

Conflict of Interest in Right-to-Die Cases

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Citing unresolved issues in two prominent right-to-die court cases, Martin in Michigan and Schiavo in Florida, the thesis of this paper is that the laws should be changed to require that the highest standard of evidence be introduced to prove that guardians of incompetent patients harbor no conflict of interest with regard to these patients. Analogous to the ruling of the U.S. Supreme Court in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), that the “clear and convincing” evidence standard must be applied to demonstrate that the incompetent patient would wish to die if comatose or in a persistent vegetative state; so the same “clear and convincing” standard should be applied to show that anyone whose guardianship of a particular patient must be determined by a court would in no way gain from that patient’s death. To have already enacted such a law or established such a precedent would have reduced much of the heartbreaking and unreasonable extension of litigation in the current Schiavo case. The law since the 1976 Quinlan decision has recognized the need to safeguard the right of patients to refuse medical treatment or forced sustenance, but has not been able to ensure that questionably motivated legal guardians will not do away with their incompetent wards, whom they might consider “inconvenient,” by exploiting this right within the law. Legislatures or courts could close this loophole to protect incompetent patients from being murdered by surrogate decision makers, while at the same time leaving secure for all patients the right of informed refusal.

The law since *Quinlan* has recognized the need to safeguard the right of patients to refuse medical treatment or forced sustenance, but has not been able to ensure that questionably motivated legal guardians will not do away with their incompetent wards, whom they might consider “inconvenient,” by exploiting this right within the law. Could legislatures or courts close this loophole to protect incompetent patients from being murdered by surrogate decision makers, while at the same time leaving secure for all patients the right of informed refusal?

Karen Ann Quinlan, for causes unknown, but probably related to an interaction of drugs and alcohol, suffered cardiopulmonary arrest on 15 April 1975 at the age of 21 and lapsed into a coma and persistent vegetative state (PVS).¹ Joseph and Julia Quinlan, Karen’s parents, both devout

¹ One could be both PVS and comatose; or PVS and not comatose, i.e., waking and sleeping but always unaware; or

Catholics and with Karen's best interests at heart, discussed their decision with their pastor, Father Tom Trapasso. Convinced that the Catholic Church would not require the artificial prolongation of life, they asked the New Jersey State Superior Court on 12 September 1975 to appoint Joseph Quinlan as Karen's guardian so that he could order her artificial life support discontinued. The court denied this request and appointed a third party as Karen's guardian. The Quinlans took their case to the New Jersey State Supreme Court, which ruled in their favor on 31 March 1976, thus setting an important precedent.² Karen's ventilator was gradually removed over five days in May 1976, but her medically assisted nutrition and hydration (MANH) systems were kept. To everyone's surprise, she survived until 11 June 1985, though she never regained consciousness.

Elizabeth Bouvia *née* Castner was born with cerebral palsy and quadriplegia in 1957. When she was five, her parents divorced and she remained with her mother. When she was ten, her mother remarried and put her in a home for crippled children, where she remained until she was eighteen, seeing her mother only twice during that time. Upon leaving the institution, she enrolled in Riverside City College, California, transferred to San Diego State University, earned a bachelor's degree in social work, and began studying for a master's. She dropped out when one of her professors told her she was unemployable and would not have been admitted if the school had known the extent of her disabilities. In 1982 she married an ex-convict, Richard Bouvia, suffered a miscarriage, and soon separated from him.³

In constant pain from degenerative arthritis, Bouvia voluntarily checked into the psychiatric clinic of Riverside General Hospital on 3 September 1983 to request morphine for her pain while she starved herself to death by refusing to eat or drink. The hospital would not comply, and, as she had never been able to eat or drink on her own, it also forced MANH upon her. She sued for her right to a comfortable voluntary death.⁴ Her suit was denied on 16 December 1983 and she was subsequently, by court order, forced to consume nourishment against her will, sometimes brutally,⁵ as the hospital considered her a "problem patient."⁶ She endured two more years of similar indignities at several hospitals in Mexico and California.⁷

Even though Bouvia was willing to eat in December 1985 at High Desert Hospital, the staff forced MANH on her to add about 40 pounds to her weight. She sued unsuccessfully for removal of the nasogastric tube,⁸ but on 16 April 1986 the Court of Appeal of California unanimously granted her request to refuse any and all medical treatment.⁹ She could now legally choose death

comatose and not PVS, i.e., possibly able to emerge from the coma. Cf. Thomas Mappes, "Persistent Vegetative State, Prospective Thinking, and Advance Directives," *Kennedy Institute of Ethics Journal* 13, no. 2 (June 2003): 119-139.

² *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), cert. denied, 429 U.S. 922, 97 S.Ct. 319, 50 L.Ed.2d 289.

³ Mary Johnson, "Right to Life, Fight to Die: The Elizabeth Bouvia Saga," *The Disability Rag* 4 (1984): passim.

⁴ *Bouvia v. County of Riverside*, No. 159780, Tr. 1238-1250 (Super. Ct. Riverside Co. Calif., December 16, 1983).

⁵ George J. Annas, "When Suicide Prevention Becomes Brutality: The Case of Elizabeth Bouvia," *Hastings Center Report* 14, no. 2 (April 1984): 20-21, 46.

⁶ Robert Steinbrook, Bernard Lo, "The Case of Elizabeth Bouvia: Starvation, Suicide, or Problem Patient?" *Archives of Internal Medicine* 146, no. 1 (January 1986): 161-164.

⁷ George J. Annas, "Elizabeth Bouvia: Whose Space Is This Anyway?" *Hastings Center Report* 16, no. 2 (1986): 24-25.

⁸ *Bouvia v. Glenchur*, L.A. Super. Ct. C583828 (February 21, 1986).

