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Right-to-Die Cases: A New York Historical Perspective

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RIGHT-TO-DIE CASES: A NEW YORK HISTORICAL PERSPECTIVE

*Every human being of adult years and sound mind has a right to determine what shall be done with his own body.*¹

After I was named Chief Judge of New York State, a position previously occupied by one of the noblest of jurists, Benjamin Cardozo, I went with my mother to see my new chambers and the desk I was to use—the desk that had been used by Cardozo himself. I said to my mother, “Just think of it, I will be using Benjamin Cardozo’s desk.” And my wise mother replied, “Yes, but remember, fifty years from today, it will still be Benjamin Cardozo’s desk.” Humbling, but sage advice for me and all judges, namely, to remain cognizant of both the past and the future, particularly when asked to resolve some of society’s most perplexing issues, such as whether there is a right to forego life-sustaining medical treatment.

Indeed, in addition to his desk, we in New York have embraced Cardozo’s wise philosophy of jurisprudential circumspection—restraint where called for, but innovation when necessary.² Because our state’s population is so large and diverse, and its lawyers so creative, the cases brought before our state courts are often both complex and challenging.

After serving on the New York Court of Appeals for twenty years, the last nine as its Chief Judge, I can tell you that the most difficult cases for us involved the withdrawal of life-support systems from patients in a persistent vegetative state. These cases, roughly grouped under the heading of “right-to-die” cases, emerged when advancing medical technology allowed life to be prolonged by artificial means well beyond what had been previously possible.

Today we have statutes that allow for substituted judgment, advance directives, living wills, health care proxies, durable springing powers of attorney, and a myriad of other ways by which persons can decide, while they have decisionmaking capacity, whether and when they want their lives to be prolonged by this technology, or can designate others to make these decisions if they lack decisionmaking capacity. But I want to take you back to a time before the legislature provided these options, when judges were called upon to decide these cases without legislative guidance or judicial precedent.

Working from a virtually blank slate, we had to develop a body of law that addressed the problems posed by these cases. Benjamin Cardozo, in speaking of the interrelationship of law and medicine, said to the New York Academy of Medicine some eighty years ago that “[w]hen the seas are so boisterous and their perils so insidious, one [best] creeps from cape to cape” as we go from case to case.³

The first cases to reach our courts came like a bolt out of the blue, for which, as a result, we had no contingency plan. Existing precedents, drawn from the age-old common law, seemed obsolete and inadequate to deal with the legal consequences of implementing this rapidly emerging and literally “life-altering” medical technology. These would have been matters best addressed by legislative bodies as they have the

1. *Schloendorff v. Soc’y of N.Y. Hosp.*, 211 N.Y. 125, 129 (1914).

2. *See* BENJAMIN N. CARDOZO, *THE NATURE OF THE JUDICIAL PROCESS* 141 (1921).

3. BENJAMIN N. CARDOZO, *LAW AND LITERATURE AND OTHER ESSAYS AND ADDRESSES* 118 (1931).

ability to proactively provide legal solutions that reflect the consensus of society. But in New York, as in most states, there were few statutes specifically tailored or even generally helpful to resolve the many novel issues posed by the life-sustaining ability of this new technology.

Physicians faced a seemingly impossible dilemma. A brief submitted to our court at the time noted that “[f]or over 2,000 years, the predominant responsibility of the physician has not been to preserve life at all costs but to serve the patient’s needs while respecting the patient’s autonomy and dignity.”⁴ At the same time, the Hippocratic Oath directs the physician: “To please no one will I . . . give advice which may cause [a patient’s] death.”⁵ These vague and conflicting dictates, albeit inspirational, were of little assistance in helping physicians, and ultimately our court, resolve these matters.

