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Family Conflict and Family Privacy: The Constitutional Violation in Terri Schiavo's Death

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FAMILY CONFLICT AND FAMILY PRIVACY: THE CONSTITUTIONAL VIOLATION IN TERRI SCHIAVO'S DEATH

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The public understanding of Terri Schiavo's death was refracted through the polarized politics of the abortion wars. By the time the Florida legislature intervened in her case in 2004 and the United States Congress followed suit in 2005, the debate surrounding her had become hardened into the familiar antagonisms of our times—religion vs. secularism, pro-life vs. pro-choice, liberals vs. conservatives. On the left, the claim was that Terri had chosen to end her life rather than endure the endless limbo of her persistent vegetative state but that outsiders were attempting to force their own conception of a "life worth living" on her; on the right, the claim was that Terri's medical condition was uncertain, that she might benefit from some further therapy, and that her "right to life" was being scorned by those pressing for removal of her feeding tube.[1]

This stylized conflict obscured a more immediate issue at stake in Terri's case. This issue was presented by the family conflict between Terri's husband, Michael Schiavo, and her parents, Robert and Mary Schindler, about the continuance of Terri's life-prolonging medical treatment. The issue was not the substantive disagreement between them but the simple fact of their conflict regardless of its merits. By the time of Terri's death, this conflict had escalated beyond any sensible proportions and beyond even the most remote possibility of reconciliation between them. Thus after Terri's death, following the removal of her feeding tube as Michael had sought, her parents were not in-

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1. *See* George J. Annas, *'Culture of Life' Politics at the Bedside—The Case of Terri Schiavo*, 352 N. ENG. J. MED. 16 (2005); Anna Quindlen, *The Culture of Each Life*, NEWSWEEK MAGAZINE, April 4, 2005, p. 62.

formed of the time or location of her burial.[2] Soon thereafter, in response to the Schindlers' repeated allegations, a criminal investigation was initiated by Governor Jeb Bush of Florida to determine whether Michael was responsible for injuring Terri fifteen years earlier when she suffered her anoxic event.[3] This increasingly bitter family conflict was the impetus for the proliferating public engagement as competing advocates for Terri's husband and parents sought allies to join their struggle. The family conflict was generally understood, however, as merely the backdrop for the real issue at stake—that is, whether Terri's treatment should be continued. The family conflict was noted by Florida courts as the self-evident justification for their initial intervention to render a definitive judgment about Terri's continued treatment. The need for and propriety of governmental involvement in resolving this dispute was similarly viewed as self-evident in the subsequent involvement of Florida's governor and legislature, and then Congress. The Florida courts rebuffed this involvement on the basis of constitutional assertions of judicial autonomy;[4] the federal courts rapidly disposed of substantive claims for which Congress had authorized de novo review.[5] But none of the courts and virtually none of the other official and unofficial disputants about Terri's fate explicitly asked whether this family dispute should properly have been resolved in any public forum. A principle of family privacy—a principle, I would argue, of constitutional dimensions—was thereby dishonored.

I. PROTECTING TERRI SCHIAVO'S RIGHT TO SELF-DETERMINATION

Neither Terri's husband nor her parents resisted governmental intervention as such. Michael explicitly claimed that governmental assistance was necessary and appropriate to carry out Terri's wishes, notwithstanding that she had never completed an advance directive or appointed any health care proxy to act on her behalf if she became incompetent. The Schindlers asserted both in judicial and subsequent legislative proceedings that

2. *Controversy Continues as Terri Schiavo's Remains Interred in Clearwater*, June 20, 2005, *http://journals.aol.com/justice1949/JUSTICEFORTERRISCHIAVO/*entries/958.

3. *Florida Closes Its Inquiry Into Collapse of Schiavo*, N.Y.TIMES, July 8, 2005, p. A20, col. 6 ("In the new report, Mr. [Bernie] McCabe [prosecutor for Pinellas and Pasco Counties] said that to open a full homicide investigation, there must be some fact or evidence indicating that a criminal act caused the death. He said his review had found none.").

4. Bush v. Schiavo, 885 So. 2d 321 (Fla. 2004).

5. Schiavo ex rel. Schindler v. Schiavo, 403 F.3d 1223 (11th Cir. 2005).

Terri's medical condition was treatable and on this substantive basis argued that state officials should not direct abandonment of life-prolonging treatment. Neither Michael nor the Schindlers asserted that they were pursuing interests of their own; they purported to speak only for and on behalf of Terri. And Florida law specified that the only proper focus for inquiry was Terri's prior wishes.[6]

In 1990, the U.S. Supreme Court had effectively endorsed the proposition that mentally competent individuals have a constitutional right to choose about the continuance of life-prolonging medical treatment, including artificial feeding.[7] The *Cruzan* case itself dealt with an incompetent person who, like Terri Schiavo, had left no formal advance indication of her wishes; the Court divided on the issue of the quantum of proof that a state might require to justify treatment discontinuance, with the majority accepting Missouri's specification of "clear and convincing evidence." By 2005, virtually every state had legislatively provided that individuals are entitled to specify advance directives and/or to appoint health care proxies to direct their medical treatment if they should become incompetent.

Most people, however, do not take advantage of this entitlement[8]; and for such people, most states provide for automatic appointment of a health care proxy based on a fixed statutory hierarchy (with spouse first, adult children second, parents third and so on). Under most of these state laws, the statutory proxy appointment effectively resolves any conflict among family members about treatment decisions without any specific inquiry about the incompetent patient's actual prior preferences.[9] (Some

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6. In re Guardianship of Browning, 568 So. 2d 4 (Fla. 1990).

7. Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261 (1990).

8. See the data cited by Justice O'Connor in her concurring opinion in *Cruzan*, 497 U.S. at 289 n.1.

9. *See* Alabama: Ala. Code 1975 § 22-8A-11 and -6; Alaska: Alaska Stat. § 13.52.030; Arizona: Ariz. Rev. Stat. Ann. § 36-3231; Arkansas: Ark. Code Ann. § 20-17-214; California: Cal. Health & Safety Code § 24178; Delaware: Del. Code Ann. tit. 16, § 2507; Washington, D. C.: D.C. Code 1981 § 21-2210; Florida: Fla. Stat Ann. § 765.401; Georgia: Ga. Code Ann. § 31-9-2 (informed consent statute) and Ga. Code Ann. § 31-36A-1 to -7; Illinois: 755 ILCS 40/1 to 40/65, specifically 40/25; Iowa: Iowa Code Ann. § 144A.7; Kentucky: Ky. Rev. Stat. § 311.631; Louisiana: La. Rev. Stat. Ann. § 40:1299.58.1 to .10; Maine: Me. Rev. Stat. Ann tit. 18-A, § 5-801 to § 5-817, specifically § 5-805; Maryland: Md. Health-Gen. Code Ann., § 5-605; Mississippi: Miss. Code Ann. §§ 41-41-201 to -229, particularly §§ 41-41-203(s), -211, and -215(9); Montana: Mont. Code Ann. § 50-9-106; Nevada: Nev. Rev. Stat. § 449.626; New Mexico: N.M. Stat. Ann. 1978 § 24-7A-5; New York: N.Y. Pub. Health Law § 2965; North Carolina: N.C. Gen. Stat. § 90-322 (assigning priority first to patient's spouse, then to "relatives of the first degree"); North Dakota: N.D. Cent. Code § 23-12-13; Ohio: Ohio Rev. Code Ann.

state laws provide that where the statutory proxy is a multi-member group—e.g., adult children—any disagreement is conclusively resolved by majority vote; and tie votes require appointment of a different, presumably more resolute, proxy.[10]) The justification for this imposed hierarchy offered by the drafters of the widely influential proposed uniform law was that a "presumed majority" would prefer these results.[11] If an individual constitutional right to control one's medical treatment is at stake, this rough calculation about majority preference would arguably be insufficient; and individualized inquiry might instead be required.[12]

Florida law cannot, however, be faulted on this ground. Though Florida follows other states in providing automatic appointment of a proxy for incompetent patients who had not made their own prior arrangements, Florida explicitly requires this appointed proxy to use a "substituted judgment" standard—that is, to act on the basis of the incompetent patient's prior values and wishes—in making treatment decisions. Unlike most other states, moreover, Florida puts bite into this requirement by specifying that any family member who disagrees with the automatically appointed proxy's decision can secure immediate judicial review; and in these proceedings, the incompetent patient's wishes must be determined by "clear and convincing evidence."[13] Thus more explicitly and rigorously than most states, Florida seeks to vindicate the incompetent patient's prior intentions.