⁹ *Bouvia v. Superior Court*, 179 Cal.App.3d 1127, 225 Cal.Rptr. 297 (1986).

and control her own morphine dosage, but freely chose not to exercise her newly recognized right to self-starvation. As of this writing (December 2003), she is still alive. Her case provided fresh impetus to the “death with dignity” movement¹⁰ that led on 27 October 1997 to physician assisted suicide (PAS) becoming legal for terminally ill patients in Oregon.¹¹ It also prompted protests that California, by recognizing her right of informed refusal, confirmed societal prejudice against the disabled, authorized assisted suicide, and started on a slippery slope of authorizing euthanasia for “useless” citizens.¹²

Nancy Beth Cruzan, born on 20 July 1957, lost all higher brain function in a single-vehicle collision in Missouri on 11 January 1983. She was PVS and received MANH, but after three weeks was not comatose, did not need a ventilator, and perhaps could have survived thirty more years. Her parents, Lester (“Joe”) and Joyce Cruzan, frustrated that the Missouri Rehabilitation Center in Mount Vernon refused their request to stop Nancy’s MANH, sued in Jasper County Circuit Court, which ruled in their favor on 27 July 1988.¹³ The Missouri State Supreme Court reversed this ruling on 16 November 1988, finding “absence of clear and convincing evidence of the patient’s wishes,”¹⁴ firmly believing that they were doing only what Nancy would have wanted,¹⁵ the Cruzans appealed to the U.S. Supreme Court. On 25 June 1990 the high court upheld the Missouri ruling five-to-four,¹⁶ thus establishing the “clear and convincing” standard for right-to-die cases and showing the Cruzans how to proceed. They returned to the Jasper County Circuit Court with a stronger case, bolstered by several new witnesses to provide clear and convincing evidence of what Nancy’s own choice might have been.¹⁷ The court ordered MANH stopped on 14 December 1990. Nancy died on 26 December. The cause of death was certified as the automobile accident. Two death dates appear on her gravestone, 1983 and 1990.¹⁸

Michael Martin suffered permanent closed head brain damage at age thirty-five on 16 January 1987, when a Conrail train struck the car he was driving. His wife Mary and two of their three children were injured. Their middle child, Melanie, died. After recovery, Michael was conscious and alert, neither PVS nor terminally ill, but dependent on colostomy and MANH and unable to walk or talk. Neuropsychologist Walter Zetusky claimed that his IQ had dropped to 63. He could understand and respond to simple questions, seemed happy, and was not uncomfortable or in pain. He shook his head “no” when brain injury rehabilitation specialist Robert K. Kreitsch asked him “if there were ever any times when he felt that he did not want to go on living.”¹⁹ A team of physicians, including neurologist and bioethicist Ronald E. Cranford, disagreed about the extent

¹⁰ George J. Annas, “Death by Prescription: The Oregon Initiative,” *New England Journal of Medicine* 331, no. 18 (November 3, 1994):1240-1243.

¹¹ *Lee v. Oregon*, 107 F.3d 1382 (9th Cir.), cert. denied, 522 U.S. 927 (1997).

¹² Paul K. Longmore, “Elizabeth Bouvia, Assisted Suicide, and Social Prejudice,” *Issues in Law and Medicine* 3 (December 1987): 141-170.

¹³ *Cruzan v. Harmon & Lampkins*, No. CV384-9P (Mo. Cir. Ct., Jasper Co., July 27, 1988)

¹⁴ *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988) (en banc).

¹⁵ Susan M. Wolf, “Nancy Beth Cruzan: In No Voice At All,” *Hastings Center Report* 20, no. 1 (January-February 1990): 38-41.

¹⁶ *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990).

¹⁷ *Cruzan v. Mouton*, No. CV384-9P (Mo. Cir. Ct., Jasper Co., December 14, 1990).

¹⁸ A moving account of the whole story is: William H. Colby, *Long Goodbye: The Deaths of Nancy Cruzan* (Carlsbad, Calif.: Hay House, 2002).

¹⁹ *In re Martin*, 538 N.W.2d 399 (Mich. 1995) (Martin III).

of Michael's cognitive impairment, but agreed that he was unlikely ever to improve.²⁰

On 19 March 1992 Mary petitioned in probate court to have Michael's MANH withdrawn. On many occasions before the collision, he had confided orally to Mary, his sister Patricia Major, and two colleagues that he would not want to live on a ventilator if he were ever PVS. Mary interpreted these statements to mean that he would not want to live in his present condition, but the two colleagues testified that his present condition was not what he meant. Michael's mother, Leeta Martin, and sister opposed the petition and sought to have Mary removed as Michael's legal guardian. The probate court ruled against Mary on 30 October 1992, but the Michigan State Court of Appeals remanded the case back to probate court,²¹ which on 18 October 1993 reversed its ruling in her favor,²² a decision confirmed by the Court of Appeals in 1994.²³ Leeta and Patricia appealed to the Michigan State Supreme Court, which on 22 August 1995 overruled both the probate and appeals courts six-to-one,²⁴ holding that Mary did not present clear and convincing evidence of Michael's intentions and therefore could not stop his MANH, but could remain as his guardian.

Theresa Marie ("Terri") Schiavo *née* Schindler, born on 3 December 1963, collapsed under mysterious if not suspicious circumstances on 25 February 1990, suffering severe brain damage, perhaps from cardiac arrest and about five minutes of anoxic encephalopathy. Since then she depends on MANH, is likely PVS, but is not comatose. Her husband and legal guardian, Michael Schiavo, won a medical malpractice lawsuit on her behalf in November 1992 for over a million dollars, most of which was placed in a trust fund for her care.²⁵ In February 1993 her parents, Robert and Mary Schindler, began to question why Michael was not using the proceeds of this settlement for her rehabilitation. On 29 July 1993 the Schindlers filed their first of many petitions to remove Michael as guardian.

In May 1998 Michael petitioned for stoppage of Terri's MANH, a request which the Circuit Court for Pinellas County, Florida, granted on 11 February 2000, because it found that Michael offered clear and convincing evidence that Terri would not want to be alive after ten years of PVS. The Schindlers lost their appeal in the Second District Court of Appeal of Florida on 24 January 2001.²⁶ Terri's MANH was stopped on 24 April 2001, but restored on 26 April by an emergency stay to give the Schindlers more time to litigate. Rulings continued back and forth between the trial court and the appellate court, with both the Florida and U.S. Supreme Courts refusing to hear any of the cases.²⁷ On 17 October 2001 the appellate court ordered five physicians to examine Terri, two appointed by Michael, two by the Schindlers, and one by the court.²⁸ The three appointed by Michael and the court, neurologists Melvin Greer, Peter Bambakidis, and Cranford,

²⁰ Ronald E. Cranford, Lawrence J. Nelson, "Michael Martin and Robert Wendland: Beyond the Vegetative State," *Journal of Contemporary Health Law and Policy* 15, no. 2 (Spring 1999): 427-453.

