

Relitigating Life and Death

REBECCA DRESSER*

In recent articles, both Nancy Rhoden¹ and I² criticize the “subtly dishonest”³ legal standards governing life and death decisionmaking for incompetent patients. Both of us argue for replacing the current standards with ones that more accurately reflect the dynamics of such decisionmaking. At this point, however, we part ways. Rhoden endorses the use of living wills, the patient’s prior values and preferences, and family discretion to resolve treatment questions. In this Article, I take issue with her position on the ground that it insufficiently meets our moral obligation to protect incompetent patients.

Part I is a summary of Rhoden’s Article. In Part II, I contest her claim that an objective treatment standard dehumanizes patients,⁴ and contend instead that such a standard demonstrates the highest regard for these individuals. I also point out that Rhoden’s suggested “reasonableness” test itself incorporates an objective standard. Part III addresses the merits of Rhoden’s argument that living wills should invariably govern subsequent treatment decisions. Her position must be recognized as subordinating the welfare of incompetent patients to the desires of competent persons to have future control. Part IV analyzes Rhoden’s proposal for family discretion in treatment decisionmaking. In it, I express doubts about the proposal’s ability to protect patients from inappropriate treatment decisions. I conclude by calling on courts to adopt an objective treatment standard that acknowledges the moral relevance of quality-of-life judgments, family preferences, and other external considerations in treatment decisionmaking.

I. RHODEN’S POSITION

Rhoden begins by criticizing the courts’ overly expansive application of a subjective treatment standard that purports to implement the incompetent patient’s “right” of self-determination.⁵ According to this standard, nontreatment is acceptable if there is evidence demonstrating that the patient when competent would have chosen this outcome. The freedom to choose life-sustaining treatment is part of the competent patient’s right of self-determination. Rhoden shows, however, that it is frequently misleading to adopt this analysis in cases

* Associate Professor, School of Law and Center for Biomedical Ethics, School of Medicine, Case Western Reserve University. I am grateful to Bob Arnold, Max Mehlman, Tom Murray, Nancy Rhoden, and Stuart Youngner for their comments on a previous draft of this article. I especially want to acknowledge my debt to Nancy Rhoden. For three years, we discussed and debated these issues, clarifying and refining our own positions in the process. Indeed, her response to this Article will be published in Rhoden, *The Limits of Legal Objectivity*, 68 N.C.L. REV. 845 (1990). I am one of many in the bioethics community who now mourns the loss of an important scholar and good friend.

1. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375 (1988).

2. Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373 (1986).

3. Rhoden, *supra* note 1, at 419.

4. *Id.* at 409.

5. *Id.* at 375-77, 380-89.

involving incompetent patients, because there is no patient choice to implement.⁶ Unless the patient previously issued an explicit treatment directive, such as a living will, Rhoden argues against analyzing treatment decisions in terms of the patient's right to decide.⁷ Instead, courts should acknowledge that a patient's prior informal statements, medical practices, and religious beliefs can supply only a weak indication of what the patient would choose. In reality, Rhoden argues, proxy decisionmakers are inevitably influenced by their own interests and values, as well as their subjective interpretations of what the patient would want.⁸ Except when an explicit treatment directive exists, Rhoden concludes that courts demand the impossible when they require clear and convincing evidence that incompetent patients would refuse treatment if they were competent.⁹

Having rejected the courts' subjective standard as largely unattainable, Rhoden proceeds to argue that a purely objective standard is an inadequate substitute.¹⁰ Objective standards resolve treatment dilemmas based on an assessment of the benefits and burdens a proposed medical intervention would confer on the incompetent patient. Because the patient is no longer able to make a competent choice based on that individual's subjective values and preferences, treatment decisions are to embody observers' best judgments on what outcome would be most solicitous of the patient's present interests.¹¹

According to Rhoden, an objective treatment standard dehumanizes patients by treating them as mere repositories of sensations and deprives incompetent patients of their past¹² by failing to consider the desires, intentions, and values they held as competent individuals. For Rhoden, conceiving of these patients as having radically different interests than they once had, or as in some sense being different persons, has morally objectionable consequences. The better course, in her view, is to incorporate into the legal standard the ordinary "notion that a person is one person, and one person only, from birth through old age, despite whatever changes and vicissitudes she might undergo."¹³ Thus, when a living will exists, it should determine the treatment outcome; in other cases, courts should allow proxy decisionmakers to consider the incompetent patient's less formally expressed values and preferences, but acknowledge that this is not the same as determining precisely what the patient would choose.

To compensate for the medical profession's tendency to be overly liberal with its life-sustaining interventions, Rhoden proposes the creation of a legal presumption favoring the treatment choice of the patient's close relative.¹⁴ Families should be advised to consider the patient's prognosis, existing pain and pleasure, and former values. The decision ideally would mirror what the patient

6. *Id.* at 377, 385-89.

7. *Id.* at 381-82, 385-94.

