The Fusion of Medicine and Law for *In Extremis* Health and Medical Decisions: Does It Produce Energy and Light or Just Cosmic Debris?

Hon. Joseph W. Bellacosa, Judge

> The physician is still the wonder-worker, the soothsayer, to whose reading of the entrails we resort when hard beset. We may scoff at him in health, but we send for him in pain. The judge, if you fall into his clutches, is still the Themis of the Greeks, announcing mystic dooms. You may not understand his words, but their effects you can be made to feel. Each of us is thus a man of mystery to the other, a power to be propitiated in proportion to the element within it that is mystic or unknown. . . . More and more we lawyers are awaking to a perception of the truth that what divides and distracts us in the solution of a legal problem is not so much uncertainty about the law as uncertainty about the facts—the facts which generate the law. Let the facts be known as they are, and the law will sprout from the seed and turn its branches toward the light. We make our blunders from time to time as rumor has it that you make your own. The worst of them would have been escaped if the facts had been disclosed to us before the ruling was declared (Benjamin N. Cardozo, *What Medicine Can Do for Law*).[1]

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You invited me to present a paper at your annual meeting on this topic of current interest and requested a title many months ago, before my thinking jelled on substantive content. Having selected a title designed to pique some curiosity among your members and attendees, I found myself over the last month perspiring with trepidation at what I had undertaken. I quizzically searched to fill the gap, looking for answers, themes, meat and potatoes, if you will, to match a very slippery set of concepts and operating principles to the somewhat exotic title. I concluded that the nature of the subject matter in this veritable minefield could be conquered only by a charge up the hill, recognizing the danger—a risk worth taking—of tumbling down the unknown other side.

I struggled, too, to convince myself that I could tender to you a meaningful morsel and context from my perch and perspective as the newest member of a leading state's highest court, certainly a discipline distinct from yours. So much

has been written and said on this vast issue; yet so much more awaits understanding. I satisfied myself that something might be accomplished just by my daring to show up and utter some sounds and thoughts reflecting my struggle and, thus, the struggle within us all, on this profound subject affecting every one of us—in our individual personas, in our families and circle of friends, and in our respective professional responsibilities to patients, clients, litigants, and society at large. It is a struggle for fairness, decency, humanity, compassion, understanding, knowledge, and respect for individuals and for values. And, frankly, it is a struggle for certainty where there is none.

I chose six key road map markers for the landscape over which I intend to journey with you this afternoon. They are:

1: Framing some statement of the problems, issues, and questions.

2: Trying to explain how and why so many of these matters are ending up in courthouses.

3: Identifying some of the technical, practical, and varying procedures under which courts rule on such matters.

4: Collating some of the root jural principles (e.g., constitutional, legislative, common law decisional, administrative regulation) which have emerged, which govern, or which may provide guidance to the fast-paced and varied changes we are experiencing as a society.

5: Venturing to gaze mistily for the direction of the winds as we enter our new decade, leaving the millennium forecasting for longer-range soothsayers.

6: Closing with a caution against heightened expectations for the imminent stabilization of this process and its problems, at least as far as the legal-judicial-legislative contributions are concerned.

In that same great speech to the Academy of Medicine Chief Judge Cardozo uttered an admonitory metaphor that applies with equal force 61 years later: "When the seas are so boisterous and their perils so insidious, one creeps from cape to cape."[2] Thus, we go case to case and you go patient to patient.

One of the biggest problems we face together may be described as: How do you physicians and psychiatrists, and how do we lawyers and judges, ensure that an individual's known and reliably expressed wishes about *in extremis* health and medical decisions and treatments will be faithfully implemented?

The critical corollary is how we all ensure the fulfillment of those wishes, especially—and this is more and more frequent—after the individual loses capacity to communicate, confirm and participate—other than as a passive object—in those decisions and treatments.

At this commemorative stage in our grand history, the 200th anniversary of the ratification of the Bill of Rights in this very same month in 1789, we should reflect on the centrality of the individual person in our society and in our form of government, a cherished inheritance from wise founders and a trust to be passed on to succeeding generations. Each of us emerges swaddled in personal rights springing not from some government, not from the majority of the gov-

erned, and not from a paternalistic, oligarchical, or aristocratic few. Rather, our rights are spawned within that common, universal, wellspring spirit deep within the individual self. Some call it our soul, or spirit, or human nature. But whatever we call it, we all know it even though we do not see it.

The magnificent suppleness and resilience of our judicial system find expression today in the reemergence of state courts and state constitutions offering safe havens when the federal courts and the federal constitution sometimes slip to ebb tide.[3] Not, please understand, that we can do without the latter to secure the base flooring of protections for our rights. But ponder the genius and generosity of the federalism that allows the individual states to offer more personal protections, but not fewer, than those afforded in the principal document—the United States Constitution—and by its principal interpreter and implementer—the United States Supreme Court.

The dualism can sometimes create cumbersome inefficiencies and unwelcome procedural variety but, on the whole, we as individuals in this society are well-served by the extra protections.

Thus, it seems to me, our North Star for finding some understanding in the vast cosmos of darkness and uncertainty surrounding *in extremis* health and medical decisions must always be that constellation of personal rights rooted in our common human nature and heritage. After all, we may have come of age scientifically and medically in extraordinary advances and even in deep space probes; but humanistically we seem to retain the innocence of infancy. That is not bad, as one of my adult children often reminds me; as we age, it is good to be childlike while avoiding being childish.

