January 1990

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COMMENTS

THE ELDERLY INCOMPETENT: THE RIGHT TO DIE WITH DIGNITY

INTRODUCTION

"It hath been said, that it is not death, but dying, which is terrible."

Until eight months ago, Mary Smith's daily schedule included spoon-feeding her husband, Edward, 87, who has Alzheimer's disease. Edward also suffers from heart disease, hypertension, bedsores, and a gangrenous left leg. His legs are contracted into a semi-fetal position, and he cannot speak or control his bodily functions. He is, however, minimally aware of his surroundings. When his condition deteriorated and Edward began losing weight, his $3,000 per month nursing home began feeding him through a nasogastric tube.

Based on various discussions the two had throughout their marriage, Mary feels certain that Edward would not tolerate such an invasion if he were competent. She also believes that the feeding tube causes Edward a great deal of pain. However, Mary is confused about what, if any, choices she may have with regard to terminating Edward's treatment. The state's natural death act, which allows qualified patients to terminate artificial life-sustaining treatment in certain cases, does not apply to Edward. Unfortunately, he never took the time to execute the required living will stating his desire for a natural death. Furthermore, even if Edward had executed such a document, its utility would be questionable in his case for two reasons. First, the state's act requires patients from whom treatment is terminated to be diagnosed as suffering from a terminal illness, yet Edward may live for many

more months. Second, the statute is silent as to whether a feeding tube is a type of medical treatment that may be withheld or withdrawn, and the courts in Edward's state have never addressed the issue. Edward's doctor, who visits him once per month in the nursing home, refuses to withdraw Edward's feeding tube because Edward is not brain dead, comatose or in a persistent vegetative state. Although initially horrified at the request, Mary now wonders whether she should have complied when Edward asked her to help him end his life three years ago.

Mary and Edward Smith's dilemma, though disturbing, is not uncommon. Medical technology now makes it possible to prolong the dying process of severely debilitated elderly patients for months and even years. As academic commentators have observed, a prolonged death has severe detrimental effects not only on the patient, but on third parties as well. The expense of years of hospital or nursing home care and treatment of a dying patient can burden a family and strain public resources. Further, the emotional suffering to which a family is subjected during a loved one's lingering, painful death can be devastating.

This Comment will address the right to withdraw nutrition and hydration from the growing number of elderly incompetent patients who are dying, but who retain some minimal level of consciousness. Part I will discuss the legal bases for the right to refuse medical treatment. It will note the state interests that are contrary to this right, and will review important judicial decisions which have addressed an incompetent individual's right to have life-sustaining treatment withdrawn. Part II will discuss state legislatures' responses to this delicate issue. Part III will focus specifically on the withdrawal of feeding tubes from elderly incompetent, but conscious, patients with severe and permanent mental and physical impairments and a limited life expectancy. Part III will recommend that courts, in determining whether such patients have a right to die, adopt a standard which characterizes artificial nutrition and hydration as a type of life-sustaining medical treatment which may be terminated. The standard adopted should be one which also gives determinative weight to the wishes of the patient or, alternatively, the patient's best interests.

3. Id. at 692.
4. Id.
5. This standard is adapted from a decision of the New Jersey Supreme Court.
The Right to Refuse Medical Treatment

A. The Common Law Basis

The United States Supreme Court recognized an individual's right to bodily integrity nearly 100 years ago in Union Pacific Ry. v. Botsford. The Court upheld a personal injury plaintiff's right to refuse to submit to a medical exam, stating that "[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law." This right to bodily integrity provides the basis for the common law tort doctrine of informed consent. Informed consent requires a physician to give sufficient information to a patient so that he understands his condition, prognosis, and the risks and benefits of alternatives, including no treatment. The doctrine arose in recognition of the value society places on a person's autonomy and as the primary vehicle by which a person can protect the integrity of his body.

If one can consent to treatment, it follows that one can also refuse it. Thus, as a necessary corollary to informed consent, the right to refuse treatment arose. In recent years, many courts have allowed persons to terminate or withhold life-sustaining treatment based on this common law right.

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7. Id. at 251.
8. See Cantor, A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus The Preservation of Life, 26 Rutgers L. Rev. 228, 236-38 (1973).
11. Cruzan, 760 S.W.2d at 417.
12. Id.
13. See, e.g., In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985)(court allowed the withdrawal of nutrition and hydration from incompetent, severely debilitated elderly nursing home patient); In re Peter, 108 N.J. 365, 529 A.2d 419 (1987)(court allowed removal of feeding tube from 65-year-old woman in persistent vegetative state); In re Estate of Longeway, 133 Ill. 2d 33, 549 N.E.2d 292
For example, in 1981, the New York Court of Appeals found the doctrine of informed consent sufficient to warrant termination of life-sustaining treatment in *In re Eichner*. Brother Joseph Fox, a member of the Society of Mary, suffered cardiac arrest during an operation which resulted in severe brain damage and his inability to breathe without a respirator. Fox, a high school teacher, had previously expressed to his students during a formal discussion his desire to have nothing extraordinary done to keep him alive. The court found his common law right to refuse treatment controlling under the circumstances, given the clear and convincing evidence of Fox's desire to forego extraordinary medical treatment.

