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## Encouragement of Empathy: Just Decision making for Incompetent Terminal Patients

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THE ENCOURAGEMENT OF EMPATHY: JUST DECISIONMAKING FOR  
INCOMPETENT TERMINAL PATIENTS

MICHELLE L. OXMAN\*

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As modern technology has given the medical profession the ability to sustain life for increasing periods of time at decreasing levels of functioning, there has been increasing recognition of a "right to die".<sup>1</sup> Appellate decisions<sup>2</sup> and living will statutes<sup>3</sup> have clearly established the right of a competent terminal patient to refuse life-sustaining treatment. Several states have adopted statutes which expressly permit an individual to appoint a proxy to make treatment decisions<sup>4</sup>.

Some patients requiring life-sustaining treatment become incompetent without having executed a living will or appointing a proxy decisionmaker. When this occurs, a surrogate decisionmaker must decide whether to initiate, continue, withhold, or withdraw life-sustaining treatment.

The development of legal rules governing the termination of life-sustaining treatment for incompetent patients involves the following questions: (1) the identity of the surrogate decisionmaker, (2) the standards governing that decision and (3) the appropriate procedural constraints on the exercise of the decisionmaking power. Courts that have addressed this issue have often failed to separate these three questions. Some decisions have ignored the distinction between making such decisions for oneself, as competent patients do, and having the decision made for one by another, as occurs with incompetent patients.<sup>5</sup> Further, regardless of the standard applied, some courts may have been influenced by factors not explicitly articulated in the decision and which are ethically or politically inappropriate.

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<sup>1</sup> See generally President's Comm'n for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment: A Report on Ethical, Medical, and Legal Issues in Treatment Decisions* (U.S. Gov't Printing Office, Mar. 1983) [hereinafter *Deciding to Forego*]; Hirsch, *Treatment Decisions for Terminal Patients*, 33 MED. TRIAL TECH. Q. 140 (1986); Merritt, *Equality for the Elderly Incompetent: A Proposal for Dignified Death*, 39 STAN. L. REV. 689 (1987); Vitiello, *Louisiana's Natural Death Act and Dilemmas in Medical Ethics*, 46 LA. L. REV. 259 (1985); Note, *Can A "Life Advocate" Impair the Constitutional Right to Reject Life-Prolonging Medical Treatment? In re Jobes*, 17 CUMB. L. REV. 553 (1987); Note, *In re Conroy: Self-Determination: Extending the Right to Die*, 2 J. OF CONTEMP. HEALTH LAW & POLY 351 (1986); Note, *Removal of a Nutrient Feeding Tube and the Need for a Living Will*, 3 J. OF CONTEMP. HEALTH LAW & POLY 253 (1987); Note, *John F. Kennedy Memorial Hospital, Inc. v. Bludworth: Removing Courts from the Decision to Terminate Life Support Systems*, 60 NOTRE DAME L. REV. 122 (1984); Note, *In re Storar: Euthanasia for Incompetent Patients, A Proposed Model*, 3 PACE L. REV. 351 (1983); Note, *The Right to Die in New Jersey: Another Plea for Legislation*, 18 RUTGERS L. J. 235 (1986).

<sup>2</sup> See, e.g., *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986); *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984), *appeal after remand*, 184 Cal. App. 3d 97, 228 Cal. Rptr. 847 (1986); *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 482 A.2d 713 (1984); *John F. Kennedy Memorial Hosp. v. Bludworth*, 452 So. 2d 921 (Fla. 1984); *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980); *In re Gardner*, 534 A.2d 947 (Me. 1987); *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977); *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980); *In re Farrell*, 108 N.J. 335, 529 A.2d 404 (1987); *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976); *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); *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1, 426 N.E.2d 809 (C.P. 1980); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983) (Washington later modified the law set forth in *Colyer* in *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984)).

<sup>3</sup> Forty states and the District of Columbia have enacted living will legislation in an effort to assure that the wishes of competent patients to discontinue treatment are honored. Alabama Natural Death Act, ALA. CODE §§ 22-8A-1 to 8A-10 (1984); Alaska Rights of the Terminally Ill Act, ALASKA STAT. §§ 18.12.010 to .100 (Supp. 1986); Arizona Medical Treatment Decision Act, ARIZ. REV. STAT. ANN. §§ 36-3201 to 3210 (1986); Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, ARK. STAT. ANN. §§ 20-17-201 to 218 (1987); California Natural Death Act, CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1988); Colorado Medical Treatment Decision Act, COLO. REV. STAT. §§ 15-18-101 to -113 (1987); Connecticut Removal of Life Support Systems Act, CONN. GEN. STAT. §§ 19a-570 to 19a-575 (Supp. 1988); Delaware Death with Dignity Act, DEL. CODE ANN. tit. 16, §§ 2501-2508 (1983); District of Columbia Natural Death Act of 1981, D.C. CODE ANN. §§ 6-2421 to -2430 (Supp. 1988); Florida Life-Prolonging Procedure Act, FLA. STAT. §§ 765.01 to 765.15 (1989); Georgia Living Wills Act, GA. CODE ANN. §§ 31-32-1 to -12 (1985 & Supp. 1989); Hawaii Medical Treatment Decisions Act, HAW. REV. STAT. §§ 327D-1 to -27 (Supp. 1988); Idaho Natural Death Act, IDAHO CODE §§ 39-4501 to -4508 (1985 & Supp. 1989); Illinois Living Will Act, ILL. REV. STAT. ch. 110 1/2, paras. 701 to 710 (1987 & Supp. 1988); Indiana Living Wills and Life-Prolonging Procedures Act, IND. CODE ANN. §§ 16-8-11-1 to 16-8-11-22 (Supp. 1988); Iowa Life-Sustaining Procedures Act, IOWA CODE ANN. §§ 144A.1 to 144A.11 (West 1988); Kansas Natural Death Act, KAN. STAT. ANN. §§ 65-28,101 to 28,109 (1985); Louisiana Declarations Concerning Life-Sustaining Procedures Act, LA. REV. STAT. ANN. §§ 40:1299.58.1 to 40:1299.58.10 (Supp. 1988); Maine Living Wills Act, ME. REV. STAT. ANN. tit. 22, §§ 2921 to 2934 (Supp. 1988); Maryland Life-Sustaining Procedures Act, MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (Supp. 1988); Adult Health Care Decisions Act, ch.

The question of the procedural limitations upon the decisionmaking power of the surrogate must be treated separately<sup>6</sup> from the substantive standards that govern the decision. This Article examines the substantive standards that have been enunciated by the courts and legislatures and proposes a revised standard.

3, 1989 Minn. Sess. Law Serv. 3 (West) (effective Aug. 1, 1989); Mississippi Withdrawal of Life-saving Mechanisms Act, MISS. CODE ANN. §§ 41-41-101 to -121 (Supp. 1988); Missouri Life Support Declarations Act, MO. REV. STAT. §§ 459.010 to .055 (Supp. 1988); Montana Living Will Act, MONT. CODE ANN. §§ 50-9-101 to -206 (1987); Nevada Withholding or Withdrawal of Life Sustaining Procedures Act, NEV. REV. STAT. §§ 449.540 to .690 (1986 & Supp. 1988); New Hampshire Terminal Care Document Act, N.H. REV. STAT. ANN. §§ 137-H:1-16 (Supp. 1988); New Mexico Right to Die Act, N.M. STAT. ANN. §§ 24-7-1 to -10 (1981 & Supp. 1985); North Carolina Right to Natural Death Act, N.C. GEN. STAT. §§ 90-320 to -323 (1988); Act of Apr. 12, 1989, 1989 N.D. Laws (H.B. 1481) (effective July 1, 1989); Oklahoma Natural Death Act, OKLA. STAT. ANN. tit. 63, §§ 3101 to 3111 (Supp. 1988); Oregon Rights with Respect to Terminal Illness Act, OR. REV. STAT. §§ 97.050 to -.090 (1984 & Supp. 1988); South Carolina Death with Dignity Act, S.C. CODE ANN. §§ 44-77-10 to -160 (Supp. 1987); Tennessee Right To Natural Death Act, TENN. CODE ANN. §§ 32-11-101 to -110 (Supp. 1988); Texas Natural Death Act, TEX. REV. CIV. STAT. ANN. art. 4590(h) (Supp. 1988); Utah Personal Choice and Living Will Act, UTAH CODE ANN. §§ 75-2-1101 to -1118 (1985); Vermont Terminal Care Document Act, VT. STAT. ANN. tit. 18, §§ 5251 to 5262 (1988); Virginia Natural Death Act, VA. CODE §§ 54.1-2981 to 54.1-2992 (1988); Washington Natural Death Act, WASH. REV. CODE ANN. §§ 70.122.010 to -.122.905 (Supp. 1988); West Virginia Natural Death Act, W. VA. CODE §§ 16-301 to -10 (1985); Wisconsin Natural Death Act, WISC. STAT. ANN. §§ 154.01 to -.15 (Supp. 1988); Wyoming Living Will Act, WYO. STAT. §§ 35-22-101 to -109 (1987).

For a review and analysis of living will legislation, see SOCIETY FOR THE RIGHT TO DIE, HANDBOOK OF LIVING WILL LAWS (1987).

<sup>4</sup> Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, ARK. STAT. ANN. § 20-17-202 (1987); California Durable Power of Attorney for Health Care Act, CAL. CIVIL CODE §§ 2430 to 2444, 2500 (Supp. 1988); Delaware Death with Dignity Act, DEL. CODE ANN. tit. 16, § 2502 (1983); Florida Life-Prolonging Procedure Act, FLA. STAT. §§ 765.01 to 765.15 (1987); Idaho Natural Death Act, IDAHO CODE §§ 39-4502 to 39-4506 (Supp. 1988); Illinois Power of Attorney for Health Care Law, ILL. REV. STAT. ch. 110 1/2, §§ 804-1 to 804-12 (1987 & Supp. 1988); Nevada Durable Power of Attorney for Health Care Act, NEV. REV. STAT. ANN. §§ 449.800 to 449.860 (Supp. 1988); Pennsylvania Uniform Durable Power of Attorney Act, 20 PA. CONS. STAT. §§ 5601 to 5607 (Supp. 1988); Texas Natural Death Act, TEX. REV. CIV. STAT. ANN. art. 4590(h)(3)(e) (Supp. 1988); Utah Personal Choice and Living Will Act, UTAH CODE ANN. § 75-2-1106 (1985); Vermont Durable Power of Attorney for Health Care Act, VT. STAT. ANN. tit. 14 §§ 3452 to 3463 (1987); Virginia Natural Death Act, VA. CODE ANN. §§ 54.1-2984 (1988).

The appointment of a proxy in the patient's advance directive has been approved in appellate decisions. See *Bludworth*, 452 So. 2d 921 (Fla. 1984); *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987).

<sup>5</sup> See *In re Torres*, 357 N.W.2d 332 (Minn. 1984); *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372 (1984); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983).

<sup>6</sup> Until *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. banc 1988), cert. granted, 109 S. Ct. 3240 (1989) (argued Dec. 6, 1989, summarized in 58 U.S.L.W. 3395), the consensus among appellate courts which had decided the question was that the guardian of a patient who is permanently unconscious, either comatose or in a persistent vegetative state without any reasonable hope for a return to a cognitive, sapient state, may direct the removal of a respirator without seeking court ap-

## I. THE RIGHT TO REFUSE TREATMENT

There is consensus among courts and legislatures that a competent patient who is terminally ill may decide to forego life-sustaining treatment, even though the choice will hasten the patient's death.<sup>7</sup> This right is derived from the common law right of all persons to bodily integrity and self-determination.<sup>8</sup> Many of the cases have grounded the right to refuse treatment in the constitutional right of privacy, which guarantees freedom from government interference in certain personal decisions.<sup>9</sup> Respect for the autonomy of the individual underlies the common law and constitutional doctrines and the living will legislation.