As physicians and highly specialized medical providers, you are beset and sometimes befuddled by profound ethical quandaries in your dedication principally to caring for patients, to making them well, to preserving life, to curing disease and to relieving pain. You rightfully resist and resent inappropriate intrusion and officious intermeddling with the exercise of your independent medical judgment and expertise. You understandably cringe at untoward professional, bureaucratic, regulatory, and even criminal consequences and civil liability for your well-motivated care decisions. You are sometimes caught between the Scylla of honoring a patient's or surrogate's treatment or nontreatment decision, and the Charybdis of having to resist some of those same choices. You find out very quickly in this "boisterous" and boiling caldron that there are few absolutes.

This, of course, does not mean that any of us should reject scientific, theological, or moral absolutes to the extent they can be epistemologically understood with assurance anyway. But that is not our competence or our subject today. Our humanistic experience with application of norms and precepts throughout history by error-prone humans, no matter how smart and how well-trained, helps us to appreciate the unreliability and unknowability of absolutes. That does not mean, on the

other hand, that we abandon or merely only pretend to apply as best and as ideally as we can our deeply rooted principles and values. I by no means advocate an oscillating situation ethics morality by acknowledging the experiential realism that we lack the ability to know perfectly and to act perfectly.

Historian Arthur Schlesinger, Jr., recently wrote a marvelous essay in the *New York Times* Sunday Book Review entitled *The Opening of the American Mind*, in which he summarizes so much more trenchantly what I have just tried to express: "The revival of absolutism in the twentieth century has brought with it the revival of monstrous violations of human rights;" whereas "our relative values are not matters of whim and happenstance," but are "anchored in our national experience."[4]

Perhaps, we may then agree that the patient's decisions, while presumptively supreme, can clash in certain instances with a transcendent societal policy preference, e.g., against suicide or euthanasia. Once again, with your indulgence, I harken to the inspiration of my illustrious and most renowned predecessor in office, Judge Cardozo, in the very same magnificent address to the Academy of Medicine, with which I opened my remarks and which I commend to your reading in full:

> Every now and then there crops up in popular journals a discussion of the problem of euthanasia. The query is propounded whether the privilege should be accorded to a physician of putting a patient painlessly out of the world when there is incurable disease, agonizing suffering, and a request by the sufferer for merciful release. No such privilege is known to our law, which shrinks from any abbreviation of the span of life, shaping its policy in that regard partly under the dominance of the precepts of religion and partly in the fear of error or abuse. Just as a life may not be shortened, so its value must be held as equal to that of any other, the mightiest or the lowliest. The mother will have the preference over an infant yet unborn, but from the moment of birth onward, humankind, as the law views it, is a society of equals. I am sure that thoughts of this order must rise sometimes to your minds when you move along the wards of hospitals and see the forms of men and women—the ugly and the beautiful, the wise and the foolish, the young and the old, the gay and the wretched—outstretched before you in the great democracy of suffering.[5]

I sense a tendency in many quarters and many cases that would embrace or tolerate euthanasia or significant steps towards euthanasia with the state's participation and enforcement. Such an act, it seems to me, as it seemed to Judge Cardozo decades ago, directly compromises the fundamental value in humanity's entire history—life itself. The legal and medical professions' dedication to the protection and preservation of that unique individual right seems diametrically contradicted by the promotion and official countenancing of suicide or euthanasia and especially of a state role in those acts. It would constitute the ultimate debasement of our respective missions as human service professionals and of the government's *parens patriae* protective role of people's holistic existence and rights. To me, it would constitute a leap off a precipice, not merely a misstep on a slippery slope.

May I presume to draw your attention to a guidepost in your universe. You start, of course, with your transcendent Hippocratic oath. In particular, your professional judgments are also influ-

enced by ethical guidelines like Opinion 2.18 of the Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association, adopted in 1986, which reads in pertinent part: "Even if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life-prolonging medical treatment. Life-prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition, or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained."[6]

You might likely wish that abiding by the credos within your own orbit would insulate you from error and from the probings and second-guessings and Tuesday morning quarterbacking of all others. Sorry, no, for the fact is that the legal profession and the judicial participants and decisionmakers in this complex multiplayer solar system are centrifugally pulled into the vortex of these disputes by the other direct participants. Our profession is not a group of self-starters or freewheeling interlopers roaming the countryside as "knights-errant" searching for causes to fulfill their sense of right and good.[7] Some years ago, columnist and author Russell Baker observed that in our increasingly litigious society, people are choosing the courts, not as a last resort, but as forums of first resort. Unfortunately, we must deal with that social phenomenon. We cannot declare bankruptcy or wish the cases away, ordering them like King Canute foolishly directing the tide to go out and stay out. We must decide the cases that are brought to us—period.

