomous individuals, but rather to decisions inevitably made with some degree of social choice inextricably linked with individual preferences? Should current law be changed, and if so, how drastically? And, finally, is there a case to be made for retaining the language of autonomous decision making, of the "right to die," despite the serious flaws? Even if

¹⁵² Sherlock, *supra* note 124, at 48-49.

the "right to die" is somewhat of a myth, might it be a valuable myth—one worth preserving?

IV. TERMINATING MEDICAL CARE: RIGHTS AND RESPONSIBILITIES

The decision to withhold medical treatment is not, and cannot be, solely the decision by an informed autonomous individual. While the extent of involvement by others will vary widely from case to case, this decision will always reflect some mixture of individual and social choice. The first conclusion from these premises is semantic, but like so many semantic choices, has real consequences. The glib use of the term "right to die" to cover the broad range of circumstances under which decisions about medical treatment must be made should be avoided. Not only does the term understate the importance of community choice in these decisions, but in doing so, may unduly influence those choices. Describing death as a right makes it easier to make a decision to withhold treatment to another. After all, we would merely be acting to carry out the wishes of the unfortunate patient.

This is not to say that the wishes of the patient should be disregarded, or even that there are no cases in which those wishes should be decisive. Just as the termination is not properly thought of as an entirely individual decision, neither is it entirely a social decision. In some circumstances, the patient's expressed wishes should override contrary choices of others, and in these cases, some terminology of individual rights is appropriate. But these cases are limited, and the terminology should be similarly narrowed.

The situation in which reality most closely approximates the model of autonomous decision making is the case of a competent patient who has been informed that he or she suffers from a terminal disease, and who chooses what are generally termed "passive" means of terminating treatment. Such a decision comes as close as is possible to being purely that of the individual. Of course, even this choice is not made entirely without social influence. The decision is made against the background of society's attitude toward death, an attitude that has been communicated, explicitly and implicitly, to the patient over a

number of years. Most patients will, of course, be influenced by social attitudes, but this is no more true here than in many other situations where we leave ultimate choice to the individual. No rights are exercised in a vacuum.

As critics have pointed out,¹⁵³ even in these cases, the pure model of informed consent is flawed by imperfect information about the future and by the pressure of physical and emotional stress. Still, this also is no different from the circumstances under which many other rights are exercised or waived. To abandon rights terminology in these limited types of cases is to call into question the validity of its use in legal thought at all. History has shown that the ability to make the final decision about certain things, despite necessarily imperfect information and the influence of society's teachings about how that decision should be made, is important in maintaining the proper balance between social and individual choice.¹⁵⁴ That the concept of individual rights may be overstated or misused does not mean that it is to be completely rejected, either in law generally, or in this area in particular.

The language of individual rights, as well as its most commonly accepted consequences (that an individual decision should, once it is found to be made by a competent actor under circumstances affording the best possible information, override any contrary social decision), should be limited to this type of case. Some statutes, most notably that of California,¹⁵⁵ properly restrict the efficacy of written declarations to forego medical procedures to decisions made by a competent patient after diagnosis of a terminal illness. Keeping in mind Sherlock's distinction between decisions whether to live and decisions how to live, we should insist that this type of choice be labelled a right to refuse medical treatment, rather than a "right to die." The former term is far more neutral, and does not connote death

¹⁵³ See, e.g., Kamisar, *supra* note 12; Gelfand, *supra* note 32.

¹⁵⁴ An extremely interesting debate on the value of antimajoritarian rights recently took place in Canada, concerning its new constitutional Charter of Rights. For a collection of viewpoints on the relative values of individual rights and parliamentary (majoritarian) sovereignty, see the articles collected in 4 Sup. Ct. Rev. 1-350 (1982) (special edition on the new Canadian Constitution).

