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The Expense of Expanding the Right to Die: A Trilogy

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THE EXPENSE OF EXPANDING THE RIGHT TO DIE: A TRILOGY

I used to wish for death
A lot of the time.
Then I died
For a little time.
Now I wish to die
Some of the time.
But, now I know
It will be
For all the time.[1]

INTRODUCTION

Although advances in medical technology over the past two decades have offered relief to many terminally ill patients, these same advances have sparked a continuing legal and medical debate.[2] For many Americans on the threshold of death, procedures are now available which most accurately can be "described as a means of prolonging the dying process rather than a means of continuing life."[3] The primary issue confronting American courts and medical institutions is whether it is ever legally or ethically permissible to withhold or to withdraw life-sustaining treatment from a patient.[4] An affirmative answer to this question challenges the presumption that the goal of medical treatment is to preserve life at all costs.

Since the New Jersey Supreme Court decided the seminal case

1. Poem from the diaries of "Beth," a terminally ill patient, written during the last months of her illness. E. KÜBLER-ROSS, TO LIVE UNTIL WE SAY GOOD-BYE 40 (1978). The life work of Elisabeth Kübler-Ross is centered on helping those touched by death and terminal disease cope with the effects of inevitable death. *See, e.g.*, E. KÜBLER-ROSS, AIDS: THE ULTIMATE CHALLENGE (1987); E. KÜBLER-ROSS, ON CHILDREN AND DEATH (1985); E. KÜBLER-ROSS, LIVING WITH DEATH AND DYING (1981); and E. KÜBLER-ROSS, ON DEATH AND DYING (1969).

2. *See generally* N. CANTOR, LEGAL FRONTIERS OF DEATH AND DYING (1987) [hereinafter LEGAL FRONTIERS].

3. John F. Kennedy Hosp. v. Bludworth, 452 So. 2d 921, 923 (Fla. 1984).

4. *See* LEGAL FRONTIERS, *supra* note 2, at 105—23.

involving Karen Ann Quinlan,[5] the central focus of the debate has become whether a competent patient's right to refuse medical treatment should be extended to an incompetent patient.[6] The establishment of a procedure by which the incompetent patient's desire to withhold treatment may be executed has become of paramount importance.[7] Other state courts since *Quinlan* have faced similar issues.[8] In three recent cases, the New Jersey Supreme Court has attempted to resolve many of the complicated questions arising from *Quinlan* and its progeny. The trilogy of *In re Farrell*,[9] *In re Peter*,[10] and *In re Jobes*[11] broadly expands the individual's right to refuse life-sustaining medical treatment and sets complicated guidelines to be followed by guardians, nursing homes, and patients themselves.

This Comment examines the trilogy, analyzing the unanswered questions and problems that may arise in the wake of the decisions. Part I of the Comment examines the complex legal background surrounding the individual's right to refuse life-sustaining

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

6. *See, e.g.*, Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 72, 370 N.E.2d 417 (1977) (addressing whether the state has the responsibility to require medical treatment for incompetent persons in all circumstances); *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64 (finding that a patient's right to refuse medical treatment survives incompetency), *cert. denied*, 454 U.S. 858 (1981).

7. *See* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 119—70 (1983) [hereinafter DECIDING TREATMENT].

> [P]atients who have permanently lost conciousness . . . are not dead . . . . How should such a patient be treated? What role should the family play in decisionmaking about the person's health care? What role, if any, should the law have in this process? . . . [P]rocedural and substantive policies [are needed] to guide the decisionmaking in a manner that is protective of the interests of this special group of very vulnerable patients.

Id. at 119—20.

8. *See, e.g.*, Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987) (court allowed guardian to consent to the removal of nasogastric tube from nursing home patient in chronic vegetative state); *In re* L.H.R., 253 Ga. 439, 321 S.E.2d 716 (1984) (court allowed parents of infant in chronic vegetative state to exercise the infant's right to terminate treatment); Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 497 N.E.2d 626 (1986) (court honored wife's request to discontinue the artificial hydration and nutrition sustaining her husband who was in a persistent vegetative state); *In re* O'Connor, No. 312 (N.Y. Oct. 14, 1988) (LEXIS, States library, N.Y. file) (court permitted hospital to insert nasogastric feeding tube against the request of the incompetent woman's family); *Storar*, 52 N.Y.2d 363, 420 N.E.2d 64 (1981) (court denied guardian's application to discontinue blood transfusions for a terminally ill, profoundly retarded, adult cancer patient).

9. 108 N.J. 335, 529 A.2d 404 (1987).

10. 108 N.J. 365, 529 A.2d 419 (1987).

11. 108 N.J. 394, 529 A.2d 434 (1987).

treatment, considering both constitutional and common law principles. Part II reviews *In re Farrell*, *In re Peter*, and *In re Jobes*. Part III analyzes the inevitable implications and questions connected with the rulings. These issues include the problems the rulings present to the disabled community, the possibility of right-to-die[12] litigation by AIDS patients, and the effect on health care facilities and professionals. The Comment recommends solutions to each of the dilemmas. The Comment urges courts to resist the rote application of right-to-die standards to cases involving mentally handicapped patients. When termination of treatment is sought for AIDS patients, the Comment proposes that courts closely monitor the decisionmaking during the early phases of the disease and focus on the appropriate decisionmaker in the later stages. Finally, the Comment encourages a balancing, in appropriate situations, of the rights of healthcare institutions and professionals with those of a patient wishing to exercise the right to die so that the interests of all will be protected.

I. LEGAL BACKGROUND

A. *The Right to Refuse or Accept Treatment*

The right of a person to be free from nonconsensual bodily invasion is long recognized at common law.[13] Through the doctrine of informed consent,[14] the law has consistently recognized the individual's interest in preserving her bodily integrity.[15] A patient's

12. "Right-to-die" is not a legal term of art but merely the label placed upon the individual's right of self-determination as exercised by the refusal of life-sustaining medical treatment. The label also refers to the organizations which support these rights. *See generally* LEGAL FRONTIERS, *supra* note 2.

13. *See* Union Pac. Ry. v. Botsford, 141 U.S. 250 (1891), containing the often quoted statement by Justice Gray: "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." *Id.* at 251. Subsequently, Judge Cardozo succinctly captured the theory behind this developing right, stating: "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." Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129—30, 105 N.E. 92, 93 (1914).

14. Informed consent is defined as a "person's agreement to allow something to happen (such as surgery) that is based on a full disclosure of facts needed to make the decision intelligently; i.e., knowledge of risks involved, alternatives, etc." BLACK'S LAW DICTIONARY 701 (5th ed. 1979).

15. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 739, 370 N.E.2d 417, 424 (1977) (discussing the legal bases underlying the right to refuse medical treatment).

bodily integrity is protected not only by her right to give informed consent, but also by her right to give informed refusal. Thus, a competent adult patient generally may decline both the initiation and the continuation of any medical treatment.[16]

The right to make decisions regarding one's own body is also protected by constitutional guarantees. In *Griswold v. Connecticut*,[17] the Supreme Court recognized an unwritten right of privacy associated with the specific guarantees of the Bill of Rights.[18] The Court extended this right in *Roe v. Wade*[19] by acknowledging a woman's right to have an abortion in certain situations.[20]

State courts also recognize this right of privacy.[21] The New Jersey Supreme Court in *In re Quinlan*[22] interpreted the right of privacy to be "broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions."[23] *Quinlan* is important not only for the court's extension of the right of privacy to include the right to refuse medical treatment, but also because the discontinuance of treatment was sought on behalf of an

16. *In re* Conroy, 98 N.J. 321, 329, 486 A.2d 1209, 1222 (1985). One of the most dramatic examples of a competent person's right to refuse continuation of treatment was Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986). The California Court of Appeals held that a competent adult had the right to determine whether to submit to medical treatment, even in the absence of terminal illness. In so holding, the court allowed a 28-year-old woman afflicted with cerebral palsy since birth to authorize the hospital to remove her nasogastric feeding tube. *Id.* at 1138, 225 Cal. Rptr. at 298.

17. 381 U.S. 479 (1965).

18. Griswold v. Connecticut, 381 U.S. at 484.

19. 410 U.S. 113 (1973).