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proval. See, e.g., *In re Quinlan*, 70 N.J. at 41-42, 355 A.2d at 665 (concurrence of institutional ethics committee required as to prognosis); *Rasmussen*, 154 Ariz. at 220, 741 P.2d at 688; *In re Hamlin*, 102 Wash. 2d at 818-19, 689 P.2d at 1377-78; *In re Colyer*, 99 Wash. 2d at 127-30, 660 P.2d at 746-47. There appeared to be general agreement among courts that had addressed the termination of life-support that it should be permitted without court approval when the patient is in a persistent vegetative state and is surrounded by close family who are unanimously of the opinion that the patient would so choose. *Bludworth*, 452 So. 2d at 926; *In re Spring*, 380 Mass. 629, 405 N.E.2d 115; *In re Jobes*, 108 N.J. 394, 529 A.2d 434; *In re Quinlan*, 70 N.J. 10, 355 A.2d 647; *Leach*, 68 Ohio Misc. 1, 426 N.E.2d 809; *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738. The *Rasmussen* court specifically reserved the question of the right of close family members to terminate life support without the appointment of a guardian. 154 Ariz. at 220, 741 P.2d at 687. However, the *Cruzan* court rejected this principle. 760 S.W.2d at 426-27.

Some of the recent statutes permit decisionmaking by certain family members with few or no procedural constraints. North Carolina Natural Death Act, N.C. GEN. STAT. §§ 90-320 to -322 (1988) (confirmation by two physicians of diagnosis, no other procedural protection); Oregon Rights with Respect to Terminal Illness Act, OR. REV. STAT. §§ 97.050 to -.090 (1987) (physician may decide alone if no family member available).

Others fail to address the issue of the factors that may or must be considered by the surrogate decisionmaker. Louisiana Life-sustaining Procedures Act, LA. REV. STAT. ANN. § 40:1299.58.1 to -.58.10 (West Supp. 1989); North Carolina Natural Death Act, N.C. GEN. STAT. §§ 90-320 to -323 (1988); Oregon Rights with Respect to Terminal Illness Act, OR. REV. STAT. §§ 97.050 to -.090 (1987); Natural Death Act of Virginia, VA. CODE ANN. §§ 54.1-2981 to -2992 (1988).

<sup>7</sup> *Rasmussen*, 154 Ariz. 207, 741 P.2d 674; *In re Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988); *Bouvia*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297; *Bartling*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220; *Foody*, 40 Conn. Supp. 127, 482 A.2d 713; *Severns v. Wilmington Medical Center*, 421 A.2d 1334 (Del. 1980); *Bludworth*, 452 So. 2d 921 (Fla.); *Satz*, 362 So. 2d 160 (Fla. App.); *In re Gardner*, 534 A.2d 947 (Me.); *Brophy*, 398 Mass. 417, 497 N.E.2d 626; *In re Spring*, 380 Mass. 629, 405 N.E.2d 115; *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417; *In re Hier*, 18 Mass. App. 200, 464 N.E.2d 959 (1984); *In re Torres*, 357 N.W.2d 332 (Minn.); *In re Farrell*, 108 N.J. 335, 529 A.2d 404; *In re Conroy*, 98 N.J. 321, 486 A.2d 1209; *In re Quinlan*, 70 N.J. 10, 355 A.2d 647; *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64; *Delio v. Westchester County Medical Center*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (1987); *In re Grant*, 109 Wash. 2d 545, 747 P.2d 445 (1987); *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372; *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738.

<sup>8</sup> See cases cited in note 7.

<sup>9</sup> *Rasmussen*, 154 Ariz. at 215, 741 P.2d at 682; *In re Spring*, 380 Mass. at 634, 405 N.E.2d at 119; *Saikewicz*, 373 Mass. at 739, 370 N.E.2d at 424; *In re Torres*,

The courts have balanced the patient's right to privacy in personal decisionmaking against four potentially countervailing state interests: the preservation of life, the prevention of suicide, the maintenance of the integrity of the medical profession, and the interests of third parties.<sup>10</sup> The state's interest in preserving the life of the patient is usually said to diminish with the prognosis of the patient and the intrusiveness of the treatment.<sup>11</sup> In fact, appellate decisions have rarely held that the state's interest in preserving the life of a terminal patient outweighed the patient's interest in avoiding the treatment unless the treatment offered some hope of cure, or at a minimum, restoration of a prior level of functioning.<sup>12</sup>

The state's interest in the prevention of suicide is actually one aspect of the interest in preserving life generally. However, courts that have treated this issue separately regard the decision of a patient to refuse life-sustaining treatment as a death by natural causes and not a suicide, because the patient's underlying condition actually causes the death.<sup>13</sup>

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357 N.W.2d at 340 (Minn.) (right also based on statutory authority); *In re Quinlan*, 70 N.J. at 40, 355 A.2d at 663; *Leach*, 68 Ohio Misc. at 9, 426 N.E.2d at 814; *In re Colyer*, 99 Wash. 2d at 121-22, 660 P.2d at 742; cf. *In re Conroy*, 98 N.J. at 348, 486 A.2d at 1222-23 (refused to decide whether constitutional right of privacy applied to guardian's decision whether to terminate artificial feeding of a conscious, elderly, incompetent, nursing home resident. Right considered sufficiently well grounded in common law right to self-determination).

The right to refuse treatment has also been grounded in state constitutional privacy rights. See *Bartling*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220; *In re Barry*, 445 So. 2d 365 (Fla. App. 1984); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738.

<sup>10</sup> *Rasmussen*, 154 Ariz. at 216, 741 P.2d at 683; *Bartling*, 163 Cal. App. 3d at 195, 209 Cal. Rptr. at 225; *Foody*, 40 Conn. Supp. at —, 482 A.2d at 718; *Brophy*, 398 Mass. at 432, 497 N.E.2d at 634; *Saikewicz*, 373 Mass. at 741, 370 N.E.2d at 425; *In re Torres*, 357 N.W.2d at 339 (Minn.); *In re Conroy*, 98 N.J. at 348-49, 486 A.2d at 1223; *Leach*, 68 Ohio Misc. at 9, 426 N.E.2d at 814; *In re Colyer*, 99 Wash. 2d at 122, 660 P.2d at 743; *In re Grant*, 109 Wash. 2d at 556, 747 P.2d at 451.

<sup>11</sup> *Brophy*, 398 Mass. at 433, 497 N.E.2d at 635; *Saikewicz*, 373 Mass. at 742, 370 N.E.2d at 425; *In re Quinlan*, 70 N.J. at 41, 355 A.2d at 664; *In re Colyer*, 99 Wash. 2d at 122-23, 660 P.2d at 743.

<sup>12</sup> *In re Georgetown College*, 331 F.2d 1000 (D.C. Cir.), cert. denied, 377 U.S. 978 (1964) (blood transfusions would save patient's life and preserve status quo); *John F. Kennedy Memorial Hosp. v. Heston*, 58 N.J. 576, 279 A.2d 670 (1971) (blood transfusions would save adult patient's life); *In re Storar*, 52 N.Y.2d at 375-76, 420 N.E.2d at 73, 438 N.Y.S.2d at 275-76. But see *Cruzan*, 760 S.W.2d 408 (Mo.) (state's strong interest in preserving life of patient outweighed any right to refuse treatment when treatment was not burdensome to patient because she was in a persistent vegetative state); *In re Westchester County Medical Center*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988) (common law right of self-determination in treatment decisions was personal to the patient and could not be exercised by family absent clear and convincing evidence that patient had made a settled and firm commitment to terminate treatment under similar circumstances).

<sup>13</sup> See, e.g., *Bartling*, 163 Cal. App. 3d at 196, 209 Cal. Rptr. at 225; *Satz*, 362 So. 2d at 162 (Fla. App.); *Brophy*, 398 Mass. at 439, 497 N.E.2d at 638; *In re Farrell*, 108 N.J. at 350, 529 A.2d at 411; *In re Colyer*, 99 Wash. 2d at 138, 660 P.2d at 743.

Therefore, the state interest is not contravened by the decision to refuse life support.<sup>14</sup>

The courts have reasoned that the interest in maintaining the integrity of the medical profession has not been implicated in decisions to withhold or withdraw life support because the ethics of the medical profession do not require treatment in these cases.<sup>15</sup> One later case based its decision upon the prevailing medical ethic that the continuation of life-sustaining treatment is contrary to the ethics of the profession when there is no hope for the patient's recovery.<sup>16</sup>

Finally, the interests of third parties have rarely been held to be sufficient to outweigh the choice of a competent, terminal patient who chooses to forego artificial life support, as distinguished from life-saving treatment such as blood transfusions.<sup>17</sup> In the one case involving both artificial life support and the interests of the patient's minor children, the interests of the patient's children were adequately protected by the ability of the surviving parent to raise them, and the patient herself had considered the strain that her illness caused her children in deciding to discontinue the use of the respirator.<sup>18</sup>

There is disagreement among courts and legislatures about the permissibility of terminating artificial feeding. Some authorities view artificial feeding methods through nasogastric, gastrostomy, or jejunostomy tubes and intravenous injections, as strictly medical procedures.<sup>19</sup> Others forbid the withdrawal of artificial nutrition and hydration but allow the

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<sup>14</sup> *Bartling*, 163 Cal. App. 3d at 196, 203 Cal. Rptr. at 225; *Satz*, 362 So. 2d at 162 (Fla. App.); *Brophy*, 398 Mass. at 439, 497 N.E.2d at 638; *In re Conroy*, 98 N.J. at 350-51, 486 A.2d at 1224; *In re Quinlan*, 70 N.J. at 43, 355 A.2d at 665; *In re Colyer*, 99 Wash. 2d at 123, 660 P.2d at 743.

<sup>15</sup> *Rasmussen*, 154 Ariz. at 217-18, 741 P.2d at 684-85; *Saikewicz*, 373 Mass. at 744, 370 N.E.2d at 426; *Leach*, 68 Ohio Misc. at 10, 426 N.E.2d at 814; *In re Conroy*, 98 N.J. at 351-52, 486 A.2d at 1224-25; *In re Colyer*, 99 Wash. 2d at 123, 660 P.2d at 743-44; see also *In re Quinlan*, 70 N.J. at 45-48, 355 A.2d at 666-67 (court discussed at length the change, inconsistency, and disagreement within the medical profession as to the ethical requirements regarding the treatment of permanently unconscious patients).

<sup>16</sup> *Brophy*, 398 Mass. at 439-40, 497 N.E.2d at 638.

<sup>17</sup> Most cases in which patients have been denied the right to refuse life-saving treatment involved the refusal of blood transfusions for religious reasons. For example, the *Georgetown* court ordered the transfusions when it was shown that the patient had young dependent children and that he could accept the transfusions if ordered by the court, for then he would not have chosen to disobey the religious commandment. 331 F.2d at 1008; see also *Heston*, 58 N.J. 576, 279 A.2d 670. However, the interest of the state in maintaining prison security was held to outweigh the interest of a prisoner-patient in exercising his right to refuse dialysis in *Commissioner of Corrections v. Myers*, 379 Mass. 255, 261, 399 N.E.2d 452, 456 (1979).

