

# When Vitalism is Dead Wrong: The Discrimination Against and Torture of Incompetent Patients by Compulsory Life-Sustaining Treatment

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## INTRODUCTION

[C]ontinued treatment, however well intentioned, is now inhumane and is causing suffering. From a medical standpoint, it is outside the bounds of what I consider to be medically indicated care.<sup>1</sup>

The legal revolution that established the right of patients and their families to decline life-sustaining treatment was accomplished through a patchwork of court cases and state statutes. For the competent, those patients able to make informed choices about their medical care, the revolution is complete. For the incompetent, it is not. The patchwork of laws is marred by gaps that compel health care providers to force treatment in certain cases, regardless of the pain or bodily degradation that treatment may cause.

This Article exposes these gaps in the laws that prohibit surrogates from making treatment decisions for the incompetent and explores the dire results of their limitations. Part I sets forth the laws that give most people or their surrogates the ability to avoid harmful treatment at the end of life and explains the genesis of the limitations of those laws. Part II examines the case of Sheila Pouliot, a New York resident who was subjected to a torturous death as a result of New York's limitations on surrogate decisionmaking. Part III explains how the ultimate result of the Pouliot case—the state-mandated inhumane treatment of an incompetent individual—could be repeated in the several states throughout the country that place limitations on the ability of surrogates to make decisions for others.<sup>2</sup> Part IV demonstrates that terminating treatment may be as essential to appropriate palliative care as the administration of opioids. It then analyzes post-*Cruzan* cases that make pain control and the incompetent patient's right to medically appropriate treatment integral components of the liberty interests protected by the Fourteenth Amendment, and argues that the vitalist limitations on end-of-life medical care that cause prolonged suffering for limited groups of disabled individuals illegally deprive those people of those rights and violate the Americans with Disabilities Act. Finally, Part V proposes that courts must act to stop states from mandating the provision of life-prolonging treatment for the incompetent when the treatment becomes inhumane or medically inappropriate, and

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1. Kathy Faber-Langendoen, M.D., progress note entered into Sheila Pouliot's medical chart, February 29, 2000 (on file with author) [hereinafter Faber-Langendoen progress note].

2. New York, Michigan, Missouri, Ohio, Arizona, Hawaii, Kentucky, Mississippi, Wisconsin, and Utah place a variety of limits on the ability of certain surrogates to make medical decisions for certain patients. See *infra* Part III (exploring the parameters of the limitations set by each of these states).

then discusses the possibility that the *Pouliot* case itself, through the resulting lawsuit brought against state officials,<sup>3</sup> might ultimately establish limitations to the existing vitalist laws.

#### I. BACKGROUND: THE RIGHT OF PATIENTS AND THEIR SURROGATES TO FORGO LIFE-SUSTAINING TREATMENT

The past thirty years have seen a radical shift from medical paternalism to patient autonomy as “the gold standard for ethical decision-making”<sup>4</sup> in medicine. Patient choice and self determination are now of automatic and paramount concern in doctor-patient relationships, and in ethical and legal discussions of difficult treatment cases. Thus, a competent individual may voluntarily forgo life-sustaining medical treatment, including nutrition and hydration, in any state in the country.<sup>5</sup> The right to decline treatment, which is rooted in both constitutional and common law,<sup>6</sup> is protected by statutes in all fifty states that ensure that a person’s wish to forgo life-sustaining treatment be carried out even when the person later loses competency.<sup>7</sup>

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3. *Blouin v. Spitzer*, 213 F. Supp. 2d 184 (N.D.N.Y. 2002), *appeal docketed*, No. 02-7997 (2d Cir. Mar. 5, 2003).

4. Jerry A. Menikoff, *Demanded Medical Care*, 30 ARIZ. ST. L.J. 1091, 1091 (1998). See also S. Elizabeth Wilborn Malloy, *Beyond Misguided Paternalism: Resuscitating the Right to Refuse Medical Treatment*, 33 WAKE FOREST L. REV. 1035, 1037 (1998).

5. See *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 278 (1990) (indicating that competent persons have a “constitutionally protected liberty interest in refusing unwanted medical treatment . . .”).

6. See *Washington v. Glucksberg*, 521 U.S. 702, 724 (1997); *Vacco v. Quill*, 521 U.S. 793, 795 (1997) (declaring that “everyone, regardless of physical condition, is entitled, if competent, to refuse unwanted life saving treatment”). The importance of the right to decline medical treatment was recently affirmed—and invigorated in *Sell v. United States*, 123 S.Ct. 2174 (2003).

7.

Alabama:	ALA. CODE § 22-8A-4 (Supp. 2002) (living will statute) ALA. CODE § 22-8A-6 (Supp. 2002) (proxy statute) ALA. CODE § 22-8A-4 (Supp. 2002) (surrogacy statute)
Alaska:	ALASKA STAT. §§ 18.12.010 to -.100 (Michie 2002) (living will statute) ALASKA STAT. §§ 13.26.332 to -.358 (Michie 2002) (proxy statute) (no surrogacy statute)
Arizona:	ARIZ. REV. STAT. ANN. §§ 36-3261 to -3262 (West 2003) (living will statute) ARIZ. REV. STAT. ANN. §§ 36-3281 to -3287 (West 2003) (proxy statute) ARIZ. REV. STAT. ANN. § 36-3231 (West 2003) (surrogacy statute)
Arkansas:	ARK. CODE ANN. §§ 20-17-201 to -218 (Michie 2000 & Supp. 2003) (living will statute) ARK. CODE ANN. §§ 20-17-201 to -218 (Michie 2000 & Supp. 2003) (proxy statute) ARK. CODE ANN. §§ 20-9-602, 20-17-214 (Michie 2000 & Supp. 2003) (consent generally) (surrogacy statute)
California:	CAL. PROB. CODE §§ 4650-4677, 4700-4701 (West Supp. 2003) (living will statute) CAL. PROB. CODE §§ 4680-4690 (West Supp. 2003) (proxy statute) CAL. HEALTH & SAFETY CODE § 1418.8 (West 2000) CAL. PROB. CODE §§ 4711-4716 (West Supp. 2003) (surrogacy statute)
Colorado:	COLO. REV. STAT. §§ 15-18-101 to -113 (1997 & Supp. 2002) (living will

- statute)  
 COLO. REV. STAT. §§ 15-14-501 to -509 (1997 & Supp. 2002) (proxy statute)  
 COLO. REV. STAT. §§ 15-18.5-101 to -103 (1997 & Supp. 2002) (surrogacy statute)
- Connecticut: CONN. GEN. STAT. §§ 19a-570 to -580d (2000 & Supp. 2003) (living will statute)  
 CONN. GEN. STAT. §§ 1-43, 19a-570 to -571 (2000 & Supp. 2003) (proxy statute)  
 CONN. GEN. STAT. §§ 19a-570 to -571 (2000 & Supp. 2003) (surrogacy statute)
- Delaware: DEL. CODE ANN. tit. 16, §§ 2503-2505 (Supp. 2003) (living will statute)  
 DEL. CODE ANN. tit. 16, §§ 2503-2505 (Supp. 2003) (proxy statute)  
 DEL. CODE ANN. tit. 16, § 2507 (Supp. 2003) (surrogacy statute)
- D.C.: D.C. CODE ANN. §§ 7-601, 7-621 to -630 (2001 & Supp. 2003) (living will statutes)  
 D.C. CODE ANN. §§ 21-2205 to -2213 (2001) (proxy statute)  
 D.C. CODE ANN. §§ 21-2210 to -2213 (2001) (surrogacy statute)
- Florida: FLA. STAT. ANN. §§ 765.301-.306 (Supp. 2003) (living will statute)  
 FLA. STAT. ANN. §§ 765.401-.404 (Supp. 2003), *amended by* Long Term Care Facilities-Professional and Public Guardians Act, ch. 2003-57, 2003 Fla. Session Law Serv. § 5 (West) (proxy statute)  
 FLA. STAT. ANN. §§ 765.202, .205 (Supp. 2003) (surrogacy statute)
- Georgia: GA. CODE ANN. §§ 31-32-1 to -12 (2001) (living will statute)  
 GA. CODE ANN. §§ 31-36-1 to -13 (2001 & Supp. 2002) (proxy statute)  
 GA. CODE ANN. § 31-9-2 (2001) (surrogacy statute)
- Hawaii: HAW. REV. STAT. §§ 327E-3 to -4, -16 (Supp. 2001) (living will statute)  
 HAW. REV. STAT. §§ 327E-5 to -16 (Supp. 2001) (proxy statute)  
 HAW. REV. STAT. § 327E-5 (Supp. 2001) (surrogacy statute)
- Idaho: IDAHO CODE §§ 39-4504 to -4509 (Michie 2002) (living will statute)  
 IDAHO CODE §§ 39-4501 to -4509 (Michie 2002) (proxy statute)  
 IDAHO CODE § 39-4303 (Michie 2002) (surrogacy statute)
- Illinois: 755 ILL. COMP. STAT. ANN. 35/1 to 35/9 (West 1993 & Supp. 2003) (living will statute)  
 755 ILL. COMP. STAT. ANN. 45/4-1 to 4-11 (West 1993 & Supp. 2003) (proxy statute)  
 755 ILL. COMP. STAT. ANN. 40/1 to 40/65 (West 1993 & Supp. 2003) (surrogacy statute)
- Indiana: IND. CODE §§ 16-36-4-1 to -21 (1997 & Supp. 2002) (living will statute)  
 IND. CODE §§ 30-5-1 to 30-5-10-4 (particularly 30-5-5-17) (1997 & Supp. 2002) (proxy statute)  
 IND. CODE §§ 16-36-1-1 to -14 (1997 & Supp. 2002) (surrogacy statute)
- Iowa: IOWA CODE ANN. §§ 144A.1 to -.12 (West 1997 & Supp. 2003) (living will statute)  
 IOWA CODE ANN. §§ 144B.1 to -.12 (West 1997 & Supp. 2003) (proxy statute)  
 IOWA CODE ANN. § 144A.7 (West Supp. 2003) (surrogacy statute)
- Kansas: KAN. STAT. ANN. § 59-3051 (Supp. 2002) (living will statute)  
 KAN. STAT. ANN. §§ 58-625 to -632 (1994) (proxy statute)  
 (no surrogacy statute)
- Kentucky: KY. REV. STAT. ANN. §§ 311.623-.628 (Michie 2001 & Supp. 2002) (living will statute)  
 KY. REV. STAT. ANN. § 311.629 (Michie 2001) (proxy statute)  
 KY. REV. STAT. ANN. § 311.631 (Michie 2001) (surrogacy statute)

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- Louisiana: LA. REV. STAT. ANN. §§ 40:1299.58.3-.10 (West 2001)  
(living will statute)  
LA. CIV. CODE ANN. art. 2997(6) (West Supp. 2003) (proxy statute)
- Maine: LA. REV. STAT. ANN. § 40:1299.53 (West 2001) (surrogacy statute)  
ME. REV. STAT. ANN. tit. 18-A, §§ 5-802 to -804 (West 1998 & Supp. 2002) (living will statute)  
ME. REV. STAT. ANN. tit. 18-A, §§ 5-802 to -804 (West 1998 & Supp. 2002) (proxy statute)  
ME. REV. STAT. ANN. tit. 18-A, § 5-805 (West Supp. 2002) (surrogacy statute)
- Maryland: MD. CODE ANN., HEALTH-GEN. I §§ 5-601 to -618 (2000) (living will statute)  
MD. CODE ANN., HEALTH-GEN. I §§ 5-601 to -618 (2000) (proxy statute)  
MD. CODE ANN., HEALTH-GEN. I § 5-605 (2000 & Supp. 2002) (surrogacy statute)
- Massachusetts: (no living will statute)  
MASS. LAWS ANN. ch. 201D §§ 2-7 (Law. Co-op 1994 & Supp. 2003) (proxy statute)  
(no surrogacy statute)
- Michigan: (no living will statute)  
MICH. COMP. LAWS ANN. §§ 700.5501-.5520 (West 2001) (proxy statute)  
(no surrogacy statute)
- Minnesota: MINN. STAT. ANN. §§ 145C.02-.05 (Supp. 2003) (living will statute)  
MINN. STAT. ANN. §§ 145C.02-.05 (Supp. 2003) (proxy statute)  
(no surrogacy statute)
- Mississippi: MISS. CODE ANN. §§ 41-41-205 to -209 (1999 & Supp. 2002) (living will statute)  
MISS. CODE ANN. §§ 41-41-205 to -209 (1999 & Supp. 2002) (proxy statute)  
MISS. CODE ANN. § 41-41-211 (Supp. 2002) (surrogacy statute)
- Missouri: MO. ANN. STAT. §§ 459.010-.055 (2001 & Supp. 2003) (living will statute)  
MO. ANN. STAT. § 404.705 (2001) (proxy statute)  
(no surrogacy statute)
- Montana: MONT. CODE ANN. §§ 50-9-103 to -105 (2001), *amended by* Act effective Nov. 1, 2003, ch. 240, 2003 Mont. Laws HB 585 (living will statute)  
MONT. CODE ANN. §§ 50-9-103 to -105 (2001), *amended by* Act effective Nov. 1, 2003, ch. 240, 2003 Mont. Laws HB 585 (proxy statute)  
MONT. CODE ANN. § 50-9-106 (2001) *amended by* Act effective Nov. 1, 2003, ch. 240, 2003 Mont. Laws HB 585 (surrogacy statute)
- Nebraska: NEB. REV. STAT. ANN. §§ 20-404 to -406 (Michie 1999) (living will statute)  
NEB. REV. STAT. ANN. §§ 30-3401 to -3432 (Michie 2001) (proxy statute)  
(no surrogacy statute)
- Nevada: NEV. REV. STAT. ANN. 449.600-.610 (Michie 2000) (living will statute)  
NEV. REV. STAT. ANN. 449.613, 449.800-.860 (Michie 2000) (proxy statute)  
NEV. REV. STAT. ANN. 449.626 (Michie 2000) (surrogacy statute)
- New Hampshire: N.H. REV. STAT. ANN. §§ 137-H:3 to -:7 (1996) (living will statute)  
N.H. REV. STAT. ANN. §§ 137-J:2 to -:6 (1996) (proxy statute)  
N.H. REV. STAT. ANN. § 464-A:4 (Supp. 2002) (surrogacy statute)
- New Jersey: N.J. STAT. ANN. §§ 26:2H-56 to -59 (West 1996 & Supp. 2003) (living will statute)  
N.J. STAT. ANN. §§ 26:2H-53 to -78 (West 1996 & Supp. 2003) (proxy statute)  
(no surrogacy statute)

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- New Mexico: N.M. STAT. ANN. §§ 24-7A-2 to -4 (Michie 2000) (living will statute)  
N.M. STAT. ANN. §§ 24-7A-2 to -4 (Michie 2000) (proxy statute)  
N.M. STAT. ANN. § 24-7A-5 (Michie 2000) (surrogacy statute)
- New York: (no living will statute)  
N.Y. PUB. HEALTH LAW §§ 2981-2985 (McKinney 2002 & Supp. 2003) (proxy statute)  
N.Y. PUB. HEALTH LAW § 2965 (McKinney 2002 & Supp. 2003) (surrogacy statute)
- North Carolina: N.C. GEN. STAT. § 90-321 (Supp. 2002) (living will statute)  
N.C. GEN. STAT. §§ 32A-17 to -22 (Supp. 2002) (proxy statute)  
N.C. GEN. STAT. § 90-322 (Supp. 2002) (surrogacy statute)
- North Dakota: N.D. CENT. CODE §§ 23-06.4-03 to -05 (2002) (living will statute)  
N.D. CENT. CODE §§ 23-06.5-03 to -07 (2002) (proxy statute)  
N.D. CENT. CODE § 23-12-13 (2002) (surrogacy statute)
- Ohio: OHIO REV. CODE ANN. §§ 2133.02-.06 (Anderson 2002) (living will statute)  
OHIO REV. CODE ANN. §§ 1337.12-.14 (Anderson 2002) (proxy statute)  
OHIO REV. CODE ANN. § 2133.08 (Anderson 2002) (surrogacy statute)
- Oklahoma: OKLA. STAT. ANN. tit. 63, §§ 3101.4-.6 (West 1997 & Supp. 2003) (living will statute)  
OKLA. STAT. ANN. tit. 63, §§ 3101.4-.6 (West 1997 & Supp. 2003) (proxy statute)  
OKLA. STAT. ANN. tit. 63, §§ 3080.4-.5 (West 1997 supp. 2003) (surrogacy statute)
- Oregon: OR. REV. STAT. §§ 127.510-.545 (2001) (living will statute)  
OR. REV. STAT. §§ 127.510-.545 (2001) (proxy statute)  
OR. REV. STAT. § 127.635 (2001) (surrogacy statute)
- Pennsylvania: PA. CONS. STAT. ANN. tit. 20, §§ 5404-5406 (West Supp. 2003) (living will statute)  
PA. CONS. STAT. ANN. tit. 20, §§ 5404-5406, 5601-5605 (West Supp. 2003) (proxy statute)  
(no surrogacy statute)
- Rhode Island: R.I. GEN. LAWS §§ 23-4.11-3 to -4 (2001) (living will statute)  
R.I. GEN. LAWS §§ 23-4.10-1 to -2 (2001 & Supp. 2002) (proxy statute)  
(no surrogacy statute)
- South Carolina: S.C. CODE ANN. §§ 44-77-30 to -80 (Law. Co-op. 2002) (living will statute)  
S.C. CODE ANN. §§ 62-5-504 to -505 (Law. Co-op. Supp. 2002) (proxy statute)  
S.C. CODE ANN. § 44-66-30 (Law. Co-op. 2002 & Supp. 2002) (surrogacy statute)
- South Dakota: S.D. CODIFIED LAWS §§ 34-12D-2 to -8 (Michie 1994) (living will statute)  
S.D. CODIFIED LAWS §§ 59-7-2.1 to -2.8 (Michie 1994) (proxy statute)  
S.D. CODIFIED LAWS § 34-12C-3 (Michie 1994) (surrogacy statute)
- Tennessee: TENN. CODE ANN. §§ 32-11-104 to -106 (2001) (living will statute)  
TENN. CODE ANN. §§ 34-6-202 to -207 (2001) (proxy statute)  
(no surrogacy statute)
- Texas: TEX. HEALTH & SAFETY CODE ANN. §§ 166.032-.051 (West 2001) (living will statute)  
TEX. HEALTH & SAFETY CODE ANN. §§ 166.152-.155 (West 2001) (proxy statute)  
TEX. HEALTH & SAFETY CODE ANN. §§ 166.035, 313.00.4 (West 2001) (surrogacy statute)
- Utah: UTAH CODE ANN. §§ 75-2-1102 to -1111 (1993 & Supp. 2003) (living will

The most difficult medical decisionmaking cases arise when the autonomy-based paradigm favoring patient choice does not fit; that is, when a patient lacks autonomy or has not exercised “precedent autonomy.”<sup>8</sup> People with mental retardation, people with severe mental disabilities, and children have never had decisionmaking capacity. Others have had decisionmaking capacity at some time, but have lost it through disease, accident, age, or injury. Although some people who lose their decisionmaking

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	statute)
	UTAH CODE ANN. §§ 75-2-1106 to -1111 (1993 & Supp. 2003) (proxy statute)
	UTAH CODE ANN. §§ 75-2-1105(2), 78-14-5(4) (1993 & Supp. 2003) (surrogacy statute)
Vermont:	VT. STAT. ANN. tit. 18, §§ 5253-5257 (2000) (living will statute)
	VT. STAT. ANN. tit 14, §§ 3453-3467 (2002) (proxy statute) (no surrogacy statute)
Virginia:	VA. CODE ANN. §§ 54.1-2983 to -2985 (Michie 2002) (living will statute)
	VA. CODE ANN. §§ 54.1-2981 to -2993 (Michie 2002) (proxy statute)
	VA. CODE ANN. § 54.1-2986 (Michie 2002) (surrogacy statute)
Washington:	WASH. REV. CODE ANN. §§ 70.122.030-.040 (West 2002) (living will statute)
	WASH. REV. CODE ANN. §§ 11.94.010-.046 (West 1998 & Supp. 2003) (proxy statute)
	WASH. REV. CODE ANN. § 7.70.065 (West 1992 & Supp. 2003) (surrogacy statute)
West Virginia:	W. VA. CODE ANN. §§ 16-30-4 to -18 (Michie 2001 & Supp. 2002) (living will statute)
	W. VA. CODE ANN. §§ 16-30-4 to -18 (Michie 2001 & Supp. 2002) (proxy statute)
	W. VA. CODE ANN. §§ 16-30-8 to -9 (Michie 2001 & Supp. 2002) (surrogacy statute)
Wisconsin:	WIS. STAT. ANN. §§ §154.03-.05 (West 1997 & Supp. 2002) (living will statute)
	WIS. STAT. ANN. §§ 155.05-.40 (West 1997 & Supp. 2002) (proxy statute) (no surrogacy statute)
Wyoming:	WYO. STAT. ANN. §§ 35-22-102 to -103 (Michie 2003) (living will statute)
	WYO. STAT. ANN. §§ 3-5-202 to -207 (Michie 2003) (proxy statute)
	WYO. STAT. ANN. §§ 3-5-209, 35-22-105(b) (Michie 2003) (surrogacy statute)

8. Leslie Pickering Francis, *Decisionmaking at the End of Life: Patients with Alzheimer's or Other Dementias*, 35 GA. L. REV. 539, 551, 569-79 (2001), citing Ronald M. Dworkin, *Autonomy and the Demented Self*, 64 MILBANK Q. 4, 10 (Supp. 2 1986). The autonomy-based model for medical decisionmaking for patients who lack competence is subject to much criticism. For example, Dean Boozang points out that

[t]he law's focus (perhaps a better word would be obsession) with personal autonomy loses its force when the dying individual is incompetent, and her wishes are unknown. The law's exclusive focus on personal autonomy works great harm to the families of the dying by depriving them of meaningful participation in the death of their loved one.

