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CRUZAN AND SURROGATE DECISION-MAKING

David Orentlicher*

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I. INTRODUCTION

WHEN the United States Supreme Court issued its landmark “right to die” decision in *Cruzan v. Director, Missouri Department of Health*¹ thirty years ago, the dissenting Justices and many observers criticized the Court for rejecting a right of Nancy Cruzan’s parents to refuse medical care on her behalf.²

Ms. Cruzan had not written a living will or a durable power of attorney, nor did it appear that she had left clear oral instructions about her wishes.³ But she did have loving parents who were dedicated to doing what was best for her. In one important view, when patients lose the ability to decide for themselves, the law should turn to family members to make medical decisions for them. As the New Jersey Supreme Court has observed, “Almost invariably the patient’s family has an intimate understanding of the patient’s medical attitudes and general world view and therefore is in the best position to know the motives and considerations that would control the patient’s medical decisions.”⁴

Nevertheless, according to the *Cruzan* Court, “If the State were required by the United States Constitution to repose a right of ‘substituted judgment’ with anyone, the Cruzans would surely qualify. But we do not

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1. 497 U.S. 261 (1990).

2. See *id.* at 327–28 (Brennan, J., dissenting); Ellen Goodman, *Coming to Missouri? Bring a Living Will*, ST. LOUIS POST-DISPATCH, June 29, 1990, at 3C.

3. On remand, new witnesses came forward, providing sufficient evidence of Ms. Cruzan’s wishes from her conversations with them. GREGORY E. PENCE, *MEDICAL ETHICS: ACCOUNTS OF GROUND-BREAKING CASES* 66 (7th ed. 2015).

4. *In re Jobes*, 529 A.2d 434, 445 (N.J. 1987).

think the Due Process Clause requires the State to repose judgment on these matters with anyone but the patient herself.”⁵

Accordingly, it was permissible for the Missouri Supreme Court to hold that Ms. Cruzan’s feeding tube could be withdrawn only if she had left “clear and convincing” evidence of her desire not to receive artificial feeding in the event that she became seriously and irreversibly ill.⁶ She needed to have completed an advance directive⁷ or otherwise have provided clear guidance regarding her treatment preferences.⁸

After *Cruzan*, for incapacitated patients who do not leave solid evidence of their treatment preferences, family authority to make medical decisions has depended on state law. States can follow the Missouri Supreme Court and reject family decision-making, or states can choose to recognize family decision-making on behalf of incompetent patients who have not left clear guidance. Over time, most states have recognized family decision-making, sometimes by court decision, more often by surrogate decision-making statutes.⁹ In Virginia, for example, relatives of the patients are authorized to decide for patients who are “incapable of making an informed decision.”¹⁰

II. LIMITATIONS OF SURROGATE DECISION-MAKING STATUTES AND COURT DECISIONS

But there are important gaps in state law. Some states have not recognized family decision-making by either court decision or statute.¹¹ For patients who have not left clear evidence of their treatment preferences or formally appointed a surrogate, continued treatment may be required.¹²

In states that have surrogate decision-making statutes, many limit which family members may serve as surrogates.¹³ For example, while Virginia recognizes any blood relative,¹⁴ Iowa’s authorizing statute only in-

5. *Cruzan*, 497 U.S. at 286.

6. *Id.* at 286–87.

7. By “advance directive,” I mean to include both treatment directives (also called living wills) and durable powers of attorney for health care.

8. *Cruzan*, 497 U.S. at 286–87.

9. Shana Wynn, *Decisions by Surrogates: An Overview of Surrogate Consent Laws in the United States*, 36 BIFOCAL 10, 10 (2014).

10. VA. CODE ANN. § 54.1-2986(A) (West 2010).

11. Wynn, *supra* note 9, at 10.

12. I say “may be” because health care providers vary in their approach. Some take the view that absent an affirmative authorization by the legislature or judiciary, family decision-making is not permitted. Other providers take the view that because family decision-making is well-accepted, *see, e.g.*, MINN. MED. ASS’N, MMA POLICIES 2019 § 240.22(2) (2019), https://www.mnmed.org/MMA/media/Hidden-Documents/Policy-Compendium-2019_1.pdf [<https://perma.cc/7XWE-Y7MK>], it is permissible as standard of care, absent legislative or judicial prohibition.