8. *See id.* at 390-94.

9. *Id.*

10. *See id.* at 396-419.

11. *Id.* at 409.

12. *Id.* at 396.

13. *Id.* at 414.

14. *Id.* at 437-39.

would have wanted, although Rhoden cautions that the relative's own views and values are unavoidable influences as well.¹⁵ She suggests that the presumption be implemented by changing the current system in which families must seek judicial authorization for nontreatment when physicians refuse to comply with the family's wishes. Instead, physicians wishing to override a family's nontreatment decision should have the burden of going to court to demonstrate that the family's decision is unreasonable.¹⁶ According to Rhoden, courts should deem a nontreatment decision unreasonable and hence, legally impermissible, if the patient "retains any capacity to experience and enjoy life."¹⁷

II. THE CASE FOR A MODIFIED OBJECTIVE STANDARD

Rhoden claims to oppose a present-oriented objective standard because it dehumanizes patients, treats them as "sensation receptacles,"¹⁸ and unjustifiably undermines living wills. I disagree. In reality, it is the objective standard that can demonstrate moral respect for incompetent patients by ensuring their continued care when they have significant interests in living. It can also protect them from harmful treatment decisions they issued when they were competent. Finally, the objective standard has the added virtue of delineating an appropriate role for other interested parties, including the patient's family, to play in resolving treatment dilemmas.

As her models for the objective standard, Rhoden discusses the objective tests set forth by the New Jersey Supreme Court in *In re Conroy*.¹⁹ In these tests, physical pain and suffering are weighed against any physical pleasure, emotional enjoyment, or intellectual satisfaction that treatment and continued life would provide the incompetent patient.²⁰ Nontreatment is permitted only when the patient's pain and suffering clearly outweigh the benefits that can be obtained from treatment.²¹

The problem here is not with objective standards in general, but with this specific objective test. According to *Conroy*, treatment is required as long as the patient's pain and suffering remain less than severe, even if little or no positive benefit is present. Rhoden rightly criticizes the *Conroy* standard as providing little guidance regarding the permanently unconscious patient, and conveying an impoverished view of human existence when it is applied to conscious incompetent patients.²² She is convinced that a better approach is to decide these cases by referring, whenever possible, to these patients' former competent values

15. See *id.* at 438-41.

16. *Id.* at 440-41.

17. *Id.* at 437.

18. *Id.* at 409.

19. 98 N.J. 321, 486 A.2d 1209 (1985). See Rhoden, *supra* note 1, at 396-419.

20. See *Conroy*, 98 N.J. at 365-67, 486 A.2d at 1232.

21. According to the "limited-objective" test, life-sustaining treatment may be withdrawn when "some trustworthy evidence" exists that the patient would have refused treatment and it is "clear that the burdens of the patient's continued life with the treatment outweigh the benefits of that life." *Id.* at 365, 486 A.2d at 1232. The "pure-objective" test allows treatment to be foregone in the absence of trustworthy evidence that the patient would have refused treatment. In these cases, the burdens of continued life with treatment must so "clearly and markedly" outweigh the benefits that it would be "inhumane" to treat. *Id.* at 366, 486 A.2d at 1232.

22. See Rhoden, *supra* note 1, at 396-410.

and preferences, realizing that this will not necessarily be the same as determining what the patients would choose.²³ But I believe that a more defensible solution lies in adopting a refined objective standard to govern these cases, and indeed, Rhoden proposes just such a test in the final pages of her Article.²⁴

An objective treatment standard weighs the features of life that reasonably qualify as benefits or burdens for all human beings. Severe, unremediable pain is a relatively uncontroversial example of something all but the rare individual would experience as a heavy burden.²⁵ *Conroy* includes as objective benefits physical pleasure, emotional enjoyment, and intellectual satisfaction, all of which presuppose some level of cognitive awareness.²⁶ What the *Conroy* test omits is that even in the absence of pain, life without such cognitive awareness can be of no real value to a patient.

As Rhoden points out, objective tests are inherently imprecise, given that particular individuals will differ in the values they assign to various experiences.²⁷ The accuracy with which objective tests can be applied is also limited by the uncertainty that always accompanies one person's judgments about what another is experiencing.²⁸ But Rhoden concedes that observers can perform such evaluations to decide, for example, that life-sustaining treatment is appropriate for a moderately retarded person who interacts with the surrounding environment to obtain physical, emotional, and some intellectual satisfaction.²⁹ She claims to be against adopting such an analysis as a general means of determining when treatment is required for incompetent patients, however.³⁰

I contend that a modified objective standard supplies the most satisfactory means of deciding whether incompetent patients should be treated. *Conroy's* standard is too narrow, for it fails to allow nontreatment of the permanently unconscious and barely conscious patient not in severe pain, yet obtaining virtually no benefit from continued life. The permanently unconscious patient has no ability to experience life. Similarly, if the most a patient can experience is physical sensation, then the person can gain none of the goods that make human life valuable to an individual.³¹ At minimum, some capacity for social interaction is

23. *Id.* at 415-16.