Other courts have employed a similar rationale in permitting the withdrawal of treatment from incompetent patients. Reasoning that incompetent individuals retain the same rights as those who are competent, many courts have adopted a substituted judgment standard which requires the court to determine what the incompetent individual's decision would have been under the circumstances. Still other courts allow a surrogate decisionmaker, usually a family member, to exercise the right for the incompetent patient.

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14. 52 N.Y.2d 363, 420 N.E.2d 64, 38 N.Y.S.2d 266 (1981), cert. denied, 454 U.S. 858 (1981). In the companion case to *Eichner*, the court reached a different conclusion. There, the mother of a 52-year-old man suffering from bladder cancer who had been severely retarded for most of his life sought to terminate the patient's required blood transfusions. The court refused, reasoning that the patient's life-long incompetency made it unrealistic to attempt to determine whether the patient himself would want to continue the treatment if competent. *In re Storar*, 52 N.Y.2d 380, 420 N.E.2d 72, 438 N.Y.S.2d 275 (1981). But see Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 370 N.E.2d 417 (1977)(relying on both the right of privacy and the right to informed consent to permit the withholding of chemotherapy from a severely retarded 67-year-old man with leukemia).


16. Id. at 372, 420 N.E.2d at 68, 438 N.Y.S.2d at 270.

17. Id. at 380, 420 N.E.2d at 72, 438 N.Y.S.2d at 274.


19. See, e.g., *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987)(court held that family or close friends are entitled to make a substituted judgment for 31-year-old patient in persistent vegetative state regarding patient's desire to have treatment.
B. The Constitutional Right of Privacy

The common law doctrine of informed consent is a strong basis for the right to refuse medical treatment. However, some courts addressing the issue have relied on the constitutional right of privacy to determine that a mechanically maintained incompetent individual has the right to terminate life-sustaining procedures. While some of these courts have based the right on state constitutions, most have relied on the United States Constitution and the decisions of the United States Supreme Court.

The New Jersey Supreme Court was the first to apply a constitutional right of privacy to a decision to terminate life-sustaining treatment. In In re Quinlan, Karen Quinlan suffered severe brain damage as a result of anoxia, and thereafter was kept alive by a respirator and a feeding tube. Her father sought judicial permission to disconnect the respirator. Because Karen was terminal and in a persistent vegetative state, the court found a right of privacy in Karen Quinlan to terminate her life. According to the court, the state's interest in preserving life weakens and "the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims."

The court acknowledged that since Karen was incompetent, she could not indicate whether she would want the treatment continued, nor had she ever expressed prior to her illness any desire to forego life-sustaining treatment. However, the court found that the only way to preserve Karen's privacy right was to permit her...
guardian and family to decide whether Karen would have decided to forego such treatment. Since *Quinlan*, courts addressing the right to terminate the life-prolonging medical treatment of incompetent patients have based a right to refuse treatment either on a constitutional right of privacy, the common law right to informed consent, or on a combination of the two.

C. The State's Interests

A constitutional right to refuse treatment, though widely accepted, is not absolute. The right must be balanced against the state's interests to the contrary. The four state interests commonly identified as being adverse to the right to die are preserving life, preventing suicide, protecting the ethical integrity of the medical profession, and protecting the interests of innocent third parties.

28. Id.

31. Id.
32. Id.
The state's interest in preserving life embraces an interest in prolonging the life of the individual patient and an interest in the sanctity of life itself. However, this interest usually does not overcome the patient's right to terminate treatment. While the interest in preserving life is great when an affliction is curable, it weakens where medical treatment only prolongs the life of a patient whose death would soon occur regardless of any medical treatment. In such cases, "the issue is not whether, but when, for how long, and at what cost to the individual a life may be briefly extended." Prevention of suicide, the second state interest identified, is often thought of as being included within the broader state interest in preserving life. Courts have had little trouble rejecting the argument that exercising the right to terminate life-sustaining treatment is the equivalent of committing suicide. For example, the Quinlan court carefully distinguished an act of self-destruction from one of self-determination. Other courts have widely engaged in a similar analysis, finding that a patient who chooses to have medical treatment withdrawn does not necessarily have a specific intent to die.

The third interest, that of protecting the ethical integrity of the medical profession, has not barred any court from allowing termination of medical treatment. The medical community has recognized that the development of advanced life support techniques complicates the physician's obligation to make every conceivable effort to prolong life. Accordingly, the medical profession acknowledges the necessity of striking a balance between the goals of maintaining biological life and relieving a patient's suffering.

Finally, the state's interest in protecting innocent third parties is implicated when the patient's decision could adversely affect the

33. Id.
36. Comment, supra note 20, at 261.
38. See, e.g., Superintendent of Belchertown State School, 373 Mass. at 743 n.11, 370 N.E.2d at 426 n.11.
39. Comment, supra note 20, at 262.
40. Merritt, supra note 2, at 722.
41. Id.
health, safety, or security of others. Right to die cases rarely involve this issue because the majority of the patients who are involved in decisions to terminate treatment are elderly, with no minor children or other dependents. The patient’s spouse, children or nearest relative is usually the party petitioning for termination of the life-sustaining treatment. Rather than adversely affecting these third parties, withdrawing treatment arguably benefits the patient’s family by alleviating the emotional suffering and financial burden caused by the prolonged death of their loved one.

