Treatment of the “Vegetative” Patient: The Legacies of Karen Quinlan, Nancy Cruzan and Terri Schiavo

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No man is an island, entire of itself:
Every man is a piece of the continent, a part of the main . . .
Every man's death diminishes me,
Because I am a part of mankind.

In early 2005, in the waning days of winter, Americans focused their attention upon one small, silent woman, Theresa Marie (“Terri”) Schiavo. As Terri lay unconscious in a persistent vegetative state (PVS), her husband, Michael Schiavo, and parents, Robert and Mary Schindler, fought a vicious battle in courtrooms and the news media over whether Terri should live or die. The Schindlers had for years vigorously opposed the efforts of Michael Schiavo to have Terri’s artificial nutrition and hydration terminated. Others who joined in the battle, as active participants or opinionated

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1 John Donne, Devotions Upon Emergent Occasions, Meditation XVII (1623).
2 There was some disagreement among physicians who observed her, about whether Terri was or was not in a permanent persistent vegetative state. Three neurologists, two hired by Michael Schiavo and one appointed by the court, opined that Terri was in a permanent PVS and had no chance of recovery; a neurologist and a radiologist hired by the Schindlers testified that Terri was not in a permanent PVS and could benefit from treatment and therapy. See Schindler v. Schiavo (In re Guardianship of Schiavo), 851 So.2d 182, 184-85 (Fla. Dist. Ct. App. 2003). The trial court held that Terri was in a permanent PVS, based on the testimony of the three physicians who so concluded, and this holding was affirmed on appeal. See Rebecca Dresser, Schiavo: A Hard Case Makes Questionable Law, HASTINGS CENTER REPORT, May-June 2004, 8, 8.
observers, included: disability rights advocates, the governor and legislature of Florida, the United States Congress and President George W. Bush. In addition, the national news media provided extensive coverage of every development in the conflict between Mr. Schiavo and the Schindlers, making Terri Schiavo a household name across the country.

After the Florida court issued its order authorizing Michael Schiavo, as Terri’s guardian, to terminate her feeding and hydration, and her gastrostomy tube was removed on October 15, 2003, the Florida legislature adopted House Bill 35E. That bill, which became known as “Terri’s Law,” authorized the governor to act in contravention of the court order authorizing the termination of Terri’s artificial feeding and hydration. Governor Jeb Bush then issued his Executive Order No. 03-201, pursuant to “Terri’s Law,” staying the court’s order and directing that Terri’s gastrostomy tube be reinserted and her feeding and hydration be resumed. The feeding and hydration was resumed, but Terri’s Law was subsequently found unconstitutional by the Florida Supreme Court. See Bush v. Schiavo, (Fla.Sup.Ct. No. SC04-925, Sept. 23, 2004).

The Senate (with only 3 Senators present) and the House of Representatives (with more than 100 Representatives absent) met over a weekend in March of 2005, in order to enact “An Act for the Relief of the Parents of Theresa Marie Schiavo.” That Act, P.L. 109-3, also termed the “Palm Sunday Compromise” by Republican Senators (see http://en.wikipedia.org/wiki/Palm_Sunday_Compromise), was intended to enable the Schindlers to use the federal court system in their attempt to prevent reinstatement of the Florida court order directing termination of Terri’s feeding and hydration. While the Schindlers brought their appeal to the federal courts, they were no more successful there than they had been in the Florida state courts.


America. When the Schindlers had exhausted every possible legal appeal available to them, Terri’s status remained the same: the Florida court order, directing Michael Schiavo, as Terri’s guardian, to terminate her feeding and hydration, was a valid and binding directive. Accordingly, Terri’s feeding tube was removed on March 18, 2005, and she died in hospice care thirteen days later, on March 31, 2005.9

The fact that the battle over Terri’s fate was waged in courtrooms, and that her life was placed in the hands of judges, highlights the preeminent role that the law plays as an arbiter of ethical, value-based disputes.10 Historically, decisions about the care of the sick or dying were made by families in accordance with societal customs and the guidance of spiritual advisors.11 As medical care improved and became widely accessible, physicians took on significant responsibility for these decisions.12 In recent years, law has come to play an increasingly important role in medical treatment decisions, especially in the United States and other diverse, secular societies:

We have become legalistic societies, and this change is connected to a loss of consensus on values, . . . intense individualism, and the impact of the media. Law provides a bottom-line, working consensus on values, even if in substance we still disagree. Law is also the most powerful way for individuals to challenge the state and has a very prominent role in establishing the values and symbolism of a secular society.13

In addition, law is a powerful means of ensuring protection for the most vulnerable members of society. The United States Constitution and the constitutions of the several states provide that no person may be deprived of life, liberty or property without due process of law, and that all persons are equal before the law.14 Florida’s

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12 Id.; see also, John B. Oldershaw et. al., Persistent Vegetative State: Medical, Ethical, Religious, Economic and Legal Perspectives, 1 DEPAUL J. HEALTH CARE L. 495, 496 (1997) [hereinafter Oldershaw et. al.]; see also SOMERVILLE, supra, note 10, at 11, 127.
13 See SOMERVILLE, supra note 10, at 11.
14 [N]o State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due
constitution, for example, provides as follows:

All natural persons, female and male alike, are equal before the law and have inalienable rights, among which are the right to enjoy and defend life and liberty, to pursue happiness, to be rewarded for industry, and to acquire, possess and protect property. . . . No person shall be deprived of any right because of race, religion, national origin, or physical disability.\(^{15}\)

The dispute over Terri Schiavo's treatment, like previous disputes concerning Karen Ann Quinlan\(^{16}\) and Nancy Cruzan,\(^{17}\) is paradigmatic of the way in which ethical issues relating to medical treatment are raised, explored, and resolved in this country. A lawsuit is filed in an attempt to prevent, or authorize, the termination of a particular patient's treatment—that is, the problem is introduced at the personal or micro-level of bioethics. The decision issued in that lawsuit then resonates at the institutional and societal levels of bioethical decision-making.\(^{18}\) Terri Schiavo's fate was hers alone, but her legacy may become ours. The legal decisions made concerning Terri's care are likely to affect the treatment of incompetent patients at the institutional level—in hospitals and nursing homes—in Florida and other states throughout the U.S., and to influence the rules of law adopted by courts and enacted by legislatures across the country.

The question of whether to terminate treatment provided to a patient in a vegetative state is of the utmost importance and must be carefully and thoroughly deliberated, because the end result of that deliberation could be the patient's death. Ethicist Margaret Somerville offers a helpful way to approach consideration of a bioethical dilemma by dividing it into separate questions, as follows:

1. Is the proposed act inherently wrong?
2. If not, is it ethical to proceed?
3. If so, under what conditions?\(^{19}\)

process of laws; nor deny to any person within its jurisdiction the equal protection of the laws.

U.S. CONST. Amend. XIV.

15 See FLA CONST. Art. I, § 2.
18 See SOMERVILLE, supra note 10, at 287: "We do ethics at different levels—mega or global, macro or societal, meso or institutional, and micro or individual—and the level at which we address a problem can make a difference ethically."
19 SOMERVILLE, supra note 10, at xiii-xv. Somerville stresses the importance of asking the right questions in order to reach the right and best answers to ethical dilemmas: "[W]e must ask,
This article will use these three interdependent questions to explore the appropriateness of withdrawing life-sustaining care from PVS patients in general, and from Terri Schiavo in particular, in the context of guidance provided by the judicial decisions in *Quinlan*\(^\text{20}\) and *Cruzan*.\(^\text{21}\) Guidance will also be gleaned from extra-legal sources, including bioethicists, philosophers, religious leaders, and physicians.

Part I of this article explores the first question—is it inherently wrong to withdraw life-sustaining treatment from a PVS patient—and concludes that it may be answered in the negative. The teachings of numerous ethicists, philosophers and religious leaders, together with an understanding of the nature of PVS, lead to this conclusion.\(^\text{22}\)

In order to answer the second question—whether it is ethical to withdraw life-sustaining treatment from PVS patients, Part II explores the difficulties inherent in the PVS diagnosis, the physical effects of terminating feeding and hydration, and the bioethical principles of non-maleficence and beneficence. The legal standards and conditions currently applicable to surrogate decision-making for incapacitated patients are set out in Part III. Particular attention is given to the standards enunciated in the *Quinlan* and *Cruzan* decisions, and the nature of the proof required to satisfy these standards.

Part IV summarizes the facts of Terri Schiavo’s medical trauma, diagnosis and prognosis, and provides a history of the lawsuits concerning her treatment. The nature and sufficiency of the evidence submitted in support of the petition for termination of Terri’s feeding and hydration are also examined. In addition, the legal standards discussed in Part III are applied to the facts and circumstances of the Schiavo cases. The article ends with a brief Conclusion.

It is the premise of this article that the legal standards governing proxy decision-making for incompetent patients should, in the absence of clear written or oral instructions, provide for both: (a) substituted judgment, in which a surrogate may decide to terminate treatment on the ground that this is what the patient would have chosen; and (b) the “best interest” approach, in which the termination of treatment is approved especially regarding the new science: Is it right? Is it ethical?" *Id.* at xiii.


\(^{22}\) This does not mean, however, that there are no ethicists, philosophers and religious leaders who might reach a different conclusion.
on the ground that it is, in light of several relevant factors, in the patient’s best interest. In addition, it is insisted that:

Life-sustaining treatment should never be terminated on the ground that the patient would have preferred termination, unless there is clear and convincing evidence of that preference. This clear and convincing standard would be satisfied only by substantial, reliable proof of the patient’s wishes.\(^{23}\)

Similarly, termination of treatment on the ground that it is in the patient’s best interest must be based on clear and convincing proof of the facts and circumstances supporting this conclusion.

Each and every state must be held to the same evidentiary standard in cases concerning termination of life-sustaining treatment, because the rights of the affected patient—the rights of life and liberty—are fundamental rights protected by the United States Constitution.

Part I

The question of whether to treat, and to what extent to treat, a PVS patient, has been a matter of public discussion and debate ever since Karen Ann Quinlan’s father sought in the mid-1970s to remove her from a ventilator.\(^{24}\) Prior to the middle of the twentieth century, patients who suffered from anoxia, a lack of oxygen to the brain, died before they could be revived.\(^{25}\) With advances in medical knowledge and technology, physicians could revive Quinlan and others who suffered from anoxia, but could not restore many of them to consciousness.\(^{26}\) This meant physicians had to develop a term for the condition in which these patients survived: the persistent vegetative state (PVS).\(^{27}\) It also meant that society had to examine new and difficult moral questions

\(^{23}\) A majority of state courts apply the “Clear and convincing” standard of proof in cases seeking the termination of life-sustaining treatment (see Woods v. Commonwealth of Kentucky, 142 S.W.3d 24, 44 (Ky. 2004)), but there is not a clear consensus among those courts regarding the nature, or amount, of evidence that will be needed to satisfy the standard (emphasis added).


\(^{25}\) Anoxia is defined as “Absence or almost complete absence of oxygen from inspired gases, arterial blood, or tissues . . . .” PDR Medical Dictionary 92 (2nd ed. 2000).

\(^{26}\) BRYAN JENNETT, LETTING VEGETATIVE PATIENTS DIE, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 175 (John Keown, ed., Cambridge Univ. Press, 1995) [hereinafter, JENNETT].

