NOTE

TWO-STEP FANTASTIC: THE CONTINUING CASE OF BROTHER FOX

This article is a sequel to the note by Richard A. McCormick, S.J., and Robert Veatch on the Eichner case.[1] They commented on the decision of Justice Robert Meade on December 6, 1979. That decision was appealed, and on March 27, 1980, the Supreme Court, Nassau County, handed down its opinion.[2]

McCormick/Veatch agree with the ruling of the trial court but not with its reasoning. Judge Meade refused to base his ruling on Brother Joseph Charles Fox's right of privacy. He did not see how anyone (courts, physicians, family, guardians) could validly exercise by proxy an incompetent patient's right of bodily self-determination. His ruling that Father Philip K. Eichner be appointed the "committee" (guardian) for Brother Fox for the purpose of ordering the respirator discontinued was based, instead, on the probative value of Brother Fox's voicing his own wishes, while competent, never to be subjected to extraordinary treatments. Thus, even if courts should, in medical decisions such as this, substitute their judgments for that of patients, Judge Meade saw no need to do so in this case. There would have been nothing extraordinary about a recognition in case law of, in effect, a "living will" without statutory legislation.

McCormick/Veatch list dire consequences to come from Judge Meade's reasoning. Positively, they appeal to substitute judgments concerning such a patient's "benefit" or "best interests." As to *who* shall make such a decision, the authors say: the family. "Familial autonomy" and "familial self-determination" should be given the initiative. For family surrogates are "normally in the best position to judge the real interests of the incompetent"; they know his "life style, preferences, and values" (presumably whether or not expressed in anticipatory self-management of that patient's dying). "The family knows those treatments that might be particularly disturbing and those that the patient may have accepted without distress in the past."

In passing, I may note this says nothing about the never-competent patient; nor do the facts evident in neonatal practice today support the view that families are usually the best judge concerning the best interest

[1] "The Preservation of Life and Self-Determination," *TS* 41 (1980) 390–96.

[2] *In the Matter of Eichner*, New York App. Div., 2nd Dept., March 27, 1980. There is in New York State a third level of possible appeal. Quotations from this decision and from the Spring case below are from manuscripts.

of such patients.[3] Society, then, does have the responsibility of assuring that the interests of its incompetent members are served. This "will place some limits on familial autonomy." Nevertheless, according to McCormick/Veatch, the state should intervene only when a familial decision "so exceeds the limits of reason that the compromise with what is objectively in the incompetent one's interest cannot be *tolerated*" (my italics). In summary, the authors defend the court's ruling by appeal to substitute familial judgments concerning what Brother Fox would have decided (in exercising his privacy right to be let alone) if he could have done so, limited only by the unreasonable and the intolerable. These are subjective standards in comparison with Brother Fox's predetermination of the manner of his own dying, to which Judge Meade gave control and on which he rested his ruling.

In practice, for a variety of reasons, decisions in cases such as that of Brother Fox are not moving in the McCormick/Veatch direction. As well they should not. An examination of the opinion of the Supreme Court, Nassau County, in the Eichner case will show this. If we continue to frame the question in terms of "privacy" and substitute judgments concerning a patient's "best interests," these are more likely to be the judgments of courts than a matter of "familial autonomy."

The Supreme Court's opinion is also an exceedingly interesting example of the confusion between allowing the dying to die and ill-defining them dead, the confusion between a competent patient's right to refuse medical treatment and an incompetent's "privacy" right to have someone else refuse it for him, the confusion between stopping treatments because the patient is not "alive, really" and stopping them because they fail now to have purpose and are only prolonging dying. The opinion also continues