It is therefore especially striking that the Florida courts truncated their inquiry into Terri's prior wishes by restricting

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§ 2133.08; Oregon: Or. Rev. Stat. § 127.635 and § 127.505(12) and 127.535(4); South Carolina: S.C. Code 1976 Ann. § 44-66-10 to -80; South Dakota: S.D. Codified Laws § 34-12C-1 to -8; Tennessee: Tenn. Code Ann § 68-11-1801 to -1815, particularly § 68-11-1806; Texas: Tex. [Health & Safety] Code Ann. § 166.039 (providing for joint surrogacy between supervising physician and family member, according to priority); Utah: Utah Code Ann. § 75-2-1105, -1105.5, -1107; Virginia: Va. Code § 54.1-2986; Washington: Wash. Rev. Code Ann. § 7.70.065; West Virginia: W. VA. Code Ann. § 16-30-8; Wisconsin: Wisc. Stat. Ann. § 50.06 (applicable only for certain facility admissions).

10. *See, e.g.*, Uniform Health-Care Decisions Act (1993), section 5 (c); Fla. Stat. 765.401(1)(c), (e) (2000).

11. Uniform Health-Care Decisions Act at section 5 (b). *See* Comment, at p. 16 ("If an individual does not designate a surrogate . . . subsection (b) applies a default rule for selecting a family member to act as a surrogate. Like all default rules, it is not tailored to every situation, but incorporates the presumed desires of a majority of those who find themselves so situated.").

12. For consideration of this constitutional claim, see text accompanying notes 31–36, *infra*.

13. Fla. Stat. § 765.105 (2000), In re Guardianship of Browning, 568 So. 2d 4, 15 (Fla. 1990), In re Guardianship of Schiavo, 780 So. 2d 176.179 (Fla. 2d DCA 2001).

their attention to Terri's views about life-prolonging medical treatment while they failed to ask whether she would have given preferential deference to her husband or to her parents in their conflict over this question. The courts assumed that Terri would simply decide the treatment question for herself without any consideration of deference to one or another family member. One explanation for this unexamined assumption is that the courts were ideologically blinded by the conventional idea of autonomy that has taken hold in our legal culture—the idea that "autonomous choice" implies a self-regarding rational actor who bases his decisions entirely on utilitarian calculation of his own self-interest.[14] The possibility that Terri Schiavo might have wanted to defer to her husband's or to her parent's wishes in preference to her own about treatment prolongation simply vanishes from this clichéd but nonetheless culturally powerful conceptualization.

The judges of Florida court of appeals revealed the distorting grip of this conventional conceptualization in the opinion they rendered in 2003, the fourth of their numerous reviews of Terri's case. Judge Chris Altenbernd, writing for the Court, stated:[15]

> The judges on this panel are called upon to make a collective, objective decision concerning a question of law. Each of us, however, has our own family, our own loved ones, our own children. From our review of the videotapes of Mrs. Schiavo, despite the irrefutable evidence that her cerebral cortex has sustained the most severe of irreparable injuries, we understand why a parent who had raised and nurtured a child from conception would hold out hope that some level of cognitive function remained. If Mrs. Schiavo were our own daughter, we could not but hold to such a faith.
>
> But in the end, this case is not about the aspirations that loving parents have for their children. It 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 courts to permit trial judges to serve as surrogates or proxies to make decisions about life-prolonging

14. This is the so-called "unencumbered self" critically examined by Michael Sandel in DEMOCRACY'S DISCONTENT: AMERICA IN SEARCH OF A PUBLIC PHILOSOPHY (1996).

15. Schindler v. Schiavo (In re Guardianship of Schiavo), 851 So. 2d 182, 186 (Fla. 2d DCA 2003).

> procedures. . . . It is a necessary function if all people are to be entitled to a personalized decision . . . independent of the subjective and conflicting assessments of their friends and relatives. . . .
>
> At the conclusion of our first opinion we stated: In the final analysis, the difficult question that faced the trial court was whether Theresa Marie Schindler Schiavo . . . would choose to continue the constant nursing care and the supporting tubes in hopes that a miracle would somehow recreate her missing brain tissue, or whether she would wish to permit a natural death process to take its course and for her family members and loved ones to be free to continue their lives.

This is a heart-felt statement. The formal solemnity of Judge Altenbernd's reference to "Theresa Marie Schindler Schiavo" testifies to his appreciation of the gravity of his court's role.

He is admirably open in acknowledging the conflict that he and the other judges on the panel feel between their commitment to "objectivity" and their subjective understanding and sympathy with the unwillingness, even the inability, of Terri's parents to abandon hope for her. "If Mrs. Schiavo were our own daughter, we could not but hold to such a faith." But Judge Altenbernd failed to see that Terri herself might have extended the same sympathetic understanding to her parents and might have resolved to act on that understanding. In the sad light of her parents' desperate clinging to her, Terri might have decided that "in the end, this case *is* . . . about the aspirations that loving parents have for their children." Terri might have concluded that she could best honor their love by deferring to their passionate wish that she remain alive, notwithstanding the gravity of her impairment. Would she insist on dying—as Judge Altenbernd imagined—to "permit . . . her family members and loved ones to be free to continue their lives," if they pleaded with her that they did not want this freedom?

Framing the question in these terms would not, of course, have simplified the judges' task. It would have vastly, even hopelessly, complicated their proclaimed effort to implement her values and preferences. If they had concluded that Terri valued loyalty to her family more than any isolated calculation of her own self-interest (or, more precisely, that her conception of self-interest included honoring others in a loving relationship with her), the judges must then decide how Terri would have ranked the conflicting requests from her parents and her husband.

The irrebuttable presumption in most state laws preferring spouses over parents as automatic proxies overlooks the dramatic alteration in the psychology of intimate relationships that occurs when a previously competent adult becomes incompetent and entirely dependent on others for caretaking. This status echoes the utter dependency of childhood and the centrality of the parent-child relationship. Spouses can, of course, adapt to their adult partner's altered status. But parents have already experienced this dependency relationship and can often renew it more readily than a spouse and, for this reason alone, might well be preferred by the now-incompetent, childish adult. Even the adult children of a now-incompetent adult have had more direct experience of a dependency relationship than the spouse and, for this reason alone, might be more capable and more welcomed in reversing caretaking roles with their now-needy parent. Thus it is not at all clear that a "presumed majority" of adults, if rendered incompetent, would conclusively prefer their spouse to their parents or their adult children as health care proxy.

Terri might have provided unambiguous guidance for answering this question if she had previously appointed her husband or her parents as her health-care proxy. She had not done so; and though, as noted, Florida law filled in this blank for her, it also provided that other family members could challenge her spouse/proxy's decisions, requiring a demonstration in court of "clear and convincing evidence" about her wishes. The question thus presented was whether Terri would have preferred to be seen as a "loving wife" or a "loving daughter" in circumstances where she was obliged to choose between these two intensely valued self-depictions.