20. Roe v. Wade, 410 U.S. at 153.

21. The right to refuse treatment was recently given constitutional status by a federal district court in Gray v. Romeo, No. 87-0573B (D.R.I. Oct. 17, 1988) (LEXIS, Genfed library, Dist file). In *Gray*, the husband of a woman in a persistent vegetative state sought a declaratory judgment under 42 U.S.C. § 1983 (1982) when the hospital refused to withdraw a tube providing nutrition and hydration at the family's request. In granting the husband's request, the court held that an individual's constitutional rights of self-determination, personal autonomy, and privacy included the right to refuse life-sustaining treatment. *Id.*

22. 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

23. *In re* Quinlan, 70 N.J. at 19, 355 A.2d at 663. Other state courts have also determined that the right to refuse treatment is based on constitutional premises. *See, e.g.*, *In re* L.H.R., 253 Ga. 439, 321 S.E.2d 716 (1984) (constitutional right to refuse medical treatment absent conflicting state interests); *In re* Spring, 380 Mass. 629, 405 N.E.2d 115 (1980) (general constitutional right to refuse medical treatment in appropriate circumstances); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983) (freedom to care for one's health and person falls within constitutional right of privacy).

incompetent.[24] The *Quinlan* court reasoned that the constitutional right to refuse treatment is possessed by all persons, regardless of their condition.[25] In an effort to preserve the incompetent patient's privacy right, the court held that her father, as guardian, could exercise Quinlan's right to accept or refuse treatment.[26]

The reasoning of the *Quinlan* court was followed by the Massachusetts Supreme Court in *Superintendent of Belchertown State School v. Saikewicz*.[27] The Massachusetts court reasoned that if the personal right to refuse medical treatment was to have any meaning, whether grounded in common law or constitutional terms, it would have to be exercised by a third party.[28] In determining whether or not the guardian could decline treatment on behalf of the incompetent, the court rejected an objective standard because the inquiry would focus on what a majority of competent people would do in similar situations.[29] Instead, the court adopted a subjective substituted judgment standard[30] much like that applied by the *Quinlan* court.

> In short, the decision in cases such as this should be that which

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24. *Quinlan*, 70 N.J. at 41, 355 A.2d at 664. This first articulation of the right to die by the New Jersey Supreme Court has served as the bedrock for many of the treatment decisions made by courts in recent years. The circumstances in *Quinlan* involved a 22-year-old woman who suffered two 15-minute periods in which she did not breathe. She was connected to an artificial respirator and diagnosed as being in a "chronic and persistent vegetative state." *Id.* at 26, 355 A.2d at 655. Because Quinlan had no reasonable chance of recovery and because she was incompetent, her father sought the court's permission to disconnect her respirator. *Id.* at 22, 355 A.2d at 651.

25. *Id.* at 41, 355 A.2d at 664. "If a putative decision by Karen to permit this noncognitive, vegetative existence to terminate by natural forces is regarded as a valuable incident of her right of privacy . . . then it should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice." *Id.*

26. *Id.*

27. 373 Mass. 728, 370 N.E.2d 417 (1977). The guardian of a 67-year-old mentally retarded patient in a state institution sought judicial authorization to discontinue the patient's chemotherapy treatments. The guardian felt that discontinuance would be in the patient's best interests. *Id.* at 729, 370 N.E.2d at 419.

28. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. at 747, 370 N.E.2d at 429.

29. *Id.* at 749, 370 N.E.2d at 428.

30. The substituted judgment doctrine was first articulated in the English case, *Ex parte* Whitbread, 35 Eng. Rep. 878 (1816). Essentially, the doctrine requires that the substitute decisionmaker "don the mantle of the incompetent," in an effort to pay full respect "to the dignity of the person involved." Curreri, *Incompetent's Right to Choose Medical Treatment*, 33 MED. TRIAL TECH. Q. 1, 13 (1987) [hereinafter *Right to Choose*] (quoting *In re* Carson, 39 Misc. 2d 544, 545, 241 N.Y.S.2d 288, 289 (1962)). Historically, substituted judgment was used to authorize gifts from estates of incompetents. Note, *Substituted Judgment in Medical Decisionmaking For Incompetent Persons:* In re *Storar*, 6 WIS. L. REV. 1173, 1189 (1982).

> would be made by the incompetent person, if that person were competent, but taking into account the present and future incompetency of the individual as one of the factors which would necessarily enter into the decision-making process of the competent person.[31]

The substituted judgment standard, as articulated by *Quinlan* and *Saikewicz*, has become the primary vehicle by which the right to refuse medical treatment is exercised on behalf of the incompetent.[32] The substituted judgement standard is used to reach the decision that the incompetent would reach based on the patient's own definition of well-being and self-determination. This standard is only appropriate when the patient previously was able to develop views concerning her well-being and reliable evidence exists indicating her view.[33]

If a patient has never been competent or there is insufficient evidence indicating the patient's treatment choices, the best interest standard is often applied.[34] In applying this standard, the surrogate decisionmaker must attempt to implement treatment which is in the patient's best interest by reference to factors such as "relief from suffering, preservation or restoration of functioning, and the quality of life[35] as well as the extent of life if sustained."[36] The distinction between the use of substituted judgment and the best interest standard has blurred as the situations in which the stan-

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31. *Saikewicz*, 373 Mass. at 752—53, 370 N.E.2d at 431.

32. *See, e.g., In re* Severns, 425 A.2d 156 (Del. Ch. 1980) (court allowed the husband-guardian of a 55-year-old comatose woman to refuse or discontinue all medical support measures based on the doctrine of substituted judgment); *In re* Spring, 8 Mass. App. Ct. 831, 399 N.E.2d 493 (1979) (court held that senile man's family and physician, through substituted judgment, could determine what the incompetent man would choose if able); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985) (court approved the substituted judgment approach as one of the methods that may be used to authorize discontinuance of an elderly, nursing home patient's life-support).

33. DECIDING TREATMENT, *supra* note 7, at 133.

34. *See, e.g.*, Foody v. Manchester Memorial Hosp., 40 Conn. Supp. 127, 482 A.2d 713 (1984) (absent expression of patient's desire, the surrogate decisionmaker must seek to implement best interests of patient); *In re* Torres, 357 N.W.2d 332 (Minn. 1984) (patient's best interest must be served by maintenance of life support).

35. "The phrase 'quality of life' . . . refers [sometimes] to the value that the continuation of life has for the patient, and other times to the value that others find in the continuation of the patient's life." DECIDING TREATMENT, *supra* note 7, at 135. Quality of life evaluations are particularly inappropriate in the case of a handicapped individual. *See infra* notes 136—52 and accompanying text.

36. DECIDING TREATMENT, *supra* note 7, at 135 (footnote omitted). The best interest standard, according to the Commission, should include the patient's own desires if known. *Id.*

dards are used continue to broaden.[37]

B. Limitations on the Right to Refuse Medical Treatment

The right to refuse treatment, whether exercised by a competent patient or on behalf of an incompetent patient, is not absolute.[38] Through the doctrine of *parens patriae*, a state, through the use of its police power, may limit an individual's actions, if those actions represent a threat to other persons or to basic societal values.[39] Because refusal of medical treatment may pose these threats, countervailing state interests may subordinate the right of self-determination.[40]

The state may override the individual's privacy interest and right of choice to protect four state interests: (1) the preservation of life; (2) the prevention of suicide; (3) the protection of innocent third parties; and (4) the maintenance of the ethical integrity of the medical profession.[41] These interests were first enunciated in *Saikewicz* and have been adhered to consistently by subsequent courts.[42]

The preservation of human life,[43] which simultaneously embraces preserving the sanctity of life, is the most significant state interest.[44] This interest alone will not foreclose a competent patient from declining life-sustaining treatment and must be reconciled with the interests of the individual.[45] As the degree of bodily invasion caused by treatment becomes more severe, the state's in-

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37. *See, e.g.*, Custody of a Minor, 375 Mass. 733, 753, 379 N.E.2d 1053, 1065 (1978) (finding the substituted judgment standard consistent with the best interests standard in the case of a child incompetent by reason of age). *See also* Wiseman, *Denial of Treatment to Handicapped Newborns: In Whose Interest?*, 3 GA. ST. U.L. REV. 240 (1987) [hereinafter *Whose Interest*]. "In the case of infants, then, the two tests are equivalent." *Id.* at 239—40 n.49. The President's Commission suggests that when possible, the substituted judgment standard is to be used. DECIDING TREATMENT, *supra* note 7, at 136.

38. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 740, 370 N.E.2d 417, 424—25 (1977).

39. *See* BLACK'S LAW DICTIONARY 1003 (5th ed. 1979).

40. *Saikewicz*, 373 Mass. at 740, 370 N.E.2d at 424—25.

41. *Id.* at 741, 370 N.E.2d at 425.

42. *See, e.g.*, John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921 (Fla. 1984); *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).

43. *Saikewicz*, 373 Mass. at 741, 370 N.E.2d at 425.

44. *Conroy*, 98 N.J. at 349, 486 A.2d at 1223 (citing Cantor, *Quinlan, Privacy, and the Handling of Incompetent Dying Patients*, 30 RUTGERS L. REV. 243, 249 (1977)).

45. *Id.*

terest diminishes.[46]

A corollary to the state's interest in preserving life is the state's interest in preventing suicide. Generally, courts do not view the refusal of life-sustaining treatment as an attempt to commit suicide, but rather as an action that allows disease to take its natural course.[47] If death occurs, it is perceived as the result of the disease and not of any affirmative action.[48] Consequently, courts find that a refusal of life-sustaining treatment is merely an attempt to be free from mechanical devices and not evidence of suicidal intent.[49]

The third interest the state frequently advances is the protection of third parties. Although this interest is used to justify court authorization of treatment when public health is threatened,[50] it most often surfaces when the state seeks to protect related minor children, unborn children, or other persons dependent on the patient.[51] If the patient has arranged for a dependent's care after her death, it is likely that the court will consider the patient's right to refuse treatment paramount to the state's interest.[52]

The courts since *Quinlan* have struggled to address adequately the state's fourth interest, protecting the ethical integrity of the

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46. *In re* Quinlan, 70 N.J. 10, 41, 355 A.2d 647, 664 (1976).

