LIFE, DEATH, AND INCOMPETENT PATIENTS: CONCEPTUAL INFIRMITIES AND HIDDEN VALUES IN THE LAW

Rebecca Dresser*

For more than a decade now, courts and legislatures have grappled with the awesome dilemmas created by advanced medical technology. Among the most perplexing and unsettling of their labors has been to articulate legal standards governing when life-sustaining treatment may be withheld or withdrawn from patients incapable of resolving the question for themselves. Legal decision-makers have assertedly set standards demonstrating the deepest concern for incompetent patients. In reality, however, courts and legislatures have strayed from their declared mission. The accepted legal standards are flawed, for they rest on the presumption that respect for incompetent patients is best attained by treating them like competent patients. Legal decision-makers have been preoccupied with safeguarding incompetent patients' rights of self-determination and privacy, largely overlooking these patients' more immediate interests in having their present well-being maintained. This legal approach is conceptually unsound and insufficiently protective of the incompetent patient's genuine interests.

Faulty reasoning infects both principles that have emerged as the primary legal standards guiding decisions on life-sustaining treatment for incompetent patients. The present consensus is that proxy decision-makers should look first to any relevant values and preferences patients expressed in their former competent states. If reliable evidence of prior statements or conduct bearing on the treatment question is unavailable, the accepted view is that decision-makers should select the alternative that will confer the maximum net benefit on the incompetent patient.

Each of these principles has as its purported aim to secure a decision reflecting the highest respect and solicitude for the incompetent patient. But in constructing and applying the principles, courts and legislatures actually have assigned prominence to the values and interests important to competent patients. Furthermore, close analysis of the past preferences and best interests standards reveals that they unobtrusively allow decisions on life-sustaining care for incompetent patients to incorporate a variety of consider-

---

* J.D., Harvard Law School. Assistant Professor, Center for Ethics, Medicine and Public Issues, Baylor College of Medicine. I am grateful to John A. Robertson, J.D., and Thomas C. Schelling, Ph.D., for their helpful comments on earlier drafts of this article.

ations other than the patients' welfare. Legal decision-makers have been unwilling to address explicitly the effect certain family and societal interests should have on treatment decisions for incompetent patients. Yet these factors have surreptitiously entered the decision-making process, masked by an alleged concern for incompetent patients' interests in self-determination, dignity, privacy, and bodily integrity.

This Article is a critique of the legal principles currently governing decisions on life-sustaining treatment for incompetent patients. Its goals are to reveal the conceptual infirmities in the past preferences and best interests standards and to make a case for moving what have been genuine but disguised influences into the harsh light of explicit legal attention and analysis. Part I describes the past preferences principle as manifested in the advance treatment directive and the substituted judgment doctrine. The legal reliance on past preferences is challenged on grounds that it grants prominence to values and beliefs that have no bearing on the incompetent patient's actual interests. An additional charge is that the objective of advancing an incompetent patient's former values and desires actually permits decision-makers to consider the interests of others in determining how treatment should proceed. In Part II, judicial interpretations of the best interests standard are criticized for attributing interests in privacy, dignity, and bodily integrity to patients who lack the capacities necessary to possess such interests. The claim is that this strategy has enabled courts to assign weight to deeply-held societal values without examining the merits of such an approach. Part III contains suggestions for improving the legal standards. It endorses adoption of a "present best interests" principle mandating systematic assessment of an incompetent patient's contemporaneous interests. This part also explores the legitimate interests family members and society might have in a decision for or against administering life-sustaining treatment to incompetent patients. Whether these interests should be incorporated into the legal standards is a difficult and complex question that demands extensive analysis and exchange. The aim of this part is to encourage explicit legal recognition and examination of all the interests truly at stake in the contemporary treatment setting.

I. THE PAST PREFERENCES STANDARD

In resolving decisions about life-sustaining care, the contemporary legal trend is to give first priority to the treatment preferences incompetent patients expressed when they were competent.[1] The foundations of this doctrine are in the law delineating the competent patient's right to control health care decisions. Based on their common law right of self-determination and their constitutional right of privacy, competent patients have primary legal authority to make choices about their medical care.[2] In respecting these rights, the law protects competent individuals from unwar-

---

[1] *See, e.g., In re* Conroy, 98 N.J. 321, 346-48, 486 A.2d 1209, 1229-31 (1985); Barber v. Superior Court, 147 Cal. App. 3d 1006, 1021, 195 Cal. Rptr. 484, 493 (1983).

[2] *See, e.g., In re* Estate of Brooks, 32 Ill. 2d 361, 205 N.E.2d 435 (1965); Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984); Satz v. Perlmutter, 362 So. 2d 1160, *aff'd,* 379 So. 2d 359 (Fla. 1980).

ranted interference in their personal lives and permits them to make choices in harmony with their values and goals, including their own ideas about the burdens and benefits of receiving life-sustaining treatment.[3] The individual patient is thus given the freedom to make medical treatment decisions that others may see as unwise.[4]

Courts and legislatures have sought to extend this freedom to incompetent patients as well, on the grounds that incompetency ought not destroy patients' opportunities to receive health care that is consistent with their personal, and perhaps idiosyncratic, preferences.[5] The predominant view is that effectuating the treatment decision most in harmony with the incompetent patient's formerly articulated beliefs, values, and goals successfully preserves her self-determination and privacy rights and the underlying aims of respect for individual dignity and bodily integrity.[6] This perspective is now enshrined in statutes and judicial decisions on life-sustaining care for incompetent patients. Advance treatment directives and the substituted judgment standard are the two legal vehicles implementing the past preferences principle.

A. Living Wills and Other Advance Treatment Directives

Advance treatment directives are expressions of a competent patient's self-determination and privacy rights as they bear on future health care. Through executing an advance directive, competent patients describe how they would like treatment decisions to be resolved if they become unable to make choices in the future. Advance directives take the form of living wills and other written or oral instructions requesting or refusing various medical interventions.[7] Individuals create proxy directives by designating another person to make treatment choices if illness or injury destroys their ability to make decisions for themselves.[8] In addition, they may combine instruction

---

[3] *See* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS 44-47 (1982) [hereinafter MAKING HEALTH CARE DECISIONS]; A. BUCHANAN, SURROGATE DECISIONMAKING FOR ELDERLY INDIVIDUALS WHO ARE INCOMPETENT OR OF QUESTIONABLE COMPETENCE 77 (U.S. Office of Technology Assessment) (forthcoming).

[4] *See* Buchanan, *The Limits of Proxy Decisionmaking for Incompetents*, 29 UCLA L. REV. 386, 390 (1981).

[5] *See, e.g., In re* Colyer, 99 Wash. 2d 114, 124, 660 P.2d 738, 744 (1983) (to protect their privacy and dignity, incompetent patients should possess right to refuse treatment equal to that of competent patients); Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 745, 370 N.E.2d 417, 427-28 (1977) (right to refuse treatment based on individual circumstances must be extended to incompetent patient to protect human dignity).

[6] *See* Cantor, *Conroy, Best Interests, and the Handling of Dying Patients*, 37 RUTGERS L. REV. 543, 555-56 (1985) (discussing how respecting past treatment preferences advances these values). *See also* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 132-33, 136-37 (1983) (patient's self-determination right and underlying values partially preserved by honoring past treatment preferences) [hereinafter FOREGOING LIFE-SUSTAINING TREATMENT].

[7] *See* FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 136-45; MAKING HEALTH CARE DECISIONS, *supra* note 3, at 155-66; Kapp, *Response to the Living Will Furor: Directives for Maximum Care*, 72 AM. J. MED. 855 (1982).

[8] *See* FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 145-48; Steinbrook & Lo, *Decision Making for Incompetent Patients by Designated Proxy*, 310 NEW ENGL. J. MED. 1598 (1984).

and proxy directives by selecting a decision-maker and telling that person how they would want to be treated in the future.[9]

Several state legislatures have enacted statutes conferring immunity from civil and criminal liability on health care professions and others who forego life-sustaining care in accord with incompetent patients' advance directives.[10] Advance directives have generally been endorsed by courts and commentators as optimal devices for determining when life-support systems may be withheld or withdrawn from incompetent patients.[11]

In the face of this overall support, however, several commentators have recognized that advance directives fail to constitute a panacea for the problem of deciding on treatment for incompetent patients. The most commonly cited flaw stems from patients' inability to anticipate every specific health crisis that could befall them. Patients' advance directives tend to consist of broad statements that can later raise substantial interpretation questions.[12] Furthermore, the personal preferences expressed in an advance directive cannot incorporate the up-to-date information on therapy and prognosis available when competent patients contemporaneously exercise their right to control their medical care.[13] In addition, the individual's choices set forth in an advance directive are not buttressed by the ongoing discussion with family, friends, and health care professionals that often helps competent patients discern the health care implications of their personal values and goals.[14]

Yet, legal decision-makers and commentators have by and large overlooked a much more serious theoretical challenge to the advance directive. The patient's past preferences, whether ascertained according to an advance directive or the substituted judgment standard discussed below, constitute a less satisfactory basis for treatment decision-making than has generally been assumed.

B. The Substituted Judgment Doctrine

The substituted judgment standard embodies an attempt to determine what treatment alternative an incompetent patient would choose if he were

---

[9] *See* MAKING HEALTH CARE DECISIONS, *supra* note 3, at 158-59. The advance treatment directive need not be limited to control of life-sustaining treatment, and several proposals have emerged for similar mechanisms governing psychiatric care. For a discussion of these proposals, see Dresser, *Bound to Treatment: The Ulysses Contract*, HASTINGS CENTER REPORT, June, 1984, at 13. *See also* T. Schelling, *The Intimate Contest for Self-Command* and *Ethics, Law, and the Exercise of Self-Command*, in CHOICE AND CONSEQUENCE: PERSPECTIVES OF AN ERRANT ECONOMIST 57, 83 (1984); J. ELSTER, ULYSSES AND THE SIRENS: STUDIES IN RATIONALITY AND IRRATIONALITY 36-111 (rev. ed. 1984) (discussing general topic of self-binding).

[10] *See* SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS 1981-1984 (summarizing legislation).

[11] *E.g., In re* Conroy, 98 N.J. 321, 360-63, 486 A.2d 1209, 1229-31; Cantor, *supra* note 6, at 555-56.

[12] *See* Cantor, *supra* note 6, at 559-60; Eisendrath & Jonsen, *The Living Will: Help or Hindrance?*, 249 J. AM. MED. A. 2054 (1983).

[13] *See* A. BUCHANAN, *supra* note 3, at 94; MAKING HEALTH CARE DECISIONS, *supra* note 3, at 158; Relman, *Michigan's Sensible "Living Will"*, 300 NEW ENGL. J. MED. 1270, 1271 (1979).

[14] *See* A. BUCHANAN, *supra* note 3, at 96-97; MAKING HEALTH CARE DECISIONS, *supra* note 3, at 158. Similarly, the advance choice of a proxy decision-maker is typically far removed from the actual treatment setting and is made without knowledge of how the proxy's decisions might be affected by the subsequent pressures and conflicts of interest that could arise. *See* A. BUCHANAN, *supra* note 3, at 92-93.

competent and cognizant of the information relevant to his current treatment situation.[15] Courts and legislatures have adopted this standard in an effort to respect the personal values and goals of individuals who failed to execute formal advance directives.[16] The standard has been applied in several judicial decisions on life-sustaining treatment for incompetent patients.[17] Unfortunately, courts have frequently defined and applied the standard with imprecision, producing a few highly controversial decisions, as well as some questionable legal reasoning.[18]

One highly criticized judicial decision illustrates the extent to which the substituted judgment doctrine has been manipulated. *In re Spring*[19] involved a 78-year-old senile but fully conscious nursing home patient who required dialysis to survive. At times he physically resisted the procedure and had to be heavily sedated during its administration. Although physicians testified that Spring was otherwise in good physical health and could live for five years if dialysis were continued, the Massachusetts Supreme Judicial Court authorized its termination. In applying the substituted judgment standard, the court relied on claims by Spring's wife and son that the patient would have wanted treatment withdrawn if he were competent. But the opinion omits any clear evidence on Spring's prior competent desires and beliefs; instead, it simply expresses confidence in the relatives' opinion that "there was a close relationship within the family group."[20] Conversely, the court noted that during the previous several months, when Spring was apparently competent, he had acquiesced in the dialysis treatments.[21] Moreover, there were media charges that Spring's nurses reported he had told them he wanted to live.[22] Because there were strong indications that contin-

---

[15] *See* J. ROBERTSON, THE RIGHTS OF THE CRITICALLY ILL 51 (1983) [hereinafter RIGHTS OF CRITICALLY ILL]; A. BUCHANAN, *supra* note 3, at 84. The doctrine was adopted in the nineteenth century to determine when awards could be made from the estates of incompetent persons. *See* Robertson, *Organ Donations by Incompetents and the Substituted Judgment Doctrine*, 76 COLUM. L. REV. 48 (1976).