24. *See id.* at 437-45.

25. *See Dresser, supra* note 2, at 392 & n.107.

26. *In re Conroy*, 98 N.J. 321, 365-67, 486 A.2d 1209, 1232 (1985).

27. Rhoden, *supra* note 1, at 398-99.

28. *See Dresser, supra* note 2, at 390-91. Indeed, this also limits our understanding of competent persons who are able to speak. We can never be completely certain that even the competent patient refusing treatment is truly motivated by a proclaimed preference for comfort and dignity, as opposed to some other unspoken influence such as a need for gaining a sense of control or the attention of others. *See generally*, R. BURT, TAKING CARE OF STRANGERS (1979) (explains effect of difficulties of assessing patients' needs on rule of law in doctor-patient relations in right to die context).

29. Rhoden, *supra* note 1, at 399.

30. *Id.* at 398-410.

31. These patients do have a very small positive interest in being maintained, based on two remote possibilities: physician error in the diagnosis of a permanent condition or discovery of a cure in the near future. *See* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 182-83 (1983). Barely conscious patients also have interests in avoiding negative physical sensations and obtaining positive ones. Dresser, *supra* note 2, at 384. These interests, however, are insufficient to make continued life a significant benefit to these individuals. *See infra* notes 32-42 and accompanying text.

a prerequisite to meaningful existence. Without it, treatment and continued life cannot confer a morally significant benefit on the incompetent patient. Thus, the objective standard should permit nontreatment when the patient lacks any relational capacity.³² Conversely, the standard should mandate treatment that will enable the patient capable of interacting with the environment to continue life, as long as significant pain and discomfort are absent.³³

This is essentially what Rhoden's concluding reasonableness standard achieves. The incompetent patient with "some level of awareness" who "can interact with her environment in some way—even if she is completely nonverbal" should be treated even against her family's wishes, because she has a strong present interest in continued life.³⁴ In contrast, the permanently unconscious patient need not be treated, because "if a patient cannot experience her life *at all*, then those qualities and capacities that make her human are irretrievably lost. . . ."³⁵ Similarly, the ability to experience physical sensations alone fails to confer on patients a significant interest in being treated. Some increased capacity to relate to the environment is the minimum necessary to justify continued treatment, as Rhoden has argued elsewhere.³⁶

Contrary to Rhoden's ostensible rejection of objective standards, it is simply impossible to apply her reasonableness test without engaging in an objective assessment of the incompetent patient's current capacities and interests. Moreover, in describing her reasonableness test, Rhoden fails to stipulate that a patient with relational capacity must be treated solely when this is consistent with that patient's prior competent values and preferences. This indicates that Rhoden believes, and in my view rightly so, that all such incompetent patients should be treated, based on their present capacities and experiences alone.

As Rhoden's reasonableness test illustrates, observers can make acceptable, albeit inevitably imprecise, decisions on when an incompetent patient currently has interests mandating treatment. The point is that even someone critical of an objective standard is in the end unavoidably drawn to it. The evaluation simply should be expanded beyond the *Conroy* test to incorporate the additional relational capacity that members of our society generally view as minimally necessary for meaningful human existence.³⁷ Contrary to *Conroy*, it is not simply

32. See Arras, *Toward an Ethic of Ambiguity*, 14 HASTINGS CENTER REP. at 25, 31-32 (Apr. 1984). This criterion is admittedly general, and will demand more precise definition as it is applied in individual cases. In addition, in some cases it will be unclear whether a patient is capable of interacting with the environment. In my view, however, the relational capacity criterion offers the most promising approach to determining when incompetent patients have morally significant interests in continued life.

33. See Dresser & Robertson, *Quality of Life and Non-Treatment Decisions for Incompetent Patients: A Critique of the Orthodox Approach*, 17 LAW MED. & HEALTH CARE 234, 240-41 (1989).

34. Rhoden, *supra* note 1, at 442. Rhoden notes, and I agree, that the standard should allow nontreatment in such cases if the proposed medical intervention would confer substantial burdens such as pain or invasiveness, or continued life would entail unremediable pain. *Id.* at 442-44.

35. *Id.* at 442.

36. See Rhoden, *Treatment Dilemmas for Imperiled Newborns: Why Quality of Life Counts*, 58 S. CAL. L. REV. 1283, 1318-23 (1985).

