Pace Law Review

Volume 6
Issue 2 *Winter 1986*

Article 3

January 1986

In re Conroy: A Limited Right to Withold or Withdraw Artificial Nourishment

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Notes and Comments

In re Conroy: A Limited Right to Withhold or Withdraw Artificial Nourishment

"Technology competes with compassion, legal precedent lags, and controversy is inevitable."[1]

I. Introduction

In *In re Conroy*,[2] an overwhelming six-to-one majority of the New Jersey Supreme Court decided that life-sustaining treatment, including artificial feeding, may be withdrawn from incompetent, institutionalized, elderly patients with severe and permanent mental and physical impairments and a limited life expectancy under detailed judicial guidelines.[3] One can see in *Conroy* the beginning winds of legal change. To date, *Conroy* stands as one of only three appellate court decisions[4] which have extended the right to forego life-sustaining treatment to include the right to remove or withhold artificial nourishment and hydration. In a society where technology has outpaced the legal and ethical framework which must cope with it, *Conroy* represents a significant step by the judiciary toward recognition that the indication for use of modern sophisticated technology cannot be the mere availability of that technology. *Conroy* may, therefore, serve as precedent to other states dealing with the devastating consequences of decisionmaking in relation to incompe-

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1. Wanzer, Adelstein, Cranford, Federman, Hook, Moertel, Safar, Stone, Taussig & Van Eys, *The Physician's Responsibility Toward Hopelessly Ill Patients*, 310 NEW ENG. J. MED. 955, 959 (1984) [hereinafter cited as Wanzer, *The Physician's Responsibility*].

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

3. *See infra* text accompanying notes 194-216.

4. *See* Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983); *In re* Hier, 464 N.E.2d 959 (Mass. App. Ct.), *review denied*, 392 Mass. 1101, 465 N.E.2d 261 (1984).

tent terminally ill patients being sustained by artificial nourishment and hydration. However, because the court restricts its holding to nursing home residents,[5] one may view its precedential value as somewhat limited.

Part II of this Note examines the right to refuse medical treatment as it applies to both competent and incompetent patients. Furthermore, it explores the concept and process of decisionmaking for incompetent patients. Part III sets forth the facts and procedural history of *Conroy*, highlighting the majority and minority opinions of the New Jersey Supreme Court. Part IV analyzes the opinion of the court, giving particular attention to the three tests established for decisionmaking, to the associated procedures required to implement such a decision, and to the arguments advanced by the dissent in relation to the criteria for reaching life-or-death decisions. Part V concludes that although the court may have properly expanded the right to forego life-sustaining treatment to include the right to refuse or withdraw artificial nourishment and hydration, it did so on unreasonably narrow grounds. In an attempt to establish standards that would apply to all incompetent patients on a precipitous decline as was Miss Conroy, the court used the sole criterion of pain as the measure of the best interests of such a person. In so doing, the court provided a narrow basis for future decisionmaking. Finally, although the court has enunciated a broad substantive right, it appears to have severely limited that right by the procedures required to implement it.

II. Background

A. *Right to Refuse Medical Treatment*

1. *Competent Patients*

The right of competent adults to refuse medical treatment derives from two sources — the common law right of bodily integrity and self-determination and the constitutional right of privacy. The common law recognizes and protects the right of bodily integrity. "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every indi-

5. *In re* Conroy, 98 N.J. at 342 n.1, 486 A.2d at 1219 n.1.

vidual 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."[6] As early as 1914, Justice Cardozo articulated the right of "[e]very human being of adult years and sound mind . . . 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."[7]

The right of the medical patient to exercise bodily control and self-determination has been embodied in the doctrine of informed consent. "Under this doctrine, no medical procedure may be performed without a patient's consent, obtained after explanation of the nature of the treatment, substantial risks, and alternative therapies."[8] The doctrine of informed consent has two elements. First, it must be *informed*; there must be adequate disclosure of the proposed procedure as well as its anticipated risks and benefits. Second, there must be *valid consent* which encompasses a right of *choice*; the patient must have the right to refuse treatment as well as to consent to it.[9]

Indeed, the exercise of self-determination may also include the refusal of lifesaving medical treatment. "[E]ach man is considered to be master of his own body, and he may, if he be of sound mind, expressly prohibit the performance of life-saving surgery, or other medical treatment."[10]

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6. Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891). Here, the Court repudiated attempts to compel a personal injury plaintiff to undergo pretrial medical examination.

7. Schloendorff v. Society of N.Y. Hosp., 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). The right to decline lifesaving medical care was not at issue in this case. Rather, this case concerned the alleged unauthorized removal of a fibroid tumor, when only an examination had been consented to by the patient.

8. Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228, 237 (1973). The principle of informed consent holds true except in an emergency. *See* Dunham v. Wright, 423 F.2d 940, 941 (3d Cir. 1970).

9. Clarke, *The Choice to Refuse or Withhold Medical Treatment: The Emerging Technology and Medical-Ethical Consensus*, 13 CREIGHTON L. REV. 795, 800 (1980). *See also In re* Conroy, 98 N.J. 321, 347, 486 A.2d 1209, 1222 (1985) ("The patient's ability to control his bodily integrity through informed consent is significant only when one recognizes that this right also encompasses a right to informed refusal. . . . Thus, a competent adult person generally has the right to decline to have any medical treatment initiated or continued." (citations omitted)).

10. Natanson v. Kline, 186 Kan. 393, 406-07, 350 P.2d 1093, 1104, *clarified*, 187

Another source of the right to self-determination and the right to make certain decisions concerning one's body is the unwritten constitutional right of privacy found in the penumbra of specific guarantees of the Bill of Rights.[11] In the context of medical treatment and decisionmaking, this constitutional guarantee of privacy has been found to be broad enough to protect a woman's decision to terminate her pregnancy under certain circumstances.[12] Furthermore, in *In re Quinlan*,[13] the New Jersey Supreme Court extended the right of privacy to include the right to decline medical treatment under certain circumstances, even if that decision might lead to the patient's death.[14] Subsequent courts have allowed competent patients to withdraw consent as well as refuse potentially lifesaving treatment.[15]

Kan. 186, 354 P.2d 670 (1960). This was the first case in which a court expressly acknowledged the right to refuse lifesaving treatment, although the issue in the case involved the sufficiency of the physician's disclosure of treatment risks and consequences to the patient.

11. Griswold v. Connecticut, 381 U.S. 479, 484 (1965) (state statute prohibiting use of contraceptives in marriage declared unconstitutional). The ill-defined boundaries of this right of privacy have been extended to encompass an individual's right to procreate, Carey v. Populations Servs. Int'l, 431 U.S. 678 (1977); to receive contraceptives regardless of marital status, Eisenstadt v. Baird, 405 U.S. 438 (1972); and to marry, Loving v. Virginia, 388 U.S. 1 (1967). The constitutional right of privacy has been recognized in "matters relating to marriage, procreation, contraception, family relationships, and child rearing and education." Paul v. Davis, 424 U.S. 693, 713 (1976).

12. Roe v. Wade, 410 U.S. 113 (1973).

13. 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976). The *Quinlan* court was the first state supreme court to authorize removal of life-sustaining equipment that was maintaining the existence of an irreversibly comatose patient who was not brain dead.

14. *Accord* Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 742, 370 N.E.2d 417, 426 (1977). In the words of the Supreme Judicial Court of Massachusetts:

> The constitutional right to privacy . . . is an expression of the sanctity of individual free choice and self-determination as fundamental constituents of life. The value of life as so perceived is lessened not by a decision to refuse treatment, but by the failure to allow a competent human being the right of choice.

Id. at 742, 370 N.E.2d at 426.

By establishing the right to refuse life-sustaining treatment as a constitutional privacy right, the court raised this right to a fundamental status. As such, it could not be overcome unless a compelling state interest in opposition could be demonstrated. *See infra* text accompanying notes 23-37.

15. *See*, Satz v. Perlmutter, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); *In re* Quackenbush, 156 N.J. Super. 282, 383 A.2d 785 (Morris County Ct. 1978). In *In re* Quackenbush, the court did not compel surgery but instead allowed the patient to refuse amputation of both legs above the knee and possibly amputation of

2. *Right to Refuse Treatment Extended to Incompetent Patients*

While it is clear that competent and informed adults have a right to refuse medical treatment, even life-sustaining therapy, a problem arises with regard to incompetent persons — those who are unable to make their wishes known.[16] The *Quinlan* court, in addressing just this issue, extended the right to refuse medical treatment to incompetent patients.[17] The court found "no thread of logic" that would prevent extending the right to decline treatment to an incompetent patient.[18] "[H]er right of privacy . . . should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice."[19]

The right of the incompetent terminally ill patient to refuse life-sustaining treatment or to be removed from artificial life-sustaining equipment has been widely recognized.[20] "[T]he substantive rights of the competent and the incompetent person are the same in regard to the right to decline potentially life-prolonging treatment."[21] As the value of human dignity extends to all human beings, whether they are mentally competent or not, so must the right of privacy extend to incompetent as well as competent patients.[22]

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both legs entirely. On balance, the court reasoned that such extensive bodily invasion was "sufficient to make the State's interest in the preservation of life give way to Robert Quackenbush's right of privacy to decide his future regardless of a dim prognosis." *In re* Quackenbush, 156 N.J. Super. at ___, 383 A.2d at 789. The court recognized that both decisional law and constitutional law invest a competent patient with rights that overcome the interest in the preservation of life.

In *Perlmutter*, life support apparatus could only be withdrawn from a terminally ill competent adult who had minor children and whose family unanimously approved of the treatment termination.

16. For an explanation of when a person will be deemed incompetent, see *infra* text accompanying notes 42-47.

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

18. *Id.* at 39, 355 A.2d at 663.

19. *Id.* at 41, 355 A.2d at 664.

20. Courts have followed and reinforced this extension of the rights of competent persons to incompetent persons. *See* Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334 (Del. 1980); John F. Kennedy Memorial Hosp., Inc. v. Bludworth, 452 So. 2d 921 (Fla. 1984); *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).

21. *Saikewicz*, 373 Mass. at 736, 370 N.E.2d at 423.

22. *Id.* at 745, 370 N.E.2d at 427.

3. *Right to Refuse Treatment Not an Absolute Right*

Neither the common law right nor the constitutional right to refuse medical treatment is absolute. Where lifesaving care is involved, an individual's right to self-determination and bodily integrity may collide with an important or compelling state interest. A patient's rights must, therefore, be balanced against potential countervailing societal interests.

The state retains four fundamental interests in medical decisions: 1) the preservation of life, 2) the prevention of suicide, 3) the protection of innocent third parties, and 4) maintaining the ethical integrity of the medical profession.[23] In the case of lifesaving treatment, only two state interests appear to receive particular consideration by the courts — the preservation of life and the protection of innocent third parties.

The state's interest in preserving life is considered the most significant.[24] The state's interest in relation to the competent patient generally yields to the patient's much stronger interest in directing the course of his own life.[25] In relation to an incompetent patient, the claimed state interests set forth in *Quinlan* were essentially the preservation of life and the "defense of the right of the physician to administer medical treatment according to his best judgment."[26] In balancing the state's interest against the realistic chances for Karen Quinlan's recovery and the na-

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23. *See id.* at 741, 370 N.E.2d at 425. After surveying the leading cases, the *Saikewicz* court identified these interests as being potentially applicable to cases of medical intervention. These principles were primarily derived from Application of Pres. & Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964). There, a hospital sought and was granted permission to perform a blood transfusion necessary to save a patient's life where the patient was unwilling to consent due to religious beliefs. Despite previously expressed contrary sentiments of the patient, the court justified its decision by reasoning that its purpose was to protect state interests viewed as having greater import than the individual right. *See also Perlmutter*, 362 So. 2d at 162; *In re* Torres, 357 N.W.2d 332, 339 (Minn. 1984); *In re* Colyer, 99 Wash. 2d at 122, 660 P.2d at 743.