47. *See* Satz v. Perlmutter, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); *Saikewicz*, 373 Mass. at 743, 370 N.E.2d at 426; *Conroy*, 98 N.J. at 350—51, 486 A.2d at 1224; *but see* Jarrett, *Moral Reasoning and Legal Change: Observations on the Termination of Medical Treatment and the Development of Law*, 19 RUTGERS L.J. 999 (1988) [hereinafter *Moral Reasoning*]. Professor Jarrett argues that "[p]re-existent legal doctrines regarding suicide and homicide provide a *de facto* barrier" to allowing patients to refuse life-sustaining treatment. *Id.* at 1001. Instead, Professor Jarrett believes the development of the refusal of treatment doctrine "is of a legal course charted by the moral stars" invoking dangerous legal fictions. *Id.* at 1000—01. One such legal fiction is that there was no killing in the sense that "the termination of treatment is not the cause of death." *Id.* at 1018. "[T]his claim about causation is better regarded as a normative conclusion than as a factual premise or reason for permitting these acts." *Id.* at 1017.

48. *Conroy*, 98 N.J. at 350—51, 486 A.2d at 1224.

49. *See, e.g., Satz*, 362 So. 2d at 162—63.

50. *See* Jacobson v. Massachusetts, 197 U.S. 11, 25 (1905).

51. *Conroy*, 98 N.J. at 353, 486 A.2d at 1225—26. *See, e.g., In re* President of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964) (court ordered treatment in interest of mother's seven-month-old child); United States v. George, 239 F. Supp. 752 (D. Conn. 1965) (court ordered transfusion for father of four); Hamilton v. McAuliffe, 277 Md. 336, 353 A.2d 634 (1976) (transfusion ordered for parent who was the sole support of a two-year-old child); Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 42 N.J. 421, 201 A.2d 537 (1964) (court ordered transfusion for pregnant woman to protect unborn child).

52. Note, *Equality for the Elderly Incompetent: A Proposal for Dignified Death*, 39 STAN. L. REV. 689, 704 (1987). *See also infra* notes 87—94 and accompanying text.

medical profession.[53] Most courts now recognize that medical ethics do not mandate intervention in disease at all costs and that allowing a dying patient to refuse medical treatment may be considered acceptable.[54]

Countervailing state interests rarely outweigh the competent patient's right of self-determination.[55] If, however, a court finds that the state's interests outweigh the incompetent patient's interest in bodily integrity, it may require treatment regardless of the availability of any substituted decisionmaker.[56]

C. *The Case of Claire Conroy*

In re Conroy[57] provides insight into the present state of the right to refuse medical treatment. The New Jersey Supreme Court's decision in *Conroy* contains an extensive discussion outlining the procedures for extending the right to refuse medical treatment to elderly incompetent patients; this discussion is relied on heavily in the recent trilogy of New Jersey cases.

Claire Conroy was an eighty-four-year-old nursing home resident who suffered from many serious physical ailments.[58] As her condition deteriorated, Ms. Conroy's guardian sought court authorization to have her nasogastric tube removed, an action which would

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53. *See, e.g.*, Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 743—44, 370 N.E.2d 417, 426—27 (1977); *Conroy*, 98 N.J. at 351—52, 486 A.2d at 1224—25; *In re* Storar, 52 N.Y.2d 363, 378, 420 N.E.2d 64, 71 (1981); *In re* Colyer, 99 Wash. 2d 114, 121—23, 660 P.2d 738, 743—44 (1983).

54. *See, e.g., Conroy*, 98 N.J. at 352, 486 A.2d at 1225. While it is generally accepted that medical ethics are not interfered with in instances of treatment refusal, the ethical integrity of a particular institution may be infringed upon when the institution is forced to participate in the treatment withdrawal or refusal. *See infra* notes 162—68 and accompanying text.

55. *See Moral Reasoning, supra* note 47, at 1001—03.

56. *See, e.g., Saikewicz*, 373 Mass. at 739, 370 N.E.2d at 425—27.

57. 98 N.J. 321, 486 A.2d 1209 (1985).

58. *In re* Conroy, 98 N.J. at 337, 486 A.2d at 1217. Claire Conroy suffered from arteriosclerotic heart disease, hypertension, diabetes mellitus, a gangrenous knee, several necrotic decubitus ulcers, eye infirmities, urinary and bowel dysfunction, and a limited ability to swallow food. While Ms. Conroy was not considered brain dead or in a chronic vegetative state, she was considered severely demented, unable to respond to verbal stimuli, and incapable of higher functioning or consciousness. *Id.* In this way, Claire Conroy's situation was different than that of Karen Quinlan, who was in a chronic vegetative state. *See supra* note 24 and accompanying text.

Because Ms. Conroy was unable to swallow, she was fed through a nasogastric tube that extended through her esophagus from her nose to her stomach. Medical testimony was unclear whether Ms. Conroy experienced any pain; other testimony indicated that she made occasional moaning sounds and pulled at her bandages and tubes. *Id.* at 338, 486 A.2d at 1217.

cause death by dehydration within one week.[59] Doctors testified that although death in such a manner would be painful, Ms. Conroy would be unconscious.[60] The trial court concluded that Claire Conroy's life was indeed burdensome and permitted the removal of the feeding tube even though death might be painful.[61]

On appeal, the judgment of the trial court was reversed.[62] The appellate court held that the guardian's right to authorize termination of medical treatment was limited to situations in which the patient was terminally ill, brain dead, irreversibly comatose, or vegetative.[63]

On review, the New Jersey Supreme Court reversed the appellate court and expanded the situations in which the withdrawal or withholding of life-sustaining treatment could be authorized. The court limited its analysis to the withdrawal of treatment from a once-competent but presently incompetent elderly nursing home patient with serious permanent physical and mental disabilities who has approximately one year to live.[64]

The court recognized the existence of both a constitutional and a common-law right to refuse medical treatment.[65] Citing *Quinlan*, the court opined that the right to choose medical treatment is not lost when the patient is incompetent.[66] The court noted, however, that *Quinlan* dealt only with patients in "a chronic, persistent vegetative or comatose state."[67] By imposing this limitation, the *Quinlan* court failed to provide guidance in situations in which a patient, like Claire Conroy, did not fit the chronic and vegetative criteria yet nonetheless was incompetent to make her own deci-

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59. *Id.* at 335, 486 A.2d at 1216. Ms. Conroy's only living relative, her nephew Thomas C. Whittemore, was named her general guardian prior to her entrance to the nursing home. *Id.*

60. *Id.*, 486 A.2d at 1217.

61. *See id.* at 340—41, 486 A.2d at 1218—19. Evidence produced at trial indicated that Ms. Conroy had lived a very cloistered life with her three sisters and that she had feared doctors, avoiding them for most of her life. Further evidence indicated that Ms. Conroy was a practicing Roman Catholic and that the doctrines of the church made allowances for the removal of extraordinary life-sustaining treatment. After reviewing evidence of Ms. Conroy's beliefs, the trial court permitted removal of the tube, reasoning that the focus of the inquiry should be "whether life has become impossible and permanently burdensome to the patient." *Id.* at 341, 486 A.2d at 1219.

62. *In re* Conroy, 190 N.J. Super. 453, 464 A.2d 303 (App. Div. 1983).

63. *Id.* at 469—70, 464 A.2d at 312.

64. *Conroy*, 98 N.J. at 342, 486 A.2d at 1219—20.

65. *Id.* at 347—48, 486 A.2d at 1222.

66. *Id.* at 359, 486 A.2d at 1229.

67. *Id.* at 358—59, 486 A.2d at 1228.

sion.[68] The *Conroy* court reasoned that such patients did not lose their right of self-determination merely because their situations were not encompassed by the existing standard.[69]

To ensure that patients like Ms. Conroy retain this vital right, the court suggested three tests which could be used to enable a surrogate decisionmaker to exercise the right in similar situations. The court first examined the "subjective" test which analyzed whether the patient, if competent, would have refused treatment.[70] The second test outlined by the court was the "limited-objective" test. Under this test, life-sustaining treatment could be withheld from a patient "when there is some trustworthy evidence that the patient would have refused the treatment, and the decision-maker is satisfied that it is clear that the burdens of the patient's continued life with the treatment outweigh the benefits of that life for him."[71] The final test discussed by the court was the "pure-objective" test to be applied in the absence of trustworthy evidence. The decisionmaker must be satisfied that the burdens of the patient's life with continued treatment would "clearly and markedly" outweigh any benefits from life, and the severe and continuing

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68. The court stated:

> Such people (like newborns, mentally retarded persons, permanently comatose individuals, and members of other groups with which this case does not deal) are unable to speak for themselves on life-and-death issues concerning their medical care. This does not mean, however, that they lack a right to self-determination. The right of an adult who, like Claire Conroy, was once competent, to determine the course of her medical treatment remains intact even when she is no longer able to assert that right or to appreciate its effectuation.

