The Effects of the Cruzan Case

on the Rights of Elderly Clients
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I. Introduction

An 88-year-old woman, diagnosed as being in a persistent vegetative state following a stroke, resided in a nursing home where she received all of her nutrition and hydration through a nasogastric tube. Neither the woman nor her family had at any time consented to the insertion of the nasogastric tube. In fact, the woman had expressly informed hospital staff after she suffered her first stroke that she did not want "tubes." Despite her verbal directives, the feeding tube was inserted. Her daughter, herself a senior citizen, was obligated to become the guardian of the person of her mother in order to obtain court authority to remove the nasogastric tube. /1/

An elderly man who had suffered several strokes, numerous blood clots, and paralysis, discussed with his wife his wish to die with dignity. Although he never prepared a written directive concerning health care decisions, he verbally expressed his desire not to be maintained in a vegetative state when there was no potential for recovery. Several months after suffering his second stroke he became unable to swallow, and, with the consent of his family, a gastrostomy tube was inserted for the provision of hydration and nutrition. When the man's doctor informed his family that he lacked any potential for recovery, his family, consistent with his wishes and the doctor's recommendations, requested the withdrawal of further mechanical life-support. The nursing home refused to follow the physician's directions absent a court order, and the family sought legal assistance to commence a guardianship proceeding. Before a suit could be filed, the man's doctor was able to transfer him to another nursing home that agreed to follow the doctor's orders and withdraw the gastrostomy tube without judicial intervention. /2/

The recent Supreme Court decision in Cruzan v. Director, Missouri Department of Health /3/ dealt with the withdrawal of artificial sustenance from a young woman who had been in a persistent vegetative state (PVS) /4/ for seven years with no hope of recovering. Her parents as her coguardians sought judicial approval for their decision to terminate treatment. The Missouri Supreme Court reversed the trial court and denied the family's request, and the United States Supreme Court affirmed. /5/

This highly controversial case generated substantial publicity both before and after the decision was handed down. Nevertheless, the issues that it addresses arise often, and are of real concern to elderly clients of legal services programs. Although the two cases described above sound as if they come from the front page of a newspaper, they do not. They are actual cases handled by
II. Cruzan v. Director, Missouri Department of Health

Ever since the New Jersey Supreme Court was asked to decide whether Karen Anne Quinlan's parents and guardians could authorize the removal of her ventilator, courts have been faced with the problem of determining the circumstances under which life-sustaining treatment can be withdrawn or withheld from a terminally ill or permanently unconscious patient. The Supreme Court, however, declined to hear the issues involving such circumstances on several occasions before it agreed to hear Cruzan v. Director, Missouri Department of Health.

Because Cruzan is the first case in which the Court was presented with the constitutionality of a patient's "right to die," its decision is limited and does not address all of the complexities involved. Chief Justice Rehnquist, in writing for the majority, acknowledged that he would "not attempt, by any general statement, to cover every possible phase of the subject."

The Supreme Court in Cruzan took an important first step by guaranteeing the right of a competent person to refuse unwanted medical treatment. The constitutional support for this right is based on the fourteenth amendment's protection of a person's liberty interest. Equally important, the Court departed from the Missouri Supreme Court's opinion and indicated its willingness to consider hydration and nutrition as medical treatment that could be refused by a competent person exercising his or her rights under the fourteenth amendment. This position is supported by the medical community, which characterizes artificial nutrition and hydration as medical treatment, and by the federal government's Medicare policy.

If the right to refuse treatment is to be exercised by an incompetent person, it must be exercised by a surrogate on his or her behalf. The Court, in affirming the Missouri decision, accepted that, under certain circumstances, a surrogate may refuse artificial sustenance on behalf of an incompetent person. However, a state may impose procedural safeguards to ensure that the surrogate acts in compliance with the wishes expressed by the patient when competent. The Supreme Court specifically upheld Missouri's requirement that the decision be based upon clear and convincing evidence of the incompetent person's expressed wishes. The Supreme Court approved Missouri's limitation of evidence to direct statements of the incompetent person's desires if he or she were in the situation in which the person currently finds himself or herself. Statements by family members and friends about the person's lifestyle and beliefs, as well as general statements about death with dignity are not sufficient, by Missouri standards, to meet the burden. The Supreme Court found that Missouri did not commit constitutional error by holding that Nancy Cruzan's statements that she would not want
to live as a "vegetable" did not constitute clear and convincing evidence of her wish to have
treatment withdrawn. /20/

III. The Right to Refuse Life-Sustaining Treatment After Cruzan

Clients with clear wishes concerning their medical treatment can take some comfort from the
Cruzan decision. The right of competent individuals to refuse treatment is protected under the
fourteenth amendment. And if those competent individuals express their wishes specifically,
their rights may be protected even if they should subsequently become incompetent. The
largest remaining issue is the manner in which individuals may safeguard their rights in the
event of future incapacity.