²¹ *In re Martin*, 200 Mich.App. 703; 504 N.W.2d 917 (1993) (Martin I).

²² *In re Martin*, No. 87-44115-CG (Mich.P.Ct. Allegan Co. Oct. 18, 1993).

²³ *In re Martin*, 205 Mich.App. 96; 517 N.W.2d 749 (1994) (Martin II).

²⁴ Martin III.

²⁵ *Barnett Bank Trust Company v. C. Stephen Igel MD*, Pinellas County Circuit Case No. 92-939-15 (November 1992).

²⁶ *Schindler v. Schiavo* (*In re Guardianship of Schiavo*), 780 So.2d 176 (Fla. 2d DCA 2001) (Schiavo I).

²⁷ *Schindler v. Schiavo* (*In re Guardianship of Schiavo*), 792 So.2d 551 (Fla. 2d DCA 2001) (Schiavo II).

²⁸ *Schindler v. Schiavo* (*In re Guardianship of Schiavo*) 800 So.2d 640 (Fla. 2d 2001) (Schiavo III), *rev. den.* 816 So.2d 129 (Fla. 2002).

agreed that she was PVS; but the two appointed by the Schindlers, radiologist William Maxfield and neurologist William Hammesfahr, believed she could improve with proper rehabilitative care. Upon reviewing the reports of these five experts, the trial court found on 22 November 2002 that Terri's medical prognosis was hopeless and ordered MANH stopped on 3 January 2003.²⁹ Again the Schindlers appealed, but lost on 6 June.³⁰ They petitioned in federal court,³¹ which on 10 October refused to grant a stay.

Terri's MANH was stopped on 15 October. In an extraordinary move on 21 October, the Florida State Legislature passed (68-23 in the House and 23-15 in the Senate) an act to enable Governor Jeb Bush to intervene.³² Bush instantly commanded that Terri's MANH be restored.³³ This was done on 22 October, but irreversible kidney and liver damage may have already occurred during the seven days she was without MANH. On 29 October Michael filed a brief claiming that, by overriding court decisions, the Florida legislative and executive branches violated both the federal and state constitutions.³⁴ On 31 October the Pinellas Circuit Court appointed University of South Florida professor Jay Wolfson as Terri's guardian ad litem, reporting to the governor, pending the outcome of these and other legal challenges. On 5 November the Schindlers petitioned the same court to appoint Terri's brother, Robert Schindler, Jr., as her permanent guardian.

The Concept of Suicide

Suicide is a complex, variegated phenomenon with a concept broader than is generally recognized.³⁵ Camus wrote that it is the *only* philosophical question.³⁶ It can be regarded either as the murder of an object, i.e., killing one of the state's citizens, killing one of God's creatures, or a spirit killing its own body; or as the annihilation of a subject, i.e., a person simply withdrawing forever from participation in the world by choosing to vanish from existence. Bouvia acting on her own, and Quinlan, Cruzan, Martin, and Schiavo acting by legally designated proxies, each intended what amounts to a form of suicide. Anyone's declaration, as in a standard living will, that MANH should be stopped in the event of medical futility or if artificially sustained life becomes intractably painful, burdensome, or undignified, is tantamount to that person wishing suicide in the event of permanent incapacitation.

Suicide is any voluntary death. Cases do not always fit the stereotypes of the depressed person, the chronic loser, the pathetic misfit, or the ruined careerist just giving up and wanting to end it all. Philosophers, bioethicists, lawyers, religious leaders, and politicians have long tried to

²⁹ In re Guardianship of Schiavo (Schiavo v. Schindler), Case No. 90-2908-GB-003 (Fla. 6th Jud.Cir.Ct. Nov. 22, 2002).

³⁰ Schindler v. Schiavo (In re Guardianship of Schiavo), 851 So.2d 182 (Fla. 2d DCA 2003) (Schiavo IV).

³¹ Schindler v. Schiavo, Second Verified Amended Complaint, U.S. Dist. Ct., Middle District of Florida, Tampa Division, Civil Case No. 8:03-CV-1860-T-26-TGW (September 22, 2003).

³² House Bill 35-E.

³³ Executive Order No. 03-201 (October 21, 2003).

³⁴ Schiavo v. Bush, Circ.Ct. Pinellas Co., Civil Case No. 03-008212-CI-20.

³⁵ Cf. Jacques Choron, *Suicide* (New York: Charles Scribner's Sons, 1972), esp. chap. 1, "Suicide in Retrospect," chap. 10, "Terms and Definitions," and chap. 13, "Philosophers on Suicide."

³⁶ Albert Camus (1913-1960), *Le Mythe de Sisyphe* (1942), first sentence: "Il n'y a qu'un problème philosophique vraiment sérieux: c'est le suicide. Juger que la vie vaut ou ne vaut pas la peine d'être vécue, c'est répondre à la question fondamentale de la philosophie."

distinguish among passive euthanasia, voluntary euthanasia, assisted suicide, refusal of medical care, refusal of nourishment, refusal of hydration, voluntary terminal sedation, DNR orders, wishing to be allowed to die, and expecting that doctors will not intervene to prevent death, as if some of these were not forms of suicide. In general, such arguments are unpersuasive.³⁷ Even if we accept subtle distinctions such as between “Kill me!” (assisted suicide) and “Let me die!” (passive euthanasia), it is still all suicide, the criterion being the will of the patient.³⁸ The social stigma that attaches to suicide prevents us from calling a spade a spade in such cases. Yet the fact is that our voluntarily taking any deliberate action or voluntarily determining any deliberate course of action that we know with certainty will result in our death, unless it is countered by a force beyond our control, is suicide.

Euthanasia is any “mercy killing.” It is active when one deliberately performs direct actions to cause death, but passive when one either foregoes life-sustaining treatment or deliberately withholds treatment which may or may not lead to death. Passive euthanasia could also mean deliberately withholding therapeutic or nutritive but not palliative treatment for a terminal condition. Voluntary euthanasia, i.e., mercy killing with the patient’s consent, is a form of suicide. Involuntary euthanasia, i.e., mercy killing without the patient’s consent, is a form of murder.