Id. at 359—60, 486 A.2d at 1229.

69. *Id.* at 364—65, 486 A.2d at 1231—32.

70. *Id.* at 360—61, 486 A.2d at 1229. The court reasoned that this standard was not based on what the reasonable person would wish, but rather centered around the presumed desires of the patient. Evidence of such clear intent could take various forms including: a written document or "living will;" an oral directive to a friend, family member or health care professional; a durable power of attorney authorizing a person to make decisions for the patient; previous statements regarding the medical treatment of others; or the patient's religious beliefs. *Id.* at 361—62, 486 A.2d at 1229—30. The court distinguished remote or inconsistent prior statements from evidence of clear intent found in carefully considered opinions, particularly those in written form. *Id.* at 363, 486 A.2d at 1230. This first test is similar to the substituted judgment test. *See supra* notes 30—33 and accompanying text. *See also* Note, *Withholding and Withdrawing Life-Sustaining Medical Treatment: Procedures for Subjective and Objective Surrogate Decision Making in* In re *Jobes*, In re *Peter and* In re *Farrell*, 19 RUTGERS L.J. 1029, 1041 (1988).

71. *Conroy*, 98 N.J. at 365, 486 A.2d at 1232. The court noted that this test applies when there is no unequivocal evidence of the patient's desires or the pain which the patient is probably suffering. *Id.*

pain of life with treatment would make administration of treatment inhumane.[72] The court found that the past conduct, statements, and religious beliefs of Claire Conroy constituted insufficient evidence of clear intent required by the subjective test.[73] Additionally, the information concerning the benefits and burdens of Ms. Conroy's life was insufficient to satisfy either of the objective tests. Testimony concerning the amount of pain experienced by Ms. Conroy was inconclusive and did not produce the requisite certainty on which a surrogate decisionmaker could rely.[74]

In addition to applying these three tests, the court examined many of the distinctions that previously had been drawn in life-sustaining treatment jurisprudence.[75] The court rejected the distinction between "ordinary" and "extraordinary" in defining the limits of the right to refuse medical treatment.[76] The court also rejected the common distinction between the withholding of nutrition and hydration, and the termination of other life-sustaining medical treatments.[77]

Conroy, therefore, outlines three detailed tests for determining when treatment may be withdrawn from an incompetent nursing home patient who is neither brain dead nor vegetative. The hold-

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72. *Id.* at 366, 486 A.2d at 1232. In addition, the court apparently refused to consider broader quality-of-life considerations. *Id.* at 367, 486 A.2d at 1232—33. "[W]e expressly decline to authorize decision-making based on assessments of the personal worth or social utility of another's life." *Id.* However, the court does authorize a quality-of-life type evaluation of "a patient's life in terms of pain, suffering, and possible enjoyment." *Id.* at 367, 486 A.2d at 1232. *See Moral Reasoning*, *supra* note 47, at 1004 (The *Conroy* "court allows those acting on behalf of patients to determine that . . . they are better off dead than alive."). *See also supra* note 35.

73. The court suggested that more evidence of Ms. Conroy's intent should be obtained by her guardian. *Id.* at 387, 486 A.2d at 1242—43. The court recommended specifically that more evidence of Ms. Conroy's ethical and moral beliefs was necessary. *Id.*

74. *Id.* at 386, 486 A.2d at 1243.

75. *Id.* at 369—74, 486 A.2d at 1233—36. *See Right to Choose*, *supra* note 30, at 38.

76. *Conroy*, 98 N.J. at 370, 486 A.2d at 1234. Previously, "extraordinary" could be applied to a treatment method because it was unusual, complex, "elaborate, artificial, heroic, aggressive, expensive, or highly involved or invasive." *Id.* at 371, 486 A.2d at 1235. Because these terms often vary in meaning among jurisdictions, the court determined that using the distinction between extraordinary and ordinary as a benchmark in treatment decisions was ineffective. Furthermore, the court concluded that because advances in medical technology continually redefine the terms ordinary and extraordinary, the use of the terms is irrelevant in treatment decisions. *Id.*

77. *Id.* at 374, 486 A.2d at 1236. The court held that using a nasogastric feeding tube for the purpose of artificial feeding could be viewed as the equivalent of using a respirator for artificial breathing. Both procedures "prolonged life through artificial means when the body is no longer able to perform a vital bodily function on its own." *Id.* at 373, 486 A.2d at 1236.

ing in *Conroy* is limited to Conroy-type patients with a life expectancy of one year or less.[78] The New Jersey Supreme Court's modification of the three tests and its rejection of the ambiguous distinctions in *Conroy* provide the framework for its analysis in the recent trilogy of right-to-die cases.

II. THE TRILOGY: *IN RE FARRELL*, *IN RE PETER*, AND *IN RE JOBES*

The New Jersey Supreme Court has continued to expand the individual's right to refuse medical treatment in the recent cases of Kathleen Farrell, Hilda M. Peter, and Nancy Ellen Jobes.[79] These decisions clearly establish the court's position that a patient's wishes must come before most state interests, the policy of a nursing home, and the personal preferences of health care professionals.[80] In this trilogy of right-to-die cases, the court provided procedural and substantive guidelines for determining whether life-sustaining treatment may be withdrawn from patients in three distinct situations.

A. Competent Person at Home, Nursing Home, or Hospital

In re Farrell[81] is the only unanimous decision of the three cases, perhaps because the standard applicable to a situation such as Kathleen Farrell's seems to have been firmly established. Kathleen Farrell was a thirty-two-year-old mother of two who was diagnosed in November of 1982 as suffering from amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's disease.[82] The disease affects the nervous system and renders its victim incapable of movement; the life expectancy after diagnosis is one to three years.[83] Although there is serious physical damage, victims of the disease retain the capacity for higher intellectual functioning, even in the disease's later stages.[84]

By autumn of 1983 Ms. Farrell was confined to bed in her home and received artificial nutrients and liquids. In addition, she was

78. *Id.* at 363, 463 A.2d at 1231.

79. *In re* Farrell, 108 N.J. 335, 529 A.2d 404 (1987); *In re* Peter, 108 N.J. 365, 529 A.2d 419 (1987); *In re* Jobes, 108 N.J. 394, 529 A.2d 434 (1987).

80. *See generally Moral Reasoning*, *supra* note 47 (reasoning that a conflict arises in right-to-die jurisprudence over how to rank the conflicting values and duties of the actors involved).

81. 108 N.J. 335, 529 A.2d 404 (1987).

82. *In re* Farrell, 212 N.J. Super. 294, 514 A.2d 1342 (Ch. Div. 1986).

83. *In re* Farrell, 108 N.J. at 344, 529 A.2d at 408.

84. *Farrell*, 212 N.J. Super. at 297, 514 A.2d at 1343.

connected to a life-sustaining respirator.[85] In late 1985, Ms. Farrell informed her husband that she wished to be disconnected from her respirator. A qualified psychologist determined that Ms. Farrell did not need psychiatric treatment and found her decision to be competent, informed, and voluntary. Accordingly, Francis Farrell sought judicial appointment as his wife's special medical guardian with specific authority to order the removal of her respirator.[86]

The court accepted the psychologist's finding that Ms. Farrell was capable of understanding her condition and that her decision was the result of careful consideration of all the consequences.[87] After acknowledging a competent person's right to refuse medical treatment and determining that countervailing state interests did not outweigh this right, the court granted Mr. Farrell authority to order the termination of the use of the respirator.[88]

Although Ms. Farrell died while still connected to the respirator on June 29, 1987, the supreme court agreed to hear the case because of the "inevitability of cases like this one arising in the future."[89] The supreme court held that three conditions must be met before a competent person who is living at home may be granted her request to terminate life-sustaining treatment. First, two independent physicians must determine that the patient is indeed competent[90] and that she is fully informed about her prognosis, available alternative medical treatments, the risks involved, and the possible consequences if treatment is discontinued.[91] Second, a determination must be made that the patient made her request voluntarily and was not coerced.[92] Finally, the patient's right to refuse treatment is not absolute and must be weighed against the four countervailing state interests.[93] The court found Ms. Farrell's request informed and voluntary and determined that her interests

85. *Farrell*, 108 N.J. at 345, 529 A.2d at 408.

86. *Id.* at 345, 529 A.2d at 409.

87. *Id.* Ms. Farrell testified, with some difficulty, that her decision to terminate the use of the respirator had been made after discussion with her husband, their two sons, her parents, her sisters, and her psychologist. *Id.* at 346, 529 A.2d at 409.

88. *Id.* The trial court granted the authority but stayed the order pending appellate review. Ms. Farrell died before the appeal was heard.

89. *Id.* at 347, 529 A.2d at 410.