Yet, I candidly emphasize how ill-equipped courts generally are to make some of the emergency judgment calls of mind-boggling complexity, certainly from the medical-scientific standpoint. Even when we decide a particular case on specific evidence, we cannot pretend to the competence or basis for declaring a universal rule for many varied situations, as the legislature can do in holding hearings from all interested quarters.[8]

Traditionally and jurisprudentially, courts are also loathe to adopt scientific and medical technology and results until testing provides virtually certain reliability. Their adversarial and evidentiary nature are also not well suited to that end. We are bound to seek the correct, narrow, fair result; not the broad, big truth. We are often very deliberate and deliberative—some say too much so—before moving in these foreign territories because we are not experimenters or experiential labs by institutional nature. We are not on the cusp of the advances you may more quickly embrace for your work—based upon your scientific testings and approach to matters. One only has to illustrate by reference to the respective professional communities working with and leaping to successes with respect to DNA, hypnosis, and one

would hope soon with AIDS, too, and many, many other more esoteric scientific and medical leaps, and then compare how these matters are cautiously turned over and over before acceptance within the courts.[9]

Having framed some concerns and having barely suggested how some of these cases march or are dragged into lawyers' offices and courthouses, permit me to be a bit chauvinistic in selecting several New York case illustrations, some of which many of you are somewhat familiar with, to dramatize who make up the casts of characters in some cases and why these cases symbolically and tragically find expression in judicial opinions at courthouses instead of in final, gentle, and personal farewells at home, hospice, or hospital.

The Brother Fox case, technically *Matter of Eichner v. Dillon*,[10] involved an 83-year-old member of a Roman Catholic order of religious friars. Brother Fox was placed on a respirator after lapsing into a coma during hernia surgery. When it was determined he had no reasonable chance of recovery, Father Eichner, the director of the religious order, asked the hospital to remove the respirator. The hospital refused to do so without court authorization, so Father Eichner sought to be appointed guardian with authority to direct removal of the respirator. Father Eichner based his authority and decision on repeated conversations he had had with Brother Fox regarding the *Karen Ann Quinlan* case in which Brother Fox had expressed his wish not to be kept alive by a respirator if there was no hope of recovery. The opposition party in the court proceeding was none other than the local district attorney, who called medical experts to testify that Brother Fox's condition could improve. The trial court granted the application, and the district attorney persisted in his resistance with an appeal. Brother Fox died, while still on the respirator. The two appellate courts made an exception to the mootness doctrine,[11] which generally has us forebear and eschew rendering a decision and opinion when the decree will have no practical consequence. The exception resulted in a ruling favoring Father Eichner's authority to have ordered the removal of the respirator.

Matter of Storar,[12] a case decided as a companion case to *Matter of Eichner*, was significantly different in kind and in result. John Storar was a 52-year-old profoundly retarded adult with a mental age of 18 months, who had been institutionalized since age five. He was diagnosed terminally ill with a bladder cancer. The physicians at the State Developmental Center sought the patient's mother's permission to administer blood transfusions to counteract severe blood loss. After initially agreeing to the transfusions, Mrs. Storar asked that the transfusions be discontinued. The director of the state institution sought judicial authorization to continue the transfusions, and Mrs. Storar cross-petitioned for an order prohibiting the transfusions. Again, the local district attorney was a named party. The lower courts denied the Center's application, but the New York State Court of Appeals reversed and ruled in favor of continued trans-

fusion treatment since John Storar never had the capacity to express his preference regarding continuation or cessation of life-sustaining treatment.

More recently, a year ago, the Court of Appeals had a case involving a 77-year-old stroke victim who, although conscious and not terminally ill from any diagnosed disease, required artificial nutrition and hydration.[13] Her daughters objected to the treating physician's request to insert a nasogastric tube. The hospital's Ethics Committee concluded it would be inappropriate to withhold nutrition and hydration so the hospital sought court authorization to insert the tube. The lower courts denied the hospital's petition and directed cessation of the temporary intravenous feeding; but the Court of Appeals, by divided vote, reversed, citing the lack of "clear and convincing evidence" that the patient had adequately expressed her wishes to decline artificial nutrition and hydration under these circumstances.

One of the most unusual side features of that case was a telephone call I received at my home on a Friday night at about 10:30 asking me to authorize, under the interpretation of our Court's interim stay,—a status quo injunction while we decided the appeal itself—the introduction and administration of some antibiotics through the patient's I.V. for an escalating fever and possible pneumonia. It seemed that the attending physician, the daughters and the lawyers got into a collateral dispute about this and, lo and behold, this spin-off was smack back in "court" with respect to a seemingly ministerial and purely medical call. So, I caution against wringing hands too dry on how these matters get into court. It seems, unfortunately, as simple as reaching out and touching.

Another startling and fairly recent case involved a young comatose accident victim from Long Island who was 17 weeks pregnant.[14] Her husband, with the approval of her parents, petitioned the court to be appointed temporary guardian for purposes of authorizing the hospital "to interrupt the pregnancy and to perform such medical and diagnostic procedures as may be necessary to preserve her life." The husband named the attorney general, the district attorney, and the hospital as parties. Suddenly, two strangers, with no known relationship whatever, petitioned the court for their appointment as guardians, one as legal guardian of the fetus and the other as guardian of the patient. The public official parties essentially stepped aside. Every level of our state court system rejected all relief and participation by the strangers and returned the matter and the decisions to the privacy of the family and their providers and counsellors.