According to testimony in the 2000 probate court proceeding, Terri had discussed with various relatives and friends the possibility that she would become incompetent and dependent on life-prolonging technology. But there was no testimony that she had ever anticipated conflict between her husband and her parents about her reliance on such technology. By all accounts, Terri, Michael and the Schindlers had been closely and harmoniously involved with one another, not only before Terri's cerebrovascular accident in 1990 but for some three years thereafter. When they first married in1984, Terri and Michael lived in her parents' house in Philadelphia. In 1986, the couple moved to Florida and lived rent-free in a condominium owned by the Schindlers; a year later, the Schindlers themselves decided to move to St. Petersburg near Terri and Michael who, by then, had

moved into their own home. In 1991, immediately following Terri's hospitalization, Michael and the Schindlers jointly purchased and moved together into a larger home which, they anticipated, would be suitable for Terri's caretaking when she had recovered sufficiently to leave the hospital.[16] It is thus unlikely that Terri ever imagined even hypothetically the prospect that she might have to choose between her husband and her parents in determining her own preference for life-prolonging treatment.

The breach in the relationship between Michael and the Schindlers first erupted in 1993. The occasion was a disagreement about the disposition of funds which Michael had obtained in a medical malpractice lawsuit he had initiated on Terri's behalf, successfully claiming that her physicians' negligence in prescribing a weight-loss diet for her had been responsible for her anoxic event. Terri had been awarded $700,000 in damages on her own account and Michael received $300,000 for his loss of consortium with Terri. In 1993, a heated conversation took place between Michael and Robert Schindler about the disposition of the loss of consortium funds. In his testimony seven years later, Michael asserted that Terri's father had demanded some portion of those funds notwithstanding the absence of any legal basis for his demand.[17] (Florida law provided no compensable damages for parents based on injuries suffered by their adult children unless there were no other related survivors.[18]) Robert Schindler subsequently explained that he sought some substantial portion of the award to Michael, not on his own account but to assure that additional funds would be available for Terri's medical care since Michael had recently begun a romantic relationship with another woman with whom he subsequently resided and fathered two children.[19]

Viewing this breach in its most sympathetic perspective on Michael's side, by 1993 it was apparent that he had permanently lost any possibility of renewing an intimate relationship with his wife; his decision to become romantically involved with another woman did not diminish his grief or his belief in his moral and

16. *See* transcript of Michael Schiavo's testimony, pp. 23, 28, 33, File No. 90-2908GD-003, Circuit Court for Pinellas County, Florida, Probate Division, January 24, 2000. Cf. the following exchange between Michael and his attorney: "Q. [H]ow would you describe the relationship you and Terri had with Mr. and Mrs. Schindler? . . . A. . . . In my own opinion, I thought we were pretty close." *Id.* at 35.

17. Transcript of Michael Schiavo's testimony, pp. 58-60.

18. Fla. Stat. § 768.21 (2000).

19. E-mail from Barbara Weller (bweller@gibbsfirm.com) to Robert Burt, May 14, 2005, 11:15 am (on file with author).

legal entitlement to compensation for the medical negligence responsible for his loss. Viewed most sympathetically on the Schindlers' side, it was clear by 1993 that Terri's need for intensive medical care would be prolonged and increasingly costly; while Michael might be justified in "continuing his life" in light of Terri's grim condition, it was plausible for them to believe that he was morally obliged to leave her with the funds he had obtained because of his relationship with her, in order to help meet her extraordinary medical needs which prompted his actions in seeking out another conjugal relationship.

It was not until 1999 that the dispute between Michael and the Schindlers moved into the Florida courts. But disagreements between them about Terri's treatment erupted virtually immediately after this first breach. In 1994, Terri developed a bladder infection and, acting on the diagnosing physician's advice, Michael decided as her appointed proxy that antibiotic treatment be withheld. This determination brought fierce objections from the Schindlers as well as from staff of the nursing home where Terri was a patient; and Michael relented. In the 2000 probate court proceeding, Michael testified about this prior episode:[20]

> Q. Back then in . . . 1994, . . . why didn't you pursue removal of the feeding tube?
>
> A. Because at that time my emotions were running. I couldn't—I was ready to do the natural thing. I was not ready to pull the feeding tube at that time.
>
> Q. Even though you knew Terri wanted it?
>
> A. Yes.
>
> Q. Why were you not able?
>
> A. It was—I was not ready for that yet.

This testimony offers a glimpse of an underlying question that inevitably accompanies all decision-making about terminal illnesses: the question when all of the participants—the patient herself and her family members—are emotionally prepared to accept the permanent severance of their relationships and the finality of death.[21] This is a wrenching decision for everyone in-

20. Transcript of Michael Schiavo's testimony, pp. 69–70.

21. The special difficulty for this acceptance regarding a family member in a persistent vegetative state (as Terri Schiavo had been diagnosed) is shown in this account by

volved. The patient, if she is mentally competent, may choose to disregard or override others' suffering by accepting her death before they are prepared to do so; and there can be clear moral warrant for this choice. But it is a choice, and it does have inevitable consequences on the lives of survivors.

Because it is so wrenching for everyone, these decisions are often accompanied by conflict—sometimes subdued, sometimes floridly expressed—among patients (if they are able to interact), families and physicians. Skilled clinicians can frequently help the involved participants to work their way through to some mutually agreed decisions; but some conflicts do remain raw and unresolvable.[22] The American legal system has struggled since the

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the attorney for Nancy Cruzan's family who, unlike the Schindlers, were determined to obtain judicial authorization for removing her life-prolonging feeding tube. In his book, LONG GOODBYE: THE DEATHS OF NANCY CRUZAN (2002), at pp. 131–32, William Colby describes a bedside examination of Nancy by Dr. Ronald Cranford to confirm, in preparation for his court testimony, that she was in a persistent vegetative state; also at the bedside was a Public Broadcasting System television crew that the Cruzan family had enlisted to help them in their efforts to have Nancy's feeding tube removed. Colby wrote:

> Nancy's room had been filled with lawyers for both sides, the PBS crew, her family and friends and doctors from [the hospital staff]. Joe watched from one side of her bed, and Dr. Cranford moved to the other side. . . . He talked loudly.
>
> "Nancy? Nancy. Hear me? Look at me, Nancy." He waited for a response, but Nancy did not move. . . . Cranford next grabbed hold of Nancy's stiff right leg and tried to bend it straight. She grimaced. Then he reached for the soft skin on the inside of the upper part of her right arm, and held the pinch. Slowly, as if she were a robot, Nancy's head lifted off the bed and turned. Her face locked on her father's for about ten seconds, before she lowered just as slowly to the pillow.
>
> "That's what really concerns you, when she looks like she looks?" Cranford said to Joe, as he held the pinch. "That's all involuntary, even though it looks like she's looking right at you, doesn't it, huh?" Cranford asked, talking fast as he typically did.
>
> "Right," Joe said, not sounding too sure.
>
> "But you know she's not?"
>
> "Right." Watching that scene, I thought, *How could any layperson believe at that moment that Nancy Cruzan was doing anything besides looking at her father?* That deception is part of the extreme cruelty of the persistent vegetative state for loved ones left behind. For doctors who deal with PVS, though, the grimacing and movement is simply another part of the diagnosis—primitive reflex reactions from a brain stem still intact, but not any indication of higher brain function.
>
> For families, watching these simple reflexive movements often remains emotionally devastating to witness, and Cranford's exam appeared extremely difficult for Joe Cruzan, even though Nancy had been in this state for so many years. As the PBS camera turned off at the end of the exam, tears came to Joe's eyes and fell onto his cheeks. It seemed that he'd been trying to avoid crying with the camera directly on him.