90. "A competent patient has a clear understanding of the nature of his or her illness and prognosis, and of the risks and benefits of the proposed treatment, and has the capacity to reason and make judgments about that information." *Id.* at 354, 529 A.2d at 413 n.7.

91. *Id.* at 354, 529 A.2d at 413.

92. *Id.*

93. *Id. See supra* notes 38—56 and accompanying text.

outweighed any state interests.[94]

The *Farrell* court reaffirmed a competent individual's right to refuse medical treatment and provided stringent guidelines under which the right may be exercised.[95] The court reasoned that the right to refuse treatment is the same whether that person is at home or in a medical institution[96] and that judicial intervention is only appropriate in the unusual circumstances in which there is conflict among the health care professionals or the family or between the physicians and the family.[97] Additionally, the court specifically held that no criminal or civil liability exists when any person in good faith relies on the procedures outlined by the court and withdraws life-sustaining treatment from a competent patient.[98]

B. Nursing Home Patient in a Persistent Vegetative State Whose Wishes are Known

The second case in the New Jersey trilogy, *In re Peter*,[99] addresses the removal of life-sustaining treatment from a "patient who is in a persistent vegetative state with no hope of recovery, but is not expected to die in the near future."[100] Hilda M. Peter suffered a stroke which rendered her comatose and in a persistent

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94. *Farrell*, 108 N.J. at 353, 529 A.2d at 413. The court stated that a competent person's interest in self-determination would generally outweigh any state interest. Preservation of life, prevention of suicide, and protection of the ethical integrity of the medical profession were insufficient to outweigh Ms. Farrell's rights. In addressing the remaining interest, the protection of third parties, the court concluded that Ms. Farrell's decision was made in consideration of her children's interests. Therefore, the state's interest in protecting her sons was insufficient to prohibit her from exercising her right to refuse treatment. *Id.* at 352, 529 A.2d at 412—13.

95. *See* Moore, *"Two Steps Forward, One Step Back": An Analysis of New Jersey's Latest "Right-To-Die" Decisions*, 19 RUTGERS L.J. 955 (1988) [hereinafter *Two Steps*]. Professor Moore posits that the *Farrell* decision merely reaffirms the state of the law and effects elaborate procedures in cases involving competent patients. She supports "a substantive standard under which virtually all competent patients can decline even life-sustaining treatment." *Id.* at 977.

96. *Farrell*, 108 N.J. at 352, 529 A.2d at 413—14. The court cited hospice programs as evidence of a trend of an increased desire to die at home and acknowledged a trend of increased discharges by hospitals of terminally ill patients. The court relied on the traditional judicial respect that has been afforded the sanctity of the family, reasoning that the love, support, and concern received from family and friends in the home setting is often in the patient's best interest. *Id.* at 354—55, 529 A.2d at 414.

97. *Id.* at 357, 529 A.2d at 415. Even in cases in which judicial action is prompt, the patient often dies before her right to reject treatment is adjudicated in court. *Id.*

98. *Id.* at 358, 529 A.2d at 415—16.

99. 108 N.J. 365, 529 A.2d 419 (1987).

100. *In re* Peter, 108 N.J. at 370, 529 A.2d at 421—22.

vegetative state. There was no hope that Ms. Peter would ever regain any cognitive functioning.[101]

Ms. Peter's friend sought a court order appointing him guardian so that he might authorize the removal of the nasogastric tube.[102] The trial court granted his request but ordered that he not make any decisions regarding the termination of medical treatment without first obtaining the authorization of the New Jersey Office of the Ombudsman for the Institutionalized Elderly.[103]

After investigating the situation, the Ombudsman found that Ms. Peter, although incompetent and reliant on the nasogastric tube for nutrition, was in good condition and could survive in her present state for an "indeterminant length of time."[104] Relying on *Conroy*, the Ombudsman denied the request for the removal of the feeding tube because Ms. Peter was not likely to die within one year.[105]

On appeal, the New Jersey Supreme Court stated that the Ombudsman's reliance on *Conroy* in the case of Hilda Peter was incorrect.[106] Claire Conroy was a formerly competent, elderly patient who, although severely impaired, retained a degree of consciousness which permitted her to interact with her environment to a certain extent.[107] The court viewed a life-expectancy analysis inappropriate when a patient like Peter is persistently vegetative because the analysis assumes that continued sustenance provides some benefit for the patient.[108]

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101. *Id.*, 529 A.2d at 422. Ms. Peter had been kept alive in a nursing home by a nasogastric feeding tube since January of 1985.

102. *Id.* at 371, 529 A.2d at 422. Prior to her incapacitation, Ms. Peter executed a power of attorney authorizing her close friend and roommate, Eberhard Johanning, to make all decisions concerning her health care, including consent to any medical treatment. *Id.*

103. *Id.* The purpose of the Office of the Ombudsman is to ensure adequate care and maintain the quality of life for the institutionalized elderly. The Office receives reports of abuse, investigates the allegations, and takes necessary remedial steps. The appointment of an Ombudsman to guard against the abuse of the elderly is authorized by N.J. STAT. ANN. §§ 52:27G-1 to -16 (West 1986).

104. *Peter*, 108 N.J. at 371, 529 A.2d at 422. The Ombudsman found, however, that "Hilda Peter would not have wanted to be kept alive by mechanical means in a persistent vegetative state." *Id.* at 371, 529 A.2d at 422.

105. *Id.* at 372, 529 A.2d at 423. The Ombudsman felt that *Conroy* was limited to its facts and that Ms. Peter did not fall within the previously articulated standards. *Id.* *See supra* text accompanying note 78.

106. *Peter*, 108 N.J. at 374, 529 A.2d at 423—24.

107. *Id.* at 374, 529 A.2d at 424. Ms. Peter was a different type of patient than Ms. Conroy. Like Karen Quinlan, Ms. Peter was in a persistent vegetative state.

108. *Id.* Quoting *Quinlan*, the court found that the proper focus involved the "possibility of return to cognitive and sapient life, as distinguished from the forced continu-

Initially, the Ombudsman had indicated that he could not approve the decision to remove the nasogastric tube because Ms. Peter was expected to live for an indefinite period.[109] On appeal, however, he also added that *Conroy* could not be satisfied because there was insufficient evidence to meet *Conroy's* subjective test, and the inability to gauge the pain that Hilda Peter experienced in her vegetative state made the application of either objective test inappropriate.[110]

Again the court recognized a distinction between patients such as Claire Conroy and Hilda Peter. Although the court noted that one of the three *Conroy* tests must be satisfied to remove life-sustaining treatment from "an elderly, incompetent nursing-home resident with severe and permanent mental and physical impairments and a life expectancy of approximately one year or less,"[111] Ms. Peter did not fit this description; she was persistently vegetative. Because the limited-objective test and the pure-objective test require an assessment of the unavoidable pain and suffering a patient would feel if treatment were continued, the court stated that it would be virtually impossible to ascertain the extent to which a chronically vegetative patient could experience physical and emotional pain, or any of the other burdens and benefits that were the result of continued treatment.[112]

After clarifying the specific guidelines and distinctions from *Conroy*, the court held that if a patient in a persistent vegetative

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ance of . . . biological vegetative existence." *Id.*

109. *Id.* at 375, 529 A.2d at 424.

110. *Id.* at 375—76, 529 A.2d at 424. *See supra* notes 72—74 and accompanying text.

111. *Peter*, 108 N.J. at 373, 529 A.2d at 423 (quoting *Conroy*, 98 N.J. at 363, 486 A.2d at 1231). The court reiterated its holding in *Farrell* which unequivocally announced the right of a competent patient to refuse life-sustaining medical treatment. In order to maintain the right during incompetency, a surrogate decisionmaker must assert the incompetent's rights as the patient would have done if competent. The court added that medical choices for incompetents are not to be made by any standard of reasonableness but should be based on the "unique personal experiences" of the patient. A patient's medical condition is relevant only in two contexts: the determination of competency and the determination of how the patient, if competent, would view her total situation. *Id.* at 372—73, 529 A.2d at 422—23.

