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The Current State of Termination of Medical Treatment Case Law

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Mary Stetson Lingerfeldt

Abstract

A particularly unsettled area of the law in recent years has been the sensitive and emotionally-charged subject of termination of medical treatment.

KEYWORDS: Termination, Medical Treatment, State

The Current State of Termination of Medical Treatment Case Law

I. Introduction

A particularly unsettled area of the law in recent years has been the sensitive and emotionally-charged subject of termination of medical treatment.[1] Until recently, the most common question presented to the courts was whether to allow the removal of a respirator[2] from a comatose patient existing in a chronic vegetative state.[3] The 1976 landmark case[4] involving Karen Ann Quinlan was the beginning of the evolution of case law recognizing a patient's right to have treatment discontinued based on the fundamental right to privacy.[5] Today, the removal of a respirator is routinely performed without judicial intervention.

A new aspect to this area of medical-legal ethics however, has re-

1. This discussion will focus on discontinuation of medical care, as opposed to compelling treatment. Compelling treatment involves such cases as ordering blood transfusions for a Jehovah's Witness or surgery for a severely deformed newborn. *See, e.g.*, United States v. George, 239 F. Supp. 752 (D.C. Conn. 1965); Wis. v. Yoder, 406 U.S. 205 (1972).

2. A respirator can be inserted in one of three ways: through the mouth or through the nose into the trachea (windpipe), or if needed for a long period of time it can be surgically inserted in an incision in the throat. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 1347 (25th ed. 1974).

3. Since the reader may not be familiar with some of the medical terms, they will be defined. A chronic vegetative state means "a condition in which one retain[s] the capacity to maintain some of the vegetative portions of neurological functions, such as body temperature, breathing, blood pressure, heart rate, chewing, swallowing, sleeping, and walking . . . but . . . no longer possess[es] any cognitive functions. [Such a patient has] lost the sapient functions of the brain, which control one's relation to the outside world via the capacity to talk, see, feel, sing and think." In re Quinlan, 70 N.J. 10, 24, 355 A.2d 647, 654 (1976).

4. In re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976). The widely publicized case of Karen Ann Quinlan was initiated when this twenty-one year old woman became comatose, following ingestion of alcohol and drugs, and was placed on a respirator. When it became apparent that she was in a chronic vegetative state, her father requested court permission to discontinue the respirator since her physicians were unsure of the state of the law. Quinlan did not die after the respirator was removed and remains alive in a nursing home hooked up to a nasogastric feeding tube and IVs.

5. *See infra* text accompanying notes 31-39.

cently come to light. This issue is whether there is a corresponding right to remove intravenous lines (IVs) and nasogastric feeding tubes[6] which are keeping hopeless patients alive indefinitely. Until very recently this ethical issue was not even within the imagination of the legal or medical communities. However, the rapid technological advancements occurring daily in the field of medicine has left the law in a state of confusion. Medical progress has given us the ability to delay death with methods unheard of several decades ago.[7] Arguably, when a terminally ill patient is subjected to increased pain and suffering and to a loss of dignity in exchange for a longer life span in an unconscious, irreversible state, this medical progress is not humanitarian progress. Courts have been reluctant to lay down specific guidelines for the families and doctors of such unfortunate patients. The resulting uncertainty about the legal ramifications of removing IVs and feeding devices often causes doctors to practice medicine more out of concern for the legal consequences than out of concern for the patient's well being.[8]

This note reviews the latest developments in the area of termination of medical treatment. In particular, a recent California Court of Appeals decision, *Barber v. Superior Court*,[9] provides a useful framework for analyzing the issues. It will be shown how several courts have taken the logical view that the judicial process is too cumbersome and unresponsive in this area of the law. Judicial intervention in these crucial medical decisions is often untimely.[10] There is a pressing need for specific legal guidelines so that physicians and families can make intelligent decisions without facing potential civil or criminal liability.

After a review of the background of the medical and legal issues,

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6. Nasogastric tubes are thin rubber catheters inserted through a patient's nose which extend into the stomach to provide liquid nourishment. Artificial feeding can also be provided through an artificial surgical opening into the stomach (a gastrostomy). DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 637 (25th ed. 1974).

7. Twenty or thirty years ago an unconscious patient would have had to be hydrated by intravenous feeding only, since nasogastric tubes were not yet in use. Rust, *Lifelines, Fine Lines*, STUDENT LAW., Jan. 1984, at 12, 15.

8. "The modern proliferation of substantial malpractice litigation and the less frequent but even more unnerving possibility of criminal sanctions would seem, for it is beyond human nature to suppose otherwise, to have bearing on the practice and standards as they exist." *Quinlan*, 70 N.J. at 46, 355 A.2d at 666.

9. 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983).

10. Decisions are often handed down after the patient has died. In re Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983); In re Conroy, 190 N.J. Super. 453, 464 A.2d 303, *cert. granted*, 95 N.J. 195, 470 A.2d 418 (1983); 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).

this note will focus on the most recent decisions which conclude that there is no need for routine judicial supervision to authorize ending treatment. Finally, this note outlines the logical guidelines these cases present for withdrawing life-support equipment from incompetent patients, so that appropriate decisions can be made without fear of liability.

II. The Historical Development of Termination of Medical Treatment Case Law

How society has approached the issues of death, dying, and euthanasia in the past requires some clarification in order to properly narrow the specific area covered in this note. Mercy killing is medically defined as "an easy or painless death."[11] The legal definition is "the act or practice of painlessly putting to death persons suffering from incurable and distressing disease as an act of mercy."[12] Euthanasia comes from the greek words eu, meaning painless, and thanatos, meaning death. Active euthanasia means ending the life of an incurable patient through positive action, as by administering a drug overdose. Passive euthanasia means failure to take positive action to sustain an incurable patient's life. Euthanasia can also be with the patient's consent, voluntary euthanasia, or without the patient's consent, nonvoluntary euthanasia. Euthanasia refers to mercy killing of all types. This note is restricted to discussing passive euthanasia,[13] meaning the intentional withdrawal or withholding of available medical means for the prolongation of life of a patient who has little or no hope of survival.[14]

As medical technology becomes more sophisticated, medical and legal opinion as to when death occurs also evolves.[15] Prior to 1968 the

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11. DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 553 (25th ed. 1974).