[16] *E.g., In re* Conroy, 98 N.J. 321, 361-62, 486 A.2d 1209, 1230-32 (1985) (evidence of incompetent patient's past treatment preferences may include prior relevant conduct and religious beliefs); TEX. REV. CIV. STAT. ANN. art. 4590h, § 4C (Vernon Supp. 1986) (terminally ill incompetent patient's guardian or relatives may authorize termination of life-sustaining treatment based on knowledge of what patient would desire).

[17] The substituted judgment doctrine was first explicitly adopted in a decision on life-sustaining treatment by the Massachusetts Supreme Judicial Court in Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977). In that case, the court held that chemotherapy could be withheld from a 67-year-old incompetent patient with leukemia, on grounds that he would have refused the treatment if he were competent. Because Saikewicz had been severely retarded from birth, there was no evidence on his prior competent preferences to guide the decision. In reality, the court performed a patient-centered best interests analysis, carefully examining the patient's subjective situation and concluding that in light of his individual characteristics, a decision to forego the therapy would be most beneficial for him. *See* RIGHTS OF CRITICALLY ILL, *supra* note 15, at 54. The court's failure to clarify its conceptual analysis has produced extensive confusion about the substituted judgment standard in the courts and the literature. *See* Buchanan, *supra* note 4, at 393-97.

[18] *See* Cantor, *supra* note 6, at 560-62; Weber, *The Substituted Judgment Doctrine: A Critical Analysis*, 1 ISSUES IN L. & MED. 131, 137-53 (1985).

[19] 380 Mass. 629, 405 N.E.2d 115 (1980).

[20] *Id.* at 640, 405 N.E.2d at 122.

[21] *Id.* at 636, 405 N.E.2d at 118, 120.

[22] *See* T. BEAUCHAMP & J. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 305, 307 (2d ed. 1983); M. SHAPIRO & R. SPECE, BIOETHICS AND LAW: CASES, MATERIALS AND PROBLEMS 677 (1981).

ued treatment would best serve the patient's existing interests, many observers have questioned the legitimacy of this court's application of the substituted judgment standard.[23]

Commentators criticizing *Spring* and other courts' interpretations of the substituted judgment standard primarily cite a failure to demand clear and reliable evidence of a patient's former competent treatment preferences.[24] If the substituted judgment standard seeks to protect the individual's rights of self-determination and privacy, they argue, the sole basis of its application can be the patient's prior behavior, beliefs, and desires bearing on the treatment decision. They claim that this information constitutes the only defensible evidence from which to infer the choices incompetent patients would make in their current predicaments. Any other approach entails sheer speculation, according to these critics.[25] Thus, the substituted judgment standard is inappropriate for cases involving: (1) patients who have been incompetent throughout their lives and hence have never possessed the capacities required for the exercise of self-determination and privacy rights; and (2) patients who were competent at one time but for whom trustworthy evidence of their past relevant preferences is unavailable.[26] In such cases, the treatment decision must be guided by an alternative legal standard.[27]

The New Jersey Supreme Court recently adopted the above reasoning in its *In re Conroy* opinion.[28] Other court decisions purporting to decide whether a specific incompetent patient would choose to receive or forego life-sustaining treatment have relied, however, on (1) poorly documented and suspect reports of the patient's past preferences;[29] (2) judgments of what most reasonable people would want for themselves or their families in the patient's circumstances;[30] and (3) objective and sometimes highly debatable assessments of which treatment outcome would be in the patient's best interests.[31] By failing to articulate clearly the proper components of the substi-

---

[23] *E.g.*, RIGHTS OF CRITICALLY ILL, *supra* note 15, at 58; Buchanan, *supra* note 4, at 395-96; Annas, *Quality of Life in the Courts: Earle Spring in Fantasyland*, HASTINGS CENTER REPORT, August, 1980, at 9-10.

[24] *See* Cantor, *supra* note 6, at 560; Buchanan, *Our Treatment of Incompetents* 2-4, in BORDER CROSSINGS: NEW INTRODUCTORY ESSAYS IN HEALTH CARE (D. Vandeveer & T. Regan eds.) (forthcoming).

[25] *See, e.g.*, Annas, *The Case of Mary Hier: When Substituted Judgment Becomes Sleight of Hand*, HASTINGS CENTER REPORT, August, 1984, at 23; Gutheil & Appelbaum, *Substituted Judgment: Best Interests in Disguise*, HASTINGS CENTER REPORT, June, 1983, at 8.

[26] *See* FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 133. *See also* Buchanan, *supra* note 3, at 104. A third shortcoming Buchanan discerns in the substituted judgment standard is the possibility that the competent individual was unaware of the serious implications the expressions of treatment preferences would have in the future. *Id.* at 109-10.

[27] *See* FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 134-35; Buchanan, *supra* note 4, at 396, 407.

[28] *See* 98 N.J. 321, at 364; 486 A.2d 1209, at 1231.

[29] *E.g.*, *In re* Torres, 357 N.W.2d 332, 340-41 (Minn. 1984) (court admitted testimony of relatives' "impressions" on what patient's wishes "might be"); *In re* Colyer, 99 Wash. 2d 114, 132, 660 P.2d 738, 748 (1983) (no explicit evidence on patient's former treatment wishes, but testimony that she had been "very independent" and "disliked going to doctors" supported judgment that she would want life-support system removed). *See also supra* notes 18-21 and accompanying text.

[30] *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976).

[31] *In re* Hier, 18 Mass. App. 200, 464 N.E.2d 959 (1984), *appeal denied*, 392 Mass. 1102, 465 N.E.2d 261 (1984). *See infra* notes 76-79 and accompanying text.

tuted judgment standard and the evidence necessary for its application, these courts have exposed themselves to charges that they covertly subordinated the interests of seriously ill incompetent patients in favor of economic and other third-party concerns.[32] More importantly, because of the primacy it awards to the incompetent patient's past preferences, the substituted judgment standard joins the advance directive in facing an even greater threat to its moral authority.

C. Changed Interests and Selves

The advance directive and the substituted judgment standard incorporate a deceptively simple assumption: if we can identify what the formerly competent patient once wanted, we will know what she would want in her present incompetent state. This assumption, however, can be challenged on the grounds that a person's interests can change radically over time, so radically that in some cases it could be said that a different person exists by the time the life and death treatment situation arises.[33]

When competent people make judgments on the conditions under which they desire to live and die, their judgments reflect their existing capacities and the activities that make their present lives worth living. Decisions about the future health care that will advance their interests are inextricably intertwined with their current conceptions of the good. But people experiencing various life events, including set-backs in their physical and mental functioning, may revise their goals, values, and definitions of personal well-being.[34] As a consequence, their notions of a life worth living can be modified as well. As long as individuals remain competent, they can incorporate their transformed ideas into the decisions they make. But incompetent patients lose this opportunity. If their interests diverge from those served by their previously articulated preferences, decisions based on the earlier preferences could deviate from what would maximize their current interests as incompetent patients.[35]

A more radical version of this argument builds on a theory of personal

---

[32] *See* Weber, *supra* note 18, at 149-50 & n.104; Kamisar, *Speaking Out: Karen Ann Quinlan and the "Right-to-Die,"* 29 MICHIGAN L. QUADRANGLE NOTES, 1985, at 2. Because of the substituted judgment standard's vulnerability to manipulation, some have advocated setting limits on the range of decisions that can permissibly be made by a proxy applying substituted judgment. *See, e.g.*, Buchanan, *supra* note 3, at 107-08; FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 133.

[33] An earlier version of the ideas in this section will be published in Dresser, *Advance Directives, Self-Determination, and Personal Identity*, in Advance Directives in Medicine (C. Hackler, R. Moseley & D. Vawter eds.) (forthcoming).

[34] *See* A. BUCHANAN, *supra* note 3, at 95-96; Weber, *supra* note 18, at 146-47; M. SHAPIRO & R. SPECE, *supra* note 22, at 695-96.

[35] In *In re* Jobes, No. C-4971-85E (N.J. Super. Ct. Ch. Div., April 23, 1986), the patient's husband sought legal authorization to remove a feeding tube from Ms. Jobes, who was diagnosed in a persistent vegetative state. He presented evidence that she had formerly expressed the wish not to be maintained in her current condition by mechanical means. The Public Advocate offered testimony from an opinion research consultant "to prove that certain pre-disability statements made by Ms. Jobes . . . did not necessarily represent what her wishes might be at a time subsequent to the making of such statements." *Id.*, slip op. at 15. The court admitted the evidence, but found reports of the patient's prior statements to be "trustworthy evidence" that she would want the feeding tube withdrawn. *Id.* at 11.

identity recently articulated by the British philosopher Derek Parfit. Philosophers have long debated how to define when events happen to the same person. A paramount goal has been to determine the conditions under which a life consists of stages of the same person and when a life instead is occupied by different persons over time.[36] Parfit argues for a "Complex View" of personal identity, which holds that identity exists in varied degrees over time, depending on the strength of connectedness and continuity between an individual's psychological features, such as memories, intentions, beliefs, and desires.[37] When we speak of our selves, he writes, we refer to "only the part of our lives to which, when speaking, we have the strongest psychological connections. We assign the rest of our lives to what we call our 'other selves.' "[38] The Complex View calls into question our moral obligations to honor our commitments. First, on the Complex View a person can fully commit only his present self; the strength of the commitment weakens as psychological connectedness lessens.[39] Second, the Complex View casts doubt on whether one's duty to fulfill an agreement survives when the other party has become a different person who now repudiates the earlier terms.[40]

The Complex View of personal identity has serious implications for the current legal practice of allowing incompetent patients' past preferences to govern their subsequent care. This practice rests on an assumption that the person who expressed the preferences is the same one whose treatment is later at issue. But if, as Parfit's theory graphically suggests, the past and present individuals could be different persons, the authority of the past preferences to determine future treatment is substantially reduced. If little or no psychological connectedness and continuity exist between the individual at the two points in time, then there is no particular reason why the past per-

---

[36] *See generally* Perry, *The Problem of Personal Identity*, in PERSONAL IDENTITY 3 (J. Perry ed. 1975).

[37] D. PARFIT, REASONS AND PERSONS 204-06 (1984).

[38] Parfit, *Later Selves and Moral Principles*, in PHILOSOPHY AND PERSONAL RELATIONS 137, 140-41 (A. Montefiore ed. 1973). *See also* Regan, *Paternalism, Freedom, Identity, and Commitment*, in PATERNALISM 113, 126 (R. Sartorius ed. 1983) (arguing for "time-slice view" of persons, in which "different temporal stages of one physically connected 'person' may be different persons for moral purposes"). The topic of changes in identity and interests over time is also discussed in C. FRIED, AN ANATOMY OF VALUES: PROBLEMS OF PERSONAL AND SOCIAL CHOICE 158-65 (1970).

[39] D. PARFIT, *supra* note 37, at 326; Parfit, *supra* note 38, at 144.

[40] To illustrate this point, Parfit recounts the tale of *The Nineteenth Century Russian*:

> In several years, a young Russian will inherit vast estates. Because he has socialist ideals, he intends, now, to give the land to the peasants. But he knows that in time his ideals may fade. To guard against this possibility, he does two things. He first signs a legal document, which will automatically give away the land, and which can be revoked only with his wife's consent. He then says to his wife, "Promise me that, if I ever change my mind, and ask you to revoke this document, you will not consent." He adds, "I regard my ideals as essential to me. If I lose these ideals, I want you to think that I cease to exist. I want you to regard your husband then, not as me, the man who asks you for this promise, but only as his corrupted later self. Promise me that you would not do what he asks."

D. PARFIT, *supra* note 37, at 327.

Parfit asserts that when the expected request for revocation occurs, the wife could plausibly believe that her present husband cannot authorize her to break her promise, for the young man who asked for the commitment no longer exists. *Id.* One might also ask, however, whether the wife should be bound by her promise to a person who no longer exists, when her present husband has a strong interest that will be thwarted by the earlier agreement. *See* Regan, *supra* note 38, at 132-33; *infra* notes 113-15 and accompanying text.

son, as opposed to any other person, should determine the present person's fate.[41] The Complex View suggests that a legal standard based on respect for incompetent patients would exclude the notion that a past person's statements and behavior should control her future treatment and that other parties should be obliged to effecutate the formerly expressed preferences.