112. *Id.* at 376, 529 A.2d at 424—25. The court noted difficulty in utilizing the benefits and burdens analysis, even with a marginally cognitive patient like Claire Conroy. *Id.*, 529 A.2d at 425. *See also* LEGAL FRONTIERS, *supra* note 2 at 53—57; Cantor, Conroy, *Best Interests, and the Handling of Dying Patients*, 37 RUTGERS L. Rev. 543 (1985) (analysis of the benefits-burdens requirement of the *Conroy* objective tests). The benefits-burdens analysis inevitably leads to some type of quality-of-life analysis. *Moral Reasoning*, *supra* note 47, at 1004.

state leaves clear and convincing evidence of her wishes concerning medical treatment, then regardless of her life expectancy, the subjective test of *Conroy* is to be applied and respect is to be given to the patient's choice. The objective tests of *Conroy* are not applicable to a patient in a persistent vegetative state.[113] In the absence of clear and convincing evidence of the medical preference of a patient who is persistently vegetative, courts should rely on *Quinlan* for guidance.[114]

The *Peter* court found enough evidence of Ms. Peter's desires to satisfy the subjective test.[115] The court suggested in dicta, however, that if a patient in a persistent vegetative condition left no convincing evidence of intent, the guardian and family of the patient could decide to discontinue life-sustaining treatment.[116] Following *Quinlan*, the court noted that authorization by a surrogate decisionmaker requires the agreement of the attending physician and a verification of the patient's medical condition by both the hospital prognosis committee and the attending physician.[117]

C. *Nursing Home Patient in a Persistent Vegetative State with No Adequate Expression of Attitude Toward Treatment*

The third case in the New Jersey trilogy involved Nancy Ellen Jobes, hospitalized in 1980 for injuries resulting from an automobile accident.[118] During surgery, Ms. Jobes suffered severe oxygen loss, causing massive brain damage.[119] The patient remained in a noncognitive state following the operation.[120] Her husband sought a court order for removal of the life-sustaining jejunostomy tube ("j-tube"), which provided her with nutrition and hydration, because the nursing home had refused removal.[121]

The trial court appointed a *guardian ad litem* who recom-

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113. *Peter*, 108 N.J. at 384—85, 529 A.2d at 429.

114. *Id.*

115. *Id.* at 379, 529 A.2d at 426—27. The court recognized a broad range of evidence. Although Ms. Peter did not leave a living will, the fact that she had executed a power of attorney, made statements to her guardian, and made nine other reliable statements led the court to conclude that clear and convincing evidence existed that Hilda Peter would not have desired to be kept alive on a life-support system. *Id.*

116. *Id.* at 380, 529 A.2d at 427.

117. *Id.* at 377, 529 A.2d at 425.

118. *In re* Jobes, 108 N.J. 394, 401, 529 A.2d 434, 437 (1987).

119. *Id.* At the time of her hospitalization, Ms. Jobes was four and one-half months pregnant. The purpose of the operation was to remove the fetus which had died as a result of the accident. *Id.*

120. *Id.* at 401, 529 A.2d at 437—38.

121. *Id.* at 401, 529 A.2d at 437.

mended removal of the j-tube.[122] The court denied the nursing home's motion that a "life advocate"[123] be appointed for Ms. Jobes. Finding clear and convincing evidence that Ms. Jobes would not want to be sustained by the j-tube, the court authorized Mr. Jobes to initiate the removal of the j-tube with the assistance of a physician. The court, however, held that the nursing home could not be forced to participate actively in the removal of the tube.[124]

Even though all experts agreed that Ms. Jobes was severely brain damaged, there was disagreement whether she could be classified as being in a persistent vegetative state.[125] The New Jersey Supreme Court noted that evidence of a medical condition may be clear and convincing[126] and held the evidence sufficient to establish that Ms. Jobes was in an irreversible vegetative state.[127]

Although several of Ms. Jobes' closest friends, her husband, and her minister testified that if competent, Ms. Jobes would not want to be sustained by the j-tube, the court found the evidence insufficient to meet the requirements of the subjective test.[128] The court

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122. *Id.*

123. A life advocate is one who will fight for the continuance of any medical treatment in order that the person's life be preserved regardless of the patient's mental or physical condition. *In re* Jobes, 210 N.J. Super. 543, 544, 510 A.2d 133, 134 (1986). *See generally* Note, *Can a "Life Advocate" Impair the Constitutional Right to Reject Life-Prolonging Medical Treatment?*, 17 CUMB. L. REV. 553 (1987) (discussion of the role of a life advocate).

124. *Jobes*, 108 N.J. at 400—01, 529 A.2d at 437.

125. *Id.* at 403—05, 529 A.2d at 439—40.

> Vegetative state describes a body which is functioning entirely in terms of its internal controls. It maintains temperature. It maintains heart beat and pulmonary ventilation. It maintains digestive activity. It maintains reflex activity of muscles and nerves for low level conditioned responses. But there is no behavioral evidence of either self-awareness or awareness of the surroundings in a learned manner.

Id. at 403, 529 A.2d at 438.

126. The New York Court of Appeals requires clear and convincing evidence of the patient's wishes in all cases. *See, e.g., In re* O'Connor, No. 312 (N.Y. Ct. App. Oct. 14, 1988) (LEXIS, States library, N.Y. file). The *O'Connor* court rejected the substituted judgment approach in all instances "because it is inconsistent with our fundamental commitment to the notion that no person or court should substitute its judgment concerning or about what would be an acceptable quality of life for another." *Id.* Rather, the *O'Connor* court required that the proof of intent under the clear and convincing standard must indicate "that the patient held a firm and settled commitment to the termination of life supports under the circumstances like those presented." *Id.* Mere comments made by a person in response to another's prolonged illness and death cannot be treated as calm and deliberate expressions when declining treatment for that person.

127. *Id.* at 408, 529 A.2d at 441.

128. The court found that statements made to friends and family members were too remote and offhand to be considered trustworthy evidence and that there was no indi-

referenced *Peter*, reasoning that if the evidence does not clearly and convincingly show a vegetative patient's attitude toward treatment, then *Quinlan*, rather than *Conroy*, is to be used for guidance.[129] The court stated:

> Family members are best qualified to make substituted judgments for incompetent patients not only because of their peculiar grasp of the patient's approach to life, but also because of their special bonds with him or her. Our common human experience informs us that family members are generally most concerned with the welfare of a patient. It is they who provide for the patient's comfort, care, and best interests.[130]

If close family members are unavailable to make the decision for the incompetent, the court authorized the appointment of a guardian.[131] The court in *Jobes*, therefore, authorized the husband to implement the removal of the life support system.[132]

The New Jersey Supreme Court's decision in *Jobes* is also notable for its refusal to allow the nursing home, based on moral objections, to block the withdrawal of life-sustaining treatment by forcing patients to go elsewhere to have the treatment removed.[133] Because the Jobes were not given adequate notice of the nursing home's policy on artificial feeding until Mr. Jobes sought the removal of the j-tube, the court held that it would be too difficult to find another institution which would admit Ms. Jobes.[134] The court held that by refusing to allow the removal of the tube, the nursing home compromised Ms. Jobes' right of self-determination.[135]

III. Problems with the Expansion

In re Farrell, *In re Peter*, and particularly, *In re Jobes* reaffirm the New Jersey Supreme Court's active role in resolving the complex issues surrounding an individual's right to die. Although the decisions offer guidance in specific situations involving seriously ill

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cation that she believed specifically in the tenets of her religion. *Id.* at 412, 529 A.2d at 443.

129. *Id.* at 413, 529 A.2d at 443.

130. *Id.* at 416, 529 A.2d at 445.

131. *Id.* at 423—24, 529 A.2d at 449. The guardian must comply with the same procedural requirements as the family. *Id.*

132. *Id.* at 426—28, 529 A.2d at 451—52.

133. *Id.* at 424—25, 529 A.2d at 450.

134. *Id.*

135. *Id.* "Therefore, to allow the nursing home to discharge Mrs. Jobes if her family does not consent to continued artificial feeding would essentially frustrate Mrs. Jobes' right of self-determination." *Id.*

patients, they leave many questions unanswered concerning the application of the rulings.

A. Application to the Mentally Handicapped

A growing concern among the community that supports the rights of the disabled and handicapped is that decisions such as *Jobes* could be read to provide a lesser degree of protection to a severely disabled patient than the law provides to a normal patient with a good prognosis for recovery.[136] *Jobes* allowed a substitute decisionmaker to remove life-sustaining treatment from an incompetent patient despite a lack of evidence showing her wishes.[137] One fear is that a substitute decisionmaker will be allowed to make similar choices on behalf of handicapped persons who have never been able to express their wishes. An additional fear exists that quality-of-life standards will inappropriately be applied in the treatment decisions of handicapped individuals.[138]

For the person who has never been competent, all medical decisions are often made by a surrogate decisionmaker. The New Jersey Supreme Court has established procedures to afford the right of self-determination to the previously competent, yet presently incompetent patient.[139] The temptation is to transfer these procedures to the person who has never had the capacity to make decisions.[140] For example, the *Peter* court expressly rejected any life-expectancy analysis when considering the right of a persistently vegetative patient to refuse life-sustaining treatment.[141] Additionally, the court required that two physicians inquire as to

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136. *See generally Two Steps*, *supra* note 95; Destro, *Quality-Of-Life Ethics and Constitutional Jurisprudence: The Demise of Natural Rights and Equal Protection for the Disabled and Incompetent*, 2 J. CONTEMP. HEALTH L. & POL'Y 71 (1986) [hereinafter *Quality-of-Life Ethics*]; Hoyt, *Humanitarian Duties Brushed Aside*, N.J.L.J., July 16, 1987, at 24, col. 1 [hereinafter *Humanitarian*]; Cheever & Bird, *Court: Patient's Wishes Before State Interests*, N.J.L.J., July 2, 1987, at 21, col. 3; Sullivan, *Right of Patients Who Wish to Die Widened in New Jersey*, N.Y. Times, June 25, 1987, at A1, col. 6.

137. *See supra* notes 128—31 and accompanying text.