<sup>18</sup> *In re Farrell*, 108 N.J. at 343, 529 A.2d at 412-13.

<sup>19</sup> *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1016-17, 195 Cal. Rptr. 484, 490 (1983); *Corbett v. D'Alessandro*, 487 So. 2d 368, 371 (Fla. App. 1986); *In re Gardner*, 534 A.2d at 954-55 (Me.); *Brophy*, 398 Mass. at 437-38, 497 N.E.2d at 637; *In re Conroy*, 98 N.J. at 372-74, 486 A.2d at 1236-37; *Delio*, 129 A.D.2d 1, 18, 516 N.Y.S.2d 677, 689; cf. *In re Drabick*, 200 Cal. App. 3d 185, 245 Cal. Rptr. 840.

discontinuation of other forms of life support.<sup>20</sup> A number of state statutes specifically prohibit the termination of artificial feeding or hydration.<sup>21</sup>

Logically, there may be little difference between discontinuing a machine that maintains the patient's breathing and discontinuing artificial nutrition and hydration.<sup>22</sup> However, discontinuing artificial nutrition results in death by starvation and thirst over a period of days or weeks, as contrasted with the almost immediate death produced by discontinuing a respirator.

The increased length of time that it would take for the patient to die from starvation and dehydration caused by the withdrawal of artificial feeding has influenced the opinion of some judges.<sup>23</sup> The emotional ramifications of denying food and water to a seriously ill person have also affected judicial opinions and legislation.<sup>24</sup> Clearly, this is a question about which there is no consensus among courts and legislatures.

## II. THE SUBSTITUTED JUDGMENT STANDARD

Most courts that have considered the question whether another person can refuse life-sustaining treatment on behalf of an incompetent patient have viewed the issue as involving the exercise by a surrogate of the

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<sup>20</sup> *Cruzan*, 760 S.W.2d 408, 423 (Mo.); ARIZ. REV. STAT. ANN. § 36-3201(f) (1986); COLO. REV. STAT. § 15-18-103(7) (1987); CONN. GEN. STAT. § 19a 570(1) (Supp. 1988); GA. CODE ANN. § 31-32-2(5)(A) (1985 & Supp. 1988); HAW. REV. STAT. § 327D-2 (Supp. 1988); ILL. REV. STAT. ch. 110 1/2, § 702(d) (1987); IND. CODE § 16-8-11-4 (Supp. 1987); IOWA CODE § 144A.2(5) (1987); ME. REV. STAT. ANN. tit. 22, § 2921(4) (Supp. 1988); MO. REV. STAT. § 459.010(3) (Supp. 1988); N.H. REV. STAT. ANN. § 137-H:2(II) (Supp. 1988); OKLA. STAT. ANN. tit. 63, §§ 3102(4), 3080.1 to 3080.5 (West Supp. 1988) (Hydration and Nutrition for Incompetent Patients Act); S.C. CODE ANN. § 44-77-20(b) (Law. Co-op. Supp. 1987); TENN. CODE ANN. § 32-11-103(4), (5) (Supp. 1988); WIS. STAT. ANN. § 154.01(5)(a)(b) (Supp. 1988).

<sup>21</sup> *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-3201(f) (1986); COLO. REV. STAT. § 15-18-103(7) (1987); CONN. GEN. STAT. § 19a 570(1) (Supp. 1988); GA. CODE ANN. § 31-32-2(5) (A) (1985 & Supp. 1988); HAW. REV. STAT. § 327D-2 (Supp. 1988); ILL. REV. STAT. ch. 110 1/2, § 702(d) (1987); IND. CODE § 16-8-11-4 (Supp. 1987); IOWA CODE § 144A.2(5) (1987); ME. REV. STAT. ANN. tit. 22, § 2921(4) (Supp. 1988); MO. REV. STAT. § 459.010(3) (Supp. 1988); N.H. REV. STAT. ANN. § 137-H:2(II) (Supp. 1988); OKLA. STAT. ANN. tit. 63, §§ 3102(4), 3080.1 to 3080.5 (West Supp. 1988); S.C. CODE ANN. § 44-77-20(b) (Law. Co-op. Supp. 1987); TENN. CODE ANN. § 32-11-103(4), (5) (Supp. 1988); WIS. STAT. ANN. § 154.01(5)(a)(b) (Supp. 1988).

<sup>22</sup> *Cf. Leach*, 68 Ohio Misc. at 12-13, 426 N.E.2d at 816 (allowing withdrawal of respirator, but not of nasogastric feeding tube).

<sup>23</sup> *Brophy*, 398 Mass. at 444, 497 N.E.2d at 641 (Lynch, J., dissenting) (includes graphic description of the process of death by starvation and dehydration); *In re Peter*, 108 N.J. at 390, 529 A.2d at 432 (O'Hern, J., dissenting); *Delio*, 129 A.D.2d 1, 516 N.Y.S.2d 677.

<sup>24</sup> *In re Conroy*, 98 N.J. at 372-73, 486 A.2d at 1236 (considered and rejected the emotional symbolism of food in deciding that artificial feeding and hydration should not be distinguished from other forms of life-sustaining treatment); *In re Grant*, 109 Wash. 2d at 570-71, 747 P.2d at 458 (Anderson, J., dissenting); *see also In re Peter*, 108 N.J. at 390, 529 A.2d at 432.



incompetent patient's right to refuse treatment.<sup>25</sup> Having so framed the issue, the courts initially permitted surrogate refusals of treatment under the substituted judgment doctrine. This doctrine requires the surrogate decisionmaker to make the decision that the patient would have made if competent to decide.<sup>26</sup> The surrogate decisionmaker must consider the factors that the patient would consider, including the patient's present and future incompetence.<sup>27</sup>

The courts have reasoned that application of the substituted judgment doctrine is required in order to demonstrate the respect of the law for the dignity and autonomy of the incompetent patient.<sup>28</sup> Yet, this reasoning ignores the differences between the situations of competent patients and those of incompetent patients.<sup>29</sup> Although a competent patient who refuses treatment may be exercising his or her autonomy and self-determination, the danger exists that the surrogate making a decision for an incompetent patient may be implementing his or her own values rather than those of the patient. The surrogate may be motivated by dismay at the disability of the patient or fear of financial ruin, rather than a commitment to care for the patient as he or she would do if competent. Even a surrogate acting in the utmost good faith can, at best, make an educated guess as to the choice that the patient would have made.

The substituted judgment doctrine was initially applied to incompetent patients whether or not they had any prior history of competence.<sup>30</sup> Where the patient has never been competent to make treatment decisions, however, it is impossible to determine what decision the patient would have made if competent. For example, in *In re Saikewicz*,<sup>31</sup> the court

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<sup>25</sup> *Rasmussen*, 154 Ariz. at 219, 741 P.2d at 686; *Goody*, 40 Conn. Supp. at 127, 482 A.2d at 720; *Brophy*, 398 Mass. at 430-31, 497 N.E.2d at 633-34; *In re Spring*, 380 Mass. at 634, 405 N.E.2d at 119; *Saikewicz*, 373 Mass. at 745, 370 N.E.2d at 430; *In re Conroy*, 98 N.J. at 356, 486 A.2d at 1227; *In re Quinlan*, 70 N.J. at 41-42, 355 A.2d at 664; *In re Grant*, 109 Wash. 2d at 567, 747 P.2d at 457.

<sup>26</sup> *Bludworth*, 452 So. 2d at 926 (Fla.); *Brophy*, 398 Mass. at 433, 497 N.E.2d at 634-35; *In re Spring*, 380 Mass. at 634, 405 N.E.2d at 119; *Saikewicz*, 373 Mass. at 750-51, 370 N.E.2d at 431; *In re Jobes*, 108 N.J. at 404, 529 A.2d at 444; *In re Grant*, 109 Wash. 2d at 567, 747 P.2d at 456; *cf. In re Colyer*, 99 Wash. 2d at 131-32, 660 P.2d at 747-48. See also *Deciding to Forego*, *supra* note 1, at 132.

<sup>27</sup> *In re Spring*, 380 Mass. at 634, 405 N.E.2d at 119; *Saikewicz*, 373 Mass. at 752-53, 370 N.E.2d at 431; *In re Jobes*, 108 N.J. at 404, 529 A.2d at 444; *In re Quinlan*, 70 N.J. at 41, 355 A.2d at 664; *In re Colyer*, 99 Wash. 2d at 131-32, 660 P.2d at 747-48.

<sup>28</sup> *Saikewicz*, 373 Mass. at 746-47, 370 N.E.2d at 428-29; *In re Quinlan*, 70 N.J. at 41, 355 A.2d at 664; *In re Colyer*, 99 Wash. 2d at 128, 660 P.2d at 746.

<sup>29</sup> *In re Conroy*, 98 N.J. at 392-93, 486 A.2d at 1246-47 (Handler, J., concurring and dissenting); see also *In re Drabick*, 200 Cal. App. 3d at 208, 245 Cal. Rptr. at 854 (application of substituted judgment to implement a permanently unconscious patient's right to choose was described as a legal fiction). See generally *Dresser, Life, Death, and Incompetent Patients: Conceptual Infirmities and Hidden Values in the Law*, 28 ARIZ. L. REV. 373 (1986).

<sup>30</sup> See *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417.

<sup>31</sup> *Id.* Other authorities have rejected the application of the substituted judgment doctrine to the never-competent patient in favor of a standard requiring the surrogate to be governed by the best interests of the patient. *In re Storar* involved a profoundly retarded patient afflicted with bladder cancer. His mother sought to discontinue blood transfusions which caused him discomfort but im-

applied the substituted judgment test to decide whether to allow chemotherapy for a 67 year old leukemia patient who had been mentally retarded all his life. The court's attempt to consider the effect of the treatment as perceived by the patient was appropriate. Yet, the attribution of the court's values to the patient weakened the theoretical basis of the doctrine.

The substituted judgment doctrine has also been applied in cases where there was little or no evidence of the previously competent patient's wishes regarding life-sustaining treatment.<sup>32</sup> The reasoning in these cases is insufficiently protective of the interests of the patient. Arguably, the courts in these cases have allowed inappropriate considerations to influence their decisions.

In *In re Spring*,<sup>33</sup> the Massachusetts Supreme Court approved a decision to terminate dialysis of a conscious patient suffering from chronic organic brain syndrome. The court based its decision in part upon evidence of a close family relationship between the patient, his wife and adult son in its determination that their decision should be implemented.<sup>34</sup> Although there was evidence that the patient had previously been a robust, active man, there was no evidence of the patient's beliefs or preferences. The opinion explicitly relied upon the lack of evidence that financial considerations had played a role in the wife's determination of her husband's preferences.<sup>35</sup> However, the court's concern over testimony that the financial situation had deteriorated since the initial hearing was relegated to a footnote and did not change the ultimate decision.<sup>36</sup>

The trial judge had before him expert testimony that supported the decision to terminate treatment because under a subjective quality-of-

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proved his functioning. The New York Court of Appeals found it illogical to attempt to implement the self-determination of a patient who had never had the capacity to make medical decisions. 52 N.Y.2d at 370-73, 420 N.E.2d at 72-73, 438 N.Y.S.2d at 274-77. The New Jersey Supreme Court also rejected this approach in *dicta* in *In re Conroy*, 98 N.J. at 363, 486 A.2d at 1231. The President's Commission also rejected the use of the substituted judgment standard with respect to the never-competent patient. Deciding to Forego, *supra* note 1, at 133. See also D. WALTON, *ETHICS OF WITHDRAWAL OF LIFE SUPPORT SYSTEMS* 45-48 (1983) [hereinafter *ETHICS OF WITHDRAWAL*]; Buchanan, *The Limits of Proxy Decisionmaking for Incompetents*, 29 UCLA L. REV. 386, 392 (1981).

