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In Re Conroy: Self-Determination: Extending the Right to Die

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IN RE CONROY: SELF-DETERMINATION: EXTENDING THE RIGHT TO DIE

Since Socrates consumed the hemlock, the focus of ethicists and philosophers has often converged upon an individual's right to die.[1] While suicide is not sanctioned as an ethical response or a protected right, recent judicial decisions have confronted the dimensions of a patient's right to decline life-sustaining measures and opt for a natural death.[2] There is significant juridical discord as to the nature of this right, particularly as to its procedural and substantive application.[3]

The examination of this sensitive area in this note will chart recent patterns in legal analysis which are predominately shaped by ethical and medical traditions concerning life and death. Constitutionally protected personal privacy zones fuse with these traditions resulting in judicial inclination toward favoring the right to die.[4] A reasoned response to right to die decisions is suggested allowing the decision-making process to transpire in a scenario unburdened by litigation and judicial interference. It is crucial to note that the impetus of these decisions is the failure of the state legislatures to fashion a realistic statutory response to the need for right to die legislation.[5]

I.

In 1976, the New Jersey courts pioneered the metamorphosis of this legal area through their decision, *In Re Quinlan*.[6] Most recently the court considered an incompetent nursing home patient's right to die in *In Re Conroy*.[7]

1. The phrase "right to die," as used by most legislatures, courts and commentators refers only to the right to die naturally. *See, e.g.*, Natural Death Act, ALA. CODE §§ 22-8A-1 to- 10 (Cum. Supp. 1983) (permitting only the right to die naturally).

2. *See infra* notes 6, 9, 14, 16, 17.

3. *Id.*

4. *See infra* notes 9, 12, 16 and accompanying text.

5. In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985). The court commented that "[i]n the absence of specific legislation on the termination of life-sustaining treatment, we may not properly avoid the issue that we have been asked to resolve merely because it is troubling or difficult. Every day, and with limited legal guidance, families and doctors are making decisions for patients like Claire Conroy." 98 N.J. at 344, 486 A.2d at 1221. *See also* Howell, *Caretakers Views on Responsibilities for the Care of the Demented Elderly*, 325 AM. GERIATRICS SOC'Y 657, 658-59 (1984); Hilfiker, *Sounding Board: Allowing the Debilitated to Die*, 308 NEW ENG. J. MED. 716 (1983).

6. 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied*, 429 U.S. 922 (1976).

7. 98 N.J. 321, 486 A.2d 1209 (1985). *See* Cantor, *Conroy, Best Interests, and the Han-*

The Supreme Court of New Jersey in *Quinlan*[8] upheld an incompetent's right to refuse, through a guardian, the continued use of life-support systems. This ruling was premised upon constitutionally protected zones of personal privacy.[9] Relying upon the New Jersey Constitution[10] and the United States Supreme Court decision in *Roe v. Wade*,[11] the *Quinlan* court analogized that since the right to privacy protects an individual's privilege to obtain certain types of health care, inversely its zones must also protect the right to refuse care.[12] In order to prevent destruction of this right, the New Jersey Supreme Court permitted the guardian and family of Karen Quinlan to exercise her right by proxy, subject to a judicial and medical qualification.[13]

Almost a decade after *In Re Quinlan*, the Florida Supreme Court recognized that a family may exercise an incompetent's right to refuse life-sustaining treatment in *John F. Kennedy Memorial Hospital v. Bludworth*.[14]

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dling of Dying Patients, 37 RUTGERS L. REV. 543 (1985) (hereinafter cited as Cantor); Note, *Natural Death: An Alternative in New Jersey: In re Conroy*, 73 GEO. L. J. 1331 (1985).

8. 70 N.J. 10, 355 A.2d 647 (1976).

9. *Id.* at 39-42, 355 A.2d at 663-64. At the time of the case, Karen Quinlan was a twenty-two year old woman in a chronic vegetative state due to anoxia of unknown origin. Although not clinically brain dead, she existed at a primitive level and totally required assistance with life's basic functions such as breathing, eating, and excretion. Karen's father sought appointment as her guardian with express authority to order withdrawal of all extraordinary medical treatment. He asserted that the use of the respirator violated Karen's free exercise of religion, constituted cruel and unusual punishment, and violated her right of personal privacy. The New Jersey Supreme Court rejected the first two claims but concurred in the privacy argument. It was on this basis that the court granted Mr. Quinlan's petition.

10. N.J. CONST. art. I, par. I. (This provides for "certain natural and unalienable rights, among which are those of enjoying and defending life.").