[3] The wife of a graduate student in the Department of Religion at Princeton is a social worker at a medical center in the State of New Jersey, where a neonatal intensive-care unit has recently been established. They were promptly presented with a spina bifida baby. The mother wanted the baby to be "allowed to die." The physician continued to discuss the question with her in terms of "allowing to die." This language was a euphemistic cover-up; the ethics of allowing to die and only caring for the dying did not at all apply in this case. This particular baby was not dying; it was only in need of treatment. The physician knew in the medical literature of the four or five tests that Dr. Lorber of Sheffield, England, says can be applied in the first day of life in cases of spina bifida in order to decide which baby to treat, which not to treat. Dr. Lorber requires that the baby not to be treated flunk every one of these tests. In the recent case reported to me, the baby passed all but one of those tests. That baby is not in the process of dying; it is not going to die if properly treated. It will, in fact, insist on living. It is clearly inaccurate to speak in such a case of allowing to die. Treatment in this case would do far more than prolong the dying process. This baby will have to be sedated if its death is to be brought about. If anyone believes that that is the way we should go with respect to defective newborns who are judged to have less than normal or indeed very low prospect of good quality of life, it would be more merciful, surely, to do the deadly deed at once and directly.

the creeping quality-of-life substitute judgments of *Quinlan* and *Saikewicz*. The ambiguities of the late 60's, when patients were said to be "virtually dead" in the haste to salvage organs, are presumed relieved because courts are now the decision-makers of *first* resort.

When the Karen Quinlan situation was topical, Brother Fox frequently and actively expressed his agreement with the *allocutio* of Pope Pius XII and his own desire to be "let go." No doubt Brother Fox spoke those simple words; still, it seems to me ironic that, no doubt on advice of counsel, Father Eichner's petition was cast in terms of Brother Fox's "privacy rights." Such is the power of what the U.S. Supreme Court now calls "*Wade* and its progeny." This recently discovered constitutional right holds sway in McCormick/Veatch's familial extension of "autonomy."

Brother Fox reiterated his desire to escape extraordinary life-support systems upon suffering an accident while moving flower pots in the garden, and just before he submitted to routine hernia surgery on October 2, 1979. The New Jersey court dismissed from consideration a reported similar but casual remark of Karen Quinlan. Joseph Saikewicz was incompetent to express any such judgment. By contrast, the New York Supreme Court, Nassau County, found Brother Fox's expressed will to have probative value. But its ruling and opinion, in contrast to that of Judge Meade, did not rest decisively upon this evidence. *Quinlan* was the right decision for the wrong reasons—after having stated the right reasons, namely, the standard medical practice of allowing the dying to die.[4] *Saikewicz* was a wrong decision for wrong reasons.[5] *Eichner* was the right decision for a mixture of wrong reasons. It was, indeed, a step to the fantastic.

When the Nassau County Court turned its attention to "the substantive legal problems" in the case of Brother Fox, it began auspiciously by recognizing that, "while the right of an *incompetent* patient to refuse medical treatment or to have it withdrawn may be subject to controversy, by contrast, the right of a competent patient to do so is not." Every human being of adult years and sound mind has a right to determine what shall be done to his own body. Sorts of cases are instanced in which "compelling State interests" override a competent patient's right of bodily self-determination. The case of Brother Fox fell under none of them. "It seems clear that predicated upon the foregoing principles of common law," the Court said, "had Brother Fox been fully *competent* after surgery and had he refused the assistance of a respirator, his wishes would have

[4] For a fuller discussion of *Quinlan*, see my *Ethics at the Edges of Life: Medical and Legal Intersections* (New Haven: Yale University, 1978) 268–99.

[5] Ibid. 300–317, with 335; and Paul Ramsey, "The Saikewicz Precedent: What's Good for an Incompetent Patient?" *Hastings Center Report* 8, no. 6 (Dec. 1978) 36–42.

been fully honored, absent any compelling State interest." Since, when fully competent, Brother Fox had at length expressed his refusal over a period of time (including just before a routine operation from which there was every hope of recovery) and since the Court *found* this evidence of his wishes beyond challenge, I ask: Why did not the Court's decision rest there, as did Judge Meade's?

Instead, the Court dived from the clear into the obscure. "We believe," it said, "that his right to refuse treatment when competent rests on [not what he lucidly said when competent but on] a far more fundamental principle of law: the constitutional right of privacy." That—anyone should know in advance—is going to be a precious little right still possessed by Brother Fox when comatose which the Court is going to exercise for him in place of the right of bodily self-determination about which he expressed his own firm conviction when competent. Instead of recognizing Brother Fox's competence to predetermine the circumstances in which he wanted to be "let alone," the Court assumed authority to determine what his "privacy" right would have meant were he at the later point in time competent to say.