22. *See* J. Randall Curtis, et al., *Missed Opportunities during Family Conferences about End-of-Life Care in the Intensive Care Unit*, 171 AM J. RESPIR. CRIT. CARE MED. 844 (2005); J. Way, A. L. Back & J.R. Curtis, *Withdrawing Life Support and Resolution of Conflict with Families*," 325 BRIT. MED. J. 1342 (2002).

landmark decision of the New Jersey Supreme Court in the *Karen Quinlan*[23] case to devise an appropriate role for courts in decision-making for incompetent patients. *Quinlan* itself did not involve an intra-familial conflict; Karen's entire family were agreed that her respirator should be removed but hospital officials refused to accept this course without a protective court order. The most widely cited subsequent cases addressing a claimed "right to die" for competent or incompetent patients similarly have not involved family conflict but rather conflicts with physicians or state officials.[24]

Florida, as noted, is one of the few states to have enacted legislation that explicitly addresses the possibility of family conflict.[25] When Michael had finally decided that he was prepared to insist on removal of Terri's feeding tube, he took the initiative in seeking probate court review because he knew her parents would object. In practical terms, the Florida legislative scheme meant that decision-making for incompetent patients remained a family matter only so long as there was unanimous agreement among family members. At the moment, however, when one family member disagrees with the others with sufficient adamance to seek judicial involvement, the probate judge displaces the family as dispositive decision-maker. To be sure, the judge is obliged by the statute to exercise "substitute judgment," to effectuate the incompetent patient's prior preferences; and for this purpose, the judge takes proffered testimony from family members and friends. But Florida law specified that when Michael sought probate court review, he necessarily and irrevocably placed the judge in charge of making treatment decisions for Terri. The Florida Court of Appeals made this clear in Terri's case a year after the probate judge's initial order had been entered:

> [T]he parties in this emotional case have overlooked the nature of the order entered on February 11, 2000. . . . The order is not a standard legal judgment, but an order in the nature of a mandatory injunction compelling certain actions by the guardian and, indirectly, by the health care providers. . . . [T]he trial court was not actually giving the guardian discretion on whether to discontinue the life-prolonging procedures.

23. In re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976).

24. See the extensive list of state cases discussed in the Court's opinion in *Cruzan*, 497 U.S. at 269–75.

25. *See supra* note 13.

> The guardian was obligated to obey the circuit court's decision and discontinue the treatment.[26]

Until the moment in March 2005 when Terri's feeding tube was withdrawn, the popular press portrayed this dispute as a continuing conflict between Terri's husband and parents. But this was wrong. The parents were in conflict with the probate judge; Michael was no longer his wife's guardian except in an empty, formal sense. The trial court was in charge.[27] As the Court of Appeals admitted, "It may be unfortunate that when families cannot agree, the best forum we can offer for this private, personal decision is a public courtroom and the best decision-maker we can provide is a judge with no prior knowledge of the ward, but the law currently provides no better solution . . ."

More is lost in the public proceeding than the family's privacy from public view; and more is lost than the control assumed over these familial decisions by a randomly assigned stranger. Any possible family conversations about Terri's future become frozen in a remote abstraction hardly recognizable as the way that empathic human beings should interact with one another. Once the judge resolved the conflicting testimony about Terri's wishes, once he concluded that she had decided years earlier that she would not want the feeding tube, there was no way that anyone could turn back or have second thoughts. The Schindlers could no longer appeal for understanding from their son-in-law that, just as he had not been "ready" to see Terri's treatment discontinued in 1994, they were still not ready. Even in the unlikely event that this possibility of empathic understanding from their son-in-law seemed worth pursuing, it could make no difference. Michael was no longer responsible for Terri's treatment; the judge was in command. Indeed, the very availability of judicial intervention created disincentives for conflicting family members to interact with one another on a face-to-face basis. In the 2000 probate court hearing, Michael testified that since their open breach in 1993, he and the Schindlers had never spoken directly; they only saw one another and conversed—if one could

26. In re Guardianship of Schiavo, 792 So. 2d 551, 558 (2d DCA Fla. 2001).

27. In the final proceedings before Terri's death, the U.S. Court of Appeals for the 11th Circuit misunderstood this fact in holding that withdrawal of her feeding tube was not "state action" because Michael Schiavo had merely obtained judicial authorization for his decision to terminate treatment. Schiavo ex rel. Schindler v. Schiavo, 403 F.3d 1289, 1292–93 (11th Cir. 2005).

call it that—in the conflicting testimony they offered in the judicial proceedings.[28]

The Florida court of appeals ruefully observed that, in response to family conflict about treatment choices for an incompetent patient, "the best decision-maker we can provide is a judge with no prior knowledge of the ward, but the law currently provides no better solution."

There is, however, a better solution than Florida law provided. The law should not have intervened to settle any dispute among family members about whether to withdraw medical treatment from an incompetent patient when the disputed action would lead to the patient's death. Life-prolonging treatment should be withdrawn only when all involved members of the patient's family agree. If there is dissent among the family, then life-prolonging treatment should be continued. There should be no option to take this dispute away from the family and have it conclusively resolved by some outsider, whether a judge or some other stranger such as panel of physicians or a hospital ethics committee.

There is a role for outsiders—that is, to counsel the family members, to facilitate conversation among them that might lead to some consensus. But this counseling role is radically different from what Florida law prescribes in supplanting the family with a judge; it is also radically different from the laws of most other states in appointing one member of the family as health care proxy and thereby effectively favoring him in any family dispute, notwithstanding the incompetent patient's prior failure to make this choice.

II. PROTECTING THE RIGHT TO FAMILY PRIVACY IN TERRI SCHIAVO'S CASE

As a matter of practical experience, there is good reason to believe that prolonged family disputes about withdrawing treatment are quite rare. Disputes do occur, within families or between families and physicians;[29] but these disputes are typically

28. Transcript of Michael Schiavo's testimony at p. 63.

29. *See* C. M. Breen, et al., *Conflict Associated with Decisions to Limit Life-Sustaining Treatment in Intensive Care Units*, 16 J. GEN'L INT. MED. 283 (2001); K. H.Abbot, et al., *Families Looking Back: One Year after Discussion of Withdrawal or Withholding of Life-Sustaining Support*, 29 CRIT.CARE MED. 197 (2001); M.D. Fetters, L. Churchill & M. Danis, *Conflict Resolution at End of Life*, 29 CRIT. CARE MED. 921 (2001).

resolved in days or at most weeks. In medical settings with most experience in these matters, skilled, effective clinicians are available to counsel families and assist them in avoiding the kind of pitched battle that developed in Terri Schiavo's case. According to published accounts as well as informal conversations that I have had with many clinicians involved in end-of-life care, the vast majority—well over 95%—of family disputes are resolved in this way.[30] As a practical matter, moreover, the availability of legal intervention can distort the interaction among the disputing family members. As the Schiavo case illustrates, the very availability of the judge as a back-up decision-maker tempts some or all of the disputants to cut off conversation and only "tell it to the judge."

Family resistance may, on occasion, obstruct the capacity of health care providers to avert painful conditions or abusive inflictions on incompetent patients. Families (or some members of families) may resist appropriate use of opioids to alleviate pain or may insist on aggressive CPR, involving the likelihood of broken bones, when such interventions are demonstrably unable to prolong life. This kind of abuse is not unique to intra-family conflicts; it may occur even with unanimity among family members. In either event, coercive state intervention is justified to override family wishes in order to remedy this abuse.