D. The Cruzan Decision

As previously noted, many courts after Quinlan which permitted the withdrawal from an incompetent patient of mechanical means of life support, based their decisions either partially or entirely on a constitutional right of privacy. Until recently, however, the United States Supreme Court had never squarely faced the issue of whether the right of privacy extends to a decision to refuse medical treatment. In June of 1990, the Supreme Court in Cruzan v. Director, Missouri Dep’t of Health indicated that it does not.

The Cruzan Court held that the United States Constitution does not prohibit a state from requiring that an incompetent person’s wishes as to the withdrawal of life-sustaining treatment be proved by clear and convincing evidence. In so holding, Chief Justice Rehnquist, joined by Justices White, O’Connor, Scalia and Kennedy, stated that “although many state courts have held that a right to refuse treatment is encompassed by a generalized constitutional right of privacy, we have never so held. We believe this issue is more properly analyzed in terms of a fourteenth amendment lib-

43. Merritt, supra note 2, at 723.
44. Id.
45. See supra note 29 and accompanying text.
46. The Supreme Court’s last privacy decision before Cruzan, Bowers v. Hardwick, 478 U.S. 186 (1986), emphasized that the scope of the right of privacy is limited. There, the Court upheld a Georgia statute criminalizing sodomy. The Court found that prior precedent did not justify a finding that homosexual sodomy is constitutionally protected because prior privacy decisions had been limited to issues dealing with the family, marriage or procreation. Bowers, 478 U.S. at 194.
48. Id. at 2854.
The Court emphasized that state courts are able to rely on state constitutions, the common law and state statutes for guidance in determining whether an incompetent individual may refuse medical treatment. It then noted that these sources are not available to the United States Supreme Court where the question is simply whether the United States Constitution prohibits a state - in this case, Missouri - from choosing a particular rule of law.

In choosing its rule, the Supreme Court of Missouri reversed a state trial court's decision authorizing the termination of nutrition and hydration from Nancy Cruzan, a thirty-two year old woman who sustained severe injuries in a 1983 automobile accident which rendered her incompetent. She remains in a Missouri state hospital in a persistent vegetative state. The trial court found that a person in Cruzan's position has a fundamental right under the state and federal constitutions to refuse life-sustaining treatment. The trial court also concluded that Cruzan's conversation with a former housemate suggested that she would not want to continue with her nutrition and hydration. The Missouri Supreme Court, however, read no such privacy right into either the state or federal constitutions. Furthermore, although the court recognized a common law right to refuse treatment, it questioned its applicability in Nancy Cruzan's case. The court decided that Missouri's living will statute embodied a policy strongly favoring the preservation of life, and that Cruzan's statements to her housemate were "unreliable for the purpose of determining her intent." It concluded that no person, including the patient's parents, can assume the choice for an incompetent individual in the absence of a living will or

49. Id. at 2851 n.7.
50. Id. at 2851.
51. Id.
52. Id. at 2846.
53. Id. at 2845. The Court described the term "persistent vegetative state" as "a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function." Id. Medical experts testified at the Missouri trial that Nancy Cruzan could live for another thirty years in this condition. Id.
54. Id. at 2846.
55. Id.
56. Id.
57. Id.
58. Id. (quoting Cruzan v. Harmon, 760 S.W.2d 408, 424 (Mo. 1988) (en banc)).
clear and convincing evidence of the patient’s wishes.  

In upholding the Missouri Supreme Court’s decision, the United States Supreme Court stated that it could be assumed that a competent person would have a constitutionally protected right under the Due Process Clause to refuse lifesaving nutrition and hydration. However the Court emphasized that this does not mean that an incompetent person should possess the same right. The Court also held that, in light of the particularly important individual interests at stake, a state may apply a clear and convincing evidence standard in determining whether a surrogate may act for the patient in electing to withdraw life-sustaining treatment. Here, according to the Court, the Missouri Supreme Court did not err by concluding that such evidence was lacking. Finally, the Court held that the Due Process Clause does not require a state to accept the family member’s substituted judgment absent substantial proof that their views reflect those of the patient’s.