12. BLACK'S LAW DICTIONARY 497 (5th ed. 1979).

13. The distinctions between these forms of euthanasia can mean the difference between first degree murder and legally permissible conduct. *See generally* Foreman, *The Physician's Criminal Liability for the Practice of Euthanasia*, 27 BAYLOR L. REV. 54 (1975).

14. Ward, *Euthanasia: A Medical and Legal Overview*, 49 J. KAN. B.A. 317 (Winter 1980).

15. This medical-legal dilemma is commensurate with the medical- legal dilemma at the other end of the spectrum, determining when life begins. Justice O'Connor, dissenting in Akron v. Akron Center for Reprod. Health recognized that due to advances in medical technology, past decisions are often on a collision course with each other in the abortion context. 462 U.S. 416, ___, 103 S. Ct. 2481, 2507 (1983) (O'Connor, J., dissenting).

commonly accepted standard to determine death was the permanent cessation of respiration and circulation.[16] But advances in the medical field, such as respirators, pacemakers, and cardiac medications, have enabled physicians to generate artificial breathing and circulation when the capacity to do so naturally has been irreversibly lost.[17] Therefore, the traditional means for determining death is no longer satisfactory when dealing with artificially maintained bodies.[18] As a result of this inadequacy the brain-death standard for determining death emerged and is now widely accepted.[19] Brain death has been further defined as

16. The classical definition of death is "a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc." BLACK'S LAW DICTIONARY 488 (rev. 4th ed. 1968).

17. *See generally* Brennan & Delgado, *Death: Multiple Definitions or a Single Standard?*, 54 S. CAL. L. REV. 1323 (1981).

18.

> The most frequent causes of brain death are massive head injuries, massive spontaneous brain hemmorhage secondary to complications of hypertension, or rupture of a congenital berry aneurysm, and lack of blood pumped into the brain because of cardiac arrest or systemic hypotension. Brain death occurs when the swelling is so severe that the pressure within the cranial cavity exceeds the pressure of blood flowing into the brain and the brain stem, causing cerebral circulation to cease. In this condition, there is no clinical evidence of brain function. Intense stimulation may bring no response or voluntary motor movements, and there are no eye movements at the brain stem level. Spontaneous respiration ceases because the vital respiratory centers of the brain have been destroyed. The patient depends entirely on mechanical support to maintain cardiorespiratory function. Normal cardiac functioning can be achieved, mechanically, even in the presence of total brain destruction, and can continue for as long as an hour after a patient is pronounced dead and the respirator discontinued.
> However, mechanical maintenance of heartbeat and circulation can be continued only for a limited period of time when the brain stem has been destroyed. It is this limited survival period that distinguishes between brain death and the persistent vegetative state. In the later state, irreversible damage occurs to the cerebral cortex, but the brain stem continues to function. Considerations involved in dealing with this condition are entirely different from these [sic] involved in brain death and require the drawing of a line between severe dysfunction and no function at all. . . .
> Determination of whether cessation of brain function has occurred may be made in a matter of minutes. The decision as to whether it is irreversible may require several days. Ingestion of suppressant drugs and low body temperature may cause a reversible loss of brain function, so these possibilities must be screened out before a person is pronounced brain dead.

In re Bowman, 94 Wash. 2d 407, 417-18, 617 P.2d 731, 736-37 (1980).

19. *Report of the Ad Hoc Committee of the Harvard Medical School to Ex-*

either partial or complete.

> For medical and legal purposes, partial brain impairment must be distinguished from complete and irreversible loss of brain functions or 'whole brain death.' The cessation of the vital functions of the entire brain — and not merely portions thereof, such as those responsible for cognitive functions — is the only proper neurologic basis for declaring death. This conclusion accords with the overwhelming consensus of medical and legal experts and the public.[20]

Even though the brain death standard is now universally accepted, often a court will authorize the withdrawal of life-prolonging equipment when, even by the brain wave criteria, the patient's brain is not dead. This was the situation in *Leach v. Akron General Medical Center*,[21] which recognized the patient's right, through a guardian, to refuse life-sustaining treatment after four months on a respirator, artificial feeding and urinary catheter, even though she was not brain dead.[22] The court addressed the medical, moral, and legal dilemma which often accompanies termination of treatment decisions. The *Leach* court allowed life-sustaining equipment in general to be disconnected when it is clear that a person is near certain death, but sustained by artificial means.[23] *Leach*, however did not address the ques-

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amine the Definition of Death, A Definition of Irreversible Coma, 205 J. A.M.A. 337 (1968) reports the criteria for brain death as:

1. lack of receptivity and response to painful stimuli;
2. no spontaneous movements or breathing;
3. no reflexes; and a flat EEG, indicating a total absence of brain activity (these tests must then be repeated with the same results twenty four hours later);
4. no evidence of hypothermia or central nervous system depressants.

Id. at 338-40.

20. Abram, *The Need for Uniform Law on the Determination of Death*, 27 N.Y.L.Sch. L. Rev. 1187, 1189 (1982).

21. 68 Ohio Misc. 1, 426 N.E.2d 809 (1980).

22. *See* Note, *Constitutional Law: Right to Privacy — Removal of Life-Support Systems*, 16 Akron L. Rev. 162 (1982).

23.

> While she cannot be classified as dead, she can be classified as being very near death, and that is the crux of the problem.
>
> The problem before this court is not life or death. That question has already been decided. Edna Marie Leach is going to die. She is on the threshold of death, and man has, through a new medical technology, devised a way of holding her on that threshold. The basic question is how

tion of whether IVs or artificial feeding are part of a life-support system.[24]

Passive euthanasia can be viewed as a "humanitarian easing of terminal suffering."[25] The medical community acknowledges that passive euthanasia is a common occurrence, even with the ever-present threat of malpractice and criminal sanctions. As many as seventy-five percent of American physicians permit patients to die by withdrawing life-prolonging equipment, usually when so requested by the patient or a family member.[26] In *In re Quinlan*,[27] the court noted that "it is perfectly apparent . . . that humane decisions against resuscitative or maintenance therapy are frequently a recognized *de facto* response in the medical world to the irreversible, terminal, pain-ridden patient, especially with familial consent. And these cases, of course, are far short of " 'brain death.' "[28]

Courts often make a distinction between ordinary and extraordinary treatment. Ordinary measures are regarded as obligatory, but extraordinary measures are not. A more precise distinction would be to refer to the use of a respirator as extraordinary treatment, while comfort or pain relief measures would be considered ordinary treatment.[29] Courts recognize that physicians distinguish between curing the ill and easing the dying. The *Quinlan* court acknowledged that it is a balance "particularly difficult to perceive and apply in the context of the development by advanced technology of sophisticated and artificial life-sustaining devices."[30] Although such devices are valuable and even essential for the curable patient and thus ordinary treatment, they are " 'extraordinary' in the context of the forced sustaining by cardio-re-

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> long will society require Mrs. Leach and others similarly situated to remain on the threshold of certain death suspended and sustained there by artificial life supports.