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

25. *See, e.g., In re* Quackenbush, 156 N.J. Super. at 290, 383 A.2d at 789 (holding that the extensive bodily invasion is sufficient to make the state's interest in the preservation of life give way to the patient's right of privacy to decide his own future regardless of the absence of a dim prognosis). *See also Perlmutter*, 362 So. 2d at 162 (holding that even though a state's interest in saving life is compelling, the compelling quality wanes as the patient's chances for recovery diminish).

26. *In re* Quinlan, 70 N.J. at 40, 355 A.2d at 663.

ture of her care, the court was faced with circumstances quite unlike those cases where the medical procedure required "constituted a minimal bodily invasion and the chances of recovery and return to functioning life were very good."[27] Thus, the court found that "the State's interest . . . weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims."[28]

The state's interest in the prevention of suicide has failed to compel medical intervention in relation to a patient's right to refuse lifesaving treatment. Death resulting from failure to use life support systems on a terminally ill patient is not suicide but death from natural causes.[29] Furthermore, some courts have held that a patient refusing life support did not have the specific intent to die.[30]

The state's interest in protection of innocent third parties, particularly minor children, is rooted in the concept of *parens patriae*.[31] The possible impact on minor children of a decision to forego treatment could weigh heavily in the court's balancing process. The state's interest may well be superior to an adult's right of privacy or self-determination when there is no available source of support and care for the dependents.[32]

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27. *Id.* at 41, 355 A.2d at 664.

28. *Id.*

29. *Perlmutter*, 362 So. 2d at 162. *See also In re* Colyer, 99 Wash. 2d at 123, 660 P.2d at 743.

30. *See Saikewicz*, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11; *In re* Colyer, 99 Wash. 2d at 123, 660 P.2d at 743 ("A death which occurs after the removal of life sustaining systems is from natural causes neither set in motion nor intended by the patient.").

31. The phrase *parens patriae* refers to the state's traditional responsibility for supervising the affairs of incompetents.

32. *See, e.g.*, Application of Pres. & Directors of Georgetown College, Inc., 331 F.2d at 1006. The court authorized the hospital to administer blood transfusions to a Jehovah's Witness who had a seven month old son and was unwilling to consent to treatment. *Id.*

> The state, as *parens patriae*, will not allow a parent to abandon a child, and so it should not allow this most ultimate of voluntary abandonments. The patient had a responsibility to the community to care for her infant. Thus the people had an interest in preserving the life of this mother.

Id. at 1008. *See also* United States v. George, 239 F. Supp. 752 (D. Conn. 1965). In *George*, the court authorized a transfusion for a patient who said he would not agree to the procedure, but further indicated that he would not resist a court ordered transfusion. *Id.* at 753.

Finally, the impact of the state's interest in protecting the ethical integrity of the medical profession has been lessened by prevailing medical ethical standards which do not always require medical treatment to be administered at all costs.[33] When a doctor follows the choice of a competent adult patient who refuses medical treatment, he cannot be deemed to have violated his professional responsibilities.[34] Furthermore, "there is reliable information that for many years physicians and members of patients' families, often in consultation with religious counselors, have in actuality been making decisions to withhold or to withdraw life support procedures from incurably ill patients incapable of making the critical decisions for themselves."[35]

Although in most instances, the right to self-determination outweighs countervailing state interests,[36] there are instances, al-

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33. Prevailing medical ethical practice seems to recognize that the dying are more often in need of comfort than treatment. *Saikewicz*, 373 Mass. at 743-44, 370 N.E.2d at 426. "[P]hysicians distinguish between curing the ill and comforting and easing the dying; . . . they refuse to treat the curable as if they were dying or ought to die, and . . . they have sometimes refused to treat the hopeless and dying as if they were curable." *In re* Quinlan, 70 N.J. at 47, 355 A.2d at 667 .

On March 15, 1986, at a meeting on medicine and ethics co-sponsored by the American Medical Association and the Hastings Center, the judicial council of the American Medical Association issued its most recent opinion concerning ethical standards and the care of patients in irreversible comas. Under this new ruling, it would be ethical for doctors to withhold "all means of life prolonging medical treatment," including food and water, from patients in irreversible comas even if death was not imminent. According to the judicial council, such therapy should only be withheld when a patient's coma "is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis." Altman, *A.M.A. Sets Ethics on Care of Dying*, N.Y. Times, Mar. 16, 1986, § 1, at 1, col. 1. According to the new American Medical Association opinion, "[l]ife prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained." *Id.*

34. *In re* Storar, 52 N.Y.2d at 377, 420 N.E.2d at 71, 438 N.Y.S.2d at 273.

35. *Id.* at 385, 420 N.E.2d at 75, 438 N.Y.S.2d at 277 (Jones, J., dissenting). See generally the sources cited in *In re* Storar, 52 N.Y.2d at 385 n.3, 420 N.E.2d at 75 n.3, 420 N.Y.S.2d at 277 n.3.

36. The *Perlmutter* court, in considering the request of a competent adult that life support apparatus be removed, summarized its balancing process as follows:

> It is all very convenient to insist on continuing Mr. Perlmutter's life so that there can be no question of foul play, no resulting civil liability and no possible trespass on medical ethics. However, it is quite another matter to do so at the patient's sole expense and against his competent will, thus inflicting never ending physical torture on his body until the inevitable, but artificially suspended, moment of death. Such a course of conduct invades the patient's constitutional right of pri-

beit very few, when the court may decide in favor of the state's compelling interest.[37]

B. *Implementing the Right of Refusal for Incompetent Patients*

1. *Competent Patients vs. Incompetent Patients*

For the purpose of consenting to medical treatment, a patient is considered competent if he understands the nature of a proposed treatment and the consequences if treatment is not administered, and if he is capable of exercising choice.[38] A competent patient has the mental ability to make a rational decision, which includes the ability to understand the information conveyed, to "appreciate all relevant facts, and to reach a rational judgment upon such facts."[39] Furthermore, while a patient's choice may appear unwise, foolish, or ridiculous to others, the patient may still be considered competent as long as he or she comprehends the nature and consequences of the decision.[40] Le-

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vacy, removes his freedom of choice and invades his right to self-determine. *Perlmutter*, 362 So. 2d at 164. *See also Saikewicz*, 373 Mass. at 742, 370 N.E.2d at 426; *In re* Quackenbush, 156 N.J. Super. at 290, 383 A.2d at 790.

37. *See* Application of Pres. & Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir. 1964). *See also* Commissioner of Correction v. Myers, 379 Mass. 255, 399 N.E.2d 452 (1979). In *Meyers*, the Supreme Judicial Court of Massachusetts held that the state's interest in upholding the authority of the prison administrators overcame the incarcerated competent patient's right to decline lifesaving hemodialysis treatment. The patient in this case was a young state prison inmate who required regular hemodialysis treatments to remain alive. The patient refused further treatment. The court ordered the continuation of treatment after determining that he was merely attempting to manipulate the prison system, i.e., attempting to coerce his transfer to another facility. For other cases overriding the refusal right, see United States v. George, 239 F. Supp. 752 (D. Conn. 1965); Powell v. Columbian Presbyterian Medical Center, 49 Misc. 2d 215, 267 N.Y.S.2d 450 (N.Y. Sup. Ct. 1965).

38. ROBERTSON, THE RIGHTS OF THE CRITICALLY ILL 40 (1983).

39. *See* Department of Human Servs. v. Northern, 563 S.W.2d 197, 209 (Tenn. Ct. App. 1978).

40. *See In re* Yetter, 62 Pa. D. & C.2d 619 (1973). In *Yetter*, the court upheld the right of a state mental institution inmate, diagnosed as schizophrenic, to refuse to consent to a biopsy for suspected breast cancer. The court was convinced she understood the nature of the procedure and the consequences of refusing. *See also* Lane v. Candura, 376 N.E.2d 1232 (Mass. App. Ct. 1978). In *Lane*, the court upheld the right of a seventy-seven year old diabetic woman to refuse amputation of her gangrenous feet even though the decision seemed irrational to her doctors. The court found ample evidence that the patient was aware of the consequences of refusing the surgery; she retained the "ability to understand that in rejecting the amputation she . . . [chose] death over life." *Id.* at

gally, patients are presumed to be competent to make decisions for their own care, unless declared otherwise by a court.[41]

Patients may be incompetent for any of several reasons. Advanced stages of an illness or a combination of illnesses may render a patient unable to understand the nature and consequences of a choice of treatment in his or her care. Severe head trauma or brain hypoxia[42] secondary to drug overdose may also result in patient incompetence. Furthermore, advanced age may bring on senility or disorientation, especially when trauma or a disabling disease is present.[43] The emotional trauma accompanying physical illness may undermine comprehension and judgment. "Fear and pain may rob the patient of the capacity to consent rationally to further medical care."[44]

A patient may be incompetent for reasons unrelated to the trauma or illness requiring treatment. A patient may be severely mentally retarded or an earlier illness or trauma may prevent the patient from making an informed decision to accept or to decline medical treatment. Certainly an unconscious patient is incompetent to decide.

Resolving doubts about competency is the responsibility of the courts. As a practical matter, the treating physician will initially determine whether there are doubts about a patient's competency to decide for or against medical treatment.[45] The doctor may confer with nurses, family members, and the patient, as well as call in other physicians or psychiatrists. Any treating physician who suspects that a patient is incompetent should seek a judicial determination of competency, and if the patient is deemed incompetent, ask that a guardian be appointed to consent to medical care.[46] "A judicial decision will give the parties some certainty about the legality of their actions, and may prevent the abuse of a patient who is helpless to protect his

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1236.

41. See Lane v. Candura, 376 N.E.2d 1232 (Mass. App. Ct. 1978), where the court emphasized that one's competence is presumed and that irrationality is not analogous to incompetence.

42. Brain hypoxia is decreased amount of oxygen to the brain.

43. D. MEYERS, MEDICO-LEGAL IMPLICATIONS OF DEATH AND DYING 267 (1981).

44. *Id.*

45. ROBERTSON, *supra* note 38, at 43.

46. *Id.*

right to have care withheld."[47]

2. *Standards That Have Guided Decisionmaking for Incompetents*

Recognizing that the rights of incompetent patients to self-determination, bodily integrity, and privacy cannot be exercised by the incompetent patients themselves, the courts have developed doctrines of surrogate decisionmaking to implement the rights of incompetent patients. The two standards that have traditionally guided decisionmaking for incompetent patients are the "substituted judgment" standard and the "best interests" standard.

a. *The Substituted Judgment Standard*

The substituted judgment standard is a subjective one requiring that a surrogate decisionmaker attempt to reach the decision that the incompetent person would have made if he or she had been able to choose.[48] In *Quinlan*, the first judicial decision on withholding treatment to adopt the substituted judgment standard, the patient's father, as her guardian, was empowered to make a judgment on her behalf.[49] On the basis of his determination of what her preference would have been, her right of privacy and self-determination could be exercised.[50]

> If a putative decision by Karen to permit this non-cognitive, vegetative existence to terminate by natural forces is regarded as a valuable incident of her right of privacy, as we

47. *Id.* at 45.

48. PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 132 (1983) [hereinafter cited as PRESIDENT'S COMMISSION REPORT]. The substituted judgment standard was first applied to the determination of a medical issue in an organ transplant case in Strunk v. Strunk, 445 S.W.2d 145 (Ky. Ct. App. 1969). The court authorized removal of a kidney from an incompetent adult donor to save the life of his twin brother who had a fatal kidney disease. The court reasoned that the organ donation was for the "benefit" of the incompetent donor, that he would have wanted to donate the kidney to his brother on whom he was emotionally dependent. *See also* Robertson, *Organ Donations by Incompetents and the Substituted Judgment Doctrine*, 76 COLUM. L. REV. 48 (1976).

49. *In re* Quinlan, 70 N.J. at 41, 355 A.2d at 664.

50. Buchanan, *The Limits of Proxy Decisionmaking for Incompetents*, 29 UCLA L. REV. 386, 389 (1981).

> believe it to be, then it should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice. The only practical way to prevent destruction of the right is to permit the guardian and family of Karen to render their best judgment . . . as to whether she would exercise it in these circumstances.[51]

As one commentator remarked, "the *Quinlan* court thus bestowed an illusory privacy right upon the incompetent patient and gave the actual decision-making power to her guardian . . . [T]he *Quinlan* court essentially gave the decision-making power to a guardian and clothed it with constitutional legitimacy."[52]

The substituted judgment standard was recognized in *Quinlan* as the only means by which the right of self-determination could be exercised and preserved for the incompetent patient. Since the right of self-determination includes not only the right to consent to medical treatment but also the right to refuse it, a surrogate decisionmaker applying the substituted judgment standard could refuse treatment for the incompetent patient even if such a decision would not appear to be in the best interest of the incompetent or in agreement with what a reasonable person may have chosen in similar circumstances.[53]

Following the *Quinlan* lead, the Supreme Judicial Court of Massachusetts acknowledged the constitutionally protected privacy right to decline life-prolonging treatment in *Superintendant of Belchertown State School v. Saikewicz*.[54] The *Saikewicz* court was faced with a treatment decision for a congenital incompetent who had never been able to formulate a treatment preference. In finding that the right to refuse treatment is not forfeited by the incompetent patient, the *Saikewicz* court presented its own version of substituted judgment:

> We believe that both the guardian ad litem in his recommendation and the judge in his decision should have attempted (as they did) to ascertain the incompetent person's actual interests and preferences. In short, the decision in

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51. *In re* Quinlan, 70 N.J. at 41, 355 A.2d at 664.

52. Chapman, *Fateful Treatment Choices for Critically Ill Adults, Part I: The Judicial Model*, 37 ARK. L. REV. 908, 929-30 (1984).

53. *See* Buchanan, *supra* note 50, at 389-90; Gutheil & Appelbaum, *Substituted Judgment: Best Interests in Disguise*, 13 HASTINGS CENTER REP. 8 (1983).

54. *Saikewicz*, 373 Mass. at 736, 370 N.E.2d at 423.

> cases such as this should be that which 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.[55]

Subsequently, the Supreme Judicial Court of Massachusetts in *In re Spring*[56] again applied the substituted judgment standard and exercised the right to refuse dialysis treatments on behalf of the incompetent patient.

b. *The Best Interests Standard*

Surrogate decisionmakers often lack a basis for making a substituted judgment for incompetent patients because those patients in earlier times of competence may not have considered, much less communicated, their thoughts and feelings about potential life-sustaining treatment. Furthermore, as in the case of Joseph Saikewicz, some patients have never been competent so that their subjective wishes about such treatment cannot possibly be ascertained. In these situations, surrogate decisionmakers "must try to make a choice for the patient that seeks to implement what is in that person's best interests by reference to more objective, societally shared criteria."[57] Such a standard relies solely on protection of the patient's welfare rather than on the value of self-determination.[58]

In determining whether a particular course of treatment would be in a patient's best interests, the surrogate deci-

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55. *Id.* at 752, 370 N.E.2d at 431.

56. 380 Mass. 629, 405 N.E.2d 115 (1980). Earle Spring, a senile seventy-seven year old nursing home resident, suffered from a disorienting organic brain syndrome as well as total kidney failure. Unlike Saikewicz, he had at an earlier time been competent and consented to hemodialysis treatments. *Id.* at 636, 405 N.E.2d at 120. (Hemodialysis treatments consist of artificial maintenance of kidney function via regularly scheduled cleansing of blood impurities.) Spring was expected to live about five years if his treatments were continued. His wife and son petitioned the court for authorization to discontinue dialysis treatments. The Massachussets Appeals Court approved the permission granted by the probate court to discontinue treatment, finding that if Spring had been competent, he would have wished to discontinue treatment given his physical condition. *Id.* at 630, 405 N.E.2d at 117.

57. PRESIDENT'S COMMISSION REPORT, *supra* note 48, at 134-35.

58. *Id.* at 135.

sionmaker must consider whether treatment will bring relief from suffering, whether it will preserve or restore functioning, and what will be the extent of life sustained. "An accurate assessment will encompass consideration of the satisfaction of present desires, the opportunities for future satisfactions, and the possibility of developing or regaining the capacity for self-determination."[59]

One commentator has suggested that justice would have been better served had the *Saikewicz* court determined the best interests of Joseph Saikewicz instead of having relied on the substituted judgment standard.[60]

> A direct, well reasoned judicial paternalism is appropriate in the case of an institutionalized incompetent whose welfare is wholly dependent upon the wise decisions of others. This does not mean that the use of a best interests standard would lead inevitably to a sensible and humane result. It would, however, be an honest approach to the problem and would free the courts from the manipulation of reality which is necessitated by the use of substituted judgment. Institutionalized *congenital* incompetents are in need of the state's duty to protect life. This strong presumption in favor of life, anchored in the common law and our most sacred democratic declarations, should not be overcome for helpless *congenital* incompetents by the fiction of substituted judgment.[61]

In fact, there are those who believe that under the guise of substituted judgment, courts have reached their decisions based on what they believed was in the best interests of the patient.[62] In *Quinlan*, the New Jersey Supreme Court showed strong concern for the best interests of the profoundly damaged patient. The court endorsed relief from the undesired prolongation of the dying process where continued therapy offers "neither human nor humane benefit."[63] Thus, even though the court never specifically indicated that the applicable standard would be the "best interest" of the patient, there certainly appears to be lan-

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59. *Id.*
60. Chapman, *supra* note 52, at 938.
61. *Id.* (emphasis in original). *See also* Buchanan, *supra* note 50, at 397 n.36.
62. *See* Gutheil & Appelbaum, *supra* note 53.
63. *In re* Quinlan, 70 N.J. at 47, 355 A.2d at 667.

guage supporting that formula.

Where a substituted judgment for an incompetent patient is based on the presumed rather than the actual desires of the now incompetent patient, the results may often be equivalent to the application of the best interests standard. This would be so if persons are presumed to act in their own best interests. The advantage of the substituted judgment standard, however, is that it not only reaffirms the right to self-determination, but it also allows for refusal of medical treatment even if that would not appear to be in the best interest of the incompetent.

c. *Other Standards*

Other courts in deciding right-to-die issues have rejected the substituted judgment standard in decisionmaking for incompetent patients.[64] The New York Court of Appeals implicitly rejected the substituted judgment standard in deciding the fate of Brother Joseph Fox[65] and John Storar.[66] Before becoming comatose, Brother Fox had explicitly requested that his life not be supported by artificial means. The court agreed that Brother Fox's respirator could be removed but only because of the clear and convincing evidence that the patient had no desire to have his life prolonged by life-sustaining procedures if there were no hope of recovery. The case of Brother Fox is a "simple, straightforward application of the common law principle that the prior expression of treatment preference of a now incompetent person must be honored. It is a principle grounded in the autonomy of the individual and the right to self-determination."[67]

John Storar, on the other hand, was a profoundly mentally retarded fifty-two year old man dying of bladder cancer, not un-

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64. *See In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, (1981) (decision based on consolidation of *In re* Storar and Eichner v. Dillon); *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).

65. At the age of eighty-three, Brother Fox lapsed into a coma during a surgical procedure to correct a hernia. After suffering cardiac arrest which resulted in loss of oxygen to the brain and substantial brain damage, he was placed on a respirator to maintain his other vital bodily functions. Medical experts concurred that he was in a permanent vegetative state. *In re* Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).

66. *Id.* at 371, 420 N.E.2d at 68, 438 N.Y.S.2d at 270.

67. Rockford, *More on the Right to Refuse Treatment: Brother Fox and the Mentally Ill in New York*, L. MED. & HEALTH CARE, Feb. 1983, at 21 .

like Joseph Saikewicz.[68] Having been incompetent throughout his entire life, he had never been able to make a reasoned decision, let alone one with regard to his preference for medical treatment.[69] The court found it "unrealistic to attempt to determine whether he would want to continue potentially life prolonging treatment if he were competent. As one of the experts testified . . . , that would be similar to asking whether 'if it snowed all summer would it then be winter?' "[70] The court rejected the fiction of substituted judgment and required the administration of blood transfusions over the objections of the patient's mother.[71]

The Supreme Court of Washington, in *In re Colyer*,[72] appears to have disregarded the substituted judgment standard of *Quinlan* and to have established instead a "best judgment" of the guardian standard to protect and effectuate an incompetent's right to refuse life-sustaining treatment.[73] "The guardian's familiarity with the incompetent's character and personality, prior statements, and general attitude toward medical treatment will assist in making that judgment."[74] This appears to be a more reasonable approach as there was no evidence that Bertha Colyer had explicitly expressed any desire to refuse life-sustaining treatment.[75]

As one commentator has noted, the best judgment standard fundamentally alters the character of the decision in that it removes the pretense that a third party knows the choice that an incompetent patient would make.[76] It is a more "reality-based solution" than the fiction of substituted judgment, particularly in those instances where an incompetent never expressed or was never able to express a preference about foregoing life-sustaining treatment.[77]

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68. *In re* Storar, 52 N.Y.2d at 373, 420 N.E.2d at 68, 438 N.Y.S.2d at 270-71.
69. *Id.* at 380, 420 N.E.2d at 72, 438 N.Y.S.2d at 275.
70. *Id.* at 380, 420 N.E.2d at 72-73, 438 N.Y.S.2d at 275.
71. John Storar died pending appeal.
72. 99 Wash. 2d 114, 660 P.2d 738 (1983).
73. *Id.* at 128, 660 P.2d at 746.
74. *Id.* at 131, 660 P.2d at 747.
75. *Id.* at 132, 660 P.2d at 748.
76. Chapman, *supra* note 52, at 946.
77. *Id.*

3. *The Locus of Power: Who Decides for the Incompetent Patient*

All courts appear to agree that the right to refuse lifesaving medical treatment extends equally to competent as well as incompetent patients, absent overriding state interests in compelling treatment. However, courts differ in deciding who makes the decision for the incompetent patient and what procedures are to be followed to implement an incompetent's substantive right. The cases decided to date have reached varying results.