In sum, the long-awaited Supreme Court decision allows a state, if it chooses, to substantially restrict an incompetent individual’s right to have life-sustaining medical intervention terminated, even where some evidence exists that the patient would not want to continue with the treatment. In an emotional dissent, Justice Brennan described Nancy Cruzan as dwelling in a “twilight zone of suspended animation where death commences while life, in some form, continues.” Justice Brennan stated that Cruzan is entitled

59. Id.
60. Id. at 2852.
61. Id. The Court had difficulty with the Cruzans’ assertion that an incompetent person should possess the same Due Process right to refuse lifesaving treatment as is possessed by a competent person. The Court stated that the difficulty with such a claim is that “in a sense it begs the question: an incompetent person is not able to make an informed and voluntary choice to exercise a hypothetical right to refuse treatment or any other right.” Id. The Court then stated that such a right must be exercised for the incompetent person, if at all, by some sort of surrogate, and that the establishment by a state of a procedural safeguard to assure the action of the surrogate conforms to the expressed wishes of the patient is not prohibited by the United States Constitution. Id.
62. Id.
63. Id. at 2855. The testimony presented at the trial consisted primarily of Nancy Cruzan’s statements to her housemate that she would not want to live as a “vegetable,” but did not include any observations expressly dealing with the withdrawal of life-sustaining medical treatment. Id.
64. Id. at 2856.
65. Id. at 2863 (Brennan, J., dissenting) (quoting Rasmussen v. Fleming, 154 Ariz. 207, 211, 741 P.2d 674, 678 (1987)(en banc)).
to choose to die with dignity.\textsuperscript{66} He characterized the clear and convincing evidence standard imposed by the Missouri Supreme Court as an "improperly biased procedural obstacle" which impermissibly burdens an individual's fundamental right to be free of unwanted artificial nutrition and hydration.\textsuperscript{67}

\textbf{THE NATURAL DEATH ACTS}

Courts which have addressed the right to terminate treatment have consistently determined that the key to resolving the question is to ascertain the patient's wishes.\textsuperscript{68} This standard prevails, although the required degree of proof of the patient's desires varies among the jurisdictions. Since the courts consider the patient's choice to be crucial, it is problematic that the patient is nearly always incompetent when the decision to continue or terminate treatment must be made.

State legislatures have responded to this dilemma. Currently, the overwhelming majority of states have adopted some form of a natural death act which, in certain circumstances, allows the withholding or termination of mechanical or artificial means used to prolong a patient's life.\textsuperscript{69} While the acts are not identical, most contain similar provisions.\textsuperscript{70} North Carolina's natural death act\textsuperscript{71} provides that extraordinary means\textsuperscript{72} may be withheld or discontinued by the physician if two conditions are satisfied. First, the pa-

\begin{itemize}
  \item \textsuperscript{66} Id. at 2864.
  \item \textsuperscript{67} Id.
  \item \textsuperscript{68} See supra text accompanying notes 14-19.
  \item \textsuperscript{69} States with natural death acts are: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Carolina, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. See infra notes 78-81 for full citations.
  \item \textsuperscript{70} The basic provisions found in most of the acts are: a set of definitions, a procedure for executing and revoking a living will (many statutes include a form designed to meet the act's requirements), and immunity for health care providers.
  \item \textsuperscript{71} N.C. Gen. Stat. § 90-320 (1985).
  \item \textsuperscript{72} N.C. Gen. Stat. § 90-321(a)(2) (1985) defines "extraordinary means," as "any medical procedure or intervention which in the judgment of the attending physician would serve only to postpone artificially the moment of death by sustaining, restoring, or supplanting a vital function." The act is silent as to whether artificial nutrition and hydration is included in the definition of "extraordinary means."
\end{itemize}
tient must have signed a declaration of a desire for a natural death (commonly referred to as a living will). 73 Second, the patient's present condition must be terminal and incurable. 74 Meeting these conditions qualifies the patient under the Act. North Carolina's Act, unlike most, also provides that in the absence of such a declaration, extraordinary means used to prolong the life of an incompetent patient may still be terminated or withheld. 75 In such cases, the treatment may be terminated or withheld under the supervision of the attending physician and with the concurrence of the person's spouse, guardian or a majority of the relatives of the first degree, in that order. 76 If no relative or guardian is available, the extraordinary means may be withheld at the discretion of the attending physician. 77

Some of the important differences among the natural death acts involve the statutes' definitions of "terminal" and whether supplying food and water to the patient through a tube qualifies as medical treatment which can be refused or withdrawn. Only six states have adopted natural death acts which expressly include nutrition and hydration as a type of treatment that may be withdrawn or withheld in certain circumstances. 78 Sixteen of the natural death acts associate nutrition and hydration with the administration of medication and procedures to provide comfort care and alleviate pain. 79 In twelve states, the question of with-

73. N.C. GEN. STAT. § 90-321(b) (1985).
74. Id.
76. Id.
77. Id.
79. Alabama Natural Death Act, ALA. CODE § 22-8A-1 to -10 (1990); Arizona Medical Treatment Decision Act, ARIZ. REV. STAT. ANN. § 36-3201(4) (1986); Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, ARK. STAT. § 20-17-206(b) (Supp. 1989); California Natural Death Act, CAL. HEALTH & SAFETY CODE §§ 7185-95 (West Supp. 1990); Florida Life-Prolonging Procedure Act, FLA. STAT. ANN. § 765.03(3) (1986); Hawaii Medical Treatment Decisions Act, HAWAII REV. STAT. § 327D-2 (Supp. 1988); Indiana Living Wills and Life-Prolonging Procedures Act, IND. CODE ANN. § 16-8-11-4 (West 1990); Iowa Life Sustaining Procedures Act, IOWA CODE ANN. § 144A.2(5) (West 1989); Maryland Life-Sustaining
drawing nutrition and hydration is not addressed by the language of the statute; thus the matter is left for judicial interpretation.\textsuperscript{80} Six natural death acts expressly exclude nutrition and hydration from the definition of life-sustaining medical treatment which may be terminated.\textsuperscript{81}