But this kind of justifiable intervention is not at stake in the circumstances of the Schiavo case. The rationale for the Schiavo intervention is to remedy dignitary injury, to ensure that the incompetent patient's prior wishes and values are honored notwithstanding her failure to have formally specified her intentions in advance. Where there is disagreement among family members, and no formal prior indication of preference by the patient for one of the disputants, the patient's dignitary interest in having her prior wishes honored is considerably attenuated by the inevitable difficulty in determining her prior wishes with any reasonable degree of certainty. Even where patients have previously completed advance directives, empirical studies indicate that most patients would want their prior instructions disregarded in deference to the contrary wishes of their families and physicians.[31]

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30. *See supra* note 22.

31. In the most extensive empirical investigation of this question, the researchers found that some seventy-eight percent of seriously ill patients expressed this preference. C.M. Puchalski, et al., *Patients Who Want Their Family and Physician to Make Resuscitation Decisions for Them: Observations from SUPPORT and HELP*, 48 J. AMER.

The fundamental question in designing legal responses to family disagreement about life-prolonging treatment for an incompetent patient is not whether the state should value prolongation of life over death no matter what quality of life might thereby be preserved. The fundamental question is whether the state should value the specific wishes of family members for prolongation over those members opposed to prolongation where the incompetent patient has left no clear prior instruction, where the patient's suffering from prolongation is limited to dignitary injury and where considerable emotional suffering will be imposed on different family members as a result either of prolongation or termination of her life. "Practicality" gives no answer to this question. Some means for choosing between either prolongation or discontinuation of the patient's life must of course be provided for this binary decision. There are, however, many equally practicable but different means available for making this choice: judicial fact-finding, automatic appointment of a family member based on status rather than substantive commitment to prolongation or discontinuation of treatment, a default rule that provides for prolongation of treatment until all intimately affected family members agree.

Indeed, in response to a family dispute or dispute between family and clinicians, it would be practicable to resolve the question of prolongation or termination by the flip of a coin. Momentarily imagining a state law to this effect provides an entry point for considering whether state legislatures are free to adopt any conceivable technique for conflict resolution or whether there are some values of constitutional dimension that must govern legislative choice.

My own intuition is that a publicly dictated decision between life and death based on a coin flip would be literally too flippant, too inattentive to the gravity of the decision. A coin flip would be so erratic and irrational in its impact as to violate the very idea of law. The randomness of state mechanisms for imposing death was the central flaw that the Supreme Court identified in overturning all extant capital punishment laws in *Furman v. Georgia*.[32] Termination of life-prolonging treatment is not imposition of a criminal penalty; but *Furman* rested much more on equal protection than on the Eighth Amendment command against cruel and unusual punishment. On this ground, state-

GERIATRIC SOC. S84 (2000).

32. Furman v. Georgia, 408 U.S. 238 (1972).

imposed coin flips to resolve family disputes about termination is surely as arbitrary—as much reliant on a random "lightning strike"[33]—as the processes condemned in *Furman*.

Is resolution of a family dispute about termination by automatic appointment of one of the disputants—without any attention to the merits of the dispute or the prior wishes of the incompetent subject of the dispute—any less arbitrary than a coin flip?

In the absence of any dispute, it is surely not arbitrary for a state to choose one relative rather than other plausible candidates to make medical decisions on behalf of an incompetent patient. Requiring concurrence for any decision among an entire family has at least two undesirable consequences. First, it is difficult, often even imponderable, to determine as an abstract proposition who might be eligible for the status of "family." Should genealogical charts dictate the result? If so, what degree of relationship should be requisite for assembling the collective decision-makers—through first cousins? What about in-laws? And so forth.

A common-sense determination of "family member" is possible, however, where automatic appointment of one member (a spouse, say) serves only as a default rule which is overridden if an actual dispute arises about terminating treatment. The eruption of an actual dispute in itself connotes that all of the disputants feel some intense connection to the patient and the specific participants in the dispute can thus be identified as "family" so long as there is some prior emotionally involved relationship (so as to exclude intrusions from the "officious intermeddlers" spawned by the polarized politics of our time).[34]

Second, if some listed assemblage of "family members" rather than a single appointee were required from the outset, be-

33. As Justice Stewart pungently characterized the irrational imposition of capital punishment, 408 U.S. at 309–10 (Stewart, J., concurring).

34. The practical effect of this default rule would serve the goal that the Supreme Court has identified in its decisions providing constitutional protection to relations between biological parents and children; the Court has held that actual day-to-day involvement with children's lives rather than a biological connection is the key for determining a constitutionally protected relationship between parent and child. *See* Quilloin v. Walcott, 434 U.S. 246 (1978); Stanley v. Illinois, 405 U.S. 645 (1972). In envisioning some degree of constitutional protection against state termination of foster parents' custody, the Court similarly gave weight to the actuality of relations with the foster children. Smith v. OFFER, 431 U.S. 816, 844 (1977) ("[Where] the foster family . . . hold[s] the same place in the emotional life of the foster child, and fulfill[s] the same socializing function as a natural family, . . . we cannot dismiss the foster family as a mere collection of unrelated individuals.")

fore any termination dispute had arisen, this could in itself tend to breed disputes by imposing responsibility on some family member who otherwise would have been disengaged from the decisions. Automatic appointment of a single proxy as a default rule in itself serves as a marker for the intensity of other family members' commitment. If, that is, an "actual dispute" is required to override the default appointment of, say, the spouse, this requirement in effect serves as a screening mechanism for demonstrating a personally intense stake in the termination decision by other family members because they must take an initiative to participate in the decision. These considerations thus indicate the rationality of a state law appointing one family member as proxy decision-maker, so long as there is no actual dispute within the family about such decisions. When an actual dispute arises, however, the automatic appointment mechanism fails utterly to satisfy even a minimal test for rationality.

But more than minimal rationality should be required to justify state interventions in family disputes about terminating life-prolonging treatment for incompetent patients. Three different pathways can lead to this heightened scrutiny. The first pathway was initially charted by the New Jersey Supreme Court in its landmark *Quinlan* ruling. In that case, the court began by holding that a competent patient had a constitutional right to choose whether to accept or discontinue life-prolonging medical treatment. Karen Ann Quinlan was, of course, not competent to make this choice; but the court ruled that her incompetence was not an acceptable basis for depriving her of her constitutional right. In order to vindicate her right, the court held, some legal mechanism must be provided for determining what decision she would have made if she were competent.[35]

The *Quinlan* decision generated an outpouring of judicial rulings and legislation in other states, essentially endorsing its mandate. Some fifteen years later, this widespread effective ratification of the *Quinlan* decision was explicitly cited by the U. S. Supreme Court in *Cruzan* as the basis for its assumption that a competent person had a constitutional right to dictate withdrawal of treatment, including artificial provision of nutrition and hydration.[36] The question specifically at issue in *Cruzan* was whether states could require "clear and convincing" evidence

35. In re Quinlan, 70 N.J. 10, 41–42, 355 A.2d 647, 664 (1976).

36. Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 275 (1990) ("The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.").

rather than a mere preponderance before concluding that an incompetent patient would have chosen to discontinue life-prolonging treatment. While the Court majority held that this higher burden of proof did not violate the Constitution, the question presented was not whether the state was obliged to give some dispositive weight to an incompetent patient's prior wishes; the Court ruled only that states had discretion in specifying the quantum of proof necessary for determining those wishes.

The Court at least implied, however, that the state was obliged to "safeguard the personal element of this choice" between "life and death" for an incompetent person.[37] Justice O'Connor, moreover, specifically concurred in the Court's opinion with the explicit suggestion that the state was affirmatively obliged to provide some effective mechanism for determining an incompetent patient's actual wishes.[38] Automatic appointment of proxy for an incompetent person who had indicated no prior preference for this proxy would not in itself be sufficient to protect an incompetent patient's constitutional right to choose medical treatment.