37. Some would deem this capacity necessary to "personhood." See, e.g., T. ENGELHARDT, FOUNDATIONS OF BIOETHICS 104-10 (1986); Buchanan, *Advance Directives and the Personal Identity Problem*, 17 PHIL. & PUB. AFF. 277, 283-84 (1988). If incompetent individuals who lack relational capacity are no longer persons, we may not owe them the same degree of respect we owe to persons. Thus, their interests in obtaining treatment could be

absence of pain that gives a person a significant interest in continued life; some ability to interact with the environment is necessary as well. Such an enriched objective standard can take into account the absence of "human cognition, love, and awareness" that Rhoden suggests was the true source of everyone's desire to stop Claire Conroy's treatment.³⁸

It is quite true that standards defining treatment obligations according to considerations such as relational capacity and physical sensations incorporate quality-of-life judgments.³⁹ To apply such standards to determine which combinations of benefits and burdens necessitate a patient's treatment, decisionmakers must reflect on what constitutes a life worth living for the patient. As Rhoden and others have argued before me, although quality-of-life judgments are not without their dangers, they can be a morally acceptable basis for treatment decisions.⁴⁰ The relevant question is not whether a "normal" healthy person would find life worth living in the incompetent patient's condition. It is instead whether the patient, who cannot experience life in its usual complexity and abundance, still has experiences that make continued life from that person's point of view better than no life at all.⁴¹ Indeed, this is exactly what the courts in *Conroy* and other cases have struggled to determine, all the while proclaiming their contempt for quality-of-life judgments.⁴² According to Rhoden's reasonableness and my modified objective standards, patients must have some ability to relate to their environments for life to hold value for them.

Finally, contrary to Rhoden's contentions, a present-oriented objective standard is far from dehumanizing. Although the features included in an objective assessment are "person-neutral"⁴³ in that they would constitute benefits and burdens to most people, the assessment itself centers on the individual patient and is in this sense highly subjective. The test attempts to determine what life is like for *this patient*, based on observable data such as behavior, appearance, and response to medical and psychological tests.⁴⁴ The genuine moral implica-

more easily subordinated to the interests of others, such as their relatives' financial and emotional burdens. *See id.* at 287.

38. Rhoden, *supra* note 1, at 406.

39. Rhoden's reasonableness standard is based on such judgments.

40. *See* Rhoden, *supra* note 36, at 1318-23 (quality-of-life assessment focusing on handicapped newborn's potential for human interaction sufficiently protects child's interest in life with meaning and value). *See also* Quinn, *The Best Interests of Incompetent Patients: The Capacity for Interpersonal Relationships as a Standard for Decisionmaking*, 76 CALIF. L. REV. 897, 926-33 (1988)(endorsing relational capacity standard).

Alan Buchanan and Dan Brock point out that a patient-centered best interest standard must take into account quality-of-life judgments. Buchanan & Brock, *Deciding for Others*, 64 MILBANK Q. 17, 73 (Supp. II 1986). In their asserted rejections of quality-of-life considerations in treatment decisionmaking, courts have confused two variations of the concept. They have assumed that quality-of-life judgments necessarily depend on how society would value a particular incompetent patient's life as it compares with the lives of other more functional individuals. But quality-of-life assessments need not incorporate such interpersonal social worth evaluations. Instead, they can be *intrapersonal* and ask what value life holds for that individual. *Id.* at 74. By taking this approach, the law can maintain its commitment to protect incompetent patients from harm. *See* Quinn, *supra*, at 926-33 (relational capacity standard promotes sanctity of life in meaningful sense and excludes social worth considerations).

41. *See* Arras, *supra* note 32, at 30 (best interest test requires asking not whether a normal adult would rather die than live life with infant's disabilities, but whether a child who has never had normal goals and experiences would prefer death to the life the child has).

42. *See* Rhoden, *supra* note 1, at 387 n.57.

43. *Id.* at 399 n.102.

44. *See* Dresser, *supra* note 2, at 390-93.

tion of divorcing incompetent patients from their past values and preferences—which are now meaningless to them—is that they are important to us in their current state, even though they lack their former “normal” abilities.⁴⁵ By adopting a present-oriented objective standard, the law can declare that the incompetent patient is still *someone*, an individual who merits our concern despite her current lack of appreciation of the “higher-order” desires and ideas she once had.

III. THE LIVING WILL'S HIDDEN MORAL IMPLICATIONS

The modified objective standard demonstrates respect for incompetent patients by respecting what matters to them in their incompetent state. This respect should be maintained in every case. Thus, even if treatment preferences are explicitly stated in a living will, the incompetent patient's former competent preferences should be subordinate to the patient's present well-being. A major source of Rhoden's opposition to an objective standard is the threat this standard poses to the living will.⁴⁶ She is entirely correct that the objective test endangers the validity of advance treatment directives, since the standard focuses on what currently concerns the patient, as opposed to what formerly was important. Yet instead of labeling this an objectionable by-product of the objective standard, I welcome the assault on the living will. Indeed, this challenge most clearly conveys the moral costs of allowing a patient's former beliefs and values to control treatment decisionmaking.