<sup>32</sup> See, e.g., *In re Spring*, 380 Mass. 629, 405 N.E.2d 115 (patient on kidney dialysis who had acquiesced in treatment while competent removed from dialysis based upon testimony of wife and son. In relying on this testimony, the court determined that the patient, if competent, would have chosen this option); *In re Hier*, 18 Mass. App. 200, 464 N.E.2d 959 (conscious patient with long history of severe mental illness repeatedly pulled out gastric tubes); *In re Torres*, 357 N.W.2d at 340 (Minn.) (comatose patient's respirator discontinued based in part upon the testimony of cousin and friend that he had refused to wear a pacemaker and that they did not believe he would want to be sustained in that condition); *In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (respirator-dependent comatose patient did not like doctors). See text accompanying notes 33 through 44, *infra*.

<sup>33</sup> 380 Mass. 629, 405 N.E.2d 115.

<sup>34</sup> *Id.* at 640, 405 N.E.2d at 122.

<sup>35</sup> *Id.*

<sup>36</sup> *Id.* at 640, 405 N.E.2d at 122, n.3.

life standard the patient was no longer a person worthy of care.<sup>37</sup> To base the treatment decision on such a consideration is, in essence, to denigrate the value of the lives of handicapped patients. That the Supreme Court made no mention of this testimony in its opinion gives one pause.

For the court to consider this opinion *sub silentio* is far worse than to consider it openly. Explicit discussion of the values which influence a court's decision at least opens the question of the appropriateness of those values to public debate. The omission of a definite rejection of this factor from the court's opinion diminishes the reliability of the stated reasoning.

The ruling in *In re Colyer*<sup>38</sup> also appears to have been based on insufficient evidence of the patient's intentions. The patient's family presented no evidence of the patient's actual beliefs or values other than her independence and dislike of doctors and hospitals. The husband's affidavit in support of the withdrawal of the respirator stated, "[i]t is very painful for me and Bertha's family to see her in her current condition."<sup>39</sup> The emotional distress that a loved one may feel upon viewing the patient is hardly justifies a decision to discontinue treatment. Yet, relying on the unanimity of the family, the *Colyer* court approved the withdrawal of the respirator a mere twenty-five days after the patient first became comatose.<sup>40</sup>

It appears that the courts applying the substituted judgment doctrine in these cases are in fact projecting their own values and beliefs upon the patient. This phenomenon appeared in its most extreme form in *In re Hier*.<sup>41</sup> This case involved a conscious ninety-two year old woman who had been a mental patient for fifty-seven years. The issue was whether the court could consent to surgery for the implantation of a gastrostomy tube to facilitate artificial feeding. The patient had repeatedly physically resisted attempts to insert or reinsert the tube. Emphasizing the intrusiveness of the treatment, the court considered the patient's resistance as "a plea for privacy and personal dignity . . . by a person . . . for whom life has little left to offer."<sup>42</sup> Yet, her mental condition rendered it unlikely

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<sup>37</sup> One of the physicians testified that in deciding that the dialysis should be discontinued, he considered "whether the patient is a *real person*, whether the person is happy to be alive, *whether other people around him or her are happy to have him alive*." G. Annas & L. Glantz, *Withholding and Withdrawing of Life-Sustaining Treatment for Elderly Incompetent Patients: A Review of Court Decisions and Legislative Approaches* in Philosophical, Legal, and Social Aspects of Surrogate Decisionmaking for Elderly Individuals, prepared for the Office of Technology Assessment 1, 21 (May 1987) [hereinafter *Surrogate Decisionmaking*] (quoting trial transcript) (emphasis added). This document is available from Nat'l Technical Information Serv., U.S. Dep't Commerce, 5285 Port Royal Road, Springfield, Va. 22161.

<sup>38</sup> 99 Wash. 2d 114, 660 P.2d 738.

<sup>39</sup> *Id.* at 117, 660 P.2d at 740.

<sup>40</sup> *Id.* at 117, 123, 660 P.2d at 740, 743.

<sup>41</sup> 18 Mass. App. 200, 464 N.E.2d 959. See also Justice Handler's opinions in *In re Conroy*, 98 N.J. at 398-99, 486 A.2d at 1245-46 (Handler, J., concurring and dissenting) and in *In re Jobes*, 108 N.J. at 449-50, 529 A.2d at 459 (Handler, J., concurring).

<sup>42</sup> 18 Mass. App. at 206, 464 N.E.2d at 965.

that she understood that without the artificial feeding, she would experience a painful death by starvation.

The Minnesota Supreme Court engaged in similar projection in *In re Torres*.<sup>43</sup> Here, there was little evidence of the patient's values and preferences other than his refusal to wear a pacemaker. The only relative who testified was neither the guardian nor the petitioner to terminate treatment. The hospital whose negligence caused the patient's coma sought to withdraw the respirator. Although the trial court was satisfied that the patient would have chosen to discontinue the respirator, the court does not appear to have been convinced. A substituted judgment analysis is subsumed in the discussion of the patient's best interests. The court noted that the patient "may well have wished to avoid '[t]he ultimate horror . . . the possibility of being maintained in limbo, in a sterile room, by machines controlled by strangers.'"<sup>44</sup>

The substituted judgment test fulfills its purpose to promote patient autonomy only when the surrogate decisionmaker knows the patient intimately. Only then can the surrogate have sufficient information concerning the patient's behavior, values, preferences, and personality to predict with confidence the choice that the patient would have made. When no one is so close to the patient, or when the patient has never had the capacity to make treatment decisions, the substituted judgment standard is inappropriate.

### III. THE BEST INTERESTS TEST

Some courts have recognized the fallacy inherent in the application of the substituted judgment test to patients whose preferences cannot be known.<sup>45</sup> In such situations, these courts have applied the best interests test.<sup>46</sup> Under this test, the surrogate may choose to terminate life-sustaining treatment if the discontinuation of treatment is in the patient's best interests.<sup>47</sup> The best interests test is said to be objective, based on the choice of most reasonable people in similar circumstances.<sup>48</sup> The test includes consideration of the patient's prognosis for recovery of functioning, the advantages and disadvantages to the patient of treatment, and

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<sup>43</sup> 357 N.W.2d 332 (Minn.).

<sup>44</sup> *Id.* at 340.

<sup>45</sup> See *In re Conroy*, 98 N.J. at 364, 486 A.2d at 1231; *In re Storar*, 52 N.Y.2d at 378-80, 420 N.E.2d at 72-73, 438 N.Y.S.2d at 274-75. See also *In re Drabick*, 200 Cal. App. 3d at 208, 245 Cal. Rptr. 840 at 854.

<sup>46</sup> See, e.g., *Rasmussen*, 154 Ariz. at 222, 741 P.2d at 689; *In re Storar*, 52 N.Y.2d at 380-81, 420 N.E.2d at 72-73, 438 N.Y.S.2d at 274-75; *In re Torres*, 357 N.W.2d at 339 (Minn.); *In re Hamlin*, 102 Wash. 2d at 815, 820, 689 P.2d at 1375-76, 1378. The best interests standard is typically applied in probate proceedings to determine the propriety of a guardian's decision for the ward. In fact, *Rasmussen*, *In re Torres*, and *In re Hamlin* all involved guardianship proceedings.

<sup>47</sup> See *Rasmussen*, 154 Ariz. at 222, 741 P.2d at 689; *In re Torres*, 357 N.W.2d at 337 (Minn.) (conservator may direct the discontinuation of life support if treatment no longer serves the patient's best interests); *In re Hamlin*, 102 Wash. 2d at 815, 820, 689 P.2d at 1375-76, 1378. See also *Deciding To Forego*, *supra* note 1, at 135.

<sup>48</sup> *Deciding To Forego*, *supra* note 1, at 134-35; *In re Hamlin*, 102 Wash. 2d at

the quality and extent of life sustained.<sup>49</sup> The test has occasionally been formulated as permitting termination of the continuation if treatment is no longer in the patient's best interests.<sup>50</sup>

The difference between these two formulations may seem merely semantic. However, it is the opinion of this author that to determine that it is in the best interests of a patient to terminate treatment is not the same as determining that the continuation of treatment no longer serves his or her interests.

Some writers conceive of the permanently comatose patient as lacking humanity because of the absence of cognition. They therefore regard these patients as having no interests in continuing treatment.<sup>51</sup> Others conceive of the permanently unconscious patient as having an interest in preserving life in order to preserve the possibility of returning to a cognitive, sapient state. However, the possibility of a return to cognition is minimal, and the severity of the probable physical and mental disabilities is extreme. Therefore, these authorities have not considered the continued provision of life support to the permanently unconscious patient to be in his or her best interests.<sup>52</sup>

#### IV. THE CONROY FORMULATION

The New Jersey Supreme Court attempted to refine both the substituted judgment standard and the best interests standard in *In re Conroy*.<sup>53</sup> That decision announced three possible tests to be applied, depending upon the availability of information about the values, beliefs, and preferences of the incompetent patient. The subjective test is to be applied where there is clear evidence of the patient's wishes. Under the subjective test, the decisionmaker may choose to terminate life-sustaining treatment if there is clear evidence that the patient would so choose.<sup>54</sup> The decisionmaker may consider any written directive executed by the patient,

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820, 689 P.2d at 1378. *But see In re Storar* in which the best interests standard was described as protecting the health and welfare of the ward, and in which the retarded ward was considered as a child. 52 N.Y.2d at 380-81, 420 N.E.2d at 73, 388 N.Y.S.2d at 275.

<sup>49</sup> *Rasmussen*, 154 Ariz. at 222, 741 P.2d at 689; *Deciding to Forego*, *supra* note 1, at 135; *cf. In re Torres*, 357 N.W.2d at 339, 340 (Minn.) (best interests did not require continuation of treatment where permanently unconscious patient had no chance of recovery and there was some evidence that he would not have wanted to continue treatment).

<sup>50</sup> *Deciding to Forego*, *supra* note 1, at 134; *In re Torres*, 357 N.W.2d at 339 (Minn.).

<sup>51</sup> *See generally* A. Buchanan & D. Brock, *Surrogate Decisionmaking for Elderly Individuals Who Are Incompetent or of Questionable Competence* in *Surrogate Decisionmaking*, *supra* note 37, at 84-86. For a discussion of this issue see Buchanan, *The Limits of Proxy Decisionmaking for Incompetents*, 29 UCLA L. REV. 386, 402-04 (1981).

<sup>52</sup> *In re Torres*, 357 N.W.2d at 338-39 (Minn.), quoting *Deciding to Forego*, *supra* note 1, at 181-83; *cf. Brophy*, 398 Mass. at 434-35, 497 N.E.2d at 636.

<sup>53</sup> 98 N.J. 321, 486 A.2d 1209.