A second pathway for heightened scrutiny can be deduced from the constitutionally protected status of family relationships as such. Insofar as a constitutionally protected family relationship exists with an incompetent patient, the state cannot exclude that family member from decisions about the death of that patient without some specific, highly persuasive basis.[39] The strongest case for such a protected participation in decision-making, based on existing precedents, is for spouses and for parents of minor children. Thus for spouses, the clearly established constitutional right to marry necessarily implies state deference to the spouses' mutual wish to continue the relationship;[40] when one spouse becomes incompetent, this in itself provides no warrant for the state to impose termination of the relationship (whether

37. 497 U.S. at 280.

38. 497 U.S. at 289 (O'Connor, J., concurring) ("I . . . write separately to emphasize that the Court does not today decide the issue whether a State must also give effect to the decisions of a surrogate decisionmaker. . . . In my view, such a duty may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment.").

39. Thus, for example, where a husband's beating was responsible for his wife's comatose condition and termination of life-prolonging treatment would escalate criminal charges from assault to murder, the husband's obvious conflict of interest should disqualify him from decision-making authority.

40. *See* Loving v. Virginia, 388 U.S. 1 (1967).

through divorce or through death) over the other spouse's objection.

For parents of minor children, there is also well-established constitutional grounds for requiring presumptive state deference to parental child-rearing decisions generally.[41] The state's responsibility to preserve parental relations with their minor children would seem to create an almost absolute barrier to state-imposed termination of a child's life-prolonging treatment.[42] Many circumstances might be imagined where parental control of medical decisions would disserve their child's interest; refusal of state-required vaccination is the most commonly cited example from the constitutional case-law.[43] But it is difficult to imagine plausible invocation by the state of the child's best interest in overriding parental wishes to continue life-prolonging treatment.[44]

To identify a constitutional basis for requiring state deference to the wishes of a spouse or minor child's parent for life-prolonging medical treatment does not necessarily imply equal deference for their wishes to terminate treatment. The underlying basis for the constitutional guarantee is not for spousal or parental control over another person's life. The underlying basis is to honor spousal or parental interests in the preservation of their protected relationship with that person. Death ends the relationship. The willingness of a spouse or parent themselves to end their relationship by directing termination of life-prolonging treatment is not inherently wrong or even suspect. But that willingness does open the possibility that the state is entitled to assert its contrary communal interest in preserving the life of the spouse or child. So, for example, the state can legitimately act to protect a child with Downs Syndrome whose parents refuse to authorize life-prolonging surgery, as in the notorious 1982 Indi-

41. Wisconsin v. Yoder, 406 U.S. 205 (1972); Meyer v. Nebraska, 262 U.S. 390 (1923).

42. Compare Santosky v. Kramer, 455 U.S. 745 (1982), requiring the heightened standard of "clear and convincing evidence" before the state may remove a child from her parent's custody. In *Cruzan*, the Court drew a direct analogy between this constitutional requirement established by *Santosky* and decisions to terminate life-prolonging medical treatment. 497 U.S. at 284.

43. Jacobson v. Massachusetts, 197 U.S. 11 (1905).

44. Extreme examples justifying state override of parental decisions against terminating life-prolonging treatment might, for example, be an abusive parent resisting his child's death to avoid criminal prosecution for murder, as discussed *supra* note 39 regarding an abusive husband, or parental insistence on the infliction of pain and physical injury to perform CPR in a palpably impossible effort to prolong the life of an imminently terminal child.

ana *Baby Doe* case.[45] So too, as the U.S. Supreme Court held in *Cruzan*, the state is not obliged to defer to parents' wishes to terminate life-prolonging treatment merely based on their status as parents.[46]

Even assuming that the Constitution does protect the life-prolonging wishes of a spouse or minor child's parent, there is no direct case-law support for finding similar protection for the parents of an adult child. But if we look beyond what the Supreme Court has disparagingly called "narrowly defined family patterns,"[47] we can see a broader conception of family relationships for which the Court has demanded constitutional respect—a conception that would readily include the relationship between parents and adult children. In *Moore v. City of East Cleveland*, the Court invalidated a municipal ordinance which had the effect of forbidding Mrs. Moore from sharing her house with her adult son, his child and her grandchild by another adult child. The Court focused attention on the relationship between grandmother and grandchild in invalidating this peculiar ordinance; but its reasoning extends beyond this. Thus the Court stated:

> Ours is by no means a tradition limited to respect for the bonds uniting the members of the nuclear family. The tradition of uncles, aunts, cousins, and especially grandparents sharing a household along with parents and children has roots equally venerable and equally deserving of constitutional recognition. . . . [T]he accumulated wisdom of civilization, gained over the centuries and honored throughout our history, . . . supports a larger conception of the family. . . . Especially in times of adversity, such as the death of a spouse or economic need, the broader family has tended to come together for mutual sustenance and to maintain or rebuild a secure home life.[48]

This same respect for "the broader family" was evident in the landmark *Quinlan* ruling where the New Jersey Supreme Court explicitly insisted—and "repeated," as they said, "for the sake of emphasis and clarity"—that, notwithstanding the status of Karen Ann's father as her legally appointed guardian, any decision to terminate her life-prolonging treatment must be based

45. *See* ROBERT A. BURT, DEATH IS THAT MAN TAKING NAMES: INTERSECTIONS OF AMERICAN MEDICINE, LAW, AND CULTURE 161–62 (2002).

46. 497 U.S. at 285–86.

47. Moore v. City of East Cleveland, 431 U.S. 495, 506 (1977).

48. *Id.* at 504–05.

on "the concurrence of [her] guardian *and family.*"[49] The *Quinlan* court did not identify the constitutional basis for this requirement; it was in uncharted territory in 1976. But in our understanding of the roots of the constitutional rule that has emerged from *Quinlan*,[50] it is important to see the New Jersey court's assumption that concurrence among the family of an incompetent patient, and not simply the decision of one legally recognized "head of household," was essential for legitimating the momentous decision to withdraw life-prolonging treatment from an incompetent adult.

If the state is constitutionally required presumptively to defer to the wishes of any family member for continuation of life-prolonging treatment of an adult child but not required to give equal deference even to a unanimous family wish for termination, a clear direction emerges for responding to family disputes such as the Schiavo case.[51] Like any constitutionally based command, this required deference to any family member's insistence on life-prolongation could be rebutted in specific cases by some sufficiently weighty state interest. With one exception, however, it is difficult to imagine any circumstances where the state could adequately justify imposing death on an incompetent patient over the objections of a family member. If the patient were suffering considerable pain, this could always be remedied by some drug regime.[52] In any event, patients in a persistent vegetative state, as Terri Schiavo was diagnosed, do not experience any pain; this incapacity is one of the hallmarks of the diagnosis.

The one exception which could justify a state command for termination of life-prolonging treatment is to honor the incompetent patient's clear prior directive that, in the event of conflict among family members, she had specified who should prevail over others and that person was pressing for termination of

49. In re Quinlan, 70 N.J. 10, 55, 355 A.2d 647, 671 (1976) (emphasis added).

50. The "seminal" status of *Quinlan* was explicitly acknowledged by the Supreme Court in *Cruzan*, 497 U.S. at 269.

51. Cf. the Supreme Court's approval in *Cruzan* of a constitutionally relevant distinction between decisions to provide and to terminate life-prolonging treatment, sufficient to justify the added burden of proof by the state for termination decisions. Citing Santosky v. Kramer, 455 U.S. 745 (1982), the Court stated, "In *Santosky*, one of the factors which led the Court to require proof by clear and convincing evidence in a proceeding to terminate parental rights was that a decision in such a case was final and irrevocable. *Santosky, supra,* at 759. The same must surely be said of the decision to discontinue hydration and nutrition of a patient such as Nancy Cruzan, which all will agree will result in her death." 497 U.S. at 284.

