

Nancy Cruzan and the Best Interest Standard

by Robert M. Veatch

A tragic thing happened on the way to an emerging moral and legal consensus regarding the care of terminally and critically ill patients in this country. After twenty years of battle by heroic patients and their surrogates, we had reached a virtually unanimous social agreement about the moral and public policy issues regarding decisions pertaining to forgoing medical treatment. Now the Missouri Supreme Court has ruled that the state's unqualified interest in life overrides a decision made with good will that treatment should stop for a permanently vegetative patient, one who in all likelihood held strong views opposed to the care she was receiving.¹ The United States Supreme Court has upheld the right of a state to make that decision.²

A careful reading of the *Cruzan* opinion suggests that the alarm expressed by some critics may have been overstated, but it at least creates a new agenda for those committed to providing humane and respectful care for critically ill patients.

The Pre-Cruzan Consensus

We can best understand the impact of the decision by comparing where we stand today with what can be called the pre-Cruzan consensus. Prior to the Cruzan decisions, there was emerging widespread agreement on almost all of the key issues. The consensus was supported by the American Medical Association,³ the Catholic Church,⁴ the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research,⁵ almost all court decisions, and most philosophers and theologians. That consensus can be stated in a few simple propositions:

- (1) Treatment is morally and legally expendable when the benefits are judged not to exceed the burdens (the proportionality test).
- (2) Judgments of benefits and burdens are always subjective. They cannot be determined by medical science.
- (3) All medical interventions, re-

gardless of how routine, may be expendable based on the proportionality test. This includes nutrition, hydration, antibiotics, CPR, and even routine nursing care.

- (4) Since these are necessarily subjective judgments, the competent patient has the right to be the judge of his or her own care whenever possible.
- (5) If while competent the patient has designated a surrogate, that surrogate should decide based on a substituted judgment; that is, based on the patient's own expressed values.
- (6) If no surrogate has been designated, the nearest kin decides based on: (a) substituted judgment, if possible; (b) the patient's best interest if the patient's wishes are not known.
- (7) The state's only role when the welfare of other parties is not at stake is to protect an incompetent patient from surrogate decisions that are beyond reason and to provide a decision making mechanism for patients who have no qualified surrogate available.
- (8) In overriding a patient (because the welfare of others is at stake) or overriding a surrogate (because their substituted judgment or judgment of best interest is beyond reason) the burden of proof is on the state.

This, in simple form, summarizes the past twenty years of philosophical, theological, and legal debate.⁶ No competent patient has ever been forced by a court of law to undergo medical treatment against his or her will when the treatment is offered for the patient's own good. Surrogates have been overridden only when their judgments were highly implausible. Until *Cruzan* this included decisions involving medically supplied nutrition and hydration. The only previous exception was the New York case of Mary O'Connor, where the court based its decision on the (somewhat dubious) claim that it could not determine Ms. O'Connor's wishes about being fed.

Death After Cruzan

After the United States Supreme Court decision in *Cruzan*, almost all of

the pre-Cruzan consensus survives. In fact, parts of it are more firmly established than ever before. There are two important specific aspects of the decision that support the consensus, while three areas could give one concern. Let us examine the impacts supporting the consensus first.

A. Developments Supporting the Consensus

Competent Patients' Right of Refusal

The boldest and most encouraging element of the Supreme Court opinion for defenders of the consensus is the Court plurality's explicitly stated view that the Constitution provides competent patients with the right to refuse medical treatment. Never before had the federal courts spoken on this basic right. For years state courts have unanimously affirmed this right, but now the highest federal court is stating that the right of refusal is constitutionally protected. No state, even one claiming an unqualified interest in life, can now deny a competent patient the right to say no.

This is particularly important in light of the wording of the Missouri Supreme Court's opinion in *Cruzan*. Its decision was grounded in the state's unqualified interest in life.⁸ Although this reasoning was applied to a patient who would never again be competent, the logic of an unqualified interest in life would seem to support compulsory life-prolonging treatment of competent patients as well.

Nothing Unique about Nutrition and Hydration

The second encouraging feature of the Supreme Court opinion is that the Court explicitly affirmed there is nothing legally unique about withholding nutrition and hydration. Many clinicians and theorists have speculated over whether there is something unique with these treatments. Admittedly, it is uncomfortably strange to imagine cases where something as routine and basic as nourishment and fluid could offer no benefits that exceed the burdens. The instincts that make us uncomfortable when these are withheld from living human beings are well placed. Nevertheless, the view that simply because something is routine or basic it should

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be morally required, even when its burdens exceed (or at least offset) its benefits, seems bizarre.

Some scholars, such as Gilbert Meilaender, have argued that nutrition and hydration are always morally required simply because they are basic, nonmedical interventions.⁹ Aside from the pointless controversy over whether they really are medical, that position seems to commit one to the strange notion that excessively burdensome or useless medical treatments are morally expendable whereas equally burdensome or useless nonmedical interventions are morally necessary.

The Supreme Court did not buy the distinction. It explicitly affirmed that the same moral and legal logic applies to nutrition and hydration as to any other intervention. It is the relation of the benefit to the burden, not the nature of the technology, that is decisive.