13. Amber R. Comer et al., “What Do You Mean I Cannot Consent for My Grandmother’s Medical Procedure?”: Key Issues with State Default Surrogate Decision Making Laws, 14 IND. HEALTH L. REV. 1, 11–13 (2017).

14. VA. CODE ANN. § 54.1-2986(A)(6).

cludes spouses, parents, adult children, and adult siblings.¹⁵ If an Iowa patient's longtime caretaker is a niece, grandchild, or close friend, the caretaker might not be able to decide on behalf of the patient without securing an appointment by a court as the patient's legal guardian.¹⁶

Another important limitation on family decision-making turns on the patient's medical condition. The right to refuse life-sustaining treatment applies to all patients, regardless of the severity of their condition.¹⁷ A patient who only needs a blood transfusion to restore good health has the same right as a patient refusing artificial ventilation or chemotherapy at the end stage of cancer.¹⁸ Nevertheless, many statutes or court decisions that recognize surrogate decision-making limit their applicability to patients with a terminal illness or permanent unconsciousness, sometimes with a third category of very serious and irreversible illness.¹⁹ These statutes or decisions would not apply to a patient with Alzheimer's disease whose life expectancy is measured in years rather than months.²⁰ Thus, for example, while the New Jersey Supreme Court recognized family decision-making in the *Jobes* case for a permanently unconscious patient, it rejected family decision-making in the *Conroy* case for a patient with advanced dementia.²¹ New York statutory law parallels New Jersey common law. Under the Family Health Care Decisions Act, family members or close friends may refuse life-sustaining treatment for patients who are terminally ill or permanently unconscious, but generally not for other patients.²²

Finally, a few surrogate statutes limit the authority of family members to authorize the withdrawal of nutrition and hydration.²³ Even though the right to refuse treatment applies to all health care, including artificial nutrition and hydration, some states distinguish between nutrition and hydration, on one hand, and other kinds of health care, on the other hand, such as ventilators, dialysis, and surgery.²⁴ In Ohio, for example, artificial nutrition and hydration may be discontinued from a permanently unconscious patient only with a court order.²⁵

The impact of these limits on family decision-making can be illustrated by revisiting a key withdrawal of treatment case. In *In re Conroy*,²⁶ the

15. IOWA CODE ANN. § 144A.7 (West 2014).

16. *See id.*

17. MARK A. HALL ET AL., HEALTH CARE LAW AND ETHICS 522 (9th ed. 2018) (quoting *In re Conroy*, 486 A.2d 1209, 1225–26 (N.J. 1985)).

18. *Id.* at 521–24.

19. *See, e.g.*, TEX. HEALTH & SAFETY CODE ANN. § 166.031 (West 2017).

20. *See, e.g., infra* note 21.

21. HALL ET AL., *supra* note 17, at 553–54 (citing *Conroy*, 486 A.2d at 1225–26).

22. For patients who have an incurable condition, family members or close friends may refuse life-sustaining treatment that is inhumane or extraordinarily burdensome. N.Y. PUB. HEALTH LAW § 2994-d(5)(a)(ii) (McKinney 2018).

23. *See, e.g.*, OHIO REV. CODE ANN. § 2133.09 (West 2017).

24. *See* Howard Brody et al., *Artificial Nutrition and Hydration: The Evolution of Ethics, Evidence, and Policy*, 26 J. GEN. INTERNAL MED. 1053, 1054 (2011).

25. OHIO REV. CODE ANN. § 2133.09.

26. 486 A.2d 1209 (N.J. 1985).

patient, Claire Conroy, suffered from advanced dementia and was living in a long-term care facility.²⁷ At issue was whether to withdraw her feeding tube.²⁸ She had not documented her wishes in a living will or power of attorney, nor had she provided clear instructions in conversations with family members or health care providers.²⁹ In terms of family, she

had never married, and had very few friends. She had been very close to her three sisters, all of whom had died.