¹⁵⁵ See *supra* notes 68-85 and accompanying text.

as a positive thing. It is, therefore, less easily misused to disguise the issues involved when the decision will not be made by the individual as a matter of right, but must be made by others.¹⁵⁶

In all other cases, that is, all cases that do not involve a decision to refuse treatment by a competent patient under diagnosis of terminal illness, we should abandon the language of individual rights and accept the reality of the situation. Here, those who are themselves not faced with the imminent approach of death must make the ultimate decision about how to deal with someone who is. When a judge, a relative, or a guardian decides to terminate another's medical treatment, that person is the one making the choice. The decision maker may well be making that choice in a good faith attempt to act in the best interests of the patient, but that is not the same thing as merely giving voice to the patient's own choice. We must honestly admit that the patient's own choice is unknowable.

This is true even in light of a prior declaration by the patient of a wish not to be kept alive by extraordinary means. As discussed above, when such a statement is made well in advance of an actual confrontation with death, the declarant is too far removed from the reality of the choice to be making a sufficiently informed decision. The patient is thinking in terms of how a hypothetical person should act when facing death. In truth, the person is really making a decision for "another," that is, the person he or she will be at some indefinite time in the future.¹⁵⁷

To abandon the language of the "right to die," and to limit the concept of the right to refuse medical treatment to situations actually resembling the circumstances under which individual rights are validly exercised, does not necessarily lead to a jurisprudence that requires that all available means be used to extend life in all circumstances in which the right to refuse treatment has not been exercised. It does, however, require that we face the fact that those of us not on the verge of death are responsible for making policies to be applied to those who are. As long as we maintain that we can avoid these decisions by struc-

¹⁵⁶ See *supra* notes 47-85 and accompanying text.

¹⁵⁷ See *supra* notes 104-10 and accompanying text.

turing the law so that we merely defer to the "autonomous" choice of the patient, even when it is clear that no such autonomous choice exists, we will not confront questions that must be faced. Questions of society's commitment to prolong each individual life are important and even frightening. But they must eventually be resolved, and conscious resolution is preferable to a social policy that denies its nature as social policy.

In resolving individual cases, several claims carry some degree of weight: the actual wishes of the patient, the actual wishes of those closest to the patient, and the values of the larger community. A possible fourth category of those involved in the decision, the physicians involved, should not be seen as decision makers themselves, except insofar as they also participate in the articulation of society's values, along with others in the community. The physician's key role is not to resolve the dilemma, but to supply the best possible information to be assessed by those who do. When the wishes of the patient, those closest to the patient, and the community are in accord, there is, of course, little difficulty. Where there is some disagreement, the relative weight of the three opinions should vary depending upon circumstances.

As stated above, where the patient is competent, the patient's condition will lead to death in a reasonably short time, and the patient has been informed of that prognosis, the patient's decision to terminate treatment should be respected. Here, the use of the model of individual rights trumping contrary social choices seems justified. "Living will" statutes limited to these types of cases are proper.¹⁵⁸

Nevertheless, a few words of caution seem warranted even in these cases. Any irreversible medical procedure should, if based upon the patient's request, be taken only upon satisfactory proof that the patient's decision is firm and neither ambivalent nor overly deferential to the opinions of others.¹⁵⁹ Close relatives should have the opportunity to establish, in expedited proceedings, not that the patient is making the "wrong" choice, but that the choice is based upon incorrect medical information,

¹⁵⁸ See *supra* notes 68-85 and accompanying text.

¹⁵⁹ See Battin, *supra* note 146, at 334-37.

if such is the case. Even in cases where we properly respect an individual choice, society should not be uninterested in the circumstances under which the choice is made.

In all other cases, society is not merely deferring to an individual right nor merely providing for "substituted judgment" in the exercise of a patient's autonomy. Rather, it is making a decision about the fate of one who cannot choose; it is exercising power over the individual. This does not necessarily mean that only general community sentiment is important, however. To state that a prior declaration of intent by the individual should not be determinative is not to say that it is irrelevant. Prior statements by the now incompetent patient should be given some weight in the decision making process.

Just how heavily prior declarations should weigh will vary. They should be given more weight in cases where they conflict with the then prevalent views of the patient's relatives or of society at large. In these cases the statements would seem to be genuine products of individual choice, rather than mere echoes of the preferred *ars moriendi* surrounding the individual. Where the prior statement of the individual merely reflects prevailing social attitudes, it is not only less necessary to use it to justify a social choice, but it is far less certain that the prior statement was made for reasons other than its social acceptability.