11. 410 U.S. 113 (1973). Ms. Roe, a pregnant single woman, brought a class action challenging the constitutionality of a Texas statute which prohibited abortion except when necessary to save the mother's life. She sought declaratory and injunctive relief, arguing that the statute was void for vagueness and infringed her personal right of privacy. The district court granted declaratory relief and held that the abortion statute did infringe on Roe's right of privacy, in contravention of the ninth amendment. *Roe v. Wade*, 314 F. Supp. 1217, 1223 (N.D. Tex. 1970). On direct appeal, the Supreme Court affirmed this portion of the lower court ruling but took the position that the right of privacy derives from the fourteenth amendment. 410 U.S. at 153.

12. *Quinlan*, 70 N.J. at 40, 355 A.2d at 663. The court ruled that this privacy right is not absolute, but subject to legitimate state interests. According to the court, "the state interest contra weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims." The court subordinated the state's interest to Quinlan's rights. *See also* Cantor, *Quinlan, Privacy, and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 243, 244 (1977); Annas, *In re Quinlan: Legal Comfort for Doctors*, HASTINGS CENTER REP., June 1976, at 29; Wolhander, *Voluntary Active Euthanasia For the Terminally Ill and the Constitutional Right to Privacy*, 69 CORNELL L. REV. 363 (1984).

13. *Quinlan*, 70 N.J. at 41, 355 A.2d at 664.

14. 452 So.2d 921 (Fla. 1984). This case involved a hospitalized patient surviving on a respirator. The patient could not breathe without the respirator's assistance due to impaired

Unlike the *Quinlan* decision, the Florida court declined to require prior judicial approval of the withdrawal of treatment and ruled that intimate family members or appointed guardians may discharge the incompetent's right to refuse extraordinary medical treatment.[15]

Diverse state courts have addressed the issue of whether a terminally ill patient may refuse life-sustaining medical treatment and several have recognized common law and constitutionally sanctioned privacy zones protecting such decisions, subject to legitimate state interests.[16] Others have rejected this approach upon the premise that "the most basic right enjoyed by every human being is the right to life itself."[17]

Natural death acts have been enacted in twenty-one states[18] since 1976.[19]

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neurological and respiratory functions. The attending physician diagnosed the condition as terminal. Six years previous to his hospitalization, the patient had executed a living will, expressing his desire not to be kept alive by artificial means. The court declined to give primary effect to the living will, but rather, allowed the family to exercise his rights to withdraw life-support systems under the doctrine of "substituted judgment" (donning the mental mantle of the incompetent). *See Saikewicz*, 373 Mass. at 751-52, 370 N.E. 2d at 431 (quoting *In Re Carson*, 39 Misc.2d 544, 545; 241 N.Y.S.2d 288, 289 (N.Y. Sup. Ct. 1962)). *See also* Brophy v. New England Sinai Hospital, No. 85E - 0009 - G1, (Mass. Norfolk Division, October 21, 1985). In a case with issues similar to *Conroy*, a Massachusetts Superior Court is currently considering the future of Paul L. Brophy who has been in a permanent vegetative state since 1983. His family desires to withdraw sources of fluids and nutrients from Brophy under a legal rationale akin to that adopted in *Conroy*.

15. Emphasizing that an attending physician and two specialists (in the field related to the patient's illness) should certify that the patient is in a vegetative state with no reasonable chance of recovery, before family members or the patient's guardian request the termination of any medical treatment. *Bludworth*, 452 So.2d at 926.

16. *See* Severns v. Wilmington Medical Center, 425 A.2d 156 (Del. Ch. 1980) (incompetent's right to refuse medical treatment may be expressed through a guardian when the patient is in a chronic vegetative state); Satz v. Perlmutter, 379 So.2d 359 (Fla. 1980) (constitutional privacy right supports the decision of a competent adult, suffering from a terminal illness, to refuse extraordinary treatment); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977) (right to refuse medical treatment for terminal illness extended to incompetent patients); Leach v. Akron Gen. Med. Center, 68 Ohio Misc. 1, 426 N.E.2d 809 (1980) (right to privacy includes the right of a terminally ill patient in a vegetative state to decide the course of his own treatment); In Re Welfare of Coyler, 99 Wash.2d 114, 660 P.2d 738 (1983) (constitutional right to privacy includes the right of a terminally ill adult patient to refuse life prolonging treatment, subject to countervailing state interests); Storar v. Storar, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64, *cert denied*, 454 U.S. 858 (1981) (common law right to self-determination includes the right to refuse medical treatment in some circumstances).