There are at least two ways to think about why an incompetent patient's former explicit treatment wishes should be subordinate. One approach accepts Rhoden's view that a human being should be considered one person throughout life.⁴⁷ The approach acknowledges, however, that persons can also have widely varied needs, concerns, and interests over the course of their lives, as they experience different stages of development and decline. For competent healthy adults, a life worth living usually consists of work, family relationships, friendships, hobbies, and similar pleasures and challenges. A competent patient forced to choose between a drastically restricted life and a comfortable death might prefer death over the compromised existence. But when people become incompetent and debilitated, they lose touch with their past concerns, and the restricted life that once seemed demeaning can instead be of value to them.⁴⁸

In general, competent persons retain the ability to alter important personal choices to protect their changing interests over time, as long as the interests of

45. Rhoden correctly asserts that it makes no sense to attribute autonomy rights to patients who have been incompetent their whole lives. Rhoden, *supra* note 1, at 386, 388. But I find incomprehensible her argument that we should attribute to incompetent patients interests and values that can no longer have meaning for them. *Id.* at 414-15, 418-19. Although reading the *New York Times* is now an activity I seek out and enjoy each day, if I become incompetent and lose the ability to read, it would be absurd for someone to bring me the daily paper on grounds that this shows respect for my life in its “larger context.”

46. *See id.* at 410-16.

47. *Id.* at 378, 414-19.

48. *See Dresser & Robertson, supra* note 33, at 236-37.

other involved parties can also be adequately accommodated.⁴⁹ But if living wills contain binding treatment decisions, incompetent patients lose such protection. This can occur because honoring the living will rules out any reconsideration of the earlier choice, even though that choice may be detrimental to the patient's current interests.

Derek Parfit and other philosophers offer an alternative conceptual approach to these cases.⁵⁰ In analyzing the meaning of personal identity, they argue that an individual whose psychological features—beliefs, desires, memories, and intentions—change radically can become a new “self.” According to this analysis, the former treatment choices expressed in a living will could be those of another person, not the presently incompetent patient.⁵¹ If so, the former choices should have no particular bearing on the existing individual's treatment.⁵²

Rhoden rejects the argument that persons, or at least their interests, may change so dramatically over time that former choices should not determine present outcomes. For her, the incompetent patient is more properly seen as “a person who has become demented,”⁵³ whose past concerns continue in some sense, rather than as the debilitated person the patient is now. As her primary support for this position, Rhoden claims that people who issue living wills, as well as those whose competent preferences remain less formally articulated, do not want in the future to be regarded as different persons, or as people with interests unconnected to their prior history, values, and so forth.⁵⁴ Although this is probably true, it does not necessarily follow that what competent people want

49. See Rhoden, *supra* note 1, at 411-12. See also Dresser & Robertson, *supra* note 33, at 237 (distinguishing legally binding prior choices from living wills).

50. See, e.g., D. PARFIT, REASONS AND PERSONS 199-347 (1984); J. PERRY, *The Problem of Personal Identity*, in PERSONAL IDENTITY 3 (J. Perry ed. 1975) (summarizing theories of personal identity).

51. Dresser, *supra* note 2, at 380-81.

52. Rhoden, I think, conveys a misimpression of the effect Parfit's view would have on our social and institutional relationships. See Rhoden, *supra* note 1, at 414-15. In analyzing what makes an individual at two points in time the same person, Parfit points to psychological “connectedness” (direct memory and other direct psychological connections) and “continuity” (overlapping chains of strong psychological connections) between the two times. D. PARFIT, *supra* note 50, at 205-06. Strong connectedness exists when the “number of connections, over any day, is at least half the number of direct connections that hold, over every day, in the lives of nearly every actual person.” *Id.* at 206. In this framework, an individual is the same person 20 years later if psychological continuity exists. It is not necessary that the individual have the same psychological features between day one and 20 years later; it is enough if strong connectedness existed over the days that elapsed during that time. *Id.* at 206-07.

Although he offers a suggestion in his definition of strong connectedness, Parfit refuses to take a definite stance on exactly how much connectedness and continuity are necessary to maintain one's personal identity over time. *Id.* at 206 & n.6. Even in the Russian landowner case Rhoden describes, Parfit merely asserts that it would be “plausible” for the wife to regard the landowner as a different self. *Id.* at 327. The frequency with which individuals become different persons depends on how much psychological connectedness and continuity is “enough.” See Buchanan, *supra* note 37, at 283-94. Frequent changes in personal identity would occur over time only if a very high degree of connectedness and continuity were required. See *id.* at 292 (Parfit's “view is simply neutral as to what degree of psychological continuity is required for the persistence of the person.”). Otherwise, most persons would remain the same persons over the course of their lives. Acceptance of Parfit's theory as a helpful means of analyzing how individuals change over time need not have the drastic effect Rhoden suggests. In some cases, however, the advent of incompetency could so severely reduce psychological connectedness and continuity that we could properly regard the patient as a different person. See T. ENGELHARDT, *supra* note 37, at 126-27 (severe brain damage might provide basis for finding former person no longer exists).