Voluntary stopping of eating and drinking (VSED), such as Bouvia sought in 1983, is a patient’s autonomous attempt at passive self-euthanasia. Since she was quadriplegic, it would also have been assisted suicide, i.e., voluntary death with the help or through the actions of a second party. Patients have the right to refuse any kind of therapy. Anyone may refuse to eat. The normal consumption of food and drink by able people is not considered “therapy,” but using tubes to feed and hydrate those who cannot supply these needs for themselves could be so considered. That area remains gray. The question in *Bouvia* was whether a patient could legally refuse a non-therapeutic intervention. Post-*Bouvia*, patients in California may legally order health care providers not to force-feed, force-hydrate, or force-nourish them while they voluntarily stop eating and drinking.

Inconsistencies exist across the range of life/death issues. Some who would permit abortion, assisted suicide, terminal sedation, or VSED oppose the death penalty for convicted criminals. Others who would gladly execute criminals oppose abortion and all forms of suicide, euthanasia, or artificial termination of natural suffering. There is little agreement among religious leaders, even among conservative leaders of the same faith, regarding passive euthanasia.³⁹ One Roman Catholic position on right-to-die ethics is that “refusal of disproportionate treatment is morally permissible but suicide is not.”⁴⁰ Thus Quinlan would be absolved and Bouvia condemned. This position fails to see that Quinlan’s death was suicide by proxy, no different in intent than if she

³⁷ For example, the U.S. Supreme Court’s unanimous opinion that assisted suicide is suicide but that voluntarily removing life-sustaining equipment is not suicide is nitpicky and baseless. Cf. *Vacco v. Quill*, 521 U.S. 793 (1997); 117 S.Ct. 2293; 138 L.Ed. 2d 834.

³⁸ For a different point of view on this distinction, cf. Daniel P. Sulmasy, “Killing and Allowing to Die: Another Look,” *Journal of Law, Medicine, and Ethics*, 26 (1998): 55-64.

³⁹ For example, Y.M. Barilan, “Revisiting the Problem of Jewish Bioethics: The Case of Terminal Care,” *Kennedy Institute of Ethics Journal* 13, no. 2 (June 2003): 141-168.

⁴⁰ Corrine Bayley, “The Case of Elizabeth Bouvia: A Strain on Our Ethical Reasoning,” *Health Progress* 67, no. 6 (July-August 1986): 40-47, 86; here p. 45.

had woken up, realized her plight, and unplugged her own ventilator.

Suicide is not always an act of despair. It could be an act of atonement, as in the Japanese bushido tradition of seppuku. It could be the only rational course, as in the death of Socrates. Rather than violate his ethical principles by escaping prison and going into exile among friends, which he easily could have done, the 70-year-old philosopher preferred instead to die voluntarily by acceding to his city's capital verdict against him.⁴¹ Suicide could be a political act to create the martyrdom that rallies others to the cause, as did the self-immolating Buddhist monks and nuns during the Vietnam War, Irish Republican Army hunger striker Bobby Sands, or Islamicist anti-Israeli suicide bombers. Suicide can be valiant. A soldier who throws himself on a live grenade to save a platoon is praised as a hero, not damned as a *felo-de-se*.

The condemnation of suicide is by no means universal.⁴² The word itself literally means "self-killing," akin to the German *Selbstmord*, "self-murder." It was coined by English court physician Walter Charleton in *The Ephesian and Cimmerian Matrons* (1651), had its first dictionary appearance in Edward Phillips's *New World of English Words* (1658), and entered the standard philosophical vocabulary through Voltaire, who moderately defended the act in the eighteenth century. Before that the typical term was the Latin *mors voluntaria*, "voluntary death," or, more loosely, "free death." *Mors voluntaria* was honored in ancient Rome and pre-Augustinian Christendom. Roman Stoics such as Epictetus reminded us that "the door is always open" to allow us to escape trouble, misery, or disgrace. Suicide is mentioned only seven times in the Bible, and never condemned there.⁴³ The most reprehensible biblical case of suicide was Judas hanging himself as inadequate penance for betraying Jesus, and that was held loathsome because it was Judas, not because it was suicide.

Killing oneself for whatever reason began to acquire disfavor in the West only after St. Augustine condemned it in *The City of God* in the fifth century.⁴⁴ Following established medieval Christian doctrine, Dante consigned the souls of suicides to inhabit trees in hell forever, where they would be defenseless against any harm any passerby would inflict on them. The metaphor is that they are their own gallows.⁴⁵ Spinoza argued that every living thing has such a powerful *conatus in suo esse perseverare* (usually called just the "conatus"),⁴⁶ a primal and incontrovertible instinct to self-preservation,⁴⁷ that to kill oneself is literally impossible, and that the so-called act of killing

⁴¹ Plato, *Crito*, 48d-54e.

⁴² Georges Minois, *History of Suicide: Voluntary Death in Western Culture*, trans. Lydia G. Cochrane (Baltimore: Johns Hopkins University Press, 2001).

⁴³ Judges 9:53-54 (Abimelech); Judges 16:25-31 (Samson); 1 Samuel 31:4-6, 2 Samuel 1:2-17, 1 Chronicles 10:3-7 (Saul and his armor bearer); 2 Samuel 17:23 (Achithophel); 1 Kings 16:18-19 (Zimri); Matthew 27:5, Acts 1:18 (Judas). It could also be argued that Jesus in the Garden of Gethsemane resigning himself to the fate that His Father has decreed for Him amounts to suicide, in the sense that Jesus freely chose His own death by freely acceding to God's will (Matthew 26:36-39, 42, 44; Mark 14:32-36, 39).

⁴⁴ For another interpretation of the pre-Augustinian history of suicide in Christendom, cf. Cynthia B. Cohen, "Christian Perspectives on Assisted Suicide and Euthanasia: The Anglican Tradition," *Journal of Law, Medicine, and Ethics* 24 (1996): 369-379.

⁴⁵ Dante Alighieri (1265-1321), *Inferno*, Canto XIII, describing the second round of the seventh circle of hell, which punished those who were violent against themselves.

⁴⁶ Baruch Spinoza (1632-1677), *Ethics*, Part III, props. vi ("Unaquaeque res, quantum in se est, in suo esse perseverare conatur."), vii-viii ("Conatus, quo unaquaeque res in suo esse perseverare conatur ..."); Part. IV, prop. xviii ("... conatus, quo homo in suo esse perseverare conatur.").