[Her] only surviving blood relative was her nephew, the guardian, Thomas Whittimore. He had known her for over fifty years, had visited her approximately once a week for four or five years prior to her commitment to the nursing home, and had continued to visit her regularly at the nursing home for some time.³⁰

Ultimately, the New Jersey Supreme Court held that treatment could be withdrawn from a patient like Ms. Conroy on the basis of clear evidence of the patient's wishes (a "subjective" test similar to the Missouri Supreme Court standard in *Cruzan*).³¹ If clear evidence was lacking, then treatment withdrawal could be based on the patient's best interests if the patient suffered from unavoidable pain and the burdens of prolonged life markedly outweighed the benefits of maintaining treatment (under two "objective" tests).³² But the court did not authorize Ms. Conroy's nephew to decide on her behalf.³³

If a case like *Conroy* arose today, surrogate decision-making would lack authorization in many states. Ms. Conroy's closest family member was her nephew, and as indicated, many surrogate statutes do not look beyond the nuclear family.³⁴ Moreover, Ms. Conroy was neither terminally ill nor permanently unconscious.³⁵ Finally, the decision at issue involved the provision of artificial nutrition rather than a ventilator or other more intensive care.³⁶

III. ADDRESSING THE LIMITS OF SURROGATE DECISION-MAKING STATUTES

In the conventional view, the gaps in surrogate decision-making laws need to be filled in on a state-by-state basis, either through judicial decision or legislative reform. And good models exist. In Maine, for example, life-sustaining treatment decisions can be made not only by family members but also by an "adult who has exhibited special concern for the pa-

27. *Id.* at 1216–17.

28. *Id.* at 1217–18.

29. *See id.* at 1243–44.

30. *Id.* at 1218.

31. *Id.* at 1229.

32. More specifically, the *Conroy* court established two "best interests" tests: a "limited-objective" best interest test and a "pure-objective" best interests test. *Id.* at 1232.

33. *Id.* at 1243–44.

34. *See supra* notes 13–15 and accompanying text.

35. *See supra* notes 17–22 and accompanying text.

36. *See supra* notes 23–25 and accompanying text.

tient, who is familiar with the patient's personal values."³⁷ Or in Indiana, surrogates can make decisions for any treatment and for patients with any medical condition.³⁸ And in Virginia, any blood relative can authorize the withdrawal of any kind of treatment from any patient lacking decision-making capacity.³⁹

But there is good reason to think that states already have a greater obligation to recognize family decision-making than is generally appreciated. Arguably, the Constitution requires an important degree of family decision-making.

Consider in this regard an exchange between the *Cruzan* majority and a concurring Justice Sandra Day O'Connor. After the majority discussed why Missouri did not have to permit family members to make medical decisions for incapacitated patients, the Justices wrote:

We are not faced in this case with the question whether a State might be required to defer to the decision of a surrogate if competent and probative evidence established that the patient herself had expressed a desire that the decision to terminate life-sustaining treatment be made for her by that individual.⁴⁰

In her concurrence, Justice O'Connor elaborated on that footnote, saying:

I also write separately to emphasize that the Court does not today decide the issue whether a State must also give effect to the decisions of a surrogate decisionmaker. In my view, such a duty may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment.⁴¹

As both the majority and Justice O'Connor suggest, the procedural rules for designating a surrogate decision maker should parallel the procedural rules for refusing unwanted treatment. Just as patients can direct future treatment decisions by leaving clear evidence of their wishes whether or not to accept care, they should be able to direct future treatment decisions by leaving clear evidence of their wishes about the person they want to make treatment decisions for them. If a patient designates a spouse or adult child as a surrogate decision maker, the spouse or adult child should be able to speak for the patient.

To some extent, the procedural rules are in sync. For example, people can execute an advance directive to express either their wishes about treatment or about a surrogate decision maker.⁴² To document their preferences about treatment, people can write a "treatment directive," com-

37. ME. REV. STAT. ANN. tit. 18-A, § 5-805(c) (1995).

38. IND. COD ANN. §§ 16-36-1-1, 16-36-1-5(a) (West 2018).

39. VA. CODE ANN. § 54.1-2986(A) (West 2010).

40. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 287 n.12 (1990).