Leach, 68 Ohio Misc. at 6, 426 N.E.2d at 812.

24. This issue is first addressed in Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983). *See infra* text accompanying notes 58-88.

25. *See* THE DILEMMAS OF EUTHANASIA 69 (J. Behnke & S. Bok eds. 1975).

26. *See* C., BARNARD, GOOD LIFE/GOOD DEATH: A DOCTOR'S CASE FOR EUTHANASIA AND SUICIDE 52 (1980); *see also Medical Ethics: The Right to Survival: Hearings Before the Subcommittee on Health of the Committee on Labor and Public Welfare*, 93d Cong., 2d Sess. 9 (1974).

27. 70 N.J. 10, 355 A.2d 647 (1976).

28. *Id.* at 47, 355 A.2d at 667 (emphasis original).

29. Ward, *supra* note 14, at 5.

30. *Quinlan*, 70 N.J. at 48, 355 A.2d at 667.

spiratory processes of an irreversibly doomed patient."[31] As a result, many doctors "have refused to inflict an undesired prolongation of the process of dying on a patient in irreversible condition when it is clear that such 'therapy' offers neither human nor humane benefit."[32]

A. Constitutional and Common-Law Issues

The *Quinlan* court was the first to recognize a person's fundamental right to privacy as justification for authorizing withdrawal of a respirator. Although there is no explicit right to privacy in the Constitution, the *Quinlan* court determined that the penumbra of specific guarantees of the Bill of Rights includes the right of personal privacy, including terminating medical treatment.[33] This constitutionally-protected interest in personal privacy is often found to have its source in the language of the first, fourth, fifth, ninth and fourteenth amendments.[34] The Supreme Court had already included such personal decisions as the right to use contraception and to receive an abortion as falling within the protection of the right of privacy. In the celebrated case of *Roe v. Wade*[35] the Supreme Court extended the right to privacy to a woman's decision to terminate a first trimester pregnancy. In *Quinlan*, the New Jersey Supreme Court found the fundamental right to privacy "broad enough to encompass a patient's decision to decline medical treatment under certain circumstances. . . ."[36]

Although the United States Supreme Court has never addressed the specific question of an incompetent, terminally ill patient's right to terminate treatment, some of the Justices have articulated that the right to privacy assures control over one's own body and self-autonomy.[37] As early as 1891 in the case of *Union Pacific R.R. v. Botsford*,[38] the Court first recognized the privacy interest as the right of "every

31. *Id.* at 48, 355 A.2d at 668.
32. *Id.* at 47, 355 A.2d at 667.
33. *Id.* at 40, 355 A.2d at 663; *see also* Griswold v. Connecticut, 381 U.S. 479, 484 (1965) (concluding that the penumbra of the first, third, fourth and fifth amendments protects privacy).
34. *See, e.g.*, Stanley v. Georgia, 394 U.S. 557 (1969) (a narrow holding stressing the constitutional interest in the privacy of the home).
35. 410 U.S. 113 (1973).
36. 70 N.J. at 40, 355 A.2d at 663.
37. *See, e.g.*, Doe v. Bolton, 410 U.S. 179, 219 (1973) (Douglas, J., concurring) (another abortion decision based on the theory of the right of privacy).
38. 141 U.S. 250 (1891).

individual to the possession and control of his own person."[39] The right to be left alone as mentioned in the 1969 Supreme Court decision of *Stanley v. Georgia*[40] appears to extend this concept. Even Justice Cardozo as early as 1914 stated that "every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ."[41]

Each individual's inalienable right to self-determination was extended into the medical field as the tort doctrine of informed consent.[42] This doctrine requires that a patient must give consent to any medical procedure after the risks, alternatives and nature of the treatment have been explained. Medical malpractice suits have been initiated under various theories, such as assault, battery, negligence or trespass, but the patient's right to bodily control remains the basis of informed consent. According to this premise, even if an individual makes decisions irrationally or incorrectly, he must nonetheless be permitted the right of choice. This is also known as the common-law right to be free from bodily invasion which is essentially a matter of private concern beyond the reach of the courts.

Consequently, the constitutionally based right of privacy and the recognized common-law right to be free of bodily invasion support a strong argument for allowing patients to assert their choice of the time of death in a natural manner without unwanted medical intervention. However, courts have not yet recognized an absolute right to discontinue life support systems. There is a limitation on such conduct if it is outweighed by public policy considerations. Courts use a traditional balancing test. If the state's interest in protecting its citizens outweighs the individual's fundamental right to privacy, the state may be able to deny that right. In *Superintendent of Belchertown State Schools v. Saikewicz*[43] the court enumerated and considered the following four state interests:

(1) the preservation of life;
(2) the protection of innocent third parties;
(3) the prevention of suicide; and

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39. *Id.* at 251.

40. 394 U.S. 557 (1969). *See supra* note 34.

41. Scholendorff v. Society of New York Hospital, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

42. *See generally* Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228-64 (1973).

43. 373 Mass. 728, 370 N.E.2d 417 (1977).