Thus, to reach the conclusion that a "decision by the incurably ill to forego medical treatment and allow the natural processes of death to follow their inevitable course is so manifestly a 'fundamental' decision in their lives, it is virtually inconceivable that the right of privacy would not apply to it"; to reach the conclusion that "individuals have an inherent right to prevent 'pointless, even cruel, prolongation of the act of dying'"; and even to reach the conclusion that "a competent adult who is incurably and terminally ill has the right, if he so chooses, not to resist death and to die with dignity," the New York Court appealed "by parity of reasoning" to *Roe v. Wade* (of all cases!) and to "the major sister State decisions," *Quinlan* and *Saikewicz*. Here, if I do not misread the opinion, the New York Court—needlessly, since it had accepted Brother Fox's expressed determination—stepped into the confusion of having to impute to this patient a decision while comatose that God only could know.

A reason is offered for this move, it is true: "were Brother Fox competent, he could refuse treatment not only as an exercise of his common-law right of bodily self-determination, but also pursuant of his constitutional right of privacy. Although the two are quite clearly equivalent in effect since they compel the same result, the difference between them is more than semantics." The former could be abrograted by legislation; the latter cannot be abrogated by legislation.

But then, strangely, the opinion appeals to its accord with medical practice—to the fact that "increasingly the medical community has come to acknowledge that the terminally ill, and particularly those patients in irreversible coma, need care, not extraordinary, life-sustaining therapy."

It quotes words from *Quinlan*: "physicians distinguish between curing the ill and comforting and easing the dying; . . . they refuse to treat the curable as if they were dying or ought to die, and . . . they have sometimes refused to treat the hopeless and dying as if they are curable." Thus the Court appealed to another objective standard, certainly more objective than substitute judgments imputing to an incompetent patient the contents of a privacy right to be exercised in his behalf. But neither *Quinlan* nor *Eichner* tells us why courts should deprive physicians with patients and family of these decisions and disturb standard medical ethics and practice by assuming them to the judiciary.

Next the Court turned to the issue of the State's interest in the "preservation and sanctity of life." On this important point there is an extraordinary passage in the opinion. It demonstrates (1) a return to *defining* people as "virtually" dead—impacting in that definition (lost) qualities of life, and (2) the confusion of *two* quite distinct reasons for stopping "life"-sustaining treatments. One is because it has been determined that the patient behind the machines has died. The other is because continuing treatment can affect the dying process of a man-alive in no other way than by prolonging it. Not to stop in the first instance is an indignity to the newly dead; in the second instance, an indignity to those whose death is impending and whose dying is reasonably believed to be irreversibly in course. These two sorts of decisions to stop attempted curative or "life"-sustaining treatments were often melded together in the 60's, when organ transplants were topical.

Now, more than a decade later, I have a strange sense of *déja vu* when I read the newspapers, some of the medical literature, and legal cases as our courts have increasingly intervened in these matters. Today we again hear talk of people who are "virtually" dead—in other language, of course. Decision-makers—whether physicians, family members, review boards or commissions, and now the courts—are melding together the two good and sufficient reasons for stopping attempts to sustain or prolong life. In the late 60's, decision-makers were triangulated between the primary patient and potential organ recipients. In the late 70's and 80's, they are triangulated between the primary patient and their own attempts to formulate and employ concepts of the "quality of life" in prospect. At least some current proposals for further updating the "definition of death" must be viewed as moves to encompass within that definition some of a human life's lost qualities. I warn: you can define a patient to death. Something of the reverse happened in the case of the wealthy Texas oil tycoon who left as his last will and testament that he be buried in his Cadillac. As he was being lowered, fully dressed in sports attire, into a great gulch, someone on the edge of the crowd was heard to exclaim, "Man, that's livin'!"