Kathleen M. Boozang, *An Intimate Passing: Restoring the Role of Family and Religion in Dying*, 58 U. PIT. L. REV. 549, 550 (1997); see also John A. Robertson, *Assessing Quality of Life: A Response to Professor Kamisar*, 25 GA. L. REV. 1243, 1243 (1991) (“Too many commentators and policy makers have tried to fit the incompetent patient into the model of an autonomous decisionmaker . . .”); Michael R. Flick, *The Due Process of Dying*, 79 CAL. L. REV. 1121, 1146 (1991).

capacity have exercised their autonomy through some sort of advance directive or appointment of a health care proxy, most have not.<sup>9</sup> Thus, for many people, the decisionmaking model that relies on self-determination is inaccessible. Because the concept of autonomy is so firmly entrenched in the modern paradigm for medical decisionmaking, however, states have created surrogate decisionmaking mechanisms to manufacture autonomy for people who lack decisionmaking capacity.<sup>10</sup>

Surrogacy statutes and case law in all fifty states give surrogates the ability to make most health care decisions for patients who have never had decisionmaking capacity or who lost their decisionmaking capacity without executing an advance directive.<sup>11</sup> Surrogate decisionmaking procedures work in essentially one of two ways.

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9. One study shows only 10-25% of all people have executed an advance directive. Elizabeth H. Bradley et al., *Institutional Efforts to Promote Advance Care Planning in Nursing Homes: Challenges and Opportunities*, 25 J.L. MED. & ETHICS, 150, 150 (1997). Another shows that only 18% of Americans have executed an advance directive. Stanley S. Herr & Barbara L. Hopkins, *Health Care Decision-Making for Persons with Disabilities: An Alternative to Guardianship*, 271 JAMA 1017, 1017 (1994).

10. John A. Robertson, *Cruzan and the Constitutional Status of Nontreatment Decisions for Incompetent Patients*, 25 GA. L. REV. 1139, 1142 (1991) ("The tendency to recast decisions about incompetent patients as questions of prior autonomy, rather than to assess directly the worth of the patient's life, is most evident when an incompetent patient has not issued a prior directive to guide current decisions. Most courts faced with this question remain wedded to personal autonomy and require that proxies determine what the patient, if competent, would have decided about the choice before her.") (citing *Brophy v. New England Sinai Hosp.*, 497 N.E.2d 626, 631-33 (Mass. 1986) (holding by means of substituted judgment); *In re Spring*, 405 N.E.2d 115 (Mass. 1980)). To be sure, some state legislatures and some courts have recognized that a surrogacy statute does not give autonomy to a person who lacks competency. These statutes were originally developed, however, to protect the autonomy and right to informed consent of the incompetent.

11. The following statutes allow surrogates to make decisions without an advance directive:

Alabama: ALA. CODE § 22-8A-4 (Supp. 2002); Arizona: ARIZ. REV. STAT. ANN. § 36-3231 (West 2003); Arkansas: ARK. CODE ANN. § 20-17-214 (Michie 2000); California: CAL. HEALTH & SAFETY CODE § 1418.8 (West 2000) & CAL. PROB. CODE §§ 4711-4716 (West Supp. 2003); Colorado: COLO. REV. STAT. §§ 15-18.5-101 to -103 (1997 & Supp. 2002); Connecticut: CONN. GEN. STAT. § 19a-571 (Supp. 2003); Delaware: DEL. CODE ANN. tit. 16, § 2507 (Supp. 2003); D.C.: D.C. CODE ANN. § 21-2210 to -2213 (2001); Florida: FLA. STAT. ANN. §§ 765.401, 765.404 (West Supp. 2003); Georgia: GA. CODE ANN. § 31-9-2 (2001); Hawaii: HAW. REV. STAT. § 327E-5 (Supp. 2001); Idaho: IDAHO CODE § 39-4303 (Michie 2002); Illinois: 755 ILL. COMP. STAT. ANN. 40/20 (West Supp. 2003); Indiana: IND. CODE §§ 16-36-1-1 to -14 (1997 & Supp. 2002); Iowa: IOWA CODE ANN. § 144A.7 (West Supp. 2003); Kentucky: KY. REV. STAT. ANN. § 311.631 (Michie 2001); Louisiana: LA. REV. STAT. ANN. § 40:1299.53 (West 2001); Maine: ME. REV. STAT. ANN. tit. 18-A, § 5-805 (West Supp. 2002); Maryland: MD. CODE ANN., HEALTH-GEN. I § 5-605 (2000 & Supp. 2002); Mississippi: MISS. CODE ANN. § 41-41-211 (Supp. 2002); Montana: MONT. CODE ANN. § 50-9-106 (2001) *amended by* Act effective Nov. 1, 2003, ch. 240, 2003 Mont. Laws HB 585; Nevada: NEV. REV. STAT. ANN. 449.626 (Michie 2000); New Mexico: N.M. STAT. ANN. § 24-7A-5 (Michie 2000); North Carolina: N.C. GEN. STAT. § 90-322 (Supp. 2002); North Dakota: N.D. CENT. CODE §§ 23-12-13 (2002); Ohio: OHIO REV. CODE ANN. § 2133.08 (Anderson 2002); Oklahoma: OKLA. STAT. ANN. tit. 63, §§ 3080.4-.5; Oregon: OR. REV. STAT. § 127.635 (2001); South Carolina: S.C. CODE ANN. § 44-66-30 (Law. Co-op. 2002 & Supp. 2002); South Dakota: S.D. CODIFIED LAWS § 34-12C-3 (Michie 1994); Texas: TEX. HEALTH & SAFETY CODE ANN. §§ 166.035, 313.00.4 (West 2001); Utah: UTAH CODE ANN. §§ 75-2-1105(2), 78-14-5(4) (1993 & Supp. 2003); Virginia: VA. CODE ANN. § 54.1-2986 (Michie 2002); Washington: WASH. REV. CODE ANN. § 7.70.065 (West 1992 &



The surrogate is either asked to make the medical decision for the incompetent patient based upon what is in the best interests of the patient,<sup>12</sup> or to engage in the legal fiction<sup>13</sup> of determining what the person would want if he or she were competent.<sup>14</sup>

Regardless of the standard that the surrogate must use to make decisions, most state surrogacy laws allow a surrogate or guardian to make any and all decisions for a patient who lacks capacity. In these states, surrogates can decide to terminate all medical intervention including artificial respiration, nutrition, and hydration.<sup>15</sup> Some states limit the authority of surrogates or guardians to make medical decisions for an incompetent individual. Most of those limitations concern the termination of life-sustaining treatment,<sup>16</sup> and all are rooted in the inability to determine the incapacitated patient's intent. As a result, some states preclude a surrogate from terminating life-sustaining treatment without clear proof of the incapacitated person's intent.<sup>17</sup> When those wishes are not known, or when there is no intent because the incapacitated person lacks the ability to form it, the surrogate cannot choose to terminate treatment. For example, New York,<sup>18</sup> Arizona,<sup>19</sup> Michigan,<sup>20</sup> Missouri,<sup>21</sup> Ohio,<sup>22</sup> Mississippi,<sup>23</sup>

Supp. 2003); West Virginia: W. VA. CODE ANN. §§ 16-30-8 to -9 (Michie 2001 & Supp. 2002); Wyoming: WYO. STAT. ANN. §§ 3-5-209, 35-22-105(b) (Michie 2003).

12. "Under the best interests test, a surrogate decisionmaker chooses for the incompetent patient which medical procedures would be in the patient's best interest. The criteria used include 'relief from suffering, preservation or restoration of functioning, and quality and extent of sustained life.'" *In re Estate of Longeway*, 549 N.E.2d 292, 299 (Ill. 1990) (citing Rasmussen v. Fleming, 741 P.2d 674, 689 (Ariz. 1987)); see also *Lenz v. L.E. Phillips Career Dev. Ctr. (In re Guardianship of L.W.)*, 482 N.W.2d 60, 75-76 (Wis. 1992) (applying the best interests test).

13. See *Martin v. Martin*, 538 N.W.2d 399, 407 (Mich. 1995); see also Deborah K. McKnight & Maureen Bellis, *Foregoing Life-Sustaining Treatment for Adult, Developmentally Disabled, Public Wards: A Proposed Statute*, 18 AM. J.L. & MED. 203, 223 (1992) ("[T]he substituted judgment standard seeks to implement non-existent wishes . . .").

14. "The substituted judgment standard has subjective and objective components. Through this standard, the surrogate attempts to ascertain, with as much specificity as possible, the decision the incompetent patient would make if he were competent to do so." *Martin*, 538 N.W.2d at 407; see also *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 431-35 (Mass. 1977) (applying substituted judgment); *Mack v. Mack*, 618 A.2d 744, 757 (Md. 1993) (same); *In re Jobes*, 529 A.2d 434, 453-57 (N.J. 1987); *In re K.I.*, 735 A.2d 448, 455 (D.C. Cir. 1999) (rejecting substituted judgment standard with respect to an infant because an infant has no articulable judgment to be substituted, and stating that application of substituted judgment necessitates that the patient had been competent at one time and had in some manner expressed her preferences or values).

15. See Appendix (describing surrogacy and guardianship laws and their limitations in all fifty states).

16. Some states place other limits on the types of decisions a surrogate can make. See, e.g., CAL. PROB. CODE § 625 (West Supp. 2003) (prohibiting surrogate from consenting to civil commitment, electro-convulsive therapy, psycho-surgery, sterilization, or abortion); D.C. CODE § 21-2211 (2001) (prohibiting surrogate consent to abortion, sterilization, or psycho-surgery); VA. CODE ANN § 54.1-2986 (Michie 2002) (prohibiting surrogate consent to non-therapeutic sterilization, abortion, psychosurgery, or admission to a mental retardation facility).

17. E.g., *Martin*, 538 N.W.2d at 399; *In re Storar*, 420 N.E.2d 64, 72 (N.Y. 1981) cert. denied, 454 U.S. 858 (1981).

18. N.Y. PUB. HEALTH LAW § 2965 (McKinney 1999) (limiting ability of surrogate to consent to a DNR order); N.Y. SURR. CT. PROC. ACT § 1750-b (McKinney Supp. 2003) (allowing surrogate of person with mental retardation to terminate treatment); see also *In re Storar*, 420 N.E.2d at 64.

19. ARIZ. REV. STAT. ANN. §§ 36-3231 (West 2003).

Wisconsin,<sup>24</sup> and Hawaii<sup>25</sup> limit to varying degrees the ability of certain surrogates to choose to terminate life-sustaining treatment. In those states, certain caregivers and surrogates may not make the decision to terminate life-sustaining nutrition and hydration, even when the administration of nutrition and hydration has dire iatrogenic effects. These states take a vitalist position for certain classes of patients: life must be maintained whatever the cost to the patient, the families, and the caregivers. Consistently, the states that maintain a vitalist position for some of their citizens claim an unqualified interest in preserving life.<sup>26</sup>

As has been well documented elsewhere,<sup>27</sup> the states' assertion in an unqualified interest in life was validated by the United States Supreme Court in *Cruzan v. Director, Missouri Department of Health*.<sup>28</sup> Nancy Beth Cruzan was rendered incompetent because of injuries sustained in an automobile accident.<sup>29</sup> Her parents

20. See *Martin*, 538 N.W.2d at 399.

21. See *Cruzan v. Harmon*, 760 S.W.2d 408, 425-26 (Mo. 1988).

22. OHIO REV. CODE ANN. § 2133.08 (Anderson 1994).

23. MISS. CODE ANN. §§ 41-41-215(9), 41-42-211 (Supp. 2002).

24. *Lenz v. L.E. Phillips Career Dev. Ctr. (In re Guardianship of L.W.)*, 482 N.W.2d 60, 88 (Wis. 1992).

25. HAW. REV. STAT. § 327E-5 (Supp. 2001).

26. See, e.g., *Harmon*, 760 S.W.2d at 419 ("The state's concern with the sanctity of life rests on the principle that life is precious and worthy of preservation without regard to its quality."); *People v. Eulo*, 472 N.E.2d 286, 296 (N.Y. 1984) ("This court will make no judgment as to what is for another an unacceptable quality of life.").

27. See, e.g., George J. Annas, *The "Right to Die" in America: Sloganeering from Quinlan and Cruzan to Quill and Kevorkian*, 34 DUQ. L. REV. 875 (1996); James Bopp Jr. & Daniel Avila, *The Due Process "Right to Life" in Cruzan and Its Impact on "Right-to-Die" Law*, 53 U. PITT. L. REV. 193 (1991); Judith F. Daar, *A Clash at the Bedside: Patient Autonomy v. A Physician's Professional Conscience*, 44 HASTINGS L.J. 1241 (1993); John M. Finnis, *The "Value of Human Life" and "The Right to Death": Some Reflections on Cruzan and Ronald Dworkin*, 17 S. ILL. U. L.J. 559 (1993); M. Rose Gasner, *The Unconstitutional Treatment of Nancy Cruzan*, 7 N.Y. L. SCH. J. HUM. RTS. 1 (1990); Lawrence O. Gostin, *A Line Between Killing and Letting Die: The Law, and Law Reform, on Medically Assisted Dying*, 21 J.L. MED. & ETHICS 94 (1993); Edward R. Grant & Cathleen A. Cleaver, *A Line Less Reasonable: Cruzan and the Looming Debate over Active Euthanasia*, 2 MD. J. CONTEMP. LEGAL ISSUES 99 (1991); Mark E. Haddad, *Cruzan and the Demands of Due Process*, 8 ISSUES L. & MED. 205 (1992); Harvard Law Review Association, *Right to Die-Incompetents' Right to Refuse Life-Sustaining Medical Treatment*, 104 HARV. L. REV. 257 (1990); James H. Lawlor III, *The Right to Die in Illinois in the Wake of Cruzan, Longway, and Greenspan*, 79 ILL. B.J. 72 (1991); Susan R. Martyn & Henry J. Bourguignon, *Coming to Terms with Death: The Cruzan Case*, 42 HASTINGS L.J. 817 (1991); Dorothy J. McNoble, *The Cruzan Decision—A Surgeon's Perspective*, 20 U. MEM. L. REV. 569 (1990); Martha L. Minow, *The Role of Families in Medical Decisions*, 1991 UTAH L. REV. 1 (1991); Thomas J. Orusko & Patricia Casey Cuthbertson, *The Right to Refuse Medical Treatment in Ohio after Cruzan: The Need for a Comprehensive Legislative Solution*, 5 J.L. & HEALTH 35 (1990/1991); Philip G. Peters Jr., *The State's Interest in the Preservation of Life: From Quinlan to Cruzan*, 50 OHIO ST. L.J. 891 (1989); John J. Regan, *Refusing Life-Sustaining Treatment for Incompetent Patients: New York's Response to Cruzan*, 19 N.Y.U. REV. L. & SOC. CHANGE 341 (1991/1992); Robertson, *supra* note 10; Cindy Hylton Rushton & Elizabeth E. Hogue, *The Role of Families as Surrogate Decisionmakers after Cruzan v. Director, Missouri Department of Health*, 7 J. CONTEMP. HEALTH L. & POL'Y 219 (1991); Benjamin C. Zipursky, *The Pedigrees of Rights and Powers in Scalia's Cruzan Concurrence*, 56 U. PITT. L. REV. 283 (1994).

28. 497 U.S. 261 (1990).

29. *Id.* at 265.

sought a court order directing the withdrawal of life-sustaining nutrition and hydration, which all agreed would cause her death.<sup>30</sup> The Supreme Court of Missouri “held that because there was no clear and convincing evidence of Nancy’s desire to have life-sustaining treatment withdrawn under such circumstances, her parents lacked authority to effectuate such a request.”<sup>31</sup> The Supreme Court “granted certiorari to consider the question whether Cruzan has a right under the United States Constitution which would require the hospital to withdraw life-sustaining treatment from her under these circumstances.”<sup>32</sup> The Court held that she did not.<sup>33</sup>

The *Cruzan* Court “assume[d] that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.”<sup>34</sup> The Court declined, however, to decide whether an incompetent individual has a similar liberty interest, stating:

The difficulty with petitioners’ claim is that in a sense it begs the question: An incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right. Such a ‘right’ must be exercised for her, if at all, by some sort of surrogate.<sup>35</sup>

The Court further explained that even were such a liberty interest possessed, whether the individual’s “constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests.”<sup>36</sup>

The Court found that the interests motivating Missouri were significant to all states:

As a general matter, the States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide. We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death.<sup>37</sup>

The Court explained that states’ interests in preserving life are particularly acute in withdrawal of treatment cases because “[t]he choice between life and death is a deeply personal decision of obvious and overwhelming finality.”<sup>38</sup> Thus, “a State may properly decline to make judgments about the ‘quality’ of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life.”<sup>39</sup>

Significantly, the Court rejected the argument that a state “must accept the

30. *Id.* at 267-68.

31. *Id.* at 265.

32. *Id.* at 269.

33. *See generally id.*

34. *Id.* at 279.

35. *Id.* at 280.

36. *Id.* at 279 (quoting *Youngberg v. Romero*, 457 U.S. 307, 321 (1982)).

37. *Id.* at 280.

38. *Id.* at 281.

39. *Id.*; *see also* *Washington v. Glucksberg*, 521 U.S. 702, 730 (1997) (“This remains true, as *Cruzan* makes clear, even for those who are near death.”).

'substituted judgment' of close family members even in the absence of substantial proof that their views reflect the views of the patient."<sup>40</sup> The Court refused to hold that the Due Process Clause requires the state to repose judgment on what is an acceptable quality of life with anyone but the patient herself. According to the Court, even the best intended family members cannot guarantee that their view is the same as the patient's would have been had she been confronted with the prospect of her situation while competent.<sup>41</sup>

Accordingly, the Court held that the state was not "required by the United States Constitution to repose a right of 'substituted judgment' with anyone . . . ."<sup>42</sup> In her concurrence, Justice O'Connor wrote that, under the Court's decision, the task of crafting procedures in this context was "entrusted to the laboratory of the States . . . ."<sup>43</sup> Notably, the *Cruzan* Court discussed the then-controlling New York law<sup>44</sup> as an example of what was constitutionally permissible,<sup>45</sup> discussing among other cases *In re Storar*.<sup>46</sup> Mr. Storar was a profoundly retarded man with terminal bladder cancer who "was always totally incapable of understanding or making a reasoned decision about medical treatment."<sup>47</sup> His treating physicians recommended the blood transfusions, which could "eliminate the risk of death from [a] treatable cause," and which would maintain the patient's physical and mental condition at their "usual level."<sup>48</sup> Although the patient's mother opposed the transfusions, she seemed not to understand the consequences of stopping them, including whether it might cause him to die sooner.<sup>49</sup> The mother "testified that she wanted the transfusions discontinued because she only wanted her son to be comfortable."<sup>50</sup> The hospital sought an order to administer the treatment. New York's highest court granted the hospital that order.<sup>51</sup>

The New York Court of Appeals explained that "[m]entally John Storar was an infant" and that the standard applicable to decisionmaking for minors was the "only realistic way to assess his rights."<sup>52</sup> The court explained that while a parent or guardian has a right to consent to an infant's medical treatment, a parent "may not deprive a child of life saving treatment, however well intentioned."<sup>53</sup> It stated that "[e]ven when the parents' decision to decline necessary treatment is based on constitutional grounds, such as religious beliefs, it must yield to the State's interests, as *parens patriae*, in protecting the health and welfare of the child."<sup>54</sup> The court noted that "the transfusions were analogous to food—they would not cure the cancer, but they could eliminate the

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40. *Cruzan*, 497 U.S. at 285-86.

41. *Id.* at 286.

42. *Id.*

43. *Id.* at 292 (O'Connor, J., concurring) (internal quotation omitted).

44. On September 17, 2002, "Health Care Decisions Act for Persons with Mental Retardation" became law in New York. N.Y. SURR. CT. PROC. ACT LAW §§ 1750, 1750-b (McKinney Supp. 2003). The law permits the guardian of a mentally retarded person to decide to withdraw or withhold life-sustaining treatment under specified circumstances. *See infra* Part III.

45. *Cruzan*, 497 U.S. at 271-75.

46. 420 N.E.2d 64 (N.Y. 1981), *cert. denied*, 454 U.S. 858 (1981).

47. *Id.* at 72.

48. *Id.* at 73.

49. *Id.* at 70.

50. *Id.*

51. *Id.* at 74.

52. *Id.* at 73.

53. *Id.* (citations omitted).

54. *Id.* (citations omitted).

risk of death from another treatable cause.”<sup>55</sup> Thus, the court ordered the transfusions because it would not “allow an incompetent patient to bleed to death because someone, even someone as close as a parent or sibling, feels that this is best for one with an incurable disease.”<sup>56</sup>

The *Cruzan* Court also discussed *In re Westchester County Medical Center on Behalf of O'Connor*,<sup>57</sup> where the Court of Appeals reaffirmed that the right to decline life-sustaining treatment, arising from the doctrine of informed consent, “is personal and, under existing law in [New York], could not be exercised by a third party when the patient is unable to do so.”<sup>58</sup> The *O'Connor* Court explicitly rejected a “substituted judgment” approach that would permit a third party to withdraw life-sustaining treatment, even where the patient could not, or did not ever express his or her views in a clearly convincing fashion. The court held that the substituted judgment “approach remains unacceptable because it is inconsistent with *our fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another*,”<sup>59</sup> and that “if an error occurs it should be made on the side of life.”<sup>60</sup>

Thus, the *Cruzan* Court gave states the permission to take a vitalist position in the absence of an exercise of autonomy by the patient him or herself and condoned New York’s law, which had done just that. Based on *Cruzan*, the states are free to require that incompetent patients receive life-sustaining treatment. Ten years after *Cruzan* was decided, and nineteen after *Storar*, a New York woman suffered the terrible consequences of those decisions.