> All have tried to do what is in the best interests of the incompetent patient. However, by establishing procedures to avoid the harm of premature treatment termination, they may raise the spectre of greater harm: undue and inhumane prolongation of probably the most traumatic event in the lives of us all, the death of a close family member.[78]

a. *Decisionmaking Within the Patient-Physician-Family Relationship*

The majority of cases appears to favor the patient-physician-family context for decisionmaking.[79] *In re Quinlan*, the leading case, concerned a patient in a chronic persistent vegetative state, with no reasonable probability of returning to a cognitive sapient state.[80] The *Quinlan* court viewed health care decisionmaking as "primarily within the patient-doctor-family relationship,"[81] with review by a hospital ethics committee, but without need for court involvement.[82] The court found that the necessity of applying to the courts to confirm such a decision would generally be "inappropriate, not only because that would be a gratuitious encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome."[83] The court considered it essential that physicians exer-

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78. D. MEYERS, *supra* note 43, at 380.

79. *See* John F. Kennedy Memorial Hosp., Inc. v. Bludworth, 452 So. 2d 921 (Fla. 1984); *In re* Barry, 445 So. 2d 365 (Fla. Dist. Ct. App. 1984); *In re* Dinnerstein, 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976); and *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).

80. *In re* Quinlan, 70 N.J. at 26, 355 A.2d at 655.

81. *Id.* at 50, 355 A.2d at 669.

82. *Id.* at 54, 355 A.2d at 671.

83. *Id.* at 50, 355 A.2d at 669.

cise their "independent medical judgments for the well-being of their dying patients."[84]

> Upon the concurrence of the guardian and family of Karen, should the responsible attending physicians conclude that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to Karen should be discontinued, they shall consult with the hospital "Ethics Committee" or like body of the institution in which Karen is then hospitalized. If that consultative body agrees that there is no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state, the present life-support system may be withdrawn and said action shall be without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital or others.[85]

In *In re Dinnerstein*,[86] the court also placed decisionmaking for an incompetent patient with the physician in accordance with family wishes when the patient is in the terminal stages of an "unremitting, incurable mortal illness."[87] More recently, in *In re Barry*,[88] the decision to refuse treatment was found to be primarily in the hands of the parents and their medical advisors. The *Barry* case represents one of the first judicial decisions upholding the right of the parents of a terminally ill infant to exercise the infant's right to have life support equipment removed. The court noted approvingly that "decisions of this character have traditionally been made within the privacy of the family relationship based on competent medical advice and consultation by the family with their religious advisors, if that be their persuasion."[89]

Furthermore, in *John F. Kennedy Memorial Hospital, Inc. v. Bludworth*,[90] the court held that the incompetent's right may be exercised either by a close family member or by a guardian without prior judicial approval or the consensus of a hospital

84. *Id.* at 49, 355 A.2d at 668.
85. *Id.* at 54, 355 A.2d at 671.
86. 6 Mass. App. Ct. 466, 380 N.E.2d 134 (1978).
87. *Id.* at 474-75, 380 N.E.2d at 138.
88. 445 So. 2d 365 (Fla. Dist. Ct. App. 1984).
89. *Id.* at 371.
90. 452 So. 2d 921 (Fla. 1984).

ethics committee or prognosis board.[91] The court focused primarily on the medical nature of the decision to discontinue treatment in support of its rejection of judicial involvement. It reasoned, as did the court in *Quinlan*, that "doctors, in consultation with close family members are in the best position to make these decisions. The focal point of such decisions should be whether there is a reasonable medical expectation of the patient's return to a cognitive life as distinguished from the forced continuance of a vegetative existence."[92]

The physician's role in decisionmaking has received further support from commentators, most notably Dr. Arnold Relman, Editor of the *New England Journal of Medicine*. Relman contends that the physician should be the key decisionmaker since physicians have always been involved in decisions affecting the life or death of a patient and they are expected to keep their patients' interests paramount.[93] "The traditional responsibilities of the physician demand that he make judgments to treat, or not to treat, which in effect will determine whether, and for how long, and in what condition, the patient is likely to live or die."[94] Both patients and families rely heavily on the professional judgment of their physician[95] who is obligated to confer with, to inform, and to be guided by his patients or their next of kin.[96] Relman maintains that "there is nothing more crucial to a physician's professional role than the making of such decisions."[97]

This emphasis on the primary role of the physician has generated charges of paternalism from other commentators who would prefer to deemphasize the role of the physician.[98] One criticism of the physician as decisionmaker has been the absence of safeguards which would be found in the judicial forum. That

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91. *Id.* at 926.

92. *Id.*

93. Relman, *The* Saikewicz *Decision: A Medical Viewpoint*, 4 AM. J.L. & MED. 233, 236 (1978).

94. *Id.*

95. *Id.*

96. *Id.*

97. *Id.* at 237.

98. *See, e.g.*, Baron, *Medical Paternalism & the Rule of Law: A Reply to Dr. Relman*, 4 AM. J.L. & MED. 337 (1979); Buchanan, *Medical Paternalism or Legal Imperialism: Not the Only Alternatives for Handling* Saikewicz-*type cases*, 5 AM. J.L. & MED. 97 (1979).

is,

> [t]here are no institutional frameworks that require doctors to develop principles of decisionmaking that are consistent from one doctor to another and from one time to another. As a result, few doctors have worked out principles of decisionmaking that will survive even the most rudimentary criticism, and decisions which are made on the same set of facts will differ from day to day and from doctor to doctor.[99]

b. *Judicial Decisionmaking*

The basis for judicial decisionmaking rests on a "gradual development of a body of common law principles, based in societal values, that can be used for deciding fundamental questions with which a 'new technology' is now challenging our society."[100] The leading case requiring judicial decisionmaking with respect to questions of discontinuing treatment for incompetent patients was *Saikewicz*. "We take a dim view of any attempt to shift the ultimate decision-making responsibility away from the duly established courts of proper jurisdiction to any committee, panel or group, ad hoc or permanent."[101] The *Saikewicz* court thus rejected the *Quinlan* approach of entrusting treatment decisions to the patient's guardian, family, physician and hospital ethics committee.[102] Instead, the court saw such questions of life and death as requiring the "process of detached but passionate investigation and decision that forms the ideal on which the judicial branch of government was created."[103]

The same Massachusetts court, in deciding that the guardian need not authorize any further life-prolonging hemodialysis treatments for an incompetent patient, made it clear that judicial approval is not always required prior to withholding treatment from an incompetent patient.[104] In *Spring*, the court suggested a variety of factors that should be taken into account in deciding whether a court order might be needed. These in-

99. Baron, *supra* note 98, at 349-50 (1979).
100. *Id.* at 353.
101. *Saikewicz*, 337 Mass. at 758, 370 N.E.2d at 434.
102. *Id.*
103. *Id.* at 759, 370 N.E.2d at 435.
104. *In re* Spring, 380 Mass. at 636-39, 405 N.E.2d at 120-22.

cluded, *inter alia*, the extent of the patient's mental impairment, whether the patient is in the custody of a state institution, the prognosis with and without treatment, the risk of the proposed treatment, side effects, and urgency of decision.[105] However, the court was not specific about which combination of circumstances would make prior court approval necessary.[106] Thus, the court left considerable confusion by failing to articulate clearly when judicial involvement is required.

The court felt strongly that private medical decisions must be made responsibly and would be subject to judicial scrutiny if good faith or due care were questioned in subsequent litigation.[107] Furthermore, once a court is properly presented with the legal question of whether treatment may be withheld, it cannot delegate that decision but must decide that question itself.[108]

In *In re Storar*,[109] the New York Court of Appeals held that judicial involvement in treatment decisions was optional, not mandatory. The court recognized that those charged with the care of incompetents may want to apply to the courts for a ruling on the propriety of a proposed decision to discontinue life-sustaining treatment before making such a decision, but that such a procedure was not required.[110]

One commentator points out the advantages in allowing courts to decide when to discontinue lifesaving treatment for incompetent terminally ill patients. These advantages are as follows: 1) the public nature of judicial proceedings, 2) the requirement that a judge's decision be principled, 3) the impartiality of the decisionmaker, and 4) the adversarial nature of the judicial proceedings.[111] "Perhaps the greatest virtue of a decision-making process that possesses the four features listed above is that it provides a framework for ongoing criticism and revision both of particular decisions and of the decision-making process itself."[112] Another commentator contends:

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105. *Id.* at 637, 405 N.E.2d at 121.
106. *Id.*
107. *Id.* at 639, 405 N.E.2d at 122.
108. *Id.*
109. 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981).
110. *Id.* at 382, 420 N.E.2d at 74, 438 N.Y.S.2d at 276.
111. Baron, *supra* note 98, at 347-49.
112. Buchanan, *supra* note 98, at 107.

> [w]ithout judicial scrutiny, it is impossible to determine whether family members or physicians are acting in accordance with appropriate standards in making a decision which will terminate the life of another. Although the judicial process is somewhat awkward for parties who must confront a formal mechanism at a time of great emotional stress, the courts should make the judgment in the most difficult of withholding of treatment situations because of their neutrality.[113]

Finally, the courts must always continue to play a role in the decisionmaking for congenital incompetents housed in state facilities.

Having the judicial system act as decisionmaker in cases requiring life-sustaining treatment has its disadvantages. One practical disadvantage is the "slow grinding of the wheels of justice."[114] Many patients whose fates were argued and decided in the courts died long before those decisions were handed down.[115] One critic has also indicated that routine court involvement intrudes on sound medical practice.[116] "The courts cannot be expected to exercise sound judgment when the moral issues are so intertwined with complex medical considerations, nor can they act promptly and flexibly enough to meet the rapidly changing needs of clinical situations."[117]

The highest courts of four states[118] have rejected the judicial forum for the resolution of controversies related to declining lifesaving treatment. Furthermore, the New York Court of Appeals, while not rejecting or encouraging the use of the courts in right-to-die cases, has deemed their involvement "optional."[119] Most recently the Florida Supreme Court, in *Bludworth*, found judicial involvement in these cases unnecessary and that the in-

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113. Brant, *Last Rights: An Analysis of Refusal and Withholding of Treatment Cases*, 46 Mo. L. REV. 337, 354 (1981).

114. Chapman, *supra* note 52, at 959.

115. Saikewicz, Spring, Fox, Storar, and Perlmutter all died before the judicial procedure had run its course.

116. Relman, *supra* note 93, at 237-40.

117. *Id.* at 240.

118. Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334 (Del. 1980); John F. Kennedy Memorial Hosp., Inc. v. Bludworth, 452 So. 2d 921 (Fla. 1984); *In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976); and *In re* Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983).

119. *In re* Storar, 52 N.Y.2d at 382, 420 N.E.2d at 74, 438 N.Y.S.2d at 276.

competent's right may be exercised by either a close family member or a guardian.[120]

C. *Right to Withdraw or Withhold Artificial Nourishment*

Two intermediate appellate courts have addressed the controversial issue of withholding or withdrawing artificial feeding and fluids. Each has approved the withholding or withdrawing of artificial nourishment in very limited circumstances.