\(^{27}\) This term was coined by Bryan Jennett and Fred Plum. RICHARD HEDGES, BIOETHICS,
about the obligations of family, physician and society to these patients. As the New Jersey Supreme Court noted when addressing Karen Ann Quinlan’s situation, it was necessary for the court to respond to that situation, and to Mr. Quinlan’s petition, “with its most informed conception of justice in the previously unexplored circumstances presented to it.” In order to reach this “most informed conception of justice,” and to determine whether it would be inherently wrong to withdraw life-sustaining nutrition and hydration from a PVS patient, it is essential, first, to explore two threshold issues: (1) what makes an action “inherently wrong,” and (2) how does being afflicted with PVS affect a person?

According to ethicist Margaret Somerville:

[W]e can view as inherently wrong that which breaches either of two values. These values are that we must have profound respect for life, in particular human life, and we must act to protect the human spirit—the intangible, invisible, immeasurable reality that we need to find meaning in life and to make life worth living—that deeply intuitive sense of relatedness or connectedness to the world and the universe in which we live. That which fails to show respect for life, in particular human life, or puts at serious risk or harms the human spirit is inherently wrong.

These values of respect for human life and respect for the human spirit—or human dignity—are values that diverse, secular societies may well be able to agree upon as deserving of protection, even if different segments of those societies differ strongly about specific aspects of what constitutes life and what sorts of protection might be warranted. In this country, the federal Constitution provides formal recognition of the

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28 “As the capabilities of medicine evolve, the role of a patient’s particular values and beliefs become more significant.” Thomas May, BIOETHICS IN A LIBERAL SOCIETY: THE POLITICAL FRAMEWORK OF BIOETHICS DECISION MAKING 16 (Johns Hopkins Univ. Press, 2002) [hereinafter MAY]; see generally JENNETT, supra note 26.


30 SOMERVILLE, supra note 10, at xiii-xiv. Somerville proposes these values as two fundamental values that can be agreed upon by those who favor a religious or “pure mystery” approach to life and those who favor a “pure science” approach. Id. at 17-21.
value and importance of human life and human dignity, and it provides the legal basis for their protection.

In the search for an answer to the question of what makes an action inherently wrong, then, we may turn to philosophy, to natural law and to moral and religious teachings for guidance. Natural law is described by Robert Araujo, S.J., as follows:

In the Catholic tradition, natural law is... a means by which the human mind formulates legal principles that can then be applied to govern a specific jurisdiction. In the Summa Theologica, Thomas Aquinas identified natural law as those precepts that are ‘appointed by reason.’ The first principle of the practical reason is: ‘[G]ood is to be done and pursued, and evil is to be avoided.’ Aquinas noted in his discussion of the natural law that ‘other matters of law are to be ordained toward the moral common good.’ Aquinas further refined the notion of justice as being the mutuality or reciprocity shared among the members of society and essential to the dignity of each person.

Natural law, then, would guide us, as does Somerville, toward a conclusion that any act which harms human life or human dignity—or which is contrary to reason and the common good—is inherently wrong. Is terminating the life-sustaining treatment of a patient in a permanent PVS an act that would be contrary to reason and the common good? It is not an easy matter to determine whether such an act would violate natural law, a law that “is said to bind us all because we all share a human essence.” Other schools of thought may provide assistance and guidance in the pursuit of an answer to whether the termination of life-sustaining treatment violates the common good and human dignity.

Adherents of the philosophy of utilitarianism “are primarily concerned with

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31 Human dignity is protected by the Bill of Rights and the Thirteenth and Fourteenth Amendments. See Doe v. Heck, 327 F.3d 492, 512 (7th Cir. 2003); see also Fontana v. Haskin, 262 F.3d 871, 878 (9th Cir. 2001); See also Rev. John J. Coughlin, O.P., Canon Law and the Human Person, 19 J. L. & RELIGION 1, 17 (2003-04) (“The rights of... free speech, association and assembly, education of children, expression of research, and fundamental due process are all rights inherent to the dignity of each human being”).
33 JOHN ARRAS & ROBERT HUNT, ETHICAL THEORY IN THE MEDICAL CONTEXT, in BIOETHICS: HEALTH CARE LAW AND ETHICS 6, 21 (Barry R. Furrow et al., eds., 2004) [hereinafter ARRAS & HUNT].
raising the quality of our lives; they hold that we are morally obligated to increase well-being and to decrease the amount of pain and suffering in the world." The PVS patient would seem to pose an unsolvable puzzle for utilitarians: the patient's quality of life is minimal and will not change; the patient does not, according to most medical experts, experience pain and suffering; and the life of a PVS patient can often be maintained in a nursing home facility at a relatively low cost. The utilitarian school of thought does not, therefore, move us toward a resolution of this problem.

There is another school of thought, however, that does offer guidance in connection with the treatment of PVS patients: Kantianism. Immanuel Kant focused on the intent behind an action, rather than the action itself: "[I]t is the principle upon which the agent acts that is the morally decisive factor." Kant developed two "categorical imperatives" which he believed should govern all human conduct:

Kant's first "categorical imperative" is: "I ought never to act except in such a way that I can also will that my maxim should become a universal law." This principle is Kant's supreme test for the morality of our acts.... At the risk of oversimplifying somewhat, Kant's categorical imperative may be compared to the golden rule, "Do unto others as you would have them do unto you"; alternatively, "Do not do unto others what you would not have them do unto you." Kant's categorical imperative is predicated on the principle of the moral equality of all persons....

Kant's second "categorical imperative" is that one person may never treat another person merely as a means to an end, but must always treat that other person as an end in himself or herself—in other words, as an autonomous being of equal value and dignity. Out of this value and dignity arise certain personal rights and duties. First, there are "perfect" duties, with corresponding rights, the violation of which can never be morally acceptable. These perfect duties would include the duty "to refrain from unjustly harming another human being." The corresponding right would be the

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34 Id., at 12.
36 Id.
37 Id. at 13.
38 Id. at 16; see also His Holiness John Paul II, CROSSING THE THRESHOLD OF HOPE 201 (Alfred A. Knopf trans., 1994).
39 ARRAS & HUNT, supra note 33, at 14.
right to expect that one will not be unjustly harmed by others. An example of an "imperfect" duty would be "the duty to contribute to the well-being of others." This duty is an "imperfect" one because:

It is not constantly and universally binding; that is, we are not obligated or duty-bound to help everyone all the time. This is not to say that we are not still morally obligated to be benevolent; rather, ... inclination can play a legitimate role in determining whom to aid and when to aid them.

In order to determine what sort of duty is owed to the PVS patient, and whether the termination of life-sustaining treatment would be harmful to the patient's life and personal dignity, it is necessary to acquire an understanding of the physical realities of PVS. A person in a persistent vegetative state hovers between life and death. There is said to be no awareness of self or surroundings, no higher cognitive functioning whatsoever. The brain stem continues to operate, however, governing the patient's autonomic functions such as breathing, digestion, maintenance of body temperature, and blood circulation. One medical dictionary defines "vegetative" as:

Growing or functioning involuntarily or unconsciously, after the assumed manner of vegetable life; especially a state of grossly impaired consciousness, as after severe head trauma or brain disease, in which an individual is incapable of voluntary or purposeful acts and only responds reflexively to painful stimuli.

The PVS patient is not dead, but alive; is unconscious but not terminally ill.

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40 Id., at 15.
41 Id.
43 See NINDS Website, supra note 41 (giving the definition of "Persistent Vegetative State").
44 PDR MEDICAL DICTIONARY 1395 (2d Ed. 2000).
45 Mappes, supra note 41, at 121; see also, JOHN HARRIS, EUTHANASIA AND THE VALUE OF LIFE, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 7-8 (John Keown, ed., Cambridge Univ. Press, 1995) [hereinafter HARRIS] ("Persistent vegetative state is not fatal and so
Patients caught in the tragic limbo that is permanent PVS “cannot and never will be able to experience any of the events occurring in the world or in their bodies.” Dr. Bryan Jennett, one of the men who coined the term “persistent vegetative state” describes the condition as follows:

Without the thinking, feeling and motivating part of the brain these patients are unconscious, in the sense that they make no responses that indicate any meaningful interaction with their surroundings. . . . More primitive parts of the brain that are responsible for periodic wakefulness and for a wide range of reflex activities are still functioning, giving the paradox of a patient who is at times awake but always unaware. When open the eyes roam around but do not fix or follow for long, whilst the spastic paralyzed limbs never move voluntarily or purposefully. They can, however, withdraw reflexively from a painful stimulus which may provoke a grimace and a groan—but there is no evidence that pain or suffering is experienced.

A Persistent Vegetative State becomes “permanent” when it appears “very likely” that there is no chance of recovery. If the patient does not emerge from PVS within six to twelve months after the initial injury or trauma, the usual prognosis is that the condition is permanent.

Several state legislatures have adopted a statutory definition of PVS, or of long as feeding is maintained people . . . can remain alive for thirty or more years.”); See also, e.g., JOSEPH BOYLE, A CASE FOR SOMETIMES TUBE-FEEDING PATIENTS IN PERSISTENT VEGETATIVE STATE, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 190 (John Keown, ed., Cambridge Univ. Press, 1995) [hereinafter BOYLE].

JENNETT, supra note 26, at 171. [Although I lack medical training, I have had considerable experience as a patient in need of more effective pain relief, and it appears to me that the acts of grimacing, groaning and pulling back from a painful stimulus are evidence that pain is felt by the PVS patient. I fear that what is “known” about the ways in which the brain works may affect the conclusions healthcare professionals reach regarding PVS patients’ sensitivity to pain].

Maples, supra note 41, at 124-25; see also JENNETT, supra note 26, at 173-75.

Maples, supra note 41, at 124-25; see also JENNETT, supra note 26, at 173-74.

See ME REV. STAT. ANN. tit. 18-A, §5-801(s) (2005) (“Persistent vegetative state’ means a state that occurs after coma in which the patient totally lacks higher cortical and cognitive function, but maintains vegetative brain stem processes, with no realistic possibility of recovery, as diagnosed in accordance with acceptable medical standards”); see also NEB. REV. STAT. § 20-403(6) (2004); see also UTAH CODE ANN § 75-2-1103(8) (2005); VA. CODE ANN. § 54.1-2982 (2005).
Florida defines PVS as follows:

"Persistent Vegetative State" means a permanent and irreversible condition of unconsciousness in which there is:

(a) The absence of voluntary action or cognitive behavior of any kind.
(b) An inability to communicate or interact purposefully with the environment.  

The definition of PVS has made its way from medical and nursing texts to statute books for two reasons: first, disputes about the treatment of PVS patients often end up in litigation; and second, the duty owed to PVS patients is one the medical community shares with the rest of society, including its law-makers, legislators and judges. In cases such as Quinlan and Cruzan, the court becomes the ultimate legal guardian of the vulnerable, incapacitated patient. Accordingly, the legal standards governing the treatment of PVS patients must be carefully crafted and strictly and uniformly applied. These standards must serve to protect two competing rights, both of which are entitled to legal protection under the U.S. Constitution; the patient's fundamental right to life, and the patient's fundamental right of personal autonomy, which is an essential component of human dignity.

The New Jersey Supreme Court's Quinlan decision confirmed the importance of the principle of personal autonomy in connection with incapacitated patients. This principle holds that every person has the right to make an informed choice with regard to medical treatment, and can choose either to accept or reject that treatment. When a person is incapacitated and thus unable to exercise his or her right of autonomy, a court-
appointed guardian, family member or healthcare proxy must make medical treatment
decisions for that person. In Quinlan, the court held that Karen did not lose her
constitutional right of autonomy when she became incapacitated, but rather that her
father could, as her court-appointed guardian, exercise that right for her.\textsuperscript{56}

Since the holding in Quinlan, many more courts have recognized the principle
that a patient's fundamental liberty and privacy interests—which encompass the right to
exercise personal autonomy—are not lost as a result of the patient's incapacity.\textsuperscript{57} Each
time a court so holds, it is implicitly holding, as did the New Jersey Supreme Court in
Quinlan and the U.S. Supreme Court in Cruzan, that life in a permanent PVS is still
human life. In other words, the PVS patient remains a human being who is a person in
the legal sense of that word, with all the rights guaranteed to persons by the
constitutions and laws of state and federal governments. This was not something the
Quinlan court addressed explicitly, nor should it have, because no party to the litigation
argued that Karen was no longer a "person" or no longer "human." However, in
discussions among laypersons observing such cases, the term "vegetative" often is
construed to indicate someone who has become something that is less than a person and
more like a vegetable.