41. *Id.* at 289 (O'Connor, J., concurring) (internal citations omitted).

42. Kathy L. Cerminara & Joseph R. Kadis, *Give Me Liberty to Choose (a Better) Death: Respecting Autonomy More Fully in Advance Directive Statutes*, 10 ST. LOUIS U. J. HEALTH L. & POL'Y 67, 69-70 (2016).

monly called a living will.⁴³ To document their preferences about a surrogate decision maker, people can grant a power of attorney.⁴⁴ Both types of documentation are legally valid, and their recognition is almost certainly required by the Constitution.⁴⁵

But when it comes to other kinds of clear and convincing evidence of a patient's wishes, it is assumed that the rules diverge between preferences about treatment and preferences about a surrogate decision maker. This divergence can be illustrated by California statutory law. California defines an "individual health care instruction" as "a patient's *written or oral* direction concerning a health care decision for the patient."⁴⁶ But it defines a "power of attorney for health care" as "a *written* instrument designating an agent to make health care decisions for the principal."⁴⁷

Judicial decisions also illustrate the divergence between patient wishes about treatment and patient wishes about a surrogate. On one hand, courts routinely recognize that treatment decisions may be guided by clear and convincing evidence of a patient's wishes, even when unwritten.⁴⁸ Accordingly, in case after case, courts parse past conversations between the patient and family members or friends to see if the patient's wishes were clearly stated. Courts also consider other evidence of a patient's preferences, such as religious beliefs or the patient's past practices with respect to health care decisions.⁴⁹

Thus, for example, in *In re Swan*,⁵⁰ the court considered statements made by Chad Swan less than two years before he suffered serious injuries in an auto accident and was left permanently unconscious.⁵¹ The court concluded that the statements provided clear evidence of his wishes not to be treated.⁵² He had spoken to his mother about a highly publicized local case in which the patient had also become permanently unconscious from a motor vehicle accident.⁵³ Chad said to his mother, "If I can't be myself . . . no way . . . let me go to sleep."⁵⁴ In addition, just eight days before his own auto accident, after visiting a comatose friend in the hospital, Mr. Swan told his brother, "I don't ever want to get like that. . . . I would want somebody to let me leave—to go in peace."⁵⁵

But courts do not ask whether patients have left unwritten, clear and convincing evidence of their preferences for a surrogate decision maker,

43. *See id.*

44. *Id.*

45. *Id.* at 78 (indicating that the *Cruzan* Court was talking about powers of attorney).

46. CAL. PROB. CODE § 4623 (West 2000) (emphasis added).

47. *Id.* § 4629 (emphasis added).

48. *See, e.g., Cruzan v. Harmon*, 760 S.W.2d 408, 415 (Mo. 1988), *aff'd*, *Cruzan*, 497 U.S. 261; *In re Swan*, 569 A.2d 1202, 1205 (Me. 1990).

49. *Brophy v. New Eng. Sinai Hosp., Inc.*, 497 N.E.2d 626, 631 (Mass. 1986); *In re Conroy*, 486 A.2d 1209, 1230 (N.J. 1985).

50. *Swan*, 569 A.2d 1202.

51. *Id.* at 1205.

52. *Id.*

53. *See id.*

54. *Id.*

55. *Id.*

even though in many cases consideration of the relevant evidence will make it quite clear that the patient wanted—and expected—that medical decisions would be made by a spouse or other family member.⁵⁶

Such consideration might well change the outcome if the issue came up with another patient like Ms. Conroy. The court might discover that the new patient relied heavily on a niece and nephew for guidance when making important decisions, including financial and medical decisions. The court also might find that the niece and nephew accompanied the patient to doctors' appointments, that the patient routinely turned to them for advice, and that the patient always followed their advice.

We don't have to speculate to recognize that many cases would come out differently if courts asked whether patients had left clear and convincing evidence of their wishes for a surrogate decision maker. The Michael Martin case provides a good example.