17. Maine Medical Center v. Houle, No. 74-145 (Me. Super Ct., Cumberland County, February 14, 1974).

18. ALA. CODE §§ 22-8A-1 to 22-8A-10 (supp. 1982); ARK. STAT. ANN. §§ 82-3801 to 82-3804 (Michie Supp. 1983); CAL. HEALTH & SAFETY CODE §§ 7185-95 (West Supp. 1983); DEL. CODE ANN. tit. 16, §§ 2501-09 (1983); D.C. CODE ANN. §§ 6-2421 to 6-2430 (Michie Supp. 1983); LIFE-PROLONGING PROCEDURE ACT OF FLORIDA, ch. 84-58, 3 FLA. SESS. LAW SERV. 40 (West 1984); GA. CODE ANN. §§ 31-32-1 to 31-32-12 (Michie Supp. 1984); IDAHO

This right to die legislation gives effect to a written declaration[20] by an individual, stating her desire not to have life artifically prolonged if death is at hand and she is unable to speak for herself. State laws authorizing such validly executed documents relieve the physician, staff and hospital from civil and criminal liability for removing or withholding life-sustaining treatment[21] from an incompetent patient in a terminal condition.[22]

The recent judicial resolution of the plight of Claire Conroy, a case mired in a myriad of constitutional, ethical, medical and moral questions, challenges both the judges' and physicians' competence in their respective missions to "do justice" and "to heal." Unlike the court's task in *Quinlan*, the New Jersey court in *Conroy* was faced with an elderly, incompetent nursing home patient, confined to a bed and surviving in a semi-fetal position.[23]

CODE §§ 39-4501 to 39-4508 (Michie Supp. 1983); ILL. ANN. STAT. ch. 110 1/2, §§ 701-710 (Smith-Hurd Supp. 1984-85); KAN. STAT. ANN. §§ 65-28, 101 to 65-28, 101 to 65-28, 109 (1980)); Act. of Apr. 16, 1984, ch. 365, 1984 Miss. Law 98; NEV. REV. STAT. §§ 449.540 to 449.690 (1983); N.M. STAT. ANN. §§ 24-77-1 to 24-7-11 (1981); N.C. GEN. STAT. §§ 90-320 to 90-323 (1981); OR. REV. STAT. §§ 97.050 to 97.090 (1981); TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon Supp. 1983); VT. STAT. ANN. tit. 18, §§ 5251-5262 (Supp. 1984); VA. CODE §§ 54-325.8:1 to 54-325.8:13 (Michie Supp. 1984); WASH. REV. CODE ANN. §§ 70.122.010 to 70.122.905 (West Supp. 1983-84); W. VA. CODE §§ 16-30-1 to 16-30-10 (Michie Supp. 1984); WIS. STAT. ANN. §§ 154.01 to 154.15 (Supp. 1985); WYO. STAT. §§ 33-26-144 to 33-26-152 (Michie Supp. 1984).

19. California enacted the first natural death act in the United States. CAL. HEALTH & SAFETY CODE §§ 7185-95 (West Supp. 1983) (enacted 1976).

20. Florida also recognizes a witnessed oral statement. LIFE-PROLONGING PROCEDURE ACT OF FLORIDA, ch. 84-58, §§ 3-4, 3 FLA. SESS. LAW SERV. 40, 41-42 (West 1984); *see also* VA. CODE § 54-325.8:2 (Michie Supp. 1984).

21. Generally, the acts limit their coverage to life-sustaining procedures and do not cover curative measures. The definition of life-sustaining procedures varies among jurisdictions. Most acts define life-sustaining procedures as medical procedure or intervention which, by artificial or mechanical means, "only serves to prolong the moment of death." Excluded from the definition of life-sustaining procedures in most acts are procedures necessary to provide comfort, care, or to alleviate pain. *See, e.g.*, ILL. ANN. STAT. ch. 1101/2 § 702 (Smith-Hurd Supp. 1984-85); ORE. REV. STAT. § 97.050 (1981); WYO. STAT. § 33-26-144 (Michie Supp. 1984).

22. Many acts define a terminal condition as an incurable condition resulting from illness, disease, or injury which would cause death regardless of the application of life-sustaining procedures. *See, e.g.*, CAL. HEALTH AND SAFETY CODE § 7186 (West Supp. 1983); N.M. STAT. ANN. § 24-7-2 (1981); OR. REV. STAT. § 97.050 (1981); TEX. REV. CIV. STAT. ANN. art. 4590h § 2 (Vernon Supp. 1983); VT. STAT. ANN. tit. 18, § 5252 (Supp. 1984); WASH. REV. CODE ANN. § 70.122.020 (West Supp. 1983-84); W. VA. CODE § 16-30-2 (Michie Supp. 1984). The words "would cause death regardless of the application of life-sustaining procedures" seem to exclude the situation where a person may be kept alive on life support indefinitely. Other legislatures have avoided this problem by defining a terminal condition as a condition which would cause imminent death if life-support was not applied. *See, e.g.*, NEV. REV. STAT. § 449.590 (1983).