53. Rhoden, *supra* note 1, at 415.

54. *Id.* at 418.

should determine the legal treatment standard. The justifications for this position merit closer scrutiny than Rhoden gives them. It is not surprising that competent persons tend to favor having control over how they are perceived and treated as incompetent patients. But if the law is to express equal respect for incompetent individuals, despite their compromised mental and physical condition, the competent person should be denied absolute control. In my view, future control should not extend to harming incompetent patients who retain significant interests in continued life.

To claim that living wills should determine the incompetent patient's treatment is to affirm the authority of competent persons to control their own futures. Just as people may wish to purchase health insurance to pay for their subsequent care, they may also wish to ensure that they are not kept alive in a condition they now see as "degrading and without human dignity" and burdensome to their loved ones.⁵⁵ Making a living will to this effect gives competent people peace of mind and helps them feel more comfortable about growing old.

Suppose, however, that such a person becomes physically and cognitively impaired from a stroke. Several months later, she gets pneumonia. Her living will clearly directs that antibiotic treatment should be withheld. If the pneumonia is treated, however, she can return to a highly restricted—but enjoyable to her—existence of watching television and eating meals with her acquaintances in the nursing home.⁵⁶ By honoring this patient's living will, the law elevates the interests of the competent person in controlling her future care above the welfare of an incompetent patient who retains material interests in continued life. Conversely, applying the objective standard to this case announces that the incompetent patient deserves protection from a harmful treatment decision, even though she herself once approved such a decision.

Rhoden neglects to mention that living wills can also produce detrimental decisions to treat incompetent patients. Take the committed vitalist who instructs that she should be treated as long as there is any physiological activity in her body. Later she becomes terminally ill, experiences severe, unremediable pain and distress and, although conscious, is incompetent and cognitively unable to appreciate her former vitalist values. Prolonging her life requires a ventilator and full ICU care. Must she endure her misery until she dies naturally, because of her previous instruction?⁵⁷ Or can the objective standard be applied to allow her nontreatment and death? Again, the objective standard yields the decision most solicitous for the incompetent patient.

The moral choice is thus starkly presented: Should the competent person's interest in exercising future control prevail over the incompetent patient's current well-being? Of course, in many cases no conflict exists, because the living will fails to pose a threat to the incompetent patient's significant interests.⁵⁸

55. *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 434, 497 N.E.2d 626, 636 (1986).

56. See Buchanan, *supra* note 37, at 301-02.

57. *Conroy* adopts this position: "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." *In re Conroy*, 98 N.J. 321, 366-67, 486 A.2d 1209, 1232 (1985).

58. An example is Rhoden's paradigm living will case. See Rhoden, *supra* note 1, at 380. The decision not to treat an AIDS patient who has permanently lost the capacity to recognize friends and caretakers is supported

Here I have no objection to following the will's provisions. In such cases, however, treatment decisions can also be justified without reference to the living will. I submit that if the law is to embody genuine moral respect for the incompetent patient, despite that person's loss of higher level abilities, the objective standard must control.⁵⁹ By honoring living wills, the law instead reveals a moral preference for the interests of the competent individual. If Rhoden's view that living wills should govern these cases becomes the law, then this normative judgment should at least be made explicit, instead of portrayed as showing humanity to incompetent patients.

IV. SHIFTING THE LEGAL PRESUMPTION — THE DRAWBACKS

Rhoden proposes that courts adopt a presumption in favor of family decisionmaking. This would, she asserts, serve to acknowledge the uncertainty inherent in many treatment cases and to counter the modern American physician's tendency to treat patients who receive no significant benefit from such treatment.⁶⁰ She would implement this presumption by placing the burden of initiating legal proceedings on the physician who seeks to treat an incompetent patient against the family's wishes.⁶¹ Again, I differ with Rhoden on how best to recognize the family's undeniable involvement in an incompetent patient's life and death. Rather than assigning family members presumptive decision-making authority, I would openly integrate family and other external concerns into the substantive treatment standard. My proposal is to maintain the objective standard's initial patient-centered inquiry, but to defer to external considerations when the patient lacks significant interests in receiving treatment.

Rhoden recognizes that a family's discretion to choose nontreatment must be constrained to safeguard the incompetent patient's welfare.⁶² This is because family choices may be motivated by considerations independent of the patient's well-being. While there are probably few cases in which relatives advocate harmful nontreatment for indisputably selfish financial or other reasons, it is easy for emotionally and financially burdened families to confuse their own dis-

by the objective test allowing treatment to be foregone when a patient lacks significant interest in continued life. See *supra* notes 31-43 and accompanying text.