## II. THE TRAGIC CASE OF SHEILA POULIOT

Ms. Pouliot[’s] . . . family, guardian and physicians . . . are clearly acting in what they believe to be Ms. Pouliot’s best interests and on the basis of reasonable medical judgment. We do not appear in this case to prolong the anguish of Ms. Pouliot or her family. We are here because New York law does not appear to permit anyone—a family, a guardian, even a court—to prevent a person like Ms. Pouliot, who has never been competent to express a desire to forgo life-sustaining treatment, from receiving nutrition and hydration.<sup>61</sup>

### A. An Epoch Death

Sheila Pouliot was a terminally ill and profoundly retarded forty-two-year-old

55. *Id.*

56. *Id.*; see also *In re Fosmire v. Nicoleau*, 551 N.E.2d 77, 82 (N.Y. 1990) (“[W]here the patient [in *Storar*] was incapable ever of making such a choice because of retardation . . . we ordered that medical care continue.”). The court noted that there was convincing evidence that the transfusions did not involve excessive pain, and expressly left open the question of the appropriate result if a life-sustaining treatment did involve excessive pain. *Storar*, 420 N.E.2d at 73.

57. 531 N.E.2d 607 (N.Y. 1988).

58. *Id.* at 612 (citing *People v. Eulo*, 472 N.E.2d 286 (N.Y. 1984)).

59. *Id.* at 613 (citing *Eulo*) (emphasis added).

60. *Id.*

61. Memorandum of Law in Opposition to Motion for Vacatur of Stay, *In re Pouliot v. Marzella*, to the Appellate Division of the New York Supreme Court, Fourth Department No. 99-7835 (N.Y. Sup. Ct. Mar. 2, 2000) (on file with author).

woman when she was admitted to University Hospital at the State University of New York in Syracuse on December 21, 1999.<sup>62</sup> She had suffered complications from the mumps as an infant that left her severely disabled.<sup>63</sup> The mumps caused Olivo-Pontine-Cerebellar degeneration and partial blindness.<sup>64</sup> Ms. Pouliot was unable to speak, read, walk, or eat. She communicated pain by groaning and suffered flexion contractures in all four limbs.<sup>65</sup> She was fed through a gastrostomy tube ("G tube"). Ms. Pouliot's parents and sister took care of her at home until she was twenty years old, at which time she was moved to a state-run group home. Her mother visited frequently until she became debilitated by Alzheimer's disease. Ms. Pouliot's sister, Alice Blouin, became her primary caregiver and visited Ms. Pouliot regularly. During the course of Ms. Pouliot's last stay in the hospital, Ms. Blouin kept a regular vigil at Ms. Pouliot's bedside.<sup>66</sup>

Ms. Pouliot was admitted to the hospital in December 1999 with bleeding in her gastrointestinal tract and what was initially diagnosed as aspiration pneumonia.<sup>67</sup> Because of the bleeding, Ms. Pouliot could not tolerate feeding through the G tube.<sup>68</sup> She "had an 'acute' abdomen, manifested by generalized, severe, abdominal pain and a nonfunctioning intestine."<sup>69</sup> The physicians who examined Ms. Pouliot advised her family that she was suffering from what was likely to be her terminal illness, that she was in pain, and that further treatment would likely prolong the suffering.<sup>70</sup>

After meetings with the treating physicians, the University Hospital's Ethics Committee, and clergy to discuss her medical treatment, Ms. Pouliot's family members asked her treating physicians to withhold all treatment, including nutrition, hydration, and antibiotics.<sup>71</sup> Initially, her physicians complied with the request. The family and physicians agreed that only palliative treatment would be maintained because any additional treatment would prolong Ms. Pouliot's suffering.<sup>72</sup>

62. Blouin v. Spitzer, 213 F. Supp. 2d 184, 186 (N.D.N.Y. 2002).

63. Kathy Faber-Langendoen, *Sheila Pouliot's Story*, at <http://www.familydecisions.org/pouliot> (last visited Sept. 14, 2003) [hereinafter Faber-Langendoen].

64. *Id.*

65. Contractures are "[a] condition of fixed high resistance to passive stretch of a muscle, resulting from fibrosis of the tissues supporting the muscles or the joints, or from disorders of the muscle fibers." RICHARD SLOANE, *THE SLOAN-DORLAND ANNOTATED MEDICAL LEGAL DICTIONARY* 164 (1987).

66. Aff. of Kathleen McGrail, M.D., Joint Appendix on Appeal at 1647-48, Blouin v. Spitzer, No. 02-7997 (2d Cir. docketed Mar. 5, 2003) [hereinafter McGrail aff.].

67. Blouin v. Spitzer, 01-CV-0925 HGM/GJD, 2001 U.S. Dist. Lexis 18243, at \*1 (N.D.N.Y. November 5, 2001). In his brief to the United States Court of Appeals for the Second Circuit, Attorney General Eliot Spitzer argues that the medical records do not support a finding that Ms. Pouliot suffered from pneumonia at the time she was admitted to the hospital. See Brief for Appellees, Blouin v. Spitzer, No. 02-7997 (2d Cir. docketed Mar. 5, 2003). In addition to the bleeding, Ms. Pouliot suffered "osteoporosis (thinning of the bones), with associate fractures in her right humerus and pelvis; dislocation of her left hip as well as possibly of her right shoulder; widespread flexion contractures involving elbows, knees and hips; and a seizure disorder." McGrail aff., *supra* note 65, at 1639.

68. Faber-Langendoen, *supra* note 63.

69. McGrail aff., *supra* note 65, at 1639.

70. *Id.*

71. Blouin v. Spitzer, 213 F. Supp. 2d 184, 186 (N.D.N.Y. 2002).

72. As defined by the World Health Organization, palliative care is:

On December 27, 1999, however, the University Hospital administration learned that the treating physician had not administered nutrition or antibiotics to Ms. Pouliot and, after consultation with the State Office of Mental Retardation and Development Disabilities (“OMRDD”), determined that under New York law,<sup>73</sup> Ms. Pouliot should be provided nutrition, hydration, and antibiotics.

On December 30, after learning that the treating physician had not provided all the required care,<sup>74</sup> the hospital petitioned the state trial court to appoint a guardian ad litem for Sheila Pouliot. The court appointed a guardian, who petitioned the court to terminate all nutrition and hydration.<sup>75</sup> The trial judge held a hearing at the hospital on December 30, 1999.

During the hearing, the treating physicians informed the court that there is a 14-day period during which is it medically appropriate to withhold nutrition and that it was their intention to do so while continually assessing Ms. Pouliot’s readiness to receive nutrition. The treating physicians also testified that further treatment to provide nutrition to Ms. Pouliot would result in prolonging her agony without any significant health or medical benefits.<sup>76</sup>

On January 3, 2000, the trial judge issued an order that all medical treatment for Ms. Pouliot be terminated, except for nutrition, as tolerated, and palliative hydration care.<sup>77</sup>

The next day, the guardian ad litem and plaintiff commenced an Article 78 proceeding and petitioned the Supreme Court of New York to enjoin permanently the State of New York, its agents, officers, and/or employees from further medical intervention, nutritional sustenance, or other life-sustaining treatment for Ms. Pouliot. At the conclusion of the hearing, the trial judge temporarily enjoined the named respondents from providing any medical intervention with regard to nutritional sustenance.<sup>78</sup>

Ms. Pouliot received hydration only until January 7. Then, after the trial judge was

[T]he total active care of patients whose disease is not responsive to curative treatment. Control of pain, of other symptoms and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best possible quality of life for patients and their families. . . . Palliative Care: affirms life and regards dying as a normal process; neither hastens nor postpones death; provides relief from pain and other distressing symptoms; integrates the psychological and spiritual aspects of patient care; offers a support system to help patients live as actively as possible until death; offers a support system to help the family cope during the patient’s illness and their own bereavement.

David A. Pratt, *Too Many Physicians: Physician-Assisted Suicide After Glucksberg/Quill*, 9 ALB. L. J. SCI. & TECH. 161, 225 n.346 (1999), quoting WORLD HEALTH ORGANIZATION, CANCER PAIN RELIEF AND PALLIATIVE CARE, TECHNICAL REPORT SERIES 804, at 11 (1989).

73. See *In re Storar*, 420 N.E.2d 64 (N.Y. 1981), cert. denied, 454 U.S. 858 (1981); *In re Matthews*, 650 N.Y.S.2d 373 (N.Y. App. Div. 1996).

74. *Blouin v. Spitzer*, 01-CV-0925 HGM/GJD, 2001 U.S. Dist. Lexis 18243, at \*2 (N.D.N.Y. November 5, 2001).

75. *Blouin*, 213 F. Supp. 2d at 187.

76. *Id.*

77. *Id.*

78. *Id.*

made aware of the limitations in New York law, the family, guardian, and hospital attorneys agreed to provide Ms. Pouliot hydration and to attempt to provide 900 calories of nutrition, which was an amount sufficient to maintain life.<sup>79</sup> The court ordered the continuing provision of artificial nutrition and hydration.<sup>80</sup>

Doctors made efforts to provide Ms. Pouliot with the planned 900 calories a day.<sup>81</sup> The attempt caused projectile vomiting and intractable hiccups.<sup>82</sup> As a result, doctors were able to provide only about 300 calories a day through intravenous (“IV”) fluids,<sup>83</sup> consisting essentially of sugar water.<sup>84</sup> The calories provided contained no protein.

The long-term provision of calories in the absence of protein causes more problems than it solves. The nutrition contained in the fluids—consisting only of glucose—is sufficient to maintain life (heart and lung function). But it cannot prevent protein starvation. In fact, there is universal medical agreement that the prolonged provision of calories in the absence of the ability to provide protein is inappropriate medical care.<sup>85</sup> Despite their agreement that it was not appropriate medical care, the doctors gave Ms. Pouliot the 300 calories a day for two and a half months because of the court order.

During that time, Ms. Pouliot's body began to catabolize her own tissue. The hydration provided through the IV tubes damaged her organs and caused her severe pain. Further, it caused her severe edema, which stretched her skin to the point where it fell off and left raw painful areas.<sup>86</sup> She was in agony. She spent the next two months moaning and curled in the fetal position.

Despite aggressive efforts to control her symptoms, such control was not achieved and the principle of safe and comfortable dying was violated. All observers agreed she had *significant and excessive pain*, manifested by moaning and crying, by furrowing her forehead and by flexing her extremities. These symptoms occurred despite the fact that she was on the equivalent of approximately 5000 mg of oral morphine a day. She could sometimes be partially consoled by stroking her forehead or placing a

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79. *Id.*

80. *Id.*

81. *Id.*

82. Faber-Langendoen progress note, *supra* note 1.

83. David F. Lehmann, M.D., progress note entered into Sheila Pouliot's medical chart (Feb. 29, 2000) (on file with author) [hereinafter Lehmann progress note].

84. Faber-Langendoen progress note, *supra* note 1.

85. [L]oss of appetite and poor function of the gut with reflux and constipation mark the final stage of . . . illness, as occurred to Sheila. When forced to eat or pushed to eat against their will or if fed through a feeding tube, these patients often display reflux and aspiration and sometimes vomiting. The muscles for swallowing also weaken, making swallowing difficult, leading to painful and frightening choking, even on one's oral secretions. . . . This protective synergy is totally countermanded when intravenous fluid or hyperalimentation is given . . . . *Dying is easier and less distressing when we do not give fluids by artificial means.*

McGrail aff., *supra* note 65, at 1644-45.

86. During that time, Ms. Pouliot's skin broke down with “excessive maceration,” she was “edemous, with total body bloating from hydration in the absence of protein. Hydration alone . . . resulted in severe protein malnutrition, which is typified by skin, peripheral muscle, and cardiac muscle breakdown.” Faber-Langendoen progress note, *supra* note 1.



musical angel next to her head on her pillow.<sup>87</sup>

On February 29, 2000, more than two months after Ms. Pouliot entered the hospital, one of her treating physicians entered the following progress note in her chart:

[T]he intravenous fluids promote that the patient is kept alive for her own body to consume/eat itself . . . . [T]his current plan of IV hydration promotes an *increase* in patient suffering, does not promote life quality, and maintains her heart/lung capacity only—and, indeed, therefore this current tact is outside of acceptable medical bounds, in effect worsening her condition, since she is consuming herself calorically. It is thus, *not* medically indicated.<sup>88</sup>

Another of Ms. Pouliot's physicians stated in a consultation note, "Sheila is edematous, with total body bloating from hydration in the absence of protein. Hydration . . . has resulted in severe . . . cardiac muscle breakdown. She will die a slow lingering death from protein malnutrition."<sup>89</sup> The treating physician also noted that the provision of artificial hydration ordered by the Court was "inhumane and is causing suffering . . . . From a medical standpoint, it is outside the bounds of . . . medically indicated care."<sup>90</sup>

Finally, the guardian decided to take action. He went back to court seeking an order that would allow the physicians to withdraw the IV fluids.<sup>91</sup> At the hearing, Ms. Pouliot's physicians testified that Ms. Pouliot was essentially a living corpse. "[T]he continuation of hydration for this patient is affirmatively causing significant physical harm to the patient in that it is bringing about unnatural and painful decomposition of her body tissues . . . ."<sup>92</sup> Further treatment would cause affirmative harm by prolonging her suffering, adding to her pain, and causing her organs, including her skin to break down further. Terminating nutrition and hydration would lessen her pain.

But it would also cause her death. Ms. Pouliot's life expectancy was approximately two to four months if hydration was continued.<sup>93</sup> She would die within three to fourteen days if hydration was discontinued.<sup>94</sup> Thus, the treatment that was harming Ms. Pouliot was technically "life sustaining." As discussed below,<sup>95</sup> New York law prohibited a third party, even a court appointed guardian or loving family member, from making the decision to terminate life-sustaining treatment for another person.<sup>96</sup>

After visiting Sheila Pouliot's bedside, the Supreme Court judge issued an order to

87. McGrail aff., *supra* note 65, at 1646 (emphasis added).

88. Lehmann progress note, *supra* note 81 (emphasis in original).

89. Faber-Langendoen progress note, *supra* note 1.

90. *Id.* at 409.

91. See Joint Appendix on Appeal at 409, *Blouin v. Spitzer*, No. 02-7997 (2d Cir. docketed Mar. 5, 2003).

92. Aff. of Kathy Faber-Langendoen, M.D., Joint Appendix on Appeal at 797, *Blouin v. Spitzer*, No. 02-7997 (2d Cir. docketed Mar. 5, 2003) [hereinafter *Faber-Langendoen aff.*].

93. *Id.* at 796.

94. *Id.* at 797.

95. See *infra* Part III.

96. *Blouin v. Spitzer*, 213 F. Supp. 2d 184, 193 (N.D.N.Y. 2002) ("New York law does not allow a third party to decide that the quality of life of another has declined to a point where treatment should be withheld and the patient should be allowed to die."); *In re Westchester County Med. Ctr. ex rel. O'Connor*, 531 N.E.2d 607, 613 (N.Y. 1988) ("[N]o person or court should substitute its judgment as to what would be an acceptable quality of life for another.").

terminate all nutrition and hydration. He acknowledged that New York law did not allow his order, but he explained: "There's the law, and there's what's right."<sup>97</sup> The hospital and OMRDD appealed seeking firmer legal ground for their actions or inactions. In the brief filed on their behalf, the Attorney General's office took an unusual position. Instead of acting as an adversary, it recognized the moral and legal problems with the apparent state of the law and asked the appellate court to tell the parties what to do.<sup>98</sup>

The appeal invoked a statutory provision that automatically stayed the judge's order. That day, the physician wrote in the hospital chart that the nutrition and hydration were causing "grotesque harm" to Ms. Pouliot.<sup>99</sup> On March 3, 2000, a judge of the Appellate Division granted an order to vacate the stay until a hearing before the full panel could be held on March 7, 2000.<sup>100</sup> Nutrition and hydration were terminated on March 3.<sup>101</sup> Ms. Pouliot died on March 6, 2000, just before the full court was to hear oral argument. The Attorney General withdrew the appeal. No written precedent resulted from the case.

### *B. Aftermath: Blouin v. Spitzer and the Health Care Decisions Act for Mentally Retarded Persons*

There have been two important developments since Ms. Pouliot's death: legislation and a lawsuit. First, after much publicity and advocacy by Sheila Pouliot's supporters,<sup>102</sup> the state enacted the "Health Care Decisions Act for Persons with Mental Retardation," which was signed into law by Governor George Pataki on September 17, 2002.<sup>103</sup> The statute now permits the guardian of a mentally retarded person to decide to withhold life-sustaining treatment, including nutrition and hydration, where "[t]here is no reasonable hope of maintaining life" or "[t]he artificially provided nutrition or hydration poses an extraordinary burden."<sup>104</sup>

The Health Care Decisions Act is an important, but limited, development in New York law. For the first time, a surrogate can make the decision to terminate life-sustaining treatment for a person who lacks competence. The act is very restrictive however.<sup>105</sup> As its name implies, it applies only to those people certified by physicians to suffer from mental retardation. Thus, it would have helped Sheila Pouliot, but not a terminally ill child or person with brain damage or mental illness.<sup>106</sup> Nor would it have

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97. Michael D. Goldhaber, *The Law v. What's Right*, NAT'L L.J., Apr. 3, 2000, at A1.

98. See generally Memorandum of Law in Opposition to Motion for Vacatur of Stay, *In re Pouliot v. Marzella* No. 99-7835 (N.Y. Sup. Ct. Mar. 2, 2000) (on file with author).

99. Joint Appendix on Appeal at 960, *Blouin v. Spitzer*, No. 02-7997 (2d Cir. docketed Mar. 5, 2003).

100. *Id.* at 790.

101. *Id.* at 964.

102. See <http://www.familydecisions.org/sheila.html> (collecting newspaper accounts of the Pouliot case) (last visited Sept. 14, 2003).

103. 2002 N.Y. Laws, ch. 500, *codified at* N.Y. SURR. CT. PROC. ACT §§ 1750, 1750-b (McKinney 2003).

104. N.Y. SURR. CT. PROC. ACT §1750-b (McKinney 2003).

105. Ben Golden, *New Law Gives Guardians Authority to End Futile Treatment for Adults with Retardation*, 75 N.Y. ST. B.J. 16 (2003).

106. A bill proposing a law that would allow the families or other surrogates of all incompetent patients to terminate life-sustaining treatment has been introduced and rejected by the New York State Senate every year for the past several years. See [www.familydecisions.org](http://www.familydecisions.org)

helped Mary O'Connor<sup>107</sup> or similar patients, who once had competency, but lost it.

The second important development since Ms. Pouliot's death is a lawsuit filed by Ms. Pouliot's family against New York State Attorney General Eliot Spitzer, Assistant Attorney General Win Thurlow, who handled the Pouliot case in the trial court, the New York State Office of Mental Retardation and Developmental Disabilities, and the University Hospital/SUNY Health Science Center at Syracuse.<sup>108</sup> This litigation has the potential to bring even more sweeping changes for the incompetent than the limited legislation passed by New York.

The lawsuit alleges that the defendants violated Ms. Pouliot's rights under the First, Fourth, and Fourteenth Amendments to the United States Constitution.<sup>109</sup> It also raises claims of negligence, unlawful practice of medicine, battery, and intentional or reckless infliction of emotional and mental distress and anguish.

The defendants moved for summary judgment on the ground that they are entitled to absolute and qualified immunity for their actions taken in their official capacities.<sup>110</sup> The district court first held that the defendants were not entitled to absolute immunity because they did not act in a traditional prosecutor's role in pursuing the case.<sup>111</sup> The court went on to hold, however, that the defendants were entitled to qualified

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(last visited Sept. 14, 2003) (detailing history of the movement to get broad legislation passed).

107. *In re Westchester County Med. Ctr. ex rel. O'Connor*, 420 N.E.2d 607 (N.Y. 1988).

108. *Blouin v. Spitzer*, 213 F. Supp. 2d 184, 193 (N.D.N.Y. 2002). Ms. Blouin apparently dropped the suit against the office of Mental Retardation and Developmental Disabilities, the University Hospital/SUNY Health Science Center at Syracuse, and the various John and Jane Does. Those defendants were never served with the complaint.

109. *Id.* at 187. The complaint also alleged violations of the Fifth and Eighth Amendments, but those allegations were abandoned in the trial court. *Id.* at 188.

110. *Id.* at 189.

111. *Id.* The Supreme Court has granted absolute immunity to officials who "perform 'special functions' which, because of their similarity to functions that would have been immune when Congress enacted § 1983, deserve absolute protection from damages liability." *Buckley v. Fitzsimmons*, 509 U.S. 259, 268-69 (1993). As a result, absolute immunity from damages liability "has been accorded to a few types of government officials whose duties are deemed as a matter of public policy to require such protection to enable them to function independently and effectively, without fear or harassment." *Barrett v. United States*, 798 F.2d 565, 571 (2d Cir. 1986). In determining whether actions are deserving of absolute immunity, the Supreme Court has applied a "functional approach," *Buckley*, 509 U.S. at 269, which looks to "the nature of the function performed, not the identity of the actor who performed it." *Forrester v. White*, 484 U.S. 219, 229 (1988).