(4) the maintenance of the ethical integrity of the medical profession.[44]

The preservation of life is the most important of the state's interests. But courts afford it less weight when there is no reasonable possibility that the patient will return to a cognitive and sapient condition. As noted in *Quinlan*: "We think that the state's interests *contra* weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately, there comes a point at which the individual's rights overcome the state interest."[45] This emphasis on the quality of life is at the heart of these decisions. A terminally ill comatose patient often no longer has a life he would wish to prolong. Accordingly, as in *Saikewicz*, the courts should distinguish between an artificially maintained vegetative life and a valuable, curable life.[46]

Joseph Saikewicz was a profoundly retarded sixty-seven year old patient afflicted with terminal, incurable leukemia. The court allowed his guardian to refuse the use of chemotherapy as in his best interests, since the disease was invariably fatal and treatment would cause significant side effects and discomfort.[47] The court distinguished between curing the ill and comforting the dying:

> The essence of this distinction in defining the medical role is to draw the sometimes subtle distinction between those situations in which the withholding of extraordinary measures may be viewed as allowing the disease to take its natural course and those in which the same actions may be deemed to have been the cause of death.[48]

B. The Physician's Liability

Any physician making a decision to terminate medical treatment faces the possibility of criminal and civil liability. The two doctrines which are applicable to the physician's liability are informed consent[49] and standard of care. Without consent, a medical treatment or opera-

44. *Id.* at 425.
45. 70 N.J. at 41, 355 A.2d at 664 (emphasis original).
46. 373 Mass. 728, 370 N.E.2d 417 (1977).
47. *Id.* at 729-30, 370 N.E.2d at 420. This is the case most often quoted in support of a requirement of judicial intervention.
48. *Id.* at 738, 370 N.E.2d at 423.
49. *See supra* note 40 and accompanying text.

tion can be a technical battery, even if the results are satisfactory.[50] The standard of care doctrine requires that a physician use "that skill, knowledge, and training possessed by an average member of the profession in the same or similar locality."[51]

There is little precedent on the subject of criminal liability when medical treatment has been terminated without judicial approval. It appears that a physician will be protected as long as he uses good faith judgment that is not unreasonable by medical standards.[52] Although the possibility of criminal actions against doctors is a deterrent to practicing good medicine, it should be noted that there are relatively few prosecutions and virtually no convictions under these circumstances.[53] Juries often return verdicts of not guilty in recognition of the humanity of ending treatment, although the letter of the law may be clearly different.

This discrepancy between the written law, which considers withdrawal of treatment illegal, and the reality of what courts and juries actually do, leaves the medical practitioner in a quandary.[54] Physicians are often forced to practice defensive medicine, ordering unnecessary diagnostic tests or superfluous treatment simply to avoid legal liability. As a result, terminal, comatose patients are often left in a virtual state of suspended animation, held on the threshold of death by modern machines.

C. Living Wills

It should be noted that twenty-two states have enacted natural death legislation[55] which in essence legalizes passive euthanasia if there is a properly executed living will.[56] As admirable as the concept of liv-

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50. *See generally* Comment, *Euthanasia: The Physician's Liability*, 10 J. MAR. J. PRAC. & PROC. 148 (1976).

51. Ward, *supra* note 14, at 322.

52. *See* Collester, *Death, Dying and the Law: A Prosecutorial View of the Quinlan Case*, 30 RUTGERS L. REV. 304, 310-11 (1977).

53. *See generally* Foreman, *The Physician's Criminal Liability for the Practice of Euthanasia*, 27 BAYLOR L. REV. 54-61 (1975).

54. *See generally* Note, *In re Storar: Euthanasia for Incompetent Patients, A Proposed Model*, 3 PACE L. REV. 351-74 (1983).

55. Tifft, *Debate on the Boundary of Life*, TIME, April 11, 1983 at 70; *see also* Flaherty, *A Right to Die?*, Nat'l L.J., Jan. 14, 1985, at 1, col. 1.

56. A living will is "a document, similar to a will, executed by a person during his lifetime setting forth his wishes concerning medical treatment in contemplation of illness or death." Note, *In re Living Will*, 5 NOVA L. J. 445 (1981).

ing wills may be, however, even its proponents acknowledge that only the most motivated of individuals are likely to take the anticipatory step of preparing such a document.[57] It is typical human nature to procrastinate and ignore the need for such arrangements. Therefore, the vast majority of difficult decisions involving terminating treatment will not have the advantage of a written directive to help guide the physician.

III. Recent Case Law

The courts in several states have been extremely active in recent years in handling medical decisionmaking cases. Many courts have taken new approaches and suggested rational and practical guidelines for terminating treatment. These guidelines provide caregivers and families of irreversibly ill patients some reassurance as to the propriety and legality of their decisions concerning discontinuation of medical treatment.

A. Barber v. Superior Court

The preceding background material on how termination of treatment cases have been handled in the past can be compared with the recent enlightened decision handed down in the case of *Barber v. Superior Court*.[58] The California Court of Appeals dismissed murder charges against two doctors who had removed the feeding tubes from fifty-five year old Clarence Herbert, a man severely brain-damaged following routine abdominal surgery. After general anesthesia during an operation to remove a colostomy bag, Mr. Herbert suffered a cardiopulmonary arrest in the recovery room. Attempts to resuscitate him were successful only to the point of leaving him permanently brain-damaged and in a coma.[59] His family insisted on removal of all life support devices, including IVs and nasogastric feeding tubes, stressing that Mr. Herbert had clearly stated before surgery that he did not want to be kept artificially alive.

After consultation with the family and in compliance with the

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57. *Barber*, 147 Cal. App. 3d at 1016, 195 Cal. Rptr. at 489.

58. *Id.* at 1006, 195 Cal. Rptr. at 484 (1983). Los Angeles County District Attorney Robert Philibosian, in a brief to the California Supreme Court, asked them to decertify the case. Reaves, *Cutting Off the IV*, 70 A.B.A. J. 31 (Feb. 1984).

59. *Barber*, 147 Cal. App. 3d at 1010, 195 Cal. Rptr. at 486.

family's wishes, the physicians found themselves embroiled in a dramatic precedent-setting medicolegal episode when charged with murder by Los Angeles prosecutors.[60] The court of appeals acknowledged that this case belies the commonly expressed belief that such decisions would most likely not become the subject of criminal prosecution.[61] Many physicians in private consultation with families of hopeless patients routinely withdraw IV and nasogastric tube nourishment. The case of Clarence Herbert appears to be the first instance of a criminal prosecution for the medical decision of removing life-sustaining equipment.[62]

The appeals court reviewed the superior court finding that although the doctor's conduct was well motivated, ethical, and sound in the eyes of the medical profession, it was unlawful under California law.[63] The court also defined the concepts of excusable or justifiable homicide, stating that they "evolved and were codified at a time well prior to the development of the modern medical technology which is involved here, which technology has caused our society to rethink its concepts of what constitutes 'life' and 'death' ".[64] The *Barber* prosecution resulted from the gap between the statutory law and recent medical developments. In discussing this gap between technology and the law, the court clearly was aware that extremely personal and painful decisions concerning terminally ill patients are made even more difficult because of the lack of clear legal guidelines.[65]

The *Barber* court recognized that although Clarence Herbert was not brain dead, the physician was left with the responsibility of allowing him to remain in a vegetative state without higher cognitive brain functions.[66] Similarly, the Delaware Supreme Court in a 1980 case[67] recognized the physician's dilemma and stated the issue:

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60. Reaves, *supra* note 56 at 31.