It is not only laypersons and casual observers who equate "vegetative" with
"vegetable." There are philosophers, ethicists and physicians who do the same. For
example, philosophy professor John Harris opines that a patient in a permanent PVS is
no longer a "person."\textsuperscript{58} He bases this opinion on the fact that PVS patients lack self-
awareness, and that self-awareness is an essential component of personhood: "A person is
a creature capable of valuing its own existence. . . ."\textsuperscript{59} Once the person's ability to value his or
her own existence has been eradicated by illness or trauma, then, pursuant to this
approach, the person no longer exists. Similarly, some argue that a total loss of
consciousness, as is believed to occur in PVS, constitutes "the death of the individual as

\textsuperscript{56} Quinlan, 355 A.2d at 647; See also Norman L. Cantor, The Relation Between Autonomy-Based Rights
("In the landmark Quinlan case in 1976, the New Jersey Supreme Court held that a competent
patient has a constitutionally protected right to decline or accept life-sustaining medical
intervention. This liberty right applied even in the context of a patient mired in a permanently
unconscious state").

\textsuperscript{57} See, e.g., In re Conservatorship of Drabick, 245 Cal.Rptr. 840 (Cal. Ct. App. 1988); In re
Conservatorship of Torres, 357 N.W.2d 32 (Minn. 1984) (cases discussed by the Supreme Court
in Cruzan); see also Cantor, supra note 55, at 38, and cases listed therein at n.9.

\textsuperscript{58} HARRIS, supra note 26, at 19.

\textsuperscript{59} Id. at 9 (emphasis in original).
This view presumes that everything that makes a human being a person (or everything that makes a person "human") resides in the brain, and only in those portions of the brain above the brain stem. Other observers conclude that, while biological functioning may continue, what constitutes humanness or personhood does not: "A person in this state [is] recognized as alive, but it is a life without human existence. The person in a persistent vegetative state has only a biological existence."61

Acceptance of the view that a permanently unconscious or PVS patient has lost his or her humanness or personhood would require a corresponding conclusion that this patient has no legal rights. The Constitution and laws of the state and federal governments do not recognize different categories of human; ergo, if a PVS patient is not human, or is not a person, then he or she must be merely animal or vegetable or property. This cannot possibly be what the families of PVS patients believe them to be, nor can it be what most of society believes about these patients. The law, which often reflects and embodies principles of ethics, morality and natural law,62 has been loathe to view any part of the human body as property, even as the property of the person whose body it is.63 It would, therefore, require a radical, unprecedented shift for the law to regard persons incapacitated by PVS as something other than, or less than, human persons.

In fact, most observers and interested parties maintain that PVS patients, although seriously debilitated, are still human beings. This is the predominant viewpoint manifested in judicial opinions and in the writings of scholars, ethicists, religious leaders, and others. Professor John Finnis eloquently states the case for the enduring humanity of PVS patients:

"The human being's life is not a vegetable life supplemented by an animal life supplemented by an intellectual life; it is the one life of a unitary being. So a being that once has human (and thus personal) life

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62 SOMERVILLE, supra note 10, at 10-11; see also DIETER GIESEN, DILEMMAS AT LIFE'S END: A COMPARATIVE LEGAL PERSPECTIVE, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 201 (John Keown, ed., Cambridge Univ. Press, 1995) [hereinafter GIESEN].

will remain a human person while that life (the dynamic principle for that being's integrated organic functioning) remains—i.e., until death. Where one's brain ... has been so damaged as to impair or even destroy one's capacity for intellectual acts, one is ... [a] damaged human being. ... In sustaining human bodily life, in however impaired a condition, one is sustaining the person whose life it is. In refusing to choose to violate it, one respects the person in the most fundamental and indispensable way.  

Neuropsychologist Malcolm Jeeves writes of the apparent connection between body, mind and soul in humans, and states that: “neuropsychology stresses the unity of the human person.”  

Dr. A.A. Howsepian offers a way of viewing the human person as a being having both body and soul:

What distinguishes a human body from a non-human body is not that one is ensouled matter and the other is not, but that the human body is essentially ensouled with a rational soul—a kind of soul some of whose activities are, of necessity, not related to the body. ... [H]uman persons are essentially soul-body composites ...

In addition, many religious traditions regard the permanently unconscious person as one who is still fully human and still deserving of respect, care and compassion. One Jewish scholar and physician expresses this position as follows:

Life is of enormous significance. We dare not deliberately extinguish even a brief moment of life, even if this life is of poor quality. ... [L]ife has intrinsic value, independent of what can be accomplished, and we are cautioned not to trifle with even tiny quanta of life, even if to our mortal perception this life serves no obvious purpose.

Another Jewish physician and scholar, Dr. Muriel R. Gillick, offers this 

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64 JOHN FINNIS, A PHILOSOPHICAL CASE AGAINST EUTHANASIA, in EUTHANASIA EXAMINED: ETHICAL, CLINICAL AND LEGAL PERSPECTIVES 32 (John Keown, ed., Cambridge Univ. Press, 1995) [hereinafter FINNIS].  
The principle of the sanctity of human life is at the centre of traditional Jewish thinking. People are to be valued because they are human, and not merely in accordance with their talents, wealth, or contributions to society. The focus on the sanctity of life implies that those with severe dementia should be treated with respect and care. This includes being kept warm, being offered food and drink, being kept clothed, and being treated with gentleness and kindness.68

There is also a profound respect for human life in the Islamic faith, and a belief that life is a sacred gift or trust from Allah.69 Buddhist teachings stress the importance of pursuing and practicing the virtue of loving kindness toward all living beings.70

The Roman Catholic Church also acknowledges the humanity and value of every person, no matter how damaged or defective. John F. Kavanaugh, S.J., explains the Church’s position as follows:

At no time over the span of a human’s life does he or she become a “vegetable.” A human is always a person, no matter what the stage of diminishment. The pope’s position is that a human person is a “kind” of being, not a set of activities or performances. Nor is the person reducible to the higher cognitive faculties.71

Pope John Paul II spoke many times, and in many settings, on the subject of the obligations each person owes to his or her fellow human beings. In Crossing the Threshold of Hope, John Paul II related Kantian ethics to Jesus’ “commandment of love.”72

We are just to a person if we love him... Love for a person excludes the possibility of treating him as an object of pleasure. This is a principle of Kantian ethics and constitutes his so-called second imperative. This imperative, however, is negative in character and does not exhaust the

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70 THICH NHAT HAN, LIVING BUDDHA, LIVING CHRIST (1995).
72 “This is my commandment: Love one another as I love you.” JOHN 15:12
entire content of the commandment of love... In fact, the
commandment of love... requires more; it requires the affirmation of the
person. 73

In March of 2004, John Paul II issued a statement declaring “The sick person in
a vegetative state, awaiting recovery or a natural end, still has the right to basic health
care (nutrition, hydration, cleanliness, warmth, etc.) . . .”74 This statement, with the
remainder of the speech in which it appeared, does not require a patient to accept
artificially provided food and water in all circumstances, but rather requires caregivers to
provide food, water, and the basics of care to all who are in need of them. In that same
speech, the Pope stressed that we are morally obligated to recognize “the intrinsic value
and personal dignity of every human being . . .”75

In light of these teachings of different religions, philosophers and ethicists,
which have several significant similarities, it may reasonably be concluded that a patient
in a permanent PVS is still fully human, with a human life and a human spirit that are
worthy of acknowledgement and respect. The question remains, however, whether the
termination of that patient’s artificial nutrition and hydration (ANH) would in all
instances violate the patient’s rights to life and personal dignity. It is possible that, in
some instances, termination of ANH may be the correct medical, moral and legal course
of action.76

ANH is used when a patient cannot swallow on his or her own. While some
PVS patients retain the ability to swallow and can be spoon-fed, many others must rely
on ANH for their survival.77 The two primary means of providing ANH are the

73 John Paul II, CROSSING THE THRESHOLD OF HOPE, supra note 37, at 201 (emphasis in
original).
74 Address of John Paul II to the Participants in the International Congress on “Life-Sustaining
Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas,” March 20, 2004, at
75 Id. In March of 2005, nearing the end of his own life, John Paul II acquiesced to the insertion
of a tube into his abdomen for the provision of food and water. Unlike Terri Schiavo, John Paul
II was conscious and able to make decisions for himself in his final days. He died on April 3,
2005. See Ian Fisher, Elisabeth Rosenthal et. al, John Paul II: The Overview: As His Church Prays,
Weakened Pope Nears Death, N.Y. TIMES, March 31, 2005, at A1; see also Editorial, Pope John Paul II,
Keeper of the Flock for a Quarter of a Century, N.Y. TIMES, April 2, 2005, at 46.
76 See, LYNN & CHILDRESS, supra note 41, at 294.
77 Swallowing is an autonomic function controlled by the brain stem, which explains why some
PVS patients are able to swallow food and water. See The Multi-Society Task Force on PVS,
nasogastric tube, which is inserted through the patient’s nostril and runs down through the throat and esophagus to the stomach, and the gastrostomy tube, which is surgically inserted through the patient’s abdomen and into the stomach. Both the nasogastric tube and the gastrostomy tube can be yanked out of place by a fitful patient; neither tube is guaranteed to be discomfort-free. Since some of the medical definitions and discussions of PVS suggest the possibility that a PVS patient may experience pain, this must be accounted for by those making treatment decisions for these patients, and appropriate pain relief must be provided to prevent suffering.

There are some cases in which the nutrients necessary to sustain life cannot be properly absorbed and utilized by the patient’s body. In those cases, the continuation of ANH is not medically appropriate because it cannot improve the patient’s condition and it would, instead, actually worsen that condition and cause severe pain. Even if it is true that a PVS patient experiences no pain, the burdens of ANH on the patient’s body in such a situation would far outweigh its benefits. The imposition of ANH under such circumstances would constitute cruelty rather than care, violating the values of respect for life and human dignity, and would therefore be morally and ethically repugnant.

The quality of a person’s life, from that person’s own perspective, and the health of a person’s human dignity depend, in ordinary circumstances, upon a plethora of factors. In the extraordinary circumstance where a person is living in a state of permanent PVS, that person’s human spirit, if it has survived at all, has no way of communicating with the world around it. This closing off of the patient from his or her environment would be particularly striking and saddening. For a particularly shocking and saddening instance of this, see Alicia R. Ouellette, When Vitalism is Dead Wrong: The Discrimination Against and Torture of Incompetent Patients by Compulsory Life-Sustaining Treatment, 79 Ind. L. J. 1 passim (2004) [hereinafter Ouellette].


79 See Lynn & Childress, supra note 41, at 293. In addition, patients can be provided with hydration and some nutrients intravenously in emergency situations. In some situations, where difficulties have ensued with the nasogastric or gastrostomy tube, doctors may have to use a j-tube which is surgically inserted through the abdomen directly into the jejunum of the small intestine, or a catheter inserted into one of the main arteries in the chest. Id.