To show that we have come full circle (or at least to a co-ordinate point in the spiral), hear this from the Nassau County Supreme Court in the case of Brother Fox:

> ... the patient in a permanent vegetative coma has no hope of recovery and merely lies, trapped in a technological limbo, awaiting the inevitable. As a matter of fact, such a patient has *no* health and, in the true sense, no life, for the State to protect. Thus, the use of a respirator, or any other extraordinary means of life support, *under these circumstances,* does not serve to advance the State's interest in protecting health or life and, hence, that interest does not defeat the privacy right asserted here [case references omitted]. Indeed, with *Roe* in mind, it is appropriate to note that the State's interest in the preservation of the life of the fetus would appear to be *greater* than any possible interest the State may have in maintaining the continued life of a terminally ill comatose patient. The fetus is a potential person who, in the natural course, will develop into a whole functional human being; the terminally ill patient in a permanent vegetative coma, in striking contrast, has in most cases already enjoyed his life and now, at the last hour, depends for his continued existence upon an extraordinary life-sustaining technology. Such a claim to personhood is certainly no greater than that of the fetus [*italics* in the opinion].[6]

Was Brother Fox alive or dead? Did he have "in the true sense, *no* life, for the State to protect" (my italics)? If no life, how could he possess a right of privacy and bodily self-determination for the Court to exercise in his behalf? Our courts have manifested remarkable prowess in stretching the application of the recently discovered constitutional right of privacy, but this is my first reading of a court's including within its ambiance a patient having "in *the true sense,* no life, for the State to protect" (my italics). And if no life (vaguely defined by the Court, i.e., "virtually" dead), how could the State have either a *lesser* or a *greater* interest in protecting Brother Fox than in the preservation of the "potential life" of an unborn child?

There is, of course, some explanation in the record and opinion for why the Court launched upon this sea of confusion. The 1968 Report of the Ad Hoc Committee of the Harvard Medical School concerning "brain

[6] Following immediately, the Court quoted the formula from *Quinlan*: "the State's interest *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims." Under the head of the State's interest in the prevention of suicide, the Court said: "But withdrawal of the respirator evinces only an intent to forego extraordinary measures and *to allow the processes of nature to run their course*" (my italics). That is also a proper description of the withdrawal of treatments to allow the still-living dying to die. Why was the court impelled to (almost) define Brother Fox to death as grounds for ruling in favor of Father Eichner's petition? And contradictorily to conclude this section of its opinion by affirming that the situation "compelling in this proceeding... precluded Brother Fox from exercising his right to discontinue *life*-prolonging medical treatment"? (my italics).

death" "has not yet been accepted as legally conclusive of the issue in this State" (cases cited). Secondly, "since Brother Fox's EEG showed 'minimal activity,' he did not meet the criteria of 'brain death' at the time of the hearing" in the court below. (My reading of the summary of testimony by the Supreme Court, Nassau County, is that Brother Fox's condition *may* have satisfied the Harvard tests for determining that a patient has died, had these been conclusive in the State of New York. In any case, his condition, according to expert testimony, satisfied the second good reason for cessation of treatment: the respirator was only prolonging his dying—on which the ruling could have rested.) Thirdly, the Court assumed throughout that "advances in medical technology sometimes blur the distinction between life and death." That is true enough; but the purpose of agreed-upon tests for determining that a patient has died is precisely to remove that blur, to unmask death behind the face of life maintained by mechanical means. Finally, and most important, was the fact that the New York Court continued the *Quinlan* precedent of stressing cognitive and sapient capacity. That already was an incipient definition of death and life, by which measure the Court reasoned that Brother Fox had "in the true sense, no life, for the State to protect."

The Court distinguished between the medical component (prognosis) and the legal component (ascertaining the patient's wishes) in its ruling. The standard of proof applied to the medical testimony was "preponderance of the credible evidence" or "clear and convincing evidence"—not "beyond a reasonable doubt," as in criminal cases.

By this standard the evidence would have sustained the ruling that Father Eichner be appointed the "committee" (guardian) for the purpose of ordering the respirator to be stopped *on the grounds* that it served no other purpose than to prolong Brother Fox's dying. The *finding* of both courts was "that Brother Fox, whether on or off the respirator would die"; that the respirator only arrested his dying.