Once controversies of this kind and their myriad counterparts and permutations in other states hit the skids of what I will call Litigation Alley, they will almost invariably require a judicial resolution. A whole whirlwind of semantical labels, categories, and concepts then also fly into action. Here is where medicine and law merge or clash in a form of fusion. The problem is that less energy and light are produced from that physical phenomenon, metaphorically ap-

plied to us. Much heat is generated, to be sure; and I sense from my own direct experiences, observations, and readings that much debris and even some long-lasting damage accrues as well. It seems to me that the common good is not advanced one step when snared in the semantical traps of cataloguing the competing interests as, e.g., right to life, or right to die, or right to refuse medical treatment, or right to a natural death, or right to a dignified death, or right to a judicial declaration of death, or entitlement to death, etc., etc., etc. These sample titles and almost all of their words are loaded with biases, predispositional winks and nods, and result orientations. However, perception wins every time over reality in this business; and "right to die" it is, according to the media drumbeat. Recently, the Conference of Chief Justices of all the states created a task force to study this subject and issue what we hope will be an important contributing study in about a year. Its title? "*Right to Die*," until my chief judge, Sol Wachtler, vice chair of that task force, objected and got the title changed to *Coordinating Council on Life-Sustaining Decisionmaking by the Courts.*

So, what do I propose in the place of all the labels? We must struggle to shed the "spin doctoring" implicit in the use of these words and phrases, to try instead to embrace with analysis and sensitivity the root respect and knowledge which allows anyone else or any institution or government—however expert, professional, or powerful—to so profoundly dare to affect the life, values, and interests of another human being.

The refusal or cessation of *in extremis* medical treatment is elementally premised on the patient's most personal right to self-determination, which in some states is grounded in a common law or decisional law right, not on more sweeping constitutional grounds.

As early as 1891, the Supreme Court of the United States recognized that competent adults have the right to make their own health care decisions. "No right is held more sacred, or is more carefully guarded, *by the common law*, than the right of every individual to the possession and control of his own person free from all restraint or interference of others, unless by clear and unquestionable authority of law."[15] Indeed, unconsented-to medical treatment is cognizable in damages as an intentional tortious act. Again, the great Judge Cardozo helped us in opinion language this time: "Every human being of adult years and sound mind has the right to determine what shall be done with his own body, and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages".[16]

More recently, some state and lower federal courts have begun to apply the penumbral constitutional right to privacy as a source of authority supporting a patient's or even a surrogate's decision to refuse or terminate certain kinds of medical treatment in certain situations.[17] Both the common law and constitutional invocations function well and fairly when the patient is competent to exercise and communicate the treatment or nontreatment decision. But a problem of Sequoian dimensions rises up when courts try to apply either doc-

trine with respect to the suddenly incompetent patient. If the right is so personal, one may legitimately ask: How can someone else, transported in time, accomplish that quintessentially unique choice on behalf of another, and to whose satisfaction and on what evidentiary basis and burden level?

Many courts employ the "substituted judgment" doctrine allowing a proxy to declare the choice of what the patient would have decided. The seminal and nationally known substituted judgment case is the *Karen Ann Quinlan* case, where the New Jersey Supreme Court allowed a parent to exercise a choice where the then-incompetent patient had never expressed any treatment preference. The court allowed Karen's father to "substitute" his judgment based on his unique relationship with Karen, and his insight in knowing what she would want done, and his judgment as to what most reasonable people in her condition would want. "The only practical way to prevent destruction of the right [Karen's] is to permit the guardian and family of Karen to render their best judgment, . . . as to whether she would exercise it in these circumstances."[18]

The Massachusetts Supreme Court allowed substituted judgment where the patient was *never* competent to express a treatment preference. *Superintendent of Belchertown State School v. Saikewicz*[19] involved a 67-year-old mentally retarded man who was suffering from terminal leukemia. The patient's guardian petitioned the court for authorization to terminate the chemotherapy initiated by the doctors at the state institution, claiming that the treatment was painful and caused adverse side effects. There was, of course, no evidence of the patient's preference since he had always been legally incompetent. The court allowed the chemotherapy treatment to be discontinued, citing the limited benefits expected from treatment and the patient's inability to cooperate with or understand the painful treatment. In reaching this conclusion, the court added this ingredient to the standard of decision:

> In short, 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.[20]

Sounds easier than it is to apply. But the quote underscores one of the practical and metaphysical problems inherent in the "substituted judgment" approach. We have to honestly face up to the use of pretense or legal fiction or call it what you will. The premise or starting point is one of the most personal rights known to us and our form of government, yet it is transformed and transferred into someone else's best guess as to what is good for the right-possessing patient. And the choice is then governmentally enforced by state action court decree. This is very hard stuff because, as our Chief Judge Sol Wachtler grimly commented, this may well be referred to as "the last right."

After all, we don't allow similarly significant personal rights to be invoked or exercised by others; e.g., you do not see anyone but "the person" taking the Fifth Amendment, not even the lawyer does

this for the client. Even ordinary fiduciaries have to act with the strictest faithfulness, measured against the toughest standards. The fiduciary's precept is "the duty of the finest loyalty" that is "undivided and unselfish," "something stricter than the morals of the market place." The standard is "unbending and inveterate" of "uncompromising rigidity" designed to keep the level of conduct "higher than that trodden by the crowd."[21] And that language is from a business case involving mere money and property, decided, by the way, by a 4–3 vote. We cannot tolerate lesser standards of conduct and proof when someone else's life hangs in the balance.

New York has specifically rejected the substituted judgment approach, but not unanimously and not without some critical commentary. New York courts also require clear and convincing proof of prior expressions and choices made while the patient was competent, which must be referable to the medical situation presented. These, too, are tough matters. The New York experience has found expression in three major cases at the highest court level: *Matter of Eichner*, *Matter of Storar*, and *Matter of O'Connor*—all coincidentally authored by our present, remarkable chief judge, Sol Wachtler. The most recent of the three, *Matter of O'Connor*, underscores the kind of proof required to satisfy the "clear and convincing" standard.