80 See, Lynn & Childress, supra note 41, at 293-94; see also Gillick, supra, note 67, at 14.


82 For a particularly shocking and saddening instance of this, see Alicia R. Ouellette, When Vitalism is Dead Wrong: The Discrimination Against and Torture of Incompetent Patients by Compulsory Life-Sustaining Treatment, 79 Ind. L. J. 1 passim (2004) [hereinafter Ouellette].

83 Id.

84 See Lynn & Childress, supra note 41, at 295; see also Mapes, supra note 41, at 123-24.
her environment, family and friends adversely affects the quality of the patient’s life.\footnote{85} That does not mean, however, that this patient’s life is of any less value, or has any less innate dignity, than any other human life. In such a tragic circumstance, we must treat the PVS patient in a way that pays respect to the person, and to the human spirit that was once an integral part of that person. This is essential not only for the patient, but for the healthcare professionals treating that patient, for the patient’s family and surrogate decision-maker, and for the rest of society.\footnote{86}

There is present in most persons some desire, or sense of obligation, to treat the sick and needy among us.\footnote{87} Perhaps this is the influence of natural law; perhaps it is simply our sense that we would want others to care for us in time of illness or need. Whatever its genesis might be, this sense of obligation is universal, as is the expectation that fulfilling the obligation will be a benefit not just for the person who needs care or assistance, but also for the caregivers and the community at large.

The care of a person in need ordinarily includes an intention to maintain solidarity with that person. That intention manifests love and respect for the person in need, and the benefit it anticipates is interpersonal, a good realized not only in the person cared for but within the community of patients and caregivers.\footnote{88}

It is arguable that the philosophers and ethicists who have so long labored over the question of whether PVS patients are or are not human have been asking the wrong question. Perhaps the question that needs asking is “What does it mean to be human when one is healthy and fully conscious, and has responsibility for the care of someone less fortunate?” The way in which a society treats the most vulnerable of its members does not determine whether those unfortunates are fully human or are equal to others in society.\footnote{89} Instead, it merely reveals that society for what it is, and exposes the extent to

\footnote{85} See generally, discussion regarding patient Julia Tavalero, infra p. 28.

\footnote{86} Witness, for example, the strong, widespread reactions among every element of American society to Terri Schiavo’s plight.

\footnote{87} The desire, indeed compulsion, to help one’s neighbors is an innate and irrepressible human characteristic. One example of this is the behavior of the many persons in and around the World Trade Center on September 11, 2001, who went out of their way, even in their own distress, to help others who were injured, lost, or in distress.

\footnote{88} BOYLE, supra note 44, at 194.

\footnote{89} An extreme example of this would be Nazi Germany. The Nazi regime’s treatment of Jews, “gypsies,” mentally retarded and mentally ill persons, homosexuals, and others it deemed persons of lesser value than themselves made the Nazis and those who voluntarily assisted them more beastly than ordinary humans. The Nazis’ policies and practices did not, on the other hand, alter
which it does or does not value human life in all its variety of conditions and capabilities. There is a real and grave risk that, in treating PVS patients as less than human, or in acquiescing to such treatment of these patients, the rest of us would be doing great harm to ourselves, to the value of human life in general, and to the collective human spirit or sense of integrity.

A patient rendered unconscious by PVS is entitled to the rights of life, liberty, and autonomy, as is any other person in this country. The recognition and enforcement of these rights is necessary to protect the vulnerable patient, and to prevent erosion of society’s moral bedrock—to protect the “moral common good.” This does not mean that life must be preserved at any and all costs, however. It means that the patient’s own wishes about the provision or termination of treatment must be honored, if those wishes were made clearly known. It means that the patient must be treated in a way that will not cause pain, suffering, or grave indignity. Because the patient has the right to reject treatment in favor of a natural death, and to be free from pain, the withdrawal of ANH from a PVS patient is not, therefore, inherently wrong in any and all situations. Any decision to continue or terminate the provision of ANH to a PVS patient must be made in light of the patient’s human and legal rights, and in compliance with ethical considerations.

Part II

While it may not be inherently wrong to terminate the feeding and hydration of a PVS patient, there are several key factors to consider when determining whether it is ethical to do so in a given situation. First, it must be recognized that there is a problem with the PVS diagnosis: it is a difficult one to make, and doctors sometimes get it wrong. There is no test that doctors can administer to determine whether a patient is or is not in a vegetative state. Instead, the diagnosis relies on clinical observation, which requires time and expertise. A lack of behavioral norms and responses is deemed to indicate a lack of consciousness. This means that a person who is unable to voice or otherwise indicate a response to questions, due to physical impairment, could be deemed

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the innate and essential humanness and dignity of their victims.
90 See generally THOMAS AQUINAS, SUMMA THEOLOGICA; see also Araujo, supra note 32.
91 See, e.g., BOYLE, supra, note 44, at 190 (if it is true that PVS patients experience no pain, then the pain and discomfort that a nasogastric tube or other form of ANH can cause is of no relevance).
92 Oldershaw et. al, supra note 12 at 496.
93 Mappes, supra note 41, at 122; Oldershaw et. al, supra note 12, at 498 and 500.
unconscious. Furthermore, it is not entirely clear that all PVS patients are completely lacking in awareness; it is possible that there is a continuum of awareness levels in PVS patients, from none at all, to some uncharted demarcation below full awareness. Many physicians describe PVS as a condition in which patients respond to noxious or painful stimuli. If they are indeed reacting to the noxiousness or painfulness of the stimuli, this would appear to indicate that some degree of awareness survives in the PVS patient.

Errors in connection with the diagnosis of coma or PVS are not common, but neither are they rare. Studies have found errors in the initial diagnosis, and also in the prognosis of permanence. There are some startling stories of misdiagnosis and recovery. For example, Ms. Rus Cooper-Dowda was misdiagnosed with PVS in 1985. She was not in a vegetative state, but was instead fully conscious, unable to speak, and almost totally paralyzed. She attempted to communicate with nurses and doctors by blinking at them and tracing letters in the air with her fingers. Her efforts, however, went largely unnoticed, or were misunderstood. As she lay in her hospital bed trying to memorize everything she saw and heard so that she could prove, once able, that she had never lost consciousness, Cooper-Dowda observed: “a ‘school’ of doctors in their white coats planning when to disconnect my ventilator and feeding tube.” One nurse finally recognized that Cooper-Dowda was trying to communicate, helped her to write out her messages by putting ink on her fingertips and holding a pad of paper for her, and notified physicians that the patient was conscious. Even then, that nurse had to work aggressively to convince the physicians that their diagnosis of Cooper-Dowda was wrong.

Another startling example of misdiagnosis is that of Julia Tavalero, who told her

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94 See, A. Shiel et al., Difficulties in diagnosing the vegetative state, 418 BRITISH J. OF NEUROSURGERY 5, 5 (2004).
95 Mappes, supra note 41, at 123, 134; see also Howsepian, Taskforce, supra note 80, at 4, 14.
96 Oldershaw et. al., supra note 12, at 501-02; see also PDR, supra note 25 (giving definition of PVS).
97 Howsepian, Taskforce, supra note 93, at 21-22.
98 Id.
100 Id.
102 Cooper-Dowda, supra note 97.
story in the book, Look Up for Yes.\textsuperscript{103} Ms. Tavalero suffered two massive strokes in quick succession when she was just thirty-one years old. For a year, she lay in a coma. When she awoke, she was fully conscious but had no physical control over anything but her eye muscles. She could see and hear and comprehend what was happening around her, but could not speak or move. Doctors concluded that she was in a PVS, and their error was not discovered for six years. After six years of inhumane treatment at the hands of healthcare personnel who assumed she was unconscious and unaware of everything, including pain, Julia received a visit from a young speech therapist who asked her a simple question and instructed her to “look up for yes.” To the therapist’s astonishment, Julia responded appropriately, and set in motion a course of action that would change her life dramatically for the better. Once Ms. Tavalero could communicate with those around her, she received improved care and pain management, and was eventually treated with the respect and compassion that was her due.\textsuperscript{104}

These stories are dramatic, and they are not the norm, but neither are they the only stories of this sort that exist.\textsuperscript{105} Medicine, like any other human endeavor, is not infallible. This is painfully clear when it comes to a condition as complex as PVS. While magnetic resonance imagings (MRIs) and other technology can assist physicians in the diagnosis of PVS, these tests are not definitive, and the diagnosis remains a difficult and uncertain one.\textsuperscript{106} For this reason, every possible test and diagnostic tool should be brought to the aid of a PVS patient before the cessation of treatment is considered.

When a choice must be made between continuation or termination of medical treatment, the bioethical principles of non-maleficence and beneficence are called into play. First, non-maleficence requires that physicians “do no harm” to their patients.\textsuperscript{107} This is a minimal, negative standard, one which prohibits the physician from making the patient’s condition worse, or causing the patient unnecessary pain or anguish. This principle is an ancient one, and has since the time of Hippocrates governed the doctor-

\textsuperscript{103} See generally JULIA TAVALERO & RICHARD TAYSON, LOOK UP FOR YES (Penguin Books, 1998).
\textsuperscript{104} \textit{Id.} Arlene Kraat was that young linguist who first spoke with Julia and then worked with her to facilitate her communication with others.
\textsuperscript{105} See, e.g., Adam J. Hildebrand, \textit{Masked Intentions: The Masquerade of Killing Thoughts Used to Justify Dehydrating and Starving People in a “Persistent Vegetative State” and People with Other Profound Neurological Impairments}, 16 ISSUES L. & MED. 143, 151-52 (2000).
\textsuperscript{106} William J. Winslade, Ph.D., J.D., \textit{Research on Minimally Conscious Patients: Innovation or Exploitation?} 19 J. HEAD TRAUMA REHABILITATION 178, 178 (2004) (“Researchers understandably want to know more about the relationship between brain states and consciousness. Magnetic resonance imagings (MRIs) and positron emission tomography (PET) scans may help reveal more about the brain/consciousness connection”).
\textsuperscript{107} See GIESEN, \textit{supra} note 61, at 201, 202.
patient relationship:

According to the principle *neminem laedere*, or non-maleficence, a doctor ought not to inflict evil or harm or bring his patients into the risk of evil or harm. The law closely reflects this position, imposing civil and sometimes criminal sanctions for failure to exercise due care in the performance of medical procedures. . . .

The ethical principle of non-maleficence correlates to the natural law principle that evil is always to be avoided, to Kant’s first categorical imperative (“do not do unto others what you would not have them do unto you”), and Margaret Somerville’s principle proscribing any action that would harm human life or the human spirit. In connection with a patient who is in a permanent PVS, this principle, in its various guises, seems to require only that nothing be done to worsen the patient’s medical condition.

Beneficence demands more than non-malefiance. It is an affirmative ethical principle that demands positive action to alleviate the patient’s suffering and to improve the patient’s condition if possible. It correlates to the natural law principle that good is a value always to be pursued, and to Kant’s second categorical imperative. Once a physician-patient relationship is established, the principle of beneficence requires the physician to treat the patient in accordance with the patient’s wishes for the patient’s benefit. If what the patient wants is to be allowed to die, it is necessary to ask whether life is always a good or benefit, and death is always a harm or evil.

If death is regarded as something that is always evil and life is always a benefit to be pursued at all costs, then an act or omission that leads to the death of a patient, or fails to prevent that death, will always violate the principles of non-maleficence and beneficence. If, however, death is regarded as a natural part of the life cycle, or as an event to be welcomed as the gateway to a better after-life, then the prevention of death is not mandated by these ethical principles. For Christians, Jews, Muslims and others who believe that life on earth is followed by an after-life spent at peace with God/Yahweh/Allah, death is not necessarily an evil.