The New York Court of Appeals first encountered these problems in 1981, in a pair of cases consolidated on appeal entitled *In re Eichner* and *In re Storar*.⁶ In both cases, “the guardians of incompetent patients objected to the continued use of medical treatments or measures to prolong the lives of the patients who were diagnosed as fatally ill with no reasonable chance of recovery.”⁷

In *Eichner*, Brother Joseph Fox, “an 83-year-old member of the Society of Mary, was being maintained in a permanent vegetative state by a respirator.”⁸ Based on Brother Fox’s prior statements made while competent, “[t]he local director of the Society applied to have the respirator removed on the ground that it was against his wishes” to have his life sustained artificially when there was no hope of recovery.⁹

In *Storar*, “a State official applied for permission to administer blood transfusions” to John Storar, a “profoundly retarded 52-year-old man with terminal cancer of the bladder.”¹⁰ Mr. Storar’s “mother, who was also his legal guardian, refused to provide consent on the ground that the transfusions would only prolong her son’s discomfort and would be against his wishes if he were competent.”¹¹

When these cases landed on our desks, there was a hue and cry from numerous quarters. Doctors objected to the court’s intervention because they felt these were matters that should be resolved by the treating physician and either the patient or the patient’s family if the patient lacked decisionmaking capacity at the time, not by a

4. Brief in Support of Petitioner at 19, *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261 (1990) (No. 88-1503), 1989 WL 1115247 at *19.

5. *Hippocratic Oath Definition*, MERRIAM-WEBSTER.COM, <http://www.merriam-webster.com/dictionary/hippocratic%20oath> (last visited Dec. 26, 2013).

6. See *In re Storar*, 52 N.Y.2d 363 (1981). The cases were consolidated on appeal from *In re Storar*, 433 N.Y.S.3d 388 (Sup. Ct. Monroe Cnty. 1980), and *In re Eichner*, 423 N.Y.S.2d 580 (Sup. Ct. Nassau Cnty. 1979).

7. *In re Storar*, 52 N.Y.2d at 369.

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.*

judge. The district attorney in *Eichner* argued that even if a patient's right to decline medical treatment survives his loss of decisionmaking capacity, that right must yield to the state's overriding interest in preventing one person from causing the death of another, as reflected in the state's homicide laws.¹² He argued that if the removal of the life-support system resulted in the demise of the patient, a homicide charge should be brought against the responsible party, with the court's authority limited to upholding the application of these laws.¹³

It was also argued that both Brother Fox and Mr. Storar were legally deceased by the time these matters reached our court and, therefore, these cases were moot. Our court was indeed not permitted by the New York State Constitution to decide moot cases. However, we had held in the past that if the underlying issues of a case are of public importance and are recurring in other courts throughout the state, and if because of the nature of the case are likely to escape full appellate review even when appeals are expedited, we could address the issues despite their technically being moot.¹⁴ As a result, we decided to exercise our discretion to reach the issues in these cases even if they were possibly moot.

I will note parenthetically that some years later, I had an opportunity to engage Edwin Meese, then U.S. Attorney General under President Ronald Reagan, in a discussion regarding right-to-die cases at the Chautauqua Institution. Mr. Meese was a strong proponent of searching for the "original intent" of the framers when engaging in constitutional interpretation and, relatedly, condemned activist judges, arguing that if the Constitution made no specific provision for judicial relief or intervention, then the courts had no business deciding a case. When I asked him how the Constitution would apply to the cases before our court dealing with the withdrawal of life-support systems, he responded that this was a matter for the legislature to decide. When I noted that we were confronted with these cases before the legislature had acted, he said that we still should not have taken jurisdiction.

At the time, I would very much have welcomed being able to take this course. While I agree that the courts should generally interpret the laws rather than make them, as far as our court's jurisdiction with regard to this issue was concerned, my view was that when you have a genuine controversy between doctors, district attorneys, hospitals, and family members that needs to be resolved, the courts have an obligation to respond when the issue is presented to them in a petition for relief. As far as waiting for the legislature to take action, as hard as the courts pressed for such action during this era, the legislature consistently refused to present us with guidance, perhaps reflecting its own deep uncertainty regarding the proper resolution of these cases.