The possibility that a person's interests can change significantly and that a different person might emerge with the passage of time casts doubt on the authority of past preferences to govern treatment decisions for incompetent patients. The priority assigned to past preferences under current law is most troubling when an incompetent patient's present interests differ from those protected by his previous expressions. Because illness and injury often produce significant changes in an individual's beliefs, values, and goals, and hence in her interests, conflicts between past and present interests, and perhaps the development of a new person, might not be uncommon.[42] The claim that the competent patient's former exercise of self-determination and privacy rights ought to control treatment in these cases is unconvincing. Incompetent patients are no longer capable of valuing their prior exercise of these rights. As a result, they can receive no present benefit from treatment decisions in accord with their former preferences; indeed, they could now be burdened by such decisions. Furthermore, why should a patient who is now a different person be burdened by a treatment decision consistent with the former person's preferences?[43] Compelling justification is lacking for according greater respect to the wishes of the earlier person (no longer in existence) than to the interests of the existing one.[44] These arguments support the need for a legal standard protecting incompetent patients from the harm they could suffer if their past preferences govern subsequent treatment decisions.

D. *Potential Conflicts*

Conflicts between an incompetent patient's past and present interests take two forms. The first arises when an incompetent patient's current interests would be most advanced by continued life-sustaining treatment, but his previous preferences were to forego treatment if he were reduced to his current condition.[45] In the second conflict, the incompetent patient formerly requested or behaved in a manner indicating that she wanted all available

---

[41] *See* D. PARFIT, *supra* note 37, at 319-21; Regan, *supra* note 38, at 126-27, 135.

[42] *See* Morris, Suissa, Sherwood, Wright & Grier, *Last Days: A Study of the Quality of Life of Terminally Ill Cancer Patients*, 39 J. CHRONIC DISEASES 47, 48 (for dying patients, values change and formerly important concerns become insignificant, while what was formerly ignored becomes important). *See also* T. ENGELHARDT, FOUNDATIONS OF BIOETHICS 126-27 (1986) (with severe brain damage, impaired memory may provide basis for holding some persons no longer present; with less impairment and some memory preservation, more sensible to view as same person in "damaged condition").

[43] *See* D. PARFIT, *supra* note 37, at 319-21 (need to protect future self from suffering that could be imposed by present self); Regan, *supra* note 38, at 126-27, 135 (harm imposed by self-binding must be justified paternalism).

[44] *See* Regan, *supra* note 38, at 133-34 (harm to present person could be more important than honoring former person's preferences).

[45] *See* A. BUCHANAN, *supra* note 3, at 98-100; Eisendrath & Jonsen, *supra* note 12, at 2055-56 (describing potential cases).

treatment in the event of serious illness or injury. The patient's situation, however, is now so burdensome to her that her present interests would be best served by a decision to withhold or withdraw life-support.[46] In each of these settings, honoring the past treatment preferences could inflict significant harm on the incompetent patient. Yet the law has thus far ignored this problem, made only minor concessions to it,[47] or simplistically asserted that past preferences ought to take priority.[48]

Statutes and judicial decisions have also avoided facing a third disturbing effect of their reliance on past treatment preferences. Suppose an individual's previous statements and actions clearly evidence a desire for aggressive life-sustaining treatment. The individual in his present condition, however, has little or no interest in having life maintained. Must he receive costly treatment simply because he formerly desired it? Or is a more defensible course to examine his present interests, together with the interests his family and society might have in the treatment outcome?[49]

Faced with the awesome task of setting the legal standards governing discontinuance of life-sustaining treatment, courts and legislatures have embraced the past preferences principle as an apparently straightforward way out of many treatment dilemmas. But in empowering the competent individual to control the medical care she later receives as an incompetent patient, legal decision-makers have unjustifiably avoided acknowledging other formidable concerns at stake in the treatment setting. The incompetent patient's contemporaneous interests and the interests of others should instead be scrutinized carefully and explicitly as potential determinants of a treatment decision. The current law's failure to examine and weigh openly these considerations exposes it to charges of according insufficient protection to defenseless incompetent patients,[50] covertly assigning priority to economic and other third-party interests,[51] and neglecting the legitimate interests others could have in the treatment decision.[52]

---

[46] *See infra* notes 105-106 and accompanying text. *See also* FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 157 (person could consent while competent to future participation in research involving greater than minimal risk); Robertson, *Dealing with the Brain-Damaged Old—Dignity Before Sanctity*, 8 J. MED. ETHICS 173, 176 (1982) (elderly individuals could consent in advance to physically risky drug treatment to control future violent, noisy or degrading behavior).

[47] Many statutes authorizing living wills provide that declarants can revoke their document in writing, verbally, or by physically damaging it without regard to their mental state or incompetency. *See, e.g.*, TEX. REV. CIV. STAT. ANN. art. 4590h, § 4(a) (Vernon Supp. 1986).

[48] *See, e.g.*, *In re* Conroy, 98 N.J. 321, 366-67, 486 A.2d 1209, 1232 ("even in the context of severe pain, life-sustaining treatment should not be withdrawn from an incompetent patient who had previously expressed a wish to be kept alive in spite of any pain that he might experience"). *See also* Cantor, *supra* note 6, at 562 (situations will arise in which patient's past wishes should govern care even though will produce decision contrary to patient's present best interests).

[49] *See infra* notes 90-97 and accompanying text.

[50] *See* Weber, *supra* note 18, at 152-53 (arguing substituted judgment standard fails to protect incompetent patients).

[51] *See id.* at 149-53 & n.104 ("attractive rhetoric" of substituted judgment standard facilitates decisions against treatment by incompetent patient's burdened family and allows society to conserve economic resources). *See also* Cassel, *Deciding to Forego Life-Sustaining Treatment: Implications for Policy in 1985*, 6 CARD. L. REV. 287, 293 (1984) ("It makes one pause to hear policy planners make presentations about . . . prospective payment systems and also suggest that on admission all patients should be offered living wills.").

[52] *See* Buchanan, *supra* note 4, at 402-04 (endorsing higher brain function concept of death so

II. THE BEST INTERESTS PRINCIPLE

Best interests is an alternative legal standard to past preferences. When a patient is incompetent to exercise control over her medical care, the moral principle of beneficence instructs others to protect the patient's well-being.[53] In its pristine form, the best interests inquiry is patient-centered and guides others to the decision that will confer the greatest net benefit on the patient.[54] The inquiry focuses on the patient's contemporaneous interests, thus eluding the difficulties associated with the past preferences principle. But the best interests standard presents its own conceptual problems. In interpreting the standard, courts have failed to distinguish adequately its two elements: the incompetent patient's personal interests, and interests a "reasonable person" in the patient's situation would have. As a consequence, judicial opinions have at times incorrectly attributed to the incompetent patient the concerns of others, raising questions about whose interests the court decisions actually serve.[55]

The source of the conceptual muddle is the best interests principle's melding of the subjective and objective. Because incompetent patients are incapable of determining the treatment course that will most advance their well-being, others must make this determination for them. In doing so, decision-makers examine the individual patient's condition and attempt to ascertain which treatment alternative would most benefit the average person in the patient's position.[56] Assessing the specific circumstances of the individual patient is essential to this process, however. The patient-centered best interests standard requires decision-makers to marshal evidence on the patient's life as *he* experiences it, instead of merely imagining how most people would feel in his situation.[57]

A. Interests and Capacities

Individual incompetent patients' interests are invariably a function of their physical and mental capacities. The clearest example is the permanently comatose patient. As the philosopher Joel Feinberg has argued, "without awareness, expectation, beliefs, desires, aim, and purpose, a being can have no interests; without interests he cannot be benefited. . . ."[58] Ac-

---

that interests of family and state could be considered in treatment determinations for permanently comatose patients).

[53] *See* T. BEAUCHAMP & J. CHILDRESS, *supra* note 22, at 143; MAKING HEALTH CARE DECISIONS, *supra* note 3, at 180-81.

[54] *See* A. BUCHANAN, *supra* note 3, at 123; RIGHTS OF CRITICALLY ILL *supra* note 15, at 50-51.

[55] An earlier version of the ideas in this section and subsection III.A. will be published in Dresser, *Legal Issues in Making Decisions for Incompetent Elderly Patients: Refining the Best Interests Standard*, in ETHICAL ISSUES IN HEALTH CARE FOR THE ELDERLY (T. Ackerman & W. Applegate eds.) (forthcoming).

[56] *See* MAKING HEALTH CARE DECISIONS, *supra* note 3, at 178, 180-81.

[57] The President's Commission directs decision-makers applying the best interests standard to take into account "the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of life sustained," together with "the satisfaction of present desires, the opportunities for future satisfactions, and the possibility of developing or regaining the capacity for self-determination." *Id.* at 180.

[58] Feinberg, *The Rights of Animals and Unborn Generations*, in PHILOSOPHY AND ENVIRONMENTAL CRISIS 43, 61 (W. Blackstone ed. 1974). Elsewhere, Feinberg writes that to have an interest

cording to existing scientific knowledge, patients diagnosed as deeply comatose have no mental life at all and are thus unable to have any positive or negative experiences.[59] Feinberg and others maintain that the sole interest these patients can possess is in having their mental capacities restored.[60] The remote possibility that a patient was misdiagnosed or that a cure will be discovered in the near future gives these patients an interest in receiving life-sustaining treatment. Although continued life thus would technically confer a net benefit on such patients, commentators generally agree that the magnitude of this benefit is quite small.[61]

The same reasoning applies to incompetent patients with more extensive capacities. "Barely conscious" patients with capacities for experiencing physical pain and pleasure have corresponding interests in avoiding pain and obtaining physical comfort.[62] Patients able to intract with the people and objects in their environment have additional interests in pursuing the activities they enjoy and avoiding those that displease them. In addition, if there is a possibility that these patients could in the future attain a higher level of functioning, then they possess an interest in doing so.

The work of the philosopher Tom Regan sheds further light on the interests concept. According to Regan, living creatures have interests that reflect their biological, psychological, and social needs.[63] Incompetent patients can have two kinds of interests. Preference interests consist of what patients like and what they seek to avoid.[64] Welfare interests concern matters that contribute to patients' overall well-being, but may not always be preferred by patients themselves.[65] The more mentally complex an individual is, the more complex are her interests and the more numerous are the conditions that must be met if she is to live well.[66] Individuals are benefited, Regan writes, when they receive opportunities to attain "the kind of good life within their capacities."[67] In sum, a truly patient-centered best interests assessment will incorporate an examination of the particular incompetent patient's interests in light of his individual capacities.

---

is to have a stake in something, to stand to gain or lose depending on what happens regarding it. J. FEINBERG, HARM TO OTHERS 33-34 (1984) [hereinafter HARM TO OTHERS].

[59] *See* FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 174-75.

[60] *See* Feinberg, *supra* note 58, at 60-61. *See also* Buchanan, *supra* note 3, at 119-20; FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 182-83.

[61] *See* A. BUCHANAN, *supra* note 3, at 119-20; FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 182-83, 186. Some commentators argue that patients in this condition should be defined as legally dead. *See infra* note 107.

[62] *See* A. BUCHANAN, *supra* note 3, at 113, Arras, *Toward an Ethic of Ambiguity*, HASTINGS CENTER REPORT, Apr., 1984, at 25, 31-32.

[63] T. REGAN, THE CASE FOR ANIMAL RIGHTS 89-90 (1983).

[64] *Id.* at 87.

[65] *Id.* at 89-91. *See also* HARM TO OTHERS, *supra* note 58, at 37, 42.

[66] T. REGAN, *supra* note 63, at 89-90. Regan describes two kinds of harm incompetent patients may experience: inflictions and deprivations of opportunities to satisfy their needs. *Id.* at 94-99. Death is harmful because it deprives an individual of all such opportunities, he notes. But Regan also believes that death can be preferable to a life promising only severe inflictions, such as a life of constant and extreme suffering. *Id.* at 99-100. *See also infra* notes 106-07 and accompanying text.

For a description of the competent person's welfare interests, *see* HARM TO OTHERS, *supra* note 58, at 37.

[67] T. REGAN, *supra* note 63, at 116.

B. Judicial Assessment of Incompetent Patients' Interests

The trouble regarding the best interests standard arises when courts ascribe to incompetent patients interests the patients are simply incapable of possessing. Matters such as dignity, privacy, and bodily integrity arguably are integral to the well-being of the average or reasonable *competent* person in our culture. But it is nonsense to claim that these matters affect the well-being of many incompetent patients with severely compromised mental abilities.[68] Despite this conceptual impediment, court decisions have imputed such reasonable person interests to incompetent patients and have even elevated these interests above patients' personal interests.