<sup>54</sup> *Id.* at 360-61, 486 A.2d at 1229.

the patient's past behavior with respect to medical treatment, moral and religious beliefs, and any statements made in conversation regarding how he or she would wish to be treated in the event of terminal illness.<sup>55</sup> This test is essentially similar to the substituted judgment test, except that the court has stipulated that it is not to be applied where the evidence of the patient's desires is less than clear.<sup>56</sup>

*Conroy* requires the application of a limited objective test where there is some evidence of the patient's wishes, but not enough to justify the application of the subjective test.<sup>57</sup> Under this test, the surrogate may decide to terminate life-sustaining treatment where the benefits of the treatment are markedly outweighed by the burdens of life with treatment.<sup>58</sup> The decisionmaker may consider the patient's prognosis, level of functioning, level of pain, and the patient's potential for experiencing physical pleasure, emotional enjoyment, and intellectual satisfaction.<sup>59</sup> However, the decisionmaker may not consider the value of the patient's life to others.<sup>60</sup>

Where there is no evidence of the patient's wishes as to treatment, the surrogate's action is governed by the pure objective test.<sup>61</sup> This standard permits the termination of life-sustaining treatment only if the benefits of treatment are clearly and markedly outweighed by the burdens to the patient of life with treatment.<sup>62</sup> In examining the benefits and burdens to the patient, the decisionmaker may consider the patient's prognosis, level of functioning, and level of pain. Consistent with the limited objective test, the pure objective test requires that continued treatment produce such unavoidable, severe pain as to render its continuation inhumane before treatment may be foregone.<sup>63</sup>

The pure objective test is similar to the best interests test in that it focuses on the benefits and detriments of treatment and the prognosis of restoration to the former level of functioning. Further, it disallows consideration of the interests of others or the social value of the patient's life. However, it differs from the traditional best interests test in its emphasis on unavoidable physical pain.

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<sup>55</sup> *Id.* at 361-62, 486 A.2d at 1229-30. In *Conroy*, the New Jersey Supreme Court overruled its prior decision in *Quinlan* which had prohibited evidence of statements made by Ms. Quinlan in conversation, regarding her desire to forego life-sustaining treatment. *Id.* at 362-63, 486 A.2d at 1230, *overruling Quinlan*, 70 N.J. at 21, 41, 355 A.2d at 664, 672. The weight given statements is based upon (1) the remoteness, consistency, and thoughtfulness of the statements, (2) the maturity of the declarant when the statements were made, and (3) the degree of detail as to the circumstances the patient would prefer not to endure. *Conroy*, 98 N.J. at 363, 486 A.2d at 1230-31.

<sup>56</sup> *In re Conroy*, 98 N.J. at 360-61, 486 A.2d at 1229.

<sup>57</sup> *Id.* at 365, 486 A.2d at 1232.

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> *In re Conroy*, 98 N.J. at 367, 486 A.2d at 1232-33.

<sup>61</sup> *Id.* at 366-67, 486 A.2d at 1232.

<sup>62</sup> *Id.* at 366, 486 A.2d at 1232.

<sup>63</sup> *Id.*

The *Conroy* limited objective and pure objective tests have been criticized for their emphasis on pain as a criterion for deciding to withhold or withdraw life support.<sup>64</sup> There is evidence that most pain can be relieved with medication, so that severe, unremitting physical pain is unusual.<sup>65</sup> Of more importance to many terminal patients is the loss of independence and self-control. The emphasis on pain may distort the decisionmaker's analysis because it fails to encompass other factors which should affect the decision when these factors are of more importance to the person affected.<sup>66</sup>

In 1987, the New Jersey Supreme Court refined the *Conroy* analysis in a trilogy of cases. *In re Farrell*<sup>67</sup> reiterated the right of a competent patient to refuse life-sustaining treatment in a case involving a competent patient. *In re Peter*<sup>68</sup> recognized the right of a proxy decisionmaker, appointed in writing by the patient while competent, to refuse life-sustaining treatment on behalf of a currently incompetent patient in a persistent vegetative state. The *Peter* court held that the subjective test announced in *Conroy* applies in all cases where a surrogate seeks to make treatment decisions for an incompetent patient, regardless of the patient's prognosis or life expectancy.<sup>69</sup> There must be clear and convincing evidence of the patient's choice either to forego life-sustaining treatment or to designate an attorney-in-fact or other proxy to make treatment decisions.<sup>70</sup>

The court distinguished between patients in a persistent vegetative state and patients with some cognitive functioning, both in the procedure to be followed and in the substantive standard to be applied by the decisionmaker. The *Conroy* life-expectancy requirement does not apply to patients in a persistent vegetative state because such patients derive no benefit from continued treatment.<sup>71</sup>

In the third case in the trilogy, *In re Jobes*, the court held that the limited objective and pure objective tests announced in *Conroy* do not

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<sup>64</sup> *In re Conroy*, 98 N.J. at 394-96, 486 A.2d at 1247-48 (Handler, J., concurring and dissenting). See also G. Annas & L. Glantz, *supra* note 37, at 17 (The "limited objective test" is merely an alternative description of the "substituted judgment test." The pure objective test tends to ignore the plight of the individual patient, by justifying actions that otherwise could not objectively be viewed as in his or her 'best interests'). *Id.*

<sup>65</sup> Deciding to Forego, *supra* note 1, at 277-78, nn.1, 2.

<sup>66</sup> *In re Conroy*, 98 N.J. at 394-96, 486 A.2d at 1247-48 (Handler, J., concurring and dissenting); N. CANTOR, LEGAL FRONTIERS OF DEATH AND DYING 72-73 (1987).

<sup>67</sup> 108 N.J. 335, 529 A.2d 404 (1987).

<sup>68</sup> 108 N.J. 365, 529 A.2d 419 (1987).

<sup>69</sup> *Id.* at 377-78, 529 A.2d at 425.

<sup>70</sup> *Id.* at 377-78, 384, 529 A.2d at 425, 429. When the patient is an elderly nursing home resident, notification of the Ombudsman for the Institutionalized Elderly is required. The Ombudsman must obtain the concurrence of two independent physicians in the prognosis before life-sustaining treatment may be terminated. *Id.* at 383-84, 529 A.2d at 429. The Ombudsman should defer the actual decision to any designated proxy or close family member. *Id.* at 384, 529 A.2d at 429. If the patient has no close family and has not appointed a proxy decisionmaker, a guardian must be appointed. *Id.*

<sup>71</sup> *Id.* at 375, 529 A.2d at 424.

apply to patients in a persistent vegetative state.<sup>72</sup> Rather, if the patient in a persistent vegetative state has one or more close and caring family members, and there is some trustworthy evidence that the patient would refuse life-sustaining treatment, the family may decide to forego that treatment in an exercise of substituted judgment.<sup>73</sup> Because the family will generally have the greatest knowledge of the patient's personal values and the greatest concern for the patient's welfare, the court found the family to be the best qualified entity to make treatment decisions.<sup>74</sup> The court specifically reserved ruling on the substantive standard to be applied in situations where there is no one who is sufficiently familiar with the patient's personality to provide the kind of detailed information necessary to apply the subjective standard.<sup>75</sup>

#### V. RECENT REJECTION OF THE TRADITIONAL TESTS

Two recent decisions have rejected both the substituted judgment standard and the best interests standard in making decisions to forego artificial feeding for incompetent patients.<sup>76</sup> Both express concern with the preservation of the patient's autonomy and the need for certainty as to the patient's desires. Yet, the two courts have followed very different lines of reasoning, perhaps because of their different political climates.

*In re Westchester County Medical Center ex rel. O'Connor*<sup>77</sup> involved an elderly stroke victim with severely limited cognitive abilities, who required intravenous feeding after she had lost her gag reflex but was not suffering from any other terminal condition. The hospital petitioned for approval to insert a nasogastric tube on the ground that the patient would die of thirst and starvation without it. Her family objected because the patient had always opposed the use of artificial life support. The court held that the provision of life support to an incompetent patient could be withheld only if the patient's clearly expressed intention to forego such treatment in similar circumstances had been established by clear and convincing evidence.<sup>78</sup> The court rejected the use of the substituted judgment standard and of objective factors generally, reasoning that "no person or court should substitute its judgment as to what would be an acceptable quality of life for another."<sup>79</sup>

<sup>72</sup> 108 N.J. at 420-24, 529 A.2d at 447-50; see also *In re Peter*, 108 N.J. at 384-85, 529 A.2d at 429.

<sup>73</sup> *In re Jobes*, 108 N.J. at 415, 529 A.2d at 445.

<sup>74</sup> *Id.* at 416, 529 A.2d at 445. As with other incompetent patients, if the patient has no close family and has not left clear and convincing evidence of his or her treatment decision or of a choice of a proxy decisionmaker, a guardian must be appointed. *Id.* at 420, 529 A.2d at 447. Regardless of the standard used and the identity of the surrogate decisionmaker, the surrogate must obtain the opinions of two disinterested physicians knowledgeable in neurology who concur in the diagnosis of the patient's persistent vegetative state and in the prognosis that there is no reasonable possibility of a return to cognitive functioning. *Id.* at 422, 529 A.2d at 448.

<sup>75</sup> *Id.* at 424, 529 A.2d at 449.

<sup>76</sup> *Cruzan*, 760 S.W.2d 408 (Mo.); *In re Westchester Cty. Medical Center ex rel. O'Connor*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988).

<sup>77</sup> 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886.

<sup>78</sup> *Id.* at 531, 531 N.E.2d at 613, 534 N.Y.S.2d at 892.

<sup>79</sup> *Id.* at 530, 531 N.E.2d at 613, 534 N.Y.S.2d at 892. In the case before it, the



The court noted that the requirement of clear and convincing proof, through oral statements of the patient's commitment to forego life support under the circumstances, presented several difficulties. First, there is the possibility that the patient has changed his or her mind.<sup>80</sup> Second, because human beings cannot foretell the future, the medical treatment and the circumstances that require a decision may be quite different from those that the patient envisioned.<sup>81</sup> Third, there is a danger that the patient might have made the statements casually, without the deliberation in which he or she would engage if actually making the decision.<sup>82</sup> Nevertheless, the court's primary concern was the right of the individual patient to make his or her own treatment decisions rather than having those decisions made by others. Therefore, the court required clear and convincing evidence demonstrating the firm and settled purpose of the patient to forego life support, rather than permitting the exercise of substituted judgment.<sup>83</sup>

The rule requiring a finding of the patient's present intent has been criticized as demanding the impossible in that the patient's desires at the time of making the decision are, by definition, unknowable.<sup>84</sup> In addition, there is no way to exclude the possibility that the patient has had a change of mind.<sup>85</sup> Further, the rule does not distinguish between the conscious patient and one in a persistent vegetative state, nor does it distinguish between the patient suffering from a terminal condition, for whom further treatment might be painful and futile, and one who is not.<sup>86</sup> If a humane rule of law would be likely to allow the withholding or withdrawal of life support from the permanently unconscious or terminal patient, this rule would not permit such a result.<sup>87</sup>

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court ruled that the proof was insufficient to justify the conclusion that the patient would have declined artificial feeding. *Id.* at 534, 531 N.E.2d at 613, 534 N.Y.S.2d at 894. Ms. O'Connor had repeatedly stated over a period of many years that she would never want to be a burden to anyone, that she found the use of life support machinery "monstrous" and that she would never want to lose her dignity. Nevertheless, the situations which prompted these statements were primarily the painful deaths of family members from terminal cancer. The patient's need for life support was not caused by any terminal illness, but by the gradual debilitation caused by a series of strokes, and to decline the treatment would be likely to cause, rather than prevent, a painful death. *Id.* at 533-34, 531 N.E.2d at 614-15, 534 N.Y.S.2d at 894.

<sup>80</sup> *In re Westchester Cty. Medical Center ex rel. O'Connor*, 72 N.Y.2d at 530, 531 N.E.2d at 613, 534 N.Y.S.2d at 892.