⁴⁷ Don Garrett, "Spinoza's Conatus Argument," in Olli I. Koistinen and John I. Biro (eds.), *Spinoza: Metaphysical*

oneself is, in fact, being “murdered” by the world. Partially following Spinoza’s metaphysics of self-preservation, Kant argued that suicide should not be allowed because it should not be universally allowed.⁴⁸ Wittgenstein wrote: “If suicide is allowed, then everything is allowed. If anything is not allowed, then suicide is not allowed. This throws light on the nature of ethics, for suicide is, so to speak, the elementary sin.”⁴⁹

Acceptance of Augustine’s teaching about suicide was not unchallenged. Montaigne wrote that “voluntary death is the fairest” and “Unendurable pain and fear of a worse death seem ... the most excusable motives for suicide.”⁵⁰ Donne, the Anglican clergyman who wrote that “any man’s death diminishes me, because I am involved in mankind,”⁵¹ nevertheless offered in *Biathanatos* the first coherent English-language defense of suicide.⁵² Hume countered the argument that suicide is unnatural and therefore impious by recalling that is also unnatural “to build houses, cultivate the ground, or sail upon the ocean.”⁵³ Nietzsche harked back to Epictetus when he claimed that the thought of suicide helped him through many bad nights.⁵⁴

Charles Dickens’s character in *A Tale of Two Cities*, Sydney Carton, created by voluntarily going to the guillotine a better world than would have been possible if he had not given his life. Such altruistic sacrifice seems to tell against Kant and Wittgenstein. Carton’s suicide can be defended from many ethical standpoints. Utilitarians could claim that he made two people (Lucie and Charles) happy instead of two people (Lucie and Sydney) miserable, deontologists might argue that he obeyed a duty to sacrifice himself to save an innocent life, Humeans may assert that he acted out of sympathy and fellow feeling, Hegelians might see him as restoring some measure of balance to an overturned world, and Aristotelians would say that he simply “did the right thing.”

Spiritual and Family Dynamics

A tragedy can bring a family closer together or tear it apart. The unexpected death of a loved one can make in-laws or siblings forget their usual animosity and share their common grief. The death of a child can lead once happily married parents to divorce. Untimely death is agonizing enough for the survivors when it is swift, but when the patient lingers between life and death, that agony is even greater. Death is concrete, the suffering is over, and closure for the survivors is usually

Themes (New York: Oxford University Press, 2001), 127-158.

⁴⁸ Immanuel Kant (1724-1804), *Groundwork of the Metaphysics of Morals* (1785), *The Metaphysics of Morals* (1797), *Lectures on Ethics* (compiled posthumously), passim.

⁴⁹ Ludwig Wittgenstein (1889-1951), *Notebooks 1914-16*, ed. G.H. von Wright and G.E.M. Anscombe, trans G.E.M. Anscombe (Oxford: Blackwell, 1979), p. 91e. Several members of Wittgenstein’s family committed suicide.

⁵⁰ Michel Eyquem, Seigneur de Montaigne (1533-1592), *Essays*, Book II, Chapter 3, “On the Custom of the Island of Cea”; in *The Complete Works of Montaigne*, trans. Donald M. Frame (Stanford: Stanford University Press, 1957), 252, 262.

⁵¹ John Donne (1572-1631), *Devotions upon Emergent Occasions*, “Meditation XVII: Now, This Bell Tolling Softly for Another, Says to Me: Thou Must Die,” ed. Anthony Raspa (Montreal: McGill-Queen’s University Press, 1975), 87.

⁵² Written around 1608 but published posthumously as: *Biathanatos: A Declaration of That Paradoxe, Or Thesis, that Selfe-Homicide is not so Naturally Sinne, that it may Never be Otherwise, Wherein the Nature, and the Extent of all those Lawes, which Seeme to be Violated by this Act, are Diligently Surveyed* (London: John Dawson, 1644).

⁵³ David Hume (1711-1776), “Of Suicide” (written around 1755, published posthumously in 1777), in *Of the Standard of Taste and Other Essays*, ed. John W. Lenz (Indianapolis: Bobbs-Merrill, 1965), 157.

⁵⁴ Friedrich Nietzsche (1844-1900), *Beyond Good and Evil* (1886), “Maxims and Interludes,” § 157.

soon forthcoming, but PVS prolongs the family's fear, guilt, sorrow, and helplessness beyond the period of normal endurance.

Reactions to a family member's PVS occur across a wide spectrum, from vigorous denial to meek resignation, especially when the diagnosis, assessment, and prognosis are uncertain. As with Schiavo, differences of professional medical opinion about the degree of hope that may reasonably be expected can contribute toward the dissolution of the patient's family. Since such disagreements can be even more devastating to the family than the PVS itself, the psychological and spiritual goal should be that the family achieves consensus about the patient, mutual acquiescence to the patient's fate, and serenity in their shared decision. To convince all or even most of the patient's loved ones to agree about the patient's presumed wishes is a difficult task for any psychological or spiritual counselor, yet it must be pursued with all energy. It is essential to the completion of the grieving and healing process. If there is to be a surrogate decision or substituted judgment that some form of suicide is what an incompetent patient would have wanted, then the family, if it is to survive emotionally, must be unanimous. The fact that such unanimity of interested parties was achieved in *Quinlan*, *Bouvia*, and *Cruzan*, but not in *Martin* or *Schiavo*, is very significant.

American jurists and bioethicists increasingly acknowledge, post-*Quinlan*, that competent patients or the legal surrogates of incompetent or incapacitated patients have the right to refuse medical treatment, and post-*Bouvia*, involuntary MANH, even if such refusal would result in death.⁵⁵ Nevertheless, the Judaeo-Christian idea that our lives are not our own, but God's, and that God therefore forbids us to shorten their natural length, remains a social factor. In keeping with this religious view, the church or the theocratic state would have the right to save our lives against our will. But believing that we each belong to ourselves alone, not to God, church, or state, and espousing instead the legal and bioethical right of refusal, is not necessarily irreligious. Many who believe that our lives are indeed our own to do with as we please would also agree with Meister Eckhart that there is a "spark of the divine" (*Funklein*) deep within each of us that animates and connects us and makes life worth living. No inconsistency obtains in simultaneously holding both of these beliefs. The issue concerns control. We may still believe that we ourselves, not the church or the state, control our own lives, while believing that God creates and sustains those lives.