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While natural death acts provide the means to relieve a patient's family of the burden of deciding whether to continue with life-sustaining procedures, it must be recognized that they are narrowly drawn. The acts apply only to patients who are in a terminal condition.\textsuperscript{82} And, while the definition of terminal varies among the statutes, many of the acts require that death be imminent or will occur within a short period of time.\textsuperscript{83} Still other acts including North Carolina's, do not define "terminal" at all.\textsuperscript{84}

All of the natural death acts also require the execution of a living will by the patient prior to his incompetency.\textsuperscript{85} The absence of such a document does not create a presumption that the patient desired either the continuance or withdrawal of life-sustaining procedures.\textsuperscript{86} However, like North Carolina, twelve states have enacted statutory surrogate decision making provisions which authorize certain individuals to make treatment decisions on behalf of incompetent patients who otherwise qualify under the act.\textsuperscript{87}

\textbf{The Elderly Incompetent and the Conroy Standard}

Despite the general judicial and legislative acceptance of an incompetent patient's right to terminate medical treatment, some problems remain. First, the current body of case law addressing the issue is limited almost exclusively to patients who are both incompetent and either brain dead, comatose or in a persistent vege-

\textsuperscript{82} Comment, supra note 20, at 247.
\textsuperscript{83} \textit{Id.} at 248.
\textsuperscript{84} N.C. GEN. STAT. § 90-321(a) (1985) provides a list of definitions for terms used in the act. Definitions of "declarant," "extraordinary means," and "physician" are the only terms for which statutory definitions are provided. Section 90-321(b) provides that if a person has declared a desire that his life not be prolonged by extraordinary means and it is determined by the declarant's attending physician and one other physician that the declarant's condition is terminal and incurable, then extraordinary means may be withheld. However, the statute in no way attempts to define either "terminal" or "incurable."
\textsuperscript{85} \textit{See supra} notes 78-81.
\textsuperscript{86} Comment, supra note 20, at 256.
\textsuperscript{87} In addition to North Carolina, the states are: Arkansas, Connecticut, Florida, Iowa, Louisiana, New Mexico, Oregon, Texas, Utah, Virginia, and the District of Columbia. \textit{See supra} notes 78-81 for full citations to these statutes.
tative state. Incompetent patients who retain a minimal level of consciousness have been the subject of few reported decisions, despite the fact that patients in this category are increasingly becoming involved in decisions to terminate treatment. Second, the natural death acts set forth strict requirements for patients attempting to qualify for the right to terminate life-prolonging procedures. Finally, as previously noted, there remains a question regarding whether mechanically supplied nutrition and hydration is a type of medical treatment that may be terminated.

As a result of these gaps in the law, the legal community has overlooked a significant number of elderly incompetent patients with regard to their right to die. The following discussion will focus on the withdrawal of nutrition and hydration from elderly incompetent patients. In particular, it will focus on patients who have severe and permanent mental and physical impairments and a limited life expectancy, but who remain minimally conscious.

A. The Conroy Decision

The New Jersey Supreme Court in In re Conroy extensively discussed the legal, ethical and social policy implications of its decision to extend the right to refuse treatment to the special class of elderly incompetent, but conscious patients. The decision is justified, and should be followed by those courts which will face the same question.


89. Unquestionably, the key decision addressing the ramifications of extending the right to die to this class of individuals is In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985), discussed extensively in this Comment.

90. See supra Part II.
91. See supra text accompanying notes 78-81.
92. It is estimated that there are nearly 55,000 nursing home patients receiving tube feeding at any given time, many of whom are minimally conscious. See U.S. CONGRESS, OFFICE OF TECHNOLOGY ASSESSMENT, LIFE SUSTAINING TECHNOLOGIES AND THE ELDERLY 297 (1987).
94. Courts facing this issue should not be restricted by the United States Supreme Court's recent "right to die" opinion, Cruzan v. Director, Mo. Dep't of Health, ___ U.S. ___, 110 S. Ct. 2841 (1990) (discussed in Part I of this Com-
Claire Conroy, an adjudicated incompetent, was an 84-year-old nursing home patient who suffered from numerous severe mental and physical ailments. All of Claire’s illnesses were incurable, and her doctor had predicted that she would live for only a few months. Still, Claire was marginally aware of her environment. She was not brain dead, comatose, or in a persistent vegetative state. For this reason, her doctor did not think that it would be “acceptable medical practice” to remove the nasogastric feeding tube that supplied her with water and nutrients. Claire’s nephew, her guardian, sought judicial permission to have the tube removed.