<sup>81</sup> *Id.*

<sup>82</sup> *Id.*

<sup>83</sup> *Id.*

<sup>84</sup> *Id.* at 536, 531 N.E.2d at 616, 534 N.Y.S.2d at 895-96 (Hancock, J., concurring). The impossible demands also include the expectation that the patient foretell the future by anticipating both his or her condition and the means that will be available to sustain life, if the desire to forego life support is to be respected. *Id.* at 549-50, 531 N.E.2d at 625, 534 N.Y.S.2d at 904 (Simons, J., dissenting).

<sup>85</sup> *In re Westchester Cty. Medical Center ex rel. O'Connor*, 72 N.Y.2d at 536, 531 N.E.2d at 617, 534 N.Y.S.2d at 896 (Hancock, J., concurring).

<sup>86</sup> *Id.* at 537, 531 N.E.2d at 617, 534 N.Y.S.2d at 896 (Hancock, J., concurring).

<sup>87</sup> *Id.*

The requirement that the patient's statements have anticipated the nature of the condition, the type of support available, and the circumstances which necessitate a decision as to life support renders the rule extremely difficult to satisfy. The rule has been criticized as making unrealistic demands upon the lay person to understand and express his or her desires concerning future treatment in precise medical terms.<sup>88</sup> Perhaps the close and loving families of those patients who are unable to express themselves precisely should be able to make treatment decisions on behalf of those patients. Yet, this rule may not allow them to do so. In summary, because of the requirement of clear and convincing evidence of the values and desires that the patient has actually expressed, the rule may be overly restrictive.

The Missouri Supreme Court also rejected the use of the substituted judgment standard in *Cruzan v. Harmon*.<sup>89</sup> *Cruzan* is the only appellate decision which refused to allow the guardian of a patient in a persistent vegetative state to withdraw life-sustaining treatment. The *Cruzan* court's analysis of the issues regarding the right to refuse treatment, the right to privacy, and the authority of the guardian differs substantially from that of the other courts which have addressed these issues.

Although the court recognized the common law right to refuse treatment, it framed this right as a corollary of the doctrine of informed consent. It failed to recognize that the doctrine of informed consent grew out of the principle that unconsented medical treatment constituted a battery.<sup>90</sup> It then reasoned that a patient could not possibly make an informed decision under hypothetical circumstances because the requirement that the patient clearly understand the risks and benefits of treatment or refusal could not be met.<sup>91</sup>

The *Cruzan* court also resisted the applicability of the constitutional right of privacy to treatment decisions.<sup>92</sup> It refused to apply the *Quinlan* reasoning that a right of privacy broad enough to encompass the decision to choose abortion would also protect the right to refuse life-sustaining treatment for oneself. Rather, the court emphasized the Supreme Court's focus on procreation and family relationships within marriage in its analysis of the constitutional right of privacy and its concomitant refusal to extend the privacy right to protect homosexual conduct.<sup>93</sup> Even assuming that the constitutional right of privacy applies to treatment decisions, the court held that the right was too personal to be exercised by a guardian or other third party without rigid formalities.<sup>94</sup>

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<sup>88</sup> *Id.* at 549-51, 531 N.E.2d at 624-26, 534 N.Y.S.2d at 904-05 (Simons, J., dissenting).

<sup>89</sup> 760 S.W.2d 408 (Mo. 1988) (en banc), cert. granted, 109 S. Ct. 3240 (1989).

<sup>90</sup> 760 S.W.2d at 417. See *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972) (analysis of the doctrine of informed consent and its doctrinal sources).

<sup>91</sup> 760 S.W.2d at 417.

<sup>92</sup> *Id.* at 418.

<sup>93</sup> *Id.*

<sup>94</sup> *Id.* at 425.

The Missouri Supreme Court's analysis of the state's interests involved in decisions concerning life-sustaining treatment departs substantially from those of other courts. Missouri claims a two-pronged interest in life: an interest in the prolongation of the life of the particular patient and an interest in preserving the sanctity of life generally.<sup>95</sup> The court relied on the abortion statute at issue in the recent case of *Webster v. Reproductive Health Services*<sup>96</sup> which granted the right to life to all human beings, born or unborn,<sup>97</sup> and defined a viable fetus as one whose life "may be continued indefinitely outside the womb by natural or artificial life support systems."<sup>98</sup> The court also noted that Missouri's version of the Uniform Rights of the Terminally Ill Act contained provisions which reflected a greater state interest in life than the Uniform Act.<sup>99</sup>

The *Cruzan* court refused to consider the patient's prognosis in the determination of the extent of the state's interest in preserving the patient's life, reasoning that a focus on the prognosis for recovery to the patient's former capacity has resulted in decisions based on the quality of the patient's life.<sup>100</sup> Rather, it characterized the state's interest in life as unqualified.<sup>101</sup> The state's interest in life did not vary with the prognosis of the patient, but remained constant and undiminished regardless of the patient's condition.<sup>102</sup> It also noted that the possibility for the prolongation of Nancy Cruzan's life was substantial since she might live another thirty years if artificial feeding and hydration were continued.<sup>103</sup>

The court's analysis of the responsibilities of the patient's guardian also differed from those of other courts that have considered the question. Rather than viewing the right and responsibility to consent to medical treatment on behalf of a ward as including the right to make an informed refuse choice to or to terminate treatment, the *Cruzan* court interpreted the Missouri guardianship statute as requiring the guardian only to provide medical care.<sup>104</sup>

The source of the guardian's authority to act for the ward was crucial to the court's analysis. Because the guardian's authority was derived from the court rather than from the ward, and arose from the *parens patriae* power of the state, the guardian could not exercise any personal right of the ward which would cause the ward to die.<sup>105</sup> The *Cruzan* court relied in part upon *Planned Parenthood v. Danforth*<sup>106</sup> for the proposition that

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<sup>95</sup> *Id.* at 419.

<sup>96</sup> *Webster v. Reproductive Health Services*, 109 S. Ct. 3040 (1989).

<sup>97</sup> MO. REV. STAT. § 188.010 (1986).

<sup>98</sup> 760 S.W.2d at 419, quoting MO. REV. STAT. § 188.015(7).

<sup>99</sup> 760 S.W.2d at 419-20, comparing the UNIFORM RIGHTS OF THE TERMINALLY ILL ACT § 1(4), 9B U.L.A. 611 (1987) (Act amended 1989 and referred to Style Committee; expected out of Committee Spring 1990) with MO. REV. STAT. § 459.010(3).

<sup>101</sup> *Id.*

<sup>102</sup> *Id.*

<sup>103</sup> *Id.* at 419, 424.

<sup>104</sup> *Id.* at 424.

<sup>105</sup> 760 S.W.2d at 426.

<sup>106</sup> 428 U.S. 52, 74-75 (1975).

the state cannot authorize a third party to exercise the patient's right of privacy in decisionmaking.<sup>107</sup> In the court's view, the application of the substituted judgment doctrine in treatment termination cases abrogated rather than furthered the state's *parens patriae* power to protect the helpless and to preserve life, because it allowed the guardian to make a private, unilateral decision to cause the death of the ward.<sup>108</sup> For these reasons, the court rejected the application of the substituted judgment standard in life-sustaining treatment cases.<sup>109</sup> The reasoning used would clearly prohibit the use of the best interests test as well.

In balancing the interests involved, the court ruled that treatment must be continued because the prognosis for recovery of functioning was irrelevant, the state's interest in the preservation of Cruzan's life outweighed any rights that were invoked on her behalf, and the treatment was not burdensome or invasive.<sup>110</sup> It also found the evidence of Nancy's wishes inherently unreliable, and therefore insufficient to justify the guardian's exercise of substituted judgment.<sup>111</sup> In summary, the majority left no opening for the withholding or withdrawal of life-sustaining treatment from any patient who was not competent to request it.

It appears that the *Cruzan* court's unwillingness to accept a right of privacy in medical decisionmaking influenced the result. The court refused to rely upon the reasoning of any of the abortion cases except to the extent that they limited the exercise of the right of privacy. Its claim of an unqualified interest in life regardless of medical prognosis is unique in this area of the law. In fact, the court has been criticized for preparing the way for anticipated pro-life litigation rather than applying the law to the task at hand.<sup>112</sup>

The reasoning of the New York Court of Appeals in *O'Connor*<sup>113</sup> is much better suited to address the issue of the propriety and limits that should be placed upon third party decisionmaking. Yet, that court's resistance to any decision to terminate treatment that cannot be justified by reference to a long standing commitment on the part of the patient to forego life support may result in continuing the treatment of persons in a persistent vegetative state with no possibility of a return even to limited consciousness.

When a patient has been correctly diagnosed as permanently unconscious, so that she will never again experience contact with the environment or the care that she is receiving, the best rule should permit the withholding of life support. Nevertheless, when patients have even the most limited contact with their environment, it is necessary that the law require a decisionmaking process and a substantive standard which protect the patient from abuse. Yet, to require the continued provision of life

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<sup>107</sup> 760 S.W.2d at 425.

<sup>108</sup> *Id.* at 426.

<sup>109</sup> *Id.*

<sup>110</sup> *Id.*

<sup>111</sup> *Id.*

<sup>112</sup> 760 S.W.2d at 441 (Welliver, J., dissenting).

<sup>113</sup> 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886.

support to such patients solely because they did not adequately express a clear, settled purpose to forego it may create a danger that family members and physicians will circumvent the law because it is too restrictive. Then, they may make decisions to forego treatment *sub silentio* or for inappropriate reasons.

## VI. PROHIBITED FACTORS

In deciding upon the standard which should govern the decision of a surrogate to forego life-sustaining treatment on behalf of a patient, courts have generally eliminated certain factors from consideration by the surrogate. Among these are the quality of life of the patient and the financial interest of the surrogate or other family members in the decision.

Courts which have allowed the consideration of the quality of life to any extent have distinguished the value of the patient's life to others from the value that life in the terminal condition has for the patient.<sup>114</sup> If the surrogate exercising substituted judgment believes that the patient would have considered the extent of his or her incompetence as militating in favor of terminating treatment, the surrogate can consider this factor.<sup>115</sup> However, the surrogate cannot consider the utilitarian value of the patient's life to others in deciding to terminate treatment.<sup>116</sup>

Some writers, however, would allow the surrogate to consider the social value of the patient's life. They consider that the patient's life has social value only to the extent that the patient is capable of interacting with others. The patient who is no longer capable of communicating thoughts and feelings has lost his or her humanity. Since the patient is no longer a human being, a decision to end treatment does not terminate a human life.<sup>117</sup>

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<sup>114</sup> *Rasmussen*, 154 Ariz. at 222, 741 P.2d at 689; *In re Gardner*, 534 A.2d at 955; *Brophy*, 398 Mass. at 434, 497 N.E.2d at 635; *Saikewicz*, 373 Mass. at 754, 370 N.E.2d at 432; *In re Conroy*, 98 N.J. at 367, 486 A.2d at 1232-33; see also *Deciding to Forego*, *supra* note 1, at 135.

<sup>115</sup> *Rasmussen*, 154 Ariz. at 222, 741 P.2d at 689; *Brophy*, 398 Mass. at 434, 497 N.E.2d at 635; *In re Conroy*, 98 N.J. at 367, 486 A.2d at 1232-33; *Deciding to Forego*, *supra* note 1, at 135.

<sup>116</sup> *Rasmussen*, 154 Ariz. at 222, 741 P.2d at 689, n. 23; *Brophy*, 398 Mass. at 434, 497 N.E.2d at 635; *In re Conroy*, 98 N.J. at 367, 486 A.2d at 1232-33. But see *Brophy*, 398 Mass. at 427, 497 N.E.2d at 631 (apparent approval of trial court's consideration of the effects of continuation of treatment on the patient's family as one of the factors that the patient would have considered).