23. *Conroy*, 98 N.J. at 341, 486 A.2d at 1219. Claire Conroy died while this case was pending from an appeal from order allowing her guardian to remove the nasogastric conduit.

Conroy suffered from severe physical impairments including arteriosclerosis, heart disease, hypertension, diabetes mellitus and possessed a severely limited intellectual capacity.[24] Unable to discern or respond to verbal stimuli, there was no tangible scientific evidence that Conroy was capable of higher functioning or experienced consciousness.[25] Physicians characterized her physical and mental impairments as irreversible[26] yet they did not consider her condition to be painful.[27] Claire Conroy's only surviving blood relative[28] was appointed guardian and sought removal of a nasogastric feeding tube which was her sole source of life-sustaining nutrients.[29] Physicians considered that removing the tube would lead to Conroy's death, due to dehydration, within one week.[30]

The trial court reasoned that the legal focus required the *ad hoc* balancing of whether life for the patient had become impossibly and permanently burdensome.[31] The court concluded that prolonging such a life would be an unjustified state infringement of Conroy's protected zone of privacy and would be pointless and cruel.[32] Owing to Conroy's primitive cognitive functions and the burdens of such a life, the trial court sanctioned her guardian's request and ordered the nasogastric conduit removed.[33]

The Appellate Division reversed, ruling in the wake of *Quinlan*, that the guardian's judgment is limited to the termination of life-sustaining treatment only when a terminally ill patient is brain dead, irreversibly comatose and vegetative, and when continued treatment would render no putative medical benefit.[34] Alternatively, this court held that such an active deprivation of a basic necessity of life such as food, provided to Conroy through the nasogastric tube, would hasten the dying process, rather than simply allowing death to transpire naturally.[35] The court reasoned that such action would be com-

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Due to the legal significance of whether life-sustaining treatment may be withdrawn from an incompetent, institutionalized, elderly patient with severe mental and physical impairments and a limited life expectancy, the court did not consider the issue moot.

24. *Id.*

25. *Id.*

26. *Id.*

27. *Id.*

28. *Id.*, at 339, 486 A.2d at 1218. Ms. Conroy's sole relative was her nephew and guardian, Thomas Whittemore. Whittemore knew Conroy for over fifty years and had visited her regularly for some years prior to this action. The nephew's intentions were not in dispute and there was no conflict of interest arising from a possible inheritance.

29. *Id.*

30. *Id.*

31. 188 N.J. Super. 523, 457 A.2d 1232 (Ch. Div. 1983).

32. *Id.*

33. *Id.*

34. 190 N.J. Super. 453, 460, 464 A.2d 303, 306 (App. Div. 1983).

35. *Id.* at 469, 464 A.2d at 312. "Some commentators have contended that nourishment

mensurate to killing Conroy and that such active euthanasia was ethically and legally impermissible.[36] The appeals court decision follows an ethical and legal tradition which holds the sanctity of human life above all individual rights, both as a societal value and as a necessary ingredient to the public well-being.[37]

The New Jersey Supreme Court reversed in a narrow ruling limited to the circumstances where life-sustaining treatment is withdrawn from elderly nursing home patients suffering serious, permanent mental and physical impairments, who will nonetheless die within a year with continued treatment.[38] Furthermore, the court required that there be a judicial determination of incompetence antecedent to such a decision, with a finding that the patient is unlikely to regain competence.[39]

In its decision, the court enunciated three legal standards. Under the subjective rule, life-sustaining treatment, including sources of nutrients, may be withheld or withdrawn from a patient when it is clear in the surrounding circumstances, that the patient would have refused the treatment.[40] Advance directives such as living wills, oral directives to family members, appointment of proxy and previous reactions the patient voiced regarding treatment given to others similarly situated, are relevant evidence of the patient's subjective intent.[41] The patient's religious beliefs and the principles of that religion are to be considered when appropriate.[42]

The limited objective rule would allow the withdrawal of life-sustaining treatment if there is some trustworthy evidence that the patient would have refused treatment concurrent with the decisionmaker's satisfaction that clearly, the "burdens of the patient's continued life with the treatment outweigh the benefits of that life for [her]."[43] However, in order to trigger this standard, the party petitioning the court must proffer trustworthy evidence that the patient would have wanted the treatment terminated.[44] Further, medical evidence must establish that the onerousness of the treatment, in terms of pain and suffering to the patient, supercedes the benefits wrought by

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has a special symbolic significance—involving human compassion—which differentiates it from other aspects of treatment. Cantor, *supra* note 7, at 552.

36. *Id.* at 475, 464 A.2d at 312.