61. *Barber*, 147 Cal. App. 3d at 1014, 195 Cal. Rptr. at 488.

62. *Id.* at 1015, 195 Cal. Rptr. at 488. Prior to the Barber case, courts were usually involved merely for the purpose of obtaining declaratory judgments or guidelines for hospitals and physicians to follow before ending treatment, and not in a criminal context.

63. *Id.* at 1012, 195 Cal. Rptr. at 487.

64. *Id.* at 1013, 195 Cal. Rptr. at 487.

65. *Id.* at 1015, 195 Cal. Rptr. at 488.

66. *Id.* at 1014, 195 Cal. Rptr. at 488.

67. Severns v. Wilmington Medical Center, Inc., 421 A.2d 1334 (Del. 1980); Mr. Herlihy, attorney for Mr. Severns, originally asked for a court order to remove the fifty-seven year old Mrs. Severns from the respirator and artificial feeding, but the

> Now, however, we are on the threshold of new terrain—the penumbra where death begins but life, in some form, continues. We have been led to it by the medical miracles which now compel us to distinguish between "death" as we have known it, and death in which the body lives in some fashion but the brain (or a significant part of it) does not.[68]

1. *IVs and Nasogastric Feeding Tubes*

As the issue of removing hydration and nourishment is sure to arise in the future, the *Barber* opinion will likely be quoted as the first ever to compare the removal of IVs and feeding tubes as being similar to the removal of respirators. Prior to *Barber* no court had ever specifically allowed the removal of IVs and artificial feeding devices. This was a very important comparison, reflecting the court's view that there is no morally relevant distinction between the two forms of mechanical devices.

> In examining this issue we must keep in mind that the life-sustaining technology involved in this case is not traditional treatment in that it is not being used to directly cure or even address the pathological condition. It merely sustains biological functions in order to gain time to permit other processes to address the pathology. The question presented by this modern technology is, once undertaken, at what point does it cease to perform its intended function and who should have the authority to decide that any further prolongation of the dying process is of no benefit to either the patient or his family?[69]

The result of the *Barber* decision was that the surgeon and the

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request was later amended to mean only the respirator. She was weaned from the respirator in the five months it took the Delaware Supreme Court to reach a decision and remains in a vegetative state in a nursing home. The reasons given for asking only that the respirator be removed were first, the husband and family were somewhat queasy about the artificial feeding request, and second, in discussion with the doctors involved and the hospital, it was determined that the hospital personnel would have some difficulty handling such a situation. Also, the attorney recognized that by asking for an end to feeding, the decision would be going beyond *Quinlan* and would cause the case to be considerably prolonged. Telephone interview with Thomas Herlihy III, attorney for Mr. Severns (July 19, 1984).

68. *Id.* at 1344.

69. *Barber*, 147 Cal. App. 3d at 1017, 195 Cal. Rptr. at 490.

internist would not have to go to trial for the death of Clarence Herbert because their medical decision, "though intentional and with knowledge that the patient would die, was not an unlawful failure to perform a legal duty."[70] The court did not consider the withdrawal of heroic life support measures as an affirmative act, but rather an omission of further treatment.[71] Once the treatment has been proven ineffective the physician no longer has a duty to continue it.[72] This reasoning resolved the critical issue of determining the duties owed by a physician to a patient who was extremely unlikely to have any meaningful recovery of cognitive brain function.[73]

In this monumental decision, the court touched on what is perhaps the crux of the medical-legal-ethical dilemma involved. There is a psychological burden inherent in the thought of, as opponents of the decision may put it, starving and dehydrating a patient to death. The court was aware of "the emotional symbolism of providing food and water to those incapable of providing for themselves. . . ."[74] Plainly, food and water normally provide a net benefit to most patients most of the time.[75] Naturally, if there is any doubt as to the benefit provided, feeding may be continued because of the usual moral standards and because food is symbolic of human life that is "inescapably social and communal."[76] Treatment may be appropriate for most patients but not be suitable in a particular case because of the burdens it would place on the patient. In judging all forms of medical care, it seems proper to determine whether the particular patient will derive a net benefit.

Since hospitals routinely remove respirators from hopeless patients without fear of legal action, the court rationally extended the *Quinlan* standards to artificial feeding in the same type of situation. Since air provided by artificial means is allowed to be discontinued, the court also allowed food provided by artificial means to be withdrawn. It has been noted that this decision was the natural culmination of this is-

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70. *Id.* at 1022, 195 Cal. Rptr. at 493.
71. *Id.* at 1016, 195 Cal. Rptr. at 490.
72. *Id.* at 1017, 195 Cal. Rptr. at 491.
73. *Id.* at 1017, 195 Cal. Rptr. at 490.
74. *Id.* at 1016, 195 Cal. Rptr. at 490.
75. *See* Brief for Amicus Curiae, Commissioners and Professional Staff of the Recent President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research at 19, In re Conroy, 190 N.J. Super. 453, 464 A.2d 303 (1983), *rev'd*, _ N.J. _ (1985) [hereinafter cited as Brief for Amicus Curiae].
76. Callahan, *On Feeding the Dying*, 13 HASTINGS CENTER REP. 22 (Oct. 1983).

sue.[77] For years, much of society has accepted this point of view as proper. Although it may offend many people to dehydrate a patient, the *Barber* decision appears to be the natural evolution in the law. The *Barber* case appears to reflect the feeling that "[w]here a terminally ill patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis, all means of life support may be discontinued."[78]

