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THE REAL ETHIC OF DEATH AND DYING

Norman L. Cantor*

RETHINKING LIFE AND DEATH. By Peter Singer. New York: St. Martin's Press. 1994. Pp. 256. \$22.95.

When medical science became capable of prolonging the dying process beyond the point that most patients would wish, medical management of the dying process became a necessity. Health-care providers no longer could strive inexorably to extend waning human lives. The search thus began for an ethic to govern medical management of the dying process.¹

Peter Singer's *Rethinking Life and Death*,² a provocative and entertaining book, purports both to critique "the old ethic" — the book is subtitled "The Collapse of Our Traditional Ethics" — and to propound a "new ethic" to regulate the medical handling of dying patients.³ Although the book does underscore some anomalies in end-of-life care, its account of the dominant ethic of death and dying proves inaccurate. Rather than portraying the existing order — or disorder — it creates a straw man. Moreover, despite the highly problematic nature of his "new ethic," Singer defends it only superficially.

This review essay contains three parts. The first exposes the deficiencies in Singer's depiction of the old ethic. The second lays bare the key ingredients in his new ethic and discusses some of its major issues and weaknesses. The third presents my own prescription for an appropriate ethic to govern medical management of the dying process.

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1. For description of diverse ethical theories suggested for the field of bioethics in general, and the death-and-dying context in particular, see TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 44-111 (4th ed. 1994); THOMAS A. MAPPES & DAVID DEGRAZIA, *BIOMEDICAL ETHICS* 4-46 (4th ed. 1996); Susan M. Wolf, *Shifting Paradigms in Bioethics and Health Law: The Rise of a New Pragmatism*, 20 *AM. J.L. & MED.* 395 (1994).

2. Peter Singer is a philosophy professor at Monash University in Australia and has written extensively on animal rights and on bioethics topics such as reproductive technology and care of the dying.

3. The book touches on an ethic toward fetal life and animal life as well as dying medical patients. Its focus, however, rests on the medical handling of human life. This essay centers on that feature.

I. THE OLD ETHIC AS STRAW MAN

According to Singer, a "sanctity of life" ethic dominates the traditional approach to death and dying. A central premise of that supposed ethic is that all human beings, no matter how rudimentary their mental function and capacity, deserve protection. That protection includes a prohibition against the intentional taking of innocent human life and, in the medical context, a ban on letting patients die⁴ simply because of deteriorated quality of life (pp. 73-75). Exceptions to this sanctity-of-life approach supposedly exist to allow for the cessation of "extraordinary means of medical treatment" and for the use of analgesics that are intended to relieve pain but incidentally hasten death (p. 147). However, the strict sanctity-of-life ethic described by Singer has not prevailed in Anglo-American jurisprudence since 1976, when the New Jersey Supreme Court in *In re Quinlan*⁵ upheld the discontinuation of life support maintaining a permanently unconscious patient.

Singer contends that physicians who remove life-sustaining machinery with the object of allowing a patient to die take an innocent human life — a violation of what he sees as the old sanctity-of-life principle. In Singer's view, the medical profession secured authorization to take such steps in the 1993 *Bland*⁶ case, in which Britain's House of Lords upheld the removal of a feeding tube sustaining a permanently unconscious patient (pp. 65-66). This assertion ignores the fact that American courts for twenty years have upheld the right to remove life support, including artificial nutrition, from permanently unconscious patients even though the acting parties involved understood that death would ensue. *Quinlan* was the first such decision,⁷ but a succession of cases from other jurisdictions have followed suit.⁸ Singer attempts, unsuccessfully, to distinguish these American precedents as being grounded in autonomy — the prior expressions of now incompetent patients (p. 64). *Quinlan* did

4. Singer contends that the existing whole-brain definition of death has "come apart." See p. 36. That contention rests principally on the fact that even after brain death — under current definitions — occurs, certain endocrinal or hormonal functions of the body continue for some period. See p. 36. Yet Singer does not articulate an alternative definition of death. Instead, he reformulates the concept of "personhood" and declares that the lives of "nonpersons" merit no legal protection. I critique that reformulation of personhood, a part of Singer's "new ethic," in Part II.

5. 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976).

6. *Airedale N.H.S. Trust v. Bland*, 2 W.L.R. 332 (C.A. 1993).

7. *Quinlan* involved the withdrawal of a respirator, not artificial nutrition, and the patient surprisingly endured for nine years. Nonetheless, the firm medical expectation had been that withdrawal of the respirator would cause the prompt death of the patient. See *Quinlan*, 355 A.2d 647.

8. Justice Stevens's dissent in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 348 n.21 (1990) (Stevens, J., dissenting), contains a list of decisions so holding. For an analysis of the judicial rationales employed in these cases, see Norman L. Cantor, *The Permanently Unconscious Patient, Non-Feeding and Euthanasia*, 15 AM. J.L. & MED. 381 (1989).

not rely on the patient's prior expressions.⁹ Furthermore, subsequent decisions have endorsed the withdrawal of life support from patients even in the absence of clear-cut prior expressions.¹⁰ In short, American jurisprudence on death and dying generally accepts that physicians sometimes may "take innocent life," as Singer defines the concept.

The second aspect of Singer's old sanctity-of-life ethic — the notion that poor quality of life can never justify the termination of life-sustaining medical intervention — never really has prevailed. Since 1976, American courts have recognized that a person's health may deteriorate to such a degree that she may be better off dead than alive.¹¹ Cases have applied this principle to both competent and incompetent patients. For incompetent patients, judicial acceptance of end-of-life determinations has relied both on the dismal status of the patient — such as permanent unconsciousness — and on determinations that the burdens of existence, such as pain and suffering, can outweigh the benefits of extended life.¹² Contrary to what Singer suggests, courts frequently consider diminished quality of life, in the sense of grievous bodily deterioration, in shaping the bounds of medical intervention in the dying process.¹³

With regard to the asserted "old ethic," Singer suggests that permitting the removal of "extraordinary means" of life preservation constitutes the main deviation from a strict sanctity-of-life principle (p. 188). The concept of extraordinary means, which originated in a 1957 pronouncement of Pope Pius XII,¹⁴ influenced the original position of the devoutly Catholic Quinlan family.¹⁵ In fact, the concept sometimes was cited as a possible demarcation of permissible medical conduct in ending life-sustaining intervention. For exam-

9. See *Quinlan*, 355 A.2d at 664.

10. See *Rasmussen v. Fleming*, 741 P.2d 674, 685-86 (Ariz. 1987); *In re Drabick*, 245 Cal. Rptr. 840, 855-60 (Cal. Ct. App.), cert. denied, 488 U.S. 958 (1988); *In re L.H.R.*, 321 S.E.2d 716 (Ga. 1984); *In re Jane Doe*, 583 N.E.2d 1263 (Mass. 1992); *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977); *In re Torres*, 357 N.W.2d 332 (Minn. 1984); *In re Crum*, 580 N.E.2d 876 (Ohio P. Ct. 1991); *In re L.W.* 482 N.W.2d 60, 67 (Wis. 1992).