The trial court granted the request, and the appellate court reversed on two grounds. First, the court held that the right to terminate life-sustaining treatment based on a guardian’s substituted judgment is limited to “incurable and terminally ill patients who are brain dead, irreversibly comatose, or vegetative.” Second, the court found that nutrition is not an artificial life-sustaining device and therefore should not be withdrawn.

The New Jersey Supreme Court reversed the appellate court. The court acknowledged the distinction between vegetative patients like Karen Quinlan and those who are awake and con-
scious, like Claire.\textsuperscript{105} It stated that the capacities of those who are awake and conscious, while significantly diminished, are not as limited as those of irreversibly comatose persons, and that their deaths, while no longer distant, may not be imminent.\textsuperscript{106} Nevertheless, the court placed those like Claire Conroy in the same category as other incompetent patients with regard to their inability to speak for themselves on life and death issues concerning their medical care.\textsuperscript{107} This inability, the court said, does not mean that such patients lack a right to self-determination.\textsuperscript{108} While the court recognized that a federal right of privacy might apply in this case, it instead based its decision to allow the withdrawal of Claire Conroy's feeding tube on the common law right to self-determination and informed consent.\textsuperscript{109} According to the court, a guardian can assert an incompetent individual's right to refuse medical treatment if one of three tests is satisfied: the subjective test, the limited-objective test, or the pure-objective test.\textsuperscript{110}

1. The Subjective Test

Under the subjective test, life-sustaining treatment may be withheld or withdrawn from an incompetent patient when it is clear that the particular patient would have refused the treatment under the circumstances involved.\textsuperscript{111} The question is not what a reasonable or average person would have chosen to do under the circumstances, but what the particular patient would have done if able to choose for himself.\textsuperscript{112} Relevant evidence of a patient's intent not to continue life-sustaining medical intervention includes written documents such as a living will or durable power of attorney,\textsuperscript{113} oral directives given

\textsuperscript{105} Id. at 359, 486 A.2d at 1228-29.
\textsuperscript{106} Id.
\textsuperscript{107} Id.
\textsuperscript{108} Id.
\textsuperscript{109} Id. at 360, 486 A.2d at 1229.
\textsuperscript{110} Id. at 360-67, 486 A.2d at 1229-32.
\textsuperscript{111} Id. at 360, 486 A.2d. at 1229.
\textsuperscript{112} Id. at 360-61, 486 A.2d at 1229.
to a family member, friend, or health care provider, reactions to the treatment of others, the patient's religious beliefs, or a pattern of the patient's conduct with regard to prior decisions about his own medical care.\textsuperscript{114} "The probative value of such evidence may vary depending on the specificity, remoteness, consistency, and thoughtfulness of the prior statements or actions and the maturity of the person at the time of the statements or acts."\textsuperscript{115}

Medical evidence bearing on the patient's condition, treatment, and prognosis is also required under the subjective test.\textsuperscript{116} The medical evidence must establish that the individual is an elderly incompetent nursing-home\textsuperscript{117} patient with severe and permanent mental and physical ailments and a life expectancy of one year or less.\textsuperscript{118}

Often, the subjective test cannot be met because there is inadequate proof to clearly establish the patient's intent either to accept or reject the life-sustaining treatment.\textsuperscript{119} In such cases, "it is naive to pretend that the right to self-determination serves as the basis for substituted decision making."\textsuperscript{120} However, the possibility

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\textsuperscript{115} Id. at 362, 486 A.2d at 1230.

\textsuperscript{116} Id. at 363, 486 A.2d at 1231.

\textsuperscript{117} The court's rationale for narrowing its decision to nursing-home patients is that these individuals are particularly vulnerable, often have no surviving immediate family members, receive limited attention from physicians, and are residents of institutions which suffer from "peculiar industry-wide problems to which hospitals are less prone." \textit{See Conroy}, 98 N.J. at 374-77, 486 A.2d at 1237-38. In a trilogy of cases after \textit{Conroy}, the New Jersey Supreme Court emphasized that the analysis used in \textit{Conroy} was limited to elderly incompetent patients with a limited life expectancy, and established alternative approaches for dealing with different types of patients. \textit{See In re Farrell}, 108 N.J. 335, 529 A.2d 404 (1987)(37-year-old terminally ill woman's right to removal of respirator based on common law and constitutional principles); \textit{In re Peter}, 108 N.J. 365, 529 A.2d 419 (1987)(65-year-old woman in persistent vegetative state had right to removal of feeding tube based on the clear and convincing proof of her intent to have treatment withdrawn); \textit{In re Jobes}, 108 N.J. 394, 529 A.2d 434 (1987)(31-year-old woman in persistent vegetative state entitled to have feeding tube removed because, under \textit{Quinlan}, family or close friends allowed to make substituted judgment for patient).

\textsuperscript{118} \textit{Conroy}, 98 N.J. at 363, 486 A.2d at 1231.

\textsuperscript{119} Id. at 364, 486 A.2d at 1231.

\textsuperscript{120} Id.
of humane actions, which may involve the termination of life-sustaining treatment, should not be foreclosed for persons who never clearly expressed their desires about such treatment, but who are now suffering a prolonged and painful death.\footnote{121} The state’s \textit{parens patriae} power permits it to authorize guardians to terminate treatment if it would further the patient’s best interest.\footnote{122} Both the limited-objective and the pure-objective tests involve a “best interests” standard.