I only wish that legislative bodies had acted then, as they have acted subsequently, so that we did not have to decide these cases in a vacuum. As I said at the time,

12. *See id.* at 378.

13. *See id.*

14. *See* *Hearst Corp. v. Clyne*, 50 N.Y.2d 707, 714 (1980); *Westchester Rockland Newspapers v. Leggett*, 48 N.Y.2d 430, 436–37 (1979); *Oliver v. Postel*, 30 N.Y.2d 171, 177–78 (1972).

judges do not walk hospital corridors looking for business. Virtually no one disagrees with the proposition that decisions of this sort should be made by either the patient or the patient's family with the assistance of the treating physician and perhaps members of the clergy; however, when this cannot be accomplished and there is a controversy between parties, they turn to the courts for resolution, and the courts must address their issues. As we noted in these early cases:

[I]t has been suggested by the District Attorney in the *Eichner* case that these applications do not present a justifiable controversy; that they call for innovations in the law, both substantive and procedural, which should be left to the Legislature, subject only to review by the courts for compliance with constitutional requirements. We, of course, cannot alter statutory responsibility but we can declare the rights and obligations of the parties under existing law. In fact the District Attorney does not contend that the courts can never rule upon the legality of such activities but suggests that the courts should wait for the parties to act before considering whether there is any civil or criminal liability. However, responsible parties who wish to comply with the law, in cases where the legal consequences of the contemplated action is uncertain, need not act at their peril. Nor is it inappropriate for those charged with the care of incompetent persons to apply to the courts for a ruling on the propriety of conduct which might seriously affect their charges.

We emphasize, however, that any such procedure is optional. Neither the common law nor existing statutes require persons generally to seek prior court assessment of conduct which may subject them to civil and criminal liability. If it is desirable to enlarge the role of the courts in cases involving discontinuance of life sustaining treatment for incompetents by establishing . . . a mandatory procedure of successive approvals by physicians, hospital personnel, relatives and the courts, the change should come from the Legislature.¹⁵

But back to the cases themselves. In *Eichner*, we looked for some sort of precedent from our court to help resolve the matter. We found the language quoted above from a 1914 decision written by then-Chief Judge Cardozo to be helpful:

Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.¹⁶

Of course this was said in the context of a case addressing a physician's obligation to obtain a patient's consent before commencing treatment, but, taking our lead from that language, we held in *Eichner* that if a doctor can be held liable for disregarding a patient's treatment request, the law cannot, at the same time, hold the doctor liable for honoring the patient's request. The underlying principle is that a patient has a right to direct the course of his or her medical treatment.

15. *In re Storar*, 52 N.Y.2d at 382–83 (citations omitted).

16. *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125, 129–30 (1914).

Rather than impose a “reasonable doubt” standard, we felt that a “clear and convincing” standard would be proper, and we found, by “clear and convincing” evidence, that Brother Fox had previously stated his desired course of treatment under the existing circumstances.¹⁷ Some time prior to the operation during which he suffered cardiac arrest, a resulting loss of oxygen to the brain, and substantial brain damage, and which ultimately led to his being maintained by a respirator in a persistent vegetative state, Brother Fox during a public discussion of the celebrated *In re Quinlan*¹⁸ case had said to some of his companions that he would not want any of this “extraordinary business” done for him under similar circumstances.¹⁹ We took that as an effective and dispositive statement of what would be his intent regarding the course of treatment for the existing, similar situation (a statement that would later be referred to as an oral living will). Much to the dismay of the district attorney, who was prepared to indict the treating physician for manslaughter if he withdrew life support, we held that the doctor could remove Brother Fox from the life-support machinery without criminal or civil liability.²⁰