11. See, e.g., *Saikewicz*, 370 N.E.2d 417; *Quinlan*, 355 A.2d 647; *In re Grant*, 747 P.2d 445 (Wash. 1987).

12. See, e.g., *In re C.A.*, 603 N.E.2d 1171, 1181-82 (Ill. App. Ct. 1992), cert. denied, 610 N.E.2d 1264 (Ill. 1993); *In re Conroy*, 486 A.2d 1209, 1232 (N.J. 1985); *Grant*, 747 P.2d at 450-51.

13. In the context of assessing an incompetent patient's best interests, the quality-of-life consideration sometimes occurs under the heading of "dignity." See Norman L. Cantor, *Quality of Life in Legal Perspective*, in 3 *ENCYCLOPEDIA OF BIOETHICS* 1361-66 (Warren T. Reich et al. eds., 1995).

14. See *Quinlan*, 355 A.2d at 658.

15. The family petitioned for removal of "all extraordinary means," by which they meant the patient's respirator, but not her antibiotic therapy or artificial nutrition. See *In re Quinlan*, 348 A.2d 801, 806, 813 (N.J. Super. Ct. Ch. Div. 1975).

ple, the American Medical Association House of Delegates used the extraordinary means terminology in 1973 in suggesting guidelines for terminal care.¹⁶

Nevertheless, American jurisprudence long since has abandoned the ordinary-extraordinary dichotomy.¹⁷ Authorization to withhold or withdraw life support now extends to the most basic forms of medical intervention, including blood transfusions,¹⁸ artificial nutrition,¹⁹ and chemotherapy.²⁰

In sum, the old ethic of death and dying presented by Singer bears little resemblance to the prevailing ethic found in American cases of the past twenty years. Had Singer articulated and defended a sensible new direction in the death and dying ethic, that flaw would seem forgivable — but he did not. Although he does endorse some unconventional positions, he fails adequately to defend or even to articulate their implications. I turn to consideration of those positions.

II. WEAKNESSES OF THE NEW ETHIC

A. *Human Nonpersons*

Singer's new ethic centers around the notion that not all human beings are persons (pp. 180-83). To be a "person," he says, a being must have an awareness of self over time and enough reasoning capacity to plan for the future (pp. 182, 218). Under this theory, certain human beings — including anencephalics, permanently vegetative patients, and neonates — are deemed nonpersons. On the other hand, certain nonhuman animals — including whales, dolphins, monkeys, dogs, and pigs — are deemed persons (pp. 180-82, 205-06, 209-10). Although Singer does not address it, his framework also might classify some severely retarded or demented human beings as nonpersons. This might include patients with advanced Alzheimer's, for example.²¹

Singer's personhood framework falters in its superficial consideration of the implications for human nonpersons. Many commentators have argued that absence of neocortical function — which includes the capacity to interact with others — ought to form the

16. See James Rachels, *Active and Passive Euthanasia*, 292 *NEW ENG. J. MED.* 78 (1975).

17. For a clear-cut repudiation of that dichotomy, see *In re Conroy*, 486 A.2d 1209, 1234-35 (N.J. 1985); ALAN MEISEL, *THE RIGHT TO DIE* 481-86 (2d ed. 1995).

18. See *In re Brooks*, 205 N.E.2d 435 (Ill. 1965).

19. See *In re Guardianship of L.W.*, 482 N.W.2d 60 (Wis. 1992).

20. See *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977).

21. Some of these beings have lost their sense of self over time, a factor critical to self-identity and personhood under Singer's framework.

boundary of death.²² Singer does not, however, classify his nonpersons as dead. Rather, he sees them as creatures with diminished rights and expectations, retaining some interests but lacking normal protection against involuntary death (p. 198).

Singer briefly considers the implications of nonpersonhood in the context of neonates. He supports medical infanticide, at the parents' discretion, during the first few weeks of a neonate's existence, asserting that these young infants are "not yet full members of the moral community" (p. 130). In his view, the parents of a Down's syndrome neonate may withhold her life support if they prefer to raise only children better equipped to deal with life's challenges (pp. 212-15). Singer does not discuss the concomitant issues of organ harvesting, medical experimentation, or allocation of scarce medical resources; however, it seems fair to assume that his theory would favor the interests of live persons over the interests of nonperson neonates in prospective life.²³

Singer's approach to the implications of nonpersonhood proves even more perfunctory in the context of permanently unconscious patients. Must we honor the request of a previously competent patient to be maintained in a permanently vegetative state? Singer says that such wishes should be "taken into account," but should not be decisive (p. 192). What about the independent emotional and financial interests of the patient's relatives and other caretakers? Singer merely says that such interests "deserve consideration" (p. 192). What about the competing interests of potential organ recipients and potential beneficiaries of nontherapeutic medical experimentation on the permanently unconscious patient? While Singer comments that we "cannot ignore the needs of others" (p. 192), he does little to elucidate a hierarchy of interests regarding the treatment of human nonpersons.

Labelling permanently vegetative patients as nonpersons achieves very little. If Singer's concern is the indefinite preservation of a dismal quality of life — with no real benefit to the perma-

22. See John P. Lizza, *Persons and Death: What's Metaphysically Wrong With Our Current Statutory Definition of Death?*, 18 J. MED. & PHIL. 351 (1993); David R. Smith, *Legal Recognition of Neocortical Death*, 71 CORNELL L. REV. 850 (1986); Robert M. Veatch, *The Impending Collapse of the Whole-Brain Definition of Death*, HASTINGS CTR. REP. July-Aug. 1993, at 18. No court has ever adopted the neocortical definition of death. See *In re Baby K*, 16 F.3d 590 (4th Cir.), cert. denied, 115 S. Ct. 91 (1994) (entitling an anencephalic infant to medical treatment); *In re T.A.C.P.*, 609 So. 2d 588 (Fla. 1992) (prohibiting organ harvesting from an anencephalic infant before death). One major reason to reject a neocortical definition of death is that it would entail affirmative steps to end the life of some spontaneously breathing human beings. See Raymond J. Devettere, *Neocortical Death and Human Death*, 18 LAW MED. & HEALTH CARE 96, 102 (1990).

23. See John Harris, *Euthanasia and the Value of Life*, in EUTHANASIA EXAMINED 6, 19-20 (John Keown ed., 1995). Harris, who subscribes to a definition of personhood identical to Singer's, argues that the interests of nonpersons must give way to the significant needs of actual persons.

nently insensate being and with real opportunity costs to society — that concern can be met without denominating the vegetative patient a nonperson. I have argued elsewhere²⁴ that permanently unconscious patients should be allowed to die. My rationale, however, is not that these patients are nonpersons, but that withdrawal of life support in this circumstance very probably accomplishes the result that the patients would want. The vast majority of people, when asked, say that they want no life support to maintain them in a permanently insensate state.²⁵ We ought to respect this common, and therefore putative, wish in the absence of prior instructions or personal indications to the contrary. Furthermore, even if the vegetative patient did in fact request life-sustaining measures, this does not mean necessarily that nonpatient sources must fund this care.²⁶

Singer might ask in return: What do we gain by calling permanently unconscious beings “persons,” especially if we should let them die anyway? I base my response on a factor that Singer largely ignores — namely, society’s interest in sanctity-of-life, not as a mandate to prolong every human life, but as an injunction to respect the interests of human beings and humanlike beings in helpless and vulnerable states. Sanctity-of-life in that sense centers on the promotion of social sensibility to the interests of humans and of the moral tone of society.²⁷ From *this* sanctity-of-life perspective, human beings ought to be deemed persons with moral status regardless of their intellectual capacities.