The Catholic Church was not involved in *Schiavo* from the beginning, as it was in *Quinlan*. Many prominent Catholic laypersons⁵⁶ accused the Catholic clergy in Florida of cowardice, apathy, theological error, or "deafening silence" regarding Terri's fate. On 15 October 2002 and 7 August 2003 Bishop Robert N. Lynch of the Diocese of St. Petersburg, Terri's bishop, issued meekly

⁵⁵ Robert S. Olick, *Taking Advance Directives Seriously: Prospective Autonomy and Decisions Near the End of Life* (Washington, D.C.: Georgetown University Press, 2001), 9-11, 30.

⁵⁶ Notably Cecilia H. Martin, editor of *The Catholic Advocate* and member of the Catholic Media Coalition, whom Jeff Johnson of Cybercast News Service (CNS) quoted on 7 August 2003 as saying, "The Florida bishops have made no less than ten appeals to the governor for criminals on death row, asking that their sentences be changed to life in prison. For Terri Schiavo, there has not been one single public word"; and Thomas A. Droleskey, editor of *Christ or Chaos*, who wrote in the 4 September 2003 issue of *Seattle Catholic*, "The Florida Catholic Conference found time in the last few weeks to plead for the life of Presbyterian minister Paul Hill, who was executed on September 3, 2003, for killing a baby-killer, but did not believe it to be its business to plead in absolute terms for the sparing of Terri Schiavo's life."

worded statements of the Church's preference that Terri live. On 18 July 2003 Mary Ann Kreitzer, president of the Catholic Media Coalition, sent an open letter demanding that the Florida bishops "publicly condemn the injustice and moral evil of this deliberate act of euthanasia." On 28 July physicians Robert J. Saxer, president of the Catholic Medical Association, and Steven White, president of the Florida Catholic Medical Association, issued a joint statement questioning Terri's PVS, insisting that she is not terminally ill, reminding concerned parties that Catholic Catechism No. 2277 condemns euthanasia by either act or omission, and concluding that Catholicism cannot justify the withdrawal of Terri's MANH.

Responding to these and other pressures, Lynch published on 12 August a stronger and more detailed statement that noted the familial and medical disagreements, chastised various parties for inflammatory rhetoric, and urged prayer for a "peaceful, moral, legal, and just resolution," to this extremely difficult case. On 25 August Bishop John H. Ricard, writing for all ten bishops of the Florida Catholic Conference, appealed forcefully and directly to the governor to commute the death sentence of Paul Hill, the convicted murderer of abortion provider John Bayard Britton and his bodyguard, Lt. Col. James Barrett. Defenders of the Schindlers were furious that the bishops begged for the life of a murderer whose political agenda happened to agree with theirs, but would not do so for an innocent woman who was perhaps herself the victim of an attempted murder. They called in vain upon the bishops to make an even stronger proclamation about Schiavo.

Enacted mostly in reaction to *Cruzan*,⁵⁷ the Patient Self-Determination Act (PSDA), signed 5 November 1990 and effective 1 December 1991,⁵⁸ required hospitals and related health care organizations to educate patients about advance directives,⁵⁹ especially living wills and durable powers of attorney (health care proxies).⁶⁰ Since then, federal and state governments have further urged citizens to plan carefully for future health contingencies and to create the appropriate documents.⁶¹ The law thus accepts the "prospective autonomy" of presently competent individuals who may someday become incompetent or incapacitated patients,⁶² but does not sufficiently ensure its implementation in right-to-die cases, even when it takes the form of advance directives. Even post-*Cruzan*, many patients who wish to die and have a legitimate reason for doing so are denied this right.⁶³ Hence psychiatric as well as legal and spiritual counseling comes into play.⁶⁴

⁵⁷ One interpretation was that the 1988 decision in *Cruzan v. Harmon* was tyrannical; cf. Giles Scofield, "The Calculus of Consent," *Hastings Center Report* 20, no. 1 (January-February 1990): 44-47.

⁵⁸ Omnibus Budget Reconciliation Act (1990), Sections 4206 and 4751, P.L. 101-508. 42 U.S.C. Section 1395 cc(f) (West 1992 and Supp. 1996).

⁵⁹ *Black's Law Dictionary* defines "advance directive" narrowly to refer only to the selection of a durable power of attorney, but here we use it broadly, in tune with ordinary bioethical parlance, to refer to any clear and convincing expression by a competent person of specific wishes for health care should that person ever become incompetent or incapacitated.

⁶⁰ D.C. Park, T.A. Eaton, E.J. Larson, and H.T. Palmer, "Implementation and Impact of the Patient Self-Determination Act," *Southern Medical Journal* 87, no. 10 (October 1994): 971-977.

⁶¹ C.M. Galambos, "Preserving End-of-Life Autonomy: The Patient Self-Determination Act and the Uniform Health Care Decisions Act," *Health and Social Work* 23, no. 4 (November 1998): 275-281.

⁶² Olick, 22.

⁶³ Norman L. Cantor, "Twenty-Five Years After Quinlan: A Review of the Jurisprudence of Death and Dying," *Journal of Law, Medicine, and Ethics* 29 (2001): 182-196.

⁶⁴ M.B. Kapp, "Implications of the Patient Self-Determination Act for Psychiatric Practice," *Hospital and Community Psychiatry* 45, no. 4 (April 1994): 355-358.

Questions such as whether a physician may ever allow a patient to commit suicide or must always intervene to prevent suicide cannot be answered in absolute terms. Each case is different and patients have well established ethical and legal rights to most forms of suicide. The physician should always consult the incompetent or incapacitated patient's family regarding end-of-life decisions, especially when advance directives do not exist. Spiritual counselors should never be too far way.⁶⁵ The goal, even if quixotic, is unanimity.

Since the enactment in 1986 of the Emergency Medical Treatment and Active Labor Act (EMTALA)⁶⁶ and in the wake of several test cases, patients and their proxies have had the upper hand over physicians in deciding whether life support is employed, continued, or withdrawn.⁶⁷ The family of an incapacitated patient can legally demand treatment, even if futile, and sometimes even if the patient is already dead by neurological criteria (brain dead). Sound medical judgment as to futility of treatment is trumped by subjectivity when the family is in denial of their loved one's condition and prognosis.