37. *See* Hegland, *Unauthorized Rendition of Life Saving Medical Treatment*, 53 CALIF. L. REV. 860 (1965); *See also* Reynolds v. United States, 98 U.S. 145 (1978).

38. *Conroy*, 98 N.J. at 342, 486 A.2d at 1219.

39. *Id.*

40. *Id.* at 360, 486 A.2d at 1229.

41. *Id.* at 362-63, 486 A.2d at 1229-30.

42. *Id.* at 362, 486 A.2d at 1230.

43. *Id.* at 365, 486 A.2d at 1232.

44. *Id.* at 366, 486 A.2d at 1232.

such a regimen.[45] The court gives special attention to pain and suffering[46] without treatment and the availability of drugs and other means to reduce such hardship, short of terminating life-sustaining measures.[47] Other factors to be considered include the patient's life expectancy, her prognosis, level of functioning, humiliation, dependency and treatment options.[48] Justice Handler's separate opinion criticizes the court's emphasis upon pain as a determinative factor within the decisionmaking process.[49] Due to the availability of new drugs and techniques, pain may be reduced to endurable levels without undesirable side-effects.[50] Justice Handler further asserts that health care professionals often find evaluating the degree of pain experienced by a patient to be problematic.[51] The pain standard is alternately considered to be a possible barrier to the justified termination of life-support systems, when other factors militate in favor of ending treatment.[52]

The third standard operative in the absence of any evidence that the patient would have subjectively desired termination of the life-sustaining treatment[53] is the pure objective test.[54] Like the limited objective rule, the pure objective test allows termination of life-sustaining treatment when the "net burdens of the patient's life with the treatment should clearly and markedly outweigh the benefits the patient derives from life."[55] Furthermore, "the recurring, unavoidable and severe pain of the patient's life with the treatment should be such that the effect of administering life-sustaining treatment would be inhumane."[56] The New Jersey Supreme Court explicitly refused to

45. *Id.* at 365-66, 486 A.2d at 1232.

46. The court found no exploration of the discomfort and risks attendant to nasogastric feedings. *Conroy*, 98 N.J. 321 at 387, 486 A.2d at 1243. Justice Handler, concurring in part and dissenting in part, criticized the majority's focus upon pain in fashioning its rule based on his belief that "health care providers frequently encounter difficulties in evaluating the degree of pain experienced by a patient [in Conroy's condition]. *Id.* at 394-95, 486 A.2d at 1247 (Handler, J., concurring in part and dissenting in part). Furthermore, Handler notes the ready availability of drugs and techniques to reduce pain, in almost all patients, with negligible side effects. *See* J. TWYCROSS, RELIEF OF PAIN IN THE MANAGEMENT OF TERMINAL DISEASE 71 (Saunders ed. 1978); PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 50-51 (1983).

47. *Conroy*, 98 N.J. at 366, 486 A. 2d at 1232.

48. *Id.*

49. *Id.* at 394, 486 A.2d at 1247 (Handler, J., concurring in part and dissenting in part).

50. *Id.*

51. *Id.* at 394-95, 486 A.2d at 1247.

52. *Id.* at 395, 486 A.2d at 1248.

53. *Id.* at 366, 486 A.2d at 1232.

54. *Id.* The court recognized that regardless of pain, life-sustaining treatment should not be withdrawn from an incompetent patient previously expressing a wish to be kept alive.

55. *Id.*

56. *Id.*

attach value to such variables as personal economic worth or the patient's social utility or her value to others.[57]

II. THE CONROY PROCEDURE

Noting the special vulnerability of the nursing home population,[58] the *Conroy* court offered a procedure distinct from that used in *Quinlan* to implement one's right to terminate life-sustaining measures.[59] In order to elicit these procedures and surrogate decisionmaking, there must be a judicial determination that the patient is incompetent.[60] Incompetence will be premised upon an inability to understand imparted information, evaluation of options or communication of decisions.[61] Two physicians with expertise in relevant fields, who have personally examined the patient must submit information bearing on her relative competence.[62] Proof must also be clear and convincing that the patient will not regain competence.[63] At this juncture, a guardian will be appointed or, if the patient already has a guardian, the court will decide whether this person is suitable to represent the patient.[64]

The New Jersey Office of Ombudsman,[65] established by legislative action

57. *Id.* at 367, 486 A.2d at 1232-33.