At the very least, personhood status should not depend upon awareness of self over time. A societal interest in moral tone compels a showing of full respect for beings with the capacity to experience human feelings and emotions.²⁸ Calling such beings persons does not mean that we must preserve them at all costs or in situations in which their own welfare or putative preferences indicate that they should be allowed to die.²⁹ Acknowledging personhood simply implies a respect for the significant interests of such beings,

24. See Cantor, *supra* note 8, at 410-17.

25. See James Lindgren, *Death by Default*, LAW & CONTEMP. PROBS. 1993, at 185, 197-99.

26. See Kristi E. Schrode, Comment, *Life in Limbo: Revising Policies for Permanently Unconscious Patients*, 31 HOUS. L. REV. 1609, 1648-53 (1995).

27. Judicial opinions have recognized that notion of sanctity-of-life. See *In re Farrell*, 529 A.2d 404, 411 (N.J. 1987); *In re Conroy*, 486 A.2d 1209, 1223-24 (N.J. 1985).

28. For views that the capacity for feelings and interactions is sufficient for moral status as a person, see Daniel Callahan, *Terminating Life-Sustaining Treatment of the Demented*, HASTINGS CTR. REP. NOV.-DEC. 1995, at 25; Stephen G. Post, *Dementia in Our Midst: The Moral Community*, 4 CAMBRIDGE Q. OF HEALTH CARE ETHICS 142 (1995).

29. For an elaboration on the appropriate criteria for allowing incompetent patients to die, see Part III.

including their autonomous choices, their human dignity,³⁰ and their presumptive right to continued existence. It reverses Singer's ostensible indifference toward the lives and interests of those human beings, including neonates and profoundly incapacitated adults, who experience pleasure and pain despite their intellectual deficits. That indifference may stem from Singer's equating the interests of humans and nonhuman animals. In other words, his reluctance to recognize a presumptive right to life for humans with gravely diminished mental capacity may reflect an unwillingness on his part to recognize a parallel right for fish and fowl (p. 222).

B. *Transition to Active Euthanasia*

Singer cannot fathom a regime of medical management of the dying process that permits the cessation of life-sustaining medical intervention but forbids the administration of lethal poisons, or active euthanasia. For him, removal of artificial nutrition, or of any life-sustaining measures, constitutes the intentional taking of human life (p. 68). He understands that such removal is permissible in response to the wishes of a competent patient because of the patient's strong interest in shaping a dignified death and in avoiding suffering. Singer also understands that those same interests underlie any request for active euthanasia. He therefore sees a "moral incoherence" in forbidding active administration of death while permitting removal of life support (p. 80). He sees two medical actions that "are equally certain ways of bringing about the death of the patient" (p. 221). Indeed, active administration of a poison, with its immediately fatal result, seems to him more humane than a withdrawal of care, which creates a more protracted end-of-life ordeal for both the patient and her family.³¹ All this leads Singer to endorse, as part of his new ethic, physician-assisted suicide and active euthanasia when they fulfill a suffering patient's firm wish to die.

Singer sees it as anomalous to authorize some but not all actions that precipitate death. He mistakenly believes that the "old ethic" simply embodies an action-inaction dichotomy. In fact, that old ethic distinguishes between inaction in the face of a fatal natural affliction and the introduction of outside agents such as poisons or bullets that accelerate death. While "pulling the plug" — with-

30. "Human beings who lack or have lost the capacity for autonomous actions are nonetheless humans who retain their inherent dignity. Respect for persons comprises more than respect for autonomy." Edmund D. Pellegrino, *Patient and Physician Autonomy: Conflicting Rights and Obligations in the Physician-Patient Relationship*, 10 J. CONTEMP. HEALTH L. & POLY. 47, 49 (1994).

31. Singer asks: "How can it be lawful to allow a patient to die slowly, though painlessly, over a period of weeks from lack of food but unlawful to produce his immediate death by lethal injection, thereby saving his family from yet another ordeal . . . ?" P. 78.

drawing life support, such as a respirator — is indeed an action, it traditionally has been treated, so long as it merely removes a medical obstacle to a natural death, as the moral and practical equivalent of medical nonintervention.³² When a dying patient objects to further medical intervention, no difference exists between failing to activate her respirator, failing to replenish her expired oxygen supply, or withdrawing her respirator. All these forms of medical behavior allow a natural dying process to run its course.

From the outset, death-and-dying jurisprudence has regarded medical withdrawal of life support as equivalent to medical nonintervention.³³ It also has distinguished both forms of conduct — withholding and withdrawing medical intervention — from the introduction of outside lethal agents. In fact, cases upholding the prerogative of a patient to reject life-sustaining treatment uniformly have distinguished that behavior from suicide on the basis of the distinction between letting nature take its course and initiating lethal agents.³⁴ Recent cases have maintained that distinction in rejecting dying patients' asserted right to physician-assisted suicide. The Michigan Supreme Court recently commented:

[W]hereas suicide involves an affirmative act to end a life, the refusal or cessation of life-sustaining medical treatment simply permits life to run its course, unencumbered by contrived intervention There is a difference between choosing a natural death summoned by uninvited illness or calamity, and deliberately seeking to terminate one's life by resorting to death-inducing measures unrelated to the natural process of dying.³⁵

The question then becomes whether a meaningful distinction exists between letting nature take its course and accelerating a natural dying process. Singer sees the difference as perverse — nonintervention, as opposed to active euthanasia, tends to prolong the dying process and to increase the burdens on patients and their caretakers.³⁶

32. See cases cited *infra* note 34.

33. An important policy concern reinforces the willingness of courts to treat life-support withdrawal as equivalent to noninitiation. If medical personnel cannot remove life support, they would be deterred from initiating it when a patient faces a strong chance of a protracted existence in a dismal, deteriorated state, yet has at least a slight chance of recovery. See Council on Ethical and Judicial Affairs, American Medical Assn., *Decisions Near the End of Life*, 267 JAMA 2229, 2231 (1992) (finding "no ethical distinction between withdrawing and withholding life-sustaining treatment"); see also *Extracts from the Report of the House of Lords Select Committee on Medical Ethics*, in *EUTHANASIA EXAMINED* 96, 105 (John Keown ed., 1995).

34. See *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 305 (Cal. Ct. App. 1986); *McKay v. Bergstedt*, 801 P.2d 617, 632 (Nev. 1990); *In re Conroy*, 486 A.2d 1209, 1224 (N.J. 1985).

35. *Michigan v. Kevorkian*, 527 N.W.2d 714, 728-29 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995). *But see* *Compassion in Dying v. State of Washington*, 1996 WL 94848 (9th Cir. 1996); *Quill v. Vacco*, 1996 WL 148605 (3d Cir. 1996).