> This is a demanding standard, the most rigorous burden of proof in civil cases. It is appropriate here because if an error occurs, it should be made on the side of life.
>
> Viewed in that light, the "clear and convincing" evidence standard requires proof sufficient to persuade the trier of fact that the patient held a firm and settled commitment to the termination of life supports under the circumstances like those presented. As a threshold matter, the trier of fact must be convinced, as far as is humanly possible, that the strength of the individual's beliefs and the durability of the individual's commitment to those beliefs (*see, Matter of Eichner, supra*, at 380) makes a recent change of heart unlikely. The persistence of the individual's statements, the seriousness with which those statements were made and the inferences, if any, that may be drawn from the surrounding circumstances are among the facts which should be considered.[22]

While the court recognized certain inherent problems with meeting the standard, the majority expressed its fundamental dissatisfaction with the substituted judgment doctrine in these words:

> That approach remains unacceptable because it is inconsistent with our fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another (*People v. Eulo*, [63 NY2d 341], at 357). Consequently, we adhere to the view that, despite its pitfalls and inevitable uncertainties, the inquiry must always be narrowed to the patient's expressed intent, with every effort made to minimize the opportunity for error.[23]

Some critics also argue that the New York "clear and convincing" evidence standard is too difficult to meet. But if that standard is required to protect incompetents against undue involuntary civil commitment,[24] can a lesser standard be justified to protect against a perhaps erroneously inflicted certain death? After all, we enforce rigorously the rules governing decedents' affairs and the execution and expressions of their wills, dead men's evidentiary preclusions and the like. How anomalous it would be to do less with respect to the state's overrid-

ing interest and responsibility in protecting lives of people, especially those incapable of protecting, aiding, or asserting their own present interests. We are, at bottom, dealing in these decisions with certain death, which is different. It is a transformation from which there is no return should there be a mistake, or change of mind, or change of circumstances.

The mistaken exercise of that last right under a lesser standard would be oxymoronic. Besides, even under the criticized high tough standard, mistakes manifest themselves. New York State was startled by one, unexpectedly soon after the first application of the *O'Connor* holding by a trial judge directing removal of a gastrotomy tube.[25] The patient, an 86-year-old Albany, New York, woman, suffered a stroke. When first admitted to the hospital, she was cognitive and communicative. She eventually lost her ability to eat and drink and a gastrotomy tube was inserted to provide nutrition and hydration. As her condition deteriorated, her older sister petitioned the court for appointment as committee of the person and property with authority to remove the gastrotomy tube. The hospital and the patient's treating physician opposed the application. Medical testimony established that while not comatose, she was in an "irreversible persistent vegetative state." In addition to the medical testimony, the sister testified that if the patient were able, "she would say I led a happy life, a good life, and I want to be released from all this and go home to my Maker."[26] Based on this and other testimony, the court concluded that there was compelling proof that the patient "had made a firm and settled commitment, while competent, based on deep-seated thought and moral conviction and not upon immediate and fleeting reactions to unsettling experiences—to decline the medical procedures at issue, under her present medical circumstances."[27] The court ordered the patient transferred to a hospital which would remove the tube and, if none could be found, the hospital she was in would have to remove the tube. Before the decree or the patient could be carried out, the blood clot apparently moved or dissolved, and the patient became alert and communicative and was asked whether she wanted the tube removed. It was explained to her by a nurse that if the feeding tube remained, she could probably live a few more years; without it, she would die in less than two weeks—most likely, very painfully. According to local newspaper accounts, she at first drew back from the question, eventually responding: "That's a very difficult decision to make." When asked again, she said, "I never really thought of it in quite that way."[28] The judge recalled his decree and the medical expert who had given the critically relied upon testimony spoke of the uncertainty of it all.

I know of no court which has directed, at the request of someone other than the affected person, cessation of nutrition and hydration (food and water, the most elemental human needs along with oxygen) for a *conscious, sensate, nonterminally ill* human being.[29] Yet, the proposition that cessation of artificially pro-

vided food and water is, under some exceptional circumstances, an acceptable nontreatment, in cases of vegetative, comatose, or neocortically dead, *and* terminally ill and dying persons who had clearly expressed their views as to such exceptional circumstances by provable clear and convincing evidence, may be legally and even morally supportable. But even then, it seems to me, the relief should be framed in the alternative, allowing the family the freedom to carry out the person's wishes and allowing the state and the medical professionals to refrain from becoming active participants in an active ritual of death.

The Missouri Supreme Court, in the case rising to the highest visibility and on everyone's mind for this term of the United States Supreme Court, rejected the legal analysis used by many state courts to support the right to terminate life-sustaining treatment. The *Cruzan*[30] case involves a 30-year-old woman who, as the result of a car accident, has been in a persistent vegetative state for the past five years. Shortly after the accident, the patient lost her gag reflex and a feeding tube was inserted to assist in providing food and water. Her respiration and circulation are not artificially maintained and she is not terminally ill. Her parents sought a judicial authorization to order the tube removed. The Missouri Supreme Court, 4–3 (so many of these cases are sharply divided in result and in the level of rhetoric employed), reversing the lower court, held that the patient's guardian did not have the authority to order the withdrawal of hydration and nutrition. In so holding, the court specifically rejected the notion that the common law right of self-determination was applicable. The court noted that the common law right to refuse treatment is implicated when medical procedures are performed without the patient's informed consent or refusal. The court reasoned that there could be no "informed" refusal based on a patient's statements made while healthy and where the consequences of the decision could not be fully understood. "[I]t is definitionally impossible for a person to make an informed decision—either to consent or to refuse—under hypothetical circumstances [because] neither the benefits nor the risks of treatment can be properly weighed or fully appreciated."[31]