This creates something of a paradox. In the early years of cases involving termination of medical treatment, a prior declaration of a desire to avoid extraordinary means of life support was inconsistent with a general social position favoring heroic measures. Because it was contrary to public opinion, it deserved serious consideration. But as such decisions have become more common, and more acceptable, it is now possible that a prior statement favoring treatment, rather than one rejecting it, deserves more respect. In other words, the statement that should weigh heavily is neither the one favoring nor disfavoring treatment, but rather the one disagreeing with the prevalent choice of society on the question.

If society recognizes that it must articulate views on the termination of medical cases and may not escape by merely calling this a matter of individual choice, what will those views be? It may be that the ultimate question of when to terminate care will be answered no differently than it is now by courts

employing the "right to die" label. A strong presumption in favor of medical treatment will be overcome upon a showing of an illness leading to death within a relatively short period of time, with no reasonable hope of recovery and no expression by the patient to indicate a desire for continued treatment.¹⁶⁰ But these similar outcomes will be seen for what they are, social decisions.

Possibly, the "right to die," even if largely a myth, is a myth that serves an important social purpose. Would recognition of the reality of social choice in these decisions give too much impetus to the position that society may decide that certain lives are not worth living?¹⁶¹ After all, if society may decide to keep individuals alive, regardless of their own wishes, may it not decide to terminate care, regardless of contrary individual choice?

It seems unlikely that this is the case. Denying the inevitable social choice involved in decisions whether to terminate treatment does not eliminate society's role. If anything, the myth of the "right to die" makes a decision to disvalue individual lives more likely by disguising its true nature. To frame a decision to terminate treatment as mere deference to some hypothetical individual choice merely makes the employment of community values less obvious, less problematic, and easier for the decision maker. Recognition of the social nature of the choice may make disrespect for the life of the individual less likely. And clearly limiting the scope of the individual right to terminate treatment to those cases actually presenting circumstances conducive to informed individual consent preserves an appropriate sphere in which the individual's choice remains supreme.

The final part of the decision making calculus is the role of those closest to the patient: spouse, children, or others. As discussed above, the current trend is to delegate decision making power to these people, but to label these decisions matters of "substituted judgment," that is, the decision maker merely making the patient's "own" decision for him or her. Once

¹⁶⁰ This seems to be a rough statement of the principles now applied in most courts. See *supra* notes 23-67 and accompanying text.

¹⁶¹ See Sherlock, *supra* note 124.

again, the concept of substituted judgment serves to mask the extent to which the decision is being made by another. While it may be far too cynical to dismiss a family member's assertion that the patient "would have wanted it this way" as a disguise for selfish considerations, it is also quite unrealistic to expect a family member to make a decision about continuing medical treatment without some consideration of his or her own values, emotions and, perhaps, practical concerns such as the financial effect on the entire family of continued treatment.¹⁶² At best, a decision by a relative will be made in the best interests of the patient; it is not, however, that patient's decision, but that of the decision maker.

A strong argument can be made that a delegation of decision making power from society as a whole to a relative or other surrogate is the best resolution of the question of where to locate those decision making powers. Not only will this decentralize ultimate decision making power, but it respects the genuine interests of those closest to the patient. The costs of a decision to continue or to terminate treatment are not spread evenly throughout society. Inevitably, close family members will disproportionately suffer the emotional consequences more intensely, and unless and until society decides to assume the financial burden for extended extraordinary care, close family members will disproportionately bear the financial consequences as well.

Still, the decision to delegate the power to either relatives or other surrogates itself involves a social choice. While there is a strong current of deference to family decision making in American law,¹⁶³ it is not nearly as strong as the rhetoric of

¹⁶² The financial burdens of extended care for a terminal patient are obvious and often noted. See, e.g., Battin, *supra* note 146. But the psychological pressures of coping with a dying person are just as severe, and the fact that the death of another will cause different reactions in relatives is something that must be faced: "Dying people run the gamut of all types of human beings, some likeable, some not Some dying persons we will feel like helping, others not. The death of some people will cause us sorrow, others who die will provide a sense of relief" Pattison, *Psychological Factors in Coping With Dying*, in *DEATH AND DECISION* (AAAS Selected Symposium 18 E. McMullen ed.) 45, 47 (1978).