58. The court stipulates that nursing home patients are quite elderly, the average age being eighty-two. In re Conroy, 98 N.J. 321, 375, 486 A.2d 1209, 1237 (1986) (citing S. REP. No. 1420, 93d Cong., 2d Sess. 16 (1974)). Most nursing home patients suffer severe chronic or crippling disabilities and those who enter a home usually die there. Social isolation is severe and fewer than half of these patients have close, surviving family members. S. REP. NO. 1420, 93d Cong., 2d Sess. 16-17 91974). Physicians play a more limited role in nursing homes than in hospitals and generally are not chosen by the residents, S. REP. NO. 1420, 93d Cong., 2d Sess. 323-24 (1974) (Supporting Paper No. 3), and generally are neither chosen by their patients, nor are they familiar with their patients' personalities and preferences. *Decisions to Withhold Treatment from Nursing Home Residents*, 31 J. AM. GERIATRICS SOC'Y 602, 603 (1983). Furthermore, the contemporary nursing home industry, as an institution, suffers "peculiar" industry-wide problems to which hospitals are less prone. S.REP. NO. 1420, 93d CONG., 2D SESS. III (1974).

59. *In re Conroy*, 98 N.J. at 374-75, 486 A.2d at 1237 (1985).

60. *Id.* at 380, 486 A.2d at 1240. The court stipulates that the judicial determination at hand satisfies fourteenth amendment due process considerations as well as ethical demands. *See also* Veatch, *An Ethical Framework for Terminal Care Decisions: A New Classification of Patients*, 32 J. AM. GERIATRICS SOC'Y 665, 668 (1984).

61. *Conroy*, 98 N.J. at 382, 486 A. 2d at 1241.

62. *Id.*

63. *Id.*

64. *Id.* at 383, 486 A.2d at 1241. If the patient already has a guardian, the court will inquire into that person's suitability. Such a determination will include the guardian's knowledge of the patient and her motivations or possible conflicts of interest. In the absence of a guardian, the court will appoint a suitable person to provide treatment decisions for the incompetent.

65. The Office of the Ombudsman for the Institutionalized Elderly is charged with responsibility to guard against abuse of such elderly patients.

to safeguard the institutionalized elderly from abuse, is to receive notification by interested persons[66] that the withdrawal of life-sustaining measures would effectuate the incompetent's wishes or be in her best interests.[67] Those believing the contrary to be so are to also contact the Ombudsman who is to treat all such notifications as possible abuse, investigate the situation and report it within twenty-four hours to the Commissioner of Human Services.[68]

The Ombudsman then appoints two physicians unaffiliated with either the nursing home or the attending physician, to confirm the attending physician's medical prognosis of the patient.[69] If the necessary medical foundation is satisfied, the guardian, with the concurrence of the attending physicians, the Ombudsman and the patient's family,[70] may withhold life-sustaining medical treatment.[71] Such a withholding must be made in good faith and based upon medical evidence and any evidence of the patient's wishes in order to clearly satisfy either the subjective, limited objective or pure objective tests.[72] The *Conroy* court grants civil and criminal immunity for those acting in the absence of bad faith, in accordance with the *Conroy* procedure.[73]

III. The Basis in Privacy

The New Jersey Supreme Court admitted that it was not the most competent forum to resolve questions of essentially ethical and societal value.[74] It viewed the legislature as the superior body to make such a determination, both as factfinder and as an intimate monitor of the public pulse.[75] In a vacuum of legislation and confronting situations such as Claire Conroy's in the absence of legal guidance, the *Conroy* court plunged into the imprecisely charted, value laden waters of constitutional privacy.

The *Conroy* court, following in the footsteps of *Quinlan*, found that the fundamental constitutional right to personal privacy is "broad enough to

66. The court refers to close family members, the patient's guardian, the attending physician or the nursing home itself as "interested parties." *Conroy*, 98 N.J. at 383, 486 A.2d at 1241.

67. *Id.*

68. *Id.* at 384, 486 A.2d at 1242.

69. *Conroy*, 98 N.J. at 384, 486 A.2d at 1242.

70. Neither the spectre nor the significance of familial disagreement over the withholding or withdrawal of life-sustaining treatment is raised by the court.

71. 98 N.J. at 384, 486 A.2d. at 1242.

72. *Id.*

73. *Id.* at 385, 486 A.2d at 1242.

74. *Id.* at 344, 486 A.2d at 1220.

75. *Id.* at 344-45, 486 A.2d at 1221.

encompass a patient's [own] decision to decline medical treatment under certain circumstances."[76] The United States Supreme Court has never addressed this point and has vaguely fashioned the boundaries of the fundamental right of privacy in such landmark decisions as *Griswold v. Connecticut*[77] and *Roe v. Wade*.[78] The only certainty which emanates from these decisions giving the privacy right substance, is that specific guarantees in the Bill of Rights such as the first, third, fourth, fifth, ninth and fourteenth amendments have penumbras assuring personal zones of privacy against state infringement.[79] United States Supreme Court doctrine articulating this right focuses upon "matters relating to marriage, procreation, contraception, family relationships, childrearing and education . . ."[80] It is within these values that Claire Conroy's right was properly fashioned.[81]

The *Conroy* decision alternately embraces the common law right to self-determination as an independent matrix to the right to decline medical treatment in certain circumstances.[82] However, this right is not absolute and is qualified by legitimate state interests.[83] The four countervailing societal interests articulated which may attenuate medical treatment refusal rights are preserving life, preventing suicide, safe-guarding the medical profession and protecting innocent third parties.[84]

The most compelling of the four state interests is the preservation of life concern, encompassing two related strata: the interest in preserving the life

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76. *Id.* at 348, 486 A.2d at 1223.