59. There is no question that giving priority to a patient's current interests would confer a burden on competent persons seeking future control. My position is that the incompetent patient's present welfare interest carries greater moral weight than the competent individual's interest in controlling subsequent care. I do not deny that the exercise of future-oriented autonomy is a value meriting legal recognition through property wills and contracts. But I argue that the right to exercise future-oriented autonomy should be qualified by the incompetent patient's interest in protection from harm. Thus, in the treatment setting, when such autonomy conflicts with the incompetent patient's significant interest in continued life, the latter should take priority. Similarly, when such autonomy conflicts with the incompetent patient's interest in avoiding severe, unremediable pain, the incompetent patient's interest should prevail. See Buchanan, *supra* note 37, at 301-02 (presenting case in which paternalistic decision to override living will might be justified); Dworkin, *Autonomy and the Demented Self*, 64 MILBANK Q. 4, 13 (Supp. II 1986)(acknowledging that there may be reasons to override individual's future-oriented autonomy).

60. See Rhoden, *supra* note 1, at 420-29.

61. *Id.* at 440-41.

62. *Id.* at 440.

stress and suffering with that of the patient.⁶³ Thus, as Rhoden cautions, families should not have *carte blanche* to decide; instead, courts should apply the (objective) reasonableness test to ensure that incompetent patients with significant interests in continued life are treated.⁶⁴ But instead of giving family members the responsibility to obtain legal authority for the decisions health care professionals oppose, Rhoden seeks to “equaliz[e] control between family and physician”⁶⁵ by shifting this responsibility to the physicians unhappy with the family’s choice.

Devising workable procedures to govern treatment decisionmaking has been an ongoing challenge for courts. Rhoden aptly describes how abusive overtreatment can result from requiring decisionmakers to obtain judicial approval for nontreatment.⁶⁶ Even the more streamlined procedures set forth in *Conroy* create this possibility, for families and guardians may acquiesce in unwarranted treatment to avoid incurring the emotional and financial costs entailed in the review process.⁶⁷ Less formal review mechanisms, such as institutional ethics committees, offer some promise as compromises, but thus far no completely satisfactory alternative has emerged.⁶⁸

The challenge is to design procedures that strike an acceptable balance—demanding enough to guard against inappropriate nontreatment, yet not so demanding as to invite unwarranted treatment. I am concerned that Rhoden’s proposal errs too much on the side of undertreatment. Although the proposal might work well in some well-staffed private health care facilities, a general rule giving physicians the burden of going to court fails to furnish adequate safeguards to incompetent patients who would benefit from treatment.

Just as the current situation substantially burdens families, Rhoden’s proposal would substantially burden physicians. Many physicians could be reluctant to invest the time and energy necessary to obtain court approval to treat. I fear this would not be uncommon, especially in nursing homes where, as Rhoden reports, “doctors seldom visit” and “curable illnesses are often neither investigated nor treated.”⁶⁹ Rhoden suggests that hospital risk managers “will undoubtedly advise undertaking a [court] challenge when the family’s choice is questionable.”⁷⁰ I am not so sure of this. Even in the current “defensive medicine” climate, many hospital administrators will perceive the litigation threat as minimal when the patient’s relatives, who normally would assert a malpractice claim, are unified in advocating nontreatment.

Rhoden believes that the physician’s overwhelming desire to preserve life will also ensure that unreasonable nontreatment cases end up in court.⁷¹ She

63. See Meier & Cassel, *Nursing Home Placement and the Demented Patient*, 104 ANNALS OF INTERNAL MED. 98, 102 (1986) (staff caring for demented patients often feel family’s suffering exceeds that of patients, who often appear content).

64. Rhoden, *supra* note 1, at 440-42.

65. *Id.* at 441.

66. See *id.* at 434-37.

67. See *id.* at 435-36 (describing *Conroy*’s nonjudicial procedures).

68. See Brennan, *Ethics Committees and Decisions to Limit Care*, 260 J. AM. MED. A. 803 (1988) (describing ethics committees and their limitations).

69. Rhoden, *supra* note 1, at 435 n.269.

70. *Id.* at 441.

71. *Id.*

may exaggerate the current strength and consistency of this desire, however. The medical norms governing life-sustaining treatment are in flux, and in recent years growing professional acceptance of nontreatment is evident. A prime illustration is the American Medical Association's statement that it is ethical for physicians to discontinue life-prolonging treatment, including medical nutrition and hydration, from terminally ill and irreversibly comatose patients.⁷² It is now rare for more than a few months to pass between articles in major medical journals addressing nontreatment issues.⁷³ Although I am sure that some physicians still unreasonably oppose nontreatment, I question whether overtreatment in opposition to a family's wishes is now as pervasive as Rhoden characterizes it.

Furthermore, I question whether Rhoden's proposed modification would have a significant effect on improper overtreatment. As she puts it, "[o]nly assertive, well-informed patients and families are likely to believe, before some medical professional suggests it, that the choice of withholding treatment really exists."⁷⁴ Similarly, their unwillingness to assume responsibility for their loved one's death keeps many family members from raising the possibility of nontreatment.⁷⁵ Rhoden's proposal does nothing to increase the likelihood that physicians will inform families of the nontreatment option. Greater efforts to educate physicians on the ethics and law governing treatment decisionmaking seem a much more formidable weapon against unwarranted treatment.