2. \textit{The Limited-Objective Test}

Under the limited-objective test, life-sustaining treatment may be terminated from a patient in Claire Conroy’s condition when two conditions are met. First, there must be some trustworthy evidence that the patient would have refused the treatment.\footnote{123} Second, the decision-maker must be satisfied that the burdens of the patient’s continued life with the treatment clearly outweigh the benefits of that life for him.\footnote{124} Thus, this test requires that there be some evidence, though not of the formal nature required under the subjective test, that the patient would have wanted the treatment terminated and that the patient is suffering.\footnote{125}

3. \textit{The Pure-Objective Test}

When there is absolutely no evidence of the patient’s desire to have life-sustaining treatment terminated, the test simply focuses on whether the patient is suffering.\footnote{126} This pure-objective test, however, requires a higher degree of suffering than the limited-objective test.\footnote{127} “The recurring, unavoidable and severe pain of the patient’s life with the treatment should be such that the effect of administering life-sustaining treatment would be inhumane.”\footnote{128} It must be emphasized that this test does not authorize decisions based on assessments of the personal worth or social utility of the patient’s life, or the value of his life to others.\footnote{129} Thus, a quality of

\begin{itemize}
\item \footnote{121} Id.
\item \footnote{122} Id. at 364-65, 486 A.2d at 1231-32.
\item \footnote{123} Id. at 365, 486 A.2d at 1232.
\item \footnote{124} Id.
\item \footnote{125} Id.
\item \footnote{126} Id. at 366, 486 A.2d at 1232.
\item \footnote{127} Id.
\item \footnote{128} Id.
\item \footnote{129} Id.
\end{itemize}
life assessment is impermissible.

4. Type of Treatment

The Conroy court rejected certain distinctions that had been drawn by prior courts in right to die cases. For example, the court refused to find controlling any distinction between hastening death by terminating treatment and passively allowing a person to die of a disease.\textsuperscript{130} The court also refused to distinguish withholding versus withdrawing life-sustaining treatment,\textsuperscript{131} and ordinary versus extraordinary forms of treatment.\textsuperscript{132} In particular, the court saw no significant distinction between the termination of artificial feedings and the termination of other forms of life-sustaining medical treatment.\textsuperscript{133} Each of the three Conroy tests primarily focuses on the patient's wishes and the experience of pain - not the type of treatment involved.\textsuperscript{134}

The Conroy court acknowledged the emotional significance attached to feeding, but saw a clear difference between artificial feedings and bottle-feeding or spoon-feeding.\textsuperscript{135} It noted that feeding an incompetent patient through a tube is a "medical procedure with inherent risks and possible side effects, instituted by skilled health-care providers to compensate for impaired physical functioning."\textsuperscript{136} In the court's view, feeding a patient by means of a

\textsuperscript{130}. \textit{Id.} at 369, 486 A.2d at 1233-34. The court characterized the distinction as "one of limited use in a legal analysis of such a decision-making situation." \textit{Id.} at 369, 486 A.2d at 1234. The court emphasized that the distinction is "particularly nebulous" in the context of decisions regarding the withholding or withdrawal of artificial sustenance. \textit{Id.} For example, the court asked whether a physician who discontinued tube feeding would be actively causing death by removing the patient's primary source of nutrients, or merely passively allowing the patient's medical condition to take its natural course. \textit{Id.}

\textsuperscript{131}. \textit{Id.} at 369, 486 A.2d at 1234. The court stated that "whether necessary treatment is withheld at the outset or withdrawn later on, the consequence—the patient's death—is the same." \textit{Id.} at 370, 486 A.2d at 1234. It then noted that from a policy standpoint, it would be unwise to prohibit the termination of treatment under circumstances in which the same treatment could have been permissibly withheld since such a rule might encourage premature decisions to allow a patient to die. \textit{Id.}

\textsuperscript{132}. \textit{Id.} at 370, 486 A.2d at 1234. The court stated that the terms "ordinary" and "extraordinary" have too many conflicting meanings to be useful in determining whether treatment should be given. \textit{Id.} at 371, 486 A.2d at 1236.

\textsuperscript{133}. \textit{Id.} at 372, 486 A.2d at 1236.

\textsuperscript{134}. \textit{Id.} at 369, 486 A.2d at 1233.

\textsuperscript{135}. \textit{Id.} at 372-73, 486 A.2d at 1236.