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108 Id.
109 See generally Araujo, supra note 32.
110 Id.
111 See Part I, infra.
112 See MAY, supra note 28, at 94-96.
113 See Woods v. Commonwealth of Kentucky, 142 S.W.3d 24, 49 (2004):

These authorities are consistent with the Judeo-Christian-Muslim belief that
The pursuit of the spiritual goods of life is intimately connected with human life in that physical existence affords one the opportunity to enter into communion with God through engaging others in human relationships. One is able to love God in the context of human life by loving others as oneself. ... Applying this understanding to PVS patients suggests that the duty to protect and to preserve their lives has ceased. Because these patients have reached a point where their ability to pursue the spiritual goods of life has been totally eclipsed, the best treatment is no treatment.\textsuperscript{114}

Death may be viewed as good when a minimally conscious patient is experiencing unbearable pain that cannot be relieved by safe doses of morphine.\textsuperscript{115} If a person whose entire life has been devoted to something he or she can no longer enjoy—whether a career or relationships with children and grandchildren—because of the effects of PVS, then perhaps death would, in that person’s opinion, be a benefit rather than harm, or at least more good than evil. And if life-sustaining treatment is imposed upon a PVS patient despite the existence of clear and unambiguous statements requiring otherwise, then the life of that patient would not be “good” and that patient would, though alive, be seriously harmed by the lack of respect afforded his or her right of self-determination.

There may be times, therefore, when the termination of ANH would be morally and ethically permissible:

[T]hey are few and limited to the following three kinds of situations: 1. The procedures that would be required are so unlikely to achieve nutritional and fluid levels that they could be correctly considered futile; 2. the improvement in nutritional and fluid balance, though achievable, could be of no benefit to the patient; 3. the burdens of receiving the treatment may outweigh the benefits.\textsuperscript{116}

\begin{itemize}
\item there is an afterlife more desirable than the earthly one. To those who espouse that belief, it may seem more egregious to delay a natural death and the beginning of eternal life than to needlessly prolong an unnatural, artificially-maintained existence on earth.
\end{itemize}

\textsuperscript{114} MICHAEL PANICOLA, CATHOLIC TEACHING ON PROLONGING LIFE: SETTING THE RECORD STRAIGHT, in HASTINGS CENTER REPORT 21, Nov.-Dec. 2001 (emphasis in original).

\textsuperscript{115} See generally Ouellette, supra note 80.

\textsuperscript{116} LYNN & CHILDRESS, supra note 41, at 294.
According to a majority of physicians and nursing professionals, a PVS patient does not experience pain when ANH is terminated.\textsuperscript{17} If the caregivers have any concern that pain or discomfort might be experienced, then they are obligated to take appropriate measures to prevent or alleviate that pain. If they fail to do so, then the act of terminating ANH would be a heinous one, causing serious harm to the patient and everyone around the patient.

Part III

Once a determination has been made that it may be morally and ethically permissible to terminate a PVS patient's life-sustaining treatment, it must still be determined whether it is legally permissible to do so. The case of Karen Ann Quinlan was the first to bring this question to the attention of the American public.\textsuperscript{18} The opinion, issued by the New Jersey Supreme Court, deciding Quinlan's fate remains an influential source of guidance in current cases involving comatose or vegetative patients.

Karen Ann Quinlan was a young and healthy woman when, after a night of partying with friends, she passed out and suffered a loss of oxygen to her brain, which caused severe and permanent brain damage.\textsuperscript{19} Her doctors concluded that she was in a vegetative state, from which she would never recover.\textsuperscript{20} Her father subsequently sought a state court order appointing him guardian of Karen's person and property.\textsuperscript{21} In his petition, Mr. Quinlan also sought authority to have his daughter removed from the ventilator that forced air into and out of her lungs in order to keep her alive.\textsuperscript{22} Karen's attending physicians and the hospital in which she was being treated were added as parties to Mr. Quinlan's action, so they would be bound by the court's decision. The hospital and physicians had resisted removing Karen from the ventilator because to do so would not have conformed to accepted medical practices.\textsuperscript{23} In addition, the local

\textsuperscript{17} See, In the Matter of Christopher, 177 Misc.2d 352, 675 N.Y.S.2d 807, 808 (Sup. Ct., Queens, 1998).
\textsuperscript{19} Id. at 654.
\textsuperscript{20} Id.
\textsuperscript{21} Id. at 651.
\textsuperscript{22} Id. at 655.
\textsuperscript{23} In re Karen Ann Quinlan, 355 A.2d 647, 654 (N.J. Sup. 1976), cert. denied, Garger v. New Jersey, 429 U.S. 922 (1976) ("It seemed to be the consensus not only of the treating physicians but also of the several qualified experts who testified in the case, that removal from the respirator would not conform to medical practices, standards and traditions"). Since Karen had an intact brain stem, she did not meet the criteria for "brain death," which meant that then-current
county prosecutor intervened, seeking a declaratory judgment on the relevance of homicide laws in the event that Karen was removed from the ventilator and died.\[124\]

The trial court had refused to appoint Mr. Quinlan guardian of his daughter's person, precisely because he had made it clear that he intended to remove her from the ventilator.\[125\] The New Jersey Supreme Court overruled that decision, concluding that Mr. Quinlan was an appropriate person to be appointed guardian for his daughter and, as her guardian, to exercise on her behalf her right to refuse unwanted medical treatment.\[126\] The court balanced Karen's constitutionally protected right of privacy against the state's interest in preserving life, and found the state's interest wanting:

We have no doubt, in these unhappy circumstances, that if Karen were herself miraculously lucid for an interval (not altering the existing prognosis of the condition to which she would soon return) and perceptive of her irreversible condition, she could effectively decide upon discontinuance of the life-support apparatus, even if it meant the prospect of natural death. . . . We have no hesitancy in deciding . . . that no external compelling interest of the state could compel Karen to endure the unendurable . . . .\[128\]

According to the New Jersey Supreme Court, it was appropriate for Mr. Quinlan to assert his daughter's Constitutional right of privacy, which encompasses the right to refuse unwanted medical treatment, "under the peculiar circumstances here present."\[129\] "The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment . . . as to whether she would exercise it in these circumstances."\[130\]

This sort of judgment exercised on the patient's behalf, in accordance with what is thought to be the choice the patient would make for himself or herself, is commonly

\[124\] Id. at 652.
\[125\] Id. at 670.
\[126\] Id. at 671-72
\[128\] Id. at 663.
\[129\] Id. at 664.
referred to as “substituted judgment.” When substituted judgment must be relied upon, the Quinlan court held, application to a court for authority to act upon that judgment should not be necessary. Instead, the court envisioned, and mandated, the following scenario:

Upon the concurrence of the guardian and family of Karen should the responsible attending physicians conclude that there is no reasonable possibility of Karen’s ever emerging from her present comatose condition to a cognitive, sapient state and that life-support apparatus now being administered to Karen should be discontinued, they shall consult with the ‘Ethics Committee’ or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen’s ever emerging from her present comatose condition . . . the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefor on the part of any participant . . .

The U.S. Supreme Court has addressed the issue of a surrogate’s decision to terminate a patient’s life-sustaining medical treatment in only one case, that of Cruzan v. Director, Missouri Dept. of Health. Nancy Cruzan, like Karen Ann Quinlan, was a young and healthy woman when disaster struck. She was injured in an automobile accident, thrown from her car into a water-filled ditch, and suffered a loss of oxygen to the brain that left her in a PVS. Once her doctors determined that Nancy had virtually no chance of recovery, her parents sought to terminate her ANH. The medical professionals and hospital refused to terminate the ANH, however, because that would have led to Nancy’s death. The Cruzans then petitioned a state court for authority to terminate Nancy’s ANH. The trial court granted them that authority, finding that oral statements made by Nancy in the past indicated her preference not to live a life prolonged by mechanical means, and that her parents were appropriate persons to exercise on Nancy’s behalf her right to refuse unwanted medical treatment.

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131 See discussion infra Part IV.
132 Quinlan, 355 A.2d at 671.
133 Id.
135 Id. at 265-66.
136 Id. at 268.
137 Id.
138 Id.
The Missouri Supreme Court, however, reversed, holding that Nancy's parents could not terminate treatment on her behalf unless Nancy had executed a Living Will directing such action, or unless clear and convincing evidence established her preference to refuse life-sustaining treatment. It found that the evidence of oral statements submitted at trial did not satisfy the requirement of clear and convincing evidence. The Cruzans then brought their case to the Supreme Court of the United States.

The issue before the Supreme Court was whether Missouri's clear and convincing standard was an unconstitutional infringement upon Nancy Cruzan's right of self-determination. The Court held, in a five-to-four decision, that the U.S. Constitution does not prohibit Missouri from requiring clear and convincing evidence of an incompetent patient's wishes with regard to the withdrawal of life-sustaining treatment. In their Cruzan opinions, the Justices offer guidance for cases involving the termination of an unconscious patient's life-sustaining treatment.

Of particular importance is the way in which the Justices addressed the underlying question of whether the right to refuse unwanted medical treatment is protected by the federal Constitution, or is grounded solely in common law and state constitutions. According to Chief Justice Rehnquist, who wrote for the majority: "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." Justice O'Connor, in her concurrence, opined that there is "[A] protected liberty interest in refusing unwanted medical treatment . . . and that the refusal of artificially delivered food and water is encompassed within that liberty interest." And, in his dissenting opinion, Justice Stevens also recognized a right to refuse unwanted medical treatment that is grounded in, and protected by, the federal Constitution.

This recognition of a constitutionally protected liberty interest in refusing unwanted medical treatment is of importance to patients faced with undesirable treatment options. Once a liberty interest is determined to exist, however, it must be balanced against any compelling, countervailing state interests. Chief Justice

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140 Id.
141 Id. at 277.
142 Id. at 280, 284.
143 Id. at 278.
145 Id. at 331 (Stevens, J., dissenting).
146 Id. at 279 "But determining that a person has a 'liberty interest' under the Due Process Clause does not end the inquiry; whether respondent's constitutional rights have been violated must be
Rehnquist assumed, for purposes of the *Cruzan* decision, "[T]hat the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving nutrition and hydration."147 The balancing of individual right against state interest, then, was affected significantly by the fact that the patient at issue, Nancy Cruzan, was incompetent and therefore unable to exercise on her own her liberty interest in refusing treatment.148

Missouri’s general state interests, in requiring clear and convincing evidence of Cruzan’s wishes regarding treatment, were the preservation and protection of human life.149 In the case of an incompetent patient for whom someone else must decide whether treatment continues or ceases, "[A] State has more particular interests at stake."150 In order to protect the patient who is incompetent and, therefore, especially vulnerable, the state is entitled to impose “heightened evidentiary requirements”151 upon the very personal and irreversible decision to terminate life-sustaining treatment.152 This is for the benefit of the patient, whose fundamental right to life is at stake just as much as is his or her right to liberty in such cases:

It cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment. Not all incompetents will have loved ones available to serve as surrogate decisionmakers. 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.” *In re Jobes*, 108 N.J. 394, 419, 529 A.2d 434, 447 (1987). A State is entitled to guard against potential abuses in such situations.153

In discussing the clear and convincing standard, the Supreme Court observed that the purpose of a standard of proof “[i]s to ‘instruct the fact-finder concerning the degree of confidence our society thinks he should have in the correctness of factual conclusions for a particular type of adjudication.’”154 The clear and convincing standard,