Under this analysis, "prosecutors sued under 42 U.S.C. § 1983 are entitled to absolute immunity from claims for damages arising out of duties that are intimately associated with the judicial phase of the criminal process." *Parkinson v. Cozzolino*, 238 F.3d 145, 150 (2d Cir. 2001) (internal quotation omitted); *see also Barr v. Abrams*, 810 F.2d 358, 361 (2d Cir. 1987) (acts of Attorney General and deputy prosecutors in instigating criminal contempt proceedings protected by absolute immunity). This absolute immunity "also extends to 'acts undertaken by a prosecutor in preparing for the initiation of judicial proceedings or for trial, and which occur in the course of his role as an advocate for the State.'" *Smith v. Garretto*, 147 F.3d 91, 94 (2d Cir. 1998) (quoting *Buckley*, 509 U.S. at 273). However, "[a] prosecutor's administrative duties and those investigatory functions that do not relate to an advocate's preparation for the initiation of a prosecution or for judicial proceedings are not entitled to absolute immunity." *Buckley*, 509 U.S. at 273. Thus, the "ultimate question" is whether the officials "were functioning as 'advocates' when they engaged in the challenged conduct." *Parkinson*, 238 F.2d at 150 (internal quotation omitted).

immunity.<sup>112</sup> Qualified immunity shields government officials from liability for damages allegedly arising from the performance of discretionary official functions “insofar as their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known.”<sup>113</sup> In the Pouliot family lawsuit, the district court held that Sheila Pouliot’s rights were not violated, and even if they were, they were not clearly established. New York law, said the court, clearly “does not allow a third party to decide that the quality of life of another has declined to a point where treatment should be withheld and the patient should be allowed to die.”<sup>114</sup> Thus, said the court, the defendants’ actions were objectively reasonable and not in violation of the Fourth Amendment.

Nor did they violate her Fourteenth Amendment due process rights. Relying on *Cruzan* and its endorsement of New York’s clear and convincing evidence of specific subjective intent standard, the court held that New York’s laws simply act to protect life, and that the state attorney general acted reasonably in enforcing them.<sup>115</sup> Moreover, said the court, “defendant’s actions were objectively reasonable given the state of the law in New York and cannot be described as ‘shocking the conscience.’”<sup>116</sup>

The court further held that plaintiff had failed to allege any cognizable equal protection violation. Ms. Pouliot’s family had based its equal protection claim on four assertions:

- A. Patients in palliative care like Ms. Pouliot are treated differently from those who are mentally competent and receiving palliative care.
- B. The State of New York and defendants permitted surrogate decision-making panels to operate in Albany and New York City, but not in Central and Western New York, which resulted in unequal treatment for mentally disabled individuals within the State of New York.
- C. Defendant Spitzer handled the issue of medical consent differently in different parts of the State of New York.
- D. The differentiation in New York law between a DNR order and other decisions pertaining to life support is so arbitrary that it denies equal protection.<sup>117</sup>

The court rejected the initial claim holding that “New York’s distinction between competent and incompetent individuals is rationally related to the legitimate state interests of preserving life.”<sup>118</sup> The second claim, said the court, is without merit because no decisionmaking panel in New York was authorized to discontinue life-

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112. A qualified immunity defense is established where “(a) the defendant’s action did not violate clearly established law, or (b) it was objectively reasonable for the defendant to believe that his action did not violate such law.” *Poe v. Leonard*, 282 F.3d 123, 133 (2d Cir. 2002). The “concern of the immunity inquiry is to acknowledge that reasonable mistakes can be made as to the legal constraints on particular [official] conduct . . . . If the officer’s mistake as to what the law requires is reasonable, however, the officer is entitled to” immunity. *Saucier v. Katz*, 533 U.S. 194, 205 (2001). Thus, the doctrine “‘gives ample room for mistaken judgments’ by protecting ‘all but the plainly incompetent or those who knowingly violate the law.’” *Hunter v. Bryant*, 502 U.S. 224, 229 (1991) (quoting *Malley v. Briggs*, 475 U.S. 335, 343, 341 (1986)).

113. *Blouin*, 213 F. Supp. 2d. at 190.

114. *Id.* at 193.

115. *Id.* at 194.

116. *Id.* at 194-95.

117. *Id.* at 195.

118. *Id.* at 196.

sustaining treatment.<sup>119</sup> The third claim failed because the two cases handled by Spitzer's office involved completely different factual scenarios, one dental treatment and the other a life or death decision.<sup>120</sup> The court's rejection of the final equal protection argument may be the most tenuous conclusion in the case. Ms. Blouin argued that

suffering patients like Ms. Pouliot have just as strong an interest in avoiding other forms of support as they do in avoiding cardiopulmonary resuscitation and to the extent the state has an interest in averting quality of life determinations by surrogates, its interest is just as applicable to DNR orders as it is to other forms of medical intervention.<sup>121</sup>

The court disagreed, stating with no support or explanation that the decision to sign a DNR order "and the decision to cause death by the withdrawal of life-sustaining treatment are not comparable. *These decisions are faced by individuals that are not similarly circumstanced, so the differentiation in treatment does not violate the Equal Protection Clause.*"<sup>122</sup> Finally, the court rejected each of the pendant state law claims as without merit.

Ms. Pouliot's family appealed the decision to the United States Court of Appeals for the Second Circuit. The court heard oral argument on March 5, 2003.

### III. VITALISM IN THE LAW: HOW SHEILA POULIOT'S TRAGEDY COULD BE REPEATED IN STATES THROUGHOUT THE COUNTRY

Sheila Pouliot was a victim of vitalism run amuck. The principle of vitalism "holds that the preservation of individual human life is an end in itself, irrespective of the social, economic, or personal cost. The vitalist aggressively defends human biological existence."<sup>123</sup> To the vitalist, life is "an intrinsic good, irrespective of whether it is of value to its possessor."<sup>124</sup> "Life is so sacred . . . [that all] customary medical procedures to prolong or save a life must be used."<sup>125</sup> All vitalists would agree that "medical treatment chosen for an otherwise healthy person *must* also be chosen for one with physical and mental handicaps, however severe."<sup>126</sup>

The commitment to vitalist principles runs along a continuum.<sup>127</sup> "[T]he more

119. *Id.*

120. *Id.*

121. *Id.*

122. *Id.* (emphasis added).

123. Laurence O. Gostin, *A Moment in Human Development: Legal Protection, Ethical Standards and Social Policy on the Selective Non-Treatment of Handicapped Neonates*, 11 AM. J.L. & MED. 31, 37 (1985).

124. Boozang, *supra* note 8, at 568.

125. Gostin, *supra* note 123, at 37.

126. *Id.* (emphasis added).

127. Gostin defines a continuum of vitalist thought, from the most robust or pure (requiring all heroic or extraordinary measures) to the more moderate which "recognizes that decisions affecting individual human life are already made as a consequence of allocating scarce health care resources." Gostin, *supra* note 123, at 37. Philosopher Helga Kuhse argues that to qualify vitalism in any way is logically inconsistent because it infringes upon the absolute prohibition on the intentional termination of life and requires consideration of quality of life. See generally HELGA KUHSE, *THE SANCTITY-OF-LIFE DOCTRINE IN MEDICINE: A CRITIQUE* (1987). She submits that it is inconsistent to say that all lives are equally valuable while at the same time allowing

extreme sanctity-of-life adherents view non-treatment as intentional termination of life, which is prohibited. Consequently, they would mandate continued treatment in every instance, irrespective of the patient's condition."<sup>128</sup> Moderate vitalists recognize that "there is no logical rationale for providing extraordinary treatment for handicapped [persons] when the same treatment would not customarily be used for patients with comparable medical needs."<sup>129</sup> Thus, some vitalists suggest that letting certain patients die is justifiable, at least when prolonging life is merely prolonging the dying process.<sup>130</sup>

New York's laws that prohibited Sheila Pouliot's family from choosing the medically indicated course of terminating nutrition and hydration reflected extreme vitalist policy. Most states take a different approach. They allow surrogates to make medical decisions based in part on the quality of life of the patient.<sup>131</sup> But vitalism is alive and well in a minority of states. The minority states limit to varying degrees the ability of certain surrogates to make decisions to terminate treatment that is sustaining life. Vitalism requires continued life-sustaining treatment for virtually all incompetent patients who have not executed advance directives in New York, Missouri, and Michigan. In Arizona, Wisconsin, Ohio, Hawaii, Kentucky, Mississippi, and Utah, statutes or case law place specific limitations on the ability of certain surrogates to terminate artificial nutrition and hydration for certain incompetent patients.<sup>132</sup>

Each of the laws that prohibits surrogates from terminating treatment leaves various groups of incompetent people vulnerable to the same painful, lingering death suffered by Sheila Pouliot. This Part of the Article will explore the limitations that states place on surrogate decisionmakers for incompetent patients to expose the situations in which the Pouliot scenario could be repeated.

### A. New York

Until this year, when New York took a small step back from its extreme vitalist position in the wake of Sheila Pouliot's death,<sup>133</sup> New York law was the paradigm of

the withholding of treatment from certain patients. *Id.* at 5.

128. Boozang, *supra* note 8, at 568.

129. Gostin, *supra* note 123, at 37.

130. Boozang, *supra* note 8, at 568, citing Paul Ramsey, who argues in favor of a medical indications policy. According to Ramsey, caregivers need not attempt curative treatments that are not medically indicated for the dying. Curative treatments that merely prolong the dying process, says Ramsey, are not ethically required; caregivers should focus on care rather than on the cure of the dying. *Id.* Interestingly, Ramsey's position and that of other more moderate vitalists is that adopted in the position paper of the Catholic Bishops. National Conference of Catholic Bishops, *Nutrition and Hydration: Moral and Pastoral Reflections*, 15 J. CONTEMP. HEALTH L. & POL'Y 455 (1999).

131. All states that allow surrogates to use the best interests standard allow surrogates to consider quality of life. Boozang, *supra* note 8, at 572.

132. Kathleen Boozang argues that all states using a substituted judgment test "essentially adopt a sanctity of life jurisprudence . . . Unless explicit patient instructions exist to terminate treatment, these states prioritize the state's interest in the sanctity of life, rejecting entirely or according comparatively insignificant weight to other factors." Boozang, *supra* note 8, at 578-79. Boozang's thesis is proving itself in Terry Schiavo's case in Florida. There, because Schiavo's wishes were not documented in writing, a vitalist governor, Jeb Bush, and the Florida legislature have forced life despite court findings that Schiavo herself would decline treatment in her current condition.

133. Health Care Decisions Act for Persons with Mental Retardation. N.Y. SURR. CT.

extreme vitalism. Now, New York's protection of life yields to the express exercise of autonomy,<sup>134</sup> in cases involving cardio-pulmonary resuscitation,<sup>135</sup> and for people with mental retardation. In all other cases, the general rule requiring treatment applies.

New York's general rule is well-grounded in both common and statutory law. Under common law, a "patient alone had the right to decide on terminating life support systems."<sup>136</sup> Consistent with the personal nature of this right, the Court of Appeals has expressed a "fundamental commitment to the notion that no person or court should substitute its judgment as to what would be an acceptable quality of life for another."<sup>137</sup>

Thus, a third party may not decide to terminate life-sustaining sustenance for a person who has not stated a "specific subjective intent"<sup>138</sup> to forgo such treatment under the circumstances presented.<sup>139</sup> The requirement that the patient have expressed a specific subjective intent is so strict that it is almost never satisfied absent a written directive.<sup>140</sup>

Of course, certain patients have never had the ability to express a specific subjective intent. As to them, New York law requires that all life-sustaining treatment be provided. The rule applies with particular force to nutrition and hydration. Parents and guardians "cannot and should not be permitted to make a decision that would result in [the incompetent patient] starving to death, if such could be medically avoided, regardless of how soon he may or may not succumb from other causes."<sup>141</sup>

New York's policy prohibiting third-party decisions to withhold life-sustaining treatment where the patient's wishes are not known or knowable is reflected in statute. In 1985, the legislature enacted Mental Hygiene Law Article 80, providing for "surrogate decision-making committees" to make health care decisions for incompetent residents of mental hygiene facilities who need "major medical treatment" and do not have family members, guardians, committees or conservators available to make those decisions.<sup>142</sup> The types of "major medical treatment" within a committee's purview were explicitly defined to exclude "nutrition or . . . the withdrawal or discontinuance of medical treatment which is sustaining life functions."<sup>143</sup>

Subsequent statutes changed little. In 1990, the legislature passed New York's first

PROC. ACT § 1750(b) (McKinney 2003).

134. *In re Estate of Eichner*, 426 N.Y.S.2d 517, 537-38 (N.Y. App. Div. 1980).

135. N.Y. PUB. HEALTH LAW § 2963 (McKinney 2002).

136. *Grace Plaza of Great Neck, Inc. v. Elbaum*, 623 N.E.2d 513, 515 (N.Y. 1993).

137. *In re Westchester County Med. Ctr. ex rel. O'Connor*, 531 N.E.2d 607, 613 (N.Y. 1988).

138. Stewart F. Hancock, Jr., *The Role of the Judge in Medical Treatment Decisions*, 57 ALB. L. REV. 647, 652 (1994) (citing *O'Connor*).

139. See *In re Matthews*, 650 N.Y.S.2d 373, 377 (N.Y. App. Div. 1996) ("It further follows that a medical recommendation to effectively deny sustenance to a starving patient would be unreasonable on its face."), *leave denied*, 678 N.E.2d 501 (1997).

140. See *O'Connor*, 531 N.E.2d at 613 (holding that patient's statements that she would not want to live like a vegetable or be a burden to her family made after watching a relative die of cancer were insufficient to satisfy the clear and convincing evidence standard).

141. *Matthews*, 650 N.Y.S.2d at 377. Although the *Matthews* court upheld the parents' decision to decline aggressive treatment of their retarded son based on their family doctor's recommendation to pursue another effective course of therapy, the court stated it would have reached a different conclusion had the proof been that the patient "was being deprived of life-sustaining treatment." *Id.*

142. See N.Y. MENTAL HYG. LAW §§ 80.03, 80.07 (McKinney 1996).

143. N.Y. MENTAL HYG. LAW § 80.03(a) (McKinney 1996).

health care proxy statute, permitting a competent individual to designate an agent who could “make any and all health care decisions on the principal’s behalf that the principal could make.”<sup>144</sup> Even under this scheme, however, the state maintained its policy against withdrawal of life-sustaining nutrition and hydration where the patient’s views were not known. The statute provides that “if the principal’s wishes regarding the administration of artificial nutrition and hydration are not reasonably known and cannot with reasonable diligence be ascertained, the agent shall not have the authority to make decisions regarding these measures.”<sup>145</sup>

In 1992, the legislature enacted a new, comprehensive guardianship scheme,<sup>146</sup> but that statute still did not authorize a guardian to discontinue another’s life-sustaining treatment,<sup>147</sup> and thus “[t]he petitioner seeking such authority must proceed according to the common law of New York regarding the right to make decisions regarding life-sustaining treatment.”<sup>148</sup>

New York deviated from its strict vitalist stance only in response to public outcry. The first time it created a statutory exception to the general rule was with its do-not-resuscitate (“DNR”) law. These laws were enacted after the “purple dot affair” of 1984,<sup>149</sup> in which a grand jury determined that health-care providers were entering do not resuscitate orders on patients’ charts without the patient’s or family’s consent. The providers indicated the order by placing a purple dot on patients’ charts. The affair brought to light the need to place DNR decisions in the hands of patients and their families.

The second statutory exception to New York’s vitalist position is the Health Care Decisions Act for Persons with Mental Retardation,<sup>150</sup> which was passed after the negative publicity following the Pouliot case.<sup>151</sup> The act allows court-appointed surrogates for the mentally retarded to terminate life-sustaining treatment after following a fairly rigorous protocol. The act makes “refusal of life-sustaining treatment the option of last resort, to be employed only when treatment is futile and inhumane.”<sup>152</sup>

The cumulative effect of these laws is that certain incompetent patients in New York may be relieved of certain types of medical care at the discretion of a third party.<sup>153</sup> Most may not. The surrogate for the minority of patients who once had competence and who left clear and convincing evidence of a specific subjective intent

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144. N.Y. PUB. HEALTH LAW § 2982(1) (McKinney 2002).

145. N.Y. PUB. HEALTH LAW § 2982(2)(b) (McKinney 2002).

146. See N.Y. MENTAL HYG. LAW § 81 (McKinney 1996).

147. See N.Y. MENTAL HYG. LAW §§ 81.03(i), 81.29(e) (McKinney 1996).

148. Rose Mary Bailly, *Practice Commentaries*, N.Y. MENTAL HYG. LAW § 81.03, at 267-68 (McKinney 1996); see also Law Revision Comm’n Comments to N.Y. MENTAL HYG. LAW § 81.29, at 414 (McKinney 1996).

149. Ronald Sullivan, *Hospital’s Data Faulted in Care of Terminally Ill*, N.Y. TIMES, Mar. 21, 1984, at B1 (reporting a state grand jury finding that DNR orders at one hospital were indicated on patients’ charts with a purple dot to avoid detection).

150. N.Y. SURR. CT. PROC. ACT. §§ 1750, 1750-b (McKinney 2003).

151. See, e.g., Deborah Williams, *Who Has the Right to Choose Death*, BUFFALO NEWS, April 23, 2000, at H1.

152. Golden, *supra* note 105, at 17.

153. The extent to which New York’s general rule applies to mechanical ventilation is questionable. A recent trial court decision holds that a mother may order that her infant ought to be removed from mechanical respirator rather than languish in a persistent vegetative state. See *In re AB*, No. 401184/03, 2003 N.Y. Misc. LEXIS 878 (May 16, 2003).



to decline treatment under the circumstances presented or the agent for those who appointed a health care proxy and had the required conversation about nutrition and hydration with the agent may make the choices. Also, a surrogate for a person with mental retardation may make what is sometimes the medically appropriate choice to terminate life-sustaining treatment.<sup>154</sup>

Other surrogates and family members of incompetent patients may not decide to terminate treatment that is sustaining an incompetent patient's life even if the patient is suffering as a result of the treatment.

### B. Missouri

When it comes to the provision of artificial nutrition and hydration, Missouri is the strictest vitalist state in the nation. Missouri surrogates (aside from designated health care agents) can prevent the provision of artificial nutrition and hydration only if the patient previously left clear and convincing evidence that he or she would have wanted that course followed under the circumstance now at hand.<sup>155</sup> Thus, for the permanently incompetent, and for those who failed to indicate wishes ahead of time, the only legal option is continued nutrition and hydration. There are no statutory exceptions.

Interestingly, Missouri's intermediate appellate courts appear to have limited the scope of the limitations on surrogate decisionmaking to artificial nutrition and hydration. One court held that the *Cruzan* rules do not apply to DNR decisions.<sup>156</sup> Another summarized Missouri law:

Courts permit guardians to make decisions for a ward which serve the ward's best interests. When appropriate constraints are met, courts may even authorize a guardian to withdraw life-sustaining treatment from the ward. The current law in Missouri with regard to a guardian's power to terminate the use of a gastrostomy tube for a ward who is in a persistent vegetative state is set forth in *Cruzan*.<sup>157</sup>

Thus, Missouri wards might not have to suffer the medical consequences of all life-sustaining treatment.<sup>158</sup> However, the majority of those wards, all those who have never had competence and those who did not express their wishes with clarity while competent, remain vulnerable to the same fate suffered by Sheila Pouliot.

### C. Michigan

Michigan dramatically limited the ability of surrogates to terminate life-sustaining treatment for the incompetent in 1995 in *In re Martin*.<sup>159</sup> In *Martin*, Michigan's top court held that a surrogate could not terminate life-sustaining treatment unless the

154. N.Y. SURR. CT. PROC. ACT § 1750 (McKinney 2003).

155. *Cruzan v. Harmon*, 760 S.W.2d 408, 415 (Mo. 1988) (en banc), *aff'd sub nom. Cruzan v. Dir.*, Mo. Dep't of Health, 497 U.S. 261 (1990).

156. *In re Warren v. Wheeler*, 858 S.W.2d 263 (Mo. Ct. App. 1993) (holding that a surrogate of an incompetent patient may decline resuscitation on behalf of that patient if the decision is made in the patient's best interests).

157. *In re Busalacchi*, No. 59582, 1991 Mo. App. LEXIS 315, at \*12 (Mar. 5, 1991).

158. Because *Warren* and *Busalacchi* were not reviewed by the state's highest court, their value as precedent is limited.

159. 538 N.W.2d 399 (Mich. 1995).

surrogate could prove by clear and convincing evidence that a patient had expressed a specific subjective intent to decline treatment under the circumstances presented. Specifically, the court denied the request of Mary Martin to terminate life-sustaining nutrition and hydration for her husband, who although incompetent, still had the capacity to relate to his environment.<sup>160</sup>

Michael Martin sustained severe and permanent neurological injuries in a car accident that also injured his wife and three children. For eleven years, he existed in pain, completely paralyzed on his left side and with minimal movement on his right. He was unable to walk, eat, talk, or control his bladder or bowels. He was unable to communicate in any meaningful way, and was dependent on medically provided nutrition and hydration.<sup>161</sup> Prior to the accident, Michael “had an almost pathological fear of illness, weakness, helplessness, and dependency. Michael’s wife, Mary, felt very strongly that his prior lifestyle, conduct, and explicit statements indicated that Michael would not want to continue living in a dependent state.”<sup>162</sup>

The trial court and intermediate appellate court both agreed that there was clear and convincing evidence that Michael Martin had expressed an intent to decline life-sustaining treatment under the circumstances presented, and granted the wife’s request. The Michigan Supreme Court reversed the decision.<sup>163</sup> It rejected all arguments that a surrogate should be able to decide—under any standard—that terminating treatment is what would be best for a patient in a state like Michael Martin’s.<sup>164</sup> It recognized that the right to refuse treatment could be discharged by a surrogate, but essentially limited that right to those who acted while competent. “In other words, the patient possesses the right to have his own decisions enforced, and not to have the right to refuse treatment exercised by another on his behalf.”<sup>165</sup>

Consequently, in Michigan, a surrogate for a patient who has never had competence, or for a patient whose views are not known, lacks any ability to terminate life-sustaining treatment. “Only when the patient’s prior statements clearly illustrate a serious, well thought out, consistent decision to refuse treatment under these exact circumstances, or circumstances highly similar to the current situation, should treatment be refused or withdrawn.”<sup>166</sup>

Thus, certain Michigan patients, those who had competence but did not express their wishes in a formal way while competent, could be subjected to the inhumane treatment inflicted upon Sheila Pouliot. There is some hope for those patients and for those who never had competence. The court expressly limited its holding to the facts presented. It expressed

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160. *Id.*

161. See Lawrence J. Nelson & Ronald E. Cranford, *Michael Martin and Robert Wendland: Beyond the Vegetative State*, 15 J. CONTEMP. HEALTH L. & POL’Y 427, 432 (1999) (summarizing facts from a variety of sources).