In *Barber v. Superior Court*,[121] the California Court of Appeal in a unanimous decision dismissed a murder charge against two California physicians who, at the request of the family, had removed first the respirator and then the intravenous feeding tubes of a patient they judged to be hopelessly comatose.[122] The patient, a fifty-five year old husband and father, underwent successful surgery for an ileostomy repair.[123] Shortly thereafter, while in the recovery room, he suffered cardio-respiratory arrest, was resuscitated and immediately placed on a respirator.[124] Subsequent tests and examinations revealed that he had suffered severe brain damage, leaving him in a vegetative state with an extremely poor prognosis for recovery.[125] The patient's family requested that all life-sustaining equipment be removed.[126] After the respirator was disconnected, the patient began breathing on his own but showed no signs of improvement.[127] Two days later, at the further request of the family, the intravenous tubes which provided hydration and nourishment were removed. Six days later the patient died.[128]

Subsequently, a hospital employee brought the incident to the attention of the district attorney and it was determined that the patient had died of dehydration. The doctors were then charged with murder and conspiracy to commit murder.[129]

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120. *Bludworth*, 452 So. 2d at 926.
121. 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).
122. *Id.*
123. *Id.* at 1010, 195 Cal. Rptr. at 486.
124. *Id.*
125. *Id.*
126. *Id.*
127. *Id.*
128. *Id.* at 1011, 195 Cal. Rptr. at 486.
129. *Id.*

In rendering its decision, the court acknowledged that the current gap between the law and advances in medical technology had forced physicians and families to make intensely painful decisions without clearly defined guidelines.[130] The court realized that it was the province of the legislature to provide a long-term solution to the complex problems confronting them in cases such as this. Nevertheless, the court recognized the need to pass judgment on the physicians' conduct and the related issues so as to provide guidelines of a general nature for future conduct in the absence of such legislation.[131]

This case represents the first time an appellate court equated the discontinuation of intravenous nourishment with the removal of a respirator. The court declared that the administration of intravenous nourishment and fluid was equivalent to the use of the respirator or other form of life support equipment.[132] Each is a medical treatment to be administered only as long as it is of reasonable benefit to the patient and improves the prognosis for recovery. "There is no duty to continue [to provide medical treatment or life-sustaining machinery] once it has become futile in the opinion of qualified medical personnel."[133] Thus, when such intervention merely sustains the biological functions and does not improve the prognosis for recovery, it may be discontinued without concern for criminal liability. Since the court found artificial feeding to be equivalent to medical care, it prohibited the lower court from taking any criminal action against the physicians responsible for removal of the patient's feeding tubes.

In *In re Hier*,[134] the Appeals Court of Massachusetts, citing *Barber*, ruled that a ninety-two year old incompetent patient need not undergo surgery to reinsert a gastrotomy tube. The patient, a severely retarded mentally ill woman, had been a patient for fifty-seven years at a psychiatric hospital before being transferred to a nursing home in 1983.[135] The combined effect of all

130. *Id.* at 1014, 195 Cal. Rptr. at 488.
131. *Id.* at 1014, 195 Cal. Rptr. at 488-89.
132. *Id.* at 1016, 195 Cal. Rptr. at 490.
133. *Id.* at 1018, 195 Cal. Rptr. at 491.
134. 464 N.E.2d 959 (Mass. App. Ct.), *review denied*, 392 Mass. 1101, 465 N.E.2d 261 (1984).
135. *Id.* at 960.

her medical ailments was to greatly impede her ability to ingest food orally.[136] While hospitalized in 1974, she received a gastrotomy — a surgical implantation of a feeding tube directly through the abdominal wall into her stomach.[137] She repeatedly pulled out the tube.[138] Reinsertion was possible without surgery but only if that insertion was accomplished within a relatively short time.[139] Otherwise, reinsertion required open abdominal surgery. Multiple abdominal scars indicated that several surgical procedures had been performed to reinsert her gastrotomy tube.[140]

In early 1984, when the patient was transferred to a hospital because of difficulties encountered in replacing the tube, she refused to allow reinsertion and soon required another abdominal operation.[141] The patient refused to consent to the surgery.[142] A guardian was appointed to obtain court authorization to administer medication as well as to consent to the surgery.[143]

The lower court applied the "substituted judgment" standard as in *Saikewicz*, the goal of which is to determine with as much accuracy as possible the wants and needs of the incapacitated person.[144] The court held that the patient need not undergo the surgery necessary to reinsert the tube, having determined that the patient, if competent to make the decision for herself, "would reject all the several forms of surgical intervention which might enable adequate nutritional support."[145]

The Massachusetts Appeals Court affirmed the lower court judgment, even though it recognized that the intravenous feeding the patient was receiving as her sole source of nutrition and hydration was "useful as a short term technique only and mainly for hydration rather than as a source of an adequate and balanced diet."[146] The court rejected the argument of the guardian

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136. *Id.*
137. *Id.*
138. *Id.*
139. *Id.*
140. *Id.*
141. *Id.* at 961.
142. *Id.*
143. *Id.*
144. *See supra* text accompanying notes 54-56.
145. *In re* Hier, 464 N.E.2d at 961.
146. *Id.*

ad litem that nutrition should be differentiated from treatment and that the right of choice be confined to treatment decisions.[147] Rather, it found more plausible the contention that "[m]edical procedures to provide nutrition . . . [were] more similar to other medical procedures than to typical human ways of providing nutrition . . . . It should be possible to evaluate their benefits and burdens, as we evaluate any other medical procedure."[148]

The court noted that its decision was qualitatively different from *Barber* because it was not addressing the issue of whether to terminate ongoing nutritional support. "Here the issue [was] whether to put an unwilling patient through a major surgical procedure in order to provide adequate nutritional support which [was] not possible through the ongoing intravenous feeding."[149]

III. *In re* Conroy

A. *The Facts*

Claire Conroy was an eighty-four year old nursing home resident who suffered from serious and irreversible physical and mental impairments, including arteriosclerotic heart disease, diabetes, hypertension and a gangrenous leg.[150] She had a urinary catheter and no bowel control.[151] She could not speak and her ability to swallow was very limited.[152] She was fed and medicated through a nasogastric tube.[153] Her movements were very limited although she could smile or moan in response to some stimuli.[154] She was not brain dead, comatose, or in a chronic vegetative state.[155] Medical evidence was inconclusive as to whether

147. *Id.* at 964.

148. *Id.* (quoting Lynn & Childress, *Must Patients Always Be Given Food and Water?*, 13 HASTINGS CENTER REP. 17, 20 (1983)).

149. *Id.*

150. *In re* Conroy, 98 N.J. 321, 337, 486 A.2d 1209, 1217 (1985).

151. *Id.*

152. *Id.*

153. *Id.* A nasogastric tube extends from the nose through the esophagus to the stomach.

154. *Id.*

155. *Id.*

or not she experienced pain.[156]

Thomas Whittemore, Conroy's nephew and only living blood relative, had been appointed her guardian before she entered the nursing home.[157] He had known her for over fifty years and had visited her weekly for four or five years before she entered the nursing home. The court found that Conroy's interest was the nephew's only concern.[158] He had good intentions and no real conflict of interest due to possible inheritance.[159] He sought court permission to remove her nasogastric tube because he believed she would not have permitted its insertion in the first place if she had had the choice.[160]

She was expected to die within a year if nasogastric feeding were continued. If the tube were removed, physicians concurred that she would die of dehydration within a week and that such a death might be painful.[161] Hospital physicians disagreed as to whether or not the tube should be removed.[162]

B. *Lower Court Opinions*

The trial court granted the guardian permission to remove the feeding tube because the patient's life had become impossibly and permanently burdensome for her and her intellectual functioning had become irreversibly reduced to an extremely primitive level.[163] In such circumstances, the court noted that prolonging life becomes pointless and perhaps cruel.[164]

The trial court decision was appealed by the guardian *ad litem* but Conroy died while the appeal was pending — her nasogastric tube intact. The appellate division, nevertheless, considered the issue to be of too much public importance not to be resolved.[165] The court found that this type of case was capa-

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156. *Id.* at 338, 486 A.2d at 1217.

157. *Id.* at 339, 486 A.2d at 1218.

158. *Id.*

159. *Id.*

160. *Id.* at 340, 486 A.2d at 1218.

161. *Id.* at 338, 486 A.2d at 1217.

162. *Id.* at 338-39, 486 A.2d at 1217-18.

163. *In re* Conroy, 188 N.J. Super. 523, 457 A.2d 1232 (N.J. Super. Ct. Ch. Div.), *rev'd*, 190 N.J. Super. 453, 464 A.2d (N.J. Super. Ct. App. Div. 1983), *rev'd*, 98 N.J. 321, 486 A.2d 1209 (1985).

164. *Id.* at 528, 457 A.2d at 1235.

165. *In re* Conroy, 190 N.J. Super. 453, 459-60, 464 A.2d 303, 306 (N.J. Super. Ct.

ble of repetition but would evade review because the patients involved frequently die during the litigation.[166] It reversed the trial court, holding that the right to terminate treatment was limited to "incurabl[y] and terminally ill patients who are brain dead, irreversibly comatose or vegetative and who would gain no medical benefit from continued treatment."[167] The court concluded that withdrawal of the feeding tube would be tantamount to killing the patient.[168] It determined that withholding nourishment from a patient in Conroy's condition would hasten death rather than simply allow an illness to take its natural course.[169] The court held as an alternative ground for its decision that artificial nourishment and hydration were not medical treatments that could be refused by a third party.[170] That is, a guardian's decision may never be used to withhold nourishment from an incompetent patient who is not comatose, brain dead, or vegetative, and whose death is not irreversibly imminent.[171]

Conroy's guardian, Whittemore, petitioned the New Jersey Supreme Court for certification.

C. *Opinion of the New Jersey Supreme Court*

1. *The Majority*

The New Jersey Supreme Court reversed the decision of the appellate division and declared that life-sustaining treatment, including artificial nourishment and hydration, may be withheld or withdrawn from incompetent, institutionalized, elderly patients with severe and permanent mental and physical impairments and a limited life expectancy under detailed judicial guidelines.[172] Writing for the majority, Justice Schreiber recognized that a "tragic situation like that of Claire Conroy raises profoundly disturbing questions" that involve the interplay of

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App. Div. 1983), *rev'd*, 98 N.J. 321, 486 A.2d 1209 (1985).

166. *Id. See supra* note 115.

167. *In re* Conroy, 190 N.J. Super. 453, 466, 464 A.2d 303, 310 (N.J. Super. Ct. App. Div. 1983).

168. *Id.* at 475, 464 A.2d at 315.

169. *Id.* at 473, 464 A.2d at 314.

170. *Id.* at 469-70, 464 A.2d at 311-12.

171. *Id.*

172. See *infra* text accompanying notes 194-216 for the three court devised tests for determining when life-sustaining treatment may be withdrawn or withheld.

many disciplines, questions that do not lend themselves to ideal solutions.[173] The court suggested that the legislature may be better equipped to formulate clear standards for resolving requests to terminate life-sustaining treatment for incompetent patients.[174] However, in the absence of any such specific legislation, the court acknowledged its obligation to resolve the issue before it so as to "place appropriate constraints on such private decision-making and to create guideposts that will help protect people's interests in determining the course of their own lives."[175]

The court began its analysis of whether life-sustaining treatment may be withheld or withdrawn from an incompetent patient with an examination of the rights of a competent patient with respect to accepting or rejecting medical care.[176] The court acknowledged that the right to make certain decisions concerning one's body is protected by the federal constitutional right of privacy.[177] It noted that while the right of privacy might apply in the instant case, it need not decide that issue since the right of a competent adult to decline medical treatment is embraced within the common law right to self-determination.[178] Through the doctrine of informed consent, a competent adult generally has the right to refuse the initiation or continuation of any medical treatment.[179]

The court recognized, however, that the right to decline life-sustaining treatment may yield to countervailing societal interests in sustaining the person's life.[180] The court balanced the right to refuse treatment against state interests in the preservation of life,[181] the prevention of suicide,[182] the maintenance of the ethical integrity of the medical profession[183] and the protec-

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173. *In re* Conroy, 98 N.J. 321, 343, 486 A.2d 1209, 1220 (1985).

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

175. *Id.* at 345, 486 A.2d at 1221.

176. *Id.* at 346, 486 A.2d at 1221.

177. *Id.* at 348, 486 A.2d at 1222.