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148 *Id.* at 280.
149 *Id.*
150 *Id.*, 497 U.S. at 281
151 *Id.*
152 *Id.*
154 *Id.* at 282.
an “intermediate”\textsuperscript{155} standard of proof, has been required by the U.S. Supreme Court in proceedings in which the individual interests at stake were significant, such as deportation hearings, proceedings to terminate parental rights, and civil commitment proceedings.\textsuperscript{156} In a case such as Nancy Cruzan’s, the clear and convincing standard is, accordingly, clearly permissible, since a decision by her surrogate or guardian would affect the most significant of individual rights, the right to life, or another fundamental individual right, that of personal liberty.\textsuperscript{157} Although he dissented in \textit{Cruzan}, Justice Stevens did not disagree with the Supreme Court’s conclusion about the clear and convincing standard of proof: “I agree that the underlying facts must be established with unmistakable clarity.”\textsuperscript{158}

Justice O’Connor took special note of the fact that all of the techniques used for ANH are physically intrusive, can cause the patient discomfort, and require some degree of restraint of the patient.\textsuperscript{159} As a result, these techniques violate, or at the very least burden significantly:

\ldots [T]he patient’s liberty, dignity, and freedom to determine the course of her own treatment. Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual’s deeply personal decision to reject medical treatment, including the artificial delivery of food and water.\textsuperscript{160}

In August of 2004, the Supreme Court of Kentucky issued its decision in the case of \textit{Woods v. Commonwealth of Kentucky}.\textsuperscript{161} This case concerned a patient, Matthew Woods, who was unconscious and incompetent, kept alive by ANH and a ventilator. Woods’ prognosis was the worst possible; “He remained in a state of permanent unconsciousness, a condition more severe than an persistent vegetative state, in \textit{mors interraptus}, suspended by “[M]erger of body and machine” in a limbo somewhere between cognizant life and legal death.”\textsuperscript{162}

Prior to his medical trauma, Woods resided in a group home and his affairs

\textsuperscript{155} \textit{Id.}
\textsuperscript{156} \textit{Id.} at 282-83.
\textsuperscript{157} \textit{Id.} at 283.
\textsuperscript{158} \textit{Id.} at 350 (Stevens, J., dissenting).
\textsuperscript{160} \textit{Id.}
\textsuperscript{161} \textit{Woods v. Commonwealth of Kentucky}, 142 S.W.3d 24 (Ky. 2004).
\textsuperscript{162} \textit{Id.} at 29.
were managed by the state’s Cabinet for Human Resources, because he was not mentally competent and never had been capable of making decisions or caring for himself without assistance. Mr. Woods died of natural causes before his case could be heard, but the case proceeded as one that was not moot because it presented issues “[C]apable of repetition, yet evading review.”163 The decision in this case offers detailed guidance for situations requiring others to make treatment decisions for unconscious patients, whether those patients were or were not mentally competent prior to their medical trauma or illness.

At issue in *Woods* was the constitutionality of a Kentucky statute, KRS §311.63, which authorizes a court-appointed guardian to make healthcare decisions on behalf of incompetent patients, “[I]ncluding withdrawal of life-support systems, without obtaining advance judicial approval, so long as the guardian acts in good faith and in the best interest of the patient.”164 The court held the statute constitutional, but also held that life-sustaining treatment cannot be terminated by the guardian unless there is clear and convincing evidence that the patient is in a PVS or is otherwise permanently unconscious, and either that the patient’s own choice would have been to terminate treatment or that termination of treatment is in the best interest of the patient.165

The Kentucky Supreme Court provided, in *Woods*, a thorough review of all available judicial precedent concerning withdrawal of life-sustaining treatment, including the decisions in *Quinlan, Cruzan, In re Conroy*,166 *In re Jobes*,167 *In re Conservatorship of Wendland*,168 *In re Conservatorship of Drabick*,169 and the court’s own prior opinion in *DeGrella by and through Parrent v. Elston*.170 From these precedents and its own analysis in *Woods*, the court fashioned a framework for the surrogate decision-making process concerning termination of a PVS patient’s life-sustaining treatment:

1. First, if the patient executed clear written instructions, or made clear and unequivocal statements, while competent, indicating that life-sustaining treatment should be refused or withdrawn under the extent circumstances, those instructions are to be honored.171

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163 Id., at 31.
164 Id., at 30-31.
165 Id., at 31, 44.
166 In re Conroy, 486 A.2d 1209 (N.J. Sup Ct. 1985).
168 In re Conservatorship of Wendland, 28 P.3d 151 (Cal. 2001).
170 DeGrella by and through Parrent v. Elston, 858 S.W.2d 698 (Ky. 1993).
171 Woods v. Commonwealth of Kentucky 142 S.W.3d 24, 33 (Ky. 2004) (“The explicit wishes of
2. If life-sustaining treatment is to be terminated on the ground that the patient would have opted for this course of action, then the fact that the patient would have made this choice must be established to a clear and convincing degree of certainty.172

3. If life-sustaining treatment is to be terminated on the ground that such termination is in the patient's best interest, then the facts and circumstances supporting this determination must be established by proof that is no less than clear and convincing.173

Under the court's analysis in Woods, there is a presumption that a living will or other document, lawfully executed by the patient when competent, accurately represents the patient's desires concerning the prolonging of life through artificial or mechanical means.174 However, serious, unambiguous oral statements made by the patient regarding a desire to refuse life-prolonging treatment "[A]lso carry great weight."175 When there is no unequivocal statement of preference by the patient, a surrogate may proceed to make a determination via "substituted judgment"176 or by the "best interest" standard.177 The factors to be considered in connection with substituted judgment include:

... [t]he patient's prior statements about and reactions to medical issues, and all the facets of the patient's personality that the surrogate is familiar with—with, of course, particular reference to his or her relevant philosophical, theological, and ethical values—in order to extrapolate what course of medical treatment the patient would choose.178

When the decision to terminate treatment is based on a determination that this is in the patient's best interest, the surrogate's focus must be on the welfare of the

an incompetent patient regarding extraordinary life-prolonging treatment should be respected if expressed while competent")

172 Id., at 44.
173 Id.
174 Id. at 33. This is a rebuttable presumption. Id.
175 Id.
176 Woods v. Commonwealth of Kentucky 142 S.W.3d 24, 34 (Ky. 2004); see also In re Tavel, 661 A.2d 1061, 1068-70 (Sup. Ct. Del. 1995).
177 Woods, 142 S.W.3d at 34.
178 Id. (citing In re Jobes, 529 A.2d 434, 444 (N.J. 1987)).
patient, rather than on the specific choice the patient would have made.\textsuperscript{179} In \textit{Woods}, the court acknowledged that a wide variety of factors are relevant to this determination, including, but not limited to: (1) the patient's present levels of functioning; (2) the physicians' prognosis for the patient and treatment options, if any; (3) whether the life-sustaining treatment is causing, or alternative treatment would cause, pain or discomfort to the patient; (4) the degree of dependency and loss of dignity endured and likely to be endured by the patient if life is prolonged; (5) whether withdrawal of treatment might cause pain or discomfort to the patient and the extent to which that pain can be ameliorated; and (6) the opinions of spouse and family members, factors that are preventing them from agreeing on a treatment decision, and circumstances that might be motivating certain family members to opt for either termination or continuation of treatment.\textsuperscript{180}

Not all states require clear and convincing proof of the patient's wishes or the best interest of the patient. In some states, a preponderance of the evidence or a "flexible" substituted judgment standard will suffice.\textsuperscript{181} However, it appears that a majority of states now apply the clear and convincing standard in cases such as \textit{Woods}:

A consensus has arisen among state courts that the withholding or withdrawal of artificial life-prolonging treatment is authorized only upon a finding of clear and convincing evidence that the incompetent ward or patient is permanently unconscious or in a persistent vegetative state and that the ward or patient would choose to withhold or withdraw the life-prolonging treatment if able to do so or that it would be in the best interest of the ward or patient to withhold or withdraw treatment.\textsuperscript{182}

The Supreme Court of Kentucky decided to "join the majority" because, when the evidence is less than unequivocal, it is best to err on the side of life.\textsuperscript{183}

\section*{Part IV}

In February 1990, Terri Schiavo, at the age of 27, went into cardiac arrest and

\textsuperscript{179} \textit{Id.}, at 35.
\textsuperscript{180} \textit{Id.}
\textsuperscript{182} \textit{Woods v. Commonwealth of Kentucky} 142 S.W.3d 24, 44 (Ky. 2004)
\textsuperscript{183} \textit{Id.} at 45 (citing \textit{In re Conroy}, 486 A.2d 1209, 1233 (N.J. Sup Ct. 1985)).
suffered a loss of oxygen to her brain.\textsuperscript{184} Physicians at the hospital to which she was taken revived Terri, and determined that a severe potassium imbalance had caused her cardiac arrest.\textsuperscript{185} Terri never regained consciousness, however, and her physicians diagnosed her as being in a persistent vegetative state from which she would not recover. As a result of a medical malpractice action brought by her husband Michael against the physician who had been treating Terri before her collapse, Terri was awarded approximately $1,000,000 in damages, and Michael received approximately $300,000 for loss of consortium.\textsuperscript{186} Terri’s award was placed into a trust fund for her care, and she resided primarily in nursing home facilities from that time until her death in 2005.\textsuperscript{187}

In May of 1998, Mr. Schiavo petitioned a Florida guardianship court for an order authorizing termination of Terri’s ANH.\textsuperscript{188} He alleged that Terri had given him an oral living will, stating that she did not wish to be kept alive by artificial means. In addition, Schiavo requested that the Court act as Terri’s healthcare proxy in this instance.\textsuperscript{189} In other words, he did not, as Terri’s guardian, decide to terminate her ANH, but instead asked the Court to decide whether termination would be appropriate in light of the advice of Terri’s doctors and her alleged oral living will. The guardianship court did not appoint a separate guardian \textit{ad litem} for Terri in connection with this

\begin{footnotesize}
\footnote{\textsuperscript{184} In re Guardianship of Schiavo (Schindler v. Schiavo), 780 So.2d 176, 177 (Fla. Dist. Ct. App. 2001), reh’g denied, Feb. 2001, review denied, 789 So.2d 348 (Fla. 2001) [Schiavo I].}

\footnote{\textsuperscript{185} Id.}

\footnote{\textsuperscript{186} See Schiavo I, at 178.}


\begin{quote}
For years after this happened to Terri, I tried desperately to find a cure for her.
\ldots I took Terri to California. I stayed with her while doctors performed an experimental procedure to implant electrodes in her brain to stimulate its function. \ldots I took Terri to Mediplex in Bradenton, Florida, which is a residential rehabilitation facility that specializes in brain injuries. She spent months there in intensive physical, speech, and occupational therapy and testing. \ldots Finally, the doctors told me and the Schindlers they could do nothing more for her.
\end{quote}

\footnote{\textsuperscript{188} Bush v. Schiavo, 2004 WL 2109983 (Fla. 2004).}

\footnote{\textsuperscript{189} Florida law allows the court to take on the role of healthcare proxy and make the decision as to termination of treatment. See, In re Guardianship of Browning, 543 So.2d 258, 273-74 (Fla. Dist. Ct. App. 1989); see also Schiavo I, at 178-79.}
\end{footnotesize}
proceeding, because "[i]n this context, the trial court essentially serves as the ward's guardian." 190

After a trial on the issue of whether termination of ANH was warranted, the court issued its order on February 11, 2000, directing Michael Schiavo, as Terri's guardian, to terminate her feeding and hydration. 191 In response, Terri's parents, the Schindlers, filed an appeal, which was not successful. 192 The Second District Court of Appeal found no ground for reversing the lower court: "We conclude that the lower court's decision is supported by competent, substantial evidence and that it correctly applies the law." 193 As to that evidence,  

[T]he Schindlers argue that the testimony, which was conflicting, was insufficient to support the trial court's decision by clear and convincing evidence. We have reviewed that testimony and conclude that the trial court had sufficient evidence to make this decision. The clear and convincing standard of proof, while very high, permits a decision in the face of inconsistent or conflicting evidence. . . . The testimony in this case establishes that Theresa was very young and very healthy when this tragedy struck. Like many young people without children, she had not prepared a will, much less a living will. . . . Her statements to her friends and family about the dying process were few and they were oral. Nevertheless, those statements, along with other evidence about Theresa, gave the trial court a sufficient basis to make this decision for her. 194

There was also substantial evidence concerning Terri's medical condition, which the appellate court spelled out in detail:  

The evidence is overwhelming that Theresa is in a permanent or persistent vegetative state. . . . She has cycles of apparent wakefulness and apparent sleep without any cognition or awareness . . . . Over the span of this last decade, Theresa's brain has deteriorated because of the lack of oxygen it suffered at the time of her heart attack. By mid 1996,

190 In re Guardianship of Schiavo (Schindler v. Schiavo), 780 So.2d 176, 179 (Fla. Dist. Ct. App. 2001), reh'g denied, Feb. 2001, review denied, 789 So.2d 348 (Fla. 2001) [Schiavo I].
191 Id. at 177.
192 See generally Schiavo I.
193 Schiavo I, at 177.
194 Id., at 179.
the CAT scans of her brain showed a severely abnormal structure. At this point, much of her cerebral cortex is simply gone and has been replaced by cerebral spinal fluid. Medicine cannot cure this condition.