Also rejected was the concept that the right to privacy under the federal constitution or Missouri state constitution extends to permit a patient or guardian to direct withdrawal of food and water. The court likewise dismissed as "logically inconsistent" the substituted judgment doctrine in cases where it is tied to the right of privacy or the common law right to refuse treatment. "[T]hese rights have been explained as rooted in personal autonomy and self-determination. Autonomy means self-law—the ability to decide an issue without reference to responsibility to any other. It is logically inconsistent to claim that rights which are found lurking in the shadow of the Bill of Rights and which spring from concerns for personal autonomy can be exercised by another absent the most rigid of formalities."[32] To say *Cruzan* is controversial and evokes deep passions is the height of understatement.

While the case is the first in its cate-

gory ever chosen by the Supreme Court for review, the opportunity to resolve the multitude of questions which remain unanswered or inadequately answered under the current state of the law may still elude the high court. It is highly doubtful that we will get a North Star guiding principle out of the likely plurality set of opinions customary to that court. Besides, even that great institution, the United States Supreme Court, is not immune from the fallibility of the human condition. It is a human institution, and as its own great Justice Jackson observed of the Supreme Court: "We are not final because we are infallible, but we are infallible only because we are final."[33] Tragic historical decisions reflecting fundamental misunderstandings and mistakes about the true nature and scope of the judicial process affecting real people are all too numerous (*see, e.g., Plessy v. Ferguson*[34] [upholding separate but equal educational systems]; *Dred Scott v. Sandford*[35] [holding that black slaves were property, not persons]). Such decisions prove that preserving the most cherished rights and values of free individuals requires vigilance almost every waking moment and a willingness to confess and correct error, too, as in *Brown v. Bd. of Education*,[36] which overruled *Plessy*. This philosophy found a magnificent expression in Justice Jackson's dissent in another ignominious blot on our constitutional history—the interment of Japanese-Americans during World War II authorized in *Korematsu v. United States*: "A military commander may overstep the bounds of constitutionality, and it is an incident. But if we review and approve, that passing incident becomes the doctrine of the Constitution. There it has a generative power of its own, and all that it creates will be in its own image."[37] The instruction there concerning fallibility and *stare decisis* or adherence to precedent provides a very valuable lesson in jurisprudence. So let us not expect too much from *Cruzan*, but what we do get will nevertheless be momentous.

At this point, I believe a brief, somewhat digressive reference to another category of case and problem may serve a useful point. Consider *Rivers v. Katz*,[38] where lawsuits were initiated on behalf of three involuntary patients of a state psychiatric facility who had been medicated with antipsychotic drugs against their wishes. All three sued to enjoin the nonconsensual administration of drugs and for a declaration of their common law and constitutional right to refuse treatment. The patients were denied relief by the lower courts, but the New York State Court of Appeals reversed and declared that a patient, including one suffering from mental illness, has a constitutional right to refuse medical treatment under New York's state constitution as long as the patient has the capacity to make a reasoned decision with respect to the proposed treatment. A hearing procedure, not without its critics, too, was installed.

Our decision in that case stands in sharp relief to a case now winding its way through the federal courts, again in Missouri, the seeming center of all high profile litigation in this country right now (e.g., *Webster, Cruzan, Charters*[39]).

The United States Supreme Court will shortly decide whether to hear a case from the Fourth Circuit Court of Appeals sitting en banc, which held that it was not a violation of federal due process to medicate an involuntary psychiatric patient against his will and without a judicial determination that the patient is incompetent to make the treatment decision. The case, *U.S. v. Charters*,[40] incidentally pits the American Psychological Association, which filed an amicus brief supporting the patients' right to refuse treatment, against the American Psychiatric Association, which also appeared as amicus supporting the government's position to medicate without consent. We are in a fascinating and fast moving world—friends of court are not what they used to be, but appear to be full partisans.

As we wind down, a word of balance is necessary to illustrate that courts are not the only institutions grappling with these issues. Legislatures across the country have also been called to act and have responded by adopting statutory guidelines in the hope of keeping people and these issues out of courts. These legislative responses have taken the form of living will statutes, health care proxy legislation, and *Do Not Resuscitate* guidelines. Thirty-eight states currently have living will statutes.[41] New York is one of the 12 states that has failed to enact a living will statute, although legislation has been introduced since 1977.[42] Have living will statutes provided any guidance to families, the medical profession, or the courts? Of course,—some—but we are deluding ourselves to think the adoption of a statute would solve such a complex issue in a plenary fashion. For example, a majority of the statutes authorize withdrawal of treatment *only* from patients who are *terminal*, and most do not include instructions on artificial nutrition and hydration.[43] Since a great deal of recent case law has been generated where the patient is nonterminal and where the "treatment" involved was artificial nutrition and hydration, you can be sure the adoption of living will statutes will not end the controversy or the litigation. Indeed, Missouri has one and its efficaciousness was controverted by the majority and dissents in *Cruzan* itself.[44]