77. 381 U.S. 479 (1965).

78. 410 U.S. 113 (1973).

79. Griswold v. Connecticut, 381 U.S. 479 (1965).

80. Paul v. Davis, 424 U.S. 693, 713 (1976).

81. A distinguished commentator notes, "There is much that is sound and useful in *Conroy*. Its articulation of legal principles applicable to medical response to death and dying is as persuasive and comprehensive as that provided by any court to date." Cantor, *supra* note 7, at 577.

82. *Conroy*, 98 N.J. at 348, 486 A.2d at 1233. *Accord Storar v. Storar*, 52 N.Y.2d 363, 376-77, 420 N.E.2d 64, 70, 438 N.Y.S. 2d 266, 272-73, *cert. denied*, 454 U.S. 858 (1981). *See also* Cantor, *supra* note 7, at 547 (The author states that the advantages in basing the self-determination right in the common law are several. "First, the patient does not have to worry about establishing state action in order to assert his right. His claim is as applicable to a private hospital or private practitioner as it is to a government sponsored institution subject to the fifth or fourteenth amendments. Further, the opportunity for collecting damages when medical sources override the patient's right is enhanced. The patient, or patient's estate, can invoke the well-established tort doctrine of informed consent without having to cope with the more uncertain strictures of constitutional torts. Through the common law, the moribound patient is likely to have firmer legal footing in his effort to compel medical sources to respect his determinations in shaping the dying process.").

83. *Id.*

84. *Id.*

of the particular patient and the interest in preserving life *qua* life.[85] This abstract state interest usually will give way to a competent patient's much stronger interest in directing his own life.[86] An incompetent patient's interest vests in the judicially appointed guardian as the valued reflection of self-determination. The state suicide interest is not activated in the *Conroy* or *Quinlan* scenarios. The distinction, leveled in degrees, is between self-infliction or self-destruction and self-determination.[87] In both cases death results from the underlying disease rather than from a self-inflicted injury.[88]

The third interest, safeguarding the integrity of the medical profession, is dismissed by the *Conroy* court through two policy considerations. First, the ethics of the medical profession do not direct heroic intervention at all costs in the instance of a competent patient refusing life-sustaining treatment.[89] Thus, the free exercise of this self-determination right encompassed within constitutionally protected privacy zones, does not threaten the integrity of the healing arts professions. Secondly, if the right to informed consent is to be afforded meaningful value, it must be respected even when conflicting with medical advice or normative medical values.[90]

Finally, the State's interest in protecting third parties who may be harmed by the patient's treatment decision supersedes the right to refuse treatment in only a few scenarios and is given little weight by the New Jersey court. However, some courts require individuals to undergo some treatment to protect the public health,[91] such as in instances of epidemic, or to safeguard the lives of minors over parental religious objections.[92]

The balance exercised by the *Conroy* court results in the individual interest considered ascendent to any state interest.[93] Cases holding otherwise either dispute the premise of the quality of life analysis or are those where the rational capabilities of the patient are in dispute.[94] It is at this juncture, however, that the *Conroy* decision parts with recently established jurisprudence and vests the patient's penumbral and common law privacy rights in

85. *Id. See* Cantor, *Quinlan, Privacy and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 239, 249 (1977); Annas, *In Re Quinlan: Legal Comfort for Doctors*, HASTINGS CENTER REP., June 1976, at 29.

86. *Id.*

87. *Conroy*, 98 N.J. at 351, 486 A.2d at 1224.

88. *Id.*

89. *Id.*

90. *Id.* at 352-53, 486 A.2d at 1225.

91. *Id.*; *see also* Jacobson v. Massachusetts, 197 U.S. 11 (1905).

92. *Id.*; *see also* Application of President and Directors of Georgetown College, Inc., 331 F.2d 1000, 1008 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964); Holmes v. Silver Cross Hospital, 340 F. Supp. 125, 130 (N.D. Ill. 1972).