36. Singer also perceives an anomaly in contemporary medical ethics' endorsement of analgesics that may mitigate a patient's pain but that also may accelerate her death. Again,

His position deprecates any societal interest in promoting sanctity-of-life in the sense of maintaining respect for human existence in all its forms. We promote respect for human life by limiting the circumstances in which we permit humans to terminate human life. We already tolerate war, capital punishment, and self-defense. Arguably, we should hesitate to add to this list, even for an object as appealing as the relief of suffering. Some commentators perceive a useful social message in drawing the dividing line between cessation of treatment — when disease causes the ultimate death — and euthanasia — when a human act causes the patient's demise.³⁷ Cases rejecting a right of people to starve themselves to death in hunger strikes have drawn just such a line.³⁸ They distinguish between a person's decision to starve and a dying person's rejection of life-sustaining treatment.³⁹ Although we ultimately may come to regard the distinction between allowing and precipitating death as a shallow psychological or symbolic anachronism,⁴⁰ it surely deserves more than the short-shrift consideration that Singer accords it.

Singer cannot fathom how society can permit active administration of possibly lethal outside agents like analgesics while proscribing active euthanasia. See p. 188. Cf. *Compassion in Dying*, 1996 WL 94848 (holding that a Washington statute prohibiting doctors from prescribing life-ending medication for the terminally ill who want to hasten their own deaths violates due process).

The current legal authorization of analgesic administration, at first blush, does seem inconsistent with a ban on euthanasia. The customary explanation — that physicians administer analgesics with a primary intent to relieve pain — proves unpersuasive. Physicians might commit euthanasia with the same primary intent. A better explanation lies in the difference between the criminal law's authorization of some risky yet potentially beneficial acts and its condemnation of probably lethal conduct undertaken for the same benevolent purposes. For example, a surgeon may perform an operation for an important cosmetic benefit even though the operation poses some modest risk of death to the patient, yet he cannot perform the same operation if the mortal risk is very great. Along similar lines, a physician may administer an analgesic that is necessary to relieve pain even though the act causes some risk of death. She may not, however, administer a risky dosage when a smaller dosage would do, when alternative means to relieve the patient's pain exist, or when death probably will be caused. Thus, the tension between the authorization of risky analgesics and the prohibition on euthanasia is not as great as it appears. For a full account of the legalities of analgesic administration, see George C. Thomas & Norman L. Cantor, *Pain Relief, Acceleration of Death, and Criminal Law*, in 6 KENNEDY INST. OF ETHICS J. (forthcoming 1996) (manuscript on file with author).

37. See Daniel Callahan, *Can We Return Death to Disease?*, HASTINGS CTR. REP. Jan.-Feb. 1989, Special Supp. at 4, 5-6; Marion Doenhoff & Reinhard Merkel, *Not Compassion Alone: On Euthanasia and Ethics*, trans. Hunter & Hildegard Hannum, HASTINGS CTR. REP. Special Issue 1995, at 44; Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, HASTINGS CTR. REP. May-June 1993, at 32.

38. See *Thor v. Superior Court*, 855 P.2d 375, 389 n.16 (Cal. 1993); *In re Caulk*, 480 A.2d 93, 97 (N.H. 1984); *Van Holden v. Chapman*, 450 N.Y.S.2d 623, 624-25 (N.Y. App. Div. 1982). But see *Zant v. Prevatte*, 286 S.E.2d 715, 716-17 (Ga. 1982).

39. See also *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 280 (1990) (indicating in dictum that although a dying person might have a right to reject life-sustaining medical intervention, a healthy person has no comparable right to starve himself to death).

40. The distinction certainly leads to some fine line drawing. A healthy person who engages in a hunger strike initiates an unnatural dying process and therefore is regarded as committing suicide, but if a deteriorated, fatally stricken patient makes a deliberate decision to stop eating, the strong medical and legal inclination is to acquiesce in the patient's fatal

Even if Singer is right about the shaky moral basis of the traditional line between letting die and killing, his leap to the endorsement of active euthanasia seems premature. Practical concerns cause many bioethicists to shy away from supporting the legalization of active euthanasia. While acknowledging that it may be morally justifiable to administer a poison to some suffering patients who request it, they still oppose legalization of euthanasia because of the perceived social hazards.⁴¹

Their apprehensions cover a wide range. They include fear of outright abuse. For example, some bioethicists worry that slanted presentations of the choices available will taint the patients' consent received, or that society will use euthanasia to eliminate socially isolated and unwanted individuals. Their apprehensions also include more subtle hazards supposedly flowing from the availability of active euthanasia: pressure on fatally stricken patients to accept death rather than undergo expensive life-sustaining therapy; diminution of medical efforts to palliate patients' suffering; weakening of society's commitment to care for the dying; erosion of professional medical mores; erosion of health-care providers' morale; and erosion of patient confidence in the medical profession flowing from concern about physician-caused death. Although these hazards may prove chimerical,⁴² Singer's book fails to address them.

One might respond to these various concerns by arguing that doctors rarely abuse their current role in withholding or withdrawing life support. Health-care providers have ample opportunity to exploit gravely afflicted patients by manipulating informed consent leading to life-support withdrawal decisions, by administering analgesics with an incidental effect of accelerating death and by removing life support from incompetent patients. In short, similar potential for abuse plagues both active euthanasia and withdrawal

course. Of course, this may indicate only that suicide is more understandable and tolerable in some circumstances than in others.

41. See Joan Teno & Joanne Lynn, *Voluntary Active Euthanasia: The Individual Case and Public Policy*, 39 J. AM. GERIATRICS SOC'Y. 827 (1991). Some study commissions have taken the position that the social hazards of authorizing active euthanasia outweigh the potential benefits. See *Crafting Public Policy on Assisted Suicide and Euthanasia*, in NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 117-48 (1994); *Extracts from the Report of the House of Lords Select Committee of Medical Ethics*, in EUTHANASIA EXAMINED, *supra* note 33, at 96.

42. For a spirited defense of active euthanasia against these supposed dangers, see JAMES RACHELS, *THE END OF LIFE: EUTHANASIA AND MORALITY* (1986); Dan W. Brock, *Voluntary Active Euthanasia*, HASTINGS CTR. REP. Mar.-Apr. 1992, at 10, 14; Stephen Newman, *Euthanasia: Orchestrating "The Last Syllable of . . . Time,"* 53 U. PITT. L. REV. 153 (1991).

of life support, and yet abuse has not materialized in the latter context.⁴³

I find this only partially reassuring. As I explain in Part III, the legal doctrine on the handling of incompetent dying patients and the standards for surrogate decisionmaking still are evolving. While medical professionals and surrogate decisionmakers have not perpetrated abuse on helpless patient populations, this fact may be attributable partially to the cautious evolution of legal standards for life-support removal. Those standards are still in flux and still need assessment.

Furthermore, advocates of active euthanasia cannot avoid the difficulties associated with surrogate decisionmaking simply by insisting that we confine active euthanasia to competent patients. Once we authorize active euthanasia, a natural impetus to extend its "benefits" to incompetent persons will follow. If a competent patient in unremitting pain would likely request and receive euthanasia, a strong impulse will emerge to extend the same benefit to an incompetent patient in a similar condition who never provided or never had the capability to provide advance instructions. Experience in the Netherlands confirms the existence of this impetus.⁴⁴ Thus, proponents of active euthanasia ultimately must confront the issue of the standards for surrogate decisionmaking, a topic that Singer neglects except as to nonpersons.