Sixteen states have adopted health care proxy statutes,[45] which allow an individual to appoint an agent to make health care decisions on behalf of the principal. A health care proxy bill is before the New York Legislature,[46] although passage this year faltered just when it seemed assured by the acquiescence of a previous prime objector—the New York Catholic Conference.[47] However, the new majority leader of the state senate objected, and that ended legislative discussion and consideration for this year. Supporters of health care proxy legislation argue that the appointment of a proxy avoids the problem of trying to anticipate future medical circumstances and treatment choices. Agents are asked to make contemporaneous decisions, knowing the patient's prognosis and treatment alternatives and, one hopes, knowing the patient's treatment preferences. In addition to making treatment decisions, the proxy can be used

to authorize the agent to expend funds for medical treatment, to gain access to medical records, or to choose health care professionals. Of course, the health care proxy concept is not a panacea either. Disputes will still arise concerning the scope of the agent's authority, the events which either trigger or revoke the agent's authority, and whether the agent is acting in a manner consistent with the patient's best interest. Significant dangers lurk if these legislative efforts are viewed or used as panaceas.

Do Not Resuscitate statutes attempt to provide clear and comprehensive guidelines to allow physicians to indicate when further medical treatment would no longer be helpful to particular patients. In 1987, New York became one of the growing number of states to adopt legislation regulating the use of *Do Not Resuscitate* orders, and this has worked very well and with apparently little lingering controversy.[48]

While problems abound, how should we, the lawyers and judges, maintain our jurisprudential, and you, the doctors and psychiatrists, your medical equilibrium?

For myself in my judicial decision-making function, I must remain open to the facts and evidence of the particular case, to a respectful consideration of competing viewpoints in our pluralistic society and government, to fresh and improved understanding of the operative principles, and especially to subtle calibration and interplay of the jural roots of all we have been talking about, i.e., the United States and state constitutions, to public policy choices expressed in broad-based legislative enactments, and the common law decisional *stare decisis* (faithfulness to precedent and the built-up wisdom of those who struggled with cases and principles before ourselves, as defined by Governor Mario Cuomo at the press conference announcing my appointment to the Court of Appeals). A daunting task, if you don't mind my saying so, requiring hard thinking and, yes, even hard praying, since it is the ultimate decision of life or death we are putting to the risk of our feeble and sometimes fumbling human understanding in these cases.

As a law teacher for many years and as someone associated in a number of capacities with the courts of New York State for many years, where a kind of teaching role is ongoing and inherent, I have personally espoused a particular philosophy of the importance of every case, no matter how momentous or mundane. Behind each case, after all, there are individuals, real people, in turmoil, conflict, pain and need, who over small or minor disputes or over the most significant dispute of all—their lives—have turned to or been summoned or even dragged into the courts for respite and resolution—for better or worse. Every one of these persons is entitled to—indeed, each rightfully demands—respectful, careful deliberation; what I call the dignity of the case and of the person. They will respect us and our processes in proportion to the respect we give them.

So what specifically can we do together? Start with openness, tolerance and mutual respect for the other's problems and maintain a daily regimen of

ego deflation because of the reality of the fallibility of the human condition and, therefore, of all its human institutions. Practicing our humanistic professions will be enhanced by that special sensitivity. Specifically, and as overly simplistic as it may sound, I also propose that we respectively approach these matters, these decisions and these cases with a set of hierarchical rebuttable presumptions alone and often in appropriate combination, remembering we are operating solely within our competence in the secular sphere:

1. Respect for the personal self-determination choices of the individual.
2. Respect for those of the closest family or equivalent unit or person on behalf of that individual.
3. Respect for the contributing views and values of the treating medical professionals and associated care providers.
4. Respect for the state's interest and purpose in representing the individual in the context of society's universal values and commonly-held principles.

Finally, may I say that our respective disciplines grope like lumbering Cyclopes trying to serve the very same societal members but often seeing only out of our single eye. I maintain we will serve those people and ourselves better when the two Cyclopes join eyes, bumpy as that may be in many instances, to effect synergistically a cooperative vision and spirit towards the solutions and service we owe every person we touch. Together we can make energy and light and avoid the debris.

My hope and goal is that my Cyclopean legal-judicial eye and your Cyclopean psychiatric-medical eye have acquired some peripheral perspective from this enterprise together today. For better peripheral vision, even in one eye, is progress; and I would count it a successful adventure and exertion before your distinguished body if we each acquire five to ten degrees more range than when we started. Ideally, we can strive for a 360-degree wraparound so that, like Oliver Wendell Holmes in a splendid letter to Benjamin Nathan Cardozo defining success, we can sing in choral paraphrase: "Success is not the place, power, prominence, or prestige we attain; rather, success is the trembling hope of striving each day to live by and for our most cherished ideals and fundamental values."[49]

Acknowledgment

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References

1. Benjamin N. Cardozo, "What Medicine Can Do For Law," (Address before The New York Academy of Medicine, November 1, 1928) *Selected Writings of Benjamin Nathan Cardozo*, Margaret E. Hall (ed.), Matthew Bender and Co., New York, 1947, p 371
2. *Id.*, at 392
3. *see, e.g.*, *People v. Class*, 57 NY2d 431 (1986), on remand from *New York v. Class*, 475 US 106 (1986), *revg People v. Class*, 63 NY2d 491 (1984); *People v. P.J. Video*, 68 NY2d 296 (1986); *see also*, Kaye, *Dual Constitutions in Practice and Principle*, 66 St. John's L Rev 399 (1986–87); Wachtler, *Our Constitutions—Alive and Well*, 61 St. John's L Rev 381 (1986–87)
4. Arthur Schlesinger, Jr., "The Opening of the American Mind," *The New York Times*, July 23, 1989, Book Reviews, p 1
5. Cardozo, "What Medicine Can Do For Law," p 388
6. Opinion 2:18 of the Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association (1986)
7. Benjamin N. Cardozo, "The Nature of the