The companion *Storar*²¹ case was more difficult to decide. As noted, John Storar was a fifty-two-year-old man with the mental capacity of a five-year-old child, and was suffering from bladder cancer that necessitated periodic blood transfusions. The evidence revealed that he benefitted from these transfusions, as afterwards he would run up and down the corridors of the institution where he resided, seeming very alert and content. Although Mr. Storar would fight the restraints that were necessary for the transfusions to be given, the hospital staff contended he fought the same way if given a penicillin shot. Nevertheless, his mother felt he should not receive any additional transfusions because they were causing him distress and because he was suffering from a terminal disease.²²

When asked to resolve this matter, we ruled that because John Storar had never had decisionmaking capacity, it was unrealistic to attempt to determine what he would have wanted under the current circumstances.²³ Furthermore, the court was unwilling to adopt the principle of “substituted judgment,” whereby someone else could make the decision on Mr. Storar’s behalf, because we felt that no third party should be permitted to make a quality-of-life judgment for another, which we felt was implicit in his mother’s desire to forego life-sustaining treatment.²⁴ Thus, we refused to defer to the wishes of Mr. Storar’s mother, notwithstanding that they were

17. *In re Storar*, 52 N.Y.2d at 379.

18. 355 A.2d 647 (N.J. 1976).

19. *In re Storar*, 52 N.Y.2d at 372.

20. *See id.* at 377.

21. *See id.* at 373–76.

22. *See id.* at 375.

23. *See id.* at 380.

24. *See id.* at 380–82.

well intended.²⁵ In essence, we concluded that Mr. Storar was a child, and held that no parent should be able to withhold a blood transfusion from a child when doing so would precipitate the child's death. We allowed the hospital to proceed with the transfusion.²⁶

Then came a case that generated national headlines. *Weber v. Stony Brook Hospital* involved Baby Jane Doe, an infant with multiple disabilities, including spina bifida.²⁷ The parents and the treating physicians all agreed that she should not receive an operation that might prolong her life but that would not cure her condition and might well aggravate it. However, a Vermont attorney brought suit in New York seeking an order directing that the surgery be performed.²⁸ His application was supported by national right-to-life groups, as well as by the Surgeon General of the United States, C. Everett Koop. Those seeking to force the doctors to operate were successful in convincing the lower courts that the baby would die if not treated, and an order was issued that the operation be performed. This case was not moot when it came to our court as the surgery had not yet been conducted.

In this case, we held that neither the Vermont attorney nor any outside party had any business interfering with the decision being made by the parents with input from the physicians and thereby interjecting their view of what was in the best interests of the baby.²⁹ We noted that there are state agencies charged with protecting children from parental neglect, and that they had found no reason to intervene in this case.³⁰ It was apparent to us that the parents and their medical advisors had acted responsibly in making a very difficult choice and that this was not a case where withholding the surgery would precipitate the child's death.³¹ I was pleased to note recently that, despite some physical and mental impairment, Baby Jane Doe is alive and doing well.

Then we faced *In re Westchester County Medical Center ex rel O'Connor*, in which a seventy-eight-year-old woman had suffered several strokes, leaving her without decisionmaking capacity, with the most recent stroke depriving her of her gag reflex.³² As a result, she was unable to eat or drink without medical assistance and the doctors at the hospital where she was receiving care wanted to insert a nasogastric tube to keep her from dying of thirst and starvation. Her daughters objected, claiming that this would be contrary to what she would want to be done. The question was whether the statements she had made before she lost decisionmaking capacity clearly indicated an intention on her part to decline such treatment when it

25. *See id.*

26. *See id.* at 382.

27. *See Weber v. Stony Brook Hosp.*, 60 N.Y.2d 208 (1983).

28. *See id.* at 211.

29. *See id.* at 213.

30. *See id.* at 212.

31. *See id.* at 213.