III. THE REAL ETHIC: AUTONOMY AND CONSTRUCTIVE PREFERENCE

Part I showed that Singer's supposed "old ethic," which mandates the preservation of human life except by extraordinary means, never prevailed. The real ethic of death and dying has developed in American jurisprudence over the past twenty years since the 1976 *Quinlan* decision. Although some discontinuity between legal doctrine and medical practice persists, that jurisprudence has had a considerable impact on the professional standards applicable to end-of-life care.

Both the relevant cases and statutes of the past twenty years have tended to direct medical responses to fatal conditions according to patient preference, whether actual or putative. That autonomy-oriented thrust seems most evident when competent patients make contemporaneous decisions about medical intervention

43. While many complaints are voiced about end-of-life medical practices, premature termination of life support is not one of them. See sources cited *infra* note 82.

44. Euthanasia has been performed there upon gravely incapacitated infants. See CARLOS F. GOMEZ, REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS, 83-85 (1991); Maurice A.M. deWachter, *Euthanasia in the Netherlands*, HASTINGS CTR. REP. Mar.-Apr. 1992, at 23, 24.

or when they have left advance instructions for their post-competence care. Yet, even when the now-incompetent patient never prepared such instructions, what I call constructive preference — a notion grounded in autonomy and respect for human dignity — emerges as the principal legal guide to the patient's medical fate. The construction of preference requires a decisionmaker to project what the now-incompetent patient would want done. I call this approach constructive preference because it seeks to replicate a now-incompetent patient's likely preference in the absence of actual patient choice. The surrogate's decision inevitably must be constructive, but, as subsequent discussion will indicate, that decision need not be disconnected from the patient's wishes.

An autonomy-constructive preference ethic does in fact underlie the current jurisprudence. Legal doctrine governing end-of-life medical care starts with the competent patient. American courts uniformly uphold the prerogative of competent patients to reject life-sustaining medical intervention.⁴⁵ In so doing, they look to the doctrine of informed consent, a doctrine based on notions of bodily integrity and self-determination that rest, in turn, on respect for human dignity and capacity for choice.⁴⁶ Thus, as to competent medical patients, a close relation exists between autonomy and dignity. The primacy of autonomy extends to "prospective autonomy" — a competent person's right to shape her post-competence medical treatment by advance instructions. Numerous cases have looked to such instructions as the key determinant in surrogate decisionmaking.⁴⁷

Legislatures also respect prospective autonomy. All fifty states accord statutory protection for some form of advance medical directive.⁴⁸ Living will and advance directive laws, for example, give legal effect to the advance instructions of now-incompetent patients.⁴⁹ Durable-power-of-attorney laws allow people to designate

45. See *Bartling v. Superior Court*, 209 Cal. Rptr. 220 (Cal. Ct. App. 1984); *State v. McAfee*, 385 S.E.2d 651 (Ga. 1989); *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990); *In re Farrell*, 529 A.2d 404 (N.J. 1987).

46. See BEAUCHAMP & CHILDRESS, *supra* note 1, at 142-46; GERALD DWORKIN, *THE THEORY AND PRACTICE OF AUTONOMY* (1988).

47. Some cases see prospective autonomy as grounded in the competent patient's constitutional right to reject medical intervention. See *Gray v. Romeo*, 697 F. Supp. 580, 586 (D.R.I. 1988); *Rasmussen v. Fleming*, 741 P.2d 674, 682 (Ariz. 1987). Other cases uphold prospective autonomy as an extension of a patient's common-law prerogative to make personal medical decisions. See *In re Drabick*, 245 Cal. Rptr. 840, 853 n.20 (Cal. Ct. App.), *cert. denied*, 488 U.S. 958 (1988); *In re Estate of Longeway*, 549 N.E.2d 292, 297 (Ill. 1989); *In re Gardner*, 534 A.2d 947, 951-52 (Me. 1987).

48. See SOCIETY FOR THE RIGHT TO DIE, *REFUSAL OF TREATMENT LEGISLATION: A STATE BY STATE COMPILATION OF ENACTED AND MODEL STATUTES* (1991).

49. See David Orentlicher, *The Limits of Legislation*, 53 Md. L. Rev. 1255, 1258-59 (1994).

health-care agents to implement their advance instructions.⁵⁰ The apparent object of these legal sources — both judicial and legislative — is to respect self-determination in shaping one's own dying process.⁵¹

Some commentators challenge the notion of prospective autonomy.⁵² They question the validity of choices made well in advance of incapacity and perhaps without a full understanding of and deliberation over the range of possible medical conditions and outcomes. They also contend that the interests that shape a declarant's advance instructions — in avoiding indignity, in avoiding the frustration of helplessness and debilitation, and in sparing loved ones from emotional and financial burdens — become largely irrelevant once incompetent patients no longer can appreciate violations of their prior choices.

Nonetheless, the overwhelming weight of judicial and legislative sentiment endorses prospective autonomy. The explanation is simple and understandable. People have a strong interest in shaping their own version of a dignified dying process regardless of whether they actually experience the feared degradation. Many adults have witnessed the demise of a loved one and can envision a level of debilitation that they deem intolerably undignified. People care about their lifetime image, which includes the memories left behind during the dying process.⁵³ They wish to imprint their values — whether grounded in religion, a personal vision of dignity, or solicitude toward loved ones — on their end-of-life story. Prospective autonomy therefore protects important interests in self-definition and self-determination.⁵⁴

Even if prospective autonomy is a meaningful concept, what about the incompetent person who never articulated her choices? Her surrogate's decision cannot invoke genuine autonomy — genu-

50. *Id.* at 1259-60.

51. "The principle of respect for persons, which supports respect for the autonomous patient's choices, also supports reliance on the nonautonomous person's prior autonomous directives." James F. Childress, *Dying Patients: Who's in Control?*, 17 *LAW MED. & HEALTH CARE* 227, 228 (1989).

52. See Dan W. Brock, *Trumping Advance Directives*, HASTINGS CTR. REP. Sept.-Oct. 1991, Special Supp., at S5; Rebecca S. Dresser, *Missing Persons: Legal Perceptions of Incompetent Patients*, 46 *RUTGERS L. REV.* 609 (1994); Rebecca S. Dresser & John A. Robertson, *Quality of Life and Non-Treatment Decisions for Incompetent Patients: A Critique of the Orthodox Approach*, 17 *LAW MED. & HEALTH CARE* 234, 236-38 (1989); John A. Robertson, *Cruzan and the Constitutional Status of Nontreatment Decisions for Incompetent Patients*, 25 *GA. L. REV.* 1139, 1159, 1180-81 (1991).

53. See *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 343-44, 356 (1990) (Stevens, J., dissenting); RONALD DWORKIN, *LIFE'S DOMINION* 201-17 (1993); Harris, *supra* note 23, at 6, 14.

54. For a more elaborate defense of prospective autonomy and discussion of its bounds, see NORMAN L. CANTOR, *ADVANCE DIRECTIVES AND THE PURSUIT OF DEATH WITH DIGNITY* 23-32, 122-34 (1993).

ine autonomy demands a personalized weighing of medical options in light of personal values and preferences.⁵⁵ Nonetheless, the applicable legal norms in this context recognize a close relation between patient choice and surrogate decisionmaking. Both of the common standards governing decisionmaking on behalf of formerly competent patients — “substituted judgment” and “best interests” — display strong preoccupation with the patient’s putative desires even when she never prepared advance instructions.