A. Living Wills and Durable Powers of Attorney

At the very least, directions concerning life-sustaining evidence that are contained in a living
will or a durable power of attorney for health care are the best form of evidence of a person's
wishes. They are written statements of a person's intention, made under oath and/or witnessed
by impartial witnesses who can certify that the person was competent to understand the
purpose of the document that he or she was signing. /21/ The Missouri Supreme Court implied
that such written documents may be the only form of evidence of intent sufficient to satisfy the
clear and convincing evidence standard in that state. /22/

Justice Rehnquist, in writing for the majority, left open the even more pressing question of
whether an individual acting pursuant to a living will or a durable power of attorney /23/ could
exercise an incompetent individual's right to refuse treatment. Many clients who execute these
documents do so for the express purpose of naming a surrogate to request withdrawal of life-
sustaining treatment, including artificial nutrition and hydration. At least one justice, Justice
O'Connor, has indicated that authorizing an agent to act in these situations adds protection to
the competent person's liberty interest in refusing medical treatment. In her opinion, states may
be required to implement the decisions of a patient's duly appointed surrogate to protect the
patient's rights. /24/

Until or unless the Supreme Court rules on the issue, state law determines whether a competent
individual can use a living will or durable power of attorney for health care to express his or her
views about life-sustaining treatment in the event of subsequent incapacity. /25/ Forty states
and the District of Columbia have enacted living will or natural death acts. /26/ In addition, a
growing number of states have health care durable power of attorney statutes. As of July 1990,
32 states have enacted specific durable health care power of attorney laws, 12 of those statutes
having been enacted since January 1990. /27/ States without specific legislation may also
authorize the use of durable powers of attorney for health care, either by specific reference in
other statutes, /28/ by attorney general's opinion, /29/ or by case law. /30/ Finally, many
commentators believe that general durable power of attorney statutes are broad enough to
authorize medical decisionmaking, including a decision to terminate life-sustaining treatment.
/31/
Elderly clients are more familiar with living wills than with durable powers of attorney for health care. Most living will statutes predate health care durable power of attorney legislation, and living wills have received more publicity. However, living wills are more restrictive than powers of attorney in that they do not become effective until a person is terminally ill. Because the definition of terminal illness varies with each state, not everyone who is in a PVS will meet the definition of terminal illness and be able to avail himself or herself of the protections of a living will, if the individual has written one. The Missouri courts, for example, found that Nancy Cruzan was not terminally ill, but was capable of living another 30 years. /33/ A Connecticut court, on the other hand, held that a woman in a PVS was terminally ill. /34/

The Supreme Court of Illinois recently found that a man who had been in a chronic vegetative state for five years following a stroke was terminally ill. /35/ The court relied on the Illinois Living Will Act, which defines a terminal condition as one in which death is imminent and death-delaying procedures serve only to prolong the dying process. /36/ The court concluded that imminence must be judged as if the death-delaying procedures were absent. Since the patient would die within a week after withdrawal of the feeding tube, his death was sufficiently imminent for him to be found terminally ill. /37/

Other restrictions may limit a living will's utility. Many living will statutes exclude artificial nutrition and hydration from the medical procedures that may be terminated or withheld pursuant to that document. /38/ An individual who executes a living will that follows such a statutory format and contains the exclusion for artificial feeding will not be able to use it to request that such feeding be withheld or terminated, or as evidence of intent that artificial feeding not be provided if the issue goes to court.

At least one state, Maryland, has construed its living will statute to be cumulative with other rights concerning life-sustaining treatment. /39/ Despite specific statutory language precluding the withholding of artificial sustenance, the Maryland attorney general concluded that an individual can still use a living will or other means to request that such treatment not be provided. The attorney general determined that interpreting the statute to require the administration of artificial sustenance to an individual who expressly rejected such treatment, or to give less decisionmaking authority to competent adults who execute living wills than to those who use other means of expressing their preferences, would not survive a constitutional challenge. /40/ Thus, in Maryland and in other states with similar provisions, clients who wish not to be artificially fed should specify their desires in their living wills, contrary statutory language notwithstanding.