In discussing the best interests test, the President's Commission also distinguishes between consideration of the social value of the patient's life and the value of the patient's life to the patient. Only the latter should be considered under the Commission's view. *Deciding to Forego*, *supra* note 1, at 135 n.43.

<sup>117</sup> ETHICS OF WITHDRAWAL, *supra* note 31, at 52-53. See also Buchanan & Brock, *Surrogate Decision Making for Elderly Individuals Who Are Incompetent or of Questionable Competence* in *Surrogate Decisionmaking*, *supra* note 37, at 86-87 (The Best Interest Principle imposes "a duty to do what best promotes someone's interests or is most conducive to his or her good. As such, the Best Interest Principle does not apply to beings who have no capacity for consciousness and whose good can never matter to them, and this includes human beings who are in a permanent vegetative state."); N. CANTOR, *supra* note 66, at 80.

This position denigrates the value of the patient's life by focusing on intellectual functioning and verbal communication. That the patient can no longer communicate thoughts and feelings does not mean that the patient has no such feelings. To withdraw care from a patient who was aware but unable to communicate his or her objections would be horrifying.

The better view is that expressed by an author who considers personhood as encompassing three related capacities: the ability to reason, to experience emotions, and to enter into relationships.<sup>118</sup> Although a patient who has none of these capacities would no longer be a person under this view, he would require the surrogate to treat as a person any patient who still had the capacity to experience emotion, even if it were only to the limited, self-absorbed extent of feeling pain.<sup>119</sup> This view more appropriately values the humanity of the patient as a whole, without unduly emphasizing intellectual functioning.

One of the four state interests traditionally required to be balanced against the right of the competent patient to choose to terminate treatment is the interests of third parties.<sup>120</sup> Originally, this state interest encompassed the interests of a patient's minor children or dependent spouse in maintaining life so that the patient could continue to meet their needs.<sup>121</sup> Yet, the emotional and financial needs of the family may work in favor of a decision to terminate treatment.

No appellate case has directly addressed the extent to which the surrogate should consider the cost of treatment. The cases have generally noted that finances were not an issue in approving the decisions to terminate treatment.<sup>122</sup> Under the logic of substituted judgment, the surrogate ought to be able to consider the interests of third parties if it can be established that the patient would have done so. However, the potential for abuse would appear to require some extra procedural protection for the patient.

The President's Commission recommended permitting the surrogate to consider the impact of a treatment decision on the patient's family even when applying the best interests standard.<sup>123</sup> The Commission reasoned that the best interests of a patient include the patient's interests in the welfare of family and close associates.<sup>124</sup> Nevertheless, the Commission would require a more stringent standard of proof to support the surrogate's claim that the reasonable person in the patient's position

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<sup>118</sup> D. CALLAHAN, SETTING LIMITS 179-80 (1987).

<sup>119</sup> See *id.* at 180.

<sup>120</sup> See text accompanying notes 17 and 18 *supra*, and cases cited therein.

<sup>121</sup> *In re Farrell*, 108 N.J. at 352, 529 A.2d at 412-13 (court noted that the interests of the patient's children did not preclude withdrawal of the respirator because there was no showing that the surviving parent would be unable to meet the children's needs alone).

<sup>122</sup> *In re Spring*, 380 Mass. at 640, 405 N.E.2d at 122. *But see Leach*, 68 Ohio Misc. at 3, 426 N.E.2d at 810 (court noted both the anxiety of family members and the cost of treatment in approving decision to terminate life support).

<sup>123</sup> Deciding to Forego, *supra* note 1, at 135-36.

<sup>124</sup> *Id.* at 135.

would subordinate the patient's interest in continuing treatment to the family's interest in avoiding the resulting financial or emotional burden.<sup>125</sup>

Some scholars have suggested that age be a criterion in determining the treatment which should be provided to a patient. Specifically, they argue that society should not provide life-sustaining treatment for elderly patients who have lived out a natural life span.<sup>126</sup> The rationale for this position is based upon the limited availability of health care resources, particularly the more expensive, high technology-based forms of treatment. It is asserted that justice between age groups requires that the elderly refrain from making unfair claims to the limited health care resources available, so that society can guarantee to all the opportunity to live out a natural life span.<sup>127</sup>

The few cases that have considered the age of the patient appear to have rejected it as a factor relevant to the treatment decision. In *Delio v. Westchester County Medical Center*,<sup>128</sup> the Appellate Division rejected the trial court's consideration of the youth of the 33-year-old patient as relevant to its refusal to allow the termination of life support. The court noted that age was relevant only in determining whether the patient had made an informed decision.<sup>129</sup>

The *Conroy* holding was limited to elderly nursing home residents who had less than a year to live.<sup>130</sup> However, the court's reasoning was based upon the distinctive vulnerability of elderly nursing home residents, not upon any difference in the claim of the elderly to medical treatment.<sup>131</sup>

When the New Jersey Supreme Court refined *Conroy*, it announced no difference in treatment or in the standard to be applied based upon the age of the patient. Rather, the court retained the distinction between elderly nursing home patients and other patients by granting the former special procedural protections.<sup>132</sup> This special concern for the elderly because of their vulnerability tends to contradict an argument that the elderly have a less weighty claim to the use of life-sustaining treatment than other patients.

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<sup>125</sup> *Id.* at 136.

<sup>126</sup> D. CALLAHAN, *supra* note 118; Battin, *Age Rationing and the Just Distribution of Health Care: Is There a Duty to Die?*, 97 ETHICS 317 (1987) [hereinafter *Duty to Die*].

<sup>127</sup> D. CALLAHAN, *supra* note 118, at 164-180; *Duty to Die*, *supra* note 126, at 324-28.

<sup>128</sup> 129 A.D.2d 1, 516 N.Y.S.2d 677.

<sup>129</sup> *Id.* at 21, 516 N.Y.S.2d at 690-91.

<sup>130</sup> *In re Conroy*, 98 N.J. at 363, 365, 486 A.2d at 1231, 1232.

<sup>131</sup> *Id.* at 374-77, 486 A.2d at 1237-38.

<sup>132</sup> *In re Jobes*, 108 N.J. at 410, 529 A.2d at 448; *In re Peter*, 108 N.J. at 384-85, 529 A.2d at 429. Where the evidence of the patient's intention is insufficient to meet the requirements of *Conroy's* subjective test, the family of the patient must exercise substituted judgment using their knowledge of the patient's personal values. *In re Jobes*, 108 N.J. at 415, 529 A.2d at 444.

## VII. THE MISCONCEPTION REGARDING THE EXERCISE OF A PATIENT'S RIGHTS

Much conceptual confusion has resulted from the characterization of the decision of a guardian or other surrogate as the exercise of the incompetent's right.<sup>133</sup> This was evident in *Rasmussen v. Fleming*.<sup>134</sup> The patient, a nursing home resident in her seventies, suffered from neurological disorders which were not clearly established in the opinion. The patient's condition was described as "essentially vegetative," but the testimony showed that she made nonverbal responses to questions and other stimuli.<sup>135</sup> She was being fed through a nasogastric tube when the Public Fiduciary sought appointment as her guardian for the purpose of consenting to the removal of the tube.

The guardian in this case was not a family member, but a public official. No one knew Ms. Rasmussen's desires. The decisions to withhold all but comfort care and to remove the source of her food and water were not made by close, concerned family members, but by strangers.

The Arizona Supreme Court held that the guardian could exercise the patient's right to terminate treatment if the guardian ad litem and family agreed.<sup>136</sup> Because there was no evidence that Ms. Rasmussen had ever expressed her wishes as to life support prior to becoming incompetent, the guardian was to apply the best interests standard.<sup>137</sup>

This decision did not prevent the possibility of allowing a semiconscious patient to die a painful death. The medical testimony appears to have been much less extensive than that in *Brophy*<sup>138</sup> or *Conroy*.<sup>139</sup> None of the witnesses mentioned in the opinion was a current attending physician. There was testimony by the investigator that the nurses attending the patient thought that she retained some cognitive functioning.<sup>140</sup> The court does not appear to have considered the suffering that death by starvation and dehydration would have caused Ms. Rasmussen. Under such circumstances, to call these actions the exercise of the patient's "rights" is to ignore reality.

Further, the court did not address the possibility of medical error. Rasmussen's physician had removed the nasogastric tube after the guardianship petition was filed, but before any hearing had been held. In fact, the patient had the ability to swallow, although she could not feed herself.<sup>141</sup> If there was medical error regarding the need for life support,

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<sup>133</sup> See *supra* text accompanying notes 33 through 44.

<sup>134</sup> 154 Ariz. 207, 741 P.2d 674 (1987).

<sup>135</sup> *Id.* at 212, 741 P.2d at 679.

<sup>136</sup> *Id.* at 224, 741 P.2d at 691.

<sup>137</sup> *Id.* at 222, 741 P.2d at 689.

<sup>138</sup> *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. at 444, 497 N.E.2d at 641 (1986).

<sup>139</sup> *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985).

<sup>140</sup> *Rasmussen*, 154 Ariz. at 212, 741 P.2d at 679.

<sup>141</sup> *Id.* at 212, 741 P.2d at 679, n.1.



perhaps there was also error with respect to the extent of Rasmussen's ability to perceive and interact with her environment.

The California Court of Appeals recently formulated a more accurate conception of the rights of incompetent patients in *In Re Drabick*,<sup>142</sup> a case involving a permanently comatose patient. The court reasoned that the right of a competent patient to choose or refuse treatment survived incompetence, so that the conservator may make treatment choices on behalf of the conservatee.<sup>143</sup> However, the court termed the characterization of the surrogate's decision as the exercise of the patient's right to choose as a legal fiction.<sup>144</sup> The incompetent's right is to have the conservator make appropriate decisions on his or her behalf.<sup>145</sup> An appropriate decision is one made in the best interests of the patient.<sup>146</sup> The conservator's choice in the patient's best interests may include consideration of the patient's known preferences for medical treatment.<sup>147</sup> However, the primary determination that must be made by the conservator of a comatose patient is whether, in good faith, he or she finds treatment medically necessary, given the patient's prognosis for a return to a cognitive, sapient existence.<sup>148</sup>

#### VIII. A PROPOSED STANDARD

By merging the two questions of whether and how treatment decisions can best be made for incompetent patients into one question — how to guarantee the right of the patient to terminate treatment, the courts have confused the issue. Both the substituted judgment and the best interests tests are insufficiently protective of patients because they permit manipulation by unaware or uncaring surrogates. Further, both tests rely too heavily upon a medical determination of the prognosis. Some patients who doctors predicted would never regain consciousness have done so, even as family members were arguing for a termination of life support.<sup>149</sup> The families contended that the patient would have made the choice to terminate treatment.<sup>150</sup> Yet, these patients, when actually confronted with the choice of ending their lives or surviving in a severely disabled condition, did not choose to terminate treatment.<sup>151</sup> The danger exists that patients may die because treatment was terminated too early, without sufficient consideration of all that could be done to help them.

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<sup>142</sup> 200 Cal. App. 3d 185, 245 Cal. Rptr. 840 (1988).

<sup>143</sup> *Id.* at 207-09, 245 Cal. Rptr. at 854-55.

<sup>144</sup> *Id.* at 208, 245 Cal. Rptr. at 854.

<sup>145</sup> *Id.* at 205, 209, 245 Cal. Rptr. at 852, 855.