The operation for hernia ordinarily requires about fifty minutes. The first forty minutes were "uneventful." Then the fact that Brother Fox had suffered cardiac arrest became evident. "Although manifestation of the signs of cardiac arrest may be sudden, the onset of arrest itself is not, and no one could say with a reasonable degree of medical certainty exactly how much time had elapsed from the onset of the arrest to its apprehension," or how extensive brain damage may be. (This crucial period of time was subsequently estimated to have been about five minutes.) Therefore the medical team managed to get his heart started and moved him onto a respirator. Cannot it, by the standard of proof the Court used, be said with the same degree of reasonable certainty that the

medical team arrested his dying, which then the respirator continued to prolong?

Physicians do this sort of thing every day in emergency rooms. Some victims of accidents are declared DOA (dead on arrival). Absent knowledge of how long a cardiac arrest or coma lasted, they rightly institute treatment. Declarations of death are made in some cases, decisions to treat or not to treat in others. I myself have never encountered a good argument for distinguishing between a medical decision to cease treatment and a medical decision not to institute treatment—except for the uncertainties mentioned above. I see no reason for physicians to feel trapped by a respirator once it is started. Indeed, by starting it they may acquire knowledge of the situation requisite to stopping it (either that the patient on a respirator is in reality already dead or that the respirator serves no purpose other than to prolong the dying of the dying). And I see no reason for the medical profession to be saddled with court-ordered definitions of life and death in terms of the precedent unfortunately set by *Quinlan*, i.e., with determining what's "in a sense no life" and what's "in a sense 'real livin'."

In any case, I suppose physicians will experience real alarm over what the New York Court said about "the legal component," namely, ascertaining a comatose patient's "decision" to refuse further treatment. In *Eichner,* the Court used *Saikewicz* and not *Quinlan* as its model. "We agree with the *Saikewicz* court that the neutral presence of the law is necessary to weigh these factors, and, thus, judicial intervention is required before any life-support system can be withdrawn. . . . Our decision recognizes that the societal interests to be safeguarded are so great that the courts have no choice but to intervene and examine each case on an *individual,* patient-to-patient basis" (italics in the opinion).[7] All three of these landmark cases were taken to court because of disagreement between concerned parties. If *Eichner* is not overruled on this point, every case of withdrawing treatment in the case of incompetent patients in New York State must be taken to court.[8]

[7] To this the Court attached the following puzzling footnote: "By this decision we make no references to cases of 'brain death' or any other medical situation in which 'no code' orders would presently be written without judicial approval." That is either a plain contradiction or else it means that the Court intends to assume no jurisdiction over such past or "presently" made orders, only future ones.

[8] See "Courts Are Nobody's Family: Life and Death Decision Will Be Made But by Whom," *New York Times,* News of the Week section, June 29, 1980, for expressions of disagreement over this result of *Eichner;* and George Annas, "Quinlan, Saikewicz and Now Brother Fox," *Hastings Center Report* 10, no. 3 (June 1980) 20–21, for partial agreement with it. The case has been appealed to the Court of Appeals. By the *Times* account, Nassau County's District Attorney, Dennis Dillon, is not one to appeal this point. Mr. Dillon sees

The following may be of importance as an addendum to the decision in the case of Brother Fox at the second judicial level. As just stated, the Supreme Court, Nassau County, understood its ruling that all decisions to withhold treatments in New York must pass "neutral" court scrutiny to be in line with the Massachusetts decision in *Saikewicz*. However, shortly before this second decision in *Eichner*, the Supreme Judicial Court of Massachusetts had already withdrawn, as a formal legal requirement, its apparent dictate that all medical decisions to cease treating incompetents in life and death cases should be subject to prior court review. On May 13, 1980, the Massachusetts Court handed down a decision *In the Matter of Earl N. Spring*. As only an addendum to the two steps so far taken in the case of Brother Fox, we should examine this decision, if only to speculate whether it gives grounds for believing that physicians in the future in the State of Massachusetts are likely to do otherwise than seek prior judicial approval of withdrawal of "life"-sustaining treatments. This is to ask whether there is as yet, or in this case, any evidence contra my opening premise that the actual practice of medicine is not tending, and will not likely move, in the direction of "familial self-determination." Not so much because there are not trends in this direction, both among physicians and moral philosophers supporting them, but because the courts will pre-empt these subjective standards, or even, as in *Spring*, by laying down such conditions for immunity from prosecution that few physicians are likely to brook the risk. *Spring*, I judge, merely equated ex post facto judicial judgment with prior consent decrees that might be sought from the courts. And who does not know which route medical practice will take?