32. *See In re Westchester Cnty. Med. Ctr. ex rel O'Connor*, 72 N.Y.2d 517 (1988).

would allow her to receive life-sustaining food and water. We held that they did not indicate an intention to decline treatment.³³

The record showed that Mrs. O'Connor had previously cared for several relatives suffering from a terminal illness and, while providing this care, had stated that she never wanted to become a burden to anyone and would not want to be kept alive by artificial means if she was unable to care for herself. But Mrs. O'Connor was not then suffering from a terminal illness, except in the sense that she was aged and infirm, and so we held that there was not clear and convincing evidence that she would want to decline the insertion of a feeding tube when she was not terminally ill. We noted that many aged persons suffer similar disabilities and before losing decisionmaking capacity often state a general desire not to become a burden on others. If such statements were viewed as clear and convincing proof of a desire to decline medical treatment once such persons lost the ability to care for themselves, few nursing home patients would ever receive medical care.³⁴

Our court has been criticized for the *O'Connor* decision. Those who were disappointed by the U.S. Supreme Court's decision in *Cruzan v. Director, Missouri Department of Health*,³⁵ which I discuss below, assert that *O'Connor* is an earlier version of *Cruzan*. In fact, the Supreme Court cited our ruling in the *Cruzan* decision.³⁶ In response to these critics, I contend that the cases were quite distinct. Nancy Cruzan was in a persistent vegetative state, but Mrs. O'Connor was not. We emphasized in our ruling that Mrs. O'Connor was neither "in a coma nor vegetative state. She is awake and conscious; she can feel pain, responds to simple commands, can carry on limited conversations and is not experiencing any pain."³⁷ We also noted that her prognosis was uncertain because she appeared to have recovered her gag reflex. I had occasion some years later to discuss the *Cruzan* case with Nancy Cruzan's parents, and they also noted how different their daughter's case was from that of Mrs. O'Connor.

In *Cruzan*, the Supreme Court held that the Due Process Clause may indeed guarantee a patient the right to decline medical treatment.³⁸ However, the Supreme Court continued, when the patient currently lacks decisionmaking capacity and some third party is asserting that, before losing this capacity, the patient expressed a desire to decline treatment under circumstances similar to those that currently exist, due process does not prevent a state from requiring the third party to establish the patient's previous expression by clear and convincing evidence. The Supreme Court recognized that some states may employ less demanding standards of proof, but disclaimed a need for uniformity across the states on this matter. The Supreme Court

33. *See id.* at 522.

34. *See id.* at 533.

35. 497 U.S. 261 (1990).

36. *See id.* at 274–76, 284 (citing *O'Connor*, 72 N.Y.2d 517).

37. *O'Connor*, 72 N.Y.2d at 533.

38. *See Cruzan*, 497 U.S. at 284.

wrote, “State Courts have available to them for decision a number of sources—state constitutions, statutes and common law—which are not available to us. In this Court, the question is simply and starkly whether the United States Constitution prohibits Missouri from choosing the rule of decision which it did.”³⁹ The actual holding was relatively narrow, but the message was clear: don’t call us, we’ll call you. So while we waited for the Supreme Court to give us guidance, to tell us which of the many states dealing with this problem were right, the Supreme Court said instead, “You’re *all* right.” However, while deference to the states is a wonderful thing, deference is not often helpful when a crisis exists where a decision one way or the other has to be made, with the maintenance of the status quo a de facto decision.

While addressing this situation at a medical conference I attended, someone, referring to our ruling in *O’Connor*, said that “if you came into New York State on a resuscitator, if you didn’t clearly say what you wanted to have done, they’d leave you on there for a hundred years.” That observation overlooks our decision in *People v. Eulo*.⁴⁰ This ruling involved two independent criminal cases consolidated for appeal, in which each defendant was charged with killing someone. As a result of the defendants’ actions, the victims had initially been placed on respirators. The doctors ultimately determined that the victims were brain dead and the respirators were discontinued.⁴¹ The accused murderers, as a defense, asserted that the victims were “brain dead,” but that they were not dead according to the old definition of death. Since there was still lung or heart activity, the accused murderers argued that they did not kill the victims, the doctors did.⁴² And so, because our legislature had not adopted the Uniform Determination of Death Act (UDDA),⁴³ our court had to define what constituted death, which we did by recognizing what we ascertained to be the prevailing medically accepted standard of brain death.⁴⁴

I have noted how often our court beseeched our legislature to address some of these right-to-die issues, including the need to attend to such basic issues as defining death. The public policy of a state should be fixed by its legislative branch. The legislature has the power and ability to hold hearings, divine public sentiment, seek and determine professional views, and explore technological developments before promulgating statutes and laws; whereas a court is limited to a specific set of facts in a particular case and is limited by the record established in that case when resolving

39. *Id.* at 277.