The substituted-judgment standard seeks to reach the same decision that the patient would reach if competent and cognizant of the circumstances. That objective — seeking to project and replicate what the patient would want — reflects the law’s pervasive interest in respecting personal choice. Actual patient choice is impossible in the absence of prior instructions; however, the substituted-judgment approach serves the patient-choice goal by examining the patient’s personal value system, including her “philosophical, religious and moral views, life goals, values about the purpose of life and the way [life] should be lived, and attitudes toward . . . suffering and death.”⁵⁶ Some versions of substituted judgment authorize a surrogate decisionmaker to use such data in order to make a best approximation of what the patient would want, if competent.⁵⁷

The substituted-judgment standard thus seeks to treat the formerly competent patient as an individual with moral dignity whose putative preferences matter.⁵⁸ By allowing a surrogate to consider a range of possible dispositions, from vigorous medical intervention to merely palliative care, it preserves the same range of options that would be available to a competent patient. In so doing, the substituted-judgment approach underlines the equivalence in stature between the now-incompetent person and her former competent self. Also, by striving to discern her likely wishes, the formula seeks to preserve the autonomy rights that the formerly competent patient no longer can exercise.⁵⁹

55. See *In re Conroy*, 486 A.2d 1209, 1231 (N.J. 1985).

56. *In re Estate of Longeway*, 549 N.E.2d 292, 299-300 (Ill. 1989).

57. See *Matter of Tavel*, 661 A.2d 1061, 1068-69 (Del. 1995); *Longeway*, 549 N.E.2d at 299-300; *Brophy v. New England Sinai Hospital*, 497 N.E.2d 626, 631-32 (Mass. 1986); *In re Spring*, 405 N.E.2d 115 (Mass. 1980); *In re Grant*, 747 P.2d 445, 456-57 (Wash. 1987); *In re Colyer*, 660 P.2d 738 (Wash. 1983).

58. See John A. Robertson, *Organ Donations by Incompetents and the Substituted Judgment Doctrine*, 76 COLUM. L. REV. 48, 63 (1976).

59. Notice how two of the earliest decisions involving incompetent patients stressed the goal of preserving a competent patient’s right to choose: “The only practical way to prevent destruction of the right [to reject treatment] is to permit the guardian and family of Karen to render their best judgment . . . as to whether she would exercise it in these circumstances.” *In re Quinlan*, 355 A.2d 647, 664, cert. denied, 429 U.S. 922 (1976). The *Saikewicz* court noted:

The problem with the substituted-judgment standard lies in its administration, especially in the absence of prior, considered instructions. Reliance on value-related or character-related data about the patient may engender uncertainty about what the patient would have wanted, if competent. To be sure, certain personal values may provide conclusive evidence of the patient's preferences. For example, a surrogate for a devout orthodox Jew or Roman Catholic who always has subscribed to her denomination's religious precepts safely can ascribe that denomination's well-developed positions regarding terminal care to the patient. Many factors commonly invoked to guide a surrogate under the substituted-judgment standard, however — such as the patient's prior attitude toward doctors, general lifestyle, and solicitude for the interests of close family — simply cannot identify the point of decline at which the patient would prefer death to continued existence.⁶⁰ Reliance on a patient's general value system, as part of a "best approximation" method for determining the patient's wishes, has prompted substantial criticism. The critics point to studies that indicate that a significant discrepancy exists between the wishes of seriously ill patients and the beliefs of their relatives as to what the patients would want.⁶¹ At best, these data suggest that some disjunction may lie between the surrogate's definition of the patient's wishes and the patient's actual, though unexpressed, wishes. At worst, they indicate that general value system or lifestyle indicia of patients' wishes leave room for surrogates to impose their own values and predispositions on patients.⁶² The ultimate specter is that surrogates, under the guise of the putative wishes of the patient, will make biased or self-interested determinations.

We think that principles of equality and respect for all individuals require the conclusion that a choice exists. . . . [W]e recognize a general right in all persons to refuse medical treatment in appropriate circumstances. The recognition of that right must extend to the case of an incompetent, as well as a competent, patient because the value of human dignity extends to both.

Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 427 (Mass. 1977).

60. See Bernard Lo, *Caring for Incompetent Patients: Is There a Physician on the Case?*, 17 LAW MED. & HEALTH CARE 214, 215-17 (1989); Nancy K. Rhoden, *Litigating Life and Death*, 102 HARV. L. REV. 375, 390-91 (1988).

61. See Linda L. Emanuel & Ezekiel J. Emanuel, *Decisions at the End of Life: Guided by Communities of Patients*, HASTINGS CTR. REP. Sept.-Oct. 1993, at 6-7; Jeremiah Suhl et al., *Myth of Substituted Judgement: Surrogate Decision Making Regarding Life Support is Unreliable*, 154 ARCHIVES INTERNAL MED. 93-94 (1994); Richard F. Uhlmann et al., *Physicians' and Spouses' Predictions of Elderly Patients' Resuscitation Preferences*, 43 J. GERONTOLOGY 115, 120 (1988); Nancy Zweibel & Christine Cassell, *Treatment Choices at the End of Life*, 29 GERONTOLOGIST 615, 618 (1989). See also sources cited in Kathryn A. Koch et al., *Analysis of Power in Medical Decision-Making: An Argument for Physician Autonomy*, 20 LAW MED. & HEALTH CARE 320, 323 n.11 (1992).

62. See Dresser & Robertson, *supra* note 52, at 235; Lo, *supra* note 60, at 216; Tracy L. Merritt, *Equality for the Elderly Incompetent*, 39 STAN. L. REV. 689, 709, 714 (1987); Rhoden, *supra* note 60, at 387.

The solution, however, is not to abandon the substituted-judgment standard's focus on putative patient wishes. Rather, it is to guard against excessive surrogate subjectivity by formulating default norms to guide and circumscribe surrogate decisionmaking.⁶³

Beside substituted judgment, the other major standard for surrogate decisionmakers is the "best interests of the patient."⁶⁴ Under one version of best interests, the surrogate seeks to assess the objective well-being of the now-incompetent patient and maintains life support unless the prospective burdens on the patient — primarily pain and suffering — appear to outweigh the benefits — pleasure and satisfaction.⁶⁵ A best-interests formula, however, can and usually does encompass more than just the observable emotions of the patient.