\textsuperscript{136}. \textit{Id.} at 373, 486 A.2d at 1236.
nasogastric tube is equivalent to a patient breathing by means of a respirator, since "both prolong life through mechanical means when the body can no longer perform a vital bodily function on its own." 137

Other jurisdictions faced with the nutrition and hydration question have engaged in a similar analysis to conclude that such treatment may be terminated. 138 Moreover, the United States Supreme Court in Cruzan implied that artificial nutrition and hydration is a type of life-sustaining medical intervention that may be terminated in the appropriate circumstances. The Court held only that a state may apply a clear and convincing evidence standard in proceedings where a guardian seeks to discontinue nutrition and hydration from a person in a persistent vegetative state. 139 The Cruzan court did not in any way distinguish nutrition and hydration from other forms of lifesaving medical treatment, and expressly stated that a competent person would hold a constitutionally protected right to refuse this particular type of treatment. 140

Furthermore, Justice O'Connor, in a concurring opinion, quite clearly indicated that artificial nutrition and hydration should be classified with other mechanical life-prolonging medical procedures. She stated that providing artificial sustenance implicates concerns identical to those raised when the state attempts any type of forced invasion into the body. 141 Explaining that "[a]rtificial feeding cannot readily be distinguished from other forms of medical treatment," Justice O'Connor provided a graphic, step-by-step description of the procedures used by medical personnel to insert nasogastric and gastrostomy tubes. 142 She then stated:

Requiring a competent adult to endure such procedures against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment. Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water. 143

137. Id.
138. See supra note 75 and accompanying text.
140. Id. at 2852.
141. Id. at 2857 (O'Connor, J., concurring).
142. Id.
143. Id.
Thus, both the majority opinion, and in particular, the concurring opinion of Justice O'Connor strongly indicate that if the Court were squarely faced with the issue, it would characterize artificial nutrition and hydration as a type of lifesaving medical treatment which may be withdrawn from a patient who otherwise qualifies under the state's law.

B. Justification For the Conroy Decision

A decision allowing the withdrawal of artificial nutrition and hydration from an incompetent, severely debilitated elderly patient with no hope of recovery, but who is not terminal or comatose as defined by state law, is both legally and ethically justified. Such a decision is legally justified because it is based on well established common law rights and because none of the countervailing state interests sufficiently outweigh the patient's right to refuse such treatment. The state's interests do not overcome the patient's right when the patient's death is no longer distant and life-sustaining medical procedures only serve to prolong the dying process.

Likewise, allowing the termination of treatment from the class of elderly patients discussed herein is ethically justified when the patient satisfies one of the three Conroy tests. Extending the right to die to these patients is based on the belief that unnecessarily prolonging the dying process when there is no hope of recovery is degrading and incompatible with respect for human dignity. It is not based on the notion that a dying elderly patient's life is worth less than the suffering of and burden on his family, or on arbitrary quality of life judgments.

If the standard set forth in Conroy is to be criticized at all, such criticism should focus on the difficulty that patients will likely encounter in meeting one of the three tests. Undeniably, the subjective test will apply to few patients, since unequivocal evidence of a patient's desire to have life-sustaining treatment terminated is only infrequently available. However, the heightened fo-
cus on right to die issues in recent years, coupled with the states' wide acceptance of living wills, should prompt a greater percentage of the population to formally document personal wishes with regard to the termination of treatment. Formal documentation should meet even the most stringent evidentiary requirements.

The majority of elderly incompetent patients are more likely to fall into one of the remaining Conroy categories — those encompassed by the limited-objective and pure-objective tests. That is, there will either be only informal evidence of their preferences regarding the withdrawal of life-sustaining treatment, or more likely, there will be no evidence available at all. In these circumstances, particularly the latter, the focus will be on the patient's suffering. Critics may argue that such a focus is too narrow — that the application of these tests will not lead to a more humane, dignified and decent end for patients because it is too difficult to prove that they experience pain.

Yet, a standard which does not give determinative weight to the element of personal pain when there is no clear evidence of the patient's wishes creates intolerable risks for the elderly. Such a standard is likely to encourage familial abuse. First, it provides family members the opportunity to succumb to the temptation of receiving their share of the estate more quickly. Second, such a standard allows families to easily relieve themselves of the tremendous expense of hospital or nursing home care. It also risks hastening the death of a pain-free patient who would prefer to have the life-sustaining procedures continued for as long as possible. As the court in Conroy noted, "[W]hen evidence of a person's wishes is equivocal, it is best to err, if at all, in favor of preserving life."

CONCLUSION

Mary and Edward Smith's dilemma could be resolved in a jurisdiction applying the Conroy standard. Edward would most likely meet the limited-objective test, since he had previously informally discussed his desire not to be kept alive by life-sustaining medical procedures, and since he appears to be experiencing a great deal of pain.

Using the safeguards inherent in the three Conroy tests, those jurisdictions that will eventually face the issue should extend the

148. See text accompanying notes 69-87.
149. See supra text accompanying notes 122-28.
right to die to elderly incompetent patients who retain a minimal level of conscious activity. In determining if such a patient's treatment may be terminated, the court should first look for clear evidence of the patient's intent not to have life-sustaining medical procedures continued, and should be bound by such evidence. In the alternative, the court should apply a balancing test to determine the patient's best interests. Application of the Conroy standard preserves a patient's right to bodily self-determination, even if he is incompetent at the time the decision to terminate treatment must be made. Perhaps more importantly, it also serves the important social goal of ensuring that the elderly incompetent are allowed to die with dignity.

Cary C. Homes