93. *Id.*

94. *Id.*

the judicially appointed guardian. To act otherwise effectively destroys the incompetent patient's protected privacy zones and renders the value of self-determination meaningless. Since *Quinlan*, the New Jersey court has recognized the proxy assertion of an incompetent's privacy interests, premised upon the notion that incompetency does not affect a surrendering of legal rights.[95]

The procedural aspects of *Conroy* and the use of the subjective, limited objective and pure objective tests duly protects the incompetent patient from malfeasance on the part of the guardian or the attending medical professionals. As a matter of both policy and urgency, the law of *In re Conroy* is a sound approach in the midst of sociological change, the aging of America, and legislative inability to fashion effective, responsive law to meet this challenge.

IV. THE ETHICAL AND RELIGIOUS DILEMMA

The *Conroy* court rejects a common distinction often drawn between active euthanasia[96] and passive euthanasia[97] as "too nebulous to constitute a principled basis for decision making."[98] In doing so, it seeks to justify its orders to remove the nasogastric conduit, the sole source of nourishment for Claire Conroy. Some commentators and theologians regard provisions of food and water as falling within the realm of ethically required, ordinary medical treatment.[99] By sanctioning the withdrawal of life-sustaining nutrients, the New Jersey Supreme Court accepts, as critics may contend, "the thin edge of the wedge," thus preparing the way for legalization of involuntary euthanasia.[100]

The *Conroy* decision also challenges Roman Catholic doctrine on euthanasia.[101] This doctrine would reject the *Conroy* analysis as a posture actively inducing the death of a person through dehydration.[102] Hence, the *Conroy*

95. *Quinlan*, 70 N.J. at 35, 355 A.2d at 661.

96. *See* Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 Rutgers L. Rev. 228, 258-62 (1975); RACHELS, *Active and Passive Euthanasia*, 292 NEW ENG. J. MED. (1975) (*hereinafter cited as Rachels*).

97. *Id.*

98. *Conroy*, 98 N.J. at 370, 486 A.2d at 1225.

99. *See* Rachels, *supra* note 96.

100. Kamisar, *Some Non-Religious Views Against Proposed "Mercy-Killing" Legislation*, 42 MINN. L. REV. 969 (1958).

101. *Sacred Congregation for the Doctrine of the Faith*, "Declaration on Euthanasia," (official declaration of the Roman Catholic Church, approved by Pope John Paul II on May 5, 1980).

102. *Sacred Congregation for the Doctrine of the Faith*, "Declaration on Euthanasia," (Official declaration of the Roman Catholic Church, approved by Pope John Paul II on May 5, 1980).

law may be violative of Church principles on two grounds. First, the decision may be seen as a dislocation of the normal care due a patient under any circumstances.[103] Secondly, the *Conroy* rule divides the union with Christ's Passion that Christians share through their own suffering at death.[104] Although the court has found these considerations unpersuasive, these are the ethical and religious challenges confronting the *Conroy* doctrine and subsequent judicial action which is sure to ensue in the midst of this decision. As the American pro-life movement has challenged the *Roe v. Wade* decision, due, in good measure, to moral and religious objections, any judicial extension of the right to die will, in all likelihood, encounter similar political resistance. Whether such religious arguments should be given credence in American law raises strong constitutional questions. Justice Frankfurter explicitly rejected such considerations since "under our Constitution a state is disabled from legislating . . . on religious grounds . . . ."[105] The Establishment Clause within the first amendment is the promulgation of the Founders' intent to rid governmental processes from the taint of religious influence, both "root and branch." The constitutional tradition is to maintain a high and impregnable wall between church and state.[106]

The ability of the courts to radically reshape a substantial area of the law by a single decision is very limited. Instead, such a burden must be met by the various state legislatures, as science becomes more complex and further beyond the layman's and the judiciary's competence. Life, itself, may be prolonged by such incredible scientific progress. Therefore, it is necessary for the law to remit such important and personal determinations to a more appropriate sphere—the patient, family, physican relationship. In such a competent forum, the privacy interest is expressed in a fuller and more meaningful fashion where legal doctrine and precedent may give way to faith, humanity, understanding and the spirit of the Hippocratic Oath.

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103. *Id.* at 10.

104. *Id.* at 6; *See also* Matthew 27:34.

105. McGowan v. Maryland, 366 U.S. 420, 459 (1961) (Frankfurter, J., concurring).

106. Everson v. Board of Education, 330 U.S. 1 (1947). Some commentators have argued that the position taken by the Court is not based on a sound analysis of the Founders' intent. The purpose of the first amendment was not to keep government and religion separated, but rather "to forbid the Federal Government from interfering in the manner in which state governments dealt with religion." C. ANTINEAU, A. DOWNEY & E. ROBERTS, FREEDOM FROM FEDERAL ESTABLISHMENT 140 (1964); *See also* W. KATZ, RELIGION AND AMERICAN CONSTITUTIONS 9 (1964).