Evaluating the Motives of Guardians

The motives of Quinlan's and Cruzan's parents were irreproachable. Bouvia acted on her own. The patients' best interests were foremost in the petitioners' minds in each of these three cases; but the motives of the legal guardians in the other two cases can be called into question. The guardians of Quinlan and Cruzan had no conflicts of interest; the guardians of Martin and Schiavo apparently do.

Mary Martin, speaking in Philadelphia at the "Families on the Frontier of Dying" conference on May 21, 1998, blamed cases like Michael's for high automobile insurance rates, lamented that Michael is likely to outlive her, complained that his life is meaningless because all he does is smile, attacked his mother and sister for allowing him to continue to exist, and suggested that his organs could be harvested to provide transplants. Her ideas about organ donation and insurance rates may be just pragmatic or, given that he is the father of her children and that her own brother, George Sears, sided with Leeta and Patricia, cruel and heartless.

As early as 1988, Mary exhibited signs of wanting to control Michael's life and environment at Leeta's and Patricia's expense. She refused to authorize antibiotics for Michael's pneumonia until Michigan Adult Protective Services ordered her to do so. Thereafter she limited Leeta's and Patricia's access to Michael and to information about him. In subsequent proceedings, Leeta and Patricia alleged several reasons why Mary is unsuitable as Michael's guardian, including her extramarital relationships and her apparent dislike of disabled persons. Beyond these allegations is that fact that as a wife or widow she collects Michael's disability payments, but if she divorced him she would lose that income. She may just want to get on with her life, which would be quite justifiable under the circumstances of her ruined marriage. The proper way to do that would be to

⁶⁵ Cf. Bernard Lo [et al.], Working Group on Religious and Spiritual Issues at the End of Life, "Discussing Religious and Spiritual Issues at the End of Life: A Practical Guide for Physicians," *JAMA* 287, no. 6 (13 February 2002): 749-754.

⁶⁶ 42 U.S.C. § 1395dd (1988 & Supp. V 1993).

⁶⁷ Judith F. Daar, "Medical Futility and Implications for Physician Autonomy," *American Journal of Law and Medicine* 21, nos. 2-3 (1995): 221-240.

divorce Michael, but heteronomous financial considerations seem to persuade her against that course.⁶⁸ Her financial situation would be much better as a widow than as either a divorcee or Michael's wife.

Both at their Web site <www.terrisfight.org> and in various court filings,⁶⁹ the Schindlers have accused Michael Schiavo of crimes, attitudes, and immoralities that should disqualify him as guardian. They believe he has the most wicked motives in asking that her MANH be stopped. They claim that her present condition resulted from his attempt to strangle her. They have collected evidence that he withholds her proper health care and rehabilitation,⁷⁰ overrides sound nursing procedures,⁷¹ wishes her dead⁷² so that he can inherit the malpractice money, and is false to his marriage vows. It is a fact that Michael, in what the Schindlers claim is an illegal and immoral violation of his duty to Terri, has been living with Jodi Centonze since 1995, has been engaged to her since July 1997, and has a daughter by her.

Medical opinions about her condition and prognosis divide between the physicians selected by the Schindlers and those selected by Michael. CT scans in 1996 showed that "much of her cerebral cortex is simply gone and has been replaced by cerebral spinal fluid,"⁷³ which supports the PVS diagnosis, but several other examinations, notably Hammesfahr's, disagree.⁷⁴ Her full-body bone scan done on 5 March 1991 at Manatee Memorial Hospital by W. Campbell Walker revealed a long history of fractures and other trauma, injuries that were previously unknown to the Schindlers. From this evidence they deduced that Terri was the victim of persistent spousal abuse. It was a small step from there to inferring attempted strangulation as the cause of her brain damage. Several physicians, including Hammesfahr, stated that Terri's rigid and elongated neck when she presented to paramedics on 25 February 1990 was consistent with attempted strangulation. Despite his CPR training, Michael did not place her on her back or try to clear her airway when he found her unconscious and called 911.

Tedium vitae ("weariness of life") is presumed to mean *taedium vitae suae* ("weariness of one's own life"). It could also be *taedium vitae eius* ("weariness of someone else's life"). For any competent person, *taedium vitae suae* is always sufficient justification for suicide, as long as the decision is free, uncoerced, and not subject to any heteronomous influences beyond those circumstances which led the person to contemplate suicide in the first place. In *Bouvia*, the California appellate court upheld this ethical principle. But to act upon *taedium vitae eius* is to attempt murder. To assert that *taedium vitae eius* motivates Michael Schiavo would be unproven and perhaps slanderous. However, given that he stands to benefit both financially and conjugally from Terri's death, to assume that *taedium vitae eius* does not motivate him is not beyond reasonable doubt. Conflict of interest certainly exists.

⁶⁸ John H. Hess, "Looking for Traction on the Slippery Slope: A Discussion of the Michael Martin Case," *Issues in Law and Medicine* 11, no. 2 (Fall 1995): 105-122.

⁶⁹ Principally in *Schindler v. Schiavo*, Verified Amended Complaint, U.S. Dist. Ct., Middle District of Florida, Tampa Division, Civil Case No. 8:03-CV-1860-T-26-TGW (August 30, 2003).

⁷⁰ Carolyn Johnson Aff. (August 28, 2003), *Schindler v. Schiavo* (August 30, 2003).

⁷¹ Heidi Law Aff. (August 30, 2003), *Schindler v. Schiavo* (August 30, 2003).

⁷² Carla Sauer Iyer Aff. (August 29, 2003), *Schindler v. Schiavo* (August 30, 2003).

⁷³ *Schiavo I*.

⁷⁴ According to Michael Schiavo's lawyer, George J. Felos, Hammesfahr is a self-promoter and grandstander with dubious medical expertise. Cf. Opposition to Emergency Motion for Stay (August 19, 2003), In re the Guardianship of Theresa Marie Schiavo, Case No. SC03-1242 (Fla.Sup.Ct.).