Judicial Process." *Selected Writings of Benjamin Nathan Cardozo*, Margaret E. Hall (ed.), Matthew Bender and Co., New York, 1947, p 164
8. *Matter of Storar*, 52 NY2d 363, 370, *cert denied* 454 US 858
9. *compare, People v Leyra*, 302 NY 353; *People v Hughes*, 59 NY2d 523 (admissibility of evidence obtained by hypnosis); *see also, People v Castro*, ___ Misc 2d ___, 1989 WL 10636
10. *Matter of Eichner v Dillon*, 52 NY2d 363
11. *Id.*, at 369-70; *see also, Matter of Hearst Corp. v Clyne*, 50 NY2d 707, 714–15
12. *Matter of Storar*, 52 NY2d 363
13. *Matter of Westchester County Medical Center (o/b/o O'Connor)*, 72 NY2d 517
14. *Matter of Klein*, 145 AD2d 145, *lv denied* 73 NY2d 705
15. *Union Pacific Railway Co. v. Bostford*, 141 US 250, 251
16. *Schloendorff v. Society of New York Hospital*, 211 NY 125, 129–130 (1914)
17. *see, e.g., Rasmussen By Mitchell v. Fleming*, 741 P2d 674 (Ariz. banc, 1987); *Brophy v. New England Sinai Hospital, Inc.*, 497 N.E.2d 626 (Mass., 1986); *Gray By Gray v. Romeo*, 697 F.Supp. 580 (Dist Ct, R.I., 1988)
18. *In re Quinlan*, 70 NJ 10, 41, 355 A.2d 647, 664, *cert. denied* 429 U.S. 992 (1976)
19. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 NE2d 417 (1977)
20. *Id.*, at 752–53, 370 NE2d, at 431
21. *Meinhard v. Salmon*, 249 NY 458, 464
22. *Matter of Westchester County Medical Center (o/b/o O'Connor)*, 72 NY2d 517, *supra*, at 531
23. *Id.*, at 531
24. *Addington v. Texas*, 441 US 418, 424
25. *Matter of Gannon, et al. v. Albany Memorial Hospital, et al.*, N.O.R. Supreme Court, Albany County (RJI #0189-017460) (April 3, 1989)
26. *Id.*, slip opn., at 38
27. *Id.*, at 19
28. Carol DeMare, "'Hopeless' Hospital Patient, 86, Comes Out of Coma," *Albany Times Union*, April 12, 1989, p A-1
29. The New York State Task Force on Life and The Law, *Life-Sustaining Treatment: Making Decisions and Appointing a Health Care Agent*, July, 1987, pp 36–40
30. *Cruzan v Harmon*, 760 SW 2d 408 (1988), *cert granted* 109 S Ct 3240, 106 L.Ed. 2d 587 (July 3, 1989) (No. A88-1503) (To be argued 12-6-89)
31. *Id.*, at 417
32. *Id.*, at 425
33. *Brown v Allen*, 344 US 443 (Jackson, J., concurring), at 540) (1953)
34. *Plessy v Ferguson*, 163 US 537, 552 (1986)
35. *Dred Scott v Sandford*, 60 US 393 (1856)
36. *Brown v Board of Education*, 347 US 483 (1953)
37. *Korematsu v United States*, 323 US 214, at 246 (Jackson, J., dissenting) (1944)
38. *Rivers v Katz*, 67 NY2d 485
39. *see, e.g., Webster v Reproductive Health Services*, 109 S Ct 3040; 106 L.Ed. 2d 410, 57 USLW 5023; *Cruzan v Harmon*, 760 SW2d 408, *supra*; *US v Charters*, 863 F2d 302 (4th Cir, 1988), *on rehearing from* 829 F2d 479 (4th Cir, 1987), petition for cert. filed (Feb. 6, 1988) (No. 88-6525)
40. *US v. Charters, id.*
41. Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming
42. Assembly Bill 2383 (M of A Hevesi, 1977), two living will proposals were introduced during the 1989 Legislative session: Senate Bill 2906 (Senator Goodhue) and Assembly Bill 4240 (M of A Koppell)
43. New York State Task Force on Life and The Law, *Life-sustaining Treatment: Making Decisions and Appointing a Health Care Agent*, July, 1987, pp 36–40
44. *Cruzan*, at 419-420; *see also*, Welliver, J., dissenting at 441–442
45. Arkansas, California, Colorado, Delaware, Florida, Idaho, Iowa, Louisiana, Nevada, North Carolina, Pennsylvania, Rhode Island, Texas, Utah, Virginia, Wyoming
46. Assembly Bill 7459 (M of A Gottfried)
47. Phil Gutis, "Patient Proxy for Treatment Gains Backing—Catholic Group Drops Fight Over Life Support," *New York Times*, May 30, 1989
48. Public Health Law Art. 29-b added by L. 1987, ch 818
49. Benjamin H. Cardozo, "Essay on Mr. Justice Holmes," (reprinted from the Harvard Law Review, 44:682-92 [1931]) *Selected Writings of Benjamin Nathan Cardozo*, Margaret E. Hall (ed.), Matthew Bender and Co., New York, 1947, p 86