Several court decisions illustrate this phenomenon. In its pathbreaking *Quinlan* opinion,[69] the New Jersey Supreme Court held that a comatose patient's constitutional right to privacy supported its decision to permit her family to arrange for removal of her life-support system. The court recognized Quinlan's interests in being restored to functioning by requiring as a condition of removal that a committee of hospital physicians agree there was no reasonable possibility of her emerging from the coma.[70] The court insisted it had "no doubt" that Quinlan would want the mechanical life-supports removed, because of her poor prognosis and the extensive bodily invasion treatment imposed on her.[71] To require that her present care be continued would force Quinlan to "endure the unendurable," the court asserted.[72] But this conclusion was not based on an examination of Quinlan's individual interests. Instead, it stemmed from the court's judgment that "the overwhelming majority" of people in our society would endorse this outcome for themselves or their relatives in Quinlan's circumstances.[73]

In applying this reasonable person criterion to the Quinlan case, the court imputed to the patient interests she was incapable of possessing in her comatose condition. Privacy, bodily integrity, pain, and suffering could no longer matter to this patient. The concerns that the court imputed to Quinlan were instead concerns of her family and of the significant portion of our society that opposes aggressive medical treatment for permanently comatose patients.[74] Rather than explicitly weighing Quinlan's own minimal interests in receiving continued treatment against these third-party interests, the court claimed to consider only the patient's interests.[75]

---

[68] *See* T. BEAUCHAMP & J. CHILDRESS, *supra* note 22, at 134 (expressing concern at including such vague terms as "dignity" and "meaningful life" in determining incompetent patient's best interests); Buchanan, *supra* note 4, at 396 (interests of patients with severe cognitive disabilities arguably limited to pleasure and absence of pain).

[69] *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976).

[70] 70 N.J. at 54, 355 A.2d at 671-72.

[71] *Id.* at 39; 355 A.2d at 663.

[72] *Id.*

[73] *Id.* at 41-42, 355 A.2d at 664.

[74] *See* Kamisar, *supra* note 32, at 3. *See also* L. TRIBE, AMERICAN CONSTITUTIONAL LAW 936 (1978) (problematic to attribute rights to Quinlan; more realistic interests were those of her parents in ridding selves of their torment and those of society in insuring that medical profession does not continue treatment on vegetative patients based simply on fear of prosecution).

[75] *See* Kamisar, *supra* note 32, at 2-3. In the more recent *Brophy* case, the Massachusetts Supreme Judicial Court attributed to a vegetative patient a current interest in avoiding maintenance

In a second decision, a Massachusetts appellate court manipulated its analysis of an incompetent patient's interests to produce a decision in conflict with the patient's apparent substantial interests in receiving treatment. *In re Hier*[76] concerned a 92-year-old nonterminally ill incompetent patient hospitalized for 57 years for psychiatric reasons. An obstruction prevented her from ingesting food orally and a gastrostomy tube had been placed to furnish her nutrition. The legal case arose when she pulled out the tube and resisted efforts to re-insert it. The court refused to order that surgery be performed to replace the tube, citing a twenty percent or more risk of mortality to this patient, its questionable benefit to her (because she would probably repeat her action) and the probable need for physically restraining her during the healing period.[77] The court also found support for the decision against surgery in Hier's resistance to the tube, which the opinion characterized as a "plea for privacy and personal dignity by a ninety-two-year-old person who is seriously ill and for whom life has little left to offer."[78]

The *Hier* decision is vulnerable to criticism on two grounds. First, in determining whether the operation would benefit Hier, the court omitted a comprehensive examination of her interests. Did she receive any pleasure or other benefits from her present life, or was she in constant pain or discomfort? Furthermore, would she experience a painful death from starvation, given that she was fully conscious and aware of at least some aspects of her surroundings? A defensible decision on whether Hier would benefit from surgery and continued life would demand an inquiry into these matters. Second, the court interpreted Hier's resistance as representing a concern with privacy and dignity. Yet the facts presented in the opinion fail to supply any basis for this interpretation. The opinion recounts no evidence indicating that Hier was mentally capable of possessing interests in privacy and dignity. Furthermore, the court failed to explain why her actions might not have conveyed an alternate message, such as a wish for attention, or dissatisfaction with some condition in her environment. Again, by imputing to an incompetent patient the interests of reasonable persons and by failing to examine closely the patient's individual interests, the court could claim that its primary concern was the patient, but issue an opinion that actually reflected other considerations.[79]

---

in a state he would find demeaning and degrading. Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 497 N.E.2d 626 (1986).

[76] 18 Mass. App. 200, 464 N.E. 2d 959, *appeal denied*, 392 Mass. 1102, 465 N.E.2d 261 (1984). The *Hier* court formally applied the substituted judgment doctrine; however, because evidence based on Hier's prior competent preferences was unavailable, the court engaged in the weighing of treatment benefits and burdens that characterizes the best interests test. The court concluded from its analysis that the burdens of performing the surgery would outweigh its prospective benefit to the patient.

[77] *Hier*, 18 Mass. App. at—, 464 N.E.2d at 962, 964.

[78] *Id.* at—, 464 N.E.2d at 965.

[79] In reaching its decision, the court took into account the recommendations against surgery made by two physicians. One physician's opposition primarily stemmed from his opinion that Hier had consumed too much professional time and that further treatment should be withheld on economic grounds. *See* Annas, *supra* note 25, at 23-24. In keeping with the judicial reluctance to acknowledge the relevance of economic considerations, the court's opinion fails to mention the physician's major reason for his recommendation.

Despite the appellate court's decision, Hier did receive the surgery. After the higher court

C. Reasonable Person Values and the Incompetent Patient

The conflict between the patient-centered and reasonable person approaches to protecting the incompetent patient's welfare was recognized only recently in a court decision. Opinions issued by members of the New Jersey Supreme Court in the *Conroy*[80] case clarify the differences in the two approaches. The *Conroy* majority adopted a best interests standard that permits life-sustaining treatment to be foregone on a finding that the "burdens of the patient's continued life with the treatment" are greater than any benefits the patient would receive if life were extended.[81] The court was addressing the situation of "an elderly, incompetent nursing home resident with severe and permanent mental and physical impairments."[82] According to the majority, the burdens to be weighed in such cases are pain and suffering; the relevant benefits are physical pleasure, emotional enjoyment, and intellectual satisfaction.[83]

In his concurring and dissenting opinion, Justice Handler took exception to the majority's statement of the appropriate burdens to weigh in these cases. In his view, the burdens concept should include such patients' dependence on others and intrusions on their bodily integrity, privacy, and dignity.[84] Handler argued that it is proper to impute to incompetent patients "cherished values of human dignity and personal privacy" when decisions are made on life-sustaining treatment.[85]

Although his opinion describes the reasonable person approach more clearly than the earlier judicial opinions adopting it, Justice Handler's opinion joins them in neglecting the problem of determining the precise content and weight of the reasonable person values. What exactly are the values the law should protect and what is their comparative importance in treatment decision-making? Those who argue in favor of incorporating reasonable person values in treatment decisions must first define these values. For instance, they might be values held by the incompetent patient's family or guardian, clinicians who routinely care for such patients, general or specific patient populations, institutional ethics committees, or the customary interpreters of the law's reasonable person standard, the judge and jury. Dignity and personal privacy might have highly disparate meanings for members of these groups.[86] In addition, criteria must be established for identifying the kinds of patients whose existence is overly burdened because societal conceptions

---

proceedings, her guardian ad litem returned to the trial court, presented additional medical testimony, and obtained a court order authorizing the surgery. *See id.* at 25.

[80] 98 N.J. 321, 486 A.2d 1209 (1985).

[81] *Id.* at 365, 486 A.2d at 1232.

[82] *Id.* at 363, 486 A.2d at 1231.

[83] *Id.* at 365, 486 A.2d at 1232. There is some question about whether the majority also intended to allow the proxy decision-maker to consider other factors. *See* Cantor, *supra* note 6, at 565-66.

[84] *Conroy*, 98 N.J. at 396, 486 A.2d at 1248.

[85] *Id.* at 399, 486 A.2d at 1250.

[86] For example, one commentator believes that a reasonable person would decide that the burdens of continued treatment outweighed its benefits only when it prolonged life in the last stages of a terminal illness. *See* Marzen, *Medical Decisionmaking for the Incompetent Person: A Comprehensive Approach*, 1 ISSUES IN L. & MED. 293, 309 (1986).

of dignity and privacy have been "sufficiently transgressed."[87] Are permanently comatose and barely conscious patients in this category? What are the characteristics of a patient's life that would place her in this category?[88] Finally, how powerful are these societal values compared with the demonsotrable interests of the individual incompetent patient? Suppose that evaluation of a patient's personal interests produces a judgment that treatment would serve, or alternatively, be detrimental to, the patient's interests. Should the treatment decision be altered if societal values would support a contradictory outcome?

In sum, attempts to incorporate reasonable person values in the best interests standard yield confusion and potential abuse. Rather than embodying an effort to protect the individual patient's welfare, they represent the search for an appropriate state policy on respecting human life in our current social and technological circumstances.[89] A more forthright approach would be to exclude these attempts from the best interests analysis. This would help to clarify the challenge the law can no longer justifiably evade. Decisions about life-sustaining treatment for incompetent patients must begin to consider openly the societal concerns that legal decision-makers have claimed to reject in their formal adherence to the past preferences and best interests principles.

III. REFINING THE LEGAL STANDARDS

Courts and legislatures have eagerly applied the past preferences principle and imputed reasonable person values in decisions on life-sustaining treatment for incompetent patients. The moral justification for doing so, however, is unpersuasive. Legal decision-makers typically announce that they adopt these criteria in an effort to extend to incompetent patients the freedom and respect accorded to competent patients in our society. But this approach ignores the possibility that showing equal respect for incompetent patients might entail something quite different.

The existing legal standards governing life-sustaining treatment of incompetent patients are inadequately examined by-products of the law articulating the rights of competent patients. Court decisions and legislation generally incorporate the principle that competent patients ought to control decisions about their medical care. The law embodies the judgment that competent persons are the best judges of their own well-being.[90] Protecting these patients' constitutional rights of privacy and common law rights of self-determination is thus viewed as the best way to protect their welfare. Courts and legislatures have unquestioningly extended this approach to the problem of deciding on the treatment incompetent patients should receive.

---

[87] 98 N.J. at 399, 486 A.2d at 1250.

[88] Norman Cantor, who endorses Justice Handler's views, advocates adoption of a "humane handling" standard that would allow treatment to be foregone from patients the broad community would deem to be in an unacceptably degrading and undignified condition. He suggests that this standard might support discontinuance of life-sustaining treatment from patients reduced to "total helplessness, dependency, and dysfunction." *See* Cantor, *supra* note 6, at 574-76.

[89] *See infra* notes 134-48 and accompanying text.

[90] *See* MAKING HEALTH CARE DECISIONS, *supra* note 3, at 44-45.

Legal decision-makers have accepted the dubious notion that what was vitally important to incompetent patients when they were competent remains vitally important to them in their incompetent states. But incompetent patients differ from competent patients in material ways that invalidate this notion. Incompetent patients are incapable of appreciating the values and preferences they once held dear. As a consequence, standards attempting to honor those values and preferences fail to advance the incompetent patient's present welfare.[91] Instead, such standards facilitate the undisclosed consideration of familial and societal interests in a purportedly patient-centered treatment decision.[92]

On close examination, then, the arguments are shaky for treating patients who can no longer exercise privacy and self-determination rights as if they were fully capable of doing so.[93] Incompetent patients are incapable of exercising these rights and of valuing what these rights protect. They have lost the goals and preferences they once espoused. With the advent of incompetency, their mental capacities diminish and they develop new desires and needs. To base medical decisions on their former competent preferences or on imputed reasonable person values is to treat these patients in conformance with things that no longer matter to them, and indeed, in potential disregard of things that do matter to them.[94] This approach clearly assigns high value to the dignity, privacy, and bodily integrity so precious to the competent individual. But in what sense does it demonstrate respect for the incompetent patient whose well-being is independent of these concerns? We would show more genuine respect for incompetent patients by treating them in accord with what rational maximizers of self-interest would want: the outcome that is most beneficial and least burdensome to them in their current situations.[95]

The true appeal of past preferences and reasonable person values is that they embody the concerns of others. Assigning priority to past preferences and reasonable person values enables decision-makers to take into account the interests of third parties without acknowledging it, thereby avoiding the criticism they would otherwise confront. This behavior indisputably serves an important function in maintaining the cultural myth that we never forsake an individual to promote the good of others.[96] But the present posture is fundamentally dishonest. Moreover, it may produce more decisions harm-

---

[91] *See* A. BUCHANAN, *supra* note 3, at 93-98 (presenting reasons why individuals may not be best judges of own future interests); BEAUCHAMP & CHILDRESS, *supra* note 22, at 166 (to show respect for autonomy, consenting patients allowed assume risks impermissible for those who cannot consent).