In *Spring* the Massachusetts Court seized an occasion to alter its opinion in *Saikewicz*, or (as courts do) correct supposed misinterpretations of that opinion. This case (the details are not needed here) had taken nine months to reach judicial resolution. This elapsed time impelled the Massachusetts Court to agree with *Quinlan* that to require judicial review of all cases of withholding life-sustaining treatment "would be impossibly cumbersome."

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no distinction between withdrawing treatments from a "terminal patient" and "giving an injection to help him die." He wants the decision overturned or else extended to the entire State of New York. Compare the recent statement of Pope John Paul II: "By euthanasia [= mercy killing or negligence] is understood an action or an omission which *of itself* or by intention causes death, in order that all suffering may in this way be eliminated" (my italics). The removal of the respirator from Brother Fox would not have, of itself or by intention, caused his death. His expressed wishes were in accord with the Pontiff's reiteration of the well-established teaching that it is "permissible to make do with the normal means that medicine can offer" and "to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life." See the *New York Times*, June 27, 1980.

It is reported that our *Saikewicz* decision was interpreted by some as requiring judicial approval before life-prolonging treatment could be withheld from an incompetent patient, even in cases of 'brain death.' ... We therefore take this occasion to point out that neither the *Saikewicz* case nor the present case presented any issue as to the legal consequences of action taken without court approval.... There is no legal basis for a duty to administer medical treatment after death.... The *Dinnerstein* case did not involve 'brain death,' but a patient in an irreversible vegetative coma; the Appeals Court ordered entry of a judgment declaring that a medical order not to resuscitate the patient in the event of cardiac or respiratory arrest was not contrary to law and that *the validity of such an order did not depend on prior court approval* (my italics).... We think that the results reached on the facts in this case were consistent with our holding in the *Saikewicz* case.

The apparent difference was only that State action was involved in *Saikewicz* because the patient was in State custody, and because in *Spring* the patient had "acquiesced in hemodialysis treatment" before the onset of his incompetence. So the Court concluded that "neither the present case nor the *Saikewicz* case involved the legality of action taken without judicial authority, and our opinions should not be taken to establish any requirement of prior judicial approval that would not otherwise exist." So far, so good.

Then the Court noted various grounds for seeking prior court approval. Among these

are at least the following: the extent of the impairment of the patient's mental faculties, whether the patient is in the custody of a State institution [as was Saikewicz], the prognosis without the proposed treatment, the complexity, risk and novelty of the proposed treatment, its possible side effects, the patient's level of understanding and probable reaction, the urgency of the decision, the consent of the patient, spouse, or guardian, the good faith of those who participate in the decision, the clarity of professional opinion as to what is good medical practice, the interests of third persons, and administrative requirements of any institutions involved.

Some physicians may think the foregoing gives them liberty of decision; I do not. While warning that the same conditions that might have led to prior court *disapproval* pertain to civil or criminal liability without such approval, the Court notes that "apparently no prosecutor has proceeded to trial in a case where a physician chose to terminate life-preserving treatment or to omit emergency treatment in a hopeless case."

That is correct. "Whenever a physician in good faith decides that a particular treatment is not called for, there is a risk that in some subsequent litigation the omission will be found to be negligent. But *the standard for determining whether the treatment was called for is the*

same after the event as before; negligence cannot be based solely on failure to obtain prior court approval, if the approval would have been given (my italics)." Any physician who believes that to be sufficient protection, please stand up.

Still, the Massachusetts Court was attempting to arrive at a neutral position in this case, one that does not *require* prior judicial approval of life-and-death medical decisions. "Thus the absence of court approval does not result in automatic civil liability for withholding treatment; court approval may serve the useful purpose of resolving a doubtful or disputed question of law or fact, but it does not eliminate all risk of liability."