It is important to note that, in the Cruzan case, Missouri used the living will language that precludes the termination of artificial sustenance as evidence of legislative policy requiring the unqualified protection of life, even though Nancy Cruzan had not executed a living will. /41/ Other jurisdictions whose living will statutes preclude the termination of nutrition and hydration have determined that the statutes do not limit the constitutional, common-law, and statutory rights of individuals without living wills to request the withdrawal of artificial nutrition and hydration. /42/
Legislation specifically authorizing a durable power of attorney for health care is less likely to restrict the termination or withholding of artificial hydration and nutrition than living will legislation. Eighteen of the thirty-two state health care durable power of attorney statutes do not limit an agent's authority to refuse or request termination of artificial hydration and nutrition. An additional nine states authorize the agent to act as long as specific conditions are met. These conditions may include stating specifically in the durable power of attorney that the principal wants artificial sustenance withheld or withdrawn under certain circumstances, and/or doctors' statements that life-prolonging intervention is not medically warranted.

A durable power of attorney for health care, like a living will, provides better protection if it contains specific instructions on the agent's authority to refuse life-sustaining treatment. For example, under the recently enacted New York law, the agent will not have the authority to refuse artificial sustenance unless the principal's wishes are reasonably known or can be ascertained with reasonable diligence. Statements contained in the document are the best way to make the principal's views "reasonably known." Also, as noted above, state law may only authorize the agent to act if the document specifically refers to the termination or withholding of artificial feeding mechanisms.

Some clients have executed both a living will and a durable power of attorney for health care. Instead of providing additional protection, the execution of both documents can create confusion as to their wishes. Problems are most likely to arise if the client executes a form living will that contains statutory language precluding its use to terminate nutrition and hydration, and a durable power of attorney authorizing the agent to refuse or withdraw artificial sustenance. At least one state court has determined that a subsequently enacted power of attorney will take precedence over the living will in that situation, as long as the agent under the durable power of attorney is available to act. Other states have enacted statutes that make the provisions contained in the more recently executed document controlling.

The best protection for any person, then, is to execute a living will or durable power of attorney for health care. The document should designate an agent to act if the person becomes incapacitated, and set forth with as much specificity as possible the treatments that the principal wants or does not want in different circumstances. Unfortunately, most Americans do not execute such documents. A survey published shortly after the Supreme Court issued the Cruzan decision found that only 11 percent of those questioned had written instructions concerning their wishes. In that case, many people with strong convictions about the treatment that they would want or not want may lose the right to have their directions followed if they become incompetent.

Justice Brennan, writing for the dissent in the Cruzan case, outlined the reasons that so few people execute formal documents expressing their wishes for medical treatment in the event of incapacity. Because the likelihood of falling into a vegetative state is so low, people feel no great urgency to express their desires formally. They may also be unwilling to face the issue of their mortality. Legal services advocates should take note of Justice Brennan's statement that a person must be aware that advanced directives about medical care exist in order to execute such a document, and that the person may need legal help in order to comply with all of the requirements.
To complicate matters for legal services programs, surveys reveal that affluent individuals are more likely to make their wishes known than are those who are less well off. Blacks also are less likely than whites to have expressed their views on medical treatment. College graduates and affluent individuals are the most likely to have heard of living wills. An outreach program explaining a person's rights to refuse treatment, especially in light of the Cruzan decision, would be helpful, as would a policy of explaining durable powers of attorney for health care and living wills to clients who request traditional wills and general powers of attorney. But what can the advocate do when faced with the situations described at the beginning of this article, in which a request to terminate treatment is made on behalf of an individual who has not executed a formal document, and who no longer retains the capacity to do so?