162. *Id.* at 433.

163. *Martin*, 538 N.W.2d at 407.

164. It rejected the substituted judgment standard as “a legal fiction that in reality substitutes the surrogate’s decision to withdraw treatment for that of the patient.” *Id.* “The problem with the best-interests test,” said the court, “is that it lets another make a determination of a patient’s quality of life, thereby undermining the foundation of self-determination and inviolability of the person upon which the right to refuse medical treatment stands.” *Id.* at 408 (quoting *In re Estate of Longeway*, 549 N.E.2d 292, 299 (Ill. 1989)).

165. Nelson & Cranford, *supra* note 161, at 439 (citing *Martin*).

166. *Martin*, 538 N.W.2d at 411.

no opinion about the proper decision-making standard for patients who have never been competent, patients existing in a persistent vegetative state, patients who are experiencing great pain, or patients who are terminally ill. If a patient has any of these conditions, or ailments of a similar nature, a more objective approach may be necessary and appropriate.<sup>167</sup>

Outside of *Martin*, however, Michigan provides no guidance to physicians, families, or lower courts on how to decide any cases involving patients who never had competence or who have excessive pain. Based upon its dismissal of substituted judgment and best interest standards, and the inevitable reluctance of courts to allow termination of treatment that will result in death without affirmative guidance from a high court or a legislature, it seems likely that all incompetent Michigan patients who have not formally expressed their wishes will be kept alive by Michigan courts until a case limiting the *Martin* standard is decided by the Michigan Supreme Court.

#### D. Wisconsin

Wisconsin allows surrogates to terminate life-sustaining treatment for patients in vegetative states,<sup>168</sup> but it does not allow surrogates of patients who have any awareness of their surroundings to make the same choice.

The seminal case involved Edna M.F., a seventy-one-year-old woman in the late stages of Alzheimer's.<sup>169</sup> She was bedridden, but responded to stimulation from voice, movement, and mildly noxious stimuli.<sup>170</sup> She breathed on her own, but her life was sustained through artificial nutrition and hydration poured into a surgically inserted feeding tube.<sup>171</sup> Edna's sister and court-appointed guardian sought permission to direct the termination of nutrition and hydration.<sup>172</sup> They testified that Edna would not have wanted to live without the use of her mind.<sup>173</sup> The court rejected their request and held that a "guardian may only direct the withdrawal of life-sustaining medical treatment, including nutrition and hydration, if the incompetent ward is in a persistent vegetative state and the decision to withdraw is in the best interests of the ward."<sup>174</sup> Edna was not in a persistent vegetative state.<sup>175</sup> Thus, the best interests test did not apply. Instead, the court said that Edna's sister could only terminate the treatment if she could "demonstrate by a preponderance of the evidence a clear statement of Edna's desires in these circumstances."<sup>176</sup> Where, as in Edna's case, those wishes were not known or not

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167. *Id.* at 409. Interestingly, the *Storar* court also explained that the result might be different if the patient was in excessive pain. Because of how that case was interpreted in later decisions, however, that caveat was of no assistance to Sheila Pouliot.

168. *In re Guardianship of L.W.*, 482 N.W.2d 60, 68 (1992) (holding that a guardian could direct the withdrawal of medical treatment, including nutrition and hydration, if the ward is in a persistent vegetative state and the decision to withdraw is in the best interests of the ward).

169. *Spahn v. Eisenberg (In re Edna M.F.)*, 563 N.W.2d 485 (Wis. 1997).

170. *Id.* at 487.

171. *Id.*

172. *Id.*

173. *Id.*

174. *Id.* at 486.

175. *Id.* at 491.

176. *Id.* at 490.

knowable, the treatment must go on.<sup>177</sup>

Thus, while Wisconsin law protects the permanently unconscious from the effects of life-sustaining treatment, it requires those who are aware of their surroundings (and thus able to experience the suffering that life-prolonging treatment might cause) to receive that treatment.

### *E. Arizona*

Arizona's legislature has carved an extreme vitalist rule regarding nutrition and hydration for incompetent patients into its state law that generally defers to the judgment of others as to what is in the best interests of a patient. The best interest standard for medical decisionmaking by third parties applies in most instances, and an early court decision allowed a public fiduciary to terminate life-sustaining treatment when it was in a patient's best interest.<sup>178</sup>

The legislature stepped in to change the rules with respect to nutrition and hydration. Statutory law absolutely prohibits surrogates of certain incompetent patients from making the decision to terminate life-sustaining nutrition and hydration. Specifically, the surrogacy statute expressly states: "A surrogate who is not the patient's agent or guardian shall not make decisions to withdraw the artificial administration of food or fluid."<sup>179</sup>

Thus, the Arizona Legislature has placed those citizens who lack competence to make their own decisions and failed to appoint an agent at risk of the same horrific death suffered by Sheila Pouliot.

### *F. Other Limitations by Statute: Hawaii, Mississippi, Ohio, and Utah*

Several states place specifically targeted limitations on the surrogates of incompetent patients that limit the ability of surrogates to stop the provision of nutrition and hydration. For example, Hawaii will allow a surrogate to withhold or withdraw nutrition and hydration only if two physicians certify that providing it "is merely prolonging the act of dying and the patient is highly unlikely to have any neurological response in the future."<sup>180</sup> Thus, a patient who is aware of her surroundings and cognizant of pain will be subject to compulsory treatment.

Mississippi law prohibits certain surrogates of patients in long-term care facilities "from withholding or discontinuing life support, nutrition, hydration, or other treatment, care or support."<sup>181</sup> When a patient lacks capacity and the surrogate is the owner, operator, or employee of a residential long-term care institution, treatment is mandatory.

The Ohio surrogacy statute restricts surrogates from terminating nutrition and hydration unless the patient has been permanently unconscious for twelve months.<sup>182</sup>

177. *Id.* The court left open the question of whether the result would be different if the life-sustaining treatment was causing pain.

178. *See Rasmussen v. Fleming*, 741 P.2d 674, 687 (Ariz. 1987) (holding that Arizona statutory law allowed a public guardian to exercise an incompetent patient's right to refuse life-sustaining nutrition and hydration if doing so is in the patient's best interest).

179. ARIZ. REV. STAT. ANN. § 36-3231(West 2003).

180. HAW. REV. STAT. § 327E-5(g) (Supp. 2001).

181. MISS. CODE ANN. §§ 41-41-211, -215(9) (Supp. 2002).

182. OHIO REV. CODE ANN. §§ 2133.08(A)(1)(a), 2133.09(C)(2)(a), (c) (Anderson 2002).

Thus, the minimally conscious who are aware of their pain must receive treatment. Moreover, Ohio requires the surrogate of a patient whose wishes were not known to make a decision under a substituted judgment approach.<sup>183</sup> The statute requires the majority of family members of a particular level of closeness to the patient to agree to withdraw treatment. “[I]f a class is equally divided, then the entire surrogate class and all those below them are disqualified and consent to withdraw life-sustaining treatment cannot be granted under the statute.”<sup>184</sup>

Utah allows the surrogate of a person who is over eighteen years old to terminate life-sustaining treatment, but does not allow the surrogate of a person under eighteen years old to make the same decision.<sup>185</sup> Thus, a child in Utah must be provided life-sustaining treatment, regardless of its effect on the child.

#### IV. PURE VITALISM IS WORSE THAN DEATH

“[A] medical recommendation to effectively deny sustenance to a starving patient would be unreasonable on its face.”<sup>186</sup>

“Dying is easier and less distressing when we do not give fluids by artificial means.”<sup>187</sup>

The foregoing review of state laws reveals that although most states allow families or other surrogates to terminate life-sustaining treatment for an incompetent patient, the laws in a significant number of states are riddled with quirks that require the maintenance of human life (mostly through the provision of nutrition and hydration) regardless of the cost to the patient or the patient’s family.<sup>188</sup> The laws are obviously meant to protect vulnerable patients. To a large extent, they succeed; by making it impossible for surrogates to withhold treatment on account of a patient’s disability, financial status, or other factor unrelated to the patient’s well being, they ensure that these factors play no part in the decisionmaking process.<sup>189</sup> Sometimes, however, their effect is perversely contrary. Rather than protecting the most vulnerable people, these laws require their suffering.

The premise of vitalist laws is that there is no harm to the patient created by continuation of the status quo.<sup>190</sup> The Sheila Pouliot case dramatically refutes the accuracy of that premise. The nutrition-and-hydration-at-all-costs approach ignores the medical reality that providing treatment that might technically sustain life can cause the patient extraordinary harm and pain. It also ignores that there are situations when

183. § 2133.08(D)(3).

184. Mark Stephen Bishop, *Crossing the Decisional Abyss: An Evaluation of Surrogate Decisionmaking Statutes as a Means of Bridging the Gap Between Post Quinlan Red Tape and the Realization of an Incompetent Patient’s Right to Refuse Life-Sustaining Medical Treatment*, 7 ELDER L.J. 153, 177 (1999).

185. See generally UTAH CODE ANN. § 75-2-1105, -1107 (2002).

186. *In re Matthews*, 650 N.Y.S.2d 373, 377 (N.Y. App. Div. 1996).

187. McGrail aff., *supra* note 65, at 1645.

188. See *supra* Part III.

189. See *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 281 (1989) (“And even where family members are present ‘[t]here will, of course, be some unfortunate situations in which family members will not act to protect a patient.’ A State is entitled to guard against potential abuses in such situations.”) (quoting *In re Jobs*, 529 A.2d 434, 447 (1987)).

190. Cf. Gostin, *supra* note 123, at 36-38 (explaining that vitalist philosophy values life over all other concerns).

providing life-sustaining treatment is outside the bounds of medically accepted care.<sup>191</sup>

When the premise that maintaining life causes no harm reflects reality, the application of vitalist laws insisting on the maintenance of life is legal.<sup>192</sup> *Cruzan* gave states permission to adopt procedures that require the maintenance of life in the absence of a personal exercise of autonomy. But *Cruzan* did not involve a factual situation like Sheila Pouliot's in which the provision of artificial nutrition and hydration was medically contraindicated because it caused extraordinary harm and excruciating pain to the patient. In such cases, the application of laws requiring treatment is highly suspect.

This Part argues that state laws that require the provision of life-sustaining treatment (in particular nutrition and hydration) violate the Fourteenth Amendment rights of patients when they require patients to receive medically inappropriate treatment that causes pain. In other words, the Constitution requires that all states that have adopted vitalist policies for some of their citizens limit them when the treatment that would prolong life also causes physical suffering with no hope of cure.

This Part goes on to explore whether the limited application of vitalist laws to incompetent patients discriminates against the patients in violation of constitutional or statutory law. Specifically, it examines whether the laws violate the equal protection rights of patients, ultimately concluding that they do not. The statutory analysis is different. When states force disabled people to receive harmful and inappropriate treatment in the name of life because they are unable to exercise the autonomy necessary to escape treatment, the states deny disabled patients a public accommodation because of their disability (i.e., current inability to make medical decisions) in violation of the Americans with Disabilities Act.

#### A. Why Providing Life-Sustaining Treatment is Sometimes Medically Inappropriate

Physicians are able to sustain a person's life functions for extended periods of time using various technologies, but doing so indefinitely is not appropriate. It is well established that prolonging a person's life indefinitely can cause unreasonable burdens to the patient.<sup>193</sup> For that reason, the consensus among palliative care specialists is that terminating life-sustaining treatment is an appropriate course of treatment in the final

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191. To be sure, there are many instances when health care providers and families skirt the vitalist laws, either by overlooking them entirely or by striving to apply the rules "to avoid clinically intolerable results." Golden, *supra* note 105, at 19 (citing Robert N. Swidler, *Harsh State Rule on End-of-Life Care in Need of Reform*, N.Y.L.J., Jan. 26, 2000, at S-4). "They may accept as clear and convincing evidence the family's recollection of a patient's isolated, informal remarks. Or they may rule out certain treatments as 'futile' because they would not restore the patient's health." *Id.* at 25 n.58 (quoting Swidler, *supra*).

192. That is not to say that vitalist laws reflect the best moral choice or the most sound policy. Vitalist limitations deny patients dignity and cause families agony by taking their concerns out of the equation. See Boozang, *supra* note 8, and McKnight & Bellis, *supra* note 13, for critiques of the state policies that defer to life, rather than the best interest of the patient or of the family. Nonetheless, these policies are legally permissible, up to a point.

193. See Thomas E. Finucan et al., *Tube Feeding in Patients with Advanced Dementia, A Review of the Evidence*, 282 JAMA 1365 (1999) (concluding that tube feeding should be discouraged in severely demented patients because the risks outweigh the benefits); Christopher M. Callahan, MD et al., *Outcomes of Percutaneous Endoscopic Gastrostomy Among Older Adults in a Community Setting*, 48 J. AM. GERIATRIC SOC. 1048 (2000) (concluding that gastrostomy tubes can burden patients without providing concomitant benefits).

stages of dying.<sup>194</sup> Terminating nutrition and hydration respects the natural dying process and provides pain relief. As death approaches “[m]ost patients completely lose their appetite and stop drinking.”<sup>195</sup> The natural urge has direct benefits. “[M]ost experts feel that dehydration in the last hour of living does not cause distress and may stimulate the release of endorphins and anaesthetic compounds that promote the patient’s sense of well being.”<sup>196</sup> Stopping nutrition and hydration can also prevent harm. “Intravenous lines can be cumbersome and particularly uncomfortable when the patient is cachectic, or has no discernible veins. Excess parenteral fluids can lead to fluid overload with consequent peripheral or pulmonary edema, worsened breathlessness, cough, and orotracheobronchial secretions, particularly if there is significant hypoalbuminemia.”<sup>197</sup> Thus, the termination of nutrition and hydration itself provides pain relief and can prevent serious harm to the patient.

Continuing to provide calories and hydration throughout the final stages of dying can be catastrophic to the patient. Sheila Pouliot suffered the dire consequences of the prolonged provisions of calories and hydration in the absence of nutritive protein. Her skin broke down, she swelled to grotesque proportions, her body began to catabolize its own organs, her muscles rotted, and her heart deteriorated. Moreover, she was in excruciating pain because of the treatment. In contrast, she rested comfortably during the several days that physicians abided her family’s request to withhold nutrition and hydration.

Most states have accepted as policy the medical view that prolonging a person’s life functions may be inappropriate by enacting laws that recognize that life-sustaining treatment can become unduly burdensome to patients.<sup>198</sup> Indeed, four states that otherwise require life-sustaining treatment for those whose wishes are not known or knowable make an exception when the treatment itself causes an undue burden or excessive pain.<sup>199</sup>

194. See Robert M. McCann et al., *Comfort Care for Terminally Ill Patients: The Appropriate Use of Nutrition and Hydration*, 272 JAMA 1263 (1994) (recognizing that providing nutrition and hydration to terminally ill patients can cause unwanted and painful side effects and finding that terminating the treatment increases patient comfort); Robert J. Sullivan, Jr., MD, *Accepting Death Without Artificial Nutrition or Hydration*, 8 J. GEN. INTERNAL MED. 220 (1993); BRITISH MEDICAL ASSOCIATION, WITHHOLDING AND WITHDRAWING LIFE-PROLONGING MEDICAL TREATMENT: GUIDANCE FOR DECISION MAKING (BMJ Books 1999).

195. Frank D. Ferris et al., *Ensuring Competency in End-of-Life Care: Controlling Symptoms*, BMC PALLIATIVE CARE, July 30, 2002, at 10, available at <http://www.biomedcentral.com/content/pdf/1472-684X-1-5.pdf> (citing Eduardo Bruera & R.L. Fainsinger, *Clinical Management of Cachexia and Anorexia*, in OXFORD TEXTBOOK OF PALLIATIVE MEDICINE 548, 548 (Derek Doyle et al. eds., Oxford Univ. Press 1998); and J.A. Billings, *Comfort Measures for the Terminally Ill: Is Dehydration Painful?*, 33 J. AM. GERIATRICS SOC., 808 (1985)) (last visited Jan. 13, 2004).

196. Ferris et al., *supra* note 195, at 10 (citing J.E. Ellershaw et al., *Dehydration and the Dying Patient*, 10 J. PAIN SYM. & MANAGEMENT 192 (1995)); C.F. Musgrave et al., *The Sensation of Thirst in Dying Patients Receiving IV Hydration*, 11 J. PALLIATIVE CARE 17 (1995); D.R. Musgrave, *Terminal Dehydration: To Give or Not to Give Intravenous Fluids?*, 13 CANCER NURSING 62 (1990).

197. Ferris et al., *supra* note 195, at 10

198. See *infra* Appendix for complete list of statutes that allow surrogates to terminate treatment.

199. KY. REV. STAT. ANN. § 311.629(3) (Michie 2001); N.Y. SURR. CT. PROC. ACT LAW § 1750-(b)(4) (McKinney Supp. 2003); N.D. CENT. CODE § 23-06.4-06.1 (2002); OR. REV. STAT. § 127.635 (2001).

Even the National Conference of Catholic Bishops recognizes that prolonging life functions may impose an "unreasonable burden" in the final stages of dying:

In the final stage of dying one is not obliged to prolong the life of a patient by every possible means: "When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted."<sup>200</sup>

Despite the medical, legal, and pastoral agreement that providing treatment to prolong life functions may become unacceptable, state laws in New York, Missouri, Michigan, Arizona, Wisconsin, Ohio, Hawaii, and Utah require indefinite treatment in certain cases involving patients who lack capacity to speak for themselves.<sup>201</sup> The threshold legal issue is whether the Federal Constitution protects those patients for whom no surrogate may speak from the harmful effects of the treatment. The answer is yes only if the patients have a liberty interest that is not outweighed by state interests.

*B. Does the Forced Provision of Life-Sustaining Treatment that Is Also Medically Contraindicated and Causes Avoidable Suffering Violate the Fourteenth Amendment?*

*Cruzan* held that a state's interest in preserving life is so important that a state can protect it by refusing to let any third party decide that the quality of life of another person has deteriorated to the point that life-sustaining treatment should be terminated. Recent cases suggest that *Cruzan* must be limited when the life-sustaining treatment causes a dying person pain or is medically contraindicated. In other words, the Due Process Clause gives all patients, including the incompetent, the right to be free from unnecessary iatrogenic pain or contraindicated medical care. The states cannot erect absolute barriers that prevent anyone from enforcing these rights on behalf of those patients who are unable to speak for themselves.

1. The Right to Pain Control

After the Supreme Court issued its decisions in the physician assisted suicide cases,<sup>202</sup> legal commentators noted that although the Court refused to recognize a right to suicide, it appeared to recognize a right to palliative care. First, Yale's Robert Burt argued that "[a] court majority effectively required all states to ensure that their laws do not obstruct the provision of adequate palliative care, especially for the alleviation

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200. Nat'l Conference of Catholic Bishops Comm. for Pro-Life Activities, *Nutrition and Hydration: Moral and Pastoral Reflections*, 15 J. CONTEMP. HEALTH L. & POL'Y 455, 457-58 (1999) (reprinted from 6 NAT'L CONFERENCE OF CATHOLIC BISHOPS, PASTORAL LETTERS AND STATEMENTS OF THE UNITED STATES CATHOLIC BISHOPS 428-29 (Patrick W. Carey ed., 1988) (quoting CONGREGATION FOR THE DOCTRINE OF FAITH, DECLARATION ON EUTHANASIA, PT. IV (U.S. Catholic Conference ed., 1980)).

201. See *supra* Part III.

202. See, e.g., *Washington v. Glucksberg*, 521 U.S. 702 (1997); *Vacco v. Quill*, 521 U.S. 793 (1997).



of pain and other physical symptoms of people facing death.”<sup>203</sup> Alan Meisel then noted a trend towards the development of an even broader right: “Over the past few years, a concrete right of terminally ill patients to adequate pain control has gradually begun to emerge, first from state legislation and later from decisions of the United States Supreme Court.”<sup>204</sup>

The argument for the emerging right to pain control is based on the unanimous recognition of a distinction between “prohibiting conduct on the part of physicians that intentionally hastens death and permitting conduct that may foreseeably hasten death but is intended for other important purposes, such as the relief of pain,”<sup>205</sup> and on Justice O’Connor’s concurrence in *Glucksberg*. The Court’s recognition that a physician can validly provide treatment that benefits the patient by relieving pain even though that treatment might hasten death suggests that the same physician can validly deny treatment that would cause pain, even if denying that treatment would cause death.