<sup>146</sup> *Id.* at 205, 245 Cal. Rptr. at 852.

<sup>147</sup> *In re Drabick*, 200 Cal. App. 3d at 210, 245 Cal. Rptr. at 856.

<sup>148</sup> *Id.* at 210-11, 245 Cal. Rptr. at 856.

<sup>149</sup> Seligman, *Whose Death Is It Anyway?*, Newsweek, Apr. 24, 1989, at 69. See also instances discussed in Currie, *The Redefinition of Death* in S.F. SPICKER, ORGANISM, MEDICINE AND METAPHYSICS 177, 184-90 (1978).

<sup>150</sup> Seligman, *supra* note 149, at 69.

<sup>151</sup> *Back from the Dead*, Time, Oct. 6, 1986, at 35; cf. Seligman, *supra* note 149, at 69.

The proper question is how best to provide care for patients who are no longer able to choose care for themselves. An appropriate decision must approximate, to the extent possible, the decision that the patient would have made if able to do so. Yet, even a surrogate who has intimate knowledge of the patient's values, behavior, beliefs, and personality can, at best, only attempt to predict the patient's choice.

Where the patient was formerly competent, the surrogate must determine and consider his or her moral, spiritual, and emotional values, goals in life, and the importance to the patient of various facets of life, such as intellectual functioning, physical independence, and spiritual and psychological connection. In addition, the surrogate should also know the patient's attitudes concerning health care, adversity, and risk-taking.

In many cases, perhaps, a spouse, adult child, or parent will have this knowledge. If the person who knows the patient best is not a relative, it would be best for the patient to have appointed this person as a proxy to make treatment decisions. However, when no one knows the patient so intimately, or when the patient has never had the capacity to make treatment decisions, the use of the substituted judgment standard is inappropriate.

Even the most well-intentioned surrogate with an intimate knowledge of the patient may project his or her own values onto the patient or confuse his or her own distress at the patient's condition with the needs of the patient. In order to avert the possibility that a patient may die because the surrogate considered inappropriate factors or failed to consider how to improve the patient's life, I propose that a new factor be added to both the substituted judgment and the best interests tests. The surrogate must be required to improve the patient's life as the patient experiences it.

As with any treatment decision, the surrogate must first determine, to the extent medically possible, the patient's present levels of physical, sensory, cognitive, and emotional functioning; the extent, severity, and duration of physical pain; the prognosis for improvement or restoration of function in any area and for further deterioration. The surrogate must also consider exactly how a proposed treatment or nontreatment alternative would affect the patient. This would necessitate inquiry into the perceptions that a patient with limited cognitive ability may have of her environment and of the care that is provided for her.

When it is possible that the patient has greater capacity to perceive reality than to communicate her perceptions to others, the surrogate should assume that the patient perceives all of the care that is provided for her and will perceive a withdrawal of life support as a withdrawal of care. The surrogate should be required not only to examine the alternatives of providing or omitting life-sustaining treatment, but also to take any other measures which might improve life as experienced by the patient.

Addition of this element to the substituted judgment test would require the surrogate to consider that the patient's experience of life may have value to him or her even though the patient may now be severely

mentally disabled and in a condition that he or she might previously have considered pitiable. By requiring that the surrogate take whatever measures would improve the patient's perceptions of life, the revised test places the surrogate emotionally and perceptually in the position of the patient insofar as that is humanly possible. This should maximize the empathy and compassion of the surrogate for the patient.

This would modify the traditional best interests test since it does not focus on the choice that most reasonable people would make for themselves in similar circumstances. Further, it requires the surrogate specifically to consider the ways in which the patient's life could be improved and to take positive steps to do so regardless of the decision reached with respect to life-sustaining treatment. It is designed to assure, to the extent possible, the maximal exercise of empathy and compassion on the part of the surrogate.

The encouragement of empathy is particularly important in those situations where the guardian or other surrogate is someone who does not know the patient intimately. Such a guardian may be motivated by pity for another ill human being. Nevertheless, he or she will not be guided by the love that family members or patient-appointed proxies will usually have for the patient.

This modified standard also differs from the limited objective and pure objective tests announced in *Conroy* in that it does not emphasize the extent of physical pain or the benefits and burdens of treatment. In addition, the surrogate's decision is not limited to the issue of life-sustaining treatment. In deciding whether to provide or forego life-sustaining treatment, the surrogate must specifically consider how each treatment or nontreatment alternative will be perceived by the patient and choose that combination of alternatives which would most improve the patient's life. At a minimum, the surrogate can make no decision that would cause new suffering. To the extent that the pain and pleasure experienced by the patient are affected by factors within the control of the surrogate, the surrogate should be required to increase pleasure, or at least be forbidden to cause new pain.

The application of this standard to the permanently unconscious patient would lead to the result on which most authorities already agree. Because the permanently unconscious patient has no perceptions of self or environment, nothing could be done to improve the patient's life as she experiences it. By definition, the patient is incapable of experiencing the care that she is receiving. For the same reason, the patient would not experience the termination of life support as a withdrawal of care. Therefore, life-sustaining treatment could properly be withdrawn.

In the more troubling case of a partially conscious patient, the surrogate would not simply decide whether to continue or stop nasogastric feeding. Suppose that, in Claire Conroy's situation, after an examination of all the medical information of this particular patient and of the cognitive abilities and perceptions of other patients with similar disabilities, it were determined that she would not suffer from significant pain with appropriate analgesics; that her moans indicated that she felt minor discomfort; and that her smiles indicated pleasure. Suppose that she would

experience more pleasure with simple human contact or other forms of loving care, such as more frequent massages. If the surrogate were required to make the decision that would improve the patient's life as she perceives it, the withdrawal of nasogastric feeding would be impermissible. The standard would require the surrogate to provide the human contact and loving care that would better the patient's life.

A surrogate may be swayed by the argument that discontinuing tube feeding and hydration is the equivalent of turning off the machine that breathes for the patient, ignoring the difference in time and suffering between death by suffocation and death by starvation. If the facts of Ms. Conroy's condition were as hypothesized, termination of treatment would have caused tremendous new suffering. Bringing the surrogate into greater touch with the emotional content of the decision would reduce the temptation to rely upon the asserted lack of any objective distinction between feeding or hydration and other life-sustaining procedures.

The emotional content of a decision is important to the surrogate as well as to the patient. One aspect of the "slippery slope" or "wedge" argument against terminating life support is that both the individuals involved and society as a whole will become accustomed to causing the deaths of others so that other killings no longer seem so wrong.<sup>152</sup> Decisionmakers who have remained sensitive to the content of their decision may well feel differently about starving Mama to death than they do about turning off the machine that breathes for her.<sup>153</sup>

Regardless of the decision a surrogate makes, sooner or later, the patient will die. Nevertheless, surrogates must live with themselves, and the rest of us must live with them, after their decision points have passed. It is important that the standards required of surrogate decisionmakers foster compassion and empathy in order to avoid the gradual erosion of society's respect for the rights and value of the lives of the severely disabled.

Some believe that the reverence for life is the quality that distinguishes humanity from other forms of life.<sup>154</sup> Others believe that our

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<sup>152</sup> Gelfand, *Euthanasia and the Terminally Ill Patient*, 63 NEB. L. REV. 741 (1984); Kamisar, *Some Non-Religious Views Against Proposed "Mercy Killing" Legislation*, 42 MINN. L. REV. 969 (1958); Deciding to Forego, *supra* note 1, at 28-29; D. BEAUCHAMP & T. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 122 (2d ed. 1983); see also D. CALLAHAN, *supra* note 118, at 188-89 which discusses the possibility that training health professionals to terminate artificial feeding of dying elderly patients might pave the way for a routine cessation of nutrition and hydration for the physically frail and demented elderly where death is not yet imminent.

<sup>153</sup> The parents of Karen Ann Quinlan never sought to terminate her artificial feeding even after the *Conroy* holding. They distinguished between the discontinuation of the respirator and depriving their daughter of food. See N.Y. Times, June 12, 1985, at A1, col.2, D27, col.3; N.Y. Times, June 16, 1985, at E22, col.3. Many health professionals also are adverse to the discontinuation of artificial feeding even though they support the withdrawal of other forms of life support from dying patients. D. CALLAHAN, *supra* note 118, at 187-88.

<sup>154</sup> See, e.g., *In re Conroy*, 188 N.J. Super. 523, 527, 457 A.2d 1232, 1235 (N.J. Super. Ct. Ch. Div. 1983), *rev'd*, 190 N.J. Super. 453, 464 A.2d 303, *cert. granted*, 95 N.J. 195, 470 A.2d 418 (1983), *rev'd*, 98 N.J. 321, 486 A.2d 1209 (1985).

distinguishing feature is the capacity for consciousness of any sort.<sup>155</sup> Perhaps, though, the behavior that differentiates humanity from other forms of life is that we imbue our actions with emotional significance, and we are conscious of the emotions that we create in ourselves and prompt in others. To the extent that our actions have consequences in the hearts and minds of the actors as well as in the outer world, we must not ignore the significance of emotional content.

## IX. CONCLUSION

The developing thought with respect to the treatment of incompetent patients seems to be focused inordinately upon the facilitation of the exercise of their right to avoid life-sustaining treatment. Further, the emphasis of courts and writers on the value of intellectual functioning devalues other aspects of life that severely disabled patients may yet be experiencing.

When the patient is permanently unconscious, she cannot perceive the cessation of care. Perhaps, then, no harm is done in allowing the guardian and family to terminate treatment of patients in a persistent vegetative state once the diagnosis and prognosis have been adequately confirmed. Nevertheless, it is possible that a patient with limited ability to communicate verbally may be learning from the experience in ways that she cannot convey to her family or caretakers.

To allow a surrogate to make a decision which results in the death of a sentient, conscious patient without the participation of the patient in making that decision is to risk the possibility of murder of the patient in the self-interest of the surrogate. Therefore, it is necessary to protect incompetent patients both with appropriate procedural constraints<sup>156</sup> and with an empathetic substantive standard governing the surrogate's actions.

The substantive standard must require the surrogate to expressly consider all of the treatment options available from the patient's perspective and to make the decision that will improve the life experienced by the patient to the extent that improvement is possible. The question

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<sup>155</sup> Buchanan & Brock, *Surrogate Decision Making for Elderly Individuals who are Incompetent or of Questionable Competence* in *Surrogate Decisionmaking*, *supra* note 37, at 85-86 ("If these individuals [in a persistent vegetative state] can be said to have interests at all, this is only because the word 'interest' is used in a very attenuated sense. A similar attenuated sense of the word may apply when speaking of what is good or bad for rudimentary forms of animal life or plants . . . . Whether . . . 'interests' are promoted or not, indeed whether it [a rudimentary form of animal life] lives or dies, does not matter . . . because it lacks (and always will lack) consciousness of any sort."); *cf.* N. CANTOR, *supra* note 117, at 80.

<sup>156</sup> The issue of the appropriate procedure should be considered separately from that of the substantive standard. The procedure to be followed is beyond the scope of this Article.

that the surrogate must ask is not, "May I discontinue treatment for this patient?" but "How can I best provide care for this patient to improve her life as she perceives it?" Unless the surrogate knows that the patient is totally incapable of perception, and not merely impaired in the ability to communicate, the surrogate should presume that the patient perceives all of the care that is being provided and will perceive the discontinuation of nutrition, hydration, or air as a withdrawal of care. This standard will maximize the empathy and compassion exercised by the surrogate in reaching a decision concerning life-sustaining treatment.