138. *See In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64 (1981). In *Storar*, the New York Court of Appeals authorized blood transfusions for an adult cancer patient who had been retarded since birth. However, the court reasoned that it would be improper for even the patient's mother to substitute judgment because it was impossible to ascertain what the patient would have desired. *Id.* at 375, 420 N.E.2d at 73.

139. *See supra* notes 107—17 and accompanying text.

140. LEGAL FRONTIERS, *supra* note 2, at 93.

141. *In re* Peter, 108 N.J. 365, 375, 529 A.2d 419, 424 (1987). *See supra* notes 113—20 and accompanying text.

whether the patient will ever return to a "cognitive and sapient" state.[142] A requirement that a patient possess a cognitive and sapient mentality exempts many of the people in this country who are mentally retarded or mentally deficient because the standard requires that the person possess the capability of awareness, judgment, and discernment.[143] Therefore, a reading of these holdings may be interpreted to mean that a surrogate decisionmaker could exercise the right of a patient if the patient was found to be incapable of sufficient judgment and awareness and if the patient could possibly exist in that state for an indefinite period of time.[144]

The use of the substituted judgment standard to effectuate the right of free choice and bodily integrity simply is not applicable in the case of a patient who has never been competent.[145] A person who has been mentally retarded for all of her life has never been capable of choice nor will she ever be.[146] Implementation of this standard would attempt to draw upon expressions of preference never made by the mentally handicapped.

The application of the best interest standard, which involves an analysis of whether the treatment relieves suffering and improves the quality of life,[147] is also inappropriate for the handicapped.[148] Quality-of-life determinations imply some judgment of the worthiness or social utility of a particular individual's life.[149] An application of this standard provides the potential for equating an existence which is impaired with a quality of life which is

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142. *Peter*, 108 N.J. at 374, 529 A.2d at 424.

143. *Humanitarian*, *supra* note 136, at col. 2. Cognition relates to the abilities of awareness and formation of judgment, while sapient refers to "great sagacity or discernment." WEBSTER'S NEW COLLEGIATE DICTIONARY 215, 1017 (1980).

144. *Humanitarian*, *supra* note 136.

145. *See* LEGAL FRONTIERS, *supra* note 2, at 93—94.

146. *See* Conservatorship of Valerie N., 40 Cal. 3d 143, 707 P.2d 760 (1985) (Bird, C.J., dissenting).

> [S]ubstituted consent derives its legitimacy from the premise that the affected individual once possessed a capacity to make informed choices or will be able to do so at some point in the future. . . . [T]he doctrine requires a court to engage in a questionable legal fiction. This departure from reality reaches its zenith when the third party deciding on a matter . . . purports to stand in the shoes of a severely retarded adult who has since birth been incapable of making such choices.

Id. at 184, 707 P.2d at 788. This problem is particularly apparent in the treatment choices for infants. *See generally Two Steps*, *supra* note 95; *Whose Interest*, *supra* note 37.

147. *See supra* notes 34—37 and accompanying text.

148. *Two Steps*, *supra* note 95, at 986—87 (substituted judgment and best interest standards inappropriate for profoundly retarded or infants).

149. LEGAL FRONTIERS, *supra* note 2, at 53.

unacceptable.[150] Thus, quality-of-life expectations for handicapped patients would always yield a decision for termination of treatment.[151] Because this potential for abuse exists in the treatment decisions of the mentally handicapped, courts should provide constraints on quality-of-life considerations used by surrogate decisionmakers and explicitly denounce the best interests test for these patients.[152]

In the continuing struggle to gain access to employment, education, rehabilitation, and public buildings, an evolving body of law that culminates with *Jobes* seems to negate the humanitarian duty to treat, care for, and cure people with disabilities.[153] Society continues to mount pressures which discount the lives of many handicapped Americans.[154] In light of these pressures, it is too dangerous to leave unaddressed the effect that any right-to-die decisions may have on the handicapped. Express rejection of the application of the standards presented in the recent right-to-die cases to those who have never been competent would afford much needed protection to the disabled and incompetent.

B. Application to the AIDS Patient

A discussion of the right to refuse life-sustaining medical treatment is not complete without considering the epidemic of Acquired Immune Deficiency Syndrome (AIDS). Recent litigation dealing with the treatment termination request of a patient diagnosed as having Aids Related Complex (ARC) is evidence of potential

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150. "Some persons contend that an existence without capacity to read, write, and care for oneself is devoid of qualities necessary to meaningful life." *Id.* at 97.

151. *See Quality-of-Life Ethics*, *supra* note 136, at 121. "The conclusion is now inescapable that the severely disabled have been singled out for lesser protection than the law would provide to 'normal' patients 'in the whole sense.' " *Id.*

152. *Two Steps*, *supra* note 95, at 992. Professor Morris, however, advocates that the substantive guidelines and procedures necessary to protect the handicapped are not warranted in the cases of all incompetents; the family is deemed the most reliable decisionmaker in all instances. *Id.* It is interesting also that Professor Morris reasons that the trilogy does "not represent a 'bold' expansion of the rights of New Jersey patients." *Id.* at 983.

153. *Quality-of-Life Ethics*, *supra* note 136, at 128—29. *Humanitarian*, *supra* note 136, at col. 3. "How and whether we nourish our weakest fellow humans is the greatest credit to us or the greatest indictment of all of us." *Id.*

154. The pressures are most obvious in the continuing debate over the withholding of treatment from handicapped newborns. *See Whose Interest*, *supra* note 37. *See, e.g.*, Nolan, *Imperiled Newborns*, 17 HASTINGS CENTER REP. 5 (Dec. 1987); Feldman & Murray, *State Legislation and the Handicapped Newborn: A Moral and Political Dilemma*, 12 LAW, MED. & HEALTH CARE 156 (1984); Parness & Stevenson, *Let Live and Let Die: Disabled Newborns and Contemporary Law*, 37 U. MIAMI L. REV. 43 (1982).

problems.[155] Absent a cure for the deadly disease, all AIDS patients eventually die but only after an existence which is often quite torturous. Many of these patients require life-support systems as they approach the terminal phase of their illnesses. However, it is often the case that these patients also require life-sustaining artificial measures during earlier periods of their illnesses.[156] Even though AIDS patients are often incompetent during these periods, it is almost certain that the patients regain competence after treatment.[157]

Certainly, *Quinlan* and its progeny would support a competent AIDS patient's choice to discontinue any life-sustaining treatment. An incompetent AIDS patient who is receiving life-sustaining treatment but is expected to regain competence is unique, however, and should not be governed by the same standards enumerated in *Jobes* and *Farrell.* The *Quinlan* standard developed in *Jobes* and the *Conroy* standard set forth in *Peter* address a patient who has no substantial chance of recovering cognitive existence.[158] Because there is a prospect for return to competence, the AIDS patient who is expected to regain competence should not have others exercise her right of self-determination for her unless fact-specific, unequivocal evidence of her desires exists. Additionally, when a competent AIDS patient who contracts a treatable condition declines medical treatment, the refusal may be characterized as suicidal, which is contra to a prevailing state interest.[159]

When an AIDS patient reaches the final stages of the illness and is not expected to regain competence, substitute decisionmaking is appropriate. However, the family of the patient is not necessarily the appropriate decisionmaker. The *Jobes* court, adhering to a long tradition, showed great deference to the family in a situation primarily reserved for family decisionmaking.[160] Although the court's recognition of the importance of family decisionmaking for the in-

155. Evans v. Bellevue Hosp., N.Y.L.J., July 28, 1987, at 24, col. 1 (N.Y. July 27, 1987) (court refused to authorize the termination of life-sustaining treatment for a man suffering from a brain disease associated with AIDS despite a request from the victim's friend based on the patient's request in a living will).

156. Yee, *The Right of a Chronically Ill Patient to Terminate Life-Support Equipment*, 7 GLENDALE L. REV. 124, 136—37 (1987) [hereinafter *Right of Chronically Ill*].

157. *Id.*

158. *In re* Jobes, 108 N.J. 394, 420—21, 529 A.2d 434, 447—48 (1987); *In re* Peter, 108 N.J. 365, 374, 529 A.2d 419, 424 (1987).

159. *Two Steps*, *supra* note 95, at 962. *See also supra* notes 47—49 and accompanying text.

160. *See Jobes*, 108 N.J. at 416—17, 529 A.2d at 445.

competent patient is commendable, it is not necessarily practical in all situations. Those close to non-AIDS patients may sometimes disagree as to the proper course of treatment; it is more probable that the family of an AIDS patient and the patient's lover may not only be antagonistic, but also may disagree vehemently on the proper course of treatment for the incompetent AIDS patient.[161] Families of these patients are faced not only with the tragedy of losing a loved one but also with the anger and embarrassment that often stems from ignorance of the disease. Patients in such situations cannot be adequately assured by decisions such as *Jobes* that their interests and rights will be preserved in the manner in which they desire. Courts should understand that the broad deference to family recognized by the New Jersey Supreme Court does not necessarily provide the same protections to terminal AIDS patients.