Finally, I believe that a modified objective standard could more effectively meet the legitimate interests families have in the care their incompetent relatives receive. Rhoden would prefer to avoid openly including these interests as part of the legal standard.⁷⁶ But in my view, such avoidance only superficially conceals such influences and permits them to operate subterraneously, where they may have morally objectionable effects.⁷⁷

Treatment dilemmas involving incompetent patients unquestionably place burdens on patients' families. Moreover, our society has an interest in devoting its limited health care resources to people who can obtain meaningful benefits from such care. The continued treatment of permanently unconscious and many barely conscious patients can conflict with these familial and societal interests. Such treatment can also violate observers' views on what constitutes dignified

72. AMERICAN MEDICAL ASSOCIATION, CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS 12-13 (1986).

73. See, e.g., Schneiderman & Spragg, *Ethical Decisions in Discontinuing Mechanical Ventilation*, 318 NEW ENG. J. MED. 984 (1988); Loewy, *Treatment Decisions in the Mentally Impaired*, 317 NEW ENG. J. MED. 1465 (1987).

74. Rhoden, *supra* note 1, at 439.

75. *Id.* at 439. Indeed, in some cases it will be the health care professionals who believe patients cannot benefit from continued treatment, and the family members who have difficulty accepting this. See Brennan, *supra* note 68, at 805 (study found increased number of such cases in recent years).

76. *Id.* at 402-03 n.114.

77. See Cantor, Conroy *Best Interests, and the Handling of Dying Patients*, 37 RUTGERS L. REV. 543, 577 (1985) (survivors' interests will continue as subconscious factor shaping treatment decisions); Veatch, *Limits of Guardian Treatment Refusal: A Reasonableness Standard*, 9 AM. J. L. & MED. 427, 436 (1984) (burdens and benefits of others unavoidably influence decisionmaking process). In at least two appellate cases, there is a strong possibility that incompetent patients' significant interests were subordinated to family concerns and financial considerations. See Dresser, *supra* note 2, at 377-79, 386 (discussing these cases).

and respectful care for these patients.⁷⁸ Legal rules ought to acknowledge and create an express, yet limited, role for these considerations. Although the patient's own interests should take priority, the external considerations need not, and indeed, cannot, be completely excluded from decisionmaking. An objective treatment standard mandating treatment for incompetent patients with the capacity for meaningful interaction can protect patients, while at the same time permitting nontreatment when patients lack the capacity to benefit from further interventions and the interests of others would be advanced by the decision to forego treatment.⁷⁹

It is naive and simplistic to charge that creating an explicit role for external considerations would inevitably expose incompetent patients to harm for the convenience of others. It is naive to pretend that this is ruled out by other approaches. If, as Rhoden skillfully argues, the courts' nontreatment decisions have rarely been justified by the articulated legal standards,⁸⁰ then it is quite possible that these decisions actually were influenced by the concerns of families and others. Rhoden's proposal for family decisionmaking also fails to guard against the possibility of other-directed outcomes. It is simplistic as well to contend that the proposal to give explicit weight to external considerations invites abuse of patients. This response ignores the objective standard's patient-centered inquiry that must precede any deference to the concerns of others. Such an inquiry, conducted skillfully and subject to procedural review, actually would be the best safeguard against harmful treatment decisions motivated by social worth and other external considerations.⁸¹

V. CONCLUSION

Instead of giving presumptive authority to living wills and family discretion, the courts should adopt an objective standard to guide decisionmaking for seriously ill incompetent patients. Decisions should rest on observers' systematic evaluations of the patient's present capacities and experiences, because these are the only things that now matter to this individual. Whether in the guise of a modified best interests standard, or Rhoden's reasonableness test, the law should mandate treatment that can provide the incompetent patient with a continued life of meaning and value. When no such benefit is attainable, the family's wishes or other external factors may justify nontreatment.⁸² With this legal standard, courts can fulfill their obligation to protect vulnerable incompetent patients from harm and also recognize the relevance of familial and societal considerations to contemporary medical decisionmaking.

78. Rhoden properly identifies these interests as belonging to the larger society rather than to the patient. Rhoden, *supra* note 1, at 394-96. See also Dresser, *supra* note 2, at 385, 387-88.

79. As with any nontreatment standard, there remains the need to determine appropriate procedures for implementation.

80. See Rhoden, *supra* note 1, at 375-77, 380-96.

81. See *supra* notes 37-40 and accompanying text for a defense of quality-of-life standards.

82. This is also where the patient's wishes and values as a competent person may appropriately shape the treatment outcome. Again, the interests of competent persons in future control merit legal recognition, but only when they fail to endanger the incompetent patient's significant interest in continued life.