Justice O’Connor’s concurrence goes further. It strongly suggests that the avoidance of pain at death is a protected liberty interest under the Fourteenth Amendment. The opinion “refers twice to the allegedly undisputed availability of medication (to alleviate suffering) and palliative care,”<sup>206</sup> and concludes that the Court need not decide “the question whether suffering patients have a constitutionally cognizable interest in obtaining relief from the suffering they may experience in the last days of their lives” because “[t]here is no dispute that dying patients in Washington and New York can obtain palliative care, even when doing so would hasten their deaths.”<sup>207</sup> Thus, her concurrence implied that “if a future case were presented to the Court in which there was a ‘dispute’ about the existence of state barriers to adequate palliative care, then this would be the ‘quite different’ and

203. Robert A. Burt, *The Supreme Court Speaks: Not Assisted Suicide but a Constitutional Right to Palliative Care*, 337 NEW ENG. J. MED. 1234, 1234 (1997).

Taking into account the tenor of Justice Souter’s opinion, a majority of the Court (Justices Stevens, O’Connor, Souter, Ginsburg and Breyer) clearly accepted that dying individuals have a right to be free of unnecessary pain and suffering at the end of life. Robert Burt concludes from this that “a Court majority has found that states must not impose barriers on the availability of palliative care for terminally ill patients” and that state laws “restricting the availability of opioids for the management of pain are the most likely targets for judicial invalidation by this criterion.”

Pratt, *supra* note 72, at 223; see also Yale Kamisar, *On the Meaning and Impact of the Physician Assisted Suicide Cases*, 82 MINN. L. REV. 895, 908 (1998) (stating that five justices appear to accept a liberty interest in pain relief).

204. Alan Meisel, *Pharmacists, Physician-Assisted Suicide, and Pain Control*, 2 J. HEALTH CARE L. & POL’Y 211, 214-15 (1999) (citing *Washington v. Glucksberg*, 521 U.S. 702, 736-38 (1997) (O’Connor, J., concurring)); see also Larry I. Palmer, *Institutional Analysis and Physicians’ Rights After Vacco v. Quill*, 7 CORNELL J.L. & PUB. POL’Y 415, 424-26 (1998) (arguing that Justice O’Connor has opened the door to future litigation regarding barriers to pain relief); Kathryn L. Tucker, *The Death with Dignity Movement: Protecting Rights and Expanding Options After Glucksberg and Quill*, 82 MINN. L. REV. 923, 935-36 (1998) (arguing that at least five members of the Supreme Court would likely strike down state legislation requiring life-sustaining treatment if it would force dying people to endure excessive pain).

205. Burt, *supra* note 203, at 1234.

206. Pratt, *supra* note 72, at 222.

207. *Glucksberg*, 521 U.S. at 737-38 (1997).

'considerably stronger' argument that could lead her to a different result."<sup>208</sup> Four other Justices agreed with her assertions.

Any requirement that a patient receive treatment indefinitely creates an impermissible barrier to palliative care. Terminating treatment is as essential to appropriate palliative care practice as is the administration of opioids. Thus, to the extent that *Quill* and *Glucksberg* recognize a right to palliative care, those cases suggest that the states may not erect absolute barriers to termination of treatment. It is noteworthy, moreover, that the courts need not recognize an affirmative right to palliative care to protect someone like Sheila Pouliot; the courts need only recognize a prohibition against state action that affirmatively causes the dying process to be prolonged and painful.

The right to be free from a state-mandated prolonged and painful death is not only supported by the O'Connor concurrence in *Glucksberg*, it is required under the analytical framework set forth by the Rehnquist majority. In *Glucksberg*, Chief Justice Rehnquist explained that the Due Process Clause "protects those fundamental rights and liberties which are, objectively, 'deeply rooted in this Nation's history and tradition.'"<sup>209</sup> Physician-assisted suicide, an act made criminal throughout the country, lacked roots in this Nation's history. In contrast, the right to be free of an unnaturally prolonged and painful death has deep historical roots in constitutional, common, and statutory law.

The roots to the right to be free of an unnaturally prolonged and painful death reside in established constitutional rights to freedom from pain, freedom from forced medication, freedom from confinement, and bodily integrity, which are well established and consistent with this Nation's history and traditions.<sup>210</sup> Indeed, it is unassailable that when a state actor inflicts "appreciable physical pain, . . . Fourteenth Amendment liberty interests are implicated."<sup>211</sup>

The constitutional liberty interests belong equally to the competent and the incompetent: "[A] child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment . . ." <sup>212</sup> An incompetent adult is like a child, unable to make informed medical decisions. For the most part, the law treats incompetent adults as children in medical treatment cases.<sup>213</sup>

The infliction of an unnaturally prolonged and painful death implicates the rights to freedom from state-inflicted pain, confinement, and bodily invasion. Life-sustaining treatment can cause pain and prevent the natural release of endorphins. Forcing

208. Burt, *supra* note 203, at 1235.

209. *Glucksberg*, 521 U.S. at 720-21 (quoting *Moore v. City of E. Cleveland*, 431 U.S. 494, 503 (1997)).

210. *See Riggins v. Nevada*, 504 U.S. 127 (1992) (state may not give unwanted medication to a defendant unless essential to ensure safety of defendant or others); *Washington v. Harper*, 494 U.S. 210 (1990) (significant liberty interest in refusing unwanted medication, here forcible injection of medication); *Winston v. Lee*, 470 U.S. 753 (1985) (forcing criminal defendant to undergo surgery to remove an evidentiary bullet violates defendant's right to be secure in his person); *Rochin v. California*, 342 U.S. 165 (1952) (forcing defendant to vomit to produce evidence "shocks the conscience"); *Skinner v. Oklahoma*, 316 U.S. 535, 541 (1942) (forced sterilization violates basic civil right to procreate); *Ingraham v. Wright*, 430 U.S. 651, 674 (1977) (finding corporal punishment implicates liberty interests despite its long tradition because individuals have a right to be free from appreciable pain inflicted by a state).

211. *Ingraham*, 430 U.S. at 674.

212. *Parham v. J.R.*, 442 U.S. 584, 600 (1979).

213. *See, e.g., In re Storar*, 420 N.E.2d 64 (N.Y. 1981).

treatment can hurt patients in two ways: by causing the painful buildup of excess fluid and by denying the body its own capacity for pain relief. Sustained treatment also confines the patient both literally in a hospital bed (often restrained or sedated to prevent the patient from pulling out the tubes through which the treatment is provided) and metaphysically in the dying process. Further, treatment that causes the body to catabolize itself or causes muscles to rot obviously destroys the integrity of the patient's body. Thus, like corporal punishment or compelled surgery, the forced treatment with nutrition and hydration implicates long standing liberty interests.

Like the Constitution, the common law also has historically protected against the infliction of pain and unwanted medication by the state. At common law, forced medication was a battery.<sup>214</sup> The *Cruzan* court reaffirmed that "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."<sup>215</sup> In *Washington v. Glucksberg*, the Court recognized "the long legal tradition protecting the decision to refuse unwanted medical treatment."<sup>216</sup>

The right to freedom from state-inflicted suffering at death also has roots in statutory law. Twenty-one states have statutes providing a right to palliative care, to allow physicians to treat patients with aggressive pain relief without fear of prosecution.<sup>217</sup>

Thus, unlike physician assisted suicide, which lacked historical roots, the law has long provided protection against state-inflicted pain through forced medication. The Due Process Clause protects against these intrusions.

## 2. A Prohibition Against Compelled Medically Inappropriate Treatment

In addition to recognizing the right to be free from state-compelled suffering, several decisions of the Supreme Court suggest that states cannot compel inappropriate medical treatment without running afoul of the Fourteenth Amendment. Indeed, the Supreme Court has applied a "medical appropriateness" limitation that requires courts to find that state-compelled medical treatment is in the patient's best medical interests before considering whether the state can justify the imposition of the medication.<sup>218</sup>

The Court has most clearly established the medical appropriateness limitation in cases involving forced treatments of inmates. Those cases make clear that involuntary treatment raises questions of clear constitutional importance<sup>219</sup> by recognizing a

214. *Glucksberg*, 521 U.S. at 725.

215. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 269 (1990) (quoting *Union Pac. R.R. v. Botsford*, 141 U.S. 250, 251 (1891)).

216. 521 U.S. 702, 703.

217. Meisel, *supra* note 204, at 216 n.26 (1999) (listing statutes).

218. *See, e.g., Washington v. Harper*, 494 U.S. 210, 222 n.8 (1990) (stating that forced medication may be administered only after "the inmate's treating physician . . . make[s] the decision that medication is appropriate").

219. *See Sell v. United States*, 123 S.Ct. 2174, 2186 (2003) (requiring State to prove that, in light of all possible alternatives, the need for antipsychotic treatment is medically appropriate and "sufficiently important to overcome the individual's protected interest in refusing it"); *Harper*, 494 U.S. at 221-22 (recognizing that an individual has a "significant" constitutionally protected "liberty interest" in "avoiding the unwanted administration of antipsychotic drugs"); *Winston v. Lee*, 470 U.S. 753, 759 (1985) (expectation of privacy and security are implicated by the compelled surgical intrusion into an individual's body).

“‘significant’ constitutionally protected ‘liberty interest’” in avoiding forced medical treatment.<sup>220</sup> The state may override that interest for the purpose of creating competency to stand trial only when the forced “treatment is *medically appropriate*, is substantially unlikely to have side effects that may undermine the fairness of the trial, and, taking account of less intrusive alternatives, is necessary significantly to further important governmental trial-related interests.”<sup>221</sup>

Thus, states may only administer anti-psychotic drugs to prisoners after proving the drugs are medically appropriate. The requirement that the treatment be “*medically appropriate*, that is, in the patient’s best medical interest in light of his medical condition”<sup>222</sup> is a threshold constitutional protection afforded by the Due Process Clause. The medical appropriateness requirement is, therefore, a fundamental constitutional limitation that may not be overcome by state interests.

The constitutional requirement that forced medical treatment be medically appropriate has not yet been applied in any cases dealing with a refusal of treatment at the end-of-life. It should be. The discussion of the contours of the liberty interest at stake when the state forces medication on anyone is clearly pertinent to end-of-life cases.<sup>223</sup> Moreover, like the right to refuse treatment itself, with its “long legal tradition,”<sup>224</sup> the ability to avoid inappropriate medical care has enjoyed historical legal protection. The malpractice laws, the informed consent cases, the regulations prohibiting the dispensation of experimental drugs, and prohibitions on experimental surgery are all part of the tradition that protects people from inappropriate medical care. Furthermore, the notion that the state could *force* any person to submit to medical care that the medical profession deems inappropriate runs against all notions of fairness and ethical behavior.

In the case of Sheila Pouliot, New York law required doctors to provide hydration and calories to maintain her life for months after it was no longer medically appropriate to do so. Because it was medically inappropriate, the state should not have been permitted to impose treatment. As in prisoner cases, the Due Process Clause should provide dying patients absolute protection against compelled treatment that is medically inappropriate. In *Sell*, the court held that medical appropriateness was a threshold requirement that must be established before the court could even consider whether the state’s interests justified overriding the patient’s liberty interests. The same protection should apply equally in end-of-life cases. Inmates have no greater liberty interest in bodily integrity than incompetent patients. States should no more be allowed to force inappropriate medical care on a dying patient than on a prisoner.

### 3. Countervailing State Interests

Vitalist states cannot justify laws that require the provision of life-sustaining treatment when the treatment causes pain and is medically inappropriate. No liberty

220. *Sell*, 123 S.Ct. at 2183 (citing *Harper*, 494 U.S. at 221).

221. *Id.* at 2184 (emphasis added).

222. *Id.* at 2185 (emphasis in original).

223. Indeed, *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 278 (1990), relied on the seminal case of *Washington v. Harper*, 494 U.S. 210, 220-22 (1990), to find a liberty interest in refusing unwanted medication. In *Harper*, the court noted that “[t]he forcible injection of medication into a nonconsenting person’s body represents a substantial interference with that person’s liberty.” 494 U.S. at 229.

224. *Washington v. Glucksberg*, 521 U.S. 702, 725 (1997).

interest is absolute. Each must be weighed against countervailing state interests. Where the liberty interest is fundamental, “the Fourteenth Amendment ‘forbids the government to infringe . . . at all, no matter what process is provided, unless the infringement is narrowly tailored to serve a compelling state interest.’”<sup>225</sup> When the liberty interest is not fundamental, the state’s means need only be rationally related to a legitimate state interest.<sup>226</sup>

The right to avoid forced medical treatment is at a minimum a “significant liberty interest.” The Supreme Court emphasized the importance of this right in June 2003, when the Court applied heightened scrutiny to state actions that deprive prisoners of their liberty interest in being free of compulsory medication. The Court held that the prisoner’s interest in avoiding unwanted medication is so important that the state may override it only when it can prove that involuntary medication will significantly further an “essential” or “overriding” state interest in giving the treatment. The “court must find that *important* governmental interests are at stake.”<sup>227</sup> Then “the court must conclude that involuntary medication will *significantly further* those concomitant state interests.”<sup>228</sup>

This test represents a more heightened protection against involuntary medication than was applied in *Glucksberg*<sup>229</sup> or *Cruzan*.<sup>230</sup> The heightened scrutiny should apply equally in cases involving state-inflicted pain and inappropriate medical care because the extraordinary burdens placed on patients in those cases are directly comparable to the burdens placed on prisoners the state seeks to medicate. Both must be restrained to receive treatment; both suffer invasions into their bodies by medical equipment and medication; and both may suffer pain from the treatment.

The presence of pain and the uniform agreement that sustaining life functions was medically contraindicated distinguish cases like Sheila Pouliot’s from Nancy Cruzan’s or the physician-assisted suicide cases. The avoidance of pain and inappropriate medical treatment have far deeper and more established roots than the right to direct one’s own care or to seek assistance in dying. Thus, the interests at stake are more fundamental, and the concomitant state interests must be that much more compelling to justify the imposition.

Traditionally, the Court weighs four state interests against the liberty interest of patients: preserving life, preserving the integrity and ethics of the medical profession, the prevention of suicide, and protecting vulnerable populations. None of these state interests outweighs the patient’s liberty interests in avoiding medical treatment that causes significant pain or is medically inappropriate.

#### a. The State’s Unqualified Interest in Preserving Life

*Cruzan* allows states to claim an unqualified interest in preserving human life. The state interest in preserving life is clearly served by vitalist laws. Thus, the state can “properly decline to make judgments about the ‘quality’ of life that a particular

225. *Id.* at 721 (quoting *Reno v. Flores*, 507 U.S. 292, 302 (1993)) (emphasis in original).

226. *Id.* at 728 (citing *Heller v. Doe*, 509 U.S. 312, 319-20 (1993), and *Reno*, 507 U.S. at 305).

227. *Sell*, 123 S.Ct. at 2184 (emphasis in original).

228. *Id.* (emphasis in original).

229. 521 U.S. 702 (1997).

230. 497 U.S. 261 (1990).

individual may enjoy.”<sup>231</sup> But the states have not asserted the unqualified interest in preserving life allowed by *Cruzan*. All the states, even the most vitalist, have qualified their interest in preserving life by adopting exceptions to the rules that allow a third party to terminate life-sustaining treatment under certain circumstances even absent an exercise of a patient’s autonomy.

In New York, for example, the state has conceded through its legislation that allows surrogates of people with mental retardation to terminate life-sustaining treatment when the treatment causes an extraordinary burden to the patient. That is, the state’s interest in preserving life gives way to a patient’s interest in avoiding extraordinary pain. Furthermore, in *Quill*, the state assured the Supreme Court that its interest in life was not so strong as to require a patient to die in pain.<sup>232</sup> Thus, New York can no longer assert with credibility an unqualified interest in preserving life that outweighs an individual’s interest in avoiding pain. To survive constitutional scrutiny then, New York’s laws requiring that incompetents who do not suffer from mental retardation must be kept alive at all costs must be justified by something other than an unqualified interest in life.

Like New York, Missouri’s interest in preserving life is not unqualified. In Missouri, the treatment-in-all-instances rules apply only when the treatment is nutrition and hydration. They do not apply to mechanical ventilation or other forms of life-sustaining treatment.<sup>233</sup> A surrogate can terminate that treatment without evidence of the intent of the patient when it is in the patient’s best interests. Thus, Missouri’s interest in preserving life may be overridden in the best interest of the patient. Missouri’s application of its laws to force life through nutrition and hydration when that treatment causes pain and suffering must therefore be justified by some other state interest.

Likewise, Mississippi’s interest in preserving life in patients needing life-sustaining treatment is qualified in most situations by the best interests of the patient. The general rule allowing surrogates to terminate life-sustaining treatment does not apply to patients in long-term-care facilities with institutional guardians.<sup>234</sup> That exception cannot be justified based upon an unqualified interest in preserving life because that interest does not apply in most cases.

The same analysis applies to each of the vitalist states.<sup>235</sup> Each has qualified its interest in preserving life in order to protect the best interests of the patient in some situations. No state can legitimately claim an *unqualified* interest in preserving the life of a dying patient to justify the gaps in its laws that place life over patient well being.

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231. *Id.* at 282.

232. See United States Supreme Court Official Transcript at 4, *Vacco v. Quill*, 521 U.S. 793, No. 95-1858 (1997) (No. 95-1858) in which then-Attorney General Dennis Vacco indicated that palliative care that hastens death is lawful in New York because the “right to ameliorate pain is recognized.”

233. See *In re Warren v. Wheeler*, 858 S.W.2d 263 (Mo. Ct. App. 1993).

234. MISS. CODE ANN. § 41-41-211(9) (1999).

235. Hawaii and Ohio allow surrogates to terminate life-sustaining treatment of the permanently unconscious. HAW. REV. STAT. § 327E-5 (1999); OHIO REV. CODE ANN. § 2133.08 (Anderson 2002). Utah allows it for those over eighteen. UTAH CODE ANN. § 75-2-1105 (2002). Michigan has no express exceptions, but the *Martin* decision indicated one might be made in the future. *In re Martin*, 538 N.W.2d 399, 409 (Hawaii 1995). Wisconsin allows surrogates to consider quality of life for those in vegetative states, but not for those with awareness of their surroundings. *In re Guardianship of L.W.*, 482 N.W.2d 60, 63 (1992); *Spahn v. Eisenberg (in re Edna M.F.)*, 563 N.W. 2d 485 (Wisc. 1997).

The states themselves have conceded that their interest in life folds when people are in pain. To survive constitutional scrutiny, then, vitalist policies for certain patients must be justified by some other state interest.

In any event, courts should weigh a state's interest in preserving life differently when preserving life requires the suffering of a person. In *Cruzan*, patient suffering was not at issue. The liberty interest in patient or family choice gave way to the state's paramount interest in preserving life. When preserving life causes suffering, however, the equation changes. The patient's right to bodily integrity, comfort, and freedom from restraint come into play, and the state's interest in preserving life is neither important in such a case, nor significantly advanced.

#### b. The State's Interest in Preserving the Integrity of the Medical Profession

States have "an interest in protecting the integrity and ethics of the medical profession."<sup>236</sup> In the case of physician-assisted suicide, the interest is incompatible because "physician-assisted suicide could . . . undermine the trust that is essential to the doctor-patient relationship by blurring the time-honored line between healing and harming."<sup>237</sup> When laws require physicians to keep patients alive at all costs, however, the integrity of the medical profession is denigrated. Forcing medical professionals to provide treatment to prolong an agonizing death changes doctors from healers to agents of harm. Sheila Pouliot's physicians tellingly revealed the impact of New York's vitalist laws on the medical profession when they wrote in her chart that the treatment was "inhuman" and "causing grotesque harm." Protecting the medical profession cannot justify such a result.

#### c. The State's Interests in the Prevention of Suicide

The state's interest in preventing suicide is not implicated by cases like Sheila Pouliot's. Because she and patients like her cannot form an intent to kill themselves, the risk of their doing so through a surrogate is absent. Moreover, the Court has affirmed the conceptual distinction between "prohibiting conduct on the part of physicians that intentionally hastens death and permitting conduct that may foreseeably hasten death but is intended for other important purposes, such as the relief of pain."<sup>238</sup> A law properly tailored to balance the intrusion on personal liberty against the risk of active killing will thus allow physicians to terminate treatment where appropriate to eliminate suffering, but prohibit conduct intentionally designed to hasten death.

#### d. The State's Interests in the Protection of Vulnerable Patients

The pockets of vitalism that remain throughout the country are probably best explained by an intent to protect certain vulnerable populations. To be sure, "the State has an interest in protecting vulnerable groups—including the poor, the elderly, and disabled persons—from abuse, neglect, and mistakes."<sup>239</sup> That interest is undoubtedly important and justifies the heightened evidentiary standard applicable to treatment termination decisions adopted by New York, Missouri, and Michigan.

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236. *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997).

237. *Id.*

238. Burt, *supra* note 203, at 1234.

239. *Glucksberg*, 521 U.S. at 731.

The failure of those states, and states like Arizona, Mississippi, Hawaii, and Utah, that create bright line rules requiring continued treatment in all cases involving particular populations, is their refusal to make exceptions when the required treatment affirmatively harms a member of a vulnerable population. In such a case, no court could conclude that the “involuntary medication will *significantly further* those concomitant state interests”<sup>240</sup> in protecting vulnerable populations. In the case of Sheila Pouliot, for example, the state’s attempt to protect her caused her grotesque harm.

Moreover, the bright line rule is not tailored in any way to serve the interest of the patient. In *Sell*, the Court required the state to show that “involuntary medication is *necessary*” to further the state’s interests.<sup>241</sup> States that attempt to protect the vulnerable from mistreatment or euthanasia through vitalist laws cannot show that treatment is necessary to protect a patient when all the patient’s medical providers and her family agree that it is not.