B. Other Evidence of a Patient's Wishes

In affirming the Cruzan decision, the Supreme Court let stand Missouri's determination that the patient's statements to her family and friends, as well as testimony concerning her values, beliefs, and lifestyle, do not constitute clear and convincing evidence of her wishes to be free of feedings via a gastrostomy tube. However, as the dissent in Cruzan indicates, Missouri's rejection of the testimony of family and friends is not followed by other states. Even Justice Rehnquist, in noting that many other jurisdictions have adopted the clear and convincing evidence standard utilized in Missouri, acknowledged that these jurisdictions have chosen that standard "whether they limit consideration of evidence to the prior expressed wishes of the incompetent individual, or whether they allow more general proof of what the individual's decision would have been." In other words, it is up to each jurisdiction to determine what evidence satisfies the clear and convincing standard.

Advocates must remember that the absence of a living will or health care power of attorney is not dispositive of the issue of the patient's views toward life-sustaining treatment. Many living will statutes provide that an individual's failure to execute a living will does not create a presumption that he or she would want medical treatment continued. Justice Brennan points out that not even the Missouri legislature believes that the absence of a living will presumes a desire to be treated forever. Justice O'Connor in her concurrence notes that "[s]tates which decline to consider any evidence other than [written] instructions may frequently fail to honor a patient's intent."

Although people are unlikely to set forth their views in a formally executed document, they are likely to discuss their concerns with their family and friends. More than half of the persons surveyed by the American Medical Association had discussed their wishes with family members. Similar findings were made by another survey. Courts have accepted testimony by family and friends about these discussions as evidence of the patient's expressed wishes or, if no statements were made, as evidence of the person's personal value system that will be used to guide the surrogate decisionmaker. Even New York, which in limiting its inquiry to the person's expressed wishes has the most stringent requirements after Missouri, considers testimony of family discussions relevant in ascertaining those wishes.
Courts have found family members to be the persons most familiar with the patient and most helpful when the surrogate must make a decision using the "substituted judgment" standard. /68/ That standard requires the surrogate to establish what decision the individual would have made if he or she were competent. The surrogate is guided not only by direct statements, but also by the person's religious and moral views, life goals, and values. /69/ These courts rely on the exact kinds of testimony about values and lifestyle that the Cruzan decision rejected. Advocates in jurisdictions other than Missouri should still be prepared to introduce this kind of testimony together with whatever evidence is available of the person's expressed directions.

Justice Stevens, in his separate dissent, argues that "[t]he critical question . . . is not how to prove the controlling facts but rather what proven facts should be controlling." /70/ He argues that the best interests of the individual, buttressed by the interests of all related third parties, must prevail over any general state policy that ignores those interests. /71/ Justice Stevens would consider various personal factors, including the circumstances under which the person wishes to die, the point at which the person considers that his or her biological existence ceases to serve his or her interests, concerns about how the person is remembered after death, and his or her interest in minimizing the burdens that the illness imposes on others. /72/

**C. Other Procedural Safeguards**

Justice Brennan advises in dissent that states are not bound by the clear and convincing evidence and limited evidentiary approach adopted by Missouri. States should be free to establish their own procedural safeguards to protect the interests of incompetents, as long as they do not lessen the likelihood of an accurate determination. /73/ He cites two other approaches, the requirement of a court proceeding or the appointment of an impartial guardian ad litem. /74/

1. **The Requirement of a Court Proceeding**

Justice Stevens notes that the debate about whether a judicial proceeding should be required before terminating life-support has already divided the states. /75/ Several states require that a court specifically grant the guardian the authority to exercise the right to refuse or withhold treatment on behalf of an incompetent person. /76/ However, other states, in acknowledging the guardian's authority, allow the guardian to assert the right of the incompetent to refuse treatment without first seeking court approval. These jurisdictions see the judicial process as unduly burdensome, and find no need for judicial intervention absent conflict among the parties. /77/

Judicial involvement in the decision to terminate or withhold treatment is increasing. Nevertheless, many decisions are made without judicial intervention, as was the case in one of the situations described at the beginning of this article. /78/ Indeed, many groups take the position that if the patient's wishes are known, and the family and physician concur, legal intervention is unnecessary. /79/
2. Appointment of a Guardian Ad Litem

Justice Brennan argues even more strongly that the appointment of a guardian ad litem to investigate and gather evidence provides greater protection to a person's interests than does an adjustment to the burden of proof or a discounting of certain types of evidence. The guardian ad litem can discover conflicts of interest, as well as find additional evidence of the patient's wishes. /80/