The *Barber* decision could have a tremendous impact on the body of case law that allows treatment to be terminated and may relieve some physicians from having their conduct viewed in a criminal context. It is important to recognize that life support decisions are essentially medical determinations with facts unique to each. As far back as the *Quinlan* case, the New Jersey Supreme Court stated:

> [T]here must be a way to free physicians, in the pursuit of their healing vocation, from possible contamination by self-interest or self-protection concerns which would inhibit their independent medical judgments for the well-being of their dying patients. We would hope that this opinion might be serviceable to some degree in ameliorating the professional problems under discussion.[79]

2. *Barber's Guidelines for Future Conduct*

The landmark case of Clarence Herbert may give families and physicians of terminal patients additional reassurance in their decision-making. While noting that the legislature is better suited for adopting specific procedural rules, the court laid down "general guidelines for future conduct."[80]

Three difficult determinations to be made in each case were enumerated as follows:

(1) the point at which further treatment will be of no reasonable benefit to the patient;

(2) who should have the power to make that decision; and

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77. *See* Reaves, *supra* note 56, at 31. Barry Silberman, a Los Angeles attorney, has written several articles on this issue.

78. In re Conroy, 190 N.J. Super. 453, 463, 464 A.2d 303, 313 (1983), *rev'd*, _ N.J. _ (1985) (citing AMERICAN MEDICAL ASSOCIATION'S COUNCIL ON JUDICIAL OPINIONS 2.11 (Jan. 10, 1981)).

79. 70 N.J. at 49, 355 A.2d at 668.

80. *Barber*, 147 Cal. App. 3d at 1019, 195 Cal. Rptr. at 491.

(3) who should have the authority to direct termination of treatment.[81]

3. *Proportionate Treatment*

In discussing the issue of which life-prolonging procedures must be used and for how long, the *Barber* court rejected the ordinary versus extraordinary treatment approach.[82] Instead the court suggested it would be more rational to determine whether the proposed treatment is proportionate to "the benefits to be gained versus the burdens caused."[83] It defined proportionate treatment as that which "has at least a reasonable chance of providing benefits to the patient, which benefits outweigh the burdens attendant to the treatment."[84] Although an IV or feeding tube may be minimally painful and not as intrusive as a respirator, if there is no chance of recovery, the treatment is disproportionate to the potential benefits.

Whether treatment is worth enduring depends on facts unique to each case. The *Barber* court follows the *Quinlan* standard that "the focal point of decision should be the prognosis as to the reasonable possibility of return to cognitive and sapient life, as distinguished from the forced continuance of [a] biological vegetative existence. . . ."[85] If a patient has virtually no chance of recovery and the medical consensus is that he will remain in a chronic vegetative state, then there appears little reason to force continued IV hydration or nasogastric tube feeding, especially since the law permits a respirator to be removed without controversy. Courts in various jurisdictions continue to distinguish between artificially sustained vegetative existence and cognitive existence. Cognitive existence is the state of being able to communicate, think, feel, express emotions, and relate to one's surroundings.[86] In other words prolonging life does not mean merely suspending an inevitable

81. *Id.*

82. *Id.*

83. *Id.*

84. *Id.* at 1020, 195 Cal. Rptr. at 491; *see also* President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment, A Report on the Ethical, Medical and Legal Issues in Treatment Decisions (Mar. 1983) [hereinafter cited as PRESIDENT'S COMMISSION]. This Commission reported on an array of bioethical topics and issued eleven reports addressing issues of medical practice and public policy.

85. 70 N.J. at 51, 355 A.2d at 669.

86. *See infra* note 95.

death, but would at least hope to provide "a remission of symptoms enabling a return towards a normal, functioning, integrated existence."[87]

4. *Substituted Judgment and Best Interests Standards*

The second issue the *Barber* court addressed was who should make the decision to end treatment. The patient, of course, should make the decision when possible. However, the most controversial cases involve patients incapable of such decisionmaking. Appropriate decisionmaking in the medical field is aided by judicial recognition of two legal standards when dealing with incapacitated patients. These are substituted judgment and best interests.[88] The substituted judgment standard allows a surrogate decisionmaker to make a choice that as closely as possible reflects the desires of the incapacitated person. The best interests standard is used when there is no evidence of what the patient would want. The latter is more of an objective criteria than the former. The substituted judgment standard reflects the incapacitated patient's individual wishes. Any concrete evidence of prior conversations or expressions of opinion as to what the patient would want should be considered. Arguably, examining a patient's earlier stated preferences should be morally and legally necessary, and honoring the person's preference should be a clear obligation. Only when a patient's preferences are unknown should it be left to the surrogate decisionmaker to make the decision that serves the patient's best interests. The decision should take into account the interest in sustaining life, the relief of suffering, possible side effects of continued treatment, as well as the quality of life.[89]

5. *Who has Authority to Make the Decision*

The final issue addressed by the *Barber* court was the necessity of judicial intervention in these cases. The court's conclusion was that it is unnecessary and unwise to require prior judicial approval before with-

87. In re Dinnerstein, 6 Mass. App. Ct. 466, 470, 380 N.E.2d 134, 138 (1978). This decision went to the issue of whether it was proper to withhold resuscitation from an elderly, terminally ill patient, without judicial approval. It permitted a no code order by the attending physician which directs the hospital personnel not to use extraordinary measures to resuscitate a patient in cardiac or respiratory arrest.

88. PRESIDENT'S COMMISSION, *supra* note 84, at 134.

89. *Id.* at 135.

drawing treatment. On this issue *Barber* again agreed with the *Quinlan* court: "We consider that a practice of applying to a court to confirm such decisions would generally be inappropriate, not only because that would be a gratuitous encroachment upon the medical profession's field of competence, but because it would be impossibly cumbersome."[90] In other words, the courts discourage routine requests to the judiciary on these decisions. The judicial system does remain available in controversies where there is family disagreement over the incompetent's wishes or the physicians disagree as to the prognosis. A court may intervene if malpractice or wrongful motives are in evidence. Thus, the court system is a final safeguard.