40. 63 N.Y.2d 341 (1984).

41. *See id.* at 346–47.

42. *See id.* at 348.

43. The Uniform Determination of Death Act would provide: “An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.” PRESIDENT’S COMM’N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE & BIOMEDICAL & BEHAVIORAL RESEARCH, *DEFINING DEATH: A REPORT ON THE MEDICAL, LEGAL AND ETHICAL ISSUES IN THE DETERMINATION OF DEATH 2* (1981).

44. *See Eulo*, 63 N.Y.2d at 355.

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the dispute before it. Although our court during this period was establishing new law, each of our decisions was accompanied by a request for legislative guidance.

Finally, in 1985, Governor Mario Cuomo convened the Task Force on Life and the Law “to develop recommendations for public policy on a range of issues arising from recent advances in medical technology: the determination of death [and] the withdrawal and withholding of life-sustaining treatment . . . in the form of proposed legislation.”⁴⁵ The Task Force was chaired by David Axelrod, M.D., New York State Health Commissioner.

The Task Force issued its report, *Life-Sustaining Treatment: Making Decisions and Appointing a Health Care Agent*, in July 1987, and although it did call for the enactment of legislation relating to living wills and health care proxies, there were many matters that were not addressed.⁴⁶ I spoke to Dr. Axelrod and asked him why, for example, the Task Force did not recommend the adoption of the UDDA approved in 1981 by the National Conference of Commissioners on Uniform State Laws, the American Medical Association, and the American Bar Association. He told me that several members of the clergy on the Task Force felt that they could not determine when life ended until they determined when life began. Inasmuch as the latter issue was one of sharp disagreement, they felt that the most prudent course to take was to simply say that the New York Court of Appeals definition of “death” in *Eulo* should be determinative. Dr. Axelrod died at age fifty-nine after a stroke that left him in a vegetative state for three years.⁴⁷

In 1990, the only guidance we had in deciding these cases were our own precedents. The last decision I wrote on the subject was *Fosmire v. Nicoleau*, where we again applied the *Schloendorff* principle that recognizes the patient’s right to determine the course of medical treatment.⁴⁸

In that case, a woman in her ninth month of pregnancy said that she did not want a blood transfusion during a caesarean section. When she suffered substantial blood loss during the delivery, but still refused on religious and personal grounds to consent to a transfusion recommended by her doctor, the hospital applied for a court order compelling the transfusion. The lower court signed an order saying that despite her expressed wishes, she was to be administered the blood.⁴⁹ Our court reversed and said the lower court was wrong because, again, there was a fundamental right on the

45. N.Y. STATE TASK FORCE ON LIFE AND THE LAW, *LIFE-SUSTAINING TREATMENT: MAKING DECISIONS AND APPOINTING A HEALTH CARE AGENT* 3.2(i) (1987).

46. *See id.*

47. *See* Robert D. McFadden, *David Axelrod Health Chief Under Cuomo Is Dead at 59*, N.Y. TIMES, July 5, 1994, at D14, available at <http://www.nytimes.com/1994/07/05/obituaries/david-axelrod-health-chief-under-cuomo-is-dead-at-59.html>.

48. *See Fosmire v. Nicoleau*, 75 N.Y.2d 218, 226 (1990) (citing *Schloendorff v. Soc’y of N.Y. Hosp.*, 211 N.Y. 125, 129–30 (1914)).