If the liability is the same, we may reasonably suppose that physicians will seek prior court approval. We may reasonably suppose that the effort of the Massachusetts Court to push medical decisions initially out of judicial proceedings will fail, unless there is some objective ground in which physicians agree to place their confidence. This is not likely to be subjective familial value judgments concerning the best interests of incompetent patients. So while I join McCormick/Veatch in the hope that the judgments of courts will not replace medical judgments, I must say that their resort to "familial self-determination" is bound to be counterproductive. So also is the employment by many physicians of sociocultural criteria instead of strictly medical criteria in deciding whether treatment should be stopped. Both are bound to load the courts with the task of making medical decisions under the category of the courts' substitute judgments.

I have no notion why many physicians today are diluting the standard medical practice that gives them discretion to allow dying patients to die by qualitative decisions that some (who may not be in an irreversible process of dying) are not deserving of every medical effort to care for them. Even less can I understand those moral theologians and bioethicists who aid and abet this medical outlook by their cogitations about family values and substitute judgments. I say here simply that these moves can only lead to more conveyance to the courts of the sole legitimacy to make such surrogate decisions.

Faced with the possibility that the courts of the several States may become, in effect, a state-wide institutional review board deciding case by case every removal of incompetent terminal patients from life-sustaining treatments, the medical profession may wish to endorse, and State legislatures might seriously consider, the proposal of Joseph M. Boyle Jr. and Germain Grisez that treating a patient against his will be made a tort that survives the death of the person on whom it was committed.[9] This

[9] *Human Life Review* 4 (1978) 26–43.

might be less cumbersome and more efficient than numerous stipulations in the statutory "living wills" that a number of States have recently enacted. Brother Fox need only have written his request to his physician (and kept a copy) or stated it orally in the presence of one of his religious brothers. This would have given Father Eichner the power of persuasion he needed. And physician decisions to continue or to stop treatment could be brought to court under the specified conditions only *post eventum* for treating a patient against his expressed will, not in all cases as now seems to be our future. This proposed revision of tort law should not at the same time destroy those "compelling State interests" that at present may override even competent patient refusals, such as the protection of third parties. (There is no legal right, and certainly no moral right, to abandon children by trivial but suicidal refusals of treatment.) I imagine a good legislative draftsman could find wording that would preserve this and other outstanding concerns rehearsed in the Supreme Court's decision in *Eichner*.

My chief plea is sufficiently clear throughout. The tests for telling whether to discontinue treatments should be clinical or physiological ones (if these are the proper words for my meaning), not anyone's "values." They should not *in themselves*, with or without intention, build into the conditions for allowing the dying to die a discriminatory definition of a life worth living. A fortiori, *whoever decides* these questions should not be able to give effect to his own "values" in this regard as if they were certainly the patient's own.

In the absence of expressed predetermination, as in the case of Brother Fox, the only remaining objective standard is medical decision to cease to combat the dying of the dying. Let's be candid about this: some of these dying may have wished still to struggle and live on for a while longer, for a variety of reasons. If they could tell us so, their wish should be honored and supported. If not, however, there is no reason for courts, physicians, or families to get bogged down in surmising what patients would wish if competent, or to pretend that sound medical decisions to discontinue treatment are correct because the patient would have said so if he could. The truly incompetent are patients we need not consult, or *pretend* to consult or represent in the finitude of medical practice. And it is only ointment to the conscience of the living to say that we do what they, if competent, would do, or that we know their best interests and act in accord with these interests. Maybe so, maybe not. All that we can say, within the fallible, finite human community of medical care, is that we have done the best we objectively know to do, namely, to cease treatment when, and only when, to continue would only prolong the dying of the dying. To claim that the justification for doing this is our substitute judgment that this is what they would wish may ordinarily be correct.

Nevertheless, since we know that there are competent patients who strive for the last possible moment of life (as Judaism teaches, one moment is the same as eternity), to ascribe to the incompetent anything less, without positive evidence, is a questionable presumption on the part of the living.

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