B. In Re Colyer[91]

Another recent decision, *In re Colyer*, examined the roles of guardians, physicians and courts, in these treatment decisions. Recognizing that determining a particular patient's prognosis is a medical decision, the Washington Supreme Court's suggestion is that a prognosis board should confirm the attending physician's diagnosis.[92] This procedure would provide protection against those who possibly may be motivated by other interests, such as an inheritance. The vast majority of physicians take their professional oaths seriously and consider their patients' interests above all others'. The *Quinlan* court was the first to address the issue of possible impropriety in medical decision making and recommended formation of a hospital ethics committee. Such a group is composed of doctors, attorneys, social workers and theologians. The purpose of such a diverse selection is to allow the responsibility for such a momentous decision to be spread over a large component of society with divergent views. The *Quinlan* court held that if the recommendations of such a committee are followed, no civil or criminal liability would ensue.

The *Colyer* court agreed with others who have criticized such an ethics committee "for its amorphous character, for its use of nonmedical personnel to reach a medical decision, and for its bureaucratic in-

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90. 70 N.J. at 50, 355 A.2d at 669.

91. 99 Wash. 2d 114, 660 P.2d 738 (1983). It should be noted that all these courts take the view that the legislature is better suited to establish these guidelines, but that in the absence of such guidance, the judiciary does suggest procedures to be followed.

92. *Id.* at 134, 660 P.2d 749.

termeddling."[93] It felt that a prognosis board composed of professional colleagues who have an understanding of the patient's medical condition would be adequate protection "against erroneous diagnoses as well as questionable motives."[94] A unanimous concurrence that the patient cannot return to a sapient state within any reasonable medical probability is sufficient to allow discontinuance of life-prolonging treatment.[95]

As to the potential criminal liability for such conduct, as long as there is good faith compliance with the court's suggested procedure, the action would not be criminal.[96] The *Quinlan* court gave two reasons for not considering an ensuing death homicide. First, death would be from existing natural causes, not from stopping the treatment. Second, it would not be unlawful even if it were homicide because "the action would be based on the exercise of a constitutional right and, as such, would be protected from criminal prosecution."[97]

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93. *Id.* Sixty-nine year old Bertha Colyer had a zero chance of returning to any meaningful existence after a heart attack resulting in massive brain damage. She had a close family familiar with her beliefs and character.

> While we do not accept the Quinlan court's view that judicial intervention is an encroachment upon the medical profession, we do perceive the judicial process as an unresponsive and cumbersome mechanism for decisions of this nature. This fact is borne out by a number of the leading cases in which arguments were heard and opinions written long after the patient had died. (Citations omitted). Obviously, the court system could not respond in a timely manner to the relief sought in those situations. Moreover, the formalities of a legal determination might chill a guardian's resolve to assert the rights of his ward.

Id. at 127, 660 P.2d at 746.

94. *Id.* at 138, 660 P.2d at 749.

95. An expert witness, Dr. Fred Plum, at the Quinlan trial explained vegetative and sapient brain function:

> We have an internal vegetative regulation which controls body temperature, which controls breathing, which controls to a considerable degree blood pressure, which controls to some degree heart rate, which controls chewing, swallowing and which controls sleeping and waking. We have a more highly developed brain which is uniquely human which controls our relation to the outside world, our capacity to talk, to see, to feel, to sing, to think.

Quinlan, 70 N.J. at 24, 355 A.2d at 654.

96. *Colyer*, 99 Wash. 2d at 138, 660 P.2d at 751.

97. *Id.*

C. In Re Conroy[98]

The New Jersey Supreme Court recently addressed the issue of appropriate guidelines for stopping artificial feeding in the case of *In re Conroy*. *Conroy* involved another patient who died before a final decision was handed down. Conroy was in a nursing home suffering from severe organic brain syndrome, necrotic decubitus ulcers, urinary tract infection, arteriosclerotic heart disease, diabetes and hypertension.[99] The New Jersey Superior Court originally held that nasogastric tube feeding could be stopped, at her nephew's request, after determining that Conroy "had no cognitive or volitional functioning."[100] The state won a stay of the order from the appellate court. With the nasogastric tube still in place, Conroy died of natural causes two weeks later.

Although Claire Conroy had already died, making the conflict merely hypothetical, the appellate court concluded that the issues should be resolved because of their great public importance. Even when patients have died, courts consistently agree to decide terminally ill patients' rights to refuse life-sustaining treatment.[101] The *Conroy* court decided that since the issues involved are recurring, yet typically avoid review because of the patient's death, the case should continue; otherwise, future parties of interest would have no guidance.[102]

The New Jersey Superior Court would not have allowed the artificial feeding to be stopped because they concluded that Claire Conroy was not comatose, not facing imminent death, nor in a chronic vegetative state.[103] They interpreted the medical testimony to hold that since Conroy was sapient, the state's interest in preserving life was substantial and overrode the patient's right to privacy. This court distinguished her from the *Quinlan* case by pointing out that she was not subject to twenty-four hour intensive nursing care and not maintained on any mechanical devices. The fact that Conroy was awake but very confused

98. *Conroy*, 190 N.J. Super. 453, 464 A.2d 303 (1983), *rev'd*, _ N.J. _ (1985).

99. Organic brain syndrome is manifested by disorientation, intellectual and memory impairment and unstable emotional response. 1 SCHMIDT'S ATTORNEYS' DICTIONARY OF MEDICINE B-99 (17th ed. 1984). It is not the same as senile dementia, which is "[a] chronic brain disorder caused by organic (structural) changes, associated with old age." 3 *id.* at S-65.

100. In re Conroy, 188 N.J. Super. 523, 524, 457 A.2d 1232, 1233 (1983).

101. *Conroy*, 190 N.J. Super. at 456, 464 A.2d at 306.

102. *Id.*

103. *Id.* at 459, 464 A.2d at 309.

was determinative.[104] She was a substantially different type of patient from the asleep, vegetative Quinlan. The court would, however, more likely have allowed termination of treatment had Conroy been incurable and terminally ill, brain dead, comatose or vegetative.

The court pointed out that withholding artificial feeding under Conroy's circumstances would violate general ethical precepts. In reviewing both sides of the ethical debate, the court noted, "[t]here is substantial disagreement among ethicists whether the provision of food and water should ever be considered extraordinary treatment. . . . To some, the natural and ordinary quality of feeding dictates that it should never be withdrawn."[105] U.S. Surgeon General C. Everett Koop holds a similar view: "Withholding fluids or nourishment at any time is an immoral act."[106] Others feel that if the patient is hopeless the "burden of continued feeding is disproportionate to the benefit it will effect."[107] The appeals court expressly declined to resolve that particular issue, however, and the New Jersey Supreme Court decision in early 1985 provided specific guidelines which help to clarify the issue.