Thus, while states are free to create safeguards to ensure that a decision to terminate treatment for an incompetent patient is being made to protect the patient, the states may not advance their interest in protecting vulnerable populations by applying bright line rules that require treatment despite the harm caused to the patient. When they force certain dying patients to suffer a prolonged death without the benefit of the natural processes that make death less agonizing, vitalist rules serve no legitimate purpose and paint with a broader brush than is permissible under the Constitution. The vitalist states therefore must create an exception to their absolute barrier to terminating life-sustaining treatment to prevent pain and the provision of medically contraindicated care.

### C. Discrimination

Just as a person’s disability must not be a reason to withhold treatment, it should not be a reason to force harmful treatment. The constitutional guarantee of equal protection of the laws and the Federal statutes prohibiting discrimination against the disabled are both implicated by cases such as Sheila Pouliot’s in which the patient is given inappropriate medical care because of a disability that leaves him or her unable to exercise autonomy.<sup>242</sup> While violation of the constitutional guarantee may be difficult to establish, the statutory violation appears clear.

#### 1. Equal Protection

An equal protection challenge is not likely to be a source of support for those who hope to change the way vitalist states treat incompetent patients. The Equal Protection Clause directs that “all persons similarly situated should be treated alike,” but those who are not competent and whose wishes are not known are not similarly situated to

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240. *Sell v. United States*, 123 S.Ct. 2174, 2184 (2003).

241. *Id.* at 2185 (emphasis in original).

242. Philip G. Peters, Jr. points out that “[t]he possibility of improper discrimination arises whenever a patient’s disability plays a role in the physician’s determination that life-sustaining care would be inappropriate.” Philip G. Peters, Jr., *When Physicians Balk at Futile Care: Implications of the Disability Rights Laws*, 91 NW. U. L. REV. 798, 805 (1997). The possibility of disability discrimination also arises when state laws limit treatment options for the disabled.



those who are competent or those whose wishes are known.<sup>243</sup> Thus, states may treat the incompetent whose wishes are not known or knowable differently from others for whom treatment may be terminated.

Even when states treat similarly situated groups of incompetent people differently (for example, when laws distinguish between dying patients depending on whether their surrogate is a family member or an institutional provider<sup>244</sup> or whether their medical need is life-sustaining surgery or nutrition and hydration<sup>245</sup>), the different treatment is probably permissible. It need only have a rational basis.

[R]ational-basis review in equal protection analysis “is not a license for courts to judge the wisdom, fairness, or logic of legislative choices.” Nor does it authorize “the judiciary [to] sit as a superlegislature to judge the wisdom or desirability of legislative policy determinations made in areas that neither affect fundamental rights nor proceed along suspect lines.” For these reasons, a classification neither involving fundamental rights nor proceeding along suspect lines is accorded a strong presumption of validity. Such a classification cannot run afoul of the Equal Protection Clause if there is a rational relationship between the disparity of treatment and some legitimate governmental purpose. Further, a legislature that creates these categories need not “actually articulate at any time the purpose or rationale supporting its classification.” Instead, a classification “must be upheld against equal protection challenge if there is any reasonably conceivable state of facts that could provide a rational basis for the classification.”<sup>246</sup>

The rational basis standard is so deferential to states that it would likely be satisfied by a state’s claim that the select group was particularly vulnerable to abuse or that the type of treatment required (nutrition and hydration) was different from all other treatments.<sup>247</sup>

## 2. The Americans with Disabilities Act

Federal statutes, especially the Americans with Disabilities Act (“ADA”), provide broader protection against disability discrimination than that provided by the Constitution.<sup>248</sup> The vitalist laws may, if applied without exception, violate the ADA in

243. *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 287 n.12 (1989).

244. MISS. STAT. ANN. §§ 41-41-211, -215 (Supp. 2002).

245. WIS. STAT. ANN. § 154.03 (West 1997).

246. *Heller v. Doe*, 509 U.S. 312, 319-20 (1993) (internal citations omitted).

247. The one place that an equal protection challenge might succeed is in Sheila Pouliot’s home state of New York. There, in the wake of Sheila Pouliot’s death, the state created distinctions among the permanently incompetent. Those who have never had capacity because of mental retardation are protected from pain-creating treatment. Those who have never had capacity for some other reason are not. The distinction is wholly arbitrary.

248. Two federal statutes protect people with disabilities from improper discrimination. Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794(a) (1994), provides that “no otherwise qualified individual with a disability . . . shall, solely by reason of her or his disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance . . .” The ADA’s coverage is broader, applying to disability-based discrimination to employers, doctor’s offices, and hospitals. 42 U.S.C. §§ 12112, 12131, 12181(7), 12182 (2000). Because the coverage of the ADA is broader, this article focuses on that statute.

certain cases.<sup>249</sup> The ADA prohibits discrimination “on the basis of disability in the full and equal enjoyment of the . . . services . . . of any place of public accommodation by any person who . . . operates [such] a place.”<sup>250</sup> The ADA also forbids “utilizing standards, criteria, or methods of administration that have the effect of discrimination on the basis of disability” without regard to whether such conduct has a rational basis.<sup>251</sup> Medical care clearly falls under the Act’s operation.<sup>252</sup>

Families and disabilities advocates have successfully turned to the ADA to force health care providers to treat the disabled. Their argument is that a disabled person is entitled to all medical care that would be provided to a nondisabled person. Thus, an HIV infected woman successfully sued under the Act after a dentist refused to fill her cavity in his office instead of the hospital, and the mother of an anencephalic infant was able to use the Act, and other causes of action, to force a hospital to keep her baby alive through ventilation.<sup>253</sup> The reasoning in these cases is that treatment that would be available to the nondisabled must be available to the disabled.

Applying the same rationale to the Pouliot case, it appears that New York law violated the ADA by limiting Ms. Pouliot’s treatment options on the basis of disability. The law prevented doctors from providing medically appropriate palliative care, which in her case required the termination of nutrition and hydration, despite their agreement, and the guardian and family’s belief, that aggressive palliative care was the appropriate course. Palliative care is—like dental treatment or life-sustaining treatment—a public accommodation available to the general public. The law thus denied Ms. Pouliot a public accommodation. She was, moreover, denied the accommodation on the basis of her disability, her inability to form or express an intent. Furthermore, the state’s standards, criteria, and methods for determining who may receive appropriate palliative care have a clear disparate impact on the disabled because they disqualify certain groups of disabled people from accessing that care. Because the ADA makes the existence of a rational basis for the disparate treatment irrelevant, the statutory violation seems clear. Thus, palliative care should be available to severely disabled people, just as it is available to others. New York and other states that make it inaccessible because it hastens death are violating the ADA.

### 3. Danger of Using Disability Laws

The advocacy of the affirmative use of disability laws to argue that a disabled person should be allowed to die will raise red flags with anyone familiar with the vocal community of disability advocates who argue vociferously that all “right-to-die” cases hurt rather than help the disabled community.<sup>254</sup> Those advocates argue that “any

249. Private individuals may not sue states or state officials for damages under the ADA. *Bd. of Trustees v. Garrett*, 531 U.S. 356 (2001). The ADA’s standards may “be enforced by the United States in actions for money damages, as well as by private individuals in actions for injunctive relief under *Ex parte Young*, 209 U.S. 123 (1908).” *Id.* at 374 n.9.

250. 42 U.S.C. § 12182 (2000).

251. 42 U.S.C. § 12112(b)(3)(A) (2000).

252. *See generally* *Bragdon v. Abbott*, 524 U.S. 624 (1998).

253. *Abbot v. Bragdon*, 163 F.3d 87 (1st Cir. 1998), *cert. denied*, 526 U.S. 1131 (1999); *In re Baby K*, 832 F. Supp. 1022 (E.D. Va. 1993), *aff’d on other grounds*, 16 F.3d 590 (4th Cir. 1994).

254. Brief of Amici Curiae Not Dead Yet et. al, *Schindler v. Schaivo*, 851 So. 2d (Fla. Dist. Ct. App. 2003) (No. 2D02-5394), at <http://www.notdeadyet.org/docs/schaivobrief.html>. Not Dead Yet, an advocacy group dedicated to pure vitalism for all people, argues that “the

decision not to treat based on patient quality of life violates the Americans with Disabilities Act."<sup>255</sup>

Thus, they argue that the ADA can be used only to require treatment, not to terminate it. Their argument goes too far. It assumes that all decisions to withhold treatment are intended to end a person's life. This assumption is fallacious. Terminating treatment is *part* of good palliative care practice. Like a decision to provide pain relieving drugs despite the fact that they might hasten death, a decision to terminate treatment may be made to increase patient comfort or to eliminate pain. If the disability advocates were right, and the ADA prohibited any decision to terminate treatment, then the ADA would prohibit the disabled from receiving appropriate palliative care. Surely a disability-rights statute could not be intended to keep the disabled from accessing an entire medical specialty. To the contrary, if applied logically and consistently with its statutory purpose, the ADA should ensure that people with disabilities have the same access to palliative care as all other patients, even if that care hastens their deaths.

The difficulty with using the ADA in medical treatment cases arises when the players—the patient's surrogate, guardian and physicians—disagree as to the appropriate course of treatment. In such cases, the ADA offers little guidance. The Act does not prescribe a particular course of treatment or demand that any particular person make choices for a disabled person. Instead, the Act ensures that whoever is making decisions has the option of choosing any appropriate course of treatment.

Indeed, the issues of who should make a treatment decision and under what standard should be decided without reference to the ADA. The ADA is an appropriate tool, however, to be sure that the decisionmaker has the right to choose any acceptable alternative that would be available to nondisabled patients. Thus, in a case like Sheila Pouliot's, when the players all agreed that terminating treatment was appropriate but the law created a barrier to an appropriate course of treatment, the use of the ADA to break the barrier would be acceptable.

To be sure, the use of disability laws in medical debate is troubling when families demand care that might be ethically inappropriate or inhumane.<sup>256</sup> That disability laws might be misused by families in some cases, however, does not mean that families that are seeking medically appropriate care should avoid using them.

For better or worse the disability laws are being applied to medical treatment cases. It is reasonable that they should be available to protect disabled persons from overtreatment, as well as undertreatment. People with disabilities should have access to good medical care, including palliative care. The care Sheila Pouliot received was by

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proposed starvation and dehydration [of an incompetent individual] would violate the Americans with Disabilities Act." *Id.*

255. Peters, *supra* note 242, at 806 (citing Jane Bryant Quinn, *Taking Back Their Health Care*, NEWSWEEK, June 27, 1994, at 36); James Bopp, Jr. & Daniel Avila, *When Worlds Collide: Disability Rights and Medical Prerogatives in Matters of Life and Death*, 7 HEC FORUM 132 (1995).

256. See, e.g., *In re Baby K*, 832 F. Supp. 1022 (E.D. Va. 1993) (allowing treatment characterized as "futile" or "inhumane" by physicians based on broad readings of disability laws), *aff'd.*, 16 F.3d 590 (4th Cir. 1994). The use of disability laws to direct medical treatment is also decried by commentators who argue that medical decisions should be made as a matter of professional discretion, not court intervention. E.g., Susan Moriarity Miltko, *The Need for Professional Discretion: Health Care Professionals Under the Americans with Disabilities Act*, 89 NW. U. L. REV. 1731 (1995).

all definitions horrific. Termination of nutrition and hydration at an appropriate time to prevent pain and ease suffering is both medically and ethically appropriate. If the disability laws can help a family obtain the right to exercise that course of treatment, the laws should be used to achieve that goal.

#### V. POTENTIAL CURES: SHEILA POULIOT'S FAMILY'S LAWSUIT, LEGISLATION, AND OTHER LITIGATION

No state should force anyone to receive medical treatment that is contraindicated or causes the body severe pain and bodily damage without offering hope of cure. The laws that gave rise to the Sheila Pouliot case required just that. Although adopted to protect vulnerable populations, their effect is just the opposite when applied without limit. The federal courts must limit those laws before anyone else suffers their terrible effects.

Most commentators, and even some courts, argue that legislation is the best answer to the problems raised by medical decisionmaking at the end of life.<sup>257</sup> State lawmakers are undoubtedly better equipped than courts to craft thoughtful policy. They can consider all aspects of an issue and build specific and careful safeguards into mechanisms for surrogate decisionmaking.<sup>258</sup> Models of thoughtful and appropriate legislation are on the books in many states<sup>259</sup> and set forth in scholarly articles.<sup>260</sup>

Unfortunately, legislation is not forthcoming in all the states that limit the ability of surrogates to terminate treatment. Indeed, legislation that would give all surrogates the ability to terminate nutrition and hydration where medically appropriate appears politically unattainable in some states. In New York, for example, proponents of a best-interests based surrogacy law for the permanently incompetent have been unsuccessful in getting a bill passed over the last decade. In other states, courts have adopted vitahist policies while state legislatures take no action.<sup>261</sup> The result is that the patchwork of laws that protect patients has large gaps that could force patients to receive inappropriate and harmful medical care to prolong their life functions.<sup>262</sup>

While not the ideal solution, court-driven change is essential to provide an

257. *E.g.*, Hancock, *supra* note 138, at 651-52; *In re Westchester County Med. Ctr.*, 531 N.E.2d 607, 616-18 (N.Y. 1988).

258. Indeed New York's legislature did just that in passing the Health Care Decisions Act for Persons with Mental Retardation. *See* Golden, *supra* note 105, at 17-18 (setting forth the multi-step process a surrogate must go through in New York to terminate life-sustaining treatment for a principal with mental retardation).

259. *See, e.g.*, MD. CODE ANN., HEALTH-GEN. 1 § 5-605(c)(3) (2001) (prohibiting a surrogate from terminating life-sustaining procedures, including artificial nutrition or hydration, based upon "either a patient's preexisting long-term mental or physical disability, or patient's economic disadvantage"); N.D. CENT. CODE § 23-12-13 (2002); OKLA. STAT. ANN. tit. 63, § 3102(A) (West Supp. 2003).

260. *E.g.*, Rima J. Oken, *Curing Healthcare Providers' Failure to Administer Opioids in the Treatment of Severe Pain*, 23 CARDOZO L. REV. 1917 (2002); McKnight & Bellis, *supra* note 13; *see also*, Pratt, *supra* note 72, at 233-34 (arguing for legislative action to facilitate palliative care instead of physician assisted suicide).

261. *See, e.g.*, *In re Martin*, 538 N.W.2d 399 (Mich. 1995); *Cruzan v. Dir.*, Mo. Dep't of Health, 497 U.S. 261 (1990); *In re L.W.*, 482 N.W.2d 60 (Wisc. 1992).

262. One result of the present situation is that desperate families are seeking to move sick and suffering patients across state lines to be allowed to terminate treatment. *See, e.g.*, *In re Busalacchi*, No. 59582, 1991 Mo. App. LEXIS 315 (Ct. App. Mar. 5, 1991).

absolute barrier against the inhumane treatment of the incompetent. Ideally, the Supreme Court or a well-respected circuit court will declare that *Cruzan's* deference to the states' interest in preserving life yields to a patient's interest in freedom from suffering. Such a ruling would prevent more vulnerable people from suffering the horrible end faced by Sheila Pouliot and would give comfort to healthcare providers who treat the most profoundly ill patients. The plaintiff in the *Blouin v. Spitzer* suit pending before the Second Circuit hopes that her case will establish that right.<sup>263</sup> This Part analyzes the possibility that *Blouin* will establish any rights. It then suggests that another case, one designed to prevent harm to other vulnerable patients before harm occurs, might be effective if *Blouin* is not.

*A. Will Blouin v. Spitzer Be the Case that Firmly Establishes the Right to Die Without Iatrogenic Pain?*

The lawsuit brought by Sheila Pouliot's sister is unlikely to bring money damages to the Pouliot family. It is possible, however, that it will give meaning to Sheila Pouliot's death by establishing for the first time a person's right to be free of inhumane but life-sustaining treatment.

New York officials are almost undoubtedly protected by absolute or qualified immunity for their actions in the case, making it unlikely that the case will bring money damages to the family. A public official charged with enforcing the law simply cannot be held liable for enforcing the law in a court. Thus, absolute immunity protects officials like Eliot Spitzer from damages arising from "acts undertaken by a prosecutor in preparing for the initiation of judicial proceedings or for trial."<sup>264</sup> Virtually all the actions by state officials were undertaken in preparation for or as part of judicial proceedings. And, as the district court held, under New York law (as written at the time Sheila Pouliot was alive), "where there is no evidence of personal intent, a third party has no recognized right to decide that a patient's quality of life has declined to a point where treatment should be withheld and the patient allowed to die."<sup>265</sup> Thus, the Second Circuit will likely dismiss the case without awarding damages.

The actions that took place before the state took the case to court may fall under the qualified immunity doctrine, however. Under that standard, the defendants remain immune from damages, but the court could declare new rights for people like Sheila Pouliot in reaching that conclusion. Qualified immunity analysis involves a two-step test. First, it asks "do the facts alleged show the officer's conduct violated a constitutional right?"<sup>266</sup> If so, "the next, sequential step is to ask whether the right was clearly established," that is, "whether it would be clear to a reasonable officer that his conduct was unlawful in the situation he confronted."<sup>267</sup> Thus, the first step of the analysis will require the court to address whether the state officials violated Ms.

263. 213 F. Supp. 2d 187, 192 (N.D.N.Y. 2002), *appeal docketed*, No. 02-7997 (2d Cir. Mar. 5, 2003).

264. *Parkinson v. Cozzolino*, 238 F.3d 145, 151 (2d Cir. 2001) (quoting *Buckley v. Fitzsimmons*, 509 U.S. 259, 273 (1993)).

265. *Blouin*, 213 F. Supp. 2d at 192 (citing *People v. Eulo*, 472 N.E.2d 286, 302 (N.Y. 1984)).

266. *Saucier v. Kate*, 533 U.S. 194, 201 (2001).

267. *Id.* at 201-202 (citing *Wilson v. Layne*, 526 U.S. 603, 615 (1999)).

Pouliot's rights by applying New York law. The court might answer the question on a very narrow ground. While the facts of the case are egregious, the case against the officials being sued is not strong. Ms. Pouliot's guardian and family consented to the order requiring care. It is therefore difficult to see how the state can be held accountable for her fate.

If the court gets around the threshold factual question to address whether Ms. Pouliot's rights were violated, the court should conclude that, although the officials acted in compliance with New York law, her rights were violated. No important state interest justified the state-required suffering and inappropriate care she endured. Nonetheless, the Pouliot suit will not survive the second part of the test. The state officials simply followed the law as written. No case clearly established any of the rights that were violated.

### B. Another Lawsuit

If the Pouliot family's lawsuit is dismissed without a decision on the merits of the Fourteenth Amendment claim, another might succeed. An action commenced as a declaratory judgment action could prevent harm before it occurs. Moreover, an action commenced prospectively could allege violation of the Americans with Disabilities Act, something not raised in the *Blouin* suit.<sup>268</sup>

Whether through the Pouliot family suit or another case, it might be strategically beneficial to advocates for choice-in-dying to bring an action challenging vitalist limitations in the law that require continued life-sustaining treatment, rather than to bring an action to try to establish a right to access to opioids or a limited right to physician assisted suicide. The court would have to take a much smaller step to establish a barrier against inhumane treatment than it would to create constitutional access to aggressive palliative care. The establishment of a barrier to state-inflicted pain through treatment would then provide a firm foundation for the attainment of an affirmative right to aggressive pain control.

### CONCLUSION

That the law could require a person to be subject to the inhumane treatment suffered by Sheila Pouliot is shocking. On the other hand, her lingering death is exactly what commentators predicted when the Supreme Court issued *Cruzan*. *Cruzan*'s validation of state laws that allowed vitalism to prevail in the absence of an exercise of autonomy created situations as in New York and around the country where certain incompetent individuals must be kept alive.

The failure of the vitalist states' interpretation of *Cruzan* is their emphasis on the role of autonomy in refusal of treatment cases. As *Quill* made clear, however, autonomy is only one piece of the puzzle, and not the most important one. Instead, the most important components of the liberty interests are bodily integrity and freedom from restraint. Both of these rights, well grounded in our nation's history, give rise to a liberty interest in freedom from state-inflicted suffering and inappropriate medical

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268. The suit might not raise the ADA because states are protected from damages suits under the ADA Eleventh Amendment. *Bd. of Trs. of Univ. of Alabama v. Garrett*, 531 U.S. 356, 356. The Eleventh Amendment does not bar suits against states for injunctive relief.

care.

The Court's reemphasis on the core values of bodily integrity and freedom from restraint, together with the heightened scrutiny it has applied in forced medication cases signals its willingness to examine the boundaries of the *Cruzan* case. Perhaps, in the end, Sheila Pouliot's death will help to establish those boundaries, and prevent anyone else from suffering the same terrible fate.