The slippery slope argument against legal decisions such as *Schiavo IV* is that allowing legal guardians to exercise substituted judgment about life or death, when their wards are incompetent or incapacitated patients without clear or convincing advance directives, could enable ulteriorly motivated guardians to commit murder. It is analogous to the typical slippery slope argument against PAS, “that societal acceptance of assisted suicide will inevitably invite abuse and lead to arbitrary medical murder.”⁷⁵ Prado and Taylor caution against allowing physicians to make end-of-life decisions on their own, because, as medical attitudes and definitions regarding life and death change and are imparted to new generations of physicians, these attitudes and definitions may not accurately reflect the subjective values of patients and their loved ones. Physicians, who naturally abide primarily by their own professional standards, may be inadequate judges of societal, familial, or even moral standards.⁷⁶ It would therefore be best to leave end-of-life decisions to patients and their families, in consultation with physicians and clergy, optimally with agreement among all concerned. The same argument could apply, *mutatis mutandis*, to questionably motivated legal guardians of incompetent or incapacitated patients.

If there is reason to suspect that someone may feel, or may eventually come to feel, *taedium vitae eius* toward an incompetent or incapacitated patient, then no court should tolerate that person as guardian of that patient. *Prima facie* conflict of interest, as exists in both *Martin* and *Schiavo*, constitutes such reason to suspect. But to argue that legal guardians ought never to initiate seeking the deaths of their wards would push the matter too far, as that would undermine *Quinlan* and *Cruzan*.⁷⁷

A Proposed Solution

Lacking the patient’s clear and convincing advance directive, unless consensus exists among all immediate relatives that life support or MANH should be withdrawn, the court should always prefer to err on the side of life.⁷⁸ That is, if the spouse, parents, siblings, and children (or the minor children’s legally appointed representatives) agree that the patient would be best served by being allowed to die, then the court should grant their request. But if any of these interested parties should disagree with the patient’s legal guardian’s wish to allow the patient to die, then the court should deny the guardian’s request.

It does not hurt Mary Martin that Michael goes on living; but his death from withdrawal of MANH would seriously upset Leeta Martin and Patricia Major. Similarly, Terri Schiavo’s continued existence may be inconvenient for Michael Schiavo, but her death would torment her parents, her brother, and her sister, Suzanne Schindler Carr. The principle of double effect would hold that greater harm is done to the Schindlers by letting Terri die than to Michael Schiavo by

⁷⁵ C.G. Prado and S.J. Taylor, *Assisted Suicide: Theory and Practice in Elective Death* (Amherst, N.Y.: Humanity Books, 1999), 23.

⁷⁶ Prado and Taylor, 142.

⁷⁷ James Bopp, Jr., “Choosing Death for Nancy Cruzan,” *Hastings Center Report* 20, no. 1 (January-February 1990): 42-44.

⁷⁸ The danger of allowing surrogate decision makers to err on the side of death has been recognized since Cruzan; e.g., Ira Mark Ellman, “Can Others Exercise an Incapacitated Patient’s Right to Die?” *Hastings Center Report* 20, no. 1 (January-February 1990): 47-50.

letting her live. Even if Cranford, Greer, and Bambakidis are right and Maxfield and Hammesfahr are wrong, Terri should not be allowed to die if her parents cling to the last trace of hope and comfort. The means of maintaining her may be disproportionate for the majority prognosis, yet proportionate for the minority, with which the Schindlers concur.

For a nation that upholds the separation of church and state, the most important principle in all right-to-die cases should be the presumption that one's life is indeed one's own to do with as one pleases, i.e., that the ultimate governor of one's own life is oneself, not the church, the state, or, for that matter, one's physician. The principle of respect for patient autonomy is well established in medical ethics, even though frequently criticized.⁷⁹ One argument against it is that individual autonomy is inadequate as a basis of public policy, so patients such as Bouvia should be forced to live against their will for the good of the community and to endorse a general respect for life.⁸⁰

None of these five patients was "terminally ill" in the sense that their present medical conditions were likely to kill them within a year, yet the courts approved death for three of them (Quinlan, Bouvia, and Cruzan), denied death to one (Martin), and remain confused about the fifth (Schiavo). *Quinlan*, *Bouvia*, and *Cruzan* show that some American courts allow euthanasia or assisted suicide not only in cases of terminal illness, but also in other low-quality-of-life situations. Neither PVS nor coma necessarily indicates terminal illness. Quinlan and Cruzan each survived a long time, and Martin and Schiavo are likely to. Bouvia was alert, rational, and generally healthy, but in great pain and discomfort. By granting her request, the 1986 court only acceded to the autonomous will of an informed person exercising her right to refuse to let others save her life, and did not pass judgment on her medical condition as a justification for removing MANH. In so ruling, the court endorsed a best interest standard, accepted a competent albeit severely disabled person's own judgment as to her best interest, affirmed the principle of respect for patient autonomy, rejected both medical and legal paternalism, and adopted the lowest standard for disclosure in an informed consent or refusal case, the "subjective patient-oriented" standard (what *this* patient wants to know), lower than either the "objective patient-oriented" standard (what a "normal" patient would want to know) or the "professional standard" (what a physician would want the patient to know).

Pace Spinoza, anyone's free choice to die should be inviolate. The trick is making sure that it is indeed free in the sense of absolutely voluntary and uncoerced. In the absence of a clear and convincing explicit statement, such as an advance directive, we should assume, in any situation, even PVS, coma, terminal illness, or other severe incapacitation, that the patient does not want to die. The burden of proof, and it should be a huge burden, should be on the guardian who chooses death for the patient. *Quinlan*, *Bouvia*, and *Cruzan* meet those high standards; *Martin* and *Schiavo* do not. An advance directive should overrule any set of wishes the patient's family may have, but, in the absence of both an advance directive and family unanimity, the court should always choose life, even a miserable PVS life.⁸¹

⁷⁹ James F. Childress, "The Place of Autonomy in Bioethics," *Hastings Center Report* 20, no. 1 (January-February 1990): 12-17.

⁸⁰ Francis I. Kane, "Keeping Elizabeth Bouvia Alive for the Public Good," *Hastings Center Report* 15, no. 6 (December 1985): 5-8.

⁸¹ I gratefully acknowledge the assistance of John H. Hess, James Lawrence, Sarah Luft, Robert S. Olick, and William O'Malley in preparing this paper.