The use of a guardian ad litem, either in addition to or in lieu of counsel for the proposed ward, is problematic in traditional guardianship cases. /81/ The guardian ad litem does not advocate for the rights of the proposed ward, but serves as an investigator for the court. The guardian ad litem often becomes the primary source of evidence about the individual's condition and functional abilities, and upon which the finding of the need for a guardian is based. /82/ However, the problems associated with the appointment of a guardian ad litem in a guardianship proceeding actually support Justice Brennan's argument for appointing one in proceedings to terminate life-sustaining treatment. In these proceedings, guardians ad litem have provided evidence relied upon by those courts /83/ and have ensured that the proceeding is adversarial and that all points of view are considered. /84/

In the context of guardianship proceedings generally, commentators prefer the appointment of an attorney to represent the proposed ward and to ensure that his or her rights are protected. /85/ Appointing an attorney to represent the incompetent in a proceeding to terminate life-support would better accomplish Justice Brennan's objectives than appointing a guardian ad litem. An attorney would, by definition, be required to advocate for the person's wishes. /86/ By challenging expert testimony and the statements of other witnesses, the attorney would add the adversarial element that some judges have found missing from these proceedings. /87/

3. Competent Medical Evidence

The Supreme Court of Illinois has adopted all of the procedural safeguards set forth in the Cruzan majority and dissenting opinions, and has imposed safeguards of its own. /88/ The most interesting safeguard requires that an incompetent person be diagnosed as irreversibly comatose or in a PVS by the incompetent's attending physician and at least two other consulting physicians. /89/ The use of medical reports eliminates the problem of decisions being made on the basis of nonexpert (or even nonexistent) evidence, which occurs in traditional guardianship cases. /90/ The requirement that the diagnosis be corroborated lessens the likelihood that a request to terminate treatment will be made on the basis of a misdiagnosis of PVS. /91/

The Illinois Supreme Court also wants to ensure that the medical evidence is competent and admissible. It recently remanded a case in which only one consulting physician testified as to the patient's diagnosis; the testimony of the other physicians was admitted via hearsay evidence. Such hearsay testimony did not satisfy the evidentiary requirements for medical diagnosis. /92/ The requirement of competent evidence protects the interests of the individual
against any unscrupulous attempt to railroad through the courts a petition to terminate treatment. /93/

IV. Conclusion

Studies show that many senior citizens support the right to die by refusing treatment. /94/ Older citizens are more accepting of death than are younger individuals, and consider death preferable to "living too long, . . . being kept alive by machines and intravenous feedings--and being incapacitated, dependent, impotent, in pain, and unable to communicate." /95/

Issues concerning the termination of treatment have arisen for legal services and Older Americans Act clients, and they will continue to arise. While the Supreme Court decision in Cruzan provides some guidance for advocates, it is only a beginning. States must formulate their own requirements and procedural safeguards. It is up to the advocate to protect the right of the client to have his or her own decisions about health care followed.

footnotes

1. Brief of Barbara Burgoon and Ruth Fields as Amicus Curiae Supporting Petitioners at 2 (Clearinghouse No. 44,045E) (Cruzan v. Director, Mo. Dep't of Health, 58 U.S.L.W. 4916 (June 25, 1990) (No. 88-1503)).

2. Id. at 2, 3.


4. "PVS is a type of comatose state in which the cerebral functioning has ceased but in which the brain stem functioning is fully or partially in tact. The brain stem controls primitive reflexes, including heart activity, breathing, the sleep/wake cycle, reflexive activity in upper and lower extremities, some swallowing motions and eye movements. [The patient] shows signs of each of these activities. The cerebrum, on the other hand, controls sensation and voluntary and conscious activities. [The patient's] cerebrum has been damaged severely, and as a result she displays no voluntary or conscious movements, nor does she display any awareness or sensation. This combination of reflexive activity in the absence of sensation or conscious activity is characteristic of PVS. PVS is generally a permanent condition." Gray v. Romeo, 697 F. Supp. 580, 582 (D.R.I. 1988) (Clearinghouse No. 44,048).

5. Cruzan, 58 U.S.L.W. at 4916, aff'g Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1989).

6. 42 U.S.C. Secs. 3001 et seq. The mandate to establish legal services programs is found at 42 U.S.C. Sec. 3027(a)(15).


11. Id.

12. Id. The Court declined to follow the lead of many of the earlier state court opinions that relied on the right to privacy as support for the right to refuse treatment. See, e.g., Quinlan, 355 A.2d at 646; Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) (Clearinghouse No. 19,942); Drabick, 245 Cal. Rptr. at 840.