## APPENDIX

<i>State</i>	<i>Source of Surrogate's Authority</i>	<i>Applies to Decisions to Terminate Nutrition and Hydration</i>	<i>Applicable Decisionmaking Standard</i>	<i>Limitations or Requirements Applicable to Decisions to Withhold Life-Sustaining Treatment</i>
AL	ALA. CODE §§ 22-8A-6, 22-8A-11 (1997).	Yes	Substituted Judgment	"[S]urrogate . . . may . . . provide, withdraw or withhold artificially provided nutrition and hydration if . . . (1) [t]he attending physician determines, to a reasonable degree of medical certainty that: (a) [t]he individual is no longer able to understand, appreciate and direct his or her own medical treatment, and (b) [t]he individual has no hope of regaining such ability. (2) Two physicians [who] have personally examined the individual have diagnosed . . . that individual has a terminal illness . . . or a condition of permanent unconsciousness. (3) The attending physician or . . . surrogate have no actual knowledge . . . of a valid advance directive [and] (4) . . . withholding or withdrawing . . . of nutrition and hydration will not result in undue pain or discomfort for the patient." § 22-8A-11 (emphasis added).
AK	ALASKA STAT. §§ 18.12.035, 18.12.040 (Michie 2002).	Apparently	Best Interest	Allows physicians to enter do-not-resuscitate ("DNR") orders and make other decisions regarding life-sustaining treatment. These decisions are subject to requests of persons for whom the order was made, except pregnant patients in certain situations.
AZ	ARIZ. REV. STAT. ANN. § 36-3231 (West 2003).	Yes	Substituted Judgment	Surrogate may not direct physician to withdraw or withhold life-sustaining nutrition or hydration, unless surrogate is patient's agent or guardian. § 36-3231(D).
AR	ARK. CODE ANN. §§ 20-17-210, -214 (Michie 2000 & Supp. 2003).	Yes	Best Interest	"This subchapter creates no presumption concerning the intention of an individual [without] a declaration with respect to the use, withholding or withdrawal of life-sustaining treatment in the event of a terminal condition or permanent unconsciousness. This subchapter does not . . . impair . . . any right or responsibility that a person has to effect the withholding or withdrawal of medical care." § 20-17-210(d)&(e).
CA	CAL. PROB. CODE §§ 4711, 4714, 4715, 4716 (West Supp. 2003).	Yes	Best Interest	"Reference to life-sustaining medical treatment includes not only [extraordinary] treatments . . . but also the provision of nutrition, hydration and medication." <i>In re Christopher I.</i> , 106 Cal. App. 4th 533, 548-52 (2003) (employing 12-factor balancing test to determine whether life-sustaining procedures should be withdrawn).
CO	COLO. REV. STAT. ANN. §§ 15-18.5-101 to -103 (West 2002).	Yes	Best Interest	"Artificial nourishment and hydration may be withheld or withdrawn from a patient upon a decision of a proxy <i>only</i> when the attending physician and a second independent physician trained in neurology or neurosurgery certify in the patient's medical record that the provision or continuation of artificial nourishment or hydration is merely prolonging the act of dying and is unlikely to result in the restoration of . . . independent neurological functioning." § 15-18.5-103(6) (emphasis added).



CT	CONN. GEN. STAT. ANN. § 19a-571 (West 1997 & Supp. 2003).	No	Best Interest	"If the attending physician does not deem the incapacitated patient to be in a terminal condition or permanently unconscious, beneficial treatment including nutrition and hydration <i>must</i> be provided." § 19a-571 (emphasis added).
DE	DEL. CODE ANN. tit. 16, § 2507 (1995 & Supp. 2002).	Yes	Substituted Judgment	"A surrogate's decision on behalf of the patient to treat, withdraw or withhold treatment[, including artificial nutrition or hydration,] shall be made . . . [(1)] in consultation with attending physician [and (2)] in accordance with the patient's [wishes based on] patient's personal, philosophical, religious and ethical values[,] likelihood of regaining decision making capacity[,] likelihood of death[,] burdens on and benefits to the patient[, previous] oral or written statement . . . by the patient . . . . If the surrogate is unable to determine . . . the patient's wishes, then] in the best interest of the patient." tit.16 § 2507(b)(7).
DC	D.C. CODE ANN. §§ 21-2210, 21-2212 (2001).	Yes	Best Interest	"Nothing in this chapter shall be construed to . . . permit any affirmative or deliberate act to end a human life other than to permit the natural process of dying." § 21-2212. "[Multiple] factors [must] be considered in conducting a 'best interests' analysis in the context of determining the forbearance or withdrawal of life-sustaining procedures in the case of an incompetent person. [T]he inquiry must [focus on] the burdens of continued life[, including whether prolonging life would be inhumane,] against the benefits and rewards of furthering life." <i>In re K.I.</i> , 735 A.2d 448, 465 (D.C. 1999).
FL	FLA. STAT. ANN. §§ 765.304, 765.401 (West 1997 & Supp. 2003); FLA. STAT. ANN. § 765.404 (West Supp. 2003).	Yes	Substituted Judgment	"Before exercising the . . . patient's right to forego [life-prolonging] treatment[, including artificial sustenance and/or hydration] the surrogate must be satisfied that: (a) [t]he patient does not have a reasonable medical probability of recovering capacity so that right could be exercised by the patient[, and] (b) [that t]he patient has an end-stage condition, the patient is in a persistent vegetative state, or the patient's physical condition is terminal." § 765.304(2). "[A] proxy's decision to withhold or withdraw life-prolonging procedures must be supported by clear and convincing evidence that the decision would have been the one the patient would have chosen had the patient been competent." § 765.401(3). Florida also has a provision allowing for withdrawal of life-prolonging treatment if the patient is in a persistent vegetative state and no surrogate exists based on the best interest of the patient to be determined by a court-appointed surrogate. See § 765.404.
GA	GA. CODE ANN. § 31-9-2 (2001).	Yes	Best Interest	"[T]he right to refuse treatment or indeed to terminate treatment may be exercised by the parents or legal guardian of the infant after diagnosis that the infant is terminally ill with no hope of recovery and that the infant exists in a chronic vegetative state with no reasonable possibility of attaining cognitive function. The above diagnosis and prognosis must be made by the attending physician. Two physicians with no interest in the outcome of the case must concur in the diagnosis and prognosis." <i>In re L.H.R.</i> , 321 S.E.2d 716, 722-23 (Ga. 1984).
HI	HAW. REV. STAT. § 327 E-5 (Supp.	Yes	Substituted Judgment	"A surrogate who has not been designated by the patient may make all health-care decisions for the patient . . . , except that artificial nutrition and hydration may be withheld or

	2001).			withdrawn . . . <i>only</i> when the primary physician and a second independent physician certify . . . that the provision or continuation of artificial hydration or nutrition is merely prolonging the act of dying and the patient is highly unlikely to have any neurological response in the future." § 327E-5(g) (emphasis added).
ID	IDAHO CODE § 39-4303 (Michie 2002).	Apparently	Best Interest	Gives general medical decisionmaking authority without mentioning nutrition and hydration.
IL	755 ILL. COMP. STAT. ANN. 40/20, 40/25 (West 1992 & Supp. 2002).	Yes	Substituted Judgment	A decision to withhold or withdraw life-sustaining treatment made on behalf of a minor or an adult who lacks capacity may be made by a surrogate if the patient (1) is deemed to have a terminal condition, (2) is in a state of permanent unconsciousness, or (3) has an incurable or irreversible condition. tit. 755 § 40/20(b-5)(1).
IN	IND. CODE. ANN. §§ 16-36-1-1 to -4, -6, -8, -11 to -14 (West 1997); §§ 16-36-5, -7, -9, -10 (West 1997 & Supp. 2002).	Yes	Best Interest	"We conclude that the administration of artificial nutrition and hydration . . . is medical treatment which can be refused. Three sources inform our understanding: the . . . Indiana medical community, Indiana statutory law, including the H[ealt]b] C[are] C[onsent] A[ct]; and persuasive authority from numerous courts across the country." <i>In re</i> Lawrence, 579 N.E.2d 32, 39 (Ind. 1999).
IA	IOWA CODE ANN. § 144A.7 (West 1997 & Supp. 2003).	Yes	Substituted Judgment	Life-sustaining procedures, including hydration and/or nutrition via intubation, may be withheld or withdrawn by a qualified surrogate, either a certain family member or a duly appointed guardian, so long as the patient is comatose or in terminal condition and the patient is not pregnant and that pregnancy could be brought to term by providing life-sustaining procedures. § 144A.7.
KA	KAN. STAT. ANN. § 59-3075(7) (2002).	Yes	Best Interest	Two physicians must certify that the patient is in PVS or suffering from an illness for which further treatment would not prolong life and court must approve certification.
KY	KY. REV. STAT. ANN. §§ 311.629, 311.631 (Michie 2001).	Yes	Substituted Judgment	"A . . . surrogate[, with or without an advanced directive,] may authorize the withdrawal or withholding of artificially provided nutrition and hydration [when: (1) inevitable death is imminent, ((2)) patient is . . . permanently unconscious], (3) w[hen] the provision of artificial nutrition cannot be physically assimilated by the person or [(4) w]hen the burden of . . . nutrition and hydration . . . outweigh[s] its benefit." § 311.629(3) (emphasis added).
LA	LA. REV. STAT. ANN. §§ 40:1299.53, .58.5 (West 2001).	Yes	Best Interest	When a comatose or incompetent person who is physically or mentally incapable of communication has been certified in writing as having a terminal and irreversible condition and has not made a previous declaration, removal of life-sustaining procedures, including artificial hydration or nutrition may be authorized by a surrogate.
ME	ME. REV. STAT. ANN. tit. 18-A	Yes	Best Interest	Withdrawal or withholding of life-sustaining treatment can be authorized by a surrogate if the patient has been determined to have a terminal condition or be in a persistent

	§ 5-805 (West 1998 & Supp. 2002).			vegetative state. tit. 18-A § 5-805(a).
MD	MD. CODE ANN., HEALTH-GEN. 1 § 5-605 (2000).	Yes	Substituted Judgment	"The decision of a surrogate regarding whether life-sustaining procedures[. including artificial hydration and/or nutrition] should be provided. . . shall not be based, in whole or in part, on either a patient's preexisting . . . mental or physical disability, or a patient's economic disadvantage." § 5-605(c)(3).
MA	Superintenden t of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 431 (Mass. 1977).	Yes	Substituted Judgment	The prolongation of life without consideration as to the previously stated wishes of the patient and for period of several years is intrusive as a matter of law, and therefore the "G-tube" could be removed at the request of a guardian with proof that this course of treatment would have been approved of by the patient. <i>Brophy v. New England Sinai Hosp., Inc.</i> , 497 N.E.2d 626 (Mass. 1986) (citing <i>Saikewicz</i> , 370 N.E.2d at 431).
MI	<i>In re Martin</i> , 538 N.W.2d 399 (Mich. 1995).	Yes	Substituted Judgment	Limited to cases where surrogate can establish clear and convincing evidence of the patient's wishes expressed while competent. <i>See Martin</i> , 538 N.W.2d at 410-11.
MN	2003 Minn. ALS. 12 § 37(A)(4)(1); <i>In re Torres</i> , 357 N.W.2d 332 (Minn. 1984).	Apparently	Best Interest	"Minnesota courts have the power to authorize a conservator to order the removal of a conservatee's life support systems." <i>Torres</i> , 357 N.W.2d at 339-40.
MS	MISS. CODE ANN. §§ 41-41-211 -215 (1999 & Supp. 2002).	Yes	Substituted Judgment	"If the patient . . . lack[s] capacity . . . and [a] surrogate is not . . . available, consent may be given by an owner, operator or employee of a residential long-term health care institution at which the patient is a resident if there is no advance health-care directive . . . and a licensed physician . . . has determined that the patient is in need of health care. This power [does not] however, extend] to consent to [remove or] withhold [artificial] nutrition [and/or] hydration." § 41-41-215(9).
MO	<i>Cruzan v. Dir., Mo. Dep't of Health</i> , 497 U.S. 261 (1990).	Yes	Substituted Judgment	Clear and convincing evidence of specific subjective interest is required for the withdrawal of artificial nutrition or hydration. <i>Cruzan</i> , 497 U.S. at 316-22.
MT	MONT. CODE ANN. § 50-9- 106 (2001).	Yes	Substituted Judgment	Life-sustaining treatment may be withheld or withdrawn from a patient who is "in a terminal condition and no longer able to make decisions regarding the administration of life-sustaining treatment; and . . . has no effective declaration." § 50-9-106. However, this does not apply if the patient is pregnant and the provision of nutrition and hydration would allow the fetus to mature to term. <i>Id.</i>
NE	NEB. REV. STAT. ANN. §§ 30- 2628(3), 43- 285(1) (Michie	Apparently	Substituted Judgment	<i>In re Tabatha R.</i> , 564 N.W.2d 598, 604 (Neb. 1997) recognizes right of surrogate to terminate treatment but does not explicitly address nutrition and hydration.

	2003).			
NV	NEV. REV. STAT. ANN. § 449.626 (Michie 2000).	Yes	Substituted Judgment	"The authority to consent or to withhold consent [for life-sustaining treatment] may be exercised by [the patient's]: (a) . . . spouse[,] (b) . . . adult child of the patient[,] (c) . . . parents[,] (d) . . . adult sibling of the patient[,] (e) [t]he nearest other adult relative . . . . A decision . . . must be made in good faith[, and not contrary to the expressed desires of the patient,]" § 449.626(2), (4).
NH	N.H. REV. STAT. ANN. § 464-A:25 (1992 & 2002).	Apparently	Best Interest	Statute gives broad power to guardian to consent to medical treatment but says nothing directly pertinent to nutrition and hydration.
NJ	<i>In re Quinlan</i> , 355 A.2d 647 (N.J. 1976).	Yes	Substituted Judgment	"[L]ife-sustaining treatment may be withdrawn or withheld whenever there is clear and convincing proof that if the patient were competent, be or she would decline the treatment." <i>In re Peter</i> , 529 A.2d 419, 425 (N.J. 1987).
NM	N.M. STAT. ANN. § 24-7A-5 (Michie 2003).	Yes	Substituted Judgment	"A surrogate may make a health-care decision for a patient who is an adult or emancipated minor if the patient has been determined . . . to lack capacity and no agent or guardian has been appointed or the agent or guardian is not reasonably available." § 24-7A-5(1).
NY	N.Y. Surr. Ct. Proc. Act Law § 1750-b (McKinney Supp. 2003) (Only for people with mental retardation).	Yes	Best Interest	"[A surrogate of a] mentally retarded [patient's] best interests shall include consideration of: . . . (iv) the unique nature of artificially provided nutrition or hydration, and the effect it may have on the mentally retarded person." § 1750-b(2)(iv).
NC	N.C. GEN. STAT. § 90-322 (2000).	Yes	Best Interest	"If a person is comatose and there is no reasonable possibility that he [or she] will return to a cognitive sapient state or is mentally incapacitated, and the life of the person could be or is being sustained by artificial nutrition or hydration . . . then, extraordinary means or artificial nutrition or hydration may be . . . discontinued." § 90-322(a)(4).
ND	N.D. CENT. CODE §§ 23-12-13, 23-6.4-6.1 (2002).	Yes	Best Interest	"In the absence of a written statement concerning nutrition or hydration, nutrition or hydration, or both, may be withdrawn or withheld if the attending physician has determined that the administration of nutrition or hydration is inappropriate because the nutrition or hydration cannot be physically assimilated by the patient or would be physically harmful or would cause unreasonable physical pain to the patient." § 23-6.4-6.1.
OH	OHIO REV. CODE ANN. § 2133.08 (Anderson 1999).	Yes	Substituted Judgment	"[I]f the patient did not previously express his intention with respect to the use or continuation, or the withholding or withdrawal, of life-sustaining treatment should he subsequently be in a terminal condition or in a permanently unconscious state . . . and no

				longer able to make informed decisions regarding the administration of life-sustaining treatment, a consent given pursuant to this section shall be valid only if it is consistent with the type of informed consent decision that the patient would have made if he previously had expressed his intention with respect to the use or continuation, or the withholding or withdrawal, of life-sustaining treatment should he subsequently be in a terminal condition or in a permanently unconscious state, whichever applies, and no longer able to make informed decisions regarding the administration of life-sustaining treatment, as inferred from the lifestyle and character of the patient, and from any other evidence of the desires of the patient, prior to his becoming no longer able to make informed decisions regarding the administration of life-sustaining treatment." § 2133.08(D)(3).
OK	OKLA. STAT. ANN. tit. 63, § 3102(A) (West Supp. 2003).	Apparently	Substituted Judgment/Best Interest	"An individual making life-sustaining decisions . . . for a declarant shall make such decisions based on the known intentions, personal views and best interests of the declarant. If evidence of the declarant's wishes is sufficient, those wishes shall control. If there is not sufficient evidence of the wishes of the declarant, the decisions shall be based on the reasonable judgment of the individual so deciding about the values of the declarant and what the wishes of the declarant would be based upon those values." Tit. 63 § 3101.16(A).
OR	OR. REV. STAT. §§ 127.635, 127.680 (2001).	Yes	Substituted Judgment	"It shall be presumed that every person who is temporarily or permanently incapable has consented to artificially administered nutrition and hydration that are necessary to sustain life except in one or more of the following circumstances (a) the person while a capable adult stated that he/she would have refused artificial nutrition and hydration, (b) administration of such nutrition and hydration is not medically feasible or would itself cause severe, intractable or long-lasting pain, (c) the person has an appointed health care representative who has been given authority to make decisions on the use, maintenance, withholding or withdrawing of artificially administered nutrition and hydration, (d) the person does not have an appointed health care representative or an advance directive that clearly states that the person did not want artificial nutrition and hydration, and the person is permanently unconscious, (e) the person does not have an appointed health care representative or an advance directive that clearly states that the person did not want artificial nutrition and hydration, the person is incapable, and the person has a terminal condition, or (f) the person has a progressive illness that will be fatal and is in an advanced stage, and it is very unlikely that the person's condition will substantially improve." § 127.680.
PA	<i>In re Fiori</i> , 652 A.2d 1350 (Pa. Super. Ct. 1995).	Yes	Substituted Judgment	"[This] court has been asked to permit the withdrawal of life sustaining treatment from a patient in a persistent vegetative state, and [we have held] that if it can be definitely determined that it would have been the patient's desire not to receive such treatment, then the patient's right to self-determination outweighs any state interest and the treatment may be withdrawn." <i>In re Fiori</i> , 652 A.2d 1350, 1355 (Pa. Super. Ct. 1995).
RI	R.I. GEN. LAWS § 33-15-29 (1995).	Apparently	Substituted Judgment	No restrictions noted. <i>In re Doe</i> , 533 A.2d 523, 526 (R.I. 1987), acknowledges the right of a surrogate to decline treatment.

SC	S.C. CODE ANN. § 44-66-30 (Law. Co-op. 2002).	Apparently	Substituted Judgment	Limited by intentions of patient expressed while competent.
SD	S.D. CODIFIED LAWS ANNOTATED §§ 34-12C-3, 59-7-2.8 (Michie 1994).	Unclear	Best Interest/ Acceptable Medical Practice	Life-sustaining treatment is required for pregnant women. § 59-7-2.8 (Michie 1994).
TN	TENN. CODE ANN. § 34-3-104 (2001).	Yes	Substituted Judgment	A surrogate may authorize the removal or withholding of nutrition or hydration if there is clear and convincing evidence that if the patient were competent, he or she would chose that particular course of treatment. <i>San Juan-Torregosa v. Garcia</i> , 80 S.W.3d 539, 545 (Tenn. Ct. App. 2002).
TX	TEX. HEALTH & SAFETY CODE ANN. §§ 166.035, 166.039, 313.001-.007 (Vernon 2001).	Yes	Substituted Judgment	"If the patient does not have a legal guardian or an agent under a medical power of attorney, the attending physician and [the patient's spouse, adult children, parents or nearest living relative] may make a treatment decision that may include to withhold or withdraw life-sustaining treatment." § 166.039(b).
UT	UTAH CODE ANN. § 75-2-1105-1107 (1993 & Supp. 2003).	Yes	Best Interest	"If a person 18 years of age or older has not executed a directive or power of attorney . . . and is unable to communicate, and the attending physician has determined that the person is in terminal condition . . . life-sustaining procedures may be withheld or withdrawn under the supervision of the attending physician [if he/she] consult[s] with . . . another physician [and the family of the patient]." § 75-2-1107.
VT	VT. STAT. ANN. tit. 14 §§ 3069(5), 3075 (2003).	N/A	N/A	Limited to court-appointed guardians.
VA	VA. CODE ANN. § 54.1-2986 (Michie 2002).	Yes	Substituted Judgment	An attending physician may withhold or withdraw life-prolonging procedures with the consent of a guardian, spouse, adult child, parent, adult sibling, or any other relative. § 54.1-2986.
WA	WASH. REV. CODE ANN. § 7.75.065 (West 1992).	Yes	Substituted Judgment/Best Interest	"We hold that the right of a terminally ill patient to have life sustaining procedures withheld includes the right to withhold nasogastric tubes, intravenous feeding, and other artificial means of nutrition and hydration." <i>In re Guardianship of Grant</i> , 747 P.2d 443, 455 (Wash. 1987).

WV	W. VA. CODE ANN. § 16-30-8 (Michie 2001 & Supp. 2003). W. VA. CODE ANN. § 16-30-9 (Michie 2001).	Yes	Substituted Judgment	"The surrogate is authorized to make health care decisions[ including withholding or withdrawing life-sustaining treatment,] on behalf of the incapacitated person without a court order or judicial involvement." § 16-30-8.
WI	<i>In re</i> Guardianship of L.W., 482 N.W.2d 60 (Wis. 1992).	Yes	Best Interest/ Substituted Judgment	Guardian of person in persistent vegetative state may terminate nutrition and hydration if in patient's best interest, but if patient is cognizant, guardian must prove subjective intent of patient. Spahn v. Eisenberg ( <i>In re</i> Guardianship of Edna M.F.), 563 N.W.2d 485, 489-90 (Wis. 1997).
WY	WYO. STAT. ANN. §§ 3-5-209(b), 35-22-105(b) (Michie 2003).	Yes	Substituted Judgment	"When an incompetent person who has not executed a [directive] is certified as suffering from a terminal condition or an irreversible coma . . . , a physician may withhold or withdraw life sustaining procedures from that person when all family members who can be contacted through reasonable diligence agree in good faith that the patient, if competent, would choose to forego that treatment." §§ 3-5-209(b), 35-22-105(b).