[92] *See* J. KATZ & A. CAPRON, CATASTROPHIC DISEASE: WHO DECIDES WHAT? 3 (1975) (advocating open, visible decision-making regarding catastrophically ill patients, to avoid abuse of traditionally vulnerable groups).

[93] *See* T. BEAUCHAMP & J. CHILDRESS, *supra* note 22, at 139-40 (it is "conceptually dubious" to treat nonautonomous patients as autonomous).

[94] *See* Weber, *supra* note 18, at 152.

[95] *See* T. BEAUCHAMP & J. CHILDRESS, *supra* note 22, at 140-41 (because of problems with treating incompetent persons as fictionally autonomous, better to rely heavily or exclusively on best interests standard). *See also* J. Robertson, Equal Respect and Distributive Justice in Nontreatment Decisions for Incompetent Patients (1984) (unpublished paper, copy on file with this author).

[96] *See* G. CALABRESI & P. BOBBITT, TRAGIC CHOICES (1978) (describing how society conceals resource allocation decisions to preserve fundamental social values). *See also* Havighurst,

ful to incompetent patients than would a forthright analysis incorporating the legitimate interests of third parties. By cloaking treatment choices with such honored labels as self-determination, privacy, dignity, and bodily integrity, the existing treatment standards allow incompetent patients' genuine interests to be quietly and conveniently subordinated to the interests of others.[97]

Courts and legislatures should abandon their confused and distorted reliance on past preferences and imputed reasonable person values and start to cope openly with the authentic moral conflicts. Legal decision-makers could initiate major improvements by (1) adopting a present best interests standard that requires systematic assessment of the existing interests of individual incompetent patients; and (2) clarifying and assigning relative weights to the additional interests implicated in treatment decision-making for incompetent patients.

A. Assesssing Patients' Present Best Interests

The first step toward improving the decision-making process is for courts and legislatures to mandate a more careful and thorough evaluation of the incompetent patient's existing interests than has generally been forthcoming. The challenge for those attempting to ascertain the interests of incompetent patients is to discover how these patients actually experience their lives. Although many such patients can tell others little or nothing about what they think and feel, it is still possible for observers to acquire information on these patients' physical and mental states.

Behavioral and physiological measurements constitute the primary avenues to understanding the nature of an incompetent patient's existence. Health care professionals rely on such data for guidance on a multitude of patient care matters. Researchers and clinicians now need to turn their attention to developing a system of behavioral and physiological assessment that will enhance the observer's ability to ascertain validly and reliably what individual incompetent patients' lives are like for them.

The task is by no means an easy one. The variety of physical and mental states incompetent patients endure and enjoy must be explored in detail. Pain, suffering, distress, discomfort, isolation, physical freedom, pleasure and comfort, emotional enjoyment, social interaction, and intellectual activity are obvious areas for study.[98] Methods must be devised to detect

---

Blumstein & Bovberg, *Strategies in Underwriting the Costs of Catastrophic Disease,* 40 LAW & CONTEMP. PROB. 122, 129 (1976) [hereinafter Havighurst]; Kamisar, *supra* note 32, at 3.

[97] *See* J. KATZ & A. CAPRON, *supra* note 92, at 3, 178-79, 217 (low visibility decision-making leads to abuse of vulnerable patients); Destro, *Quality of Life Ethics and Constitutional Jurisprudence: The Demise of Natural Rights and Equal Protection for the Disabled and Incompetent,* 2 J. CONTEMP. HEALTH L. & POLICY 71, 128-29 (charging courts' focus on self-determination, privacy, and liberty masks prejudice against mentally disabled patients). *But see* Havighurst, *supra* note 96, at 124, 129, 139-44 (advocating system in which economic considerations not openly related to life and death choices, to preserve society's humanitarian values); Blumstein, *Constitutional Perspectives on Government Decisions Affecting Human Life and Health,* 40 LAW & CONTEMP. PROB. 231, 233-34, 251-53 (courts should avoid establishing explicit rules governing individual decisions on life-sustaining treatment that incorporate allocation considerations, because of threat posed to society's "humanitarian self-image").

[98] *See* Cassell, *The Nature of Suffering and the Goals of Medicine,* 306 NEW ENGL. J. MED.

which patients are capable of experiencing these conditions and engaging in these activities. This component is crucial to assessing patients' actual interests, for individuals vary widely in how they experience similar environmental events. For example, the perception of pain can be strongly influenced by a patient's familiarity with and ability to discriminate the sensation, by his emotional state at the time of the sensation, and by his sociocultural background.[99] Other relevant states, such as suffering and emotional enjoyment, will vary even more, depending on a patient's individual characteristics.[100]

Yet the complexity inherent in assessing incompetent patients' experiences should not defeat the endeavor. Theoretical and empirical research, as well as improved methods of clinical assessment, hold significant promise for enhancing our skills at appraising the interests of individual incompetent patients. Consider the condition of pain. Besides comprising a fertile area for further theoretical examination, a number of empirical investigations could yield progress toward the goal of improved assessment. First, research could be conducted to add to our understanding of the behaviors most frequently associated with pain. For example, two researchers have developed a system for observers to assess patients' pain based on five behaviors: guarding, bracing, rubbing, grimacing, and sighing.[101] The challenge is to develop and refine a behavioral "language" of pain that can be legitimately applied to incompetent patients.[102] Detailed empirical study of the typical course of pain experienced by patients in specific physical conditions and undergoing specific treatment interventions could shed light on how incompetent patients are likely to experience the different treatment alternatives available for them.[103] In addition, research efforts to link pain with specific physiological events could furnish a basis for objectively determining when patients are experiencing this state. Even though individual patients will undoubtedly vary on all these parameters, this type of research could lead to generalizable methods of assessing pain in incompetent patients.

In the clinical setting, high quality patient assessments are possible if certain guidelines are followed. Observers should seek to assess the patient's mental and physical states without being influenced by their own views on what qualify as valid causes of pain and on the levels of pain to be expected

---

639, 643-44 (1982). *See also* Morris, Suisse, Sherwood, Wright & Grier, *supra* note 42, at 48 (quality of life for terminally ill patients generally influenced by degree of physical and psychological distress and functioning and existence of supportive relationships).

[99] *See* Jacox, *Assessing Pain*, 79 AM. J. NURSING 895-96 (1979); Shaffer, *Pain and Suffering*, in PHILOSOPHICAL DIMENSIONS OF THE NEURO-MEDICAL SCIENCES 181 (S. Spicker & H. Engelhardt eds. 1976).

[100] *See* Robinson, *Pain and Suffering: Psychobiological Principles*, in 3 ENCYCLOPEDIA OF BIOETHICS 1177, 1180-81 (W. Reich ed. 1978); Shaffer, *supra* note 99, at 225-32.

[101] Keefe & Bradley, *Behavioral and Psychological Approaches to the Assessment and Treatment of Chronic Pain*, 6 GEN. HOSP. PSYCHIATRY 49, 50 (1985). *See also* Craig & Prkachin, *Nonverbal Measures of Pain*, in PAIN MEASUREMENT AND ASSESSMENT 173 (R. Melzack ed. 1983).

[102] The scientific literature describing methods of assessing pain and suffering in nonhuman animals also provides helpful insights into understanding these states in humans who are unable to use language to convey their experiences. *See, e.g.*, M. DAWKINS, ANIMAL SUFFERING: THE SCIENCE OF ANIMAL WELFARE (1980). For discussions of improving the systematic assessment of pain in humans, *see* Fordyce, *The Validity of Pain Behavior Measurement*, in Melzack, *supra* note 101, at 145; Tursky, *The Evaluation of Pain Responses: A Need for Improved Measures*, in Spicker & Engelhardt, *supra* note 99, at 209.

[103] *See* Jacox, *supra* note 99, at 900.

from various events and situations.[104] With those incompetent patients who can describe their sensations and feelings to some degree, observers should perform thorough examinations, asking very specific questions about how the patient experiences particular aspects of treatment and the health care setting.[105] When the patient's sole means of communication is behavior, observers should watch the patient closely, noting her responses to treatment interventions and other events in her environment. Finally, any available empirical data on assessment of pain should be incorporated into the examination.

These efforts would yield a more accurate picture of individual incompetent patients' interests in obtaining life-sustaining treatment, or conversely, in having such treatment foregone. For the few unfortunate patients who suffer severe, irremediable pain and discomfort from their conditions or the medical procedures essential to preserve their lives and are also unable to experience any benefits from existence in their current states, a decision to withhold or discontinue treatment may be in their best interests.[106] In this instance, death provides the sole available escape from their trials, and forecloses no opportunities for attaining future pleasure or satisfaction.[107] Other incompetent patients have varying levels of interests in continued life, depending on the balance of benefits and burdens they will experience if treatment is administered. The persistently comatose patient who suffers no pain or discomfort, but is given no reasonable medical possibility of recovery, has only the most remote interest in being maintained.[108] Patients with more

---

[104] *Id.* at 898, 900.

[105] *Id.* at 897, 900.

[106] *See* T. ENGELHARDT, *supra* note 42, at 317; T. BEAUCHAMP & J. CHILDRESS, *supra* note 22, at 123; Arras, *supra* note 62, at 26.

[107] *See* T. NAGEL, THE VIEW FROM NOWHERE 124-25 (1986); HARM TO OTHERS, *supra* note 58, at 81-83, 85-86, 92-93; T. REGAN, *supra* note 63, at 100, 113-14.

The judgment that it is in a patient's interest to die rather than to experience future suffering rests on the belief that extreme, unremitting pain and discomfort are universal evils. In this sense, they can be categorized as objectively negative experiences, in contrast with those experiences whose positive or negative value depends on the particular individual having them. *See* T. NAGEL, *supra*, at 156-71; Feinberg, *Human Duties and Animal Rights*, in ON THE FIFTH DAY: ANIMAL RIGHTS AND HUMAN ETHICS 45, 57-58 (R. Morris & M. Fox eds., 1978). For an argument that pain can be characterized as unpleasant despite the existence of some persons who enjoy it or do not mind it, see Pitcher, *Pain and Unpleasantness*, in Spicker & Engelhardt, *supra* note 99, at 181.

[108] *See supra* notes 58-61 and accompanying text. Several philosophers and legal commentators have argued that permanently comatose patients should be included in the concept of legal death. *See, e.g.*, T. ENGELHARDT, *supra* note 42, at 210-11; Smith, *Legal Recognition of Cortical Death*, 71 CORNELL L. REV. 850 (1986); Buchanan, *supra* note 4, at 403-04; Green & Wikler, *Brain Death and Personal Identity*, 9 PHIL. & PUB. AFF. 105 (1980). These authors hold the general view that with irreversible loss of consciousness and cognition comes the loss of the capacities necessary for being a person. Thus, although a biologically living human body remains, one that may breathe without mechanical assistance, there is no entity left possessing the moral value we assign to living persons. *See, e.g.*, Smith, *supra*, at 857-61.

The drawbacks of this position are twofold. First, it addresses the nontreatment issue in a small group of patients and furnishes no guidance on the comprehensive problem of determining when treatment may be withheld and withdrawn from incompetent patients. Second, the neocortical concept of death creates its own dilemmas. For example, may active measures be taken to stop the unassisted breathing of permanently comatose patients? *See* Smith, *supra*, at 874-75. Further questions exist concerning the length of time the bodies of such individuals could be maintained for organ donation and research purposes. *See id* at 884-85.

The President's Commission rejected the neocortical definition of death, citing the difficulty in defining what capacities are essential to being a person, problems associated with defining an individextensive capacities who can obtain different forms of pleasure and satisfaction from life have more significant interests in receiving treatment, depending on the corresponding burdens their conditions and care will impose on them.[109]

In sum, a truly patient-centered best interests standard demands painstaking assessment of each incompetent patient's situation. The law has thus far settled for crude and at times unsupported portrayals of incompetent patients' interests. If courts are to fulfill the goal of protecting the patient's welfare, they must seek more precise and comprehensive evidence on the specific patient's preferences, needs, and capacities before arriving at a best interests determination.