52. See BURT, *supra* note 45, at 216–17 nn. 11–15.

treatment.[53] It would not be enough if the patient had previously expressed a generalized wish for termination of treatment; I would say that the patient must have specifically envisioned family conflict and chosen sides in advance. For most people, the eruption of family conflict dramatically changes the context of prior decisions that they may have reached without clear realization that a family member would consider himself grievously injured by that decision. Unless the incompetent patient had explicitly considered this possibility and rejected its relevance for herself, the state interest in vindicating autonomous choice is too speculative, too insubstantial, to overcome the moral and emotional force of family reluctance to accepting the patient's death.[54]

This insistence on a clear prior directive by the incompetent patient conclusively resolving family conflict might seem too demanding. It is conceivable, for example, that objection to termination might come from a family member who had been estranged from the patient for a long period of time—long enough and bitterly enough that it would be plausible to conclude that the patient would not have wanted to defer to the resistance of this particular person. This kind of determination would, however, require detailed factual inquiry into the particularities of family relationships. This requirement implicates the third constitutional law pathway that leads to the requirement for state deference to, as opposed to forced resolution of, family disputes. This third pathway is a process implication arising from the constitutional requirement that the state not intrude on the private domain of family relationships.

The Supreme Court's recent decision in *Troxel v. Granville*[55] is most directly relevant in establishing this pathway. In that case, the state of Washington had enacted legislation providing access to court for "any person" challenging parental decisions to deny visitation rights with their children; in such proceedings, the statute directed the judge to decide the dispute based on the

53. In *Cruzan*, the Supreme Court explicitly noted that it was "not faced with the question of whether a State might be required to defer to the decision of a surrogate if competent and probative evidence established that the patient herself had expressed a desire that the decision to terminate life-sustaining treatment be made for her by that individual." 497 U.S. at 287 n.12. In her concurring opinion, Justice O'Connor strongly suggested that she would endorse such a constitutional rule. *Id.* at 289-90.

54. The insubstantiality of this claimed state interest is underscored by the empirical evidence, cited in note 31, *supra*, that most patients want their prior directives disregarded in deference to the differing views of their families and physicians.

55. 530 U.S. 57 (2000).

"best interests" of the children. The Court invalidated this statute because of the "breathtakingly broad"[56] discretion granted to a judge to "award visitation whenever [she] thought [she] could make a better decision than a child's parent had done."[57] The Court left open the possibility of validating a more narrowly drawn statute (limited, for example, to disputes between parents and grandparents) with more precisely defined standards than "best interests of the child" to govern judicial interventions. The unstructured breadth of the judicial intervention into family decision-making was the grounds for its invalidation.

In family disputes about terminating life-prolonging treatment for an incompetent patient, the process requirement that state interventions be constrained by clearly defined, limiting standards appears virtually impossible to satisfy unless the incompetent patient herself had previously indicated her preference among the disputing parties or if continuation of the life-prolonging treatment was likely to inflict serious physical pain or injury on the patient. As in Terri Schiavo's case, judicial resolution of a family dispute based solely on the judge's assessment of the incompetent patient's dignitary interest in discontinuing treatment would not satisfy the process demands in *Troxel.*

A further consideration, not present in *Troxel*, amplifies the constitutional importance of state abstention from resolving family disputes about life-prolonging treatment. Insofar as determination of an incompetent patient's dignitary interests in discontinuing treatment depends on the patient's prior wishes and values, a court would inevitably be drawn into fact-finding about issues heavily freighted with religious significance for most people in American society. Terri Schiavo's case exemplifies this; quite aside from the frenzied participation of outsiders in the late stages of this dispute, her parents consistently maintained that, as an observant Catholic, Terri would never have agreed to discontinue her treatment unless it was clear that she was already terminally ill. Her husband's insistence that Terri would have wanted to accelerate her death if she were in a persistent vegetative state rested on the implicit premise that Catholic Church teachings to the contrary had not been determinative for her. The Florida probate judge purported to rest his decision exclusively on his findings about Terri's specific intentions; but

56. *Id.* at 67 (plurality opinion).
57. *Id.* at 78 (Souter, J., concurring).

in determining her intentions, he could not avoid resolving an explicit religious doctrinal dispute.

The Supreme Court has repeatedly held that the First Amendment guarantee of freedom of religion and its stricture against state-established religions together require that secular courts refrain from resolving religious doctrinal disputes. In *Jones v. Wolf*,[58] the Supreme Court reaffirmed this principle but added the proviso that the state might rely on "neutral principles" to resolve religious disputes so long as those principles were framed "in purely secular terms, and [did] not . . . rely on religious precepts."[59] State reliance on an incompetent patient's prior appointment of a health care proxy as the basis for resolving family disputes about life-prolonging treatment would appear suitably "neutral"; the state could rely, that is, on the prima facie meaning of the prior directive without inquiring into the now-incompetent patient's religious or non-religious motivation for making this directive. In the absence of an executed prior directive, however, particularized inquiry into the patient's attitudes toward life-prolonging treatment would necessarily draw courts into fact-finding about "religious precepts."

Where the incompetent patient had not executed an advance directive or health care proxy, state specification of automatic rules for proxy designation would be sufficiently "neutral" to satisfy the *Jones v. Wolf* stricture. But this automatic designation would only solve the First Amendment religion clause problems; the very feature that rendered this designation adequately "neutral" is its complete irrelevance both to the specific issues in the family dispute and to the prior preferences of the incompetent patient in favoring one or another family member in this dispute. This irrelevance is, however, precisely the reason already discussed that this "automatic" resolution of the family dispute is constitutionally invalid on grounds of arbitrariness.[60]

These, then, are the three pathways that lead to constitutional protection from state-imposed termination of life-prolonging treatment for an incompetent patient when even one family member disagrees with this course. To protect the individual right to choose termination, substantial doubt must be acknowledged about whether the incompetent patient would have wanted treatment withdrawn in the face of disagreement by even

58. 443 U.S. 595 (1979).
59. *Id.* at 604.
60. See text accompanying notes 31–33, *supra*.

one family member—unless the patient had explicitly anticipated the possibility of this disagreement and appointed some other member as the dispositive decision-maker. To protect the right of family members to preserve their relationships against state termination, the refusal of one member to acquiesce in withdrawal of life-prolonging treatment must be honored (whereas even the unanimous family agreement to terminate treatment does not command comparable state respect because this decision, however justifiable in its own terms, is not in the service of preserving a familial relationship). To protect the family from intrusive state investigation, disagreements within the family about withdrawing treatment must be respected as such; the religious doctrinal foundation of large numbers of such disputes provides additional reason for state abstention from detailed scrutiny or, a fortiori, from dispositive resolution.

Each of these three pathways independently supports the right of family privacy from state-imposed termination of life-prolonging treatment. Taken together, these three mutually reinforce and amplify the basis for this constitutional claim.

III. CLINICIANS' BURDENS IN RESPECTING FAMILY PRIVACY

Family disputes about terminating life-prolonging treatment for an incompetent family member are invariably painful for everyone involved. Health care clinicians who regularly confront such disputes are not immune to this pain. To the contrary, their regular involvement can be cumulatively wearing. Whatever effort they may feel impelled to exert to defend themselves against this pain brings its own difficulty because the defense in itself may feel like a betrayal of the medical profession's commitment—in principle, if not always or easily in practice—to remain engaged with and supportive of family's grief at the imminent death of their loved one. A legal rule that automatically awards proxy appointment to one among the disputants thus has considerable attractions for clinicians by quickly ending the family dispute and relieving them of any professional obligation to remain engaged through extended conversation, negotiation, and pleading with recalcitrant family members.