¹⁶³ See, e.g., *Moore v. City of East Cleveland*, 431 U.S. 494 (1977); *Wisconsin v. Yoder*, 406 U.S. 205 (1972); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925).

individual choice. Perhaps the wishes of the family should be held in check to some extent. If the case for termination of treatment is a close one by the standards of society, perhaps the family's decision to terminate treatment should be decisive. On the other hand, if by society's standards the decision would clearly be to provide treatment, allowing the family to override that choice is more problematic. If society would clearly wish to terminate treatment, but the family wishes to continue it, the willingness of the family to bear the practical and emotional burdens of continued treatment may indicate that society should defer.

Of course, society's claim to override the decisions of the family become stronger if and when society assumes at least the financial consequences of its decision. How health care resources are to be allocated is a subject closely connected to society's position on extraordinary medical treatment of terminal patients. Here again, the connection between society, the family, and the individual becomes clear. By deciding to fund or not to fund treatment, the community seriously affects the decisions of individuals and other groups. This is not improper, it is inevitable. The entire community must be involved in deciding how its resources are to be used.

In summary, the law should abandon the overbroad and deceptive term "right to die." The more precise concept of a right to terminate treatment should be retained only in cases that resemble the exercise of other individual rights, that is, to decisions made by a competent individual actually facing the reality of a terminal illness. All other cases should be recognized for what they are, situations in which society must make difficult, often tragic decisions about life and death. In some instances, it might be proper for society to decide to delegate those decisions to the family, but even in those cases, the community is responsible for its decision to delegate. The care of the terminally ill is at least as much a matter of community responsibility as it is a matter of individual right.

CONCLUSION

Medical technology has forced the law to resolve questions concerning termination of medical treatment to terminally ill

patients by making largely social decisions involving our attitudes toward life, and the ways in which society allocates resources best to preserve it and its quality. Courts, legislators, and commentators have attempted to avoid this fact. This avoidance has taken place through the overexpansion of the concept of an autonomous individual's "right to die," which renders social decisions about the treatment of individuals no more than a reaction to their own, often unexpressed, "wishes."

In some cases it is entirely appropriate to characterize a decision to terminate treatment as the exercise of an individual right. The terminology of individual rights should be limited to those cases, and not used to disguise choices made by society, or delegated by society to third parties such as relatives or guardians. To disguise a social choice as one made by the individual permits society to deny the consequences of its decision and may lead to social choices made with insufficient reflection. Ultimately, the overextension of the model of individual rights weakens respect for the concept in cases where it is appropriate and realistic, that is, where decisions about an individual's life are made by that individual under circumstances actually facilitating informed autonomous choice.

To describe the position society should take on the question of terminating treatment is beyond the scope of this Article.¹⁶⁴ It is entirely possible that the answers now being provided by courts and legislatures to this ultimate question under the guise of protecting the "right to die" will be substantially the same answers provided when the question is faced as one of social choice. Whatever the ultimate resolution, it should be made consciously, fully aware of the social nature of the choice. The value of heroic measures to sustain life is not one that can be entirely resolved by isolated individuals in solitary thought; it also requires the community to confront its attitudes toward

¹⁶⁴ The literature on the ultimate question of when, if ever, the decision maker should decide to terminate care is extensive. In addition to the sources cited throughout this Article, see D. CALLAHAN, *SETTING LIMITS: MEDICAL GOALS IN AN AGING SOCIETY* (1987); P. RAMSEY, *ETHICS AT THE EDGES OF LIFE: MEDICAL AND LEGAL INTERSECTIONS* (1978); R. VEATCH, *DEATH, DYING AND THE BIOLOGICAL REVOLUTION* (1976). For an extensive bibliography on the subject, see *THE HASTINGS CENTER'S BIBLIOGRAPHY OF ETHICS, BIOMEDICINE AND PROFESSIONAL RESPONSIBILITY* 28-38 (1984).

life, death, and the allocation of resources in tragic situations. Clarity about the limits of the concept of the rights of autonomous individuals can only lead to more responsible decision making in situations where that concept is inadequate.