B. Evaluating the Interests of Others

The second step in revising the law's approach to decision-making on behalf of incompetent patients entails acknowledging and weighing the external factors that could legitimately constrain best interests determinations. Courts and legislatures must openly consider whether and when the interests of others ought to limit application of the present best interests principle. The process of refining the law governing when life-sustaining treatment may be foregone will require legal decision-makers to address squarely the disturbing question they have as yet evaded: can our society adequately protect and respect the lives of incompetent patients if treatment decisions are permitted to reflect the interests of any party besides the patient?

The major external considerations that could qualify as relevant to a treatment outcome are: (1) the values and beliefs of various persons, particularly those of patients in their former competent states and those of their families, concerning the requisite conditions for a sufficiently dignified and humane existence; and (2) principles of distributive justice. These are factors that have already exerted a subterranean influence on courts and legislatures; now these institutions must openly address the propriety of this approach.

1. *The Former Competent Patient*

Incompetent patients, as we have seen, fail to retain an interest in having their former treatment preferences honored. Competent patients, however, can have an independent interest in directing their future care. This interest is distinguishable from the competent patient's interest in making contemporaneous treatment choices. It is, nevertheless, an interest in controlling subsequent care that can survive the alteration in an individual's

---

ual with brainstem function as dead, and difficulties in assessing the cessation of higher brain function. *See* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DEFINING DEATH 39-40 (1981).

[109] It is important to recognize the difference between imputing values such as dignity and bodily integrity to incompetent patients who lack the capacities to hold these values and inferring patient's individual interests from evidence of their behavior and physical conditions. Although the latter process requires observers to interpret a patient's subjective state, the interpretation is based on information indicating that particular matters are of consequence to the patient herself. This is in contrast to outsiders' judgments about incompetent patients' welfare derived solely from generalizations about what the average or reasonable person would regard as important.

interests or identity that accompanies the onset of incompetency and serious illness.

Joel Feinberg has explained how persons can possess interests that survive their deaths. According to Feinberg, when a living individual has a stake in some future outcome that fails to materialize after his death, the living person is harmed because he is "betting a substantial component of his own good on a doomed cause."[110] In Feinberg's view, the eventual thwarting of that interest harms the person before death, even though the harm does not become obvious until later, when the person no longer exists.[111]

Similarly, the competent patient's preferences about future treatment constitute an interest that can persist after the patient becomes incompetent. When competent individuals express wishes about the treatment they would like in their subsequent incompetent states, they exercise the rights of self-determination and privacy they possess as competent persons. A later decision to implement those wishes reflects a judgment that the former competent patient's interests should take priority over the other interests at stake in a treatment situation.[112] It is crucial to recognize, however, that honoring these past preferences demonstrates respect for patients in their former competent states. The past preferences principle, then, embodies a legal choice to protect this interest of competent patients in controlling their future treatment, rather than a decision to protect any such interest incompetent patients possess in their incompetent states.[113]

Courts and legislatures have failed to consider adequately the nature and weight of the competent patient's interest in future-oriented decision-making. In general, the law favors the competent patient's authority to make contemporaneous treatment choices over conflicting opinions others may have regarding the patient's welfare. But there are compelling grounds to assign less weight to competent patients' interests in future-oriented decision-making than to their interests in making contemporaneous choices. Competent patients' interests can undergo drastic change by the time they are seriously ill incompetent patients; indeed, they may become different persons during that period.[114] Furthermore, the competent patient's former choices cannot incorporate precise and up-to-date information bearing on the specific treatment dilemma that eventually develops; nor are they necessarily the choices the patient would make when faced with the actual treatment conflict.[115] For these reasons, the adoption of a legal standard advancing future-oriented decision-making cannot be justified simply by appeal to the principle protecting the competent patient's right to control contemporaneous medical care. Instead, the independent reasons for advancing the competent patient's interest in future-oriented medical decision-making

---

[110] *See* HARM TO OTHERS, *supra* note 58, at 92.

[111] *See id.* at 89-93.

[112] *See* Feinberg, *supra* note 58, at 61 n.12.

[113] Allen Buchanan has described the interest in controlling future treatment possessed by the competent patient who later becomes permanently comatose as a "right of disposal" resembling the right to distribute one's property by will. This right is not as morally weighty as the competent patient's self-determination right, he asserts. *See* Buchanan, *supra* note 24, at 11-13.

[114] *See supra* notes 34-44 and accompanying text.

[115] *See supra* notes 12-14 and accompanying text.

must be articulated and weighed against those supporting the advancement of other relevant and potentially conflicting interests, including incompetent patients' interests in protection of their present welfare, as well as interests the patients' families and society may have in a treatment determination.[116]

2. *The Family*

An incompetent patient's family can have interests in either continuing or discontinuing the patient's life-sustaining treatment. Several courts have implicitly recognized these interests by requiring the family's permission before life-sustaining treatment could be withheld or withdrawn from incompetent patients.[117] In addition, some state statutes expressly empower the incompetent patient's relatives to make decisions on life-sustaining treatment.[118] These decisions and statutes, however, fail to distinguish the patient's and relatives' interests. Instead, they openly or indirectly assume that the family will make choices based on the patient's past preferences or best interests.[119]

Courts and legislatures should acknowledge that incompetent patients and their relatives have separate and potentially conflicting interests in the treatment setting. Relatives frequently bear heavy emotional and financial burdens when an incompetent family member becomes seriously ill or injured.[120] Demands on their time, attention, and financial resources can be overwhelming as they cope with the needs of the patient and other family members.[121] In addition, seeing a formerly healthy loved one in a severely compromised state can inflict on relatives substantial emotional suffering,

---

[116] Thus, the legal policy on patients' past treatment preferences might justifiably vary from the rules governing property wills, which do not involve life and death decisions for the individual who issued the earlier instructions. *See* HARM TO OTHERS, *supra* note 58, at 35 (law must "incorporate judgments of the comparative importance of interests of different kinds so that it can pronounce 'unjustified' the invasion of one person's interest of high priority to protect another person's interest of low priority"); L. TRIBE, *supra* note 74, at 936 n.11 (questioning weight of competent person's right to determine future treatment and disposal of body relative to interests of other living persons). In this context, the law must determine the mportance of the competent patient's interest in controlling future medical treatment as compared to the incompetent patient's present interest in well-being and the interests the family and society may have in the treatment decision.

The economist Thomas Schelling has suggested that competent persons with progressively debilitating conditions might choose to preserve their interest in controlling their future life-sustaining medical care by refusing to enter a hospital, thus retaining greater authority over the medical treatment they can receive, or more drastically, by committing suicide before they become incompetent. Letter from Thomas Schelling to author (August 26, 1986). Suicide would indeed be one means for certain competent persons to ensure that their contemporaneous preferences take priority and might be chosen by those who place a very high value on controlling the circumstances of their death. Refusing to enter the hospital would be less effective, for if the person at some point becomes incompetent, the decision on hospitalization will then be controlled by guardians, family members and physicians.

[117] *See, e.g., In re* Colyer, 99 Wash. 2d 738 (1983); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976).

[118] *E.g.*, VA. CODE § 54-325.8:6 (Supp. 1985). *See* Marzen, *supra* note 86, at 310-13 (discussing such statutes).

[119] *See, e.g.*, Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (patient's family members appropriate surrogate decision-makers because in best position to know patient's former preferences and obviously concerned about his welfare).

[120] *See* FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 185; Marzen, *supra* note 118, at 304.

[121] *See* Fletcher, *Ethics and the Costs of Dying*, in GENETICS AND THE LAW II 187, 193-94, 198 (A. Milunsky & G. Annas eds. 1980).

independent of the patient's own experience of his life.[122] Their dismay at the patient's deteriorated condition can lead them to desire the patient's peaceful death over her present existence that seems to insult the person they once knew and loved. Conversely, for some families, giving care and attention to a debilitated incompetent relative is a valued labor of love;[123] these relatives may be reluctant to consider the patient's interests in foregoing further aggressive measures. Some families also persist in hope for the patient's recovery, despite a contradictory medical prognosis.[124] For others, religious beliefs or an unwillingness to confront death impels them to seek continued aggressive care for the patient, whether or not such care will advance his present interests.[125]

Should the law permit these concerns to affect treatment decisions? The issue is related to the importance of family privacy and autonomy in our society.[126] Courts have conferred constitutional protection on the exercise of family discretion in areas such as child-rearing and contraception.[127] In general, however, the power of parents to make decisions on life-sustaining treatment for their children has been strictly limited to protect the children from serious avoidable health risks.[128] In addition, the courts have not recognized a constitutionally protected right of family members to make treatment decisions for their incompetent adult relatives.[129]

Some medical ethicists argue in favor of a legal standard allowing family members to inject their own beliefs and religious and ethical views into the decision-making process.[130] Similarly, the President's Commission endorsed the inclusion of family interests in determining an incompetent patient's treatment, on grounds that "most people do have an important interest in the well-being of their families."[131] Many commentators disagree, however, insisting that family concerns have no permissible influence on the treatment choice, and that considering them only opens the door to the subordination of patients' interests for the convenience of their families.[132] Others believe it is hypocritical to claim that treatment decisions for

---

[122] *See* Meier & Cassel, *Nursing Home Placement and the Demented Patient*, 104 ANNALS INTERNAL MED. 98, 102 ("Many health care givers who work with patients with Alzheimer's disease come to feel that the pain and suffering of the family often exceeds that of the patient, who can appear to be at peace and secure in a safe familiar environment").

[123] *See* FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 183.

[124] *Id.*

[125] *See* A. BUCHANAN, *supra* note 3, at 156-57.

[126] *See* Veatch, *An Ethical Framework for Terminal Care Decisions: A New Classification of Patients*, 32 J. AM. GERIATRICS SOC'Y. 665, 668 (1984).

[127] *See, e.g.*, Burt, *Developing Constitutional Rights of, in, and for Children*, 39 LAW & CONTEMP. PROB. 118 (1975).

[128] *See* Note, *Judicial Limitations on Parental Autonomy in the Medical Treatment of Minors*, 59 NEB. L. REV. 1093 (1980).

[129] *See In re* Quinlan, 70 N.J. 10, 42, 355 A.2d 647, 664, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976) (no parental constitutional right of privacy entitled adult incompetent patient's father to relief independent of patient's right). *But see* Havighurst, *supra* note 96, at 175 n.247 (arguing for such a right).

[130] *See* Veatch, *Limits of Guardian Treatment Refusal: A Reasonableness Standard*, 9 AM. J. L. & MED. 427 (1984); Strong, *Defective Infants and Their Impact on Families*, 10 L., MED. & HEALTH CARE 168 (1983).

[131] FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 135.

[132] *See* A. BUCHANAN, *supra* note 3, at 122-25; Destro, *supra* note 96, at 89, 104-15.

incompetent patients can ever be made without some consideration of the family's interests.[133]

Family members frequently have an appreciable and independent stake in decisions about their incompetent relatives' life-sustaining care. It is likely that relatives' preferences and needs have influenced judicial and legislative treatment standards, but as yet the effect has been unacknowledged. Courts and legislators should join openly in the societal debate by adopting explicit positions on the appropriate weight family interests should carry in the decision-making process.

3. *Respect for Human Life*

Legal decision-makers must also consider the proper place of the broader society's interests in life and death treatment decisions for incompetent patients. The public's major concerns in this area are in safeguarding the value of human life and in devoting the nation's increasingly scarce health care resources to individuals who will significantly benefit from care.[134] The tension between these two interests has heightened in recent years, but it has been virtually ignored in the law governing treatment of incompetent patients.

Society's interest in the medical treatment of incompetent patients has symbolic and practical dimensions.[135] Independently of its effect on individual patients, many commentators argue that the care administered to such helpless and vulnerable people stands as a crucial indicator of the public's concern for human life. Thus, even when patients themselves receive little or no significant benefit from treatment, these commentators claim that society has a separate interest in aggressively treating such patients to maintain the principle of respect for life.[136] They also contend that this approach has

---

[133] *See* Cantor, *supra* note 6, at 577 ("survivors' burdens will remain a lurking omnipresence, a subconscious factor in the effort to shape appropriate treatment for the incompetent dying individual"); Veatch, *supra* note 30, at 436 (benefits and burdens treatment decision will impose on others "unavoidably influence" process, "though the platitude of doing only what will benefit the patient is maintained as the official policy"). *See also* Crane, *Decisions to Treat Critically Ill Patients: A Comparison of Social Versus Medical Considerations*, 53 MILBANK MEMORIAL FUND Q. 372, 387-92, 394-96 (discussing results of study on effects of family attitude and patient's social class on physician's treatment decisions).