13. Cruzan, 58 U.S.L.W. at 4920. The Court did note that the consequences of refusing life-sustaining medical treatment should be considered in determining whether such refusal is constitutionally protected.


15. Gastrostomy feedings qualify as "skilled nursing services" under Medicare. 20 C.F.R. Sec. 409.33(b)(2); HEALTH CARE FINANCING ADMIN., HHS, MEDICARE INTERMEDIARY MANUAL Sec. 3132.2 (1988).


17. Id. at 4921.

18. Id. at 4932 (Brennan, J., dissenting).

19. Id. at 4922.

20. Id.
21. Chief Justice Rehnquist notes that the requirement of a written document is well established in our legal system. Wills must be written to be enforced, and contracts cannot be modified by oral evidence. Id. at 4921.


25. Many courts that have ruled on issues involving the termination of artificial nutrition and hydration have done so reluctantly, indicating that the question is best left to state legislatures. Cruzan, 58 U.S.L.W. at 4924; Cruzan v. Harmon, 760 S.W.2d at 426.


28. ARK. STAT. ANN. Secs. 20-17-201 et seq. (Supp. 1989); DEL. CODE ANN. tit. 16, Sec. 2502 (1983); FLA. STAT. Sec. 765.05(2) (1989); HAWAII REV. STAT. Secs. 327D-1 et seq. (1986); IOWA CODE ANN. Sec. 144A.1 (West 1987); LA. REV. STAT. ANN. Sec. 40:1299.58.1 (West Supp. 1990); MINN. STAT. Sec. 145B.01 (Supp. 1989); WYO. STAT. Secs. 33-26-144 et seq. (1988).


33. Cruzan v. Harmon, 760 S.W.2d at 411.

34. McConnell v. Beverly Enters., 209 Conn. 692, 553 A.2d 596, 404 (1989) (Clearinghouse No. 44,047). In another case, Ms. Browning, who was diagnosed as being in a PVS, died before the Florida court could decide the issue of whether her written declaration that she did
not want artificial nutrition and hydration to be provided if she were terminally ill applied to her current condition. In re Browning, 543 So. 2d 258 (Fla. 1989) (Clearinghouse No. 45,085).

35. Medical testimony indicated that "Mr. Greenspan is terminally ill in the sense that his illness would have been terminal if current means of keeping him alive were unavailable." In re Greenspan, No. 67903, slip op. at 3 (Ill. July 9, 1990) (Clearinghouse No. 45,086).


37. Greenspan, slip op. at 15.

38. See, e.g., MO. REV. STAT. Secs. 459.010 et seq. (1986); MD. HEALTH-GEN. CODE ANN. Secs. 5-601 et seq. (Supp. 1990).


40. Id. at 20-23.

41. Cruzan v. Harmon, 760 S.W.2d at 420, 426.

42. Corbett v. D'Alessandro, 487 So. 2d 368 (Fla. Dist. Ct. App.), review denied, 492 So. 2d 1331 (Fla. 1986); In re Gardner, 534 A.2d 947 (Me. 1987) (Clearinghouse No. 42,926); Greenspan, slip op. at 13-14.


47. 1990 N.Y. Laws 752, adding N.Y. PUBLIC HEALTH LAW Sec. 29-C (McKinney 1990).


49. Greenspan, slip op. at 13, citing Estate of Longeway, 133 Ill. 2d at 54.

50. See e.g., W. VA. CODE Sec. 16-30A-4(d)(8) (1990).


52. TIMES MIRROR CENTER FOR THE PEOPLE & THE PRESS, THE RIGHT TO DIE 12-13 (1990) [hereinafter TIMES MIRROR]. Emmanuel & Emmanuel, supra note 51, reported in 1989 that only nine percent of Americans execute advanced directives. A 1988 survey by the AMA found that 15 percent had executed living wills. AMA, SURVEYS OF PHYSICIAN AND PUBLIC OPINION ON HEALTH CARE ISSUES 29-30 (1988) [hereinafter AMA SURVEYS].