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

179. *Id.* at 347, 486 A.2d at 1222.

180. *Id.* at 348-49, 486 A.2d at 1223. *See supra* text accompanying notes 23-37.

181. *In re* Conroy, 98 N.J. at 349, 486 A.2d at 1223. *See supra* text accompanying notes 24-28.

182. *In re* Conroy, 98 N.J. at 350, 486 A.2d at 1224. *See supra* text accompanying notes 29-30.

183. *In re* Conroy, 98 N.J. at 351-52, 486 A.2d at 1224-25. *See supra* text accompanying notes 33-35.

tion of innocent third parties.[184] None was found sufficiently compelling to prevent the removal of life-sustaining apparatus in the instant case. On balance, the court concluded that "the right to self-determination ordinarily outweighs any countervailing state interests."[185]

The majority then discussed the rights of an incompetent patient, acknowledging that in attempting to exercise an incompetent person's right to accept or refuse medical treatment, "substitute decisionmakers must seek to respect simultaneously both aspects of the patient's right to self-determination — the right to live, and the right, in some cases, to die of natural causes without medical intervention."[186] *In re Quinlan* was deemed the appropriate starting point for a discussion of withholding or withdrawing life-sustaining treatment from an incompetent person. This same New Jersey Supreme Court, in *Quinlan,* approved the designation of the father as guardian and authorized that the respirator could be removed as long as the family, the attending physicians, and an ethics committee concurred "that there [was] no reasonable possibility of Karen's ever emerging from her present comatose condition to a cognitive, sapient state."[187]

Although *Quinlan* focused on patients in a chronic, persistent vegetative or comatose state,[188] the court left open the question of whether the decision could be applied to incompetent patients in "other types of terminal medical situations . . . , not necessarily involving the hopeless loss of cognitive or sapient life."[189] *Conroy* represents just such a situation — "elderly, formerly competent nursing home residents who, unlike Karen Quinlan, are awake and conscious and can interact with their environment to a limited extent, but whose mental and physical functioning is severely and permanently impaired and whose life

184. *In re* Conroy, 98 N.J. at 353, 486 A.2d at 1225. *See supra* text accompanying notes 31-32.

185. *In re* Conroy, 98 N.J. at 353, 486 A.2d at 1225.

186. *Id.* at 356, 486 A.2d at 1227.

187. *Id.* at 357-58, 486 A.2d at 1227-28 (quoting *In re* Quinlan, 70 N.J. 10, 55, 355 A.2d 647, 671, *cert. denied*, 429 U.S. 922 (1976)).

188. *Id.* at 358-59, 486 A.2d at 1228.

189. *Id.* at 359, 486 A.2d at 1228 (quoting *In re* Quinlan, 70 N.J. 10, 54 n.10, 355 A.2d 647, 671 n.10 (1976)).

expectancy, even with the treatment, is relatively short."[190] The *Conroy* court found that incompetent patients retain the right to self-determination.[191] "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."[192] Therefore, the goal of a substitute decisionmaker should be to attempt to effectuate whatever decision the patient would have made if competent.[193]

The New Jersey court delineated three separate standards or tests under which a decision can be made for patients like Claire Conroy so that they need not be required to have life-sustaining treatment. The first standard reflects the subjective considerations of "substituted judgment," whereas the other two reflect some of the objective considerations of the "best interests" test.[194]

Under the subjective standard, the question is what the particular patient would have done if able to choose for himself and not what a reasonable person would have chosen to do under the circumstances.[195] The court articulated its version of substituted judgment by holding that

> life-sustaining treatment may be withheld or withdrawn from an incompetent patient when it is clear that the particular patient would have refused the treatment under the circumstances involved. The standard we are enunciating is a subjective one, consistent with the notion that the right that we are seeking to effectuate is a very personal right to control one's own life.[196]

The court enumerated the types of evidence bearing on the patient's intent not to have lifesaving medical intervention that may be considered in determining the course of treatment. Evidence of refusal may be found in "living wills"[197] stating the per-

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190. *Id.* at 359, 486 A.2d at 1228-29.
191. *Id.* at 359, 486 A.2d at 1229.
192. *Id.* at 359-60, 486 A.2d at 1229.
193. *Id.* at 360, 486 A.2d at 1229.
194. *Id.* at 321, 486 A.2d at 1209.
195. *Id.* at 360-61, 486 A.2d at 1229.
196. *Id.* at 360, 486 A.2d at 1229.
197. *Id.* at 361, 486 A.2d at 1229.

son's desire not to be treated or sustained under certain circumstances; in an oral directive[198] to a family member, friend or health care provider; or in a durable power of attorney[199] or appointment of a proxy[200] authorizing a particular person to make decisions on the patient's behalf. A patient's reaction with regard to medical treatment administered to others may serve as evidence of refusal.[201] Evidence of refusal may also be deduced from the person's religious beliefs[202] or consistent pattern of conduct with respect to prior decisions about his own medical care.[203]

The court noted that the probative value of such evidence may vary depending on the maturity of the person at the time of his statements or actions and the remoteness, consistency, thoughtfulness and specificity of these prior statements or actions.[204] The court limited the application of this standard to patients within the "Claire Conroy pattern"[205] — "elderly, incompetent nursing-home resident[s] with severe and permanent mental and physical impairments and a life expectancy of approximately one year or less."[206]

The second and third standards delineated by the court would be used in the absence of adequate proof of the patient's wishes because in those cases it would be "naive to pretend that the right to self-determination serves as the basis for substituted decision-making."[207] The court adopted narrow versions of the best interest standard in order not to foreclose the possibility of terminating life-sustaining treatment for persons who never clearly made their wishes known but are now "suffering a prolonged and painful death."[208] The court held that "life-sus-

198. *Id.*

199. *Id.*

200. *Id.* at 361, 486 A.2d at 1230.

201. *Id.* The court acknowledged that it had erred in *Quinlan* in not considering Karen Quinlan's own statements to friends in its attempt to assess her wishes. *Id.* at 362, 486 A.2d at 1230.

202. *Id.* at 361-62, 486 A.2d at 1230.

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

204. *Id.*

205. *Id.* at 363, 486 A.2d at 1231.

206. *Id.*

207. *Id.* at 364, 486 A.2d at 1231. *See also In re* Storar, 52 N.Y.2d 363, 378-80, 420 N.E.2d 64, 72-73, 438 N.Y.S.2d 266, 274-75, *cert. denied*, 454 U.S. 858 (1981).

208. *In re* Conroy, 98 N.J. at 364, 486 A.2d at 1231.

taining treatment may also be withheld or withdrawn from a patient in Claire Conroy's situation if either of two 'best interests' tests — a limited-objective or a pure-objective test — is satisfied."[209]

The limited-objective test could be invoked to withhold or withdraw life-sustaining treatment when there is "some trustworthy evidence that the patient would have refused the treatment, and . . . it is clear that the burdens of the patient's continued life with the treatment outweigh the benefits of that life for him."[210] This standard would allow termination of treatment for a patient when it is clear that the treatment in question would merely prolong the patient's suffering and when the patient had not unequivocally expressed his desires while competent.[211]

When there is no reliable or trustworthy evidence of the patient's wishes, life-sustaining treatment may still be withheld or withdrawn from a patient like Conroy under a third set of criteria — the pure-objective test. Under this test, life-sustaining treatment should be withdrawn or withheld only when

> the net burdens of the patient's life with the treatment . . . clearly and markedly outweigh the benefits that the patient derives from life. Further, 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.[212]

Thus, under the limited-objective and pure-objective tests, the New Jersey court restricted evaluation of a patient's life in terms of "pain, suffering, and possible enjoyment."[213] The court believed that "[w]hen evidence of a person's wishes or physical or mental condition is equivocal, it is best to err, if at all, in favor of preserving life."[214] Furthermore, the court expressly refused to authorize decisionmaking based on assessments of the personal worth or social utility of another's life, or the value of that life to others[215] because such an authorization "would cre-

209. *Id.* at 365, 486 A.2d at 1231-32.
210. *Id.* at 365, 486 A.2d at 1232.
211. *Id.*
212. *Id.* at 366, 486 A.2d at 1232.
213. *Id.* at 367, 486 A.2d at 1232.
214. *Id.* at 368, 486 A.2d at 1233.
215. *Id.* at 367, 486 A.2d at 1232-33.

ate an intolerable risk for socially isolated and defenseless people suffering from physical or mental handicaps."[216]

The court emphasized that in making these decisions for incompetent patients, the primary focus should be on the patient's desires and on the experience of pain and enjoyment, not on the type of treatment involved.[217] In the context of legal analysis and decisionmaking, the court examined and rejected any attempt to distinguish between *actively hastening death* by terminating treatment and *passively allowing a person to die* of a disease.[218] Similarly, it rejected any distinction between *withholding* and *withdrawing* life-sustaining treatment.[219] It also found unpersuasive the distinction between *ordinary* and *extraordinary* treatment except insofar as the particular patient would have made the distinction.[220] Finally, the court rejected any distinction between *artificial feeding* and *other medical treatment*.[221] Analytically, the court concluded that artificial feeding by means of a nasogastric tube or intravenous infusion was equivalent to artificial breathing by a respirator.[222] Both are medical treatments, prolonging life through mechanical means when the body, on its own, is no longer able to perform vital functions.[223] Thus, on the condition that there is sufficient proof to satisfy the subjective, limited-objective, or pure-objective test, the withdrawal or withholding of artificial nourishment, like any other medical treatment, would be permissible.[224]

Finally, the court tackled the decisionmaking procedure, well aware of the particular vulnerability of nursing home residents. The court used as its framework the 1983 amendment to New Jersey's Elderly Abuse Statute which charges the Office of the Ombudsman for the Institutionalized Elderly to guard against "abuse" of such elderly patients.[225] "The new provisions regarding abuse of the elderly create a vehicle for safeguarding

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216. *Id.* at 367, 486 A.2d at 1233.
217. *Id.* at 369, 486 A.2d at 1233.
218. *Id.* at 369, 486 A.2d at 1233-34.
219. *Id.* at 369, 486 A.2d at 1234.
220. *Id.* at 370, 486 A.2d at 1234-35.
221. *Id.* at 372, 486 A.2d at 1235.
222. *Id.* at 373, 486 A.2d at 1236.
223. *Id.*
224. *Id.* at 374, 486 A.2d at 1236.
225. *See* N.J. STAT. ANN. § 52:27G (West 1985).

the rights of elderly, institutionalized, incompetent patients both to receive medical treatment and to refuse life-sustaining medical treatment under certain circumstances."[226]

The majority requires that the following strict procedures be adhered to before life-sustaining treatment may be withdrawn from an incompetent nursing home patient. There must be a judicial determination that the patient is in fact incompetent to make the medical decision at issue; if so, a guardian is appointed to make the decision.[227] Anyone believing that the withholding or withdrawal of life-sustaining treatment would either effectuate the incompetent's wishes or would be in his or her "best interests" should notify the Office of the Ombudsman.[228] Likewise, anyone who has reasonable cause to suspect that any such action would be an abuse should report that information to the ombudsman.[229]

The ombudsman must treat every notification as a potential "abuse" and is required to investigate the situation immediately.[230] As part of his investigation, the ombudsman must obtain information about the patient's condition from the attending physicians and nurses; he should then appoint two other physicians who are unaffiliated with the nursing home to confirm the patient's medical condition and prognosis.[231] Using this medical information, the guardian, with the concurrence of the attending physician and ombudsman, "may withhold or withdraw life-sustaining medical treatment if he believes in good faith, based on the medical evidence and any evidence of the patient's wishes," that one of the three court-delineated standards is met.[232] Furthermore, in the absence of bad faith, all participants in the decisionmaking process are immune from civil or criminal liability.[233]