[134] *See* Weber, *supra* note 18, at 151 (substituted judgment standard fails to address these two potentially conflicting public policy considerations); Blumstein, *supra* note 97, at 233 (noting two concerns and that cases like Quinlan raise conflict between them); Havighurst, *supra* note 96, at 124, 129, 139 (describing importance of considerations and tensions between them). *See generally* G. CALABRESI & P. BOBBITT, supra note 96.

[135] Courts adjudicating cases on life-sustaining treatment have considered society's interest in preserving respect for life under the rubric of the state's interests in preserving life and preventing suicide. *See, e.g., In re* Conroy, 98 N.J. 321, 349, 486 A.2d 12-9, 1223 (1985); Sup't of Belchertown State School v. Saikewicz, 373 Mass. 728, 738; 370 N.E.2d 417, 425 (1977). They have not, however, extensively discussed the nature and weight of this specific societal interest, particularly as it bears on the issue of life-sustaining treatment for incompetent, as opposed to competent, patients. Instead, courts considering treatment for seriously ill incompetent patients have as a rule simply declared that the state's interest failed to override the patient's interests in privacy, dignity, and avoiding treatment that either could not significantly extend life or could only preserve life in an extremely compromised state. *See, e.g.,* Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 497 N.E.2d 626 (1986); *In re* Colyer, 99 Wash. 2d 114, 121, 660 P.2d 738, 743 (1983); *In re* Quinlan, 70 N.J. 10, 40-41, 355 A.2d 647, 663-64, *cert. denied sub nom.* Garger v. New Jersey, 429 U.S. 922 (1976).

[136] *See* FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 184-85; Kane, *Keeping*

the pragmatic effect of ensuring that patients who will benefit from care are not mistakenly classified. Representatives of this group worry that once we pave the way for nontreatment of certain classes of patients, many more incompetent patients will risk being intentionally or inadvertently assigned to those classes.[137]

This position has numerous critics, however, who counter that the symbolic value of respect for life can be preserved and advanced by adopting policies that encourage administration of life-sustaining treatment solely to patients who have a reasonable chance of significantly benefiting from it. They attack the sanctity of life view as exposing individual patients to harm from burdensome, nonbeneficial treatment. In addition, they assert that the health care system can avoid mistaken denials of treatment, because it can sufficiently discriminate between patients with a reasonable possibility of benefiting from treatment and those who cannot be significantly helped.[138]

The opposing positions disagree vehemently on the relevance of quality of life to the value of a specific human being's life. Several courts have roundly condemned the view that an incompetent patient's quality of life should affect the treatment decision,[139] and warnings from ethicists are legion on the dangers of this approach.[140] But these exchanges have generally failed to recognize that "quality of life" has two quite different meanings. In one sense, measuring an individual's quality of life entails assessing the value of that individual's life to others, based on her relative contribution to and consumption of society's resources.[141] Incorporating such an estimate of a person's social worth into medical decision-making is almost unanimously rejected as insufficiently protective of the individual.[142] In its alternative sense, however, quality of life refers to the value of a patient's life to the patient.[143] This evaluation simply entails weighing the burdens and benefits the patient will experience if treatment is continued or foregone.[144] A number of courts have adopted this analysis as a method of determining

---

Elizabeth Bouvia Alive for the Public Good, HASTINGS CENTER REPORT, Dec., 1985, at 5. The highly-charged debate over the propriety of discontinuing nutritional support offers the clearest contemporary example of concern over the symbolic dimensions of foregoing life-sustaining treatment. *See* Capron, *Ironies and Tensions in Feeding the Dying,* HASTINGS CENTER REPORT, October, 1984, at 32; Callahan, *On Feeding the Dying,* HASTINGS CENTER REPORT, October, 1983, at 22.

[137] *See, e.g.,* Derr, *Nutrition and Hydration as Elective Therapy: Brophy and Jobes from an Ethical and Historical Perspective,* 2 ISSUES IN L. & MED. 25, 27, 32-33; Sieglar & Weisbard, *Against the Emerging Stream: Should Fluids and Nutritional Support Be Discontinued?,* 145 ANNALS INTERNAL MED. 129, 130-31 (1985). *See also* T. BEAUCHAMP & J. CHILDRESS, *supra* note 22, at 122-23 (presenting similar argument regarding active euthanasia).

[138] *See, e.g.,* Rhoden, *Treatment Dilemmas for Imperiled Newborns: Why Quality of Life Counts,* 58 S. CAL. L. REV. 1283 (1985); Arras, *supra* note 62, at 33.

[139] *E.g., In re* Conroy, 98 N.J. 321, 367-68, 486 A.2d 1209, 1232-33; Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 754, 370 N.E.2d 417, 432 (1977).

[140] *See, e.g.,* P. RAMSEY, ETHICS AT THE EDGE OF LIFE 172 (1978).

[141] *See* A. BUCHANAN, *supra* note 3, at 114.

[142] *See* Childress, *Rationing of Medical Treatment,* in ENCYCLOPEDIA OF BIOETHICS 1414, 1415-17 (W. Reich ed. 1978).

[143] *See* A. BUCHANAN, *supra* note 3, at 114. For a discussion of these and other possible interpretations of the phrase "quality of life," *see* Edlund & Tancredi, *Quality of Life: An Ideological Critique,* 28 PERSP. BIOLOGY & MED. 591 (1985).

[144] *See* A. BUCHANAN, *supra* note 3, at 113.

whether treatment is in a patient's best interests.[145] Many ethicists agree that considering a patient's quality of life in the latter sense will promote his well-being and can contribute to a decision that upholds society's interest in respecting life.[146]

A further pertinent inquiry concerns the extent to which the societal interest in respect for life should incorporate the general public's concepts of privacy, dignity, and bodily integrity for incompetent patients. There are indications that these concepts have affected legislation and judicial decisions.[147] Now legal decision-makers should explicitly consider whether these public values have an appropriate role in treatment decision-making, not because they matter to the patients themselves, but because they matter to the broader society. The question is whether respect for life in our culture supports placing constraints on certain medical interventions for individuals in certain conditions, on grounds that the failure to do so violates widely shared norms of the meaning of dignified and humane health care.[148]

Undeniably, these are unsettled issues in our society. It serves no legitimate purpose, however, for the law to avoid facing them as it has. Courts and legislatures should begin to acknowledge these conflicts and grapple openly with them. They should begin to participate in the exploration and debate that is a prerequisite to reaching any societal consensus on the meaning of respect for life in the context of contemporary medicine.

4. *Scarce Resources and Distributive Justice*

The final shortcoming of the existing law governing treatment of incompetent patients is its failure to examine the role of distributive justice principles in treatment decision-making. Judicial decisions and statutes on life-sustaining treatment until now have glossed over the potential conflicts between patient-centered treatment standards and society's interest in achieving a just allocation of its limited health care resources.[149] The current approach is attributable to an understandable concern that recognizing this societal interest could open the door to massive denial on economic grounds of beneficial care to defenseless incompetent patients.[150] Yet it is becoming more and more irresponsible for legal decision-makers to persist in their blanket refusal to face the reality of the nation's commitment to contain health care costs.

There are ethical and legal reasons for courts and legislatures to ac-

---

[145] *E.g., In re* Conroy, 98 N.J. 321, 365; 486 A.2d 1209, 1232 (1985); Barber v. Superior Court, 147 Cal. App. 3d 1006, 1019-20; 195 Cal. Rptr. 484, 491-92 (1983).

[146] *See, e.g.,* McCormick, *The Quality of Life and the Sanctity of Life,* HASTINGS CENTER REPORT, Feb. 1978, at 32.

[147] *See supra* notes 68-79 and accompanying text.

[148] *See supra* notes 81-89 and accompanying text. The state's interest in maintaining the ethical standards of the health professionals caring for the patient comprises an additional consideration related to the societal aim of maintaining respect for life. Although in several cases the medical staff caring for the patient has opposed the proposal to forego life-sustaining treatment, the courts have dismissed this opposition as subordinate to the patient's rights of self-determination and privacy. *E.g.,* Satz v. Perlmutter, 362 So. 2d 160, 164 (Fla. Dist. Ct. App. 1978), *aff'd,* 379 So. 2d 359 (Fla. 1980).

[149] *See* A. BUCHANAN, *supra* note 3, at 139.

[150] *See id.*

knowledge society's distributive justice concerns. As the President's Commission pointed out,

> allowing decisions about life-sustaining care to be made with total disregard for the costs they impose has . . . serious implications. Enormous expenditures may be made for very limited benefits, such as sustaining a painful and burdened life for an individual who has little or no capacity to enjoy it. When medical resources are used without concern for cost, the pattern of expenditures that results does not accurately reflect societal values because the pursuit of other goals remains constrained by costs.[151]

Moreover, a number of federal and state laws and regulations have been enacted to reduce health care costs.[152] Critics assert that in direct opposition to the law governing discontinuance of life-sustaining treatment, these regulatory constraints imply that the "aggregate cost of health care is to be considered as an explicit factor in deciding what is ethically and clinically appropriate treatment in particular cases."[153] Physicians are becoming increasingly disturbed by the contradictory legal messages presently conveyed to them.[154] Recent regulatory actions, together with a myriad of cost-containment measures adopted in the private sector, have created a climate in which legal decision-makers face strong pressure to give explicit attention to the effect financial considerations could have on life-sustaining treatment decisions for incompetent patients.[155]

Principles of distributive justice bear on the medical care all patients receive. Competing theories of distributive justice set forth a variety of criteria for determining which individuals have stronger and weaker claims to different health care interventions.[156] The contemporary debate over distributive justice centers on defining the level of health care that should be accessible to every individual in the United States.[157] In this framework, expensive interventions beyond the "adequate level" or "decent minimum" of health care might justly be denied to individuals for a number of different

---

[151] FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 46. *See* Scitovsky & Capron, *Medical Care at the End of Life: The Interaction of Economics and Ethics*, 7 ANN. REV. PUBLIC HEALTH 59 (1986); Bayer, Callahan, Fletcher, Hodgson, Jennings, Monsees, Sieverts & Veatch, *The Care of the Terminally Ill: Morality and Economics*, 309 NEW ENGL. J. MED. 1490, 1491-92 (1983) [hereinafter Bayer] (summarizing data on medical expenditures in last years of life).

[152] Stone, *Law's Influence on Medicine and Medical Ethics*, 312 NEW ENGL. J. MED. 309, 310 (1985); Kapp, *Legal and Ethical Implications of Health Care Reimbursement by Diagnosis-Related Groups*, 12 LAW, MED. & HEALTH CARE 245 (1984).

[153] *See* Kapp, *supra* note 152. *See also* Wanzer, Adelstein, Cranford, Federman, Hook, Moertel, Safar, Stone, Taussig & Van Eys, *The Physician's Responsibility Toward Hopelessly Ill Patients*, 310 NEW ENGL. J. MED. 955, 956-57 (1984).

[154] *See* Stone, *supra* note 152; Sieglar, *Should Age Be a Criterion in Health Care?*, HASTINGS CENTER REPORT, Oct., 1984, at 24; Johnson, *Life, Death, and the Dollar Sign: Medical Ethics and Cost Containment*, 252 J. AM. MED. A. 223 (1984).

[155] *See* OFFICE OF TECHNOLOGY ASSESSMENT, DIAGNOSIS-RELATED GROUPS (DRGS) AND THE MEDICARE PROGRAM: IMPLICATIONS FOR MEDICAL TECHNOLOGY (1983). *See also* Califano, *A Revolution Looms in American Health Care*, N.Y. Times, Mar. 25, 1986, at 25, col. 1.

[156] *See* Branson, *Theories of Justice and Health Care*, in ENCYCLOPEDIA OF BIOETHICS, *supra* note 142, at 630.

[157] *See* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, 1 SECURING ACCESS TO HEALTH CARE 35-43 (1983).

reasons.[158]

Courts and legislatures have failed to explore the question of whether certain incompetent patients have weaker claims to scarce health care resources than do other patients. Could a patient's diminished mental capacities ever justify the denial of life-sustaining medical treatment to advance the interests of other patients in obtaining costly medical interventions?[159]

Several commentators have argued for legal rules allowing decisions to withhold or withdraw life-sustaining treatment from permanently comatose patients on distributive justice grounds.[160] They contend that the permanently comatose patient's interest in receiving continued treatment is so small that it is ethically defensible to withhold or withdraw medical interventions from such patients so that others who can obtain more significant benefits from treatment may receive care.[161] On this view, even though strict application of the present best interests principle yields a decision in favor of continued treatment for permanently comatose patients,[162] their minimal interest in treatment is outweighed by the more compelling interests of other patients.