In addition, the District Court of Appeal took special note of the fact that Michael Schiavo did not make the decision to withdraw life-sustaining treatment from Terri. Instead, because he and the Schindlers could not agree, Michael submitted the question of treatment termination to the court for resolution, in accordance with the options suggested in *In re Guardianship of Browning*. Therefore, the guardianship court itself served as Terri’s proxy and made the decision to terminate Terri’s treatment. The Florida statute relating to a proxy’s decision to terminate life-sustaining treatment is §765.401, which, at the time Michael Schiavo commenced this proceeding, read as follows:

Before exercising the incapacitated patient’s rights to select or decline health care, the proxy must comply with the provisions of §§ 765.205 and 765.305, except that 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 one the patient would have chosen had the patient been competent...

In its holding affirming the guardianship court’s order, the District Court of Appeal specifically confirmed that court’s individual rulings, as explained in a subsequent *Schiavo* decision:

In *Schiavo I*, we affirmed the trial court’s decision ordering Mrs. Schiavo’s guardian to withdraw life-prolonging procedures... In so doing, we affirmed the trial court’s rulings that (1) Mrs. Schiavo’s medical condition was the type of end-stage condition that permits the

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197 *Schiavo I*, at 178-79.

198 Fla. Stat. ch. 765.401 (2001). In 2001, long after Schiavo petitioned to court to make a determination on withdrawal of Terri’s treatment, this statute was amended to add, at the end of the paragraph: “[O]r, if there is no indication of what the patient would have chosen, that the decision is in the patient’s best interest.” 2001 Fla. Sess. Law Serv. 250 § 7 (West); 2001 Fla. Sess. Law Serv. 277 § 136 (West).
withdrawal of life-prolonging procedures, (2) she did not have a reasonable medical probability of recovering capacity... (3) the trial court had the authority to make such a decision when a conflict within the family prevented a qualified person from effectively exercising the responsibilities of a proxy, and (4) clear and convincing evidence at the time of trial supported a determination that Mrs. Schiavo would have chosen in February 2000 to withdraw the life-prolonging procedures.

After losing this appeal, the Schindlers filed several motions, appeals from decisions on those motions, and more, in an effort to prevent the termination of their daughter's ANH. On April 24, 2001, after her parents had exhausted all avenues of appeal available to them, Terri's gastrostomy tube was removed. Two days later, the Schindlers filed a motion for relief from the trial court's order on the basis of newly-discovered evidence relating to the credibility of Michael's Schiavo's testimony at trial, and evidence of a new medical treatment that offered hope of improvement for Terri. As a result, a Florida judge ordered re-insertion of Terri's gastrostomy tube pending argument and decision on the motion. While the legal battle raged on, Terri, unaware of it all, continued to receive nourishment and hydration.

The new evidence proffered by the Schindlers turned out not to offer them any legitimate hope. The witness who purportedly had information concerning the credibility of Schiavo's testimony never signed an affidavit attesting to that information and did not testify. The only new evidence on Schiavo's credibility was offered by a private investigator, hired by Mr. Schindler, who had nothing more than hearsay to offer. As to the possibility of a new medical treatment, the court noted that the Schindlers:

... [p]resented no medical evidence suggesting that any new treatment could restore to Mrs. Schiavo a level of function within the cerebral cortex that would allow her to understand her perceptions of sight and sound or to communicate or respond cognitively to those

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201 Id.
202 Id.
Accordingly, the order authorizing termination of treatment remained in place, as previously affirmed. The District Court did, however, offer the Schindlers the opportunity to file amended motion papers with the guardianship court.

The Schindlers took advantage of that opportunity, this time relying primarily on the information regarding a new medical treatment that could improve Terri's condition, and submitting physicians' affidavits in support of their motion. Once more, the trial court summarily denied the Schindlers' motion for relief from its order directing withdrawal of Terri's ANH. This time, however, the District Court of Appeal reversed one part of the lower court's order, holding:

We conclude that the Schindlers' motion for relief from judgment and the supporting affidavits state a "colorable entitlement" to relief concerning the issue of whether Mrs. Schiavo might elect to pursue a new medical treatment before withdrawing life-prolonging procedures.... [T]he motion establishes a colorable entitlement only as to the fourth issue.... —whether there was clear and convincing evidence to support the determination that Mrs. Schiavo would choose to withdraw the life-prolonging procedures.

The evidence the appellate judges found especially compelling in this regard was the affidavit of Dr. Webber. Of the several affidavits submitted, only Dr. Webber's suggested that a medical therapy exists that might be able to restore some cognitive function to Terri Schiavo, and this, the court concluded, was sufficient to raise a colorable entitlement to a hearing on the motion for relief from the order.

The District Court mandated specific procedures for the hearing on remand: (1) the Schindlers could have no more than two qualified physicians (one of whom the court expected would be Dr. Webber) testify with regard to the possibility of new treatment that might improve Terri's condition; (2) Mr. Schiavo could have two physicians of his own choosing testify in rebuttal; (3) "[T]he trial court should appoint a

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203 Id. at 560.
204 Id.
206 Id., at 645.
207 Id. at 646.
new independent physician to examine and evaluate Mrs. Schiavo's current condition; 208 (4) all five physicians would be entitled to examine Terri, order new tests such as brain scans, and obtain the results of prior tests performed on Terri; 209 and (5) all five physicians should provide written reports to the trial court. 210 Finally, with regard to the result of the hearing on remand, the court specified:

After the evidentiary hearing is held, if the trial court grants relief, it will vacate the judgment. It may then set a new trial or enter any appropriate new order. If the trial court denies the motion, it will once again need to enter an order scheduling the withdrawal of life-support in accordance with the instructions that this court provided in Schiavo II, 792 So.2d at 561. 211

The guardianship court had the benefit of written reports and testimony from five highly-qualified physicians, including the independent, court-appointed neurologist; and it had videotapes of some of the examinations, which presiding Judge Greer gave a thorough viewing. 212 The Schindlers argued not only that treatment could benefit Terri, but that the diagnosis of PVS was erroneous. On this point, the court found as follows:

Viewing all of the evidence as a whole, and acknowledging that medicine is not a precise science, the court finds that the credible

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208 Id.
209 Id.
211 Id. at 647.

At first blush, the video of Terry Schiavo appearing to smile and look lovingly at her mother seemed to represent cognition. This was also true for how she followed the Mickey Mouse balloon held by her father. The court has carefully viewed the videotapes as requested by counsel and does find that these actions were neither consistent nor reproducible. For instance, Terry Schiavo appeared to have the same look on her face when Dr. Cranford rubbed her neck. ... Also, Mr. Schindler tried several more times to have her eyes follow the Mickey Mouse balloon but without success. Also, she clearly does not consistently respond to her mother. The court finds that based on the credible evidence, cognitive function would manifest itself in a constant [sic] response to stimuli.
evidence overwhelmingly supports the view that Terry Schiavo remains in a persistent vegetative state. Even Dr. Maxfield [one of the Schindlers’ witnesses] acknowledges that vegetative patients can track on occasion and that smiling can be a reflex. 

The court denied the Schindlers’ motion for relief, because it was clear that Terri was in a permanent PVS, and because the physicians who testified concerning treatment that might improve her condition failed to support their claims with any case studies or clinical data. Accordingly, the court reinstated its order directing Michael to withdraw Terri’s ANH and designated January 3, 2003 as the date for that withdrawal.

The Schindlers appealed, and secured a stay of the order pending their appeal. The appellate court affirmed, concluding that the lower court had not abused its discretion. Because the Schindlers urged de novo review, the appellate judges thoroughly perused all the evidence, even though there was no requirement that they do so:

We have repeatedly examined the videotapes, not merely watching short segments but carefully observing the tapes in their entirety. We have examined the brain scans with the eyes of educated laypersons and considered the explanations provided by the doctors in the transcripts. We have concluded that, if we were called upon to review the guardianship court’s decision de novo, we would still affirm it.

The appellate court directed the guardianship court to proceed with a new order scheduling the removal of Terri’s gastrostomy tube, and the tube was removed on October 15, 2003.

In a matter of days, the Florida legislature passed into law House Bill 35E, or “Terri’s Law,” giving Governor Jeb Bush authority to stay the court order that had authorized termination of Terri’s ANH. Governor Bush immediately issued his

213 Id. at *3.
214 Id. at *4 ("It is clear from the evidence that these therapies are experimental insofar as the medical community is concerned with regard to patients like Terry Schiavo which is borne out by the total absence of supporting case studies or medical literature"); Id. at *5.
215 Id. at *5.
216 In re Guardianship of Schiavo (Schindler v. Schiavo), 851 So.2d 182 (Fla. Dist. Ct. App. 2003); reh’g denied, July 2003; review denied, 855 So.2d 621 (Fla. 2003) [Schiavo IV].
217 Id. at 186.
218 Id.
Executive Order No. 03-201, staying the court order, instructing the court to appoint an independent guardian for Terri, and directing that Terri’s ANH be immediately restarted. As a result, Terri’s ANH was resumed, and it continued for several months despite the fact that the Florida Supreme Court subsequently nullified “Terri’s Law” and the governor’s executive order.\(^{219}\) After a new date was set for removal of Terri’s gastrostomy tube, the Schindlers submitted a petition for certiorari to the United States Supreme Court, which summarily denied it.\(^{220}\)

The legal wrangling did not end there, however. The Schindlers sought relief from the federal district and appellate courts, and from the U.S. Supreme Court.\(^{221}\) As they persisted in their fight, they found themselves supported by prominent U.S. Senators and even the President of the United States.\(^{222}\) Despite their extraordinary efforts, the Schindlers did not prevail in their attempt to vacate the Florida guardianship court’s order authorizing termination of Terri’s ANH. Following the Supreme Court’s second refusal to review this matter,\(^{223}\) Terri’s gastrostomy tube was removed, on March 13, 2005. Her parents continued to seek review in the federal courts, including the Supreme Court, but to no avail. Terri remained in hospice care, provided with pain medication but with no food or water, and she died on March 31, 2005.\(^{224}\)

The framework used in *Woods v. Commonwealth of Kentucky*,\(^ {225}\) together with factors discussed in Parts I and II of this article, can be applied to analyze the situation in the *Schiavo* cases:

1. Terri did not make a living will, nor did she make repeated, unequivocal statements that she would refuse life-sustaining treatment if she became dependent upon it. Therefore, there is no clear instruction from Terri requiring the termination of her artificial nutrition and hydration. Were there such a clear instruction, it would have to be honored in order to protect Terri’s right of autonomy, and to prevent harm to her human dignity and integrity.