C. *Application to Health Care Institutions and Professionals*

Another important unresolved issue is whether health care institutions have the right to refuse to disconnect life-sustaining equipment. As the sole dissenter in *Jobes*, Justice O'Hern stated:

> I find it difficult to understand how we can order nursing professionals with an abiding respect for their patients to cease to furnish the most basic of human needs to a patient in their care. I do not believe that such an order is essential to the Court's decision, and it may impinge upon the privacy rights of those nursing professionals.[162]

The *Jobes* court employed reasoning similar to the doctrine of estoppel in addressing the nursing home's position that the removal of the j-tube from Ms. Jobes was a violation of its own ethical policy.[163] The court held that it was reasonable for the Jobes family to rely on what appeared to be the nursing home's willingness to defer to their choice of treatment because they were inadequately informed of the nursing home's policy.[164] However, the opinion explicitly refused to address the situation in which a nursing home does give adequate notice of its policy not to participate in the withdrawal of artificial feeding.[165]

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161. *Right of Chronically Ill, supra* note 156, at 136.
162. *Jobes*, 108 N.J. at 453, 529 A.2d at 464 (O'Hern, J., dissenting).
163. Cantor, *The Hardest Cases Are Yet to Come*, N.J.L.J., July 16, 1987, at 22, col. 1 [hereinafter *Hardest Cases*].
164. *Jobes*, 108 N.J. at 425, 529 A.2d at 450.
165. *Id.*

The New Jersey Supreme Court also failed to address an institution's moral or religious concerns regarding the withdrawal of treatment. Past opinions indicate that semi-public institutions such as hospitals may be required to provide medical services even if the provision conflicts with the institution's own policy.[166] Other state courts have ruled that, although the patient has the right to decline medical treatment, she must be taken home or transferred to another facility if her present facility is unwilling to withhold treatment.[167] Thus, it is unclear whether patient choice in all instances is valued to such an extent that institutional concerns always yield to the patient's right to withdraw treatment.[168]

Additionally, it is unclear whether the personal moral and religious principles of health care workers must yield to patient rights. These doctors, nurses, and support staff are the people who could be forced to perform the task of unplugging the respirator or disconnecting the feeding tube.[169] In its desire to protect the rights of the terminally ill patient, a court may overlook the effect that its order may have on health care professionals.[170]

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166. *See, e.g.*, Doe v. Bridgeton Hosp. Ass'n, Inc., 71 N.J. 478, 366 A.2d 641 (1976), *cert. denied*, 433 U.S. 914 (1977) (private hospital not allowed to prohibit abortions at its facilities).

167. *See* Brophy v. New England Sinai Hosp., Inc., 398 Mass. 417, 497 N.E.2d 626 (1986) (hospital could refuse to remove tube used for nutrition); Delio v. Westchester County Medical Center, 516 N.Y.S.2d 677, 129 A.D. 1 (1987) (medical center allowed to assist in transfer of patient rather than participate in removal of life support).

168. *See* Gray v. Romeo, No. 87-0573B (D.R.I. Oct. 17, 1988) (LEXIS, Genfed library, Dist file). In requiring a hospital to withdraw nutrition from a vegetative patient, the *Gray* court recognized the burdens that may be placed on health care professionals yet acknowledged the patient's right of self-determination as superior. The court reached this holding even after considering a Rhode Island law which allows health care workers to refuse to participate in an abortion on moral or religious grounds. R.I. GEN. LAWS § 23-17-11 (1985). The court also rejected as inapplicable a federal statute providing that an individual shall not be forced to participate in health programs funded by the Secretary of Health and Human Services if the individual objects based on moral or religious convictions. 42 U.S.C. § 300a-7(d) (1982).

169. Doctors are often able to obtain another physician to care for a patient who wishes to terminate life support. However, nurses and other health care workers have less choice and may be threatened with the loss of their jobs if they refuse to participate. Sherman, *Health Professionals Relieved, Horrified by Three Rulings*, N.J.L.J., July 2, 1987, at 25, col. 2.

170. Lynn, *Much Accomplished But Much To Be Done*, N.J.L.J., July 16, 1987, at 24, col. 4 [hereinafter *Much Accomplished*].

> How will nurses and janitors in the institutions explain what is happening? Will it be that they are being required to do society's dirty work[?] Will they feel like executioners? Or will they feel that they are finally being allowed to respond to their emotions about these cases and are being allowed to care for these patients as they would like to be cared for if they were ever in a similar situation?

If the rights of institutions and health care professionals are paramount, patients may be barred from exercising their right to refuse treatment.[171] For example, patients may be bound by geography and by physician preference to local institutions that all have a policy against the withdrawal of nutrition. If there is no convenient institution or physician that would cooperate with the patient's desires, the *Jobes* decision and common sense mandates that the patient's rights should prevail. To curb the possible abuse, in a situation in which geographic and physician choices do not effectively eliminate a patient's right of self-determination, a balancing analysis, separate from that which is performed to ascertain whether countervailing state interests outweigh the individual right of self-determination,[172] should be conducted to determine whether countervailing institutional interests outweigh the individual's right to terminate life-sustaining treatment in that institution. Factors which should be considered in this analysis include the availability and convenience of another nearby health care provider willing to assist the patient in treatment termination;[173] the economic and emotional effect that a transfer from one institution to another will have on the incompetent patient; the quality of the notice given to the patient and the family as judged by much the same standards as informed consent; the basis of the health care provider's policy concerning foregoing treatment or nutrition; and the effect that mandatory treatment termination will have on the individuals responsible for the physical act of withdrawing

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Id. at 25, col. 1. While many institutions do not have an express policy against the withdrawal of life-sustaining treatment, it may be assumed that such refusal is the policy of the institution because of the doctrines and the tenets of the religious order which it represents. "There are some groups, such as the Orthodox Jews, who have a longstanding and well-defined opposition to stopping treatment." Paris, *Personal Autonomy Over Institutional Considerations*, N.J.L.J., July 16, 1987, at 22, col. 4 [hereinafter *Personal Autonomy*].

171. *See Hardest Cases*, *supra* note 163; *Personal Autonomy*, *supra* note 170. The *Jobes* court acknowledged this difficulty when it recognized that "it would be extremely difficult, perhaps impossible, to find another facility that would accept Mrs. Jobes as a patient. Therefore, to allow the nursing home to discharge Mrs. Jobes if her family does not consent to continue artificial feeding would essentially frustrate Mrs. Jobes' right of self-determination." *Jobes*, 108 N.J. at 425, 529 A.2d at 450. The court appeared to conduct yet another balancing test when it concluded that although the burdens on some of the nursing home personnel would be great if forced to participate, the hardship on the family if forced to find an amenable institution would be considerably greater. Thus, the court was compelled to order the nursing home to continue care. *Id.*

172. *See supra* notes 38—56 and accompanying text.

173. *See Two Steps*, *supra* note 95, at 987.

treatment.[174]

Essential to this analysis is that courts perform an *ad hoc* factual inquiry. The additional balancing analysis will insure that adequate protection is afforded not only to the patient's constitutional rights, but also to the legitimate interests and rights of institutions and their employees.

CONCLUSION

The decisions of the New Jersey Supreme Court in *In re Farrell*, *In re Peter*, and *In re Jobes* clarify many of the ambiguities of right-to-die jurisprudence and affirm the court's position as a forerunner in interpreting the right to die. However, because medical advances continually redefine the boundaries of life and because new diseases and emotionally-laden cases can create new law, the extent of the right to die is uncertain. Currently, there remain many questions which have not been adequately addressed. These questions include whether the law regarding an incompetent's right to refuse medical treatment should be applied to handicapped individuals who have never been competent, how this law should be applied in the AIDS context, and whether legal consideration should be given to the effect that "pulling the plug" has on health care professionals. The legal standards and procedures that have been developed to ensure that once competent but now incompetent individuals retain their right to refuse medical treatment should not be applied to the mentally incompetent because those standards and procedures inherently depend on the existence of competence at some point in the individual's life and imply some type of quality-of-life judgments. Although substitute decisionmaking should be available to an AIDS patient, if it is likely that the patient will regain competence, substitute decisionmaking should not occur. Furthermore, although courts should recognize the importance of family decisionmaking when an AIDS victim becomes incompetent, courts should be sensitive to the possibility that the family's wishes may run contrary to what the patient would choose if competent. Finally, in situations in which a patient's choice to remove life-sustaining treatment is not limited by

174. *See Hardest Cases*, *supra* note 163; *Much Accomplished*, *supra* note 170. The effects on healthcare workers may include society's response, the healthcare workers' attitudes, and reliance on institutional policies in choosing employers. *See also Moral Reasoning*, *supra* note 47, at 1010 (integrity and desires of doctors and hospitals will rarely be ranked higher than an individual's right to decline treatment).

either geography or a lack of physician choice, the rights and interests of all affected parties should be considered; the courts should conduct an *ad hoc* factual inquiry to determine whether countervailing institutional interests outweigh the individual's right to terminate life-sustaining treatment in that particular institution.

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