After discussing general ethical concepts, the *Conroy* appellate court then looked to the medical ethics involved. The Hippocratic Oath provides that the physician's main obligation is never to harm anyone.[108] The *Conroy* court was convinced that removing the feeding tube would violate medical ethics as well as general ethics, since active euthanasia has always been considered unethical.[109] In Conroy's situation, since she was not comatose, the appeals court felt that nourishment was an essential element of ordinary care which her physicians were ethically obligated to provide.[110]

The appeals court concluded that removing the feeding tube under Conroy's circumstances amounted to active euthanasia rather than the generally accepted passive euthanasia. The court was concerned that Conroy would die from dehydration and starvation rather than from

104. *Id.* at 460, 464 A.2d at 310.

105. *Id.* at 463, 464 A.2d at 313.

106. Tifft, *Debate on the Boundary of Life*, TIME, April 11, 1983 at 68, 69.

107. *Conroy*, 190 N.J. Super. at 463, 464 A.2d at 313.

108. The Hippocratic Oath, the ethical guide of the medical profession, states: "I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death. . . ." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY 715 (25th ed. 1974).

109. *Conroy*, 190 N.J. Super. at 464, 464 A.2d at 314.

110. *Id.*

her existing medical condition.[111] The New Jersey Supreme Court recently reversed the appellate court and clarified the issue so that families and physicians can have some reassurance that their decisions will not result in criminal or civil liability.

IV. Proposals

The *Barber* decision in California was an important step in clarifying the law on terminating artificial feeding. When the New Jersey Supreme Court decided the issue in *Conroy* it provided needed guidance to families and physicians.[112] By reversing the appellate court's decision, the New Jersey Supreme Court now allows life-sustaining treatment to be withdrawn or withheld when it is clear that the patient would have refused the treatment. Since there is so little legal precedent in this narrow body of case law, many patients in other jurisdictions will be affected by the legal implications of this decision.

The crux of the problem lies in allowing courts to establish general standards for all patients, when, arguably decisions should be made based on facts unique to each case, preferably within the patient-physician-family unit. Medical intervention is normally allowed when it will improve the patient's well-being, but the benefits and burdens such treatment will afford must be judged depending on the individual patient's values and goals, and not on a court's holding that establishes as a matter of law that artificial feeding always provides a substantial benefit.[113]

Allowing treatment to be stopped when the patient is unlikely to gain any medical benefit from continued treatment is a less restrictive and more satisfactory legal standard.[114] A treatment appropriate for most patients may be unsuitable in an individual case where it imposes unbearable burdens.[115] Courts should not be relied on to make actual treatment decisions. This often turns out to be the case when there are misunderstandings about what procedures are correct. Since the judicial route tends to be time-consuming and costly these medical decisions should remain the responsibility of physicians and family. It should be made clear that medical treatment should be judged by

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111. *Id.* at 465, 464 A.2d at 315.
112. *Id.* at 456, 464 A.2d at 306.
113. *Id.* at 478, 464 A.2d at 314.
114. *Id.* at 466, 464 A.2d at 310.
115. *See* Brief for Amicus Curiae *supra* note 75, at 21.

whether a particular patient will benefit from it.

Medical decision-making often involves caregivers and surrogates acting on behalf of incapacitated patients. Collaboration between attending physician and family, in advancing the patient's best interests, will eliminate the risks of self-interest and superficiality which sometimes occur. If a decision is made based on full information and deliberation, carelessness and discriminatory behavior are less likely to occur.

Because recourse to courts as a routine matter is unduly cumbersome, institutional ethics committees can still play an important role in the decision-making process. These committees can review each case in a less expensive and more suitable setting. Institutional ethics committees can act more quickly than the courts; however, the committees may still refer to the courts when intractable disagreement occurs. Even when the committee refers the matter to the judicial process, the court should rely on the ethics committee's full report, enabling the court to make an informed decision which is less subject to error and less expensive. Of course, the court's decision should still be limited to a question of fact whether the treatment accomplishes a medical benefit.

The judiciary has proposed many suggestions and guidelines in the years since the landmark *Quinlan* decision. Because of these evolving legal and medical standards, attorneys and physicians need to be aware of legal precedent as it exists today. In many states only lower court opinions exist and often are in conflict with those of other jurisdictions.[116] Courts should address this pressing medico-legal problem by delegating responsibility to the patient-doctor-family unit.[117] Thus,

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116. D. MEYERS, MEDICO-LEGAL IMPLICATIONS OF DEATH AND DYING 5 (1981).

117. The American Medical Association Judicial Council believes that courts or legislatures may not provide the best forums for discussion of issues of euthanasia or terminal illness. It recommends the following standard:

> (1) The intentional termination of the life of one human being by another—mercy killing or euthanasia—is contrary to public policy, medical tradition, and the most fundamental measures of human value and worth.
> (2) The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family and/or his lawful representative, acting in the patient's best interest.
> (3) The advice and judgment of the physician or physicians involved should be readily available to the patient and/or his immediate family and/or his lawful representative in all such situations.

courts would be relieved from making life-and-death decisions more rationally left to the medical realm. The inconsistency of the various courts' approaches, understandable since euthanasia is such a complex issue, points out the necessity for allowing physicians, patients and families to use their own discretion in termination of treatment decisions.

If courts set forth principled standards, it would ensure that health care professionals and families would be responsible for acting according to the patient's desires, if known, otherwise in the patient's best interests. The courts should also substantially defer to careful decisions made in accordance with such standards.

Mary Stetson Lingerfeldt

> (4) No physician, other licensed health care providers, or hospital should be civilly or criminally liable for taking any action pursuant to these guidelines, nor should there be any criminal or civil penalties of any sort imposed for conduct pursuant to these guidelines.
> (5) Except as stated above, all matters not in the public domain relating to a patient's terminal illness are the private right of the patient and are protected from public scrutiny by the privacy and confidentiality of the physician-patient relationship.

Conroy, 190 N.J. Super. at 465, 464 A.2d at 315 (citing AMERICAN MEDICAL ASS'N JUDICIAL COUNCIL, OPINIONS AND REPORTS 5.17 (1979)).