In its own fashion, a best-interests standard impels the surrogate to effectuate what the now-incompetent patient would have wanted, if competent. In the absence of proof about the patient's actual wishes, the best-interests standard assumes that the patient would want the same treatment that the average person in the same circumstances would want. It defines patient well-being — the key to best interests — according to understandings about the average person's definition of well-being.⁶⁶ Extreme suffering, for example, is regarded as an integral ingredient of best interests because the vast majority of people are averse to extreme suffering. Quality of life, often addressed under the rubric of patient dignity, frequently forms an element of best interests because the average person ties the two together.⁶⁷ The hope is to implement the patient's *likely*

63. For elaboration on this idea, see *infra* notes 72-78 and accompanying text.

64. Many view the two standards — substituted judgment and best interests — as part of a continuum. The surrogate starts with substituted judgment and seeks to ascertain what the patient would have wanted by considering prior expressions and other indicia. When those indicia prove indeterminate, the surrogate attempts to define the best interests of the patient. See Phillip G. Peters, Jr., *The State's Interest in the Preservation of Life: From Quinlan to Cruzan*, 50 OHIO ST. L.J. 891, 922-23 (1989); Stewart G. Pollock, *Life and Death Decisions: Who Makes Them and By What Standards*, 41 RUTGERS L. REV. 505, 518-22 (1989); Robert M. Veatch, *Forgoing Life-Sustaining Treatment: Limits to the Consensus*, 3 KENNEDY INST. OF ETHICS J. 1 (1993).

65. See Dresser, *supra* note 52, at 657 n.2, 711; Rhoden, *supra* note 60, at 398-99.

66. See NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN OTHERS MUST CHOOSE 55-56 (1992); PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING LIFE-SUSTAINING TREATMENT 136 (1983). Dan W. Brock contends that best interests "amounts to asking how most reasonable persons would decide in these circumstances." Dan W. Brock, *Surrogate Decision Making for Incompetent Adults: An Ethical Framework*, 58 MOUNT SINAI J. MED. 388 (1991).

67. See NEW YORK STATE TASK FORCE, *supra* note 41, at 77-113 (arguing that life support seems excessively burdensome for a "patient who would have viewed continued treatment as an affront to his or her dignity"); see also BEAUCHAMP & CHILDRESS, *supra* note 1, at 219. Clinical protocols — guidelines for end-of-life care prepared by professional organizations — often include quality of life as an element of best interests. See AM. MEDICAL ASSN., CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, § 2.16;

choice by having the surrogate use the same criteria and weighting of factors that most people would choose for themselves.⁶⁸ The best-interests and substituted-judgment approaches thus have a common objective — replication of what the individual patient likely would want regarding end-of-life care.⁶⁹

While the best-interests and substituted-judgment formulae share a common ethic, they also share common difficulties. Both raise the same kinds of concerns — indeterminacy and potential subjectivity in surrogate decisionmaking. For example, to the extent that the best-interests standard considers suffering as a key element, discerning the experiential reality of gravely demented patients seems a daunting, if not impossible, task.⁷⁰ Indeed, severe problems of measurement plague any surrogate seeking to determine an incompetent's level of suffering or to compare her levels of suffering and satisfaction. Likewise, imprecision nags at any quality-of-life determination as an ingredient of best interests. Some commentators dismiss quality of life — or indignity — as a subjective, value-laden notion that lacks consistency and falls prey to surrogates' biases regarding a minimally tolerable quality of life.⁷¹

In sum, the jurisprudence of surrogate decisionmaking strives to implement the actual or putative wishes of incompetent patients. Yet if we really want to implement those wishes, we must overcome

LOS ANGELES COUNTY MEDICAL ASSN. & LOS ANGELES COUNTY BAR ASSN. JOINT COMMITTEE ON BIOMEDICAL ETHICS, FORGOING LIFE-SUSTAINING TREATMENT FOR ADULT PATIENTS: PATIENTS WITHOUT DECISION MAKING CAPACITY WHO LACK SURROGATES 3 (1993); John M. Stanley et al., *The Appleton Consensus: Suggested International Guidelines for Decisions to Forego Medical Treatment*, 15 J. MED. ETHICS 129, 131 (1989).

68. See THE HASTINGS CENTER, *GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING* 28 (1987).

69. The two standards do not ignore the actual preferences of the particular patient. The substituted-judgment standard examines them before turning to a best-interests approach, and the best-interests formula often consults the patient's discernible values and preferences in defining her best interests.

70. "The real burdens and benefits of life in extremely debilitating circumstances are often beyond our ability to know confidently or comprehend fully." Peters, *supra* note 64, at 942. For a comprehensive examination of this issue, and one urging greater efforts to discern the murky reality in question, see Dresser, *supra* note 52, at 666-91. Beside Professor Dresser, many other commentators have noted the intrinsic difficulty in measuring the burdens and benefits of a severely demented patient. See John Arras, *The Severely Demented, Minimally Functional Patient: An Ethical Analysis*, 36 J. AM. GERIATRIC SOC'Y. 938 (1988); Rhoden, *supra* note 60, at 404-05; Nancy K. Rhoden, *The Limits of Legal Objectivity*, 68 N.C. L. REV. 845, 847-50 (1990); see also *In re Peter*, 529 A.2d 419, 424-25 (N.J. 1987).

71. See Lo, *supra* note 60, at 216-17; D. Don Welch, *Walking in Their Shoes: Paying Respect to Incompetent Patients*, 42 VAND. L. REV. 1617, 1636-37 (1989); *Developments in the Law — Medical Technology and the Law, Section IV: The Right to Refuse Medical Treatment*, 103 HARV. L. REV. 1519, 1652-53 (1990); cf. Yale Kamisar, *When is There a Constitutional "Right to Die"? When is There No Constitutional "Right to Live"?*, 25 GA. L. REV. 1203, 1241 (1991) (recognizing the subjective biases involved in decisions to terminate life-sustaining treatment).

the imprecision and subjectivity inherent in concepts such as intolerable indignity or quality of life.⁷² This is essential because any effective surrogate decisionmaking standard must reassure competent persons that their post-competence care will conform to their desires and expectations. Unless we achieve a common understanding of intolerable indignity, for example, a decisionmaking standard that incorporates that element will engender anxiety rather than reassurance. We need, therefore, reliable guidelines about levels of intolerable indignity to serve as a check on arbitrariness and abuse in surrogate decisionmaking.

I use the term "constructive preference" to denote an approach that surrogates may employ when making end-of-life medical decisions for formerly competent patients who left no instructions.⁷³ The object — as with much of substituted-judgment and best-interests doctrine — is to provide the medical care that the now-incompetent patient would have chosen if she had considered the issue while competent. Because the patient never exercised her prospective autonomy prerogative or provided definitive guidance with regard to her end-of-life treatment, the surrogate will do her best to determine what most people would want in the same circumstances and to treat the patient accordingly.⁷⁴ As Nancy Rhoden argues, acting on a patient's "probable desires can be equated with implementing the patient's right of choice."⁷⁵

Constructive preference rests on the premise that most people want to avoid extreme indignity in their own post-competence dying processes. Constructive preference also assumes that widespread accord exists about intolerable levels of debilitation in the dying process, and that this accord will allow for some default

72. Sanford H. Kadish comments:

How much ability to sense and take comfort from experiences is required before we can say [a debilitated patient's] life is not worth living? At bottom, the difficulty is that we have no way to make confident judgments about how far cognitive and physical deterioration must go before life ceases to be worth living, because the value judgments implicit in such a conclusion are in sharp contention in our society.

Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CAL. L. REV. 857, 882 (1992).

Rebecca S. Dresser also cites the "highly disparate meanings" dignity can have for different people. Rebecca S. Dresser, *Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373, 387 (1986).

73. I engage in a much longer and more detailed discussion of constructive preference in Norman L. Cantor, *Discarding Substituted Judgment and Best Interests: Toward a Constructive Preference Standard for Dying, Previously Competent Patients Without Advance Instructions*, 48 RUTGERS L. REV. (forthcoming 1996) (manuscript on file with author).