The majority stressed the narrowness of its decision, which is restricted to nursing home residents like Claire Conroy who

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226. *In re* Conroy, 98 N.J. at 379, 486 A.2d at 1239.
227. *Id.* at 381, 486 A.2d at 1240.
228. *Id.* at 383, 486 A.2d at 1241.
229. *Id.* at 383, 486 A.2d at 1241-42.
230. *Id.* at 383-84, 486 A.2d at 1242.
231. *Id.* at 384, 486 A.2d at 1242.
232. *Id.*
233. *Id.* at 385, 486 A.2d at 1242.

are "suffering from serious and permanent mental and physical impairments, who will probably die within approximately one year even with treatment, and who, though formerly competent, [are] now incompetent to make decisions about [their] life-sustaining treatment and [are] unlikely to regain such competence."[234] In concluding, the court determined that the record in the instant case was not adequate to satisfy any of the standards it had set forth — the subjective, the limited-objective, or the pure-objective.[235] Were Claire Conroy still alive, the guardian would have to address these issues before reaching any decision.[236]

2. *Concurrence in Part, Dissent in Part*

Only Justice Handler dissented in part, criticizing the court's emphasis on pain as the sole criterion for determining the best interests of people like Claire Conroy.[237] According to Justice Handler, the application of either the limited-objective or pure-objective test "would not have led to a more humane, dignified, and decent end of Claire Conroy's mortal life. She would have died, as she did, with the nasogastric tube still in her body."[238] The dissent found that the majority's concentration on pain as the exclusive criterion in making life-or-death decisions "transmutes the best-interests determination into an exercise of avoidance and nullification rather than confrontation and fulfillment."[239] Handler cited the *President's Commission Report* as additional support for rejecting an exclusive focus on patient pain.[240]

Justice Handler suggests that the standard should not focus "exclusively on pain as the ultimately determinative criterion. Rather, the standard should consist of an array of factors to be medically established and then evaluated by the decision-maker both singly and collectively to reach a balance that will justify

234. *Id.* at 342, 486 A.2d at 1219-20.
235. *Id.* at 387, 486 A.2d at 1243.
236. *Id.*
237. *Id.* at 392, 486 A.2d at 1247.
238. *Id.* at 391, 486 A.2d at 1246.
239. *Id.* at 394, 486 A.2d at 1247.
240. *Id.* at 396, 486 A.2d at 1248 (quoting PRESIDENT'S COMMISSION REPORT, *supra* note 48, at 135).

the determination whether to withdraw or to continue life-prolonging treatment."[241] Those factors are then enumerated in the opinion.[242]

In his conclusion, Justice Handler reflects that "[w]hen cherished values of human dignity and personal privacy, which belong to every person living or dying, are sufficiently transgressed by what is being done to the individual, we should be ready to say: enough."[243] According to one commentator, Justice Handler would have gone further than the majority

> by allowing removal or withholding of life support, including nutrition and hydration, on the basis of a 'best interests' determination, without the stricter qualifications in regard to pain and suffering. The result, therefore, is a strong position and a firm consensus of the court on the basic philosophy to allow termination of life support in stated circumstances.[244]

IV. Analysis

In re Conroy represents the New Jersey Supreme Court's most recent struggle with life-and-death decisions concerning withholding or withdrawing life-sustaining therapy from incompetent patients. On the one hand, there is the desire to effectuate the substantive right of all persons — both competent and incompetent — to bodily integrity and self-determination. On the other hand, there is the need to act cautiously and deliberately so that incompetent patients are protected against "decisions that make death too easy and quick as well as from those

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241. *Id.* at 397, 486 A.2d at 1249.

242. The factors enumerated by the court were as follows:

> The person should be terminally ill and facing imminent death. There should also be present the permanent loss of conscious thought processes in the form of a comatose state or profound unconsciousness. Further, there should be the irreparable failure of at least one major and essential bodily organ or system. . . . Obviously the presence or absence of significant pain is highly relevant. In addition, the person's general physical condition must be of great concern. The presence of progressive, irreversible, extensive, and extreme physical deterioration, such as ulcers, lesions, gangrene, infection, incontinence and the like, which frequently afflict the bed-ridden, terminally ill, should be considered in the formulation of an appropriate standard.

Id. at 398, 486 A.2d at 1249 (citations omitted).

243. *Id.* at 399, 486 A.2d at 1250.

244. Curran, *Defining Appropriate Medical Care: Providing Nutrients and Hydration for the Dying*, 313 NEW ENG. J. MED. 940, 942 (1985).

that make it too agonizing and prolonged."[245] In one of the most far-reaching right-to-die decisions ever rendered, the New Jersey court addressed the obligation to provide artificial nourishment and fluids to elderly nursing home residents who are greatly impaired and dying. The *Conroy* decision demonstrates both compassion for the rights of elderly incompetent patients as well as a keen awareness of the staggering potential for abuse.

A. *More Than One Standard for the Decisionmaker*

Most courts have been guided by a single standard or test in surrogate decisionmaking for incompetent patients — usually either the subjective "substituted judgment" test[246] or the objective "best interests" test.[247] *Conroy* represents a significant step forward in this respect in that the court delineated three separate standards in its attempt to effectuate the rights of the incompetent patient: one subjective substituted judgment standard and two objective best interests tests.

Under the subjective standard, the court held that life-sustaining treatment may be withheld or withdrawn from an incompetent patient like Claire Conroy when it is clear that the patient would have refused the treatment under the circumstances.[248] The court should be congratulated for recognizing that the substituted judgment standard should only be applied to patients who were once competent and had at that time unequivocally expressed their preferences with respect to artificial life-sustaining treatment.[249] This is in contradistinction

245. PRESIDENT'S COMMISSION REPORT, *supra* note 48, at 23.

246. *See supra* text accompanying notes 48-56.

247. *See supra* text accompanying notes 57-63.

248. *In re* Conroy, 98 N.J. 321, 360, 486 A.2d 1209, 1229 (1985).

249. For the types of evidence bearing on the patient's intent that may be considered in determining the course of treatment, see *supra* text accompanying notes 197-205. *See also supra* text accompanying note 207.

to *Saikewicz*[250] and *Spring*[251] where the courts purported to make substituted judgments for their respective incompetent patients but where, in fact, there was no basis for the application of the standard. Joseph Saikewicz was a congenital incompetent, profoundly retarded his entire life; the use of substituted judgment in deciding to forego his chemotherapy treatments was a deceptive fiction.[252] Likewise with Earle Spring, for whom there was virtually no evidence of whether he would have declined dialysis treatments had he been competent, the application of a substituted judgment test was inapposite.

For those nursing home residents who have not unequivocally expressed a preference about life-sustaining treatment but for whom there is "some trustworthy evidence that the patient would have refused the treatment,"[253] the court would apply the limited-objective test. That is, the decisionmaker would have to balance the "burdens of treatment to the patient in terms of pain and suffering" against the "benefits that the patient is experiencing."[254] What this means is:

> that the patient is suffering, and will continue to suffer throughout the expected duration of his life, *unavoidable pain*, and that the net burdens of his prolonged life (the pain and suffering of his life with the treatment less the amount and duration of pain that the patient would likely experience if the treatment were withdrawn) markedly outweigh any physical pleasure, emotional enjoyment, or intellectual satisfaction that the patient may still be able to derive from life.[255]

Finally, for those nursing home residents for whom there is no available evidence concerning their prior views about refusing life-sustaining treatment, the court would look to the pure-objective test. Under this test, a far stricter standard of the patient's unbearable life would have to be shown; this test requires

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250. Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977).

251. *In re* Spring, 380 Mass. 629, 405 N.E.2d 115 (1980).

252. *See* Chapman, *supra* note 52 at 938. *See also supra* text accompanying notes 60-61.

253. *In re* Conroy, 98 N.J. at 365, 486 A.2d at 1232.

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

255. *Id.* at 365, 486 A.2d at 1232 (emphasis added).

"recurring, unavoidable and severe pain"[256] before treatment could be terminated.

Although the court extended the criteria for decisionmaking to three separate tests, thereby adopting both subjective and objective criteria for decisionmaking, it did so on very narrow grounds. Evaluation of a patient's condition under both objective tests is limited to "terms of pain, suffering and possible enjoyment."[257]

B. *Is Pain the Only Criterion for Treatment Refusal or Withdrawal?*

The majority's best interests tests are severely restricted, particularly when compared with the broadly defined best interests of the *President's Commission Report* which takes into account not only the relief of suffering but also such factors as "the preservation or restoration of functioning, and the quality as well as the extent of life sustained."[258] The *Conroy* court rejects the criteria of the President's Commission for fear of creating an "intolerable risk for socially isolated and defenseless people suffering from physical or mental handicaps."[259] The majority believes that "[w]hen evidence of a person's wishes or physical or mental condition is equivocal, it is best to err, if at all, in favor of preserving life."[260]

The court expressly declined to authorize decisionmaking based on "assessments of the personal worth or social utility of another's life, or of the value of that life to others."[261] This notwithstanding, it would seem that the court could somehow have established verifiable measures for a standard to withhold or withdraw life support based on the quality of the patient's life. "There is no intrinsic reason why a quality-of-life standard must remain any more vague and undefined than a standard that in-

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

257. *Id.* at 367, 486 A.2d at 1232.

258. PRESIDENT'S COMMISSION REPORT, *supra* note 48, at 135. *See also supra* text accompanying note 59. Furthermore, the court in *Barber* approved these best interest standards. Barber v. Superior Court, 147 Cal. App. 3d 1006, 1021, 195 Cal. Rptr. 484, 493 (1983). *See also supra* text accompanying notes 121-33.

259. *In re* Conroy, 98 N.J. at 367, 486 A.2d at 1233.

260. *Id.* at 368, 486 A.2d at 1233.

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

cludes pain."[262]

Justice Handler argued persuasively in dissent that quite another standard should have been formulated — one that would not give "determinative weight to the element of personal pain, which necessarily obviates other extremely important considerations."[263] He contended that the standard should accommodate as comprehensively, fairly, and realistically as possible "all concerns and values that have a legitimate bearing on the decision whether to provide particular treatment at the very end of an individual's life."[264]

> Several important criteria bear on this critical determination. The person should be terminally ill and facing imminent death. There should also be present the permanent loss of conscious thought processes in the form of a comatose state or profound unconsciousness. Further, there should be the irreparable failure of at least one major and essential bodily organ or system.[265]

The necessity of proving pain and suffering is inappropriate in these already unfortunate situations. The focus on pain as the only basis for withholding or withdrawing treatment is too narrow. It would be an absolute bar to the withdrawal of life support therapy for those patients who do not experience pain;[266] for those situations where health care providers are unable to evaluate the degree of pain, if any, experienced by an incompetent patient;[267] for those who "abhor dependence on others as much, or more than they fear pain";[268] for those who "value personal privacy and dignity, and prize independence from others when their personal needs and bodily functions are involved";[269] and for those who may have wished to avoid "the ultimate horror [not of] death but the possibility of being maintained in limbo, in a sterile room, by machines controlled by strangers."[270]

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262. *Id.* at 397, 486 A.2d at 1249 (Handler, J., concurring in part and dissenting in part).

263. *Id.* at 392, 486 A.2d at 1246.