Clinicians know, however, in their heart of hearts, that forced resolution of a family dispute leaves unreconciled members with a burden of anger against other disputants that is likely to complicate their grief. Clinicians know, in their heart of

hearts, that prolonged involvement with families nursing them toward consensus is the best kind of caretaking, the best way to honor their professional obligations as caretakers. Even if the law may appear to relieve them of their obligations, good clinicians know that forced resolution is not good for the families of their patients and, for this reason in itself, is unlikely to honor the prior preferences of their incompetent patients.

The fact is, moreover, that the laws in many jurisdictions implicitly (and some even explicitly) already require family unanimity before life-prolonging treatment can be terminated, and there has been no vocal outcry among clinicians in those jurisdictions about difficulties in coping with family conflict. Though most state statutes do provide for automatic proxy appointment of single family members, five states—Colorado, Idaho, Indiana, Michigan and Wyoming—explicitly provide for appointment of multiple family members based on their individually expressed wish to serve as proxies.[61] Even for the states that provide automatic appointment from a hierarchical list, when spouses are unavailable the statutes move to potentially multi-member categories (adult children or parents or adult siblings of the incompetent patient). (Most Americans die in their 70s, and men's life expectancy is some six years less than women's; thus automatic proxy appointments for incompetent elderly widows frequently devolve on adult children or siblings.[62]) For multi-member proxies such as adult children, some ten states explicitly provide that disputed termination decisions should be resolved by majority vote.[63] Most states, however, eschew this weirdly formalist response. ("Let's have a show of hands. Okay . . . three to two for pulling the plug on Mom's respirator . . . Let's do it."). Most states say nothing about the resolution of conflict among proxies in multi-member categories, thus implicitly requiring unanimity before termination.

If substantial numbers of clinicians had been unable to deal with familial conflicts within these multi-member classes, some evidence for this and medical demand for statutory revisions

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61. Colorado: Colo. Rev. Stat. Ann. § 15-18.5-101 to -1033; Idaho: Idaho Code § 39-4303; Indiana: Ind. Code Ann. § 16-36-1-1 to -14 (West 2005); Michigan: Mich. Comp. Laws Ann. § 333.5651 to 5661, particularly § 333.5653(g) and .5655(b); Wyoming: Wyo. Stat. § 3-5-209 and § 35-22-105.

62. *See* Committee on Care at the End of Life, Institute of Medicine, *Approaching Death: Improving Care at the End of Life* (Marilyn Field & Christine Cassel, eds.) (National Academy Press: Washington, D.C., 1997) at 35.

63. *See, e.g.*, Uniform Health-Care Decisions Act (1993), § 5 (c); Fla. Stat. § 765.401(1)(c), (e) (2000).

would surely have surfaced; but there is no such protest and from all appearances clinicians are able to cope.[64]

Requiring family unanimity before terminating an incompetent patient's life-prolonging treatment is thus not only required by constitutional principles of respect for the patient's prior wishes and of family privacy from state coercion. This requirement also follows from clinicians' professional role obligation to alleviate rather than exacerbate family grief through forced resolution of family disputes.

IV. A ROLE FOR CONGRESS IN PROTECTING FAMILY PRIVACY

None of the courts, either state or federal, enlisted in Terri Schiavo's case were presented with the constitutional arguments that I have set out here for invalidating Florida's law providing for judicial resolution of the family dispute about her treatment. This is not surprising; even though I believe I have set out a strong case for this result, there is no slam-dunk constitutional law precedent directly on point. The very novelty of the arguments does, however, mean that courts remain free to consider them in the inevitable next case of intra-familial conflict about terminating life-prolonging treatment.

This blank judicial slate presents a further opportunity—that Congress could enact legislation under its Section 5 authority to "enforce . . . the provisions" of the Fourteenth Amendment.[65] In its recent jurisprudence, the Supreme Court has been quite restrictive in construing the extent of this congressional authority. These restrictive constructions can be distilled into two propositions: where the Court and Congress disagree about the meaning of the Fourteenth Amendment, the Court's judgment always prevails; and the Court is not obliged to give any deference whatsoever to Congress's view of the meaning of the Fourteenth Amendment.[66] These propositions do not mean, however, that Congress is barred from acting on its own interpretation of its Section 5 authority where, as in this context, no court has pre-

64. For general data about the prevalence of family conflict regarding termination of life-prolonging treatment and clinician capacity to assist resolution of this conflict, see *supra* notes 22 and 29.

65. U.S. CONST. amend. XIV, § 5: "The Congress shall have power to enforce, by appropriate legislation, the provisions of this article."

66. City of Boerne v. Flores, 521 U.S. 507 (1997), United States v. Morrison, 529 U.S. 598 (2000).

viously invalidated—much less, even ruled on—this interpretation.

There is, moreover, good reason for courts to give some independent weight to congressional judgment in considering whether a constitutional principle of family privacy forbids state intervention to resolve intra-familial disputes about terminating life-prolonging treatment. There are clear financial implications for such constitutional ruling. There is no systematically gathered data available to determine the number of patients whose families disagree about the continuation of life-prolonging treatment, either currently or in the relevant recent past. Congress has better capacity than courts for gathering such data. More importantly, if Congress concludes that an important national purpose is served by forbidding states from imposing treatment termination in the face of familial objection, Congress should be willing to allocate federal funds to meet whatever medical costs might follow from this conclusion. Legislation providing federal funds to support the exercise of a constitutional right would fit more comfortably within the current constrictions of the Supreme Court's interpretation of congressional power under Section 5 of the Fourteenth Amendment. Congress might also, more modestly, invoke its spending power to condition state receipt of funds on their adoption of a rule requiring family consensus to terminate an incompetent patient's life-prolonging treatment.[67]

There are adequate reasons for a court independently to conclude that the Constitution requires continuation of this treatment for so long as any family member insists; and for judicial vindication of constitutional norms, financial implications are irrelevant. But if Congress pledges federal financial resources to support the claimed right, this should be relevant to judicial construction of the existence of such right—not because it would thereby be a fiscally manageable cost but because the pledge in itself signifies a broadly held public moral consensus about the importance of vindicating such right. As the Court has held in other contexts,[68] the existence of legislative enactments is

67. Congressional spending power is not immune from constitutional limitations. See South Dakota v. Dole, 483 U.S. 203 (1987). But if Congress may use its commerce power to preempt state laws permitting medical use of marijuana, as the Supreme Court recently held in Gonzales v. Raich, 545 U.S. 1 (2005), there could surely be no bar to use of congressional spending power to induce state adoption of this rule for termination of life-prolonging medical treatment.

68. Roper v. Simmons, 543 U.S. 551 (2005) (execution of juveniles); Atkins v. Virginia, 536 U.S. 304 (2002) (execution of mentally retarded persons).

relevant evidence to support judicial construction of constitutional rights.

At the last stages of the Schiavo case, Congress acted to involve the federal courts in determining whether constitutional rights would be violated by the removal of her feeding tube. The congressional intervention was, however, only jurisdictional; Congress explicitly disavowed any substantive mandate for a constitutional ruling in the case.[69] The prospect remains open for the Congress to return to its consideration of the issues raised by Theresa Marie Schindler Schiavo's case—but, this time, to proceed at a more stately deliberative pace and, this time, to speak substantively in support of a constitutional claim for family privacy.

69. *See* Schiavo v. Schiavo, 403 F.3d 1223, 1227–28 (11th Cir. 2005).