49. *See Fosmire v. Nicoleau*, 536 N.Y.S.2d 492, 493 (2d Dep’t 1989).

part of this woman to make decisions as she saw fit regarding the medical treatment of her body.⁵⁰

In our decision, we made clear that the patient was an adult and not a child whose parents were refusing to consent to necessary blood transfusions or other lifesaving measures. We noted again, as we had in *Storar*, that a court of this state clearly has the power and the obligation to order life-sustaining medical treatment essential to a child despite the parents' conscientious objections to the administration of this treatment. We also noted that we were not dealing with a patient who lacked decisionmaking capacity and thus were not called upon to decide whether the patient, when competent, made and expressed a firm resolve to forego the right to lifesaving treatment under existing circumstances. Here, there was no question that the patient was a competent adult who had made, for personal reasons, a conscious choice to avoid blood transfusions under all circumstances and had never wavered in that commitment. The only question was whether the hospital was bound to honor a choice that was so clearly expressed. We held that she had this right even though she was the mother of another infant child and we rejected the hospital's argument that this was tantamount to a prohibited abandonment of that child. Fortunately, both the mother and her newly born child survived.

In all of these cases, we relied primarily on common law principles while repeatedly noting the limited utility of the common law process for resolving the many problems presented by the emerging medical technology we were addressing. Moreover, our court and state courts throughout the nation have always considered judicial intervention appropriate only as a matter of last resort when inherently private medical decisions cannot be resolved by the usual channels. In 1987, at a meeting of the Conference of Chief Justices in New York, there was a recognition of the need to establish guidelines to help state court judges addressing right-to-die cases. As a result of a resolution passed by that conference, the National Center for State Courts applied for and received funds from the State Justice Institute to establish a Coordinating Council on Life-Sustaining Medical Treatment Decision Making by the Courts. The council was chaired by Douglas Amdahl, the Chief Justice of the Minnesota Supreme Court, and I was privileged to serve as vice-chairman. The council was made up of twelve outstanding professionals from various disciplines, with Thomas L. Hafemeister, J.D., Ph.D., now an associate professor at the University of Virginia School of Law, providing superb guidance as the project director. After a comprehensive study and receiving advice from many people from many disciplines, including a survey of judges and cases throughout the country, the National Center for State Courts in 1989 published *Guidelines for State Court Decision Making in Life-Sustaining Medical Treatment Cases* to assist state trial judges in resolving these cases.⁵¹ These guidelines and a revised second edition published by West Publishing Company in 1993, as well as *A Health Care Provider's Guide* by

50. See *Fosmire*, 75 N.Y.2d at 231.

51. See NAT'L CTR. FOR STATE COURTS, GUIDELINES FOR STATE COURT DECISION MAKING IN AUTHORIZING OR WITHHOLDING LIFE-SUSTAINING MEDICAL TREATMENT (1991).

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Professor Hafemeister and also published by the National Center for State Courts in 1996,⁵² have gone a long way to establish a foundation for sound and uniform judicial decisionmaking in this domain.

These issues were raised during an age of judicial infancy in resolving life-sustaining medical treatment cases. Much of the law we pronounced formed the basis for subsequent legislation, while other decisions demonstrated the need for such legislation. Today we have a more comprehensive body of law on which to rely and we are most grateful to those who have shaped this legislation and jurisprudence. Indeed, perhaps one of the most gratifying results of all the work described above is that by virtually all accounts these matters are now successfully resolved by the parties involved, with recourse to the courts having become a relatively infrequent occurrence. But if this past history has taught us anything, it is the necessity of keeping abreast of modern technology while fashioning the law in such a way as to remain faithful to traditional norms as much as possible, including employing a decisionmaking process for right-to-die cases that remains in the hands of the patient, the patient's family, and the attending medical professionals.

52. See THOMAS L. HAFEMEISTER, *RESOLVING DISPUTES OVER LIFE-SUSTAINING TREATMENT: A HEALTH CARE PROVIDER'S GUIDE* (1996).