B. Potential Threats to the Consensus

While the Supreme Court clearly supported the consensus I have described regarding competent patients, even when those patients refuse nutrition and hydration, some areas were left less clear by the Court's opinion. Some of these concerns are more significant than others, but all, I suspect, will become a major project between now and the end of the century for those committed to protecting the rights and welfare of terminally and critically ill patients.

Clear and Convincing Evidence

First, the Court let stand the position taken by Missouri that, in order for a surrogate to forgo treatment based on a patient's own wishes, the evidence of those wishes has to be clear and convincing. This is the same standard required in New York. Many "liberals" on these issues have been angry with the Supreme Court for allowing Missouri to apply this rigorous standard. It means that in cases like Nancy Cruzan's, where there was substantial evidence of her wishes, but arguably not clear and convincing evidence, treatment could not be forgone.

I am not terribly distressed by the Supreme Court's position. All it said was that a state has the right to impose the clear and convincing evidence standard without violating the federal Constitution. In fact, it would take a very aggressive reading of the Constitution to find in it a prohibition on a state's use of this standard. Almost no other states are in accord with Missouri

here.

I believe Missouri's standard is not unreasonable. After all, a decision is at stake in which a person will die soon if treatment is forgone. The treatment is life-prolonging. If I were such a patient, I would want those acting as my surrogates to be quite sure that my wishes or values excluded the proposed life-prolonging intervention before they decided to forgo it. Clear and convincing evidence seems right to me, if someone is to forgo life-prolonging treatment on the grounds of the patient's beliefs and values.

The most encouraging piece of the *Cruzan* opinion is the view that the Constitution provides competent patients with the right to refuse medical treatment.

The Fate of Those Whose Wishes are Not Clear

Here, however, is the catch. The most threatening element of the Missouri decision left intact by the Supreme Court is the approach to what should happen in cases where evidence of the patient's desire to forgo life-sustaining treatment is not clear and convincing. Missouri apparently makes the assumption that if treatment cannot be forgone on the basis of the patient's clearly expressed wishes, there are no other possible grounds for doing so. Missouri apparently presumes that all conceivable life-prolonging treatment may be required for patients who have not left clear and convincing evidence of wishes to the contrary.

Yet how preposterous to assume that in all such cases all possible treatments that could possibly preserve life are required. The pre-Cruzan consensus, supported by many courts and commentators, holds that in cases in which the patient's own values are not determinative, then we can only do the next best thing: we attempt to decide on the basis of what is believed to be in the best interest of the patient. What else can one do?

Apparently, unless Missouri rejects the best interest standard for settling these cases, it must believe that every possible treatment is in the best interest of incompetent patients whose wishes expressed while competent cannot be ascertained. New York seems to take a

similar position not only in *O'Connor*, but also in the earlier *Storar* case involving a mentally retarded man dying of cancer whose mother believed that the repeated blood transfusions necessary to prolong his life were not in his interest.¹⁰

This is an extremely serious problem. It is not limited to the approximately ten thousand persistently vegetative patients in the United States. It also raises troubling questions about the care of everyone—infants and children, mentally retarded adults and people with Alzheimer's—who for a variety of reasons either did not or could not leave an explicit record of their wishes.

A strict, literal reading of the Supreme Court's opinion gives the impression that any state may inflict any treatment no matter how burdensome, no matter how useless in restoring vital functions, on those patients who could never have had an opportunity to express contrary wishes. If this is what is meant, the Court tolerates the violation of humane, reasonable views of groups such as the Catholic Church, which accepts forgoing treatment for never competent patients when the benefits do not outweigh the burdens. In a state that has an unqualified interest in the lives of its incompetent citizens, all possible life-prolonging treatment is called for. Any burden would seem to be justified.

It is possible that Missouri, as a matter of policy, will not carry this position to such an extreme. Some people interpret the Missouri position to permit forgoing treatment, even in incompetents, under two conditions: (1) if it has not yet begun; or (2) if it has begun, but is painful.¹¹ While neither of these would apply to Nancy Cruzan, for whom treatment was begun and could not be painful, it might provide a basis for limiting care of some other never competent patients.

Of course, even if the state intends to make use of the distinction between stopping treatment and not starting it, that could force some foolish choices. Surely, emergency room physicians would hesitate to try emergency interventions if they knew that they could not be stopped were they to fail to provide benefit. Parents would be forced to consider refusing initial consent even when trying some therapy would be reasonable.

I cannot see where either the Missouri or the U.S. Court allows for these escape clauses. They seem to contra-

dict an unqualified interest in life. They are not acknowledged in either of their opinions. Surely parents and other legitimate surrogates should be permitted to make best interest determinations for their loved ones, and surely some treatments are useless or too burdensome to plausibly serve the best interests of patients. We readily acknowledge that conclusion for our own health care; we should acknowledge it as well for our loved ones, even those who are incompetent.

Some critics of surrogate best interest decisions argue that granting the family the right to make such judgments would open the door to decisions based on the family's interest rather than the patient's. John Robertson has argued this explicitly.¹² He claims the family would have to make its decision on the family's interest, not the patient's.

But this view is mistaken. Families have a right and a responsibility to fulfill duties to their wards. Insofar as the lawyers for families in such cases base their arguments on the claim that the patient's right to refuse could be exercised by her guardians on her behalf, they have perhaps made the wrong argument. It is, indeed, difficult to understand how anyone else could exercise such a right on one's behalf (except through a substituted judgment). What should be claimed is that family members have a right and a duty to use their judgment about whether the patient has an interest in treatment.

The state also has a role: to protect patients from familial judgments that are beyond reason.¹³ A family should be overruled only when the state can show that the family is unreasonable. But when the patient is permanently unconscious, it will be extremely hard for the state to show that the patient has an interest in favor of treatment so strong that the parents' judgment to the contrary can be overridden. One can imagine a state being successful in the case of a patient who could be restored to a long, conscious life. For that matter one can also imagine the state successfully arguing that parents are beyond reason in insisting on treatment of a conscious, terminally ill patient who suffered terribly from the continuation of treatment. What seems incredible, however, is that the state could show that surrogate refusal of treatment for a persistently vegetative patient is completely contrary to the patient's own interest.

Nancy's Interests and the State's Interest

This brings me to a third and final concern about what the *Cruzan* opinion might do to the consensus I have described. I think it is clear that the state of Missouri was not really overriding the patient's familial surrogates in order to promote her interest. It was, as it explicitly claimed, promoting the state's own interest. The Missouri Supreme Court identified two separate themes in the state's commitment to life. First, the state is concerned about the lives of individual patients such as Nancy Cruzan and should support individuals who want to continue their lives. But the Court also recognized a second, distinct state interest: "an interest in the sanctity of life itself."¹⁴

But this is surely a strange position for the state to find itself in. Missouri is claiming that it has a right to use an incompetent patient for its own agenda of protecting the abstract principle of the sanctity of life, even if the state's interest in the individual life is not relevant. The state can, according to this view, use individuals, even terribly vulnerable individuals, for the state's own purposes.

In Missouri those purposes seem clear. The case was brought by the attorney general, who was simultaneously pressing for reform in the state's abortion laws. The state was eager to establish the sanctity of life doctrine—an unqualified interest in life—because it was critical in the abortion debate. This means the state could use a helpless, incompetent citizen for an agenda of its own. Nancy Cruzan became a pawn in the abortion debate. Regardless of one's views on abortion, that seems unfair to Nancy Cruzan.

Following *Cruzan*, what we need most of all is a public policy that (1) gives the next-of-kin a right and a duty to make best interest determinations for patients who never expressed their wishes while competent; (2) restricts the state's authority to intervene only when surrogate decisions exceed the limits of reason. Fortunately, many states have adopted such policies either through statute or case law. In states lacking these policies, it is imperative to make sure that the best interests of incompetent citizens are protected. States need to recognize that, in some cases, the provision of every possible useless or burdensome life-prolonging treatment for incompetents is not plausible in their interest.

Endnotes

1. *Cruzan, by Cruzan v. Harmon*, 760 S.W.2d 408 (Mo.banc 1988).
2. *Cruzan v. Director, Missouri Dept. of Health*, 110 S.Ct. 2841 (1990).
3. James S. Todd. "Report of the Ad Hoc Committee on the Principles of Medical Ethics [of the American Medical Association]." unpublished report, (1980) pp. 13-14.
4. Congregation for the Doctrine of the Faith. Declaration On Euthanasia. (Rome: The Sacred Congregation for the Doctrine of the Faith, May 5, 1980.)
5. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Deciding to Forego Life-Sustaining Treatment: Ethical, Medical, and Legal Issues in Treatment Decisions. (Washington, D.C.: U.S. Government Printing Office, 1983.)
6. For a full development of this history, see Robert M. Veatch. Death, Dying, and the Biological Revolution [Revised Edition]. (New Haven, Connecticut: Yale University Press, 1989.)
7. *In re Westchester County Medical Center on behalf of O'Connor*, 72 N.Y. 2d 517, N.E. 2d 607 (1988).
8. *Cruzan, by Cruzan v. Harmon*, 760 S.W.2d 408 (Mo.banc 1988) p. 420.
9. Gilbert Meilaender. "On Removing Food and Water: Against the Stream." *The Hastings Center Report* 14 (1984), pp.11-13.
10. *In re Eichner (In re Storar)*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, cert. denied, 454 U.S. 858 (1981).
11. William H. Colby. "Missouri Stands Alone." *Hastings Center Report* 20 (1990), p. 5.
12. John A. Robertson. "Cruzan: No Rights Violated." *Hastings Center Report* 20 (1990) pp. 8-9.
13. Judith Areen. "The Legal Status of Consent Obtained from Families of Adult Patients to Withhold or Withdraw Treatment." *Journal of the American Medical Association* 258 (1987) pp. 229-235; Robert M. Veatch. "Limits of Guardian Treatment Refusal: A Reasonableness Standard." *American Journal of Law and Medicine* 9 (1984), pp. 427-468.
14. *Cruzan, by Cruzan v. Harmon*, 760 S.W.2d 408 (Mo.banc 1988) p. 419.