264. *Id.*

265. *Id.* at 398, 486 A.2d at 1249.

266. *Id.* at 394, 486 A.2d at 1247.

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

268. *Id.* at 396, 486 A.2d at 1248.

269. *Id.* at 396, 486 A.2d at 1248.

270. *Id.* at 396, 486 A.2d at 1248 (quoting Steel, *The Right to Die: New Options in*

The standard articulated by Justice Handler would properly consider "an array of factors to be medically established and then evaluated by the decision-maker both singly and collectively to reach a balance that will justify the determination whether to withdraw or to continue life-prolonging treatment."[271]

C. *Artificial Nourishment Viewed as Medical Treatment*

The court was emphatic in its concern that the primary focus of decisionmaking in cases related to withholding or withdrawing artificial life-sustaining treatment should be the "patient's desires and experience of pain and enjoyment — not the type of treatment."[272] Its examination and rejection of several sets of semantic distinctions[273] that have often been relied upon by those opposed to removal of artificial life-sustaining therapies is to be lauded; those distinctions may have only served to obfuscate an already confused and unsettled decisionmaking process.

Of utmost significiance is the court's refusal to find a distinction between termination of artificial feeding and termination of other forms of life-sustaining treatments. It appears the court would consider such a distinction more psychologically compelling than logically sound, particularly because of the "emotional symbolism"[274] of food. Ethicists have noted that "people are rightly eager to provide food and water. Such provision is essential to minimally tolerable existence and a powerful symbol of our concern for each other."[275]

Providing artificial nourishment and hydration to a terminally ill comatose patient, however, should not be confused with

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California, CHRISTIAN CENTURY, July-Dec. 1976, at 93).

271. *Id.* at 397, 486 A.2d at 1249.

272. *In re* Conroy, 98 N.J. at 369, 486 A.2d at 1233.

273. The court rejected any legal distinction between *actively hastening death* by terminating treatment and *passively allowing a person to die*; between *withholding* and *withdrawing* life-sustaining treatment; between *ordinary* and *extraordinary* treatment; and between *artificial feeding* and *any other medical treatment*. *Id.* at 369-73, 486 A.2d at 1233-36. *See also supra* text accompanying notes 217-24.

274. *In re* Conroy, 98 N.J. at 372, 486 A.2d at 1236.

275. Lynn & Childress, *Must Patients Always Be Given Food and Water?*, 13 HASTINGS CENTER REP. 17, 20 (1983).

providing food and water to a starving but otherwise well person. "Medical procedures to provide nutrition and hydration are more similar to other medical procedures than to typical human ways of providing nutrition and hydration, for example, a sip of water."[276] The majority similarly concludes that

> artificial feedings such as nasogastric tubes, gastrotomies, and intravenous infusions are significantly different from bottle-feeding or spoonfeeding — they are medical procedures with inherent risks and possible side effects, instituted by skilled health-care providers to compensate for impaired physical functioning. Analytically, artificial feeding by means of a nasogastric tube or intravenous infusion can be seen as equivalent to artificial breathing by means of a respirator. Both prolong life through mechanical means when the body is no longer able to perform a vital bodily function on its own.[277]

Accordingly, withdrawal or withholding of artificial feeding, like any other medical treatment, would only be sanctioned if there is sufficient proof to satisfy one of the court-defined standards.[278]

It is widely recognized that it is medically and ethically permissible to withdraw artificial feeding from patients in a persistent vegetative state, when the patient or family has indicated that that is what the patient would have wanted.[279] One clinician has suggested that there are grave implications if we maintain that food and water must never be withheld, even from patients in irreversible coma. It would mean perpetuating a "whole generation of Karen Quinlans."[280] Others, who agree, have argued that under specific circumstances, intravenous fluids are not morally required for dying patients. They contend that giving such solutions to a terminally ill comatose patient is a traditional maneuver whose only major benefit may be to the medical and nursing staff in that it gives them the "emotional satisfac-

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276. *Id.*

277. *In re* Conroy, 98 N.J. at 373, 486 A.2d at 1236.

278. *Id.* at 374, 486 A.2d at 1236.

279. *See, e.g.*, PRESIDENT'S COMMISSION REPORT, *supra* note 48, at 190; Lynn & Childress, *supra* note 275, at 18; Wanzer, *The Physician's Responsibility, supra* note 1, at 957.

280. Steinbock, *The Removal of Mr. Herbert's Feeding Tube,* 13 HASTINGS CENTER REP. 14 (1983).

tion and comfort of thinking that at least *something* is being done."[281]

Citing authorities in medicine and ethics,[282] the *Conroy* court discusses risks and complications that may ensue from nasogastric feedings in further support of its equation of artificial feeding with other medical treatments. The court concludes that "it cannot be assumed that it will always be beneficial for an incompetent patient to receive artificial feeding or harmful for him not to receive it."[283]

Opponents may contend that the court is setting a trend toward wider discretion in decisions to withdraw or withhold treatment from terminally ill patients. Some fear a "slippery slope whereby the lives of all terminally ill and handicapped people are endangered."[284] However, the court is not unmindful of these serious concerns, having established strict procedural guidelines to guard against the enormous potential for abuse.[285]

D. *Procedural Safeguards*

There are many nursing home residents like Claire Conroy. They are a particularly vulnerable population — often quite elderly, most suffering from crippling disabilities and mental impairments, and often without surviving family members.[286] Added to this social isolation, physicians play a very limited role in their lives, visiting infrequently and then only for brief periods of time.[287] Furthermore, nursing homes suffer from peculiar industry-wide problems and are themselves a troublesome com-

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281. *See* Towers, *Irreversible Coma and Withdrawal of Life Support: Is it Murder if the IV Line is Disconnected?*, 8 J. MED. ETHICS 203, 205 (1982). *See also* Micetich, Steinecker & Thomasma, *Are Intravenous Fluids Morally Required for a Dying Patient?*, 143 ARCHIVES INTERNAL MED. 975 (1983).

282. *See* Lo & Dornbrand, *Sounding Board: Guiding the Hand that Feeds: Caring for the Demented Elderly*, 311 NEW ENG. J. MED. 402, 403 (1984); Lynn & Childress, *supra* note 275, at 18, 20; Paris & Fletcher, *Infant Doe Regulations and the Absolute Requirement to Use Nourishment and Fluids for the Dying Infant*, 11 L. MED. & HEALTH CARE 210, 211-13 (1983); Zerwekh, *The Dehydration Question*, 13 NURSING 47, 49 (1983).

283. *In re* Conroy, 98 N.J. at 374, 486 A.2d at 1236.

284. Steinbock, *supra* note 280, at 16.

285. *See supra* text accompanying notes 225-33.

286. *In re* Conroy, 98 N.J. at 375, 486 A.2d at 1237.

287. *Id.*

ponent of an ever-pressured and burdened heath care system.[288]

Cognizant of the significant differences in the patients, the health care providers and the institutional structures of nursing homes and hospitals,[289] the court recognized that it had an obligation to protect the special needs of patients confined to nursing .homes. The New Jersey Supreme Court thus created a multi-step procedure[290] which must be complied with before life-sustaining treatment may be removed from a nursing home resident like Claire Conroy. The procedure requires participation and review by the Office of the Ombudsman as well as two additional physicians independent of the nursing home and the patient in question.

These procedural requirements should quell the fears of those who may shudder at the progression[291] from *Quinlan*[292] (in which the respirator was removed from a comatose patient in a persistent vegetative state) to *Barber*[293] (in which a respirator, nasogastric tube and intravenous line were removed from a comatose patient in a persistent vegetative state) to *Hier*[294] (in which surgery was withheld from an incompetent but noncomatose patient) to *Conroy* (in which removal of a nasogastric tube was sanctioned for an incompetent but noncomatose patient if any one of the court-delineated standards was met).

In fact, these safeguards may be too comprehensive when viewed in conjunction with the "subjective test"[295] set forth by the court. That is to say, it would appear to be unnecessary to require notification of the ombudsman when it is clear that the particular patient would have refused the treatment under the

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288. *Id.* at 376, 486 A.2d at 1237-38. *See also* SENATE SUBCOMM. ON LONG-TERM CARE OF THE SPECIAL COMM. ON AGING, NURSING HOME CARE IN THE UNITED STATES: FAILURE IN PUBLIC POLICY, S. REP. No. 1420, 93d Cong., 2d Sess. 16 (1974).

289. *See In re* Conroy, 98 N.J. at 375, 486 A.2d at 1237.

290. *See supra* text accompanying notes 227-33.

291. *See* McCormick, *Caring or Starving? The Case of Claire Conroy*, AMERICA, Apr. 6, 1983, at 273.

292. *In re* Quinlin, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976). For a more extensive discussion of this case, see *supra* text accompanying notes 80-85.

293. Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983). For a more extensive discussion of this case, see *supra* text accompanying notes 121-33.

294. *In re* Hier, 464 N.E.2d 959 (Mass. App. Ct.), *review denied*, 392 Mass. 1101, 465 N.E.2d 261 (1984). For a more extensive discussion of this case, see *supra* text accompanying notes 134-49.

295. *See supra* text accompanying notes 195-206.

circumstances involved. There would be no "abuse" in carrying out the formerly expressed intent of the now incompetent patient. If the patient had prepared a living will, given an oral directive to a family member or friend, or in a durable power of attorney had indicated his desire not to be treated or sustained under certain circumstances — that should be sufficient. Furthermore, if the patient had voiced reactions with regard to medical treatment administered to others, or if it could be deduced from the patient's religious beliefs or from a consistent pattern of conduct concerning prior medical decisions, that should be sufficient to effectuate the very personal right to control one's own life and death.

V. Conclusion

The New Jersey Supreme Court's decision in *In re Conroy* should be applauded. Absent guidelines from the legislature, families and physicians had been forced to make life-or-death decisions for incompetent patients within uncertain boundaries. The New Jersey court stepped carefully through this struggle between the head and the heart and enunciated more extensive decisionmaking standards than had heretofore been recognized by any court.[296] It overcame the emotional repugnance against discontinuance of nutrition in its determination that artificial nourishment is, in fact, medical treatment and as such may be withheld or withdrawn from incompetent patients under detailed judicial guidelines.

The court has delineated stringent procedures to protect the rights of incompetent patients and to ameliorate a difficult ethical problem facing the medical profession. The procedures require notification of and review by the ombudsman as well as participation of two independent physicians to guard against any feared abuse.[297] Thus, the necessity of proving pain and suf-

296. *See supra* text accompanying notes 194-216.

297. On March 6, 1986, in the first legal test of the *Conroy* decision, the State Ombudsman for the Institutionalized Elderly denied a request to remove a feeding tube from a comatose nursing home patient, Hilda M. Peter. The decision was based on the finding that the patient might live for years with the feeding tube in place. Thus, the life-expectancy criterion — that a patient must have a life expectancy of a year or less before life support can be removed — had not been satisfied. The ombudsman denied the request to remove the feeding tube even though the patient was in a persistent vege-

fering appears inappropriate in these already unfortunate situations. Pain as the sole measure of a person's best interests "eclipses a whole cluster of other human values that have a proper place in the subtle weighing that will ultimately determine how life should end."[298]

Helen L. Siegal

tative state and, prior to her illness, had expressed her desire not to be kept "alive as a vegetable." *See* Sullivan, *Ombudsman Bars Food-Tube Removal*, N.Y. Times, Mar. 7, 1986, at B2, col. 1.

298. *In re* Conroy, 98 N.J. 321, 394, 486 A.2d 1209, 1247 (1985).