74. Under the prevailing autonomy ethic, a patient's actual preferences, when discernible, should govern. Therefore, constructive preference provides a fallback when a patient's history and values provide no definitive guidance to her surrogate.

75. Rhoden, *supra* note 60, at 384.

guides.⁷⁶ Of course, the array of circumstances that confront dying patients is enormous and not every patient's situation can be resolved by resort to widespread accord or consensus. At least for *some* commonly confronted circumstances, though, surrogates may find guidance in people's widely shared predilections about intolerable levels of debilitation.

Permanent unconsciousness provides the best example of consensus sufficient to trigger constructive preference. Surveys consistently show that the vast majority of people would not wish to have life support to maintain them in a permanently unconscious state.⁷⁷ Given this, a surrogate should be required to authorize the cessation of life support for a permanently unconscious patient absent significant evidence that the patient's views deviate from the common preference.⁷⁸

The constructive-preference approach raises many issues: How can we measure common preferences about indignity, given the multitude of potential death-and-dying circumstances? Whose preferences should matter in establishing a norm? What impact upon a surrogate's choice should flow from the fact that *x* or *y* percentage of people deem a particular status intolerably undignified for their own future fates?

I address only the first question here. As to data sources, people's preferences regarding post-competence medical care can be gleaned from surveys and from bulk analysis of advance medical directives.⁷⁹ While some advance directives seem cursory and uninformative, others spell out clear visions of intolerable indignity in the dying process.⁸⁰ Also, although surveys cannot anticipate the

76. Several commentators recognize the need for default positions, grounded on understandings about what most people would want for themselves, to guide decisions on behalf of incompetent patients who have not left sufficient indicia of their personal preferences. See James F. Drane & John L. Coulehan, *The Best-Interest Standard: Surrogate Decision Making and Quality of Life*, 6 J. CLINICAL ETHICS 20, 24-26, 29 (1995); James Lindgren, *Death by Default*, LAW & CONTEMP. PROBS. 1993, at 185, 186, 195, 199, 228-29; Carl E. Schneider, *From Consumer Choice to Consumer Welfare*, HASTINGS CTR. REP. Nov.-Dec. 1995, Special Supp., at S25, S27 (urging default positions for patients based on "what we think they would want if they thought about it").

77. See, e.g., Lindgren, *supra* note 76, at 231.

78. Other commentators favor this kind of a presumption in the case of permanently unconscious patients. See Marcia Angell, *After Quinlan: The Dilemma of the Persistent Vegetative State*, 330 NEW ENG. J. MED. 1524 (1994); Michele Yeun, *Letting Daddy Die: Adopting New Standards for Surrogate Decisionmaking*, 39 UCLA L. REV. 581, 623 (1992); Schrode, *supra* note 26; Bernard D. Davis, *Right to Die: Living Wills are Inadequate*, WALL ST. J., July 31, 1990, at A12.

79. See Emanuel & Emanuel, *supra* note 61, at 6; Lindgren, *supra* note 76.

80. See Norman L. Cantor, *My Annotated Living Will*, 18 LAW MED. & HEALTH CARE 114 (1990). Some advance directives utilize values histories or values profiles to provide guidance about intolerable levels of debilitation. See CANTOR, *supra* note 54, at 166-70; Ezekiel Emanuel & Linda L. Emanuel, *Living Wills: Past, Present, and Future*, 6 J. CLIN. ETHICS 9, 15-16 (1990); Linda L. Emanuel, *Structured Deliberation to Improve Decisionmaking for the Seriously Ill*, HASTINGS CTR. REP. Nov.-Dec. 1995, Special Supp., at S14; Pam

multitude of circumstances that will confront incompetent patients, they can utilize scenarios that reflect a range of commonly occurring conditions in the dying process.⁸¹

Constructive preference assumes, in the end, that default presumptions can be anchored in objectively measurable data about the level of mental and physical debilitation that most people consider intolerably undignified and therefore unacceptable. It assumes that we can establish guidelines or presumptions for certain commonly occurring conditions. When a large majority of people would prefer withdrawal of life support, a surrogate should implement the popular preference and withdraw life support, unless significant indicia in the particular patient's history indicate that the patient would prefer otherwise. Default principles would have to receive wide publicity, so that any person whose preferences differed from the default position could issue advance instructions and avoid imposition of constructive preference. By focusing on what competent people commonly choose and reject, constructive preference discourages resort to surrogates' subjective visions about which lives are worth preserving or to any government-formulated view of minimally acceptable dignity. Moreover, by following a course that the majority of people would choose — that is, implementing the course that the now-incompetent patient would *likely* have chosen — constructive preference comes as close as possible to fulfilling the wishes of people who have never communicated their wishes or left other meaningful indicia of their preferences for end-of-life medical intervention.

CONCLUSION

Contrary to what Singer suggests, an ethic already exists in the context of death-and-dying that does not adopt a maximum extension-of-life principle. The ethic that permeates the past twenty years of jurisprudence places primacy on autonomy — both contemporaneous and prospective — and on constructive preference when a patient's actual preference cannot be determined. The contemporary ethic recognizes quality-of-life distinctions that are grounded in competent persons' choices regarding intolerable in-

Lambert et al., *The Values History: An Innovation in Surrogate Medical Decision-Making*, 18 LAW MED. & HEALTH CARE 202 (1990); Lawrence J. Schneiderman et al., *Relationship of General Advance Directive Instructions to Specific Life-Sustaining Treatment Preferences*, 152 ARCHIVES INT. MED. 2114, 2117-18 (1992).

81. See, e.g., Linda L. Emanuel et al., *Advance Directives for Medical Care — A Case for Greater Use*, 324 NEW ENG. J. MED. 889 (1991); Linda L. Emanuel & Ezekiel Emanuel, *The Medical Directive*, 261 JAMA 3288 (1989); Emanuel & Emanuel, *supra* note 61, at 6. Both scenarios and values profiles — documents asking people to identify elements of personally intolerable indignity — will permit us to learn about common attitudes toward end-of-life care.

dignity in the dying process or in surrogates' choices based on understandings of what most people would wish in similar circumstances. The challenge is not, as Singer claims, to propound a radically new ethic — although he may be right that active euthanasia ultimately will be added as an available option. Rather, the challenge is to translate the extant theory into practice. For in American institutions the sad reality continues to be that the dying process often is not what patients want — or would have wanted.⁸²

82. A large recent study seems to indicate that the dying process in many hospitals still is characterized by absence of communication between patients or surrogates and caregivers, misunderstanding about the wishes of the patient, and over-commitment to aggressive intervention. See The Study to Understand Prognosis and Preferences for Outcomes and Risks of Treatment (SUPPORT), *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients*, 274 JAMA 1591 (1995). For reactions to this study and suggestions about how to conform customary practice to ethical theory, see Bernard Lo, *Improving Care Near the End of Life: Why Is It So Hard?*, 274 JAMA 1634 (1995); *Dying Well in the Hospital: The Lessons of SUPPORT*, HASTINGS CTR. REP. Nov.-Dec. 1995, Special Supp., at S1-S36.