54. TIMES MIRROR, supra note 52, at 13.

55. Id.

56. Id. at 14.

57. Cruzan, 58 U.S.L.W. at 4921, 4922.

58. Id. at 4932 (Brennan, J., dissenting).


60. Cruzan, 58 U.S.L.W. at 4921.

61. MD. HEALTH-GEN. CODE Sec. 5-610 (Supp. 1989); MO. REV. STAT. Sec. 459.015 (1985).

63. Id. at 4923 (O'Connor, J., concurring).

64. AMA SURVEYS, supra note 52, at 29-30.

65. Fifty-one percent of married people had discussed with their spouses their wishes for medical treatment. TIMES MIRROR, supra note 52, at 12.

66. Longeway, 123 Ill. 2d at 33.

67. In looking to the patient's expressed intent, New York is actually applying a substituted judgment standard and requiring a greater degree of proof of the patient's intentions. The court in In re Westchester Medical Center (O'Connor), 72 N.Y.2d 517, 534 N.Y.S.2d 886, 531 N.E.2d 607 (1988), denied a petition to terminate artificial feeding after the patient's daughters testified that they did not know whether their mother would want to decline artificial hydration and nutrition under her present circumstances. Their mother was conscious, somewhat responsive, and her condition was capable of improving. In this case the result probably would have been the same had a substituted judgment test been applied.


69. Jobes, 529 A.2d at 434; Gardner, 534 A.2d at 947.

70. Cruzan, 58 U.S.L.W. at 4939 (Stevens, J., dissenting).

71. Id.

72. Id. at 4936-4938.

73. Id. at 4933 (Brennan, J., dissenting).

74. Id. See also the comments of Justice Stevens on judicial intervention and the use of a guardian ad litem in the Cruzan case. Id. at 4937 n.13 (Stevens, J., dissenting).

75. Id. at 4937 n.13 (Stevens, J., dissenting).

76. Saikewicz, 370 N.E.2d at 434-435; Longeway, 133 Ill. 2d at 33; MD. EST. & TRUSTS CODE ANN. Sec. 13-708(8) (Supp. 1990). In 1990, Maryland amended section 13-708(8) to make absolutely clear that the guardian's authority to consent to medical treatment included the authority to refuse or terminate treatment, including the provision of artificial sustenance. The legislature retained the requirement that the guardian obtain court approval before making such a decision. Even without the clarifying amendment, however, the Maryland Attorney General had concluded in a 1988 opinion that a guardian had the authority to refuse life-sustaining treatment. 73 Op. Md. Att'y Gen. 3, No. 88-046 (Oct. 17, 1988).
77. Drabick, 245 Cal. Rptr. at 844; Rasmussen, 741 P.2d at 691; Jobes, 529 A.2d at 434.

78. "At oral argument it was disclosed that on an average about 10 life support systems are disconnected weekly in Minnesota." In re Torres, 357 N.W.2d 332, 341 n.4 (Minn. 1984).

79. PRESIDENT'S COMM'N, supra note 14, at 131 ("[T]he cumbersoness and costs of legal guardianship strongly militate against its use."); Ruark, supra note 14, at 30 ("Decisions should be made by family, friends, health care providers, and facilitators. Only rarely is legal assistance necessary.").


83. See, e.g., Romeo, 697 F. Supp. at 580.

84. One guardian ad litem attempted to find a physician to contradict testimony that it would be medically appropriate to remove the patient's feeding tube, but informed the court that he was unable to do so. Greenspan, slip op. at 3.


86. Id.

87. Unlike the Cruzan majority, Justice Brennan does not view agreement between the guardian ad litem and those seeking to terminate treatment as a limitation of the adversarial procedure. Rather he interprets the lack of genuine dispute as an indication that termination of treatment is the appropriate action. Cruzan, 58 U.S.L.W. at 4921 n.9, 4931. See also, Greenspan, slip op. at 21 (Ward, J., dissenting).

88. A court must enter an order, on the basis of clear and convincing evidence, that allows the surrogate to exercise the incompetent's right to refuse treatment. A guardian ad litem is appointed during the course of the proceeding to investigate the incompetent's wishes. Longeway, 133 Ill. 2d at 47-53; Greenspan, slip op. at 3, 11.

89. Longeway, 133 Ill. 2d at 47-53; Greenspan, slip op. at 3, 11.

91. Jobes, 529 A.2d at 434.


93. The acceptance by the courts of hearsay medical evidence in the context of general guardianship proceedings has lead to the inappropriate appointment of guardians. SUBCOMM. ON HEALTH & LONG-TERM CARE, supra note 90, at 22, 32-33.