Mr. Martin had suffered serious injuries, including a head injury, from an automobile accident that left him "unable to walk or talk, and rendered him dependent on a colostomy for defecation and a gastrostomy tube for nutrition."⁵⁷ He was able to understand "only very short and very simple questions."⁵⁸ He could not "accurately comprehend questions that [were] lengthy, verbose, or that require the retention of multiple thoughts."⁵⁹ In particular, he could not understand "his physical capabilities and medical condition."⁶⁰

Mr. Martin's wife testified to eight years of discussions regarding his wishes in the event of a serious accident or disabling illness, the most recent discussion occurring one month before his accident.⁶¹ These discussions took place after the Martins watched movies about people who could no longer take care of themselves because of an accident or illness.⁶² The following is an excerpt about Mr. Martin's wife's testimony from the court's opinion:

Mike stated to me on several occasions: "That's bullshit, I would never want to live like that." He also said to me, "Please don't ever let me exist that way because those people don't even have their dignity." . . . [Regarding a movie about a football player with a terminal illness,] Mike said to me after we saw it together: "If I ever get sick don't put me on any machines to keep me going if there is no hope of getting better." He also said that if I ever put him on machines to keep him alive: "I'll always haunt you, Mary." Then he would say, "Do you understand?" I always said "Yes." We watched this movie at least two or three times and had virtually the same

56. Andrew J. Broder & Ronald E. Cranford, "Mary, Mary, Quite Contrary, How Was I to Know?" *Michael Martin, Absolute Prescience, and the Right to Die in Michigan*, 72 U. DET. MERCY L. REV. 787, 828-30 (1995).

57. *In re Martin*, 538 N.W.2d 399, 402 (Mich. 1995).

58. *Id.* at 403.

59. *Id.*

60. *Id.* at 404.

61. *Id.* at 411-12.

62. *Id.* at 412.

discussion each time. . . . Mike was an avid hunter and frequently expressed concerned [sic] about a hunting accident. Mike frequently told me that if he ever had an accident from which he would “not recover” and “could not be the same person,” he did “not want to live that way.” He would say, “Mary, promise me you wouldn’t let me live like that if I can’t be the person I am right now, because if you do, believe me I’ll haunt you every day of your life.”⁶³

While the Michigan court asked whether there was clear and convincing evidence that Mr. Martin would not want a feeding tube,⁶⁴ it did not ask whether there was clear and convincing evidence that he wanted his wife to make medical decisions for him. Had the court done so, it almost certainly would have concluded that Mr. Martin’s wife was the appropriate surrogate decision maker. In his instructions to her and his requests that she promise to abide by them, Mr. Martin clearly expected that his wife would make medical decisions for him if he became incapacitated.⁶⁵

IV. CONCLUSION

The legacy of the *Cruzan* case has been profound. It firmly established the right to refuse unwanted life-sustaining treatment in the law, it prompted legislative reform at the federal and state level,⁶⁶ and it did much to spur people to engage in end-of-life planning with their families and physicians to ensure that their wishes about treatment would be carried out.

But an important part of *Cruzan*’s legacy remains unfulfilled. Even though the case signaled that surrogate decision makers can be authorized through any kind of clear evidence of a patient’s preferences, not just through formal durable powers of attorney, courts and most scholars have not recognized this aspect of the *Cruzan* decision. Going forward, courts, hospitals, and other health care providers need to ensure that they fully respect patient preferences with regard to surrogate decision makers.

63. *Id.*

64. The court thought there was not, and it cited evidence that didn’t seem to support a finding of clear and convincing evidence. For example, two coworkers stated that, while Mr. Martin indicated his desire not to be kept alive if in a vegetative state, his present condition was “not the type referred to in conversations with them before his injury.” *Id.* at 412–13. In addition, several witnesses testified that, after his accident, Mr. Martin would shake his head “no” “when asked if he ever felt that he did not want to continue living.” *Id.* at 413.

65. Broder & Cranford, *supra* note 56, at 828.

66. Congress passed the Patient Self-Determination Act, and many states enacted advanced directive and surrogate decision-making statutes. Comer et al., *supra* note 13, at 9–10.