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\(^{219}\) *Bush v. Schiavo*, 885 So.2d 321 ( Fla. 2004).


\(^{221}\) For a listing of these cases, see the decisions listed *infra* note 3.

\(^{222}\) See generally notes 6 & 7, *supra*.

\(^{223}\) Schindler v. Schiavo, 125 S.Ct. 1622 (March 17, 2005).

\(^{224}\) See Abby Goodnough, *infra* note 9.

\(^{225}\) See *Woods v. Commonwealth of Kentucky*, 142 S.W. 3d 24 (Ky. 2004); see also discussion *infra* pp. 39-43.
2. The Florida courts concluded that clear and convincing evidence established that Terri, if competent, would choose to withdraw life-sustaining treatment rather than continue to live in a permanent PVS.226 The court based its order for withdrawal of treatment on this conclusion—on the basis of a “substituted judgment” that Terri would choose this course of action for herself were she able to do so.

3. The “best interest” standard was not available to the guardianship court as an alternative ground for withdrawing treatment.

In attempting to determine whether treatment should be withdrawn on the ground of substituted judgment, the proxy decision-maker must consider a myriad of factors in order to determine what the patient would decide for himself or herself. These factors include: (1) the patient’s present condition; (2) the prognosis for any chance of recovery; (3) treatment options, if any; (4) whether the patient is currently experiencing pain or discomfort; (5) whether withdrawal of life support would cause the patient pain or discomfort; (6) the degree of dependency and loss of dignity to which the patient is subjected by her condition; (7) the patient’s religious or personal beliefs; (8) probative statements made by the patient when competent about medical treatment or life-prolonging measures; (9) the opinions of the patient’s family members and close friends; and (10) circumstances that might be motivating family or friends to favor withdrawal of treatment over continuation of treatment.227


[The Health Care Decisions Act empowers surrogates to make medical care decisions for a patient based on a “substituted judgment” test. The Act authorizes individuals (in a specified order of priority) to make decisions based on their knowledge of what the patient would want in such a situation. The legislature has identified criteria upon which a surrogate may base a “substituted judgment” decision in health care matters. These broad criteria include factors such as the patient’s current diagnosis and prognosis with and without the treatment at issue, the patients expressed [wishes regarding health
Similar factors were used by the guardianship court in its initial decision authorizing the termination of Terri's ANH. As noted in the Schiavo I opinion, the guardianship court relied not just on the oral testimony regarding statements Terri made about what life-saving medical treatment she would or would not have wanted, but also on other information about Terri, including the fact that she "had been raised in the Catholic faith." The relevant information in Terri's case includes the following:

1. She was in a persistent vegetative state, unconscious and unaware of her environment and the people around her;
2. A majority of the physicians who examined or treated her concluded that Terri's PVS was permanent, and that she had no likelihood of recovery;
3. There was no treatment available that could regenerate brain cells destroyed by a lack of oxygen and subsequent deterioration relating to that lack of oxygen;
4. The consensus of medical opinion was that Terri did not suffer pain and felt little, if any, discomfort;
5. The consensus of medical opinion was that the withdrawal of artificial nutrition and hydration from a PVS patient does not cause that patient pain and at most imposes slight discomfort on the patient;
6. Terri could not voluntarily move or speak or do anything for herself. She was completely dependent on others to bathe her, change her diapers, check her for bed sores, monitor her gastrostomy tube, and so on. For many of us, this extreme dependency would be unbearable—at least, from our vantage point in the fullness of health, we assume it would be unbearable. If so, then prolonging life in this condition

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229 See generally Louis J. Sirico, Jr., Life and Death: Stories of a Heart Transplant Patient, 37 REAL PROP. PROB. & TR. J. 553 (2002). In this article, Professor Sirico reflects on his experience with serious, debilitating heart disease. He had executed an advance directive, believing he knew with certainty what he would want when facing death, but then facing death made him re-think that certainty:

In the debates over a seriously ill patient's right to terminate his or her life, one troublesome issue is often overlooked. When a patient signs an end-of-life directive or otherwise makes his or her wishes clear to others, the patient
would harm the patient's human spirit, personal integrity and sense of dignity. The fact that Terri was not aware of her situation does not mean that it caused her no harm. The pertinent inquiry is whether a fully aware and competent Terri would have found such a situation undignified and unacceptable. The court concluded that there was clear and convincing evidence she would;

7. Terri was raised Catholic, and apparently still believed in the teachings of the Catholic Church. Those teachings, as they relate to the withdrawal of life-supporting treatment, may be summarized as follows:

   a. Human life is a basic and precious good which must be protected and preserved.
   b. The moral obligation to prolong life through medical means is evaluated in light of a patient's overall medical condition and ability to carry on a spiritual life.
   c. Each person is entitled to make medical-moral decisions for herself. In the unfortunate circumstance that the patient has lost consciousness, a designated proxy should determine what is in the best interest of the patient.
   d. There is a moral obligation to prolong life with medical means when those means offer a reasonable hope of benefit, so long as they do not also impose an excessive burden on the patient.
   e. There is no moral obligation to prolong life with medical means when: (a) death is imminent; (b) there is no reasonable hope of benefit; or (c) medical treatment imposes an excessive burden on the patient.
   f. In weighing benefit and burden to the patient, it is not just the physiological dimension of life that must

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may have a different perspective than he or she might have at a later critical stage. For example, a patient may readily sign the directive when relatively healthy, but want to live as long as possible when death seems to loom.

_Id_, at 553. Unlike Terri Schiavo, however, Professor Sirico was conscious most of the time during his illness, and he could understand his situation and the treatment options available to him. Also unlike Terri, he had a good likelihood of recovery, and did in fact recover his health after receiving a heart transplant.
be considered, but also its psychological, social, and spiritual dimensions. 230

8. Testimony was introduced concerning statements Terri made to her husband and to friends about not wanting to be kept alive artificially. Contradictory testimony was offered as well, but the court concluded that the testimony indicating that Terri would prefer to terminate treatment was more probative, and that it amounted to clear and convincing evidence that her choice would be termination of treatment;

9. Terri's family members could not agree on either continuation or termination of treatment, which is why the Circuit Court for Pinellas County was authorized by Florida law to act as Terri's proxy and determine whether termination of her ANH would be appropriate;

10. Michael Schiavo, as Terri's husband, stood to inherit what remained of her trust fund from the medical malpractice suit. The Schindlers alleged that this unduly influenced Schiavo; and Schiavo countered that the Schindlers were interested in Terri's medical trust fund, too. The court concluded otherwise:

Since the resolution of the malpractice lawsuit, both Michael and the Schindlers have become suspicious that the other party is assessing Theresa's wishes based upon their own monetary self-interest. The trial court discounted this concern, and we see no evidence in this record that either Michael or the Schindlers seek monetary gain from their actions. 231

Although the courts did not mention it in their decisions, there was an additional influence that, according to the Schindlers, might have motivated Michael Schiavo in his interpretation of Terri's oral statements regarding life-prolonging treatment. Schiavo lives with a woman to whom he is engaged to be married, and with whom he has two children. 232 While this does not necessarily mean that he wished Terri

232 See the timeline on the Schindlers' website, at http://www.terrisfight.org (listing July 1997 as the time Michael announced his engagement to Jodi Centonze); See also, timeline in the entry on Terri Schiavo, at http://en.wikipedia.com.
any harm, it could have affected his state of mind. For this reason, it was essential that the trial court have testimony from witnesses other than Michael to establish what Terri's wishes regarding treatment would have been. Since the court did have such statements and found them probative, it appropriately and sufficiently guarded against relying too heavily on Michael Schiavo's testimony.

Based on the foregoing, it is reasonable to conclude that the guardianship court had clear and convincing evidence that Terri Schiavo would have chosen to terminate her artificial nutrition and hydration, had she been competent to make a decision for herself. The court had the benefit of observing the witnesses when they testified, which enabled it to judge their credibility and the relevance and probative value of their testimony. Judge Greer and his fellow judges in the guardianship court had the most painful of decisions to make regarding Terri Schiavo, but they approached their task with the necessary rigor and care, with concern for Terri's life, human dignity, and personal preferences. In this regard, the Second District Court of Appeal noted:

> [I]n the end, this case . . . is about Theresa Schiavo’s right to make her own decision, independent of her parents and independent of her husband. In circumstances such as these, when families cannot agree, the law has opened the doors of the circuit court to permit trial judges to serve as surrogates or proxies . . . . It is the trial judge's duty not to make the decision that the judge would make for himself or a loved one. Instead, the trial judge must make a decision that the clear and convincing evidence shows the ward would have made for herself. §765.401(3). It is a thankless task, and one to be undertaken with care, objectivity, and a cautious legal standard designed to promote the value of human life. But it is also a necessary function if all people are to be entitled to a personalized decision about life-prolonging procedures independent of subjective and conflicting assessments of their friends and relatives.  

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233 John F. Kavanaugh, *Killing and Letting Die, The Ethics Notebook*, AMERICA, Sept. 23, 2000, at 23 (“It is an unjust and uncharitable assumption to presume the ill will of persons by attributing the intent to kill and mercilessness to their actions. . . . Intentional killing is prohibited. But so is the presumption of evil intent”).

Conclusion

Every person residing in the United States has a fundamental right to life and a fundamental right to liberty, both of which are protected by the federal Constitution as well as by state statutory and common law. Unless proxy or surrogate decision-makers are held to clear and rigorous evidentiary standards, patients no longer able to speak for themselves could be deprived of one or the other of these rights without due process of law, or without the equal protection of the laws. A patient who is already a victim—of illness, crime, or other trauma—would be vulnerable to being twice victimized because a death for which she did not express a clear desire, or medical treatment she would not have wanted, could be imposed upon her nevertheless.

The right to life is the most vital and precious of the rights protected by the federal Constitution. This right should not be afforded different levels of protection in the different states of this nation. A patient's desire to end his or her life when in a PVS or similarly debilitated condition must be honored, but only when it can be established by clear and convincing evidence that this was in fact the patient's wish, or would clearly have been the patient's wish in light of everything that is known about the patient and his or her medical condition and prognosis. The clear and convincing evidentiary standard may be all that stands between the patient and a wrongful death. Therefore, this higher standard of proof is necessary, for the adequate protection of the patient's life. And if such proof is lacking, then the patient is entitled to continue receiving food and water.

It may in many instances be ethical and legal, theoretically, to withdraw artificial nutrition and hydration from a patient in a permanent, persistent vegetative state. It is only ethical and legal in actuality, however, when the proxy or proxies making the treatment decision for the patient adhere to rigorous standards of proof that protect the patient's life, honor the patient's spirit, and respect the patient's autonomy. The clear and convincing standard of proof—met by reliable, probative, corroborated testimony—should be applied both to "substituted judgment" and "best interest" decision-making for patients in the persistent vegetative state; and it should be the requisite standard of proof in all state courts to ensure the protection of these patients' constitutional rights.