The analysis can be extended to additional categories of incompetent patients. Some ethicists assert that conscious patients who lack relational potential, that is, the capacity to be self-conscious and interact with others, have so little ability to experience benefits from continued life that their interests in receiving life-sustaining treatment are negligible.[163] In a climate of resource constraints, could life-support measures be permissibly withheld or withdrawn from these patients?

A treatment standard incorporating distributive justice considerations would alter the rule that requires treatment if an incompetent patient will receive any net benefit, no matter how minimal, to one that requires treatment only if the net benefit to the patient is expected to reach a certain level. According to this analysis, life-sustaining treatment must be provided to those incompetent patients with a reasonable chance of obtaining a significant benefit from the intervention.[164] The permanently comatose patient's interest in recovery against all medical odds is not weighty enough to require us to expend extensive health care resources on such patients. Likewise, the

---

[158] *See* Buchanan, *The Right to a Decent Minimum of Health Care*, in 2 SECURING ACCESS TO HEALTH CARE, *supra* note 156, at 207; Fried, *Equality and Rights in Medical Care*, HASTINGS CENTER REPORT, Feb., 1976, at 29.

[159] *See* A. BUCHANAN, *supra* note 3, at 148; Robertson, *supra* note 95.

[160] *E.g.*, A. BUCHANAN, *supra* note 3, at 116-22; FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 185-86; Engelhardt & Rie, *Intensive Care Units, Scarce Resources, and Conflicting Principles of Justice*, 255 J. AM. MED. A. 1159, 1162 (1986). *See also supra* note 108.

[161] *See* A. BUCHANAN, *supra* note 3, at 118-22; FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 182-83.

[162] *See* Robertson, *The Courts and Non-Treatment Criteria*, in DILEMMAS OF DYING: POLICIES AND PROCEDURES FOR DECISIONS NOT TO TREAT 105 (C. Wong & J. Swazey eds. 1981) (small possibility of recovery gives patients in Quinlan's state possible interest in having life maintained).

[163] *See* J. RACHELS, THE END OF LIFE: EUTHANASIA AND MORALITY 24-38 (1986); Rhoden, *supra* note 138, at 1318-20; Arras, *supra* note 62, at 31-33.

[164] *See, e.g.*, Engelhardt & Rie, *supra* note 160, at 1162 (presenting "ICU treatment entitlement index" incorporating judgment that as costs increase and probability of successful outcome, quality of outcome, and probable length of life decrease, duty to provide treatment to patient diminishes).

barely conscious patient's interest in a continued life that can offer only food and warmth as net benefits might not be significant enough to require costly life-sustaining medical interventions. Adopting this standard would require legal decision-makers to assess the probability and magnitude of the overall benefits treatment could confer on a particular incompetent patient (for instance, on Claire Conroy or Earle Spring), and to determine whether the benefits met a threshold level beyond which treatment could not be foregone for the benefit of other patients.[165]

The courts' and legislatures' hostility to such an approach is easy to understand. The resistance grows from a number of perceived threats. Openly allowing society's economic interests to influence treatment decisions is viewed as a symbolic devaluation of human life.[166] Many fear that social worth considerations will inevitably creep into the process of ascertaining whether incompetent patients are likely to receive benefits sufficient to confer on them a strong claim to health care resources. As a result, these writers warn, the inquiry could easily shift from an examination of the value of treatment and continued life to the patient, to an assessment of the value of that life to society.[167] Commentators are also worried that outsiders would fail to appreciate adequately the variability among individuals in the extent to which disabilities affect how they value their lives. Thus, there is concern that the process would encourage decisions biased against geriatric and handicapped patients.[168] In addition, physicians and others criticize the incorporation of economic considerations into clinical decision-making as contradictory to the medical profession's norms. Physicians are trained to seek the best care for their patients, they argue, and most physicians will rebel against lowering their standards for the benefit of other patients.[169]

The problem of the identifiable victim constitutes an additional obstacle to the explicit incorporation of distributive justice factors into the legal standards governing life-sustaining treatment of incompetent patients. Decision-makers contemplating the denial of beneficial medical care to an individual incompetent patient confront an especially troubling situation. Officials making resource allocation choices at the aggregate level consider such denials only in broad, statistical terms.[170] But courts and clinicians must cope with the heavy psychological burden of denying care to an identifiable pa-

---

[165] The determination could be altered if an incompetent patient formerly requested all available care or a family wanted maximal care for an incompetent relative, and the patient or family possessed sufficient private resources to cover the costs of such measures. *See* ENGELHARDT, *supra* note 42, at 211-12 (family members have no justifiable basis to demand care to sustain permanently comatose patients unless they wish to pay for such care with private funds); Smith, *supra* note 108, at 852, 873-74 (competent patient by prior directive or incompetent patient's family should have option of maintaining biological existence if can pay for continued care).

[166] *See* Evans, *Health Care Technology and the Inevitability of Resource Allocation and Rationing Decisions* (part 2), 249 J. AM. MED. A. 2208, 2214-17 (1983); Blumstein, *supra* note 97, at 233, 252.

[167] *See* FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 98; Evans, *supra* note 166, at 2217.

[168] *See, e.g.*, Avorn, *Benefit and Cost Analysis in Geriatric Care: Turning Age Discrimination into Health Policy*, 310 NEW ENGL. J. MED. 1294 (1984).

[169] *See* Stone, *supra* note 152, at 311-12; FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 98.

[170] *See* Evans, *supra* note 166, at 2216.

tient, to an individual they have in some sense come to know. Both judicial and clinical decision-makers will typically be more concerned about the fate of the patient before them than about the theoretical benefits others could receive if the patient were not treated.[171]

A further objection is that in the present United States health care system there is no assurance that denying an intervention to one patient on economic grounds releases resources allowing more needed care to be given to others. As Norman Daniels has recently pointed out, in Great Britain's National Health Service, explicit allocation decisions are made within a closed health care system, so that when certain procedures are denied to certain patients, other patients in the system do benefit.[172] In the United States, however, there is no guarantee that money saved by public and private health care providers will be channeled into providing more beneficial health care to other patients; instead, that money may simply increase a facility's profits, be devoted to other public needs, or provide coverage for less compelling health care services.[173] Daniels contends that in this nation, concern for distributive justice in health care thus fails to supply the ethical justification for decisions to deny care to individual patients for economic reasons.[174]

For all of these reasons, the existing legal standards governing decisions on life-sustaining care assign no explicit weight to society's interest in allocating its scarce health care resources with justice and fairness. Legal decision-makers have surely recognized that contemporary social conditions put the state in an increasingly precarious position regarding the provision of expensive, life-sustaining medical treatment. As the President's Commission has cautioned, "restrictions on marginally beneficial use of funds must avoid a real or perceived conflict between the role of government as articulator of rights and responsibilities (especially regarding the protection of human life) and its role as allocator of collective financial resources."[175] Thus far, courts and legislatures have managed to steer clear of this potential conflict by pretending that resource constraints have no influence on decisions about life-sustaining treatment. Accordingly, they have either completely ignored economic considerations or hidden them in a purported concern for patients'

---

[171] *See* C. FRIED, *supra* note 38, at 207-27; A. BUCHANAN, *supra* note 3, at 140; Blumstein, *supra* note 97, at 233, 266-304; Havighurst, *supra* note 96, at 140.

[172] Daniels, *Why Saying No to Patients in the United States Is So Hard: Cost Containment, Justice, and Provider Autonomy*, 314 NEW ENGL. J. MED. 1380, 1381 (1986).

[173] *Id.* at 1381-83.

[174] Thomas Schelling disagrees that rationing health care can be justified only if the money saved from marginally beneficial treatment is used to help other patients. According to Schelling, using the proceeds to assist other patients gives the health care system a greater incentive to limit marginally beneficial care. But he points out that stronger competing claims for the resources may exist outside the health care system. Schelling contends that the most justifiable course would be to use the proceeds for whatever competing claims are most compelling, regardless of whether they are within or outside the health care system. Letter from Thomas Schelling to author (August 26, 1986). Of course, the current U.S. system provides no guarantee that the money conserved from limiting health care will be used to address such claims.

[175] FOREGOING LIFE-SUSTAINING TREATMENT, *supra* note 6, at 100, n.20. The Commission and others have urged that cost containment attempts focus on interventions such as unnecessary tests and procedures, as opposed to life-sustaining therapies. *Id.* at 98-99. *See also* Califano, *supra* note 155.

past preferences, dignity, and privacy. This approach has the advantage of permitting decisions to incorporate trade-offs that might not be acceptable if they were openly acknowledged.[176] But far from dispelling the disturbing clash between patient-centered treatment standards and principles of distributive justice, such obfuscation serves only to hinder the open discussion necessary for achieving a morally acceptable resolution to the current dilemma. It is time for courts and legislatures to own up to the disquieting choices they face and to begin the task of articulating legal standards that reflect the realities of the present constraints on health care resources.

CONCLUSION

The legal standards governing decisions on life-sustaining treatment for incompetent patients should be revised. The present reliance on patients' past preferences and on imputed reasonable person values fails to reflect true concern for incompetent patients, for it assigns priority to values and desires that can no longer matter to the patients themselves. Decisions ought to be guided by systematic assessments of incompetent patients' contemporaneous interests. If the investigation reveals that the benefits treatment can confer on specific patients will be of dubious, minimal, or uncertain value to them, then the inquiry should shift to other factors that might bear on the treatment decision. The interests of former competent patients and those of incompetent patients' families, together with societal interests in upholding respect for life, in providing patients with what others view as dignified and humane care, and in achieving a fair distribution of health care resources, are all considerations that could be incorporated into the legal standards governing treatment decision-making.

This approach would yield the following analysis. Patients diagnosed as permanently comatose have no reasonable possibility of being restored to consciousness and consequently have a minimal interest in obtaining life-sustaining treatment. In these cases, the decision ought not depend exclusively on patients' formerly expressed preferences for or against treatment, or on a desire to respect on their behalf their privacy, dignity, and bodily integrity. Instead, the inquiry should address the limited benefit treatment would bestow on these patients and examine whether considerations external to the patients should influence the decision. Should the individual's former competent treatment preferences carry any weight? Does a particular patient's family have appreciable interests in continuing or foregoing life-sustaining treatment to the patient? Would a decision to withhold or withdraw treatment impermissibly threaten society's symbolic valuing of human life? Would a determination to administer or discontinue treatment violate socie-

---

[176] *See* Bayer, *supra* note 151, at 1490-91 (if economic issues in treatment of terminally ill not discussed openly, decisions may be made based on insufficiently examined assertions and criteria); Blumstein, *supra* note 97, at 252, 303-05 & n.457 (courts' failure to articulate explicit principles governing resource allocation and life-sustaining treatment in individual cases allows nongovernmental agencies such as families, physicians, and hospital committees to make difficult choices out of public arena). *See also* Brennan, *Do-Not-Resuscitate Orders for the Incompetent Patient in the Absence of Family Consent*, 14 LAW, MED. & HEALTH CARE 13, 18 (1986) (decision to forego resuscitation of incompetent patient "undoubtedly, if less than consciously, reinforced by consideration of limited resources').

tal interests in seeing incompetent patients treated in accord with general concepts of humane and dignified care? Should treatment be foregone because other patients have more compelling claims to the resources that would be consumed in caring for this individual?

A similar investigation should be conducted in cases involving patients whose contemporaneous interests in receiving treatment appear more extensive than those of the permanently comatose patient, but are still small enough to suggest that treatment will be of questionable value to such individuals. Consider, for example, the case of Claire Conroy. The magnitude of her interest in continued care should be assessed in light of her behavior, which included periodic moaning when she was moved, tube-fed, and had her bandages changed, as well as occasional smiles when someone combed her hair or gave her a "comforting rub."[177] After this information and other data are scrutinized to ascertain the value continued treatment would have for her, the external considerations representing her former competent desires and behavior, her family, the general society, and other patients in need of health care should be examined. In the end, a judgment should emerge concerning the appropriate effect these various interests have on the treatment decision.

These are the areas courts and legislatures should explore as they set standards for life-sustaining treatment of incompetent patients. The current preoccupation with respecting incompetent patients' rights to self-determination and privacy is misguided and insufficiently attentive to their genuine interests as incompetent patients. The sole virtue of this approach is its ability to conceal the power the concerns of others exert over treatment decisions. But incompetent patients and the rest of us deserve more. Defensible legal standards will emerge only if courts and legislatures undertake the painful process of analyzing the authentic interests implicated in today's decisions on life-sustaining treatment for incompetent patients.

---

[177] *In re* Conroy, 98 N.J. 321, 337, 486 A.2